

CARE Registry™
Carotid Artery Revascularization and Endarterectomy Registry v1.09
Data Dictionary - Elements and Definitions
Carotid Artery Stenting Dataset

A. Participant Administration

Field Name: Participant ID

Seq No: 1000

Definition: Participant ID is a unique number assigned to each database Participant by the NCDR. A database Participant is defined as one entity that signs a Participation Agreement with the NCDR, submits one data submission file to the harvest, and gets back one report on their data.

Each Participant's data if submitted to harvest must be in one data submission file. If one Participant keeps their data in more than one file (e.g. at two sites), then the data must be combined into a single data submission file for the harvest. If two or more Participants share a single purchased software, and enter cases into one database, then the data must be exported into different data submission files, one for each Participant ID.

Field Name: Participant Name

Seq No: 1010

Definition: Indicate the full name of the facility where the procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling.

Field Name: Medicare Provider Number

Seq No: 1015

Definition: Indicate the participant's Medicare Provider Number. This number, assigned by the Center for Medicare and Medicaid Services (CMS), is used to uniquely identify facilities for Medicare billing purposes.

As part of the HIPAA mandate requiring a standard unique identifier for health care providers, the Medicare Provider Number will be replaced with the new National Provider Identifier (NPI).

Field Name: Participant NPI

Seq No: 1016

Definition: Indicate the participant's National Provider Identifier (NPI). This number, assigned by the Center for Medicare and Medicaid Services (CMS), is used to uniquely identify facilities for Medicare billing purposes.

As part of the HIPAA mandate requiring a standard unique identifier for health care providers, the Participant NPI will replace the participant's Medicare Provider Number.

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B. Demographics

Field Name: Patient Last Name

Seq No: 2000

Definition: Indicate the patient's last name.

Field Name: Patient First Name

Seq No: 2010

Definition: Indicate the patient's first name.

Field Name: Patient Middle Name

Seq No: 2020

Definition: Indicate the patient's middle name.

Field Name: Patient SSN

Seq No: 2030

Definition: Indicate the patient's United States Social Security Number (SSN). If the patient does not have a US SSN, leave blank and check 'No SSN'.

Field Name: No SSN

Seq No: 2031

Definition: Indicate if the patient does not have a United States Social Security Number.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Unique Patient ID

Seq No: 2040

Definition: A unique number created and automatically inserted by the software that uniquely identifies each patient. Once assigned to a patient at the participating facility, this number will never be changed or reassigned to a different patient. If the patient returns to the same participating facility or for follow-up, they will receive this same unique patient identifier.

Field Name: Other ID

Seq No: 2045

Definition: An optional patient identifier, such as medical record number, that can be associated with the patient.

Field Name: Health Insurance Claim Number

Seq No: 2046

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Definition: The Health Insurance Claim (HIC) Number is the unique identifier issued to all Medicare eligible beneficiaries by either the Social Security Administration (SSA) or the Centers for Medicare and Medicaid Services (CMS).

Field Name: No Health Insurance Claim Number

Seq No: 2047

Definition: Indicate if the patient does not have a Health Insurance Claim Number.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Date of Birth

Seq No: 2050

Definition: Indicate the patient's date of birth.

Field Name: Sex

Seq No: 2060

Definition: Indicate the patient's sex at birth.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Male	
2	Female	

Field Name: Race

Seq No: 2070

Definition: Indicate the patient's race as determined by the patient/family.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	White	
2	Black/African American	
4	Asian	
5	American Indian/Alaskan Native	
6	Native Hawaiian/Pacific Islander	
7	Other	

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Field Name: Hispanic Ethnicity

Seq No: 2076

Definition: Indicate if the patient is of Hispanic ethnicity as determined by the patient/family. Hispanic ethnicity includes patient reports of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Auxiliary 1

Seq No: 2110

Definition: Reserved for future use.

Field Name: Auxiliary 2

Seq No: 2120

Definition: Reserved for future use.

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C. Admission

Field Name: Admission Date

Seq No: 3000

Definition: Indicate the date the patient is admitted to the facility for the current procedure.

Field Name: Patient Zip Code

Seq No: 3005

Definition: Indicate the patient's United States Postal Service zip code of their primary residence. If the patient does not have a US residence, or is homeless, leave blank and check 'No Zip Code'.

Field Name: No Patient Zip Code

Seq No: 3006

Definition: Indicate if the patient does not have a United States Postal Service zip code. This includes patients that do not have a US residence or are homeless.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Insurance Payors

Seq No: 3010

Definition: Indicate the appropriate description of the patient's insurance carrier(s). If the patient has more than one, choose all that apply.

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Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Medicare	A federal health-care plan that reimburses hospitals and physicians for medical care provided to qualifying people over 65 years old, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
2	Medicaid	Any state and federal health-care program that reimburses hospitals and physicians for providing care to qualifying people who cannot finance their own medical expenses.
3	Commercial	Any health insurance provided by a commercial plan, regardless of the type of restrictions or payment arrangements. This includes managed care plans such as HMOs, PPOs, POSs, and IPAs.
4	Military/VAMC	Refers to any military or Veteran's Administration Health Plans.
5	Non-U.S. Insurance	Refers to individuals who reside in and have health insurance in another country.
6	Self/None	Refers to situations when the individual is the sole payor regardless of his/her ability to pay. Check this choice only when "self" or "none" is listed as the first insurance in the medical record.

Field Name: Auxiliary 3

Seq No: 3110

Definition: Reserved for future use.

Field Name: Auxiliary 4

Seq No: 3120

Definition: Reserved for future use.

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D. History and Risk Factors

Field Name: Height

Seq No: 4000

Definition: Indicate the patient's height in centimeters.

Field Name: Weight

Seq No: 4005

Definition: Indicate the patient's weight in kilograms.

Field Name: Preprocedure Creatinine Level Assessed

Seq No: 4010

Definition: Indicate if the patient's serum creatinine level was assessed within 3 months prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Preprocedure Creatinine Level

Seq No: 4011

Definition: Indicate the patient's most recent serum creatinine level (within 3 months prior to the current procedure) in milligrams per deciliter (mg/dL).

Field Name: Currently On Dialysis

Seq No: 4015

Definition: Indicate if, prior to the current procedure, the patient has been receiving dialysis as a result of renal failure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Tobacco History

Seq No: 4020

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Definition: Indicate if, prior to the current procedure, the patient confirms a history of any form of tobacco use either currently or in the past. This includes cigarettes, cigars, tobacco chew, or pipe smoking.

Note: even an occasional cigarette or puff on a cigarette within 30 days qualifies as current tobacco use.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Current	Use of tobacco within one month of this admission.
2	Former	Stopped using tobacco greater than one month prior to this admission.
3	Never	Never used tobacco products.

Field Name: Hypertension

Seq No: 4025

Definition: Indicate if, prior to the current procedure, the patient has a history of hypertension. Hypertension is defined by any one of the following:

1. History of hypertension diagnosed and treated with medication, diet and/or exercise
2. Blood pressure greater than 140 mmHg systolic or 90 mmHg diastolic on at least two occasions
3. Currently on antihypertensive pharmacologic therapy

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Dyslipidemia

Seq No: 4030

Definition: Indicate if, prior to the current procedure, the patient has been diagnosed with dyslipidemia and/or is currently being treated with lipid lowering agents. Additionally, for those not previously diagnosed or treated, fulfillment of National Cholesterol Education Program criteria qualifies for dyslipidemia. These criteria include documentation of the following:

1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or
2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37 mmol/l) (note: in patients with known coronary artery disease, if LDL is greater than 100 mg/dL (2.59 mmol/l) this would qualify as dyslipidemia); or
3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Peripheral Arterial Disease

Seq No: 4035

Definition: Indicate if the patient has a history of peripheral arterial disease prior to the current procedure. Peripheral arterial disease is characterized by any of the following:

1. Claudication, either with exertion or at rest
2. Amputation for arterial vascular insufficiency
3. Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities
4. Documented aortic aneurysm
5. Positive noninvasive test (e.g., ankle brachial index less than 0.8)

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Diabetes Mellitus

Seq No: 4040

Definition: Indicate if the patient has a history of diabetes (regardless of duration of disease or need for antidiabetic agents) or a fasting blood sugar greater than 7 mmol/l or 126 mg/dL. This includes diagnosis on admission or prior to the current procedure. It does not include gestational diabetes.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Chronic Lung Disease

Seq No: 4045

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Definition: Indicate if the patient has a history of chronic lung disease (e.g., chronic obstructive pulmonary disease, chronic bronchitis, emphysema) or is currently being chronically treated with inhaled or oral pharmacological therapy (e.g., beta-adrenergic agonist, anti-inflammatory agent, leukotriene receptor antagonist, or steroid) on admission or prior to the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Home O2 Therapy

Seq No: 4046

Definition: Indicate if, prior to the current procedure, the patient has been receiving home oxygen therapy for treatment of chronic lung disease.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Major Surgery Planned w/in Next 8 Weeks

Seq No: 4050

Definition: Indicate if the patient is receiving carotid revascularization in preparation for a major surgical procedure. Indicate "Yes" only if the surgical procedure will take place within eight weeks following the carotid revascularization.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Type of Major Surgery

Seq No: 4051

Definition: Indicate the type of major surgical procedure scheduled within eight weeks after the current admission. If more than one major surgery is scheduled, choose the type of surgery that is scheduled to be completed first.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Cardiac	
2	Vascular	
3	Other	

Field Name: Previous Neck Radiation

Seq No: 4055

Definition: Indicate if the patient had previous x-ray therapy to the neck prior to the current admission or prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Previous Neck Surgery

Seq No: 4060

Definition: Indicate if the patient had a previous extensive (i.e., radical) neck dissection (other than carotid endarterectomy [CEA]) prior to the current admission or prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Tracheostomy Present

Seq No: 4065

Definition: Indicate if the patient has an open tracheostomy, at the time of the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Previous Laryngeal Nerve Palsy

Seq No: 4070

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Definition: Indicate if the patient has a history of laryngeal nerve palsy, defined as paralysis of the larynx caused by damage to the recurrent laryngeal nerve or its parent nerve, the vagus nerve, prior to the current procedure. Indicate the location of the laryngeal nerve palsy, either right or left.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	No Laryngeal Nerve Palsy.
1	Yes - Right	Laryngeal Nerve Palsy located on right side of the neck.
2	Yes - Left	Laryngeal Nerve Palsy located on the left side of the neck.

Field Name: Ischemic Heart Disease

Seq No: 4200

Definition: Indicate if the patient has a history of ischemic heart disease prior to the index procedure evidenced by any one of the following:

1. Acute myocardial infarction (≤ 7 days) manifested as a rise and fall of cardiac biomarkers (preferable troponin) with at least one of the values above the range of normal for your laboratory [above the 99th percentile of the upper reference limit (URL)] together with evidence of myocardial ischemia with at least one of the following:
 - a. ischemic symptoms;
 - b. ECG changes indicative of new ischemia (new ST-T changes or new left bundle branch block),
 - c. Development of pathological Q waves in the ECG;
 - d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
2. Prior myocardial infarction (> 7 days) manifested by
 - a. A myocardial infarction meeting the criteria of an acute MI, as documented in the medical record, or
 - b. By either of the following:
 1. Development of new pathological Q waves with or without symptoms.
 2. Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.
3. History of Percutaneous Coronary Angioplasty;
4. History of Coronary Artery Bypass Graft Surgery;
5. Conventional coronary angiography demonstrates $\geq 50\%$ stenosis in at least one major coronary artery (i.e., findings on CT angiography, EBCT, or MR angiography are insufficient to make the diagnosis of angiographically-confirmed CAD).

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Two or More Major Coronary Arteries with Stenosis >= 70% (LAD, LCX, RCA)

Seq No: 4202

Definition: Indicate if the patient has a history of two or more major coronary arteries stenosis greater than or equal to 70% prior to the current procedure. Major Coronary Arteries are defined as Left Anterior Descending (LAD), Left Circumflex Artery (LCX) and Right Coronary Artery (RCA). This does not include collaterals.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: MI w/in 6 weeks

Seq No: 4205

Definition: Indicate if the patient had a myocardial infarction (MI) within 6 weeks prior to the index procedure as evidenced by the following:

1. Acute myocardial infarction (<=7 days) manifested as a rise and fall of cardiac biomarkers (preferable troponin) with at least one of the values above the range of normal for your laboratory [above the 99th percentile of the upper reference limit (URL)] together with evidence of myocardial ischemia with at least one of the following:
 - a. ischemic symptoms;
 - b. ECG changes indicative of new ischemia (new ST-T changes or new left bundle branch block),
 - c. Development of pathological Q waves in the ECG;
 - d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
2. Prior myocardial infarction (>7 days) manifested by
 - a. A myocardial infarction meeting the criteria of an acute MI, as documented in the medical record, or
 - b. By either of the following:
 1. Development of new pathological Q waves with or without symptoms.
 2. Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Angina CCS Class III or IV w/in 6 Weeks

Seq No: 4210

Definition: Indicate if the patient experienced anginal symptoms equivalent to the Canadian Cardiovascular Society (CCS) Classification System Class III or IV within 6 weeks prior to the procedure.

CCS Class III or Class IV are defined as:

Class III: Marked limitation of ordinary activity; for example, angina occurs walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace.

Class IV: Inability to carry on any physical activity without discomfort - angina syndrome may be present at rest.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	No anginal pain when at rest or with minimal exertion in the 6 weeks prior to the current procedure.
	1	Yes	Anginal pain when at rest or with minimal exertion in the 6 weeks prior to the current procedure.

Field Name: History of Heart Failure

Seq No: 4215

Definition: Indicate if the patient has a history of heart failure (systolic, diastolic, or both) documented in the medical record prior to the current procedure.

The following signs and symptoms support a diagnosis of heart failure:

1. Paroxysmal nocturnal dyspnea (PND)
2. Dyspnea on exertion (DOE) due to heart failure
3. Chest X-Ray (CXR) showing pulmonary congestion
4. Pedal edema or dyspnea treated with medical therapy for heart failure

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: NYHA Functional Class III or IV w/in 6 Weeks

Seq No: 4220

Definition: Indicate if the patient's highest New York Heart Association (NYHA) cardiac functional class has been Class III or IV anytime within 6 weeks prior to the current procedure. Patients with NYHA Class III and Class IV have anginal or heart failure symptoms, at rest, and/or resulting in marked limitation of physical activity. Class III and Class IV are formally defined as:

- Class III: Patient has cardiac disease resulting in marked limitation of physical activity. Patient is comfortable at rest. However, less than ordinary physical activity (e.g., walking one to two level blocks or climbing one flight of stairs) causes fatigue, palpitations, dyspnea, or anginal pain.
- Class IV: Patient has dyspnea at rest that increases with any physical activity. Patient has cardiac disease resulting in inability to perform any physical activity without discomfort. Symptoms may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Note: for patients without cardiac disease or patients with NYHA Class I or II, code No.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Ejection Fraction Assessed

Seq No: 4225

Definition: Indicate whether the left ventricular ejection fraction was assessed prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Most Recent LVEF%

Seq No: 4226

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Definition: Indicate the patient's most recent left ventricular ejection fraction (LVEF) as measured prior to the current procedure. The Ejection Fraction percent is the percentage of blood that has emptied from the ventricle at the end of the contraction. Use the most recent determination during or prior to intervention. Enter a percentage in the range of 01-99.

Field Name: History of Atrial Fibrillation or Flutter

Seq No: 4230

Definition: Indicate if the patient has a history of atrial fibrillation or atrial flutter at any time prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Left Main Coronary Artery Stenosis >= 50%

Seq No: 4232

Definition: Indicate if the patient has a history of Left Main Coronary Artery stenosis greater than or equal to 50% prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Moderate to Severe Aortic Stenosis

Seq No: 4235

Definition: Indicate if, prior to the current procedure, the most recent assessment of the aortic valve demonstrated moderate to severe stenosis (i.e., valve area ≤ 1.0 cm²). If the severity of stenosis is not known or if the valve is merely sclerotic, answer "No."

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Moderate to Severe Mitral Stenosis

Seq No: 4240

Definition: Indicate if, prior to the current procedure, the most recent assessment of the mitral valve demonstrated moderate to severe stenosis (i.e., valve area ≤ 1.5 cm² and/or MV gradient ≤ 5 mm Hg). If severity of stenosis is not known, answer "No."

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Mechanical Aortic or Mitral Valve

Seq No: 4245

Definition: Indicate if the patient has a history of open surgical or percutaneous valve replacement with a mechanical mitral or aortic valve. If the patient has received a biological (e.g. tissue) valve, had surgical valve repair (without valve replacement), or undergone percutaneous valve modification (including valvuloplasty, mitral annular remodeling, or mitral valve clipping/suturing), without mechanical valve replacement, code "No".

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Permanent Pacemaker or ICD

Seq No: 4250

Definition: Indicate if the patient has a permanent pacemaker or implantable cardioverter defibrillator (ICD) prior to admission or prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: ASA Grade

Seq No: 4255

Definition: Indicate the patient's level of fitness to undergo an anesthetic using the American Society of Anesthesiologists (ASA) grading system, prior to the current procedure.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	1	I	Normal healthy individual.
	2	II	Mild systematic disease that limits activity, but is not incapacitating.
	3	III	Severe systematic disease that limits activity, but is not incapacitating.
	4	IV	Incapacitating systematic disease that is constantly life threatening.
	5	V	Moribund, not expected to survive 24 hours with or without surgery.

Field Name: Dementia or Alzheimer's Disease

Seq No: 4300

Definition: Indicate if the patient has a history of dementia or Alzheimer's Disease, with global deterioration of intellectual or cognitive function as indicated in the medical record.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: History of Seizure or Known Seizure Disorder

Seq No: 4305

Definition: Indicate if the patient has a history of a seizure disorder as indicated in the medical record, or characterized by at least two unprovoked seizures that occurred at different times (excluding febrile seizures) on admission or prior to the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Previous Carotid Intervention

Seq No: 4310

Definition: Indicate if the patient had a previous carotid endarterectomy or carotid artery angioplasty or carotid stent procedure. The event may have occurred either prior to this admission, or during this admission prior to the current procedure. If there was more than one procedure (i.e. more than one carotid artery stent procedure on the right carotid artery), code the most recent occurrence for each intervention.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Previous Right CEA Timeframe

Seq No: 4311

Definition: Indicate the timeframe of the most recent carotid endarterectomy (CEA) for the right side, prior to the current procedure

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days Ago	
2	Yes, 31-180 Days Ago	
3	Yes, >= 181 Days Ago	

Field Name: Previous Right CAS Timeframe

Seq No: 4312

Definition: Indicate the timeframe of the most recent carotid angioplasty and/or stent procedure for the right side, prior to the current procedure

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days Ago	
2	Yes, 31-180 Days Ago	
3	Yes, >= 181 Days Ago	

Field Name: Previous Left CEA Timeframe

Seq No: 4313

Definition: Indicate the timeframe of the most recent carotid endarterectomy (CEA) for the left side, prior to the current procedure.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days Ago	
2	Yes, 31-180 Days Ago	
3	Yes, >= 181 Days Ago	

Field Name: Previous Left CAS Timeframe

Seq No: 4314

Definition: Indicate the timeframe of the most recent carotid angioplasty and/or stent procedure for the left side, prior to the current procedure

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days Ago	
2	Yes, 31-180 Days Ago	
3	Yes, >= 181 Days Ago	

Field Name: Neurologic Event(s) Prior to Procedure

Seq No: 4320

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Definition: Indicate if the patient experienced a neurologic event at any time prior to the current procedure. Neurologic events are defined as TIA (transient ischemic attack), ischemic stroke, or intracranial hemorrhage/hemorrhagic stroke, and are further described as:

- Transient Ischemic Attacks (TIA) are characterized by the following:
A focal neurologic abnormality of sudden onset and brief duration (i.e., lasting <24 hours) that reflects a dysfunction (presumed to be ischemic in origin) in the cerebral distribution of the affected artery. They are evidenced by neurological symptoms involving right or left retinal, right or left hemispheric, vertebrobasilar, and/or unknown territories.
- Ischemic Strokes are caused by a “blockage of a blood vessel” resulting in residual symptoms lasting greater than 24 hours, and leading to impaired functional outcomes. They are evidenced by loss of neurological function involving right or left retinal, right or left hemispheric, vertebrobasilar, and/or unknown territories.
- Intracranial Hemorrhage or Hemorrhagic Strokes are caused by “bursting or leaking of blood vessels” in the brain and may lead to impaired functional outcomes. They are evidenced by intraparenchymal (e.g., hemorrhagic conversion of prior stroke) intracranial hemorrhage, subarachnoid intracranial hemorrhage, and/or subdural intracranial hemorrhage.

Symptoms of transient ischemic attack or ischemic stroke in specific territories can include the following:

1. Ischemia in the retinal territory can be manifested as:

- transient monocular blindness (e.g., amaurosis fugax, defined as a transient episode of blindness or partial blindness, affecting one eye only).

2. Ischemia in the hemispheric territory supplied by the carotid artery can be manifested as:

- language impairment
- speech impairment or dysphasia
- hemi-neglect
- and/or, the symptoms noted in #4 (a through e) below

3. Ischemia in the vertebrobasilar territory can be manifested as:

- vertigo (spinning sensation)
- cranial nerve abnormalities (an example is dysconjugate gaze, in which eyes are no longer yoked together)
- “crossed” neurological symptoms, indicated by focal neurological deficits involving both sides of the body (example: sensory loss on the right and motor weakness on the left)
- and/or, the symptoms noted in #4 (a through e) below

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Definition: 4. Symptoms of ischemia that can be manifested in either the carotid hemispheric territory and/or Vertebrobasilar territory include:

- a) motor weakness
- b) sensory loss
- c) slurred speech ("dysarthria")
- d) visual field cut (more common in the vertebrobasilar territory)
- e) clumsiness or incoordination (more common in the vertebrobasilar territory)

Note: The specific territory of the prior event should be confirmed by a physician and prior imaging studies may be of assistance to confirm the territory involved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: TIA - Right Retinal

Seq No: 4321

Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving the right retinal territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: TIA - Left Retinal

Seq No: 4322

Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving the left retinal territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: TIA - Right Hemispheric

Seq No: 4323

Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving the right hemispheric territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: TIA - Left Hemispheric

Seq No: 4324

Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving the left hemispheric territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: TIA - Vertebrobasilar

Seq No: 4325

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Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving the vertebrobasilar territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: TIA - Unknown

Seq No: 4326

Definition: Indicate the timeframe if the patient experienced a Transient Ischemic Attack (TIA) involving an unknown territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Right Retinal

Seq No: 4327

Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving the right retinal territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Left Retinal

Seq No: 4328

Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving the left retinal territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Right Hemispheric

Seq No: 4329

Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving the right hemispheric territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Left Hemispheric

Seq No: 4330

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Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving the left hemispheric territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Vertebrobasilar

Seq No: 4331

Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving the vertebrobasilar territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes, <= 30 Days	
2	Yes, 31-180 Days	
3	Yes, >= 181 Days	

Field Name: Ischemic Stroke - Unknown

Seq No: 4332

Definition: Indicate the timeframe if the patient experienced a completed ischemic stroke involving an unknown territory.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Intracranial Hemorrhage or Hemorrhagic Stroke - Intraparenchymal

Seq No: 4333

Definition: Indicate the timeframe if the patient experienced an intraparenchymal (e.g. hemorrhagic conversion of prior stroke) intracranial hemorrhage.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Intracranial Hemorrhage or Hemorrhagic Stroke - Subarachnoid

Seq No: 4334

Definition: Indicate the timeframe if the patient experienced a subarachnoid hemorrhage.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Intracranial Hemorrhage or Hemorrhagic Stroke - Subdural

Seq No: 4335

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Definition: Indicate the timeframe if the patient experienced a subdural hemorrhage.

If there was more than one, code the most recent occurrence prior to admission or the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes, <= 30 Days	
	2	Yes, 31-180 Days	
	3	Yes, >= 181 Days	

Field Name: Acute Evolving Stroke

Seq No: 4340

Definition: Indicate if the patient has experienced an acute evolving stroke with ischemia which is ongoing and progressing at the time of the procedure. Acute evolving stroke includes all of the following:

1. Any sudden development of neurological deficits attributable to cerebral ischemia and/or infarction.
2. Onset of symptoms occurring within prior three days and ongoing at time of procedure.
3. The event is marked by progressively worsening symptoms.

Note: Possible symptoms include, but are not limited to the following: numbness or weakness of the face or body; difficulty speaking or understanding; blurred or decreased vision; dizziness; or loss of balance and coordination.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Preprocedure NIH Stroke Scale Administered

Seq No: 4400

Definition: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was administered prior to the current procedure.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Preprocedure NIH Stroke Scale Total Score

Seq No: 4401

Definition: Indicate the Preprocedure NIH Stroke Scale total score as performed prior to the current procedure. The NIHSS is a standardized neurological examination for patients with acute ischemic stroke that quantitatively measures the level of stroke severity.

Field Name: Preprocedure NIH Stroke Scale Date Administered

Seq No: 4402

Definition: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered prior to the current procedure.

Field Name: Preprocedure NIH Stroke Scale Examiner Certified

Seq No: 4404

Definition: Indicate if the NIH Stroke Scale examiner who administered the preprocedure stroke scale is certified to administer the stroke scale exam. The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Note - NIHSS examiners may become certified through the American Stroke Association.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Preprocedure NIH Stroke Scale Examiner's Last Name

Seq No: 4405

Definition: Indicate the last name of the examiner who administered the preprocedure NIH Stroke Scale.

Field Name: Preprocedure NIH Stroke Scale Examiner's First Name

Seq No: 4406

Definition: Indicate the first name of the examiner who administered the preprocedure NIH Stroke Scale.

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Field Name: Preprocedure NIH Stroke Scale Examiner's
Middle Name

Seq No: 4407

Definition: Indicate the middle name of the examiner who administered the preprocedure NIH Stroke Scale.

Field Name: Preprocedure Modified Rankin Score
Administered

Seq No: 4410

Definition: Indicate if the Modified Rankin Scale was administered prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Preprocedure Modified Rankin Score

Seq No: 4411

Definition: Indicate the Modified Rankin Scale Score administered prior to the current procedure. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. The total score can be 0-6 and can be described as follows:

0: No symptoms at all

1: No significant disability despite symptoms; able to carry out all usual duties and activities

2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3: Moderate disability; requiring some help, but able to walk without assistance

4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6: Dead

Field Name: Carotid Duplex Ultrasound

Seq No: 4500

Definition: Indicate if a carotid duplex ultrasound was performed prior to the current procedure. If yes, enter the most recent values.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Peak Systolic Velocity - Right

Seq No: 4505

Definition: Indicate the patient's right peak systolic velocity (PSV) for the internal carotid artery (ICA) in centimeters per second (cm/sec).

Field Name: Peak Systolic Velocity - Left

Seq No: 4510

Definition: Indicate the patient's left peak systolic velocity (PSV) for the internal carotid artery (ICA) in centimeters per second (cm/sec).

Field Name: End Diastolic Velocity - Right

Seq No: 4515

Definition: Indicate the patient's right end diastolic velocity (EDV) for the internal carotid artery (ICA) in centimeters per second (cm/sec).

Field Name: End Diastolic Velocity - Left

Seq No: 4520

Definition: Indicate the patient's left end diastolic velocity (EDV) for the internal carotid artery (ICA) in centimeters per second (cm/sec).

Field Name: ICA/CCA Ratio - Right

Seq No: 4525

Definition: Indicate the ratio of the peak systolic velocity in the right internal carotid artery (ICA) to the peak systolic velocity in the distal right common carotid artery (CCA).

Field Name: ICA/CCA Ratio - Left

Seq No: 4530

Definition: Indicate the ratio of the peak systolic velocity in the left internal carotid artery (ICA) to the peak systolic velocity in the distal left common carotid artery (CCA).

Field Name: MRA Angiography Performed

Seq No: 4600

Definition: Indicate if a magnetic resonance (MR) angiogram was performed prior to the current procedure.

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Carotid Artery Stenting Dataset

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: MRA CCA Highest % Stenosis - Right

Seq No: 4605

Definition: Indicate, for the MR Angiography, the highest percent (%) stenosis for the right common carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: MRA CCA Lower Range % Stenosis - Right

Seq No: 4610

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the right common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA CCA Upper Range % Stenosis - Right

Seq No: 4615

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the right common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA CCA Highest % Stenosis - Left

Seq No: 4620

Definition: Indicate, for MR Angiography, the highest percent (%) stenosis for the left common carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: MRA CCA Lower Range % Stenosis - Left

Seq No: 4625

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the left common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

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Carotid Artery Stenting Dataset

Field Name: MRA CCA Upper Range % Stenosis - Left

Seq No: 4630

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the left common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA ICA Highest % Stenosis - Right

Seq No: 4635

Definition: Indicate, for MR Angiography, the highest percent (%) stenosis for the right internal carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: MRA ICA Lower Range % Stenosis - Right

Seq No: 4640

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the right internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA ICA Upper Range % Stenosis - Right

Seq No: 4645

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the right internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA ICA Highest % Stenosis - Left

Seq No: 4650

Definition: Indicate, for MR Angiography, the highest percent (%) stenosis for the left internal carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: MRA ICA Lower Range % Stenosis - Left

Seq No: 4655

CARE Registry™
Carotid Artery Revascularization and Endarterectomy Registry v1.09
Data Dictionary - Elements and Definitions
Carotid Artery Stenting Dataset

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the left internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: MRA ICA Upper Range % Stenosis - Left

Seq No: 4660

Definition: If the MR Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the left internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CT Angiography Performed

Seq No: 4700

Definition: Indicate if a computed tomography (CT) angiogram was performed prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: CTA CCA High % Stenosis - Right

Seq No: 4705

Definition: Indicate, for CT Angiography, the highest percent (%) stenosis for the right common carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: CTA CCA Lower Range % Stenosis - Right

Seq No: 4710

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the right common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA CCA Upper Range % Stenosis - Right

Seq No: 4715

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Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the right common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA CCA High % Stenosis - Left

Seq No: 4720

Definition: Indicate, for CT Angiography, the highest percent (%) stenosis for the left common carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: CTA CCA Lower Range % Stenosis - Left

Seq No: 4725

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the left common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA CCA Upper Range % Stenosis - Left

Seq No: 4730

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the left common carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA ICA High % Stenosis - Right

Seq No: 4735

Definition: Indicate, for CT Angiography, the highest percent (%) stenosis for the right internal carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: CTA ICA Lower Range % Stenosis - Right

Seq No: 4740

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the right internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

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Field Name: CTA ICA Upper Range % Stenosis - Right

Seq No: 4745

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the right internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA ICA High % Stenosis - Left

Seq No: 4750

Definition: Indicate, for CT Angiography, the highest percent (%) stenosis for the left internal carotid artery. If the vessel is totally occluded, enter 100%. If no stenosis is present, enter 0%.

If a single percent stenosis is not available, leave blank and enter the lower and upper range % stenosis for this vessel.

Field Name: CTA ICA Lower Range % Stenosis - Left

Seq No: 4755

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the lower limit of the range (%) for the left internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

Field Name: CTA ICA Upper Range % Stenosis - Left

Seq No: 4760

Definition: If the CT Angiography report describes a range for the degree of stenosis (lower and upper limits), then provide the upper limit of the range (%) for the left internal carotid artery.

If there is no range available, leave blank and complete the highest % stenosis field for this vessel.

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E. Procedure Information

Field Name: Procedure Date

Seq No: 5000

Definition: Indicate the date of the procedure.

Field Name: Procedure Type

Seq No: 5001

Definition: Indicate the procedure type attempted, a carotid artery stent procedure or a carotid endarterectomy.

For purposes of this registry the start of the procedure is defined as the time the physician obtained vascular access. Any adverse events that occur before (i.e. in the holding room) are not attributed to the procedure. The procedure is complete when the patient leaves the procedure room.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	CAS	Indicate if the current procedure for this admission is a carotid stent and/or angioplasty procedure, which is defined as an insertion of an interventional guidewire or embolic protection device into the carotid artery with the intent of performing carotid revascularization.
2	CEA	Indicate if the current procedure for this admission is a surgical revascularization of the carotid artery, including, but not limited to, carotid endarterectomy, patch angioplasty, grafting or other operative techniques aimed at revascularizing the carotid artery.

Field Name: Target Carotid Vessel

Seq No: 5005

Definition: Indicate whether the target vessel is the right or left carotid artery for the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Right	
2	Left	

Field Name: Operator UPIN

Seq No: 5010

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Definition: Indicate the primary operator's Unique Physician Identification Number (UPIN). UPINs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

As part of the HIPAA mandate requiring a standard unique identifier for health care providers, Operator UPINs will be replaced with the new Operator National Provider Identifiers (NPIs).

Field Name: Operator NPI

Seq No: 5015

Definition: Indicate the primary operator's National Provider Identifier. NPIs, assigned by the Center for Medicare and Medicaid Services (CMS), are used to uniquely identify physicians for Medicare billing purposes.

As part of the HIPAA mandate requiring a standard unique identifier for health care providers, the Operator NPI will replace the Operator UPIN.

Field Name: Operator Last Name

Seq No: 5020

Definition: Indicate the primary operator's last name.

Field Name: Operator First Name

Seq No: 5021

Definition: Indicate the primary operator's first name.

Field Name: Operator Middle Name

Seq No: 5022

Definition: Indicate the primary operator's middle name.

Field Name: Current Procedure Part of Carotid Clinical Trial

Seq No: 5025

Definition: Indicate if the current procedure being performed is under the purview of a carotid clinical trial.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Trial Type

Seq No: 5026

Definition: Indicate the trial type.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Postmarket Surveillance	A carotid clinical trial that is a post market surveillance trial. Post market surveillance is defined by the Food and Drug Administration (FDA) as a trial established to detect unforeseen adverse events in devices intended to be implanted in the human body for more than 1 year, ones that such failure of the device would be likely to have serious adverse health consequences, or ones intended to be used to support or sustain life.
2	Premarket Approval or IDE	A carotid clinical trial that is part of a premarket approval (PMA) or investigational device exemption (IDE) trial. An IDE allows the investigational device to be used in a clinical study in order to collect safety and effectiveness data required to support a PMA application or a Premarket Notification [510(k)] submission to the Food and Drug Administration (FDA). An Investigational device is a device, including a transitional device, that is the object of an investigation.
3	Other	A carotid clinical trial that is not part of a postmarket surveillance, premarket approval or investigational device exemption trial.

Field Name: Anesthesia Type

Seq No: 5030

Definition: Indicate if the patient received general anesthesia, local anesthesia, or no anesthesia during the current procedure. If more than one given, code General.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	General	General anesthesia was administered to ensure unconsciousness, amnesia and analgesia.
2	Local	Local anesthesia was administered.

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Field Name: Urgent Cardiac Surgery w/in 30 Days**Seq No:** 5033

Definition: Indicate if the patient is having the carotid revascularization procedure because of the need for cardiac surgery within 30 days of the current procedure. Cardiac Surgery is defined as bypass, valve, ICD patches and transplant surgery.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Target Lesion Symptomatic w/in Past 6 Months**Seq No:** 5035

Definition: Indicate if the patient has had neurologic symptoms in the past six months related to the target lesion. Conditions qualifying patients as symptomatic:

- Carotid Transient Ischemic Attack (TIA): distinct focal neurologic dysfunction persisting less than 24 hours;
- Non-disabling stroke: Modified Rankin Scale < 3 with symptoms for 24 hours or more;
- Transient monocular blindness: amaurosis fugax

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Restenosis in Target Vessel After Prior CAS**Seq No:** 5040

Definition: Note if the indication for the current procedure is restenosis in the target carotid artery which was previously treated with an angioplasty and/or stent. Carotid artery restenosis is defined as greater than 50% diameter stenosis at or adjacent to the site previously treated with balloon angioplasty or stent.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Restenosis in Target Vessel After Prior CEA**Seq No:** 5045

Definition: Note if the indication for the current procedure is restenosis in the target carotid artery which was previously treated with a carotid artery endarterectomy. Restenosis is defined as renarrowing within or adjacent to a prior endarterectomy site, evidenced by greater than 50% diameter stenosis.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Contralateral Carotid Artery Occlusion

Seq No: 5050

Definition: Indicate if there is known 100% occlusion of the patient's contralateral carotid artery.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Fibromuscular Dysplasia of Carotid Artery

Seq No: 5055

Definition: Indicate if the patient has a history of known fibromuscular dysplasia of the ipsilateral carotid artery prior to admission or prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Spontaneous Carotid Artery Dissection

Seq No: 5060

Definition: Indicate if the patient has had a spontaneous carotid artery dissection prior to the current procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Lesion Difficult to Access Surgically

Seq No: 5500

Definition: Indicate if the lesion is difficult to access surgically for CEA. Lesions that are difficult to access include those which are quite high in the neck (e.g. at or above the level of C2), and those that are within the proximal 1/2 or 1/3 of the common carotid artery, at or below the clavicle rendering endarterectomy either difficult or impossible.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Lesion Location

Seq No: 5501

Definition: Indicate if the patient has high cervical internal carotid artery lesions or common carotid artery lesions below the clavicle.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	High Cervical	Lesion that is high (at or above C2) and therefore either difficult to access or inaccessible for surgery.
2	Low Intrathoracic	A lesion that is low in the carotid artery (generally the common carotid artery [CCA] within the thorax), that makes endarterectomy difficult or impossible.

Field Name: Aortic Arch Type

Seq No: 5505

Definition: Indicate the patient's aortic arch type configuration. The three types of aortic arch are based on the relationship of the innominate artery to the aortic arch. The more inferior the origin of the target artery (i.e., Type II or III aortic arch), the greater the difficulty in gaining access to the carotid artery.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Type I	The Type I aortic arch is characterized by origin of all three great vessels in the same horizontal plane as the outer curvature of the aortic arch.
2	Type II	In the Type II aortic arch, the innominate artery originates between the horizontal planes of the outer and inner curvatures of the aortic arch.
3	Type III	In the Type III aortic arch, the innominate artery originates below the horizontal plane of the inner curvature of the aortic arch.

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Field Name: Contrast Volume

Seq No: 5510

Definition: Indicate the volume of iodinated contrast injected during the procedure in milliliters (mL).

Field Name: Bovine Arch

Seq No: 5515

Definition: Indicate if the patient's aortic arch is bovine, in which the right brachiocephalic and left carotid arteries share a common trunk from the aortic arch.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Fluoro Time

Seq No: 5520

Definition: Indicate total fluoroscopy time recorded during the procedure visit to the nearest 0.1-minute. The time recorded should include the total time for the procedure.

Field Name: Procedural Arterial Access Site

Seq No: 5525

Definition: Indicate the primary arterial access site utilized to perform the carotid artery stenting (CAS) procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Femoral	Percutaneous puncture or cutdown (incision with a surgical blade) of the femoral artery.
2	Brachial/Radial/Axillary	Percutaneous puncture or cutdown (incision with a surgical blade) of the brachial, radial or axillary artery.
3	Direct Carotid Puncture	Percutaneous puncture of the carotid artery.
4	Carotid Cutdown	Cutdown (incision with a surgical blade) of the carotid artery.
5	Other	Percutaneous entry or cutdown (incision with a surgical blade) to a site that is not the femoral, brachial, radial, axillary, or carotid artery.

Field Name: Closure Method Manufacturer

Seq No: 5532

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Definition: Indicate the manufacturer of the closure device.

Field Name: Closure Method Model Name

Seq No: 5533

Definition: Indicate the method used to achieve hemostasis. Methods should include devices and non-device such as "Manual Compression".

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F. CAS Lesions and Devices

Field Name: Target Lesion Location

Seq No: 6000

Definition: Indicate the target lesion location for this procedure.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Isolated CCA	Target lesion location is a lesion isolated to the common carotid artery and does not extend to or involve the carotid bifurcation.
2	Isolated ICA	Target lesion location is a lesion isolated to the internal carotid artery and does not extend to or involve the carotid bifurcation.
3	Bifurcation	Target lesion location is any lesion that involves the carotid bifurcation. For example, a high grade stenosis in the ICA or CCA adjacent to the bifurcation wherein the plaque extends to involve the bifurcation is considered a bifurcation lesion.

Field Name: Visible Thrombus Present

Seq No: 6005

Definition: Indicate if the target lesion contains thrombus as assessed by baseline angiography and implied by presence of filling defect.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Ulceration

Seq No: 6010

Definition: Indicate if the target lesion is ulcerated as assessed by baseline angiography.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Calcification

Seq No: 6015

Definition: Indicate the degree of calcification in the target lesion as assessed by fluoroscopic inspection.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	None	No calcification present on fluoroscopic inspection.
	1	Mild to Moderate	Mild to moderate calcification present on fluoroscopic inspection, but not qualifying as densely or concentrically calcified.
	2	Dense and Concentric	Heavy, concentric calcification completely encasing the vessel present on fluoroscopic inspection.

Field Name: Lesion Length

Seq No: 6020

Definition: Indicate the length of the target lesion in millimeters (mm) as assessed by baseline angiography.

Field Name: Minimum Luminal Diameter (MLD)

Seq No: 6025

Definition: Indicate the target lesion's minimum luminal diameter in millimeters (mm) as assessed by baseline angiography. The Minimal Luminal Diameter (MLD) is defined as the minimum luminal diameter derived from the angiographic view that shows the tightest point of the stenosis.

Field Name: Diameter of Distal (non-tapered) ICA for NASCET

Seq No: 6030

Definition: Indicate the diameter of the non-tapering distal segment of Internal Carotid Artery (ICA) for North American Symptomatic Carotid Endarterectomy Trial (NASCET) measurement at the intended landing zone of the distal edge of the stent (where the vessel is no longer tapered and the walls become parallel).

Note: NASCET was a randomized clinical trial to compare the safety and efficacy of carotid endarterectomy versus medical therapy for the prevention of stroke in symptomatic patients.

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Field Name: Preprocedure % Stenosis

Seq No: 6035

Definition: Indicate the percent stenosis pre-procedure, calculated as follows:

1. When the tightest stenosis is in the Internal Carotid Artery or at the carotid bifurcation, use NASCET methodology. Percent Diameter Stenosis is calculated as:

(1- minimum luminal diameter at the lesion site/diameter of non-tapering segment of distal ICA)
*100.

"Non-tapering site" is where the walls of the ICA become parallel.

2. Do not use NASCET if the distal lumen collapses from a low-flow situation. In such cases, enter 99%, as the stenosis may be graded as a near occlusion.

3. For stenosis localized to the Common Carotid Artery, Percent Diameter Stenosis is calculated as:

(1- minimum luminal diameter/diameter of the adjacent normal segment of the Common Carotid artery)*100.

Field Name: Lesion Treatment Incomplete or Aborted

Seq No: 6040

Definition: Indicate if the lesion treatment was incomplete or aborted.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Reasons Treatment Aborted

Seq No: 6041

Definition: Indicate the reasons the lesion treatment was incomplete or aborted. Choose all that apply.

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Selections:

Coding/Sort	Selection(Choose multiple)	Explanation
1	Failure to gain vascular access	
2	Failure to confirm significant stenosis	
3	Unable to place guiding catheter/sheath	
4	Unable to cross guidewire	
5	Unable to cross balloon	
6	Unable to deploy EPD	
7	Unable to deliver stent	
8	Unable to deploy stent	
9	Difficult to access due to tortuosity	
10	Hypotension	
11	Hypertension	
12	Arrhythmia	
13	Cardiac ischemia	
14	Other	

Field Name: Embolic Protection Attempted

Seq No: 6100

Definition: Indicate if the operator attempted to use an embolic protection device (EPD).

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Predilation Pre-Embolic

Seq No: 6101

Definition: Indicate whether predilation was attempted prior to the deployment of the embolic protection device.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Embolic Protection Successfully Deployed

Seq No: 6111

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Definition: Indicate if the embolic protection device was successfully deployed for each device attempted.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Embolic Protection Manufacturer

Seq No: 6113

Definition: Indicate the manufacturer of the embolic protection device.

Field Name: Embolic Protection Model Name

Seq No: 6114

Definition: Indicate the brand or model of the embolic protection device.

Field Name: Stent(s) Implanted

Seq No: 6200

Definition: Indicate if at least one stent was implanted.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Predilation Prior to Attempted Stent Implant

Seq No: 6201

Definition: Indicate whether balloon dilation was performed on the target lesion after placement of the embolic protection device, but before delivery of the stent. Do not include predilation prior to deployment of the embolic protection device.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Stent Tapered

Seq No: 6211

Definition: Indicate if the stent device was tapered.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Stent Diameter

Seq No: 6212

Definition: Indicate the diameter of the stent. If a tapered stent was used, indicate the smallest diameter of the tapered stent in millimeters (mm).

Field Name: Stent Length

Seq No: 6213

Definition: Indicate the length of the stent in millimeters (mm).

Field Name: Malposition

Seq No: 6214

Definition: Indicate if the stent was deployed in a location or position other than that for which it was intended.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Stent Manufacturer

Seq No: 6216

Definition: Indicate the manufacturer of the stent.

Field Name: Stent Manufacturer Model Name

Seq No: 6217

Definition: Indicate the brand or model name of the stent.

Field Name: Postdilation Performed

Seq No: 6300

Definition: Indicate if postdilation was performed after the stent was implanted.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Nominal Balloon Diameter

Seq No: 6301

Definition: Indicate the nominal diameter of the largest post-dilation balloon used in millimeters (mm). The nominal balloon diameter is the "labeled" diameter noted on the balloon packaging and specifications.

Field Name: Maximum Inflation Pressure

Seq No: 6302

Definition: Indicate the maximum inflation pressure of the largest balloon used to post-dilate the stent in atmospheres (atm).

Field Name: Final Minimum Luminal Diameter

Seq No: 6305

Definition: Indicate the final residual lumen diameter in millimeters (mm).

Field Name: Final % Stenosis

Seq No: 6310

Definition: Indicate the percent stenosis postprocedure, calculated as follows:

1. For Internal Carotid artery site, use NASCET methodology. Percent Diameter Stenosis is calculated as:

$(1 - \text{minimum residual luminal diameter within the treated site} / \text{diameter of nontapering segment of distal ICA}) * 100$

"Nontapering site" is where the walls of the ICA become parallel.

2. For lesion and interventional site localized to the Common Carotid artery, Percent Diameter Stenosis is calculated as:

$(1 - \text{minimum residual luminal diameter} / \text{diameter of the adjacent normal segment of the Common Carotid artery}) * 100$

Field Name: Auxiliary 5

Seq No: 6410

Definition: Reserved for future use.

Field Name: Auxiliary 6

Seq No: 6420

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Definition: Reserved for future use.

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G. Medications

Field Name: Preprocedure Medications

Seq No: 7000

Definition: Indicate which of the following medications the patient received in adequate dosage and timing to achieve therapeutic levels at the onset of the current procedure. If the patient received the medication immediately prior to the procedure without adequate time interval or dose to achieve a therapeutic level, code "No".

Field Name: Medication Administration

Seq No: 7001

Definition: Indicate if medication was administered, not administered or contraindicated. The "Contraindicated" selection should be used if the administration of the medication is unknown due to a blinded study.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	Medication was not administered (for preprocedure, intraprocedure and postprocedure medications) or not prescribed (for discharge medications).
1	Yes	Medication was administered (for preprocedure, intraprocedure and postprocedure medications) or prescribed (for discharge medications).
2	Contraindicated	Medication was contraindicated (for preprocedure, intraprocedure, postprocedure and discharge medications). Contraindicated should be selected when the administration of a specific medication and/or category is unknown due to a patient's participation in a blinded study. This selection is excluded in all algorithms that calculate medication administration.

Field Name: Intraprocedure Medications

Seq No: 7005

Definition: Indicate if the patient received any of the following medications during the procedure.

Field Name: Postprocedure Medications

Seq No: 7010

Definition: Indicate if the patient received any of the following medications after the procedure and before discharge.

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H. Postprocedure Neurologic Assessment

Field Name: Postprocedure NIH Stroke Scale Administered

Seq No: 7100

Definition: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was administered postprocedure and prior to discharge.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Postprocedure NIH Stroke Scale Score

Seq No: 7101

Definition: Indicate the Postprocedure NIH Stroke Scale total score as performed post procedure prior to discharge. The NIHSS is a standardized neurological examination for patients with acute ischemic stroke that quantitatively measures the level of stroke severity.

Field Name: Postprocedure NIH Stroke Scale Date Administered

Seq No: 7102

Definition: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered postprocedure.

Note - Recommended timeframe to administer NIHSS is within 24 hours post procedure.

Field Name: Postprocedure NIH Stroke Scale Examiner Certified

Seq No: 7104

Definition: Indicate if the NIH Stroke Scale examiner who administered the post procedure stroke scale is certified to administer the stroke scale exam. The Stroke Scale assessment should be conducted by someone other than the operator for this procedure.

Note - NIHSS examiners may become certified through the American Stroke Association.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Postprocedure NIH Stroke Scale Examiner's Last Name

Seq No: 7105

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Definition: Indicate the last name of the examiner who administered the postprocedure NIH Stroke Scale.

Field Name: Postprocedure NIH Stroke Scale Examiner's First Name **Seq No:** 7106

Definition: Indicate the first name of the examiner who administered the postprocedure NIH Stroke Scale.

Field Name: Postprocedure NIH Stroke Scale Examiner's Middle Name **Seq No:** 7107

Definition: Indicate the middle name of the examiner who administered the postprocedure NIH Stroke Scale.

Field Name: Postprocedure Modified Rankin Score Administered **Seq No:** 7110

Definition: Indicate if the Modified Rankin Scale was administered post-procedure and prior to discharge.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Postprocedure Modified Rankin Score **Seq No:** 7111

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Definition: Indicate the Modified Rankin Scale Score administered post procedure. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. The total score can be 0-6 and can be described as follows:

0: No symptoms at all

1: No significant disability despite symptoms; able to carry out all usual duties and activities

2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3: Moderate disability; requiring some help, but able to walk without assistance

4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6: Dead

Field Name: New Stroke or TIA

Seq No: 7200

Definition: Indicate if the patient experienced a new ischemic stroke or TIA during or after the current procedure and before discharge. If yes, specify all new events and resolution status. If more than one event occurred in the same territory, code the earliest occurrence and code the latest time the deficit resolved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

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I. Adverse Events

Field Name: New Right Hemispheric or Retinal Neurologic Event Occurred

Seq No: 7205

Definition: Indicate if a new right hemispheric or retinal stroke or TIA developed during or after the current procedure. If the event occurred more than once, code the first time it occurred.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes - Intraprocedure	
2	Yes - Postprocedure	

Field Name: New Right Hemispheric or Retinal Neurologic Event Resolved

Seq No: 7210

Definition: Indicate the timeframe of resolution for the new right hemispheric or retinal stroke or TIA that developed during or after the current procedure. If the event occurred more than once, code the last time it resolved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	Not Resolved	
1	Yes - Intraprocedure	
2	Yes - w/in 24 Hours of Procedure	
3	Yes - Before Discharge	

Field Name: New Left Hemispheric or Retinal Neurologic Event Occurred

Seq No: 7215

Definition: Indicate if a new left hemispheric or retinal stroke or TIA developed during or after the current procedure. If the event occurred more than once, code the first time it occurred.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes - Intraprocedure	
2	Yes - Postprocedure	

Field Name: New Left Hemispheric or Retinal Neurologic Event Resolved

Seq No: 7220

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Definition: Indicate the timeframe of resolution for the new left hemispheric or retinal stroke or TIA that developed during or after the current procedure. If the event occurred more than once, code the last time it resolved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	Not Resolved	
1	Yes - Intraprocedure	
2	Yes - w/in 24 Hours of Procedure	
3	Yes - Before Discharge	

Field Name: New Vertebrobasilar Event Occurred

Seq No: 7225

Definition: Indicate if a new vertebrobasilar stroke or TIA developed during or after the current procedure. If the event occurred more than once, code the first time it occurred.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes - Intraprocedure	
2	Yes - Postprocedure	

Field Name: New Vertebrobasilar Event Resolved

Seq No: 7230

Definition: Indicate the timeframe of resolution for the new vertebrobasilar stroke or TIA that developed during or after the current procedure. If the event occurred more than once, code the last time it resolved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	Not Resolved	
1	Yes - Intraprocedure	
2	Yes - w/in 24 Hours of Procedure	
3	Yes - Before Discharge	

Field Name: New Unknown Event Occurred

Seq No: 7235

Definition: Indicate if a new stroke or TIA developed in an unspecified or unknown location during or after the current procedure. If the event occurred more than once, code the first time it occurred.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes - Intraprocedure	
2	Yes - Postprocedure	

Field Name: New Unknown Event Resolved

Seq No: 7240

Definition: Indicate the timeframe of resolution for the stroke or TIA that developed in an unspecified or unknown area during or after the current procedure. If the event occurred more than once, code the last time it resolved.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	Not Resolved	
1	Yes - Intraprocedure	
2	Yes - w/in 24 Hours of Procedure	
3	Yes - Before Discharge	

Field Name: Other Adverse Events

Seq No: 7300

Definition: Indicate if the patient had any of the adverse events during or after the procedure up until discharge. If Yes, specify for each event whether the event occurred.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Adverse Event

Seq No: 7304

Definition: Indicate the Adverse Events that were downloaded from the ACC website and imported into the CARE data collection tool. This element will be used to determine if the participant has the right adverse events in the CARE data collection tool for every admission.

Field Name: Adverse Event Occurred

Seq No: 7305

Definition: Indicate, for each event listed, whether the patient had the event during or after the procedure, up until discharge.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

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J. Discharge

Field Name: Peak Postprocedure Creatinine Level Assessed

Seq No: 8000

Definition: Indicate if the patient's serum creatinine level was assessed since discharge. If more than one level is available prior to discharge, code the peak value.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Peak Postprocedure Creatinine Level

Seq No: 8001

Definition: Indicate the patient's most recent serum creatinine level (obtained postprocedure) in milligrams per deciliter (mg/dL).

Field Name: Discharge Date

Seq No: 8005

Definition: Indicate the patient's date of discharge. If the patient died in the hospital the hospital discharge date is the date of death.

Field Name: Discharge Status

Seq No: 8010

Definition: Indicate whether the patient was alive or deceased at discharge from the hospitalization during which the procedure occurred.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Alive	
2	Deceased	

Field Name: Cause of Death

Seq No: 8011

Definition: Indicate the cause of death.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	1	Neurologic	Due to a new or progressive neurologic event.
	2	Cardiac	Due to a fatal arrhythmia, MI or heart failure.
	3	Pulmonary	Due to pulmonary complication.
	4	Vascular	Due to major blood loss or other vascular complication.
	5	Infection	Due to infection.
	6	Renal Failure	Due to renal failure.
	7	Other	Due to other cause.

Field Name: Death During Procedure

Seq No: 8012

Definition: Indicate if the patient died during the procedure.

For purposes of this registry the start of the procedure is defined as the time the physician obtained vascular access. Any adverse events that occur before (i.e. in the holding room) are not attributed to the procedure. The procedure is complete when the patient leaves the procedure room.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Discharge Medications

Seq No: 8020

Definition: Indicate if the patient was prescribed any of the following medications at discharge.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	Medication was not prescribed on discharge.
	1	Yes	Medication was prescribed on discharge.
	2	Contraindicated/Blinded	Code contraindicated/blinded when administration of a specific medication is contraindicated, or when the patient is in a clinical trial (where administration of the medication is unknown). This category is excluded in the algorithms that calculate medication administration.

Field Name: Anticipated Follow-up Date

Seq No: 8025

Definition: Indicate the anticipated follow-up date. The recommended timeframe for follow-up is 30 days after the procedure.

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K. Follow-Up

Field Name: Patient Follow-up Performed

Seq No: 9000

Definition: Indicate whether patient follow-up was performed for the procedure. The recommended timeframe for follow-up is 30 days.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Why Was Follow-up Not Performed

Seq No: 9001

Definition: Indicate the reason why patient follow-up was not performed.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	1	Patient Refused	
	2	Patient Unavailable	
	4	Other	

Field Name: Follow-Up Date

Seq No: 9002

Definition: Indicate the date of follow-up. The recommended timeframe for follow-up is 30 days.

Field Name: Follow Up NIH Stroke Scale Administered

Seq No: 9010

Definition: Indicate if the National Institutes of Health Stroke Scale (NIHSS) was administered during follow-up.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Follow-Up NIH Stroke Scale Score

Seq No: 9011

Definition: Indicate the Follow-up NIH Stroke Scale total score as performed at the time of follow-up for the procedure. The NIHSS is a standardized neurological examination for patients with acute ischemic stroke that quantitatively measures the level of stroke severity.

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Field Name: Follow-up NIH Stroke Scale Date Administered

Seq No: 9012

Definition: Indicate the date the National Institutes of Health Stroke Scale (NIHSS) was administered during the follow-up period.

Note - Recommended timeframe to administer NIHSS is within 30 days after the current procedure.

Field Name: Follow-up NIH Stroke Scale Examiner Certified

Seq No: 9014

Definition: Indicate if the NIH Stroke Scale examiner who administered the follow-up stroke scale is certified to administer the stroke scale exam. The Stroke Scale assessment should be conducted by someone other than the operator for the current procedure.

Note - NIHSS examiners may become certified through the American Stroke Association.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Follow-up NIH Stroke Scale Examiner's Last Name

Seq No: 9015

Definition: Indicate the last name of the examiner who administered the follow-up NIH Stroke Scale.

Field Name: Follow-up NIH Stroke Scale Examiner's First Name

Seq No: 9016

Definition: Indicate the first name of the examiner who administered the follow-up NIH Stroke Scale.

Field Name: Follow-up NIH Stroke Scale Examiner's Middle Name

Seq No: 9017

Definition: Indicate the middle name of the examiner who administered the follow-up NIH Stroke Scale.

Field Name: Follow-up Modified Rankin Score Administered

Seq No: 9020

Definition: Indicate if the Modified Rankin Scale was administered during follow-up.

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Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Follow-Up Modified Rankin Score

Seq No: 9021

Definition: Indicate the Modified Rankin Scale Score administered at the time of follow-up. The Modified Rankin Scale is a standardized neurological examination of patients with disability that provides a scale of global disability. The total score can be 0-6 and can be described as follows:

0: No symptoms at all

1: No significant disability despite symptoms; able to carry out all usual duties and activities

2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

3: Moderate disability; requiring some help, but able to walk without assistance

4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance

5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6: Dead

Field Name: Additional CEA on Target Carotid Vessel

Seq No: 9030

Definition: Indicate if there has been a carotid endarterectomy on the target vessel since the current procedure.

Selections:	Coding/Sort	Selection(Choose one)	Explanation
	0	No	
	1	Yes	

Field Name: Additional CAS on Target Carotid Vessel

Seq No: 9035

Definition: Indicate if there has been carotid artery stent procedure on the target carotid vessel since the current procedure.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Patient Status

Seq No: 9100

Definition: Indicate if the patient is alive or deceased.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Alive	
2	Deceased	

Field Name: Date of Death

Seq No: 9101

Definition: Indicate the patient's date of death.

Field Name: Cause of Death at Follow-up

Seq No: 9102

Definition: Indicate the patient's primary cause of death.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
1	Neurologic	Due to a new or progressive neurologic event
2	Cardiac	Due to a fatal arrhythmia, MI or heart failure.
3	Pulmonary	Due to pulmonary complication.
4	Vascular	Due to major blood loss or other vascular complication.
5	Infection	Due to infection.
6	Renal Failure	Due to renal failure.
7	Other	Due to other cause.

Field Name: Neurologic Deficit(s) Occurred Since Discharge

Seq No: 9110

Definition: Indicate if the patient experienced a new neurological deficit (i.e. Stroke or TIA) since discharge. If yes, choose the territory and the timeframe of resolution.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Follow-up Right Retinal Deficit

Seq No: 9111

Definition: Indicate if the patient who experienced a new right retinal neurological deficit since discharge and the timeframe of resolution.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

Field Name: Follow-up Left Retinal Deficit

Seq No: 9112

Definition: Indicate if the patient who experienced a new left retinal neurological deficit since discharge and the timeframe of resolution.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

Field Name: Follow-up Right Hemispheric Deficit

Seq No: 9113

Definition: Indicate if the patient who experienced a new right hemispheric neurological deficit since discharge and the timeframe of resolution.

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Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

Field Name: Follow-up Left Hemispheric Deficit

Seq No: 9114

Definition: Indicate if the patient who experienced a new left hemispheric neurological deficit since discharge and the timeframe of resolution.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

Field Name: Follow-up Vertebrobasilar Deficit

Seq No: 9115

Definition: Indicate if the patient who experienced a new vertebrobasilar neurological deficit since discharge and the timeframe of resolution.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

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Field Name: Follow-up Unknown Deficit**Seq No:** 9116

Definition: Indicate if the patient who experienced a new unknown territory neurological deficit since discharge and the timeframe of resolution.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No Deficit Occurred	
1	Deficit Occurred, Resolved w/in 24 hours (i.e. TIA)	
2	Deficit Occurred, Duration >24 hours, But Completely Resolved	
3	Persistent Deficit Occurred Lasting > 24 Hours, Not Completely Resolved	

Field Name: Myocardial Infarction Since Discharge**Seq No:** 9150

Definition: Indicate if the patient developed a new myocardial infarction since discharge as evidenced by either of the following:

1. Acute myocardial infarction (<=7 days) manifested as a rise and fall of cardiac biomarkers (preferable troponin) with at least one of the values above the range of normal for your laboratory [above the 99th percentile of the upper reference limit (URL)] together with evidence of myocardial ischemia with at least one of the following:
 - a. ischemic symptoms;
 - b. ECG changes indicative of new ischemia (new ST-T changes or new left bundle branch block),
 - c. Development of pathological Q waves in the ECG;
 - d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
2. Prior myocardial infarction (>7 days) manifested by
 - a. A myocardial infarction meeting the criteria of an acute MI, as documented in the medical record, or
 - b. By either of the following:
 1. Development of new pathological Q waves with or without symptoms.
 2. Imaging evidence of a region of loss of viable myocardium that is thinned and fails to contract, in the absence of a non-ischemic cause.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Renal Failure Requiring Dialysis**Seq No:** 9165

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Definition: Indicate if there is evidence of new renal failure requiring dialysis since discharge.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Follow-up Creatinine Level Assessed

Seq No: 9170

Definition: Indicate if the patient's serum creatinine level was assessed since discharge.

Selections:

Coding/Sort	Selection(Choose one)	Explanation
0	No	
1	Yes	

Field Name: Follow-up Creatinine Level

Seq No: 9171

Definition: Indicate the patient's most recent serum creatinine level (obtained since discharge) in milligrams per deciliter (mg/dL).

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Appendix A - Adverse Events (Definitions Only)

Event: New Seizure (intra or post)

Category: Other Neurologic (not TIA/ Stroke)

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced a seizure (e.g. a new convulsive episode) of sudden onset, during or after the current procedure, and prior to discharge.

Event: Hyperperfusion Syndrome

Category: Other Neurologic (not TIA/ Stroke)

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient had an incidence of hyperperfusion syndrome. Clinical diagnosis should be made by knowledgeable provider, familiar with this syndrome.

Event: Intracranial Hemorrhage

Category: Other Neurologic (not TIA/ Stroke)

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed an intracranial hemorrhage (ICH) spontaneously or secondary to suspected hyperperfusion syndrome. This is defined by evidence of new bleeding by CT or MRI, or confirmed otherwise (e.g. by neurosurgery or by unequivocal neurologic evaluation).

Event: Persistent Hypotension Requiring Treatment with Parenteral Medications >24 Hours Post-Procedure

Category: Cardiac and Hemodynamic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced persistent hypotension for >24 hours post-procedure requiring parenteral drug treatment. Hypotension is defined as a systolic blood pressure (SBP) <90 mmHg or the need for IV vasopressors and/or atropine to maintain SBP ≥ 90 mmHg.

Event: Arrhythmia Requiring Cardioversion, or Implantation of a Permanent Pacer or ICD

Category: Cardiac and Hemodynamic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced a new rhythm disturbance (not present during the 24 hours immediately pre-procedure) that persists or reoccurs during or after the procedure and requires treatment with emergency cardioversion (electrical or chemical); and/or permanent pacemaker or ICD implantation.

Event: Myocardial Infarction

Category: Cardiac and Hemodynamic

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Appendix A - Adverse Events (Definitions Only)

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed an acute myocardial infarction post procedure, as evidenced by a rise and fall of cardiac biomarkers (preferable troponin) with at least one of the values above the range of normal for your laboratory [above the 99th percentile of the upper reference limit (URL)] together with evidence of myocardial ischemia with at least one of the following:

- a. ischemic symptoms;
- b. ECG changes indicative of new ischemia (new ST-T changes or new left bundle branch block),
- c. Development of pathological Q waves in the ECG;
- d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Event: Acute Heart Failure or Pulmonary Edema

Category: Cardiac and Hemodynamic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed a new onset or acute reoccurrence of symptomatic heart failure or pulmonary edema after the procedure and before discharge.

Event: New Requirement for Dialysis

Category: Renal

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced acute or worsening renal failure that resulted in a new requirement for dialysis.

Event: Infection Related to Procedure, Requiring Antibiotics

Category: Infection

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed a documented infection at the entry or surgical site that was related to the procedure. Infection can be documented by fever, entry site erythema or purulence, sepsis, bacteremia, or other microbiological evidence indicating infection of the entry or surgical site, and requiring a course of systemic antibiotic therapy. Do not include administration of prophylactic antibiotics.

Event: Unanticipated Carotid Tear or Dissection Requiring Treatment

Category: Angiographic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced an unanticipated disruption of an arterial wall (carotid tear or dissection) extending beyond the confines of the stent which requires treatment.

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Appendix A - Adverse Events (Definitions Only)

Event: Urgent Surgery Required for Technical Problems with Stent Deployment or Placement

Category: Angiographic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient required urgent surgery for technical problems with stent deployment or placement. This can include problems such as stent malposition, underdeployment and dislodgement.

Event: Intracranial Embolization

Category: Angiographic

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed an intracranial embolization distal to the arterial access site.

Event: Procedure Related Bleeding or Hematoma Requiring Red Blood Cell Transfusion

Category: Bleeding

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient required a transfusion of red blood cells (e.g., PRBCs) due to procedure related blood loss. Blood loss could be due to access site hematoma, external bleeding, or a retroperitoneal bleed. In addition, unspecified blood loss (e.g. not related to access site or surgical site) requiring a transfusion should be included.

Event: Pseudoaneurysm Requiring Treatment w/Thrombin Injection and/or Compression During Hospitalization

Category: Arterial Access Site

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed a pseudoaneurysm that required treatment with thrombin injection and/or compression during hospital stay for current procedure. If the pseudoaneurysm requires surgical repair, code no and refer to access site related injury). Pseudoaneurysm is defined as a contained leak in the arterial wall as demonstrated by appropriate imaging study (ultrasound, arteriography, CTA or MRA).

Event: Access Site Related Injury requiring open surgical repair

Category: Arterial Access Site

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed any arterial access site complication which required open surgical repair. This could include, but is not limited to, pseudoaneurysm not treatable with compression/injection, arterial tear, occlusive flap, thrombosis or other injury. Arterial access that was obtained by pre-planned cutdown does not qualify.

Event: Vessel Thrombosis, Peripheral Embolization or New Ischemia of Extremity

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Appendix A - Adverse Events (Definitions Only)

Category: Arterial Access Site

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient developed thrombosis or peripheral embolization in the vessel at or distal to the arteriotomy site or new ischemia of that extremity.

Event: Unexpected Intubation and/or Resuscitation

Category: Other

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced unanticipated respiratory distress, neurologic compromise, or hemodynamic collapse requiring unexpected intubation and/or major resuscitation.

Event: Contrast Reaction (anaphylactoid type)

Category: Other

Effective Date: 1/1/2004

Expiration Date:

Definition: Indicate if the patient experienced an anaphylactoid type reaction to contrast materials. This is manifested as bronchospasm and/or vascular collapse, specifically in association with administration of contrast dye.

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Appendix B - Medications (Definitions Only)

Timeframe: Discharge

Medication: Warfarin (Coumadin)

Category: Anticogulants

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: ASA (Aspirin)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Clopidogrel (Plavix)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Ticlopidine (Ticlid)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Statins

Category Definition: Any of a group of cholesterol-lowering drugs whose generic names all end in "-statin." Examples include (but are not limited to) lovastatin (Mevacor), pravastatin (Pravachol), simvastatin (Zocor), atorvastatin (Lipitor), and rosuvastatin (Crestor)

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Other Lipid Lowering Agents (non-statin)

Category Definition: Any agent used to reduce cholesterol in the blood but are not considered a statin. Examples include (but are not limited to) fibrates (e.g. clofibrate, bezafibrate, or ciprofibrate), colestyramine (Questran / Questran Light), colestipol (Colestid), and nicotinic acid (niacin).

Effective Date: 1/1/2004

Expiration Date:

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Appendix B - Medications (Definitions Only)

Timeframe: IntraProcedure

Medication: Unfractionated Heparin

Category: Anticogulants

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: LMWH

Category: Anticogulants

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Atropine

Category: Atropine

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Thrombin Inhibitors

Category Definition: Thrombin Inhibitor (Any): One type of anticoagulant medication that is used to help prevent formation of harmful blood clots in the body by blocking the activity of thrombin, which plays a pivotal role in the clotting process. Examples include (but are not limited to) bivalirudin, lepirudin (Refludan), and desirudin (Revasc). Note: This category does NOT include heparin.

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: IIb/IIIas

Category Definition: Any agent used to prevent platelets from binding together, which can occur in patients with heart attacks, unstable angina, and after angioplasty with or without stent placement. Examples include (but are not limited to) Abciximab (ReoPro), Eptifibatide (Integrilin), and Tirofiban (Aggrastat)

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Vasodilators

Category Definition: Any agent that causes blood vessels in the body to become wider by relaxing the smooth muscle in the vessel wall, or vasodilation. This will reduce blood pressure (since there is more room for the blood). Examples include (but are not limited to) nesiritide (Natrecor), nitroglycerin, and sodium nitroprusside (Nipride).

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Appendix B - Medications (Definitions Only)

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Vasopressors

Category Definition: Any agent that produces vasoconstriction and a rise in blood pressure (usually understood as increased arterial pressure). Examples include (but are not limited to) dobutamine, dopamine, epinephrine, inamrinone, midodrine, milrinone, norepinephrine, phenylephrine, and vasopressin (Pitressen).

Effective Date: 1/1/2004

Expiration Date:

Timeframe: PostProcedure

Medication: Unfractionated Heparin

Category: Anticogulants

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: LMWH

Category: Anticogulants

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Atropine

Category: Atropine

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Thrombin Inhibitors

Category Definition: Thrombin Inhibitor (Any): One type of anticoagulant medication that is used to help prevent formation of harmful blood clots in the body by blocking the activity of thrombin, which plays a pivotal role in the clotting process. Examples include (but are not limited to) bivalirudin, lepirudin (Refludan), and desirudin (Revasc). Note: This category does NOT include heparin.

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: IIb/IIIas

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Appendix B - Medications (Definitions Only)

Category Definition: Any agent used to prevent platelets from binding together, which can occur in patients with heart attacks, unstable angina, and after angioplasty with or without stent placement. Examples include (but are not limited to) Abciximab (ReoPro), Eptifibatide (Integrilin), and Tirofiban (Aggrastat)

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Vasodilators

Category Definition: Any agent that causes blood vessels in the body to become wider by relaxing the smooth muscle in the vessel wall, or vasodilation. This will reduce blood pressure (since there is more room for the blood). Examples include (but are not limited to) nesiritide (Natrecor), nitroglycerin, and sodium nitroprusside (Nipride).

Effective Date: 1/1/2004

Expiration Date:

Medication: Any

Category: Vasopressors

Category Definition: Any agent that produces vasoconstriction and a rise in blood pressure (usually understood as increased arterial pressure). Examples include (but are not limited to) dobutamine, dopamine, epinephrine, inamrinone, midodrine, milrinone, norepinephrine, phenylephrine, and vasopressin (Pitressen).

Effective Date: 1/1/2004

Expiration Date:

Timeframe: PreProcedure

Medication: ASA (Aspirin)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Clopidogrel (Plavix)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date:

Medication: Ticlopidine (Ticlid)

Category: Antiplatelets

Category Definition:

Effective Date: 1/1/2004

Expiration Date: