**Variable Key – LV thrombus Database**

History

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| Biodata:   1. Age (raw value) 2. Gender  * 0: Male * 1: Female  1. Race  * 0: Chinese * 1: Malay * 2: Indian * 3: Others  1. BMI |
| Social history:   1. Smoking status  * 0: Non-smoker * 1: Ex-smoker * 2: Current smoker  1. Alcohol consumption  * 0: Non-alcoholic * 1: Ex-alcoholic * 2: Current alcoholic |
| Co-morbidities:   1. AF  * 0: Absent * 1: Present  1. Prior ACC Status  * 0: Absent * 1: Present  1. Prior ACC type  * 0: None * 1: Warfarin * 2: NOAC  1. HTN  * 0: Absent * 1: Present  1. HLD  * 0: Absent * 1: Present  1. DM  * 0: Absent * 1: Impaired Fasting Glucose * 2: Impaired Glucose Tolerance * 3: T2 DM  1. Stroke  * 0: Absent * 1: Transient Ischemic Attack * 2: Cerebral Infarction  1. Previous ACS (not including referenced AMI)  * 0: Absent * 1: UA/TVD/NSTEMI * 2: STEMI * 3: IHD  1. Heart Failure  * 0: Absent * 1: Present  1. Previous episode of venous thromboembolism  * 0: Absent * 1: Present  1. PVD  * 0: Absent * 1: Intermittent Claudication * 2: Critical Limb Ischemia  1. Asthma  * 0: Absent * 1: Present  1. COPD  * 0: Absent * 1: Present  1. Chronic liver disease  * 0: Absent * 1: Present (Presence of cirrhosis, AST or ALT >3x ULN)  1. Renal Failure  * 0: Absent * 1: CKD * 2: ESRF on dialysis * 3: Post-transplant  1. Malignancy  * 0: Absent * 1: Present  1. Post-MI Arrhythmias  * 0: None * 1: VT (either sustained or non-sustained) * 2: Pulseless VT/VF * 3: Complete Heart Block * 4: Bradycardia * 5: PEA  1. Post-MI AF  * 0: Absent * 1: Present  1. Cardiogenic shock  * 0: Absent * 1: Present  1. CPR  * 0: Absent * 1: Present |
| 1. Date of MI (exact date, usually date of presentation) |

Investigations

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| Imaging:   1. Day of Dx when investigation done 2. Type of initial scan  * 0: TTE * 1: TEE * 2: CT * 3: MRI * 4: Cardiac Ventriculography   Past and Current STEMI -   1. NSTEMI  * 0: Absent * 1: Present * 999: NA  1. Anterior 2. Septal 3. Lateral 4. Inferior 5. Posterior 6. Area of Infarct  * 0: NSTEMI * 1: Anterior * 2: Anterolateral * 3: Anteroseptal * 4: Anteroinferior * 5: Lateral * 6: Inferior * 7: Inferoposterior * 8: Inferolateral * 9: Posterior  1. EF on scan (Visual) 2. MR/MS/AR/AS/TR/TS/PR/PS  * 0: Absent * 1: Mild * 2: Mild-moderate * 3: Moderate * 4: Moderate-severe * 5: Severe  1. LVIDd/mm 2. LVIDs/mm 3. LVOT/mm 4. Any wall motion abnormality  * 0: Absent * 1: Regional * 2: Global  1. If RWMA, which wall affected  * 1: Apex * 2: Anterior * 3: Septal * 4: Inferior * 5: Lateral  1. LV aneurysm post-MI  * 0: Absent * 1: Present  1. Free mobility of LV thrombus on scan  * 0: Absent * 1: Present  1. Protrusion of LV thrombus on scan (?Large, ?Protuberant, ?Pedunculated)  * 0: Absent * 1: Present  1. Thrombus Diameter (largest cm) |
| Laboratory Investigations: (immediately before/after LV thrombus discovery)   1. Maximal troponin I (0-39 ng) or Trop T (<0.03ug) 2. Hb (g/dL) 3. TW (x10^9/L) 4. Lymphocyte 5. Neutrophil count 6. Plt (x10^9/L) 7. PT (s) 8. INR 9. APTT (s) 10. AST (U/L) 11. ALT (U/L) 12. ALP (U/L) 13. eGFR 14. Creatinine (mmol/L) |

Management

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| Concomitant Tx:   1. Use of Aspirin  * 0: Absent * 1: Present  1. Use of 2nd Antiplatelet:  * 0: Absent * 1: Clopidogrel * 2: Ticagrelor * 3: Prasugrel * 4: Ticlopidine |
| Definitive Tx for AMI:   1. Coronary Artery Disease  * 0: None * 1: Single vessel CAD * 2: Dual vessel CAD * 3: Triple vessel CAD  1. Coronary Angiogram done  * 0: None done * 1: Done  1. Number of culprit arteries 2. Which culprit arteries  * 1: LAD * 2: RCA * 3: LCx  1. Revascularisation done  * 0: None done * 1: PCI done * 2: CABG done * 3: Thrombolysis done  1. Type of stent used  * 0: POBA * 1: Drug-eluting stent * 2: Bare-metal stent * 3: Bioabsorbable vascular stent * 999: NA |
| Tx for LV thrombus:   1. Use of bridging heparin  * 0: Absent * 1: SC Clexane * 2: IV Heparin  1. Was patient started on anticoagulation at time of LVT diagnosis?  * 0: No * 1: Yes  1. Reason for no anticoagulation at time of LVT diagnosis 2. Type of Anticoagulation  * 0: Warfarin * 1: NOAC * 2: SC Clexane/IV Heparin * 3: None * 999: Died in-patient – hence not on warfarin, not because chose not to have  1. Duration of initial anticoagulation (number of days)  * 999: NA (if No ACC or 999 previously) |

Outcomes

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| 1. Type of repeat scan (next immediate scan post-LVT diagnosis) 2. Repeat scan date 3. Reason for no repeat scan 4. Type of final scan  * 0: TTE * 1: TEE * 2: CT * 3: MRI  1. Final EF 2. Duration to resolution (number of days) 3. Status of LVT  * 0: Resolved, alive * 1: Unresolved, alive * 2: Unresolved, deceased * 3: Resolved, deceased * 4: Lost to F/U  1. LV thrombus recurrence  * 0: Resolved, did not recur * 1: Resolved, recurred * 2: Did not resolve – either alive or deceased * 999: Missing data/Lost to follow up  1. Status of Bleed  * 0: Absent * 1: Present  1. Type of BARC bleeding event  * 0: Type 0 (absent) * 1: Type 1 – not actionable * 2: Type 2 – overt bleeding, require medical intervention, hospitalisation, evaluation * 3: Type 3 – a: overt bleeding, b: cardiac tamponade/require surgical intervention, c: ICH/intraocular * 4: Type 4 – CABG bleeding * 5: Type 5 – fatal  1. Bleeding Reason in prose 2. Date of Bleeding 3. Time to Bleed (days) 4. Status of Stroke  * 0: Absent * 1: Present  1. Type of Embolism event  * 0: Absent * 1: Acute limb ischemia * 2: Stroke  1. Date of Stroke 2. Time to Stroke (days) 3. Was patient on anticoagulation at time of stroke?  * 0: No * 1: Yes  1. Reason for no acc at time of stroke 2. Date of Acute Limb Ischaemia 3. Status of HF  * 0: Absent * 1: Present  1. Type of HF  * 0: no HF * 1-4: NYHA 1-4 * 5: acute decompensated, acute HF, CCF  1. Date of HF 2. Post-MI arrhythmia  * 0: Absent * 1: Post- or peri-MI AF * 2: Others (to be coded)  1. Post-MI arrhythmia date 2. Mortality  * 0: Alive * 1: Deceased  1. In-hospital mortality  * 0: Absent * 1: Present  1. Comments on in-hospital mortality 2. Date of Death 3. Time to Death (days) 4. Last Seen in Clinic Date – cap End Feb 2018 (by Aloy) 5. Last Seen by Chris 6. Reason for prolonged post-resolution / continuing ACC  * 0: Not on ACC * 1: LVT not resolved * 2: Recurrence of LVT * 3: Low EF * 4: LV aneurysm * 5: Apex akinetic * 5: Concurrent AF * 999: non-resolved deceased / lost to follow up * If LVT resolved – write reason down (ACC may have been longer than LVT resolution or currently still on) |

**Additional Stroke Variables**

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| 1. Date of stroke (already collected) 2. Previous stroke – should not have! 3. Days to stroke 4. Antiplatelet  * 0: None * 1: SAPT * 2: DAPT  1. Warfarin  * 0: Absent * 1: Present  1. BridgingTx  * 0: None * 1: Clexane * 2: IV Heparin  1. Time of stroke (last seen well) 2. NIHSS – integer  * 999: Not known  1. Imaging used to diagnose – 1 variable each  * 0: CT Brain plain * 1: CT angiogram * 2: MRI/MR angiogram * 3: ECD – Extracranial cervical duplex * 4: TCD – Transcranial doppler  1. Location of occlusion if any – in prose  * 0: None * 999: Not reported  1. Location of stroke – in prose 2. TOAST classification – mechanism of stroke  * 1: Atherosclerosis of great vessels * 2: Cardioembolism – exclude cases attributed to PFO/ASD * 3: Occlusion of small vessels (lacunar) * 4: Ischemic stroke of another etiology (defined) * 5: Two or more identified causes * 6: Cryptogenic ischemic stroke  1. Intervention for stroke  * 0: None * 1: TPA * 2: Endovascular therapy  1. Time to treatment – in minutes  * 999: N/A  1. SICH (symptomatic intracranial hemorrhage) or any form of hemorrhagic transformation  * 0: Absent * 1: Present  1. Stroke in-hospital mortality  * 0: Absent * 1: Present  1. Modified Rankin Scale at baseline/pre-stroke  * 0: No symptoms * 1: No significant disability, despite symptoms, able to perform all usual activities and duties * 2: Slight disability, unable to perform all previous activities but able to look after own affairs without assistance * 3: Moderate disability, requires 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 requires constant nursing care and attention * 6: Death  1. Modified Rankin Scale at 3-months  * 999: Lost to F/U |