

**CARE Registry™**  
**Carotid Artery Revascularization and Endarterectomy Registry v1.08**  
**Data Dictionary - Elements and Definitions**  
**Carotid Endarterectomy Dataset**

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**A. Participant Administration**

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**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.

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**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.

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**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).

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**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:**

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

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**Field Name:** Auxiliary 1

**Seq No:** 2110

**Definition:** Reserved for future use.

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**Field Name:** Auxiliary 2

**Seq No:** 2120

**Definition:** Reserved for future use.

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**C. Admission**

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**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 >=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 cm<sup>2</sup>). 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 cm<sup>2</sup> 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

**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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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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**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

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**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.

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**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).

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**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.

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**Field Name:** Operator Last Name **Seq No:** 5020

**Definition:** Indicate the primary operator's last name.

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**Field Name:** Operator First Name **Seq No:** 5021

**Definition:** Indicate the primary operator's first name.

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**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	

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**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	

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**F. CEA Intraprocedure Information**

**Field Name:** Arteriotomy Patch Used

**Seq No:** 5800

**Definition:** Indicate if there was closure of the internal carotid arteriotomy with a patch during the carotid endarterectomy (CEA) procedure.

**Selections:**

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

**Field Name:** Visible Thrombus Present

**Seq No:** 5805

**Definition:** Indicate if a thrombus (blood clot) was present on direct visual inspection interoperatively during the carotid endarterectomy (CEA) procedure.

**Selections:**

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

**Field Name:** Shunt Used

**Seq No:** 5810

**Definition:** Indicate if a shunt was used at the surgical site to maintain blood flow during the carotid endarterectomy (CEA) procedure.

**Selections:**

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

**Field Name:** Surgical Procedure Terminated

**Seq No:** 5820

**Definition:** Indicate if the carotid endarterectomy procedure was terminated.

**Selections:**

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

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**Field Name:** Reasons for Surgical Termination

**Seq No:** 5821

**Definition:** Indicate the reasons the carotid endarterectomy procedure was terminated. Choose all that apply.

**Selections:**

Coding/Sort	Selection(Choose multiple)	Explanation
1	Hypertension	
2	Hypotension	
3	Cardiac instability	Cardiac instability can include cardiac ischemia, heart failure or rhythm disturbances.
4	Nerve compromise	Nerve compromise includes injuries to cranial nerves.
5	Difficulty with anesthesia	
6	Inability to implement shunting	Inability to implement shunting procedure in someone for whom it is felt to be necessary.
7	Excessive scar tissue	
8	Difficult dissection	
9	Excessive bleeding	
10	Carotid artery thrombosis	
11	ICA string sign/atresia	
12	Inability to access lesion due to anatomical reasons	
13	Other	

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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.

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**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.

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**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.

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**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	

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**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:**

<b>Coding/Sort</b>	<b>Selection(Choose one)</b>	<b>Explanation</b>
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:** 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:** 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:** Cranial Nerve Injury

**Category:** Other Neurologic (not TIA/ Stroke)

**Effective Date:** 1/1/2004

**Expiration Date:**

**Definition:** Indicate if the patient experienced a new cranial nerve injury, involving glossopharyngeal, vagus, accessory, hypoglossal, and/or superior laryngeal nerves.

**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:**

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**Carotid Artery Revascularization and Endarterectomy Registry v1.08**  
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**Appendix A - Adverse Events (Definitions Only)**

**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

**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:** Acute Occlusion

**Category:** Surgical Site

**Effective Date:** 1/1/2004

**Expiration Date:**

**Definition:** Indicate if the patient experienced acute occlusion of the carotid artery.

**Event:** Technical Defect Requiring Revision

**Category:** Surgical Site

**Effective Date:** 1/1/2004

**Expiration Date:**

**Definition:** Indicate if there were technical defects requiring revision during the CEA procedure. A technical defect is a problem related to the surgical procedure (CEA) which requires return to the operating room for revision of some portion of the surgical procedure.

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

**Category:** Bleeding

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**Appendix A - Adverse Events (Definitions Only)**

**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:** Wound Bleeding Complications

**Category:** Bleeding

**Effective Date:** 1/1/2004

**Expiration Date:**

**Definition:** Indicate if the patient experienced wound complications (bleeding or hematoma) that required return to the operating room, caused airway compromise, or required extension of length of stay.

**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:** 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:** 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.

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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 (Natreacor), 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:** Anticoagulants

**Category Definition:**

**Effective Date:** 1/1/2004

**Expiration Date:**

**Medication:** LMWH

**Category:** Anticoagulants

**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

## CARE Registry™

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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:**