

iSCAD Registry

Event Case Report Form
Version 8
(November 2, 2018)

iSCAD Registry

Event Case Report Form

Page 2 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

0. Visit Details

0.1 Was the patient seen in person? Yes No, this is a chart review

1. Physical Exam

1.1 Date of visit: _____ Month / _____ Day / _____ Year

1.2 Height: _____ ft. _____ in or _____ cm

1.3 Weight: _____ lbs. or _____ kg

1.4 Blood pressure: _____ / _____

1.5 Heart rate: _____ bpm

2. Clinical presentation (THESE QUESTIONS RELATE TO THE MOST RECENT SCAD EVENT)

2.1 Date of hospital admission: _____ Month / _____ Day / _____ Year

2.2 Time from symptom onset to hospital presentation: _____ hours Not assessed

2.3 Time from hospital presentation to coronary angiography: <24 hours 24-48 hours >48 hours Not assessed

2.4 Blood pressure at time of presentation: _____ / _____ Not assessed

2.5 Heart rate at time of presentation: _____ bpm Not assessed

2.6 Initial clinical presentation of the SCAD episode (select all that apply):

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Atypical chest pain | <input type="checkbox"/> Stable angina | <input type="checkbox"/> Unstable angina |
| <input type="checkbox"/> NSTEMI | <input type="checkbox"/> STEMI | <input type="checkbox"/> Cardiogenic shock | <input type="checkbox"/> Cardiac arrest |
| <input type="checkbox"/> Not assessed | <input type="checkbox"/> Other, specify: | | |

2.7 Initial electrocardiogram of the SCAD episode (select all that apply):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ST elevation | <input type="checkbox"/> ST depression | <input type="checkbox"/> T wave flattening or inversion | <input type="checkbox"/> Hyperacute T waves |
| <input type="checkbox"/> Pathologic Q waves | <input type="checkbox"/> Ventricular tachycardia | <input type="checkbox"/> Ventricular fibrillation | <input type="checkbox"/> Asystole |
| <input type="checkbox"/> Normal sinus rhythm | <input type="checkbox"/> Not assessed | <input type="checkbox"/> Other, specify: | |

3. Laboratory test (THESE QUESTIONS RELATE TO HOSPITALIZATION FOR THE MOST RECENT SCAD EVENT)

3.1 Troponin T (TnT) _____ ng/mL (Peak value) UL: _____ Not assessed

3.2 Troponin I (TnI) _____ ng/mL (Peak value) UL: _____ Not assessed

3.3 Creatine kinase (CK) _____ U/L (Peak value) UL: _____ Not assessed

3.4 Creatine kinase-MB (CK-MB) _____ U/L (Peak value) UL: _____ Not assessed

3.5 Antinuclear antibody (ANA) _____ (Positive Negative) Not assessed

3.6 Erythrocyte sedimentation rate (ESR) _____ mm/hr UL: _____ Not assessed

3.7 C-reactive protein (CRP) _____ mg/dL UL: _____ Not assessed

3.8 High-sensitivity C-reactive protein (hsCRP) _____ mg/L UL: _____ Not assessed

3.9 Total cholesterol _____ mg/dL UL: _____ Not assessed

3.10 Low-density lipoprotein cholesterol (LDL-C) _____ mg/dL UL: _____ Not assessed

3.11 High-density lipoprotein cholesterol (HDL-C) _____ mg/dL UL: _____ Not assessed

3.12 Triglyceride _____ mg/dL UL: _____ Not assessed

3.13 Glycated hemoglobin (HbA_{1c}) _____ % UL: _____ Not assessed

3.14 Brain natriuretic peptide (BNP) _____ pg/ml UL: _____ Not assessed

3.15 N-terminal pro-b-type natriuretic peptide (NT-proBNP) _____ pg/ml UL: _____ Not assessed

UL = Upper Limit of Normal

4. In-hospital management (FOR THE MOST RECENT SCAD EVENT)

iSCAD Registry

Event Case Report Form

Page 3 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

4.1 Thrombolytic agent administered during hospitalization: Yes No Not assessed

4.1.1 If Yes, type (select all that apply):

- Alteplase (Activase) Anistreplase (Eminase) Reteplase (Retavase) Streptokinase (Kabikinase)
 Tenecteplase (TNKase) Other, specify:

4.2 Anticoagulant administered during hospitalization: Yes No Not assessed

4.2.1 If Yes, type (select all that apply):

- Bivalirudin Fondaparinux LMWH Unfractionated heparin
 Other, specify:

4.3 Antiplatelet agent administered during hospitalization: Yes No Not assessed

4.3.1 If Yes, type (select all that apply):

- Aspirin Clopidogrel GpIIb/IIIa inhibitor Prasugrel
 Ticagrelor Other, specify:

4.4 Other cardiovascular medications administered during hospitalization: Yes No Not assessed

4.4.1 If Yes, type (select all that apply):

- ACEI/ARB Beta blocker Calcium channel blocker Diuretic
 Ranolazine Statin Nitrate (IV, PO, or SL) Other, specify:

4.5 Percutaneous coronary intervention (PCI) performed during hospitalization: Yes No Not assessed

4.5.1 If PCI was performed, date: _____ Month / _____ Day / _____ Year

4.5.2 If PCI was performed, type of complication (select all that apply):

- No complication Abrupt closure Dissection Distal embolization
 No reflow Side branch loss Spasm Perforation
 Thrombus Other, specify: Not assessed

4.5.3 Were any stents placed? Yes No Not assessed

4.5.3.1 If Stent placement was performed, number of stents: ____ / Not assessed

4.5.3.2 If Stent placement was performed, type of stents (select all that apply): BMS DES Bioabsorbable Not assessed

4.6 CABG performed during hospitalization: Yes No Not assessed

4.6.1 If CABG was performed, date: _____ Month / _____ Day / _____ Year

4.6.2 If Yes, type of graft (select all that apply):

- Internal mammary Radial Gastroepiploic Inferior epigastric
 Saphenous vein Other, specify: Not assessed

4.6.3 If Yes, touchdown (select all that apply):

- LM LAD Diagonal Septal
 Cx/RI Obtuse marginal RCA Acute marginal
 Posterior descending Posterior ventricular Other, specify: Not assessed

4.7 Mechanical supportive therapy during hospitalization (select all that apply): Yes No Not assessed

4.7.1 If Yes, type (select all that apply): Intra-aortic balloon pump Impella device Ventricular assist device
 Transplantation Not assessed

4.8 If the patient presented with cardiac arrest, was an implantable cardiac defibrillator (ICD) placed?

Yes No Not assessed Patient did not present with cardiac arrest

5. In-hospital events (FOR THE MOST RECENT SCAD EVENT)

5.1 Recurrent MI: Yes No Not assessed

5.1.1 If Yes, number of recurrent MI: _____

Recurrent MI #1:

5.1.1.1 Date of recurrent MI: _____ Month / _____ Day / _____ Year

iSCAD Registry

Event Case Report Form

Page 4 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

5.1.1.1.2 Presentation of recurrent MI (select all that apply):

Chest pain ECG ischemic changes Arrhythmia Other, specify:

Recurrent MI #2:

5.1.1.2.1 Date of recurrent MI: _____ Month / _____ Day / _____ Year

5.1.1.2.2 Presentation of recurrent MI (select all that apply):

Chest pain ECG ischemic changes Arrhythmia Other, specify:

5.2 New arrhythmia: Yes No Not assessed

5.2.1 If **Yes**, date of diagnosis: _____ Month / _____ Day / _____ Year

5.2.2 If **Yes**, type (select all that apply):

Ventricular fibrillation Ventricular tachycardia Other, specify:

5.2.3 If **Yes**, procedure pertaining to new arrhythmia (select all that apply):

Temporary pacemaker Permanent pacemaker ICD
 Wearable cardioverter defibrillator No procedure performed Other, specify:

5.3 Cerebrovascular accident: Yes No Not assessed

5.3.1 If **Yes**, date of diagnosis: _____ Month / _____ Day / _____ Year

5.3.2 If **Yes**, type of CVA

Ischemic stroke Hemorrhagic stroke Transient ischemic attack Unclear

5.4 Heart failure requiring diuretics: Yes No Not assessed

5.5 Any other events? Yes No

5.5.1 Please describe:

6. Coronary angiogram (FOR THE MOST RECENT SCAD EVENT)

6.1 Total number of angiograms done for the most recent SCAD event: _____

6.1.1 Angiogram #1: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

6.1.1.1 Angiogram performed: Date _____ Month / _____ Day / _____ Year

6.1.1.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

6.1.1.2.1 If **Yes**, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

6.1.1.3 Vascular access site complication occurred? Yes No Not assessed

6.1.1.3.1 If **Yes**, specify (select all that apply):

Hematoma Pseudoaneurysm Acute limb ischemia Spasm
 Loss of pulse (Asymptomatic) Dissection Retroperitoneal bleed Other, specify:

6.1.2 Angiogram #2: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

6.1.2.1 Angiogram performed: Date _____ Month / _____ Day / _____ Year

6.1.2.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

6.1.2.2.1 If **Yes**, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

6.1.2.3 Vascular access site complication occurred? Yes No Not assessed

6.1.2.3.1 If **Yes**, specify (select all that apply):

Hematoma Pseudoaneurysm Acute limb ischemia Spasm
 Loss of pulse (Asymptomatic) Dissection Retroperitoneal bleed Other, specify:

6.1.3 Angiogram #3: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

6.1.3.1 Angiogram performed: Date _____ Month / _____ Day / _____ Year

6.1.3.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

6.1.3.2.1 If **Yes**, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

6.1.3.3 Vascular access site complication occurred? Yes No Not assessed

6.1.3.3.1 If **Yes**, specify (select all that apply):

Hematoma Pseudoaneurysm Acute limb ischemia Spasm
 Loss of pulse (Asymptomatic) Dissection Retroperitoneal bleed Other, specify:

7. Discharge management (FOR THE MOST RECENT SCAD EVENT)

iSCAD Registry

Event Case Report Form

Page 5 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

7.1 Date of discharge: _____ Month / _____ Day / _____ Year

7.2 Anticoagulant at discharge: Yes No Not assessed

7.2.1 If Yes, specify the indication for anticoagulation: _____

7.2.2 If Yes, type of anticoagulant: Warfarin DOAC Other, specify:

7.3 Antiplatelet agent at discharge: Yes No Not assessed

7.3.1 If Yes, type (select all that apply):

Aspirin Clopidogrel Prasugrel Ticagrelor
 Not assessed Other, specify:

7.4 Other cardiovascular medications at discharge: Yes No Not assessed

7.4.1 If Yes, type (select all that apply):

ACEI/ARB Beta blocker Calcium channel blocker Diuretic
 Nitrate Ranolazine Statin Other, specify:

8. New Events (FROM LAST VISIT. DO NOT INCLUDE CURRENT SCAD ADMISSION)

8.1 Has the patient been admitted for a myocardial infarction? Yes No Not assessed

If Yes, please answer the following specific to the MI

8.1.1 Date of Myocardial Infarction: _____ Month / _____ Day / _____ Year

8.1.2 Is the MI related to SCAD? Yes No Not assessed

8.1.3 Type of MI: ST elevation MI Non-ST elevation MI Not assessed

8.1.4 Peak Troponin T level: _____ Units: _____ Upper limit of normal: _____ Not assessed

8.1.5 Peak Troponin I level: _____ Units: _____ Upper limit of normal: _____ Not assessed

8.1.6 Angiogram done during admission: Yes No Not assessed

If Yes, please answer the following:

8.1.6.1 Number of angiograms: _____

8.1.6.1.1 Angiogram #1: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

8.1.6.1.1.1 Date of angiogram: _____ Month / _____ Day / _____ Year

8.1.6.1.1.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

8.1.6.1.1.2.1 If Yes, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

8.1.6.1.1.3 Vascular access site complication occurred? Yes No Not assessed

8.1.6.1.1.3.1 If Yes, specify (select all that apply):

Hematoma Pseudoaneurysm Acute limb ischemia Spasm
 Loss of pulse (Asymptomatic) Dissection Retroperitoneal bleed Other, specify:

8.1.6.1.2 Angiogram #2: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

8.1.6.1.2.1 Date of angiogram: _____ Month / _____ Day / _____ Year

8.1.6.1.2.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

8.1.6.1.2.2.1 If Yes, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

8.1.6.1.2.3 Vascular access site complication occurred? Yes No Not assessed

8.1.6.2.3.1 If Yes, specify (select all that apply):

Hematoma Pseudoaneurysm Acute limb ischemia Spasm
 Loss of pulse (Asymptomatic) Dissection Retroperitoneal bleed Other, specify:

8.1.7 Thrombolysis administered: Yes No Not assessed

8.1.7.1 If Yes, type (select all that apply):

Alteplase (Activase) Anistreplase (Eminase) Reteplase (Retavase) Streptokinase (Kabikinase)

iSCAD Registry

Event Case Report Form

Page 6 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

Tenecteplase (TNKase) Other, specify:

8.1.8 Anticoagulation administered during hospitalization: Yes No Not assessed

8.1.8.1 If Yes, type (select all that apply):

Bivalirudin Fondaparinux LMWH Unfractionated heparin

Other, specify:

8.1.9 Antiplatelet medication administered during hospitalization: Yes No Not assessed

8.1.9.1 If Yes, select all that apply:

Aspirin Clopidogrel GpIIb/IIIa inhibitor Prasugrel

Ticagrelor Other, specify:

8.1.10 Other cardiac medication administered during the event: Yes No Not assessed

8.1.10.1 If Yes, select all that apply:

ACEI/ARB Beta blocker Calcium channel blocker Diuretic
 Ranolazine Statin Nitrate (IV, PO, or SL) Other, specify:

8.2 If admitted for a MI (Section 8.1), was Percutaneous Coronary Intervention (PCI) attempted? Yes No Not assessed

If Yes, please answer the following:

8.2.1 Date of PCI: _____ Month / _____ Day / _____ Year

8.2.2 Were any stents placed? Yes No Not assessed

8.2.2.1 If Stent placement was performed, number of stents: ____ / Not assessed

8.2.2.2 If Stent placement was performed, type of stents (select all that apply): BMS DES Bioabsorbable Not assessed

8.2.3 Type of complication (select all that apply):

No complication Abrupt closure Dissection Distal embolization
 No reflow Side branch loss Spasm Perforation
 Thrombus Other, specify:

8.3 If admitted for a MI (Section 8.1), was Coronary Artery Bypass attempted? Yes No Not assessed

If Yes, please answer the following:

8.3.1 If Yes, Date of CABG: _____ Month / _____ Day / _____ Year

8.3.2 If Yes, type of graft (select all that apply):

Internal mammary Radial Gastroepiploic Inferior epigastric
 Saphenous vein Other, specify: Not assessed

8.3.3 If Yes, touchdown points (Select all that apply):

LM LAD Diagonal Septal
 Cx/RI Obtuse marginal RCA Acute marginal
 Posterior descending Posterior ventricular Other, specify: Not assessed

8.4 During admission for a MI (Section 8.1), did the patient require mechanical supportive therapy: Yes No Not assessed

8.4.1 If Yes, type (select all that apply): Intra-aortic balloon pump Impella device Ventricular assist device
 Transplantation Not assessed

9. Elective Procedures (DO NOT INCLUDE PROCEDURES FOR CURRENT SCAD ADMISSION)

9.1 Since the last visit, did the patient have an elective angiogram that was not included in Section 8.1? Yes No Not assessed

If Yes, please answer the following:

9.1.1 Number of angiograms: _____

9.1.1.1 Angiogram #1: Access site: Radial Femoral Brachial Not assessed **Side:** Left Right Not assessed

9.1.1.1.1 Date of angiogram: _____ Month / _____ Day / _____ Year

9.1.1.1.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

iSCAD Registry

Event Case Report Form

Page 7 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

9.1.1.1.2.1 If **Yes**, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

9.1.1.1.3 Vascular access site complication occurred? Yes No Not assessed

9.1.1.1.3.1 If **Yes**, specify (select all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Pseudoaneurysm | <input type="checkbox"/> Acute limb ischemia | <input type="checkbox"/> Spasm |
| <input type="checkbox"/> Loss of pulse (Asymptomatic) | <input type="checkbox"/> Dissection | <input type="checkbox"/> Retroperitoneal bleed | <input type="checkbox"/> Other, specify: |

9.1.1.2 Angiogram #2: Access site: Radial Femoral Brachial Not assessed Side: Left Right Not assessed

9.1.1.2.1 Date of angiogram: _____ Month / _____ Day / _____ Year

9.1.1.2.2 Intracoronary imaging performed (select all that apply): IVUS OCT No

9.1.1.2.2.1 If **Yes**, does intracoronary imaging performed support the diagnosis of SCAD? Yes No Inconclusive

9.1.1.2.3 Vascular access site complication occurred? Yes No Not assessed

9.1.1.2.3.1 If **Yes**, specify (select all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Hematoma | <input type="checkbox"/> Pseudoaneurysm | <input type="checkbox"/> Acute limb ischemia | <input type="checkbox"/> Spasm |
| <input type="checkbox"/> Loss of pulse (Asymptomatic) | <input type="checkbox"/> Dissection | <input type="checkbox"/> Retroperitoneal bleed | <input type="checkbox"/> Other, specify: |

9.2 Since the last visit, did the patient have an elective PCI that was not included in Section 8.2? Yes No Not assessed

If **Yes**, please answer the following:

9.2.1 Date of PCI: _____ Month / _____ Day / _____ Year

9.2.2 Were any stents placed? Yes No Not assessed

9.2.2.1 If **Stent placement** was performed, number of stents: ____ / Not assessed

9.2.2.2 If **Stent placement** was performed, type of stents (select all that apply): BMS DES Bioabsorbable Not assessed

9.2.3 Type of complication (select all that apply):

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> No complication | <input type="checkbox"/> Abrupt closure | <input type="checkbox"/> Dissection | <input type="checkbox"/> Distal embolization |
| <input type="checkbox"/> No reflow | <input type="checkbox"/> Side branch loss | <input type="checkbox"/> Spasm | <input type="checkbox"/> Perforation |
| <input type="checkbox"/> Thrombus | <input type="checkbox"/> Other, specify: | | |

9.3 Since the last visit, did the patient have an elective CABG that was not included in Section 8.3: Yes No Not assessed

If **Yes**, please answer the following:

9.3.1 If **Yes**, Date of CABG: _____ Month / _____ Day / _____ Year

9.3.2 If **Yes**, type of graft (select all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Internal mammary | <input type="checkbox"/> Radial | <input type="checkbox"/> Gastroepiploic | <input type="checkbox"/> Inferior epigastric |
| <input type="checkbox"/> Saphenous vein | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Not assessed | |

9.3.3 If **Yes**, touchdown points (Select all that apply):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> LM | <input type="checkbox"/> LAD | <input type="checkbox"/> Diagonal | <input type="checkbox"/> Septal |
| <input type="checkbox"/> Cx/RI | <input type="checkbox"/> Obtuse marginal | <input type="checkbox"/> RCA | <input type="checkbox"/> Acute marginal |
| <input type="checkbox"/> Posterior descending | <input type="checkbox"/> Posterior ventricular | <input type="checkbox"/> Other, specify: | <input type="checkbox"/> Not assessed |

10. New Admissions (SINCE LAST VISIT)

10.1 Did the patient present to the emergency department with cardiac symptoms (such as chest pain, shortness of breath, palpitations) but did not require admission since the last visit? Yes No Not assessed

10.1.1 If **Yes**, number of visits: _____

Date of visit 1: _____ Month / _____ Day / _____ Year

Date of visit 2: _____ Month / _____ Day / _____ Year

Date of visit 3: _____ Month / _____ Day / _____ Year

Date of visit 4: _____ Month / _____ Day / _____ Year

10.2 Was the patient hospitalized for angina without myocardial infarction? Yes No Not assessed

10.2.1 If **Yes**, number of admissions: _____

Date of admission 1: _____ Month / _____ Day / _____ Year

Date of admission 2: _____ Month / _____ Day / _____ Year

Date of admission 3: _____ Month / _____ Day / _____ Year

Date of admission 4: _____ Month / _____ Day / _____ Year

10.3 Was the patient hospitalized for decompensated heart failure since last visit? Yes No Not assessed

10.3.1 If **Yes**, number of admissions: _____

iSCAD Registry

Event Case Report Form

Page 8 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

Date of admission 1: _____ Month / _____ Day / _____ Year

Date of admission 2: _____ Month / _____ Day / _____ Year

Date of admission 3: _____ Month / _____ Day / _____ Year

Date of admission 4: _____ Month / _____ Day / _____ Year

10.4 Did the patient experience a cerebrovascular accident (stroke or transient ischemic attack) since the last visit?

Yes No Not assessed

10.4.1 If **Yes**, number of events: _____

10.4.1.1 Admission 1: Date of admission: _____ Month / _____ Day / _____ Year

10.4.1.1.1 Type of CVA: Ischemic stroke Hemorrhagic stroke Transient ischemic attack Unclear

10.4.1.2 Admission 2: Date of admission: _____ Month / _____ Day / _____ Year

10.4.1.2.1 Type of CVA: Ischemic stroke Hemorrhagic stroke Transient ischemic attack Unclear

10.5 Did the patient experience a new arrhythmia requiring admission? Yes No Not assessed

If **Yes**, please answer the following:

10.5.1 Number of admissions:

Admission 1:

10.5.1.1.1 Date admitted: _____ Month / _____ Day / _____ Year

10.5.1.1.2 Arrhythmia requiring admission (please select all that apply):

Ventricular tachycardia

Ventricular fibrillation

Supraventricular tachycardia

Atrial fibrillation

Other (Please specify): _____

Admission 2:

10.5.1.2.1 Date admitted: _____ Month / _____ Day / _____ Year

10.5.1.2.2 Arrhythmia requiring admission (please select all that apply):

Ventricular tachycardia

Ventricular fibrillation

Supraventricular tachycardia

Atrial fibrillation

Other (Please specify): _____

11. Implantable Defibrillator (SINCE LAST VISIT)

11.1 Does the patient have an implantable cardiac defibrillator (ICD)? Yes No Not assessed

11.1.1 If **Yes**, since the last visit has the ICD delivered any shocks? Yes No Not assessed

If **Yes**, please answer the following:

11.1.1.1 Since the last visit, how many shocks did the ICD deliver? _____ Not assessed

11.1.1.2 Dates ICD fired shocks:

Shock 1: _____ Month / _____ Day / _____ Year

Shock 2: _____ Month / _____ Day / _____ Year

Shock 3: _____ Month / _____ Day / _____ Year

Shock 4: _____ Month / _____ Day / _____ Year

11.1.1.3 Reason for ICD firing (select all that apply):

Ventricular tachycardia

Ventricular fibrillation

Supraventricular tachycardia

Atrial fibrillation

Other (Please specify): _____

Does not apply

11.1.1.4 Was the firing appropriate?

Yes, all shocks fired were appropriate

There was at least one inappropriate shock fired

None of the shocks fired were appropriate

Not assessed

11.1.2 if **Yes**, since the last visit has the ICD delivered any anti-tachycardia (ATP) pacing? Yes No Not assessed

11.1.2.1 Reason for ATP pacing firing (select all that apply):

Ventricular tachycardia

Ventricular fibrillation

Supraventricular tachycardia

Atrial fibrillation

Other (Please specify): _____

Does not apply

11.1.3 If **No ICD was placed**, did the patient experience sudden cardiac death: Yes No

11.1.3.1 If **Yes**, date of sudden cardiac death: _____ Month / _____ Day / _____ Year

12. Cardiac Imaging (SINCE LAST VISIT)

iSCAD Registry

Event Case Report Form

Page 9 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

12.1 Coronary CT angiogram performed since last visit: Yes No

12.1.1 Date: ____ Month / ____ Day / ____ Year

12.1.2 Appearance consistent with SCAD: Yes No Inconclusive Not assessed

12.1.2.1 If yes, vessel involved (select all that apply):

- LM LAD Diagonal Septal
 Cx/RI Obtuse marginal RCA Acute marginal
 Posterior descending Posterior ventricular Other, specify:

12.1.3 Coronary tortuosity: Yes No Not assessed

12.1.4 Aortic ectasia: Yes No Not assessed

12.1.5 Other findings present? Yes No Not assessed

12.1.5.1 If Yes, please describe:

12.2 Cardiac MRI performed since last visit: Yes No

12.2.1 Date: ____ Month / ____ Day / ____ Year

12.2.2 Ejection fraction: _____% Not assessed

12.2.3 If Yes, gadolinium enhancement: Yes No Not assessed

12.2.3.1 If Yes, pattern consistent with (select all that apply):

- Myocarditis Ischemic cardiomyopathy Nonischemic cardiomyopathy Normal
 Transmural infarction Non-transmural infarction Other, specify:

12.2.3.1.1 If transmural infarction, location (select all that apply): Anterior Inferior Lateral Posterior Apex

12.2.3.1.2 If non-transmural infarction, location (select all that apply): Anterior Inferior Lateral Posterior Apex

12.3 Echocardiogram performed since last visit: Yes No

12.3.1 Date: ____ Month / ____ Day / ____ Year

12.3.2 Ejection fraction: _____% Not assessed

12.3.3 Focal wall motion abnormalities: Yes No Not assessed

12.3.3.1 If Yes, location: Anterior Inferior Lateral Posterior Apex

12.3.4 Structural complications of myocardial infarction: Yes No Not assessed

12.3.4.1 If Yes, type (Select all that apply): Incomplete mitral leaflet closure VSD
 Myocardial rupture (non-VSD) Apical thrombus

12.3.5 Takotsubo appearance: Yes No Not assessed

12.4 Stress test performed: Yes No

12.4.1 If yes, Date ____ Month / ____ Day / ____ Year

12.4.2 Type of stress test:

- Exercise echocardiography Exercise nuclear stress test Exercise only
 Dobutamine echocardiography Pharmacologic nuclear stress test Cardiac MRI
 Not assessed

12.4.3 #METS _____ Not assessed

12.4.4 Ischemia on ECG: Yes No Not assessed

12.4.4.1 If Yes: ST Elevation ST Depression

12.4.5 Ischemia on imaging: Yes No Not assessed

12.4.5.1: If Yes, location (Select all that apply): Anterior Inferior Lateral Posterior Apex

13. Non-coronary vascular imaging (SINCE LAST VISIT)

13.1 Non-coronary vascular imaging been performed: Yes No

13.1.1 If Yes, which imaging modality (select all that apply):

- Aortogram Femoral angiogram Lower extremity angiogram

iSCAD Registry

Event Case Report Form

Page 10 of 10

Site Information

Site:

Subject ID: _____

Name of person completing the form:

- | | | |
|--|--|--|
| <input type="checkbox"/> Selective renal angiogram | <input type="checkbox"/> Upper extremity angiogram | <input type="checkbox"/> CTA aorta with lower extremity runoff |
| <input type="checkbox"/> CTA brain (intracranial) | <input type="checkbox"/> CTA neck (extracranial) | <input type="checkbox"/> CTA chest |
| <input type="checkbox"/> CTA abdomen / pelvis | <input type="checkbox"/> Duplex ultrasound of carotid arteries | <input type="checkbox"/> Duplex ultrasound of renal arteries |
| <input type="checkbox"/> MRA brain (intracranial) | <input type="checkbox"/> MRA neck (extracranial) | <input type="checkbox"/> MRA chest |
| <input type="checkbox"/> MRA abdomen / pelvis | <input type="checkbox"/> Other, specify: | |

13.1.2 Atherosclerosis in any of the non-coronary vascular beds: Yes No Not assessed

13.1.3 Specify DEFINITE abnormal findings (select all that apply) and locations (vessel code in the APPENDIX): No abnormal findings

Aneurysm (Please specify size underneath in cm) Location: _____
Size (cm): _____

Dissection Location: _____

Ectasia Location: _____

FMD: Focal (Single smoothly tapered or concentric lesion) Location: _____

FMD: Multifocal (Beading) Location: _____

Occlusion Location: _____

Pseudoaneurysm (Please specify size underneath in cm) Location: _____
Size (cm): _____

Stenosis Location: _____
% Stenosis: _____

Tortuosity Location: _____

Other, specify: _____ Location: _____

13.1.4 Specify POSSIBLE abnormal findings (select all that apply) and locations (vessel code in the APPENDIX): No abnormal findings

Aneurysm (Please specify size underneath in cm) Location: _____
Size (cm): _____

Dissection Location: _____

Ectasia Location: _____

FMD: Focal (Single smoothly tapered or concentric lesion) Location: _____

FMD: Multifocal (Beading) Location: _____

Occlusion Location: _____

Pseudoaneurysm (Please specify size underneath in cm) Location: _____
Size (cm): _____

Stenosis Location: _____
% Stenosis: _____

Tortuosity Location: _____

Other, specify: _____ Location: _____

APPENDIX: Non-coronary vessel codes

- | | | | |
|-----------------------------------|------------------------------------|----------------------------------|---------------------------------|
| 01. Internal carotid artery, left | 02. Internal carotid artery, right | 03. Vertebral artery, left | 04. Vertebral artery, right |
| 05. Brachial artery, left | 06. Brachial artery, right | 07. Renal artery, left | 08. Renal artery, right |
| 09. Celiac trunk | 10. Splenic artery | 11. Hepatic artery | 12. Superior mesenteric |
| 13. Inferior mesenteric | 14. Common iliac artery, left | 15. Common iliac artery, right | 16. External iliac artery, left |
| 17. External iliac artery, right | 18. Common femoral artery, left | 19. Common femoral artery, right | 20. Popliteal artery, left |
| 21. Popliteal artery, right | 22. Intracranial artery | 23. Other | |