

## GeneSTAR CLINICAL CHD ENDPOINTS

### 1. Sudden Cardiac Death, Definite

Witnessed, instantaneous death OR unwitnessed, apparent sudden death accompanied by a documented stenosis in at least one coronary artery of  $\geq 50\%$  diameter stenosis at autopsy.

### 2. Sudden Cardiac Death, Probable

Unwitnessed, apparent sudden death, without confirmation of significant coronary artery disease.

### 3. Myocardial Infraction, Definite

**All 3** of the following criteria:

- a. Chest pain or chest pain equivalent
- b. New pathological Q waves on ECG, OR new persistent significant ST-T wave changes (according to Minnesota Codes)
- c. Elevation of serum creatine kinase (CK) to  $\geq$  twice the upper limit of normal, AND an increase of the MB isoenzyme (if available) to  $\geq 5\%$  of the total CK, OR elevation of troponin T or I (if available) to  $\geq 2.0$  ng/ml.

### 4. Myocardial Infarction, Probable

**Two** of the following criteria:

- a. Chest pain or chest pain equivalent
- b. New pathological Q waves on ECG, OR new persistent significant ST-T wave changes (according to Minnesota Codes)
- c. Elevation of serum creatine kinase (CK) to  $\geq$  twice the upper limit of normal, AND an increase of the MB isoenzyme (if available) to  $\geq 5\%$  of the total CK, OR elevation of troponin T or I (if available) to  $\geq 2.0$  ng/ml.

### 5. Unstable Angina, Definite

Hospitalized for chest pain or chest pain equivalent occurring at rest or with minimal activity. Associated with objective evidence of ischemia **at rest** by ECG ( $\geq 1$  mm of ST depression or elevation, or new T-wave inversions compared to a baseline tracing), OR a resting reversible radionuclide perfusion defect. These findings will usually lead to coronary arteriography and myocardial revascularization (PTCA or CABG).

### 6. Unstable Angina, Probable

Hospitalized for chest pain or chest pain equivalent occurring at rest or with minimal activity. Associated with objective evidence of ischemia **during exercise** (by ECG, radionuclide perfusion study, or stress echocardiogram). Documentation of objective evidence of ischemia at rest is not available. These findings will usually lead to coronary arteriography and myocardial revascularization (PTCA or CABG).

**7. New Onset or Crescendo Angina**

New onset or crescendo chest pain or chest pain equivalent, occurring during exercise, beginning **within the past month**, associated with or without objective evidence of ischemia during exercise. These findings often result in hospitalization, coronary arteriography, and/or myocardial revascularization.

**8. Chronic Angina, Definite**

Chest pain or chest pain equivalent, beginning **more than 1 month ago**, associated with objective evidence of ischemia during exercise. These findings sometimes result in hospitalization, coronary arteriography, and/or myocardial revascularization.

**9. Chronic Angina, Probable**

Chest pain or chest pain equivalent, beginning **more than 1 month ago**, without objective evidence of ischemia during exercise, but with a documented stenosis in at least one coronary artery of  $\geq 50\%$  diameter.

**10. Chronic Angina, Possible**

Chest pain or chest pain equivalent, without objective evidence of coronary artery disease.

**11. Silent Progression of CAD**

New or worse abnormality on exercise ECG, perfusion scan, or stress echocardiogram, without symptoms, often resulting in coronary arteriography and sometimes in myocardial revascularization.

**12. Unstable Angina, Possible**

Hospitalization for Chest pain or chest pain equivalent occurring at rest or with minimal activity, without objective evidence of ischemia (at rest or during exercise), leading to coronary arteriography with the finding of significant coronary disease.

**13. Abnormal on Initial Occult Testing**

Abnormal on exercise ECG, perfusion scan, or stress echocardiogram, without symptoms, often resulting in coronary arteriography and sometimes in myocardial revascularization.

**14. Severe CAD on autopsy**