An MMCC Community Final Diagnosis Form (MDX) is completed for each ARIC community surveillance event that is sent to you as an MMCC reviewer. Please refer, as needed, to the MMCC Case Law document (Section 5.4 Manual 3) when completing this form.

When you get your case materials, check to see that all available information is included. If the event is a hospital event, a copy of HRAA16 and HRAA22 and/or the discharge summary must accompany the Event Summary Form. If the event involves a death, a copy of DTHA19-21 must be included with the Event Summary Form.

If available materials are not included for an event, send the materials back to the MMCC coordinator at the Coordinating Center. Do not attempt to fill out the MDX form with incomplete or misabstracted information.

There are three sections to the MDX form. **Part A** contains administrative information and should be completed for each review. **Part B** is not completed during typical MMCC Community Surveillance review; it is completed only by the Special Reviewer for selected hospitalized events. **Part C** is used for death classifications and should be repeated for all deaths requiring MMCC review.

**LINKED EVENTS:** In some instances, there will be multiple Event Summary Forms and attached materials clipped together. These events are referred to as “linked” events, which are hospitalizations and/or a death that occurred within 28 days of each other. When several events are so linked, EVENT ID is the ID common to all and is used to identify that set of linked events. The common ID (EVENT_ID) is listed in the upper left hand side of each Event Summary Form. Use only one MDX Form for these linked events, as these will be treated as one in analysis. The Coordinating Center (CC) will provide and MDX Form for each event already labeled with the EVENT_ID and sequence number.

**Instructions for Part A. Administrative Information**

1.a. Enter the Batch number and letter assigned to this case, if not already done so by the CC. Refer to the memo sent with the cases being reviewed for this number and letter. ‘C’ indicates a cohort surveillance event (in which case you should be completing a CDX form) and ‘S’ indicates a Community Surveillance event (for which you should continue using these instructions).

   b. Refer to the memo sent with these to identify the type of review. Circle the corresponding letter if this item was not recorded by the CC.

   c. Fill in the date of MDX completion.

2. Record the assigned code number of this reviewer.

   Initial the form where indicated.
Instructions for Part B. MI Diagnosis

This section is completed only by the Special Reviewer. If you are not a Special Reviewer, ignore Part B.

SPECIAL REVIEWER: Your task involves assigning an overall MI Diagnosis to selected Linked Hospitalizations. Using all linked Event Summary Forms provided, complete Part B of the MDX. The information on pain, enzymes and ECG contained in the Event Summary Forms for linked events may be mixed and matched in answering the questions on the MDX. Items 3-5 represent the elements used by the ARIC algorithm for MI diagnosis. For each, circle the letter that correctly characterizes the case under review. Note: Autopsy information should not be used in assigning diagnoses to non-cohort surveillance cases.

3. Consider pain information from all the linked Event Summary Forms in determining whether cardiac pain was present. Some of the individual Event Summary Forms may have had the pain criterion downgraded after review as indicated in B.1f. = “Yes, ARIC pain diagnosis changed to absent,” i.e., no evidence of cardiac pain.

4. Consider ECG diagnoses from all the linked Event Summary Forms in arriving at the ECG Diagnosis.

5. Consider enzyme diagnoses from all linked Event Summary Forms in arriving at the enzyme diagnosis. The enzyme criterion may have been downgraded after review as indicated in B.3f = “ARIC enzyme diagnosis downgraded to Equivocal.”

6. In cases where either the pain or the enzymes information has been reviewed for possible downgrading, the Event Summary Form will show two Computer MI diagnoses: (1) The original, before review (Item 4), and (2) the revised (Item 5). In cases where neither pain nor enzymes needed review only one Computer MI diagnosis will appear (Item 4). But to derive an MI diagnosis to answer item 6, apply the algorithm in the ARIC MI Diagnosis Table in Table 4.1 Manual 3 in conjunction with your answers to Items 3-5, and circle the corresponding letter in Question 6. Do not deviate from strictly applying the answers in 3-5 in arriving at an MI Diagnosis. You can indicate a disagreement with the MI Diagnosis in this item in Item 7.

7. Review carefully the discharge summary diagnoses, and other attached information to assist you in deciding on the correct MI diagnosis. You may find errors in the algorithm or in abstracted information, or you may find important clinical facts in the discharge summary. If as a result, you do not agree with the ARIC MI diagnosis assigned in Item 6, indicate this fact in Item 7a. Record in detail your reasons for disagreement with the ARIC algorithm. Cite the relevant case law, by number, supporting your diagnosis. If no such law exists, propose a new one to cover this and similar cases. Indicate your preferred diagnosis in Item 7b. Otherwise circle “Y” in 7a.

Do not fill out Item 7c for community surveillance cases. This item is not necessary for the review of MI diagnosis for community surveillance cases.
Instructions for Part C. Death Classification

8. After review of materials pertinent to this event, if, in your opinion, there is evidence that the death was due to a non-atherosclerotic or non-cardiac atherosclerotic process, circle "Y" for “Yes”. Autopsy information may not be used for community surveillance review.

If you have responded “Yes” to this item, record the source of evidence by recording the items and forms from the Event Summary Form(s) that provided this evidence. If the item number is not available, record briefly the item content.

9. If this case is an out-of-hospital death with no linked hospitalizations, circle “No”. If the event involves a hospitalization, the proper response for this question should be derived from the page entitled “Overall Hospital Diagnoses” provided with your Event Summary Form. It indicates whether the hospitalization was a definite MI. If the hospitalization was not a Definite MI, question 9 is answered “No”. If the hospitalization was definite MI and the MI occurred within 28 days of death, answer “Yes”. ARIC uses hospital admission date as a surrogate for date of onset of symptoms for the MI, unless the onset of symptoms is after hospital admission.

10. If the death is classified “out-of-hospital” and is not linked to another event, refer to Part B of the “Event Summary Form for Out-of-Hospital Deaths” and the informant narrative (if any), to determine presence of chest pain within 72 hours of death. Enter that response.

If the death is classified “in-hospital”, refer to the page entitled “Overall Hospital Diagnoses” to determine the presence of cardiac pain. Enter only that response.

If the death is classified “out-of-hospital” with linked hospitalization(s), combine the information in the “Event Summary Form for Out-of-Hospital Deaths”, the informant narrative (if any), and the page entitled “Overall Hospital Diagnoses” to complete Item 10.

11. After reviewing all available information, including Part D in the Event Summary Form for Hospitalized Events, record “Y” for “Yes” if there is evidence of a history of chronic ischemic heart disease, including angina pectoris. If there is clear evidence of either valvular heart disease or nonischemic cardiomyopathy mimicking chronic ischemic heart disease and no independent evidence for the latter, the response to this item is “No”. A history of use of medication for angina pectoris may be used as evidence of a history of angina. Autopsy information should not be used in judging medical history for non-cohort surveillance cases.

12. Review the underlying cause of death code in the header of the Event Summary Form for In-Hospital Events or in Section D of the Event Summary Form for Out-of-Hospital Deaths. If the ICD code is included among the codes listed in Item 12, circle “Y” for “Yes”.

13. Assign a death classification: Review your responses to Items 8-12 in Part C of MDX Form and apply the algorithm as specified in parentheses after each possible response. Follow the algorithm by working downward through the table and assigning the first classification that applies, based on your responses to Items 8 through 12.
14.a. After reviewing all the evidence, you may feel that a different classification is more appropriate than that specified in Item 13.

If you do not agree with the classification assigned in Item 13, circle “N” for “No” and indicate your reason for disagreement in the space provided. Cite the relevant case law supporting your diagnosis. If no such law exists, propose a new one to cover this and similar cases.

b. If you circled “N” in Item 14a, record the letter from the choices in Item 13 that you consider a more appropriate classification.

15.a. If the response to Item 13 is “A” or “B” or “C”, circle “Y” and continue to 15.b. If the response to Item 13 is “D” or “E”, circle “N” and stop.

b. Using all pertinent information, indicate the interval of time from onset of acute symptoms to death. If time of onset of acute symptoms is unknown, indicate the time interval from point when decedent was last known to be alive and free of symptoms. Circle the letter corresponding to this interval.