

Appendix

**The FADOI (Federation of Associations of Hospital Doctors on Internal Medicine)
position paper on cardiovascular prevention in the higher risk complex patients**

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Appendix Table 1. New York Heart Association heart failure functional classification.

NYHA class	Symptoms
I	Cardiac disease, but no symptoms and no limitation in ordinary physical activity, <i>e.g.</i> , no shortness of breath when walking, climbing stairs, <i>etc.</i>
II	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity
III	Marked limitation in activity due to symptoms, even during less-than-ordinary activity, <i>e.g.</i> , walking short distances (20-100 m) Comfortable only at rest
IV	Severe limitations Experiences symptoms even while <i>at rest</i> Mostly bedridden patients

Data from The Criteria Committee of the New York Heart Association (NYHA). Nomenclature and criteria for diagnosis of diseases of the heart and great vessels. 9th ed. Boston: Little, Brown & Co.; 1994. pp 253-256.

Appendix Table 2. Conditions mostly associated with a worse prognosis in heart failure as several issues.

Clinical factors	Comorbidity	ECG	Imaging	Lab	Functional data
Advanced age	Kidney failure	Increased heart rate	Lower EF	↑ BNP, ↑NTproBNP	Lower VO ₂ peak
Hypertensive etiology	Diabetes	Q waves	↑Left ventricular volumes	Hyponatremia	Reduced 6 min walking test
Ischemic etiology	COPD-OSAS	Left bundle branch block	Lower cardiac index	↑Troponin	Periodic breathing
Low adherence	Anemia	Left ventricular hypertrophy	Restrictive mitral filling pattern	↑Creatinine, BUN plasmatic values	-
Hospital readmissions	Aortic stenosis	Ventricular arrhythmias	Reduced right ventricular function	↑Liver enzymes	-
Sudden death-survival after reanimation	Depression	Atrial fibrillation	Pulmonary hypertension	↓Hemoglobin	-
NYHA class III-IV	Cachexia and ↓BMI	-	-	Hyperuricemia	-

ECG, electrocardiogram; EF, ejection fraction; COPD, chronic obstructive pulmonary disease; OSAS, obstructive sleep apnea syndrome; NYHA, New York Heart Association; BMI, body mass index.

Appendix Table 3. ABCD score.

	Age (years)	Blood pressure	Clinical features	Duration of TIA (min)	Diabetes
No point	<60	Normal	No speech disturbance and no unilateral (one-sided) weakness	<10	No diabetes
1 point	≥60	Raised (≥140/90 mmHg)	Speech disturbance present but no unilateral weakness	10-59	Diabetes present
2 points	-	-	Unilateral weakness	≥60	-
% Risk stratification after TIA					
Score	2 days risk %		7 days risk %	90 days risk %	
0-3 (low)	1.3		1.2	3	
4-5 (moderate)	4.1		5.9	10	
6-7 (high)	8.1		11.7	25	
Hospital admission is indicated if ABCD ² score is >5 or in the cases with repeated TIA. The hospitalization is reasonable in the TIA within 72 h: if ABCD ² score >3; if ABCD ² score 0-2 with uncertain diagnosis or inability to complete surveys within 48 h; if ABCD ² score 0-2 with event caused by focal ischemia, demonstrable electively with MRI-DWI					

TIA, transient ischemic attack; MRI-DWI, magnetic resonance imaging-diffusion weighted imaging.

Appendix Table 4. Lérèche-Fontaine and Rutherford classifications.

The Lérèche-Fontaine classification	The Rutherford classification
Stage I: Asymptomatic*	Stage 0: Asymptomatic
Stage II: Intermittent claudication ^o This stage takes into account the fact that patients usually have a very constant distance at which they have pain: IIa: Intermittent claudication after more than 200 m of pain free walking IIb: Intermittent claudication after less than 200 m of walking	Stage 1: Mild claudication Stage 2: Moderate claudication [§] Stage 3: Severe claudication Stage 4: Rest pain Stage 5: Ischemic ulceration not exceeding ulcer of the digits of the foot Stage 6: Severe ischemic ulcers or frank gangrene
Stage III: Rest pain [#] IIIa: Pain at rest, after a few hours of clinostatic decubitus - AP at the ankle >50 mmHg IIIb: Pain at rest, at first clinostatic decubitus - AP at the ankle <50 mmHg	
Stage IV: Ischemic ulcers or gangrene (which may be dry or humid)	

AP, arterial pressure. *Of note: Fontaine stage I does in fact describe patients who are *for the most part* asymptomatic. Careful history may actually reveal subtle and non-specific symptoms such as paresthesias; ^oThe disabling claudication was defined by the Joint Council of the Society for Vascular Surgery and the North American Chapter of the International Society for Cardiovascular Surgery (classification Rutherford) as a condition characterized by an absolute claudication distance as ≤150-100 m; [#]Rest pain is especially troubling for patients during the night. The reason for this is twofold: First, the legs are usually raised up on to a bed at night, thus diminishing the positive effect gravity may have had during the day when the legs were dependent. Second, during the night the lack of sensory stimuli allow patients to focus on their legs; [§]The distance that delineates mild, moderate and severe claudication is not specified in the Rutherford classification, but is mentioned in the Fontaine classification as 200 m.