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WHO Mortality Reference Group: Annual Report, 2004-2005

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Abstract

This paper presents the activities and status of the WHO Mortality Reference Group for 2004-2005. The WHO created the MRG as a component of the ICD updating process. Comprised of members from Collaborating Centres and regional offices, the MRG meets largely in person to review problems encountered in the application of ICD-10 to mortality. In its seventh year of work, the MRG deliberated about 80 problems, and has made recommendations to the Update and Revision Committee for further action. Many of these issues are still under review.

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Introduction

This is the seventh annual report of the Mortality Reference Group (MRG), established at the 1997 meeting of the Centre Heads as part of an updating mechanism for the International Classification of Diseases (ICD). The first annual report was presented at the WHO Centre Heads meeting in Cardiff, Wales, October 17-22, 1999.

In its first six years, the MRG dealt with more than 200 issues related to updating and clarifying the ICD-10 as it applies to mortality classification and coding. The MRG settled about 131 questions selected largely from the Mortality Forum and submitted recommendations to the Update Reference Committee (URC) for consideration.

This report describes the background of the MRG, the problems decided in the seventh year, and the problems presently under consideration. The report includes three appendices: Appendix I is the updated Terms of Reference of the MRG and work plan, Appendix II is a list of the members of the MRG, Appendix III lists the topics decided since 1998, and Appendix IV provides details for each of the issues the MRG reached closure on in 2004-2005.

Basis for the MRG

Provisions for the MRG are described in two documents: the WHO long-term strategy document (WHO/HST/ICD/C/97.39) and the Centre Heads' Report for 1997 (WHO/HST/ICD/C/97.65). Briefly, for updating the ICD, WHO - - working with the Centre Heads- - established two separate bodies: the MRG, which can make decisions regarding the application and interpretation of ICD to mortality and which makes recommendations on ICD updates and changes to the Update Reference Committee (URC), which is a separate advisory body to the Secretariat and the Centre Heads. The MRG discusses issues raised in the Mortality Forum or those referred from other sources including the Centre Heads and WHO. WHO designated membership of the MRG and the Chairperson in 1998, based on nominations from Collaborating Centres. Lars Age Johansson succeeded Harry M. Rosenberg as chair of the MRG in February 2002. In 2004-2005, membership remained similar with a one addition, 1 replacement, and several subtractions.

Decisions During the First Six Years

In the first six years (1998-2004), the MRG reached 131 decisions (see Table 1): forwarding 122 decisions to the URC: 82 recommendations for changes in the ICD and informing the URC that the MRG had discussed but decided against recommending any change for 40 issues. The URC referred six

issues back for additional work, and the MRG withdrew three recommendations to do further work during the first six years. The MRG discussions on about 55 additional issues were not complete at the end of the sixth year, and 9 decisions were not forwarded in this time period.

Decisions During the Seventh Year

In the seventh year, the MRG met in Bethesda, Maryland, US May 5-6, 2005 and Tokyo, Japan October 13-14, 2005. The MRG relied on e-mail communication to carry forward discussions and action between face-to-face meetings.

The MRG discussed about 80 issues this year. The MRG (Table 1) reached closure on a total of 24 issues in the seventh year and is approaching a resolution on more than 20 issues. Eleven decisions were forwarded to the URC for further action; 13 decisions that involved no recommended change to the ICD were forwarded for the URC's information. Each of the recommendations is described in terms of background, issues, and the decision made by the MRG (see Appendix IV). The additional issues that were not submitted to the URC were resolved at the Bethesda meeting which was after the deadline for submission of recommendations to the URC. The MRG continues to work on new issues as well as issues held over from previous years. Increasingly, the ongoing issues are complex and more difficult to resolve quickly.

Table 1. Issues potentially resulting in change considered by the MRG

Year	MRG reached decision	MRG submitted recommendations to URC				URC approved major or minor	MRG withdrew or URC referred back
		Total	Major (substantive change)	Minor (clarification)	No change to ICD		
1999	2	2	1	0	1	1	0
2000	8	5	2	3	0	4	1
2001	6	8	5	3	0	6	1
2002	33	17	7	2	8	9	0
2003	57	76	15	32	29	40	8
2004	25	14	6	6	2	12	0
2005	46	24	6	5	13	. . .	. . .
Total	**177**	**146**	**42**	**51**	**53**	**72**	**10**

. . . Not applicable

The 11 recommendations for change address a number of situations

including clarifications of instructions (e.g., sudden death); appropriate codes (e.g., white matter disease); and resolution of conflicting instructions (e.g., old/healed myocardial infarction).

The 13 issues for which decisions were sent to the URC with no recommended change to the ICD involve incorporating international consensus into decision tables used in automated software (e.g., define acceptable causal relationships between stroke and myocardial infarction in MMDS tables); resolution of variations in interpreting instructions (e.g., cardiovascular disease and hypercholesterolaemia); and improvement of the MMDS as an international tool (e.g., injuries with no nature-of-injury code).

Issues Under Review by the MRG

Approximately 60 other specific issues and general topics related to improving data quality are under active review by MRG. The problems, background, and current status of these issues are available on request to the Chairperson of the MRG.

Procedural Considerations

For the MRG to carry out its mission, it is essential that each issue be carefully studied and deliberated. Decisions are made through a democratic process, with attempts to achieve consensus. This requires preparing and distributing background and current information bearing on the problem, conducting discussions in real time about the issues, communicating by email in the interim, using teleconferences when needed, and fully documenting meetings, actions taken, and agendas. Since the face-to-face meetings have been more efficient than teleconferences, the MRG largely replaced teleconferences with face-to-face meetings in 2003.

Conclusion

In its seventh year, the MRG met twice in person, communicated extensively by e-mail, did considerable work on a number of problems outside the committee meetings, circulated documentation for issues under consideration; and comprehensively documented its activities. During the seventh year, a total of about 80 problems were reviewed by the MRG. For 46 of these, closure was reached. Eleven recommendations for change were made to the URC in 2005 including topics resolved in 2004. The decisions on the thirteen remaining issues were submitted for the URC's information.

Technical Annex I. Terms of Reference: Mortality Reference Group

The objective of the Mortality Reference Group (MRG) is to improve international comparability of mortality data by establishing standardised application of the ICD.

Functions:

1. To identify and solve problems related to the interpretation and application of ICD to coding and classification of mortality.

2. To establish standardized application of mortality coding rules and guidelines by a) making decisions regarding the interpretation of rules and guidelines for mortality, and b) deliberating on updates to the classification and the rules and guidelines. Such updates include both clarifications and correction of errors.

3. To develop recommendations for ICD updates through a democratic process which attempts to achieve consensus.

4. To forward decisions on the interpretation of rules and guidelines and to submit annual recommendations to the Update Reference Committee by the end of April.

5. To provide documentation of discussions and decisions.

6. To participate in the revision process of ICD.

The MRG will endeavour to ensure that its membership reflects the widest possible representation from centres and WHO regional offices. Members are appointed by Centre Heads, regional offices, or the Secretariat. The MRG may call in additional members when required.

The MRG elects the chairperson for a term of two years. The election is submitted to the WHO-FIC planning committee for confirmation. There is no limit to the number of successive terms that an individual may serve as chairperson.

The MRG will work through email, meet in person twice a year, and use telephone conferences as needed.

Once a recommendation to the Update Reference Committee (URC) has been agreed to by the MRG, members will support the recommendation.

A major update to Volume 2 may be implemented by countries prior to the official implementation date, if the impact of the update is considered to be statistically insignificant. When the MRG submits a recommendation for an update to Volume 2 to the URC, the recommendation should include a statement whether the update should be implemented immediately or on the official implementation date. Preferably, the assessment of the statistical impact should be based both on national data and on data from the WHO mortality database.

Decisions and recommendations from the MRG which are endorsed by the URC and the Centre Heads should be available from the WHO ICD home page.

Work Plan
2005-2006

1. Continue to hold periodic meetings: one face-to-face meeting at WHO-FIC Network annual meeting and one roughly 6 months later, and telephone conferences as needed *(2005 and 2006)*
2. Prioritize issues and problems for review *(2005 and 2006)*
3. Make recommendations to the Update and Revision Committee *(by April 2006)*
4. Prepare annual report for WHO-FIC Network meeting *(August 1, 2006)*
5. Respond to URC requests to review material on URC Web site at http://www3.fhs.usyd.edu.au/ncchwww/site/3.2.htm with linkage to http://www.who.int/classifications/en/ *(2005 and 2006)*
6. Repeat cycle for 2006- 2007.
7. Contribute to development of list of causes eligible to be leading causes of death
8. Develop and disseminate quality assurance procedures and best practices for mortality classification.

Technical Annex II. Membership, Mortality Reference Group

Brazilian Centre

Professor Cassia Maria Buchalla
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Sao Paulo SP BRAZIL

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Ms Patricia Wood
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Australian Centre

Ms Sue Walker
Associate Director
National Centre for Classification in Health
Kelvin Grove QLD 4059 AUSTRALIA

Japanese Centre

Dr. Kenji Shuto
Director, ICD Office
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Minister's secretariat
Ministry of Health, Labour and Welfare
1-2-2 Kasumigaseki, Chiyada-ku
100-8916, Tokyo, Japan

Nordic Centre

Lars Age Johansson (Chair)
EpC, National Board of Health and Welfare
Stockholm SWEDEN

German Centre

Dr. Stefanie Weber
Deutsches Institut fuer
Medizinische Dokumentation und Information, DIMDI
Cologne GERMANY

French Centre

Gerard Pavillon
Head
Centre Collaborateur OMS pour la Classification
Le Vesinet FRANCE

Other members

Dr. Robert Jakob
Classification, Assessment, Surveys and Terminology
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Technical Annex III. Decisions Made By The Who Mortality Reference Group, 1998-2005

Year Discussed and Topic	Type of Change	Action
1998-99: Rule A	Substantive change	Recommended to URC in 1999 and approved by URC
1998-99: Coding maternal conditions (revived in 2000-2002)	No change	No change in 1999 not communicated; recommended change in 2001 was withdrawn; Informed URC in 2002 of no change decision
1999-2000: Applying Rule 3 for pneumonia	Substantive change	Recommended to URC in 2000 and approved by URC in 2000
1999-2000: Rule A, additional condition	Substantive change	Recommended to URC in 2000 and approved by URC in 2000
1999-2000: Highly Improbable: Diseases causing suicide	Substantive change	Recommended to URC in 2000 and approved by URC in 2000
1999-2000: Highly Improbable: Infections due to neoplasms	Clarification	Recommended to URC in 2000 and approved by URC in 2000
1999-2000: Highly Improbable: Inconsistent durations	Clarification	Recommended to URC in 2001 and approved by URC in 2001
1999-2000: Coding perinatal conditions	Clarification, and recommended changes in Alphabetical Index	Recommended to URC in 2001 and approved in principle by URC in 2001 (URC/MRG working on details in 2002 and URC approved in 2002)
1999-2000: Highly Improbable: Angina due to Bronchitis	No change	Informed URC in 2002
1999-2001: Highly Improbable: Diseases causing accident	Substantive change	Recommended to URC in 2000, returned to MRG by URC in 2000, modification resubmitted 2001 and approved by URC in 2001
1999-2001: HIV due to blood transfusion	Substantive change	Recommended to URC in 2001 and approved by URC in 2001
1999-2001: Trivial list	Substantive change	Recommended to URC in 2001 and approved by URC in 2001
2000-2001: Forced lists	Substantive change	Recommended to URC in 2001 and approved by URC in 2001
2001: List distribution	Substantive change	Recommended to URC in 2001 (folded into other initiatives)
2001: Congenital anomalies	Substantive change	Recommended to URC in 2002 and approved by URC in 2002
2001-02: Restore consolidated section of recommendations	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
2001-02 Trivial rule	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
2001-02 Intestinal obstruction	Clarification	Submitted to URC in 2002 and approved by URC in 2002
2001-02 Intoxication	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
2001-02 Poisoning	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
1999-2002 Embolism due to digestive diseases	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
2001-02 Transitory conditions	Substantive change	Submitted to URC in 2002 and approved by URC in 2002
2000-02 Drug treatment	No change	Informed URC in 2002

2001-02 SIDS detail	No change	Informed URC in 2002
2001-02 Peripheral vascular disease causes	No change	Informed URC in 2002
1999-2002 Ischaemic due to pulmonary conditions	No change	Informed URC in 2002
2000-02 Newborn/neonatal terms	No change	Informed URC in 2002
2001-02 Circulatory insufficiency	No change	Informed URC in 2002
2002: Literal or liberal interpretation of ICD	No change	Informed URC in 2003
2002: Recent complications caused by past surgery	No change	Informed URC in 2003
2002: I20.- (Angina pectoris) more specific than I25.9	No change	Informed URC in 2003
2002: J21 Apply the same linkages for acute bronchitis (J20) and acute bronchiolitis (J21)?	No change	Informed URC in 2003
2002: Insufficiency vs. failure codes	No change	Informed URC in 2003
2002: Code for "narcotism"	No change	Informed URC in 2003
2002: Accident assumed cause of injury	No change	Informed URC in 2003
2002: Different expressions for the same time limit	No change	Informed URC in 2003
2002: Cerebral haemorrhage an obvious consequence of Waldenstrom=s macroglobulinaemia?	No change	Informed URC in 2003
2002: Wording: Can be- may- should…..	No change	Informed URC in 2003
2002: Cases when Rule 3 should not be applied	No change	Informed URC in 2003
2002: D84.9 (Immunodeficiency, unspecified) due to D45 (Polycythaemia vera) sequence	No change	Informed URC in 2003
2002: Acute or terminal circulatory diseases due to diabetes	No change	Informed URC in 2003
2002: I77.6 (Arteritis, unspecified) due to I64 (Stroke)	No change	Informed URC in 2003
2002: Cardiac arrhythmia, unspecified and Cardiac arrest, unspecified linkage	No change	Informed URC in 2003
2002: Conditions in Part I regarded as a part of the natural history of a disease reported in Part II	No change	Informed URC in 2003
2002: May an ill-defined condition block the application of Rule 3	No change	Informed URC in 2003
2002: Renal failure- obvious consequence of urinary infection?	No change	Informed URC in 2003
2002: K74.6 (Cirrhosis of liver) due to D73.5 (Infarction of spleen) sequence	No change	Informed URC in 2003
2002-03: Indexing of "coronary disease" and "coronary heart disease"	No change	Informed URC in 2003
2003: Code for euthanasia	No change	Informed URC in 2003
2003: Code for stillborn due to maternal diabetes	No change	Informed URC in 2003
2003: Hemiplegia due to hypertension- assume and code cerebrovascular disease	No change	Informed URC in 2003

2002-03: Dilated cardiomyopathy reported as due to any other disease	No change	Informed URC in 2003
2002-03: Exposure to substances (Agent Orange, asbestos, dust, pesticide) resulting in disease	No change	Informed URC in 2003
2002-03: Other diseases of pharynx due to Degenerative disease of the nervous system, unspecified, an acceptable sequence	No change	Informed URC in 2003
2002-03: Assume an unspecified infarction to be transmural	No change	Informed URC in 2003
2003: Aspiration a direct consequence of poisonings and intoxication	No change	Informed URC in 2003
2003: Pancreatitis an obvious consequence of alcoholism	No change	Informed URC in 2003
2002-03: Vascular dementia	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Cardiac categories with priority over atherosclerosis	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03/2003-04: Persons repairing transport vehicles (2 related recommendations)	Clarification	Submitted to URC in 2003; URC 0153 approved by URC in 2003; MRG submit further recommendation responding to 2003 URC comments in 2004 (URC 0255) ; Approved by URC in 2004
2002-03: Legal intervention	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-04: Priority between adverse & abnormal incidents & reactions and misadventure	Clarification	Submitted to URC in 2003 (URC 0155); held over for the MRG to provide more clarification and resubmitted in 2004; Approved by URC in 2004
2002-03: Embolic conditions	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Reapply Rule 3 after Rule D	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2000-03: Should Chapter XV be used for all maternal conditions	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2000-03: Puerperal sepsis	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: F10 and K70 coding	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Unspecified self-inflicted poisoning	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Underlying cause in face of multiple chronic lower respiratory diseases	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Priorities in stroke span	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: No reason for surgery and therapeutic misadventure	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: (Acute) pseudomembraneous colitis	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-04: Bacterial hepatitis	Substantive change	Submitted to URC in 2003 (URC 0166); held over to address comments and resubmitted in 2004; Approved by URC in 2004
2002-03: Food-borne intoxication due to Clostridium difficile	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Sequelae of TB link with pneumoconiosis	Clarification	Submitted to URC in 2003; Approved by URC in 2003

2002-03: Dementia, anemia, & malnutrition	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Arteriosclerotic chronic nephritis- how many lines	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Malignant pleural effusion, NOS	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Hypoxic ischaemic encephalopathy of newborn	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Hepatitis with reported complications	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Fractures and osteoporosis	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Dementia, subtypes	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-04+: Value of combination codes	Clarification	Submitted to URC in 2003; Withdrew in 2003 to do more work
2002-03: Term motor vehicle	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-04+: Multiple neoplasm sites in Part II	Clarification	Submitted to URC in 2003; Withdrew in 2003 to continue work
2002-03: Neuro-endocrine neoplasm	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Thrombosis or embolism and atrial fibrillation	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Renal failure and urinary infections	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Meconium ileus	Clarification	Submitted to URC in 2003; Approved by URC in 2003
1999-2004+: Postoperative complications	Clarification	Submitted to URC in 2003; Withdrew in 2003 to complete additional work
2002-03: Alcoholic and non-Alcoholic cirrhosis	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2000-03: Drug combinations	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2003: Fournier's syndrome- females	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2003: Acute coronary syndrome	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2003: Non-traumatic compartment syndrome	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2000-03: Place of occurrence	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-04+: What is I22?	Clarification	Submitted to URC in 2003 (URC 0198); Held over for MRG to liaise with WHO in getting more info from MONICA and WHO cardiovascular disease group; Submitted to URC in 2005
2000-03: Multiple valvular conditions	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2003: Hepatitis C not specified as acute or chronic	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Fractures of unspecified cause and E887	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-03: Unspecified HIV and ill-defined conditions	Clarification	Submitted to URC in 2003; Approved by URC in 2003
2003-04: Subdividing K85	Substantive change	Submitted to URC in 2003 (URC 0203); held over for German Centre to draft list of subcategories and resubmit in 2004; Approved by URC in 2004

2003: SARS code	To encourage discussion and provide temporary solution	Submitted to URC in 2003; Approved by URC in 2003
2003: Laennec's cirrhosis	Substantive change	Submitted to URC in 2003; Approved by URC in 2003
2002-04: Tobacco use as a multiple cause	Clarification	Submitted to URC in 2004; Approved by URC in 2004
2002-04: Secondary hypertension	Substantive change	Submitted to URC in 2004; Approved by URC in 2004
2003-04: Lewy body disease	Clarification	Submitted to URC in 2004; Approved by URC in 2004
2003-04: Heroin vapour leukencephalopathy	Substantive change	Submitted to URC in 2004; Approved by URC in 2004
2003-04: Lobar pneumonia in alcoholism	Substantive change	Submitted to URC in 2004; Approved by URC in 2004
2002-04: Changes to Rule 3	Clarification	Submitted to URC in 2004; Approved by URC in 2004
2002-04: Old/healed myocardial infarction	Substantive change	Submitted to URC in 2004; Approved by URC in 2004
2003-04: Intracerebral haemorrhage & warfarin use	Clarification	Submitted to URC in 2004; Approved by URC in 2004
2002-04: Chronic respiratory failure	No change	Informed URC in 2004
2002-03: Rule 3 tables & Alzheimer's disease & dementia	No change	Informed URC in 2004
2003-04: White matter disease	Clarification	Submitted to URC in 2005
2004: Sudden death	Substantive change	Submitted to URC in 2005
2002-04: Unspecified gastroenteritits	Substantive change	Submitted to URC in 2005
1999-2004: Note 4.2.2 (b) Infections in A00-B99	Substantive change	Submitted to URC in 2005
2002-05: Note 4.2.2 (d) Diabetes due to any other disease	Substantive change	Submitted to URC in 2005
2004-05: Transport accidents	Clarification	Submitted to URC in 2005
2004-05: Viral gastritis	Clarification	Submitted to URC in 2005
2004-05: Vascular parkinsonism	Substantive change	Submitted to URC in 2005
2003-05: Expanding the list for pneumonia	Clarification	Submitted to URC in 2005
2002-05: Pulmonary oedema consequence of heart disease	Substantive change	Submitted to URC in 2005
2003-04: Cardiovascular disease and hypercholesterolaemia	No change	Informed URC in 2005
2003-04: Subacute sclerosing panencephalitis	No change	Informed URC in 2005
2004: Laennec's cirrhosis	No change	Informed URC in 2005
2004: Final code for SARS	No change	Informed URC in 2005
2002-05: Longstanding tuberculosis	No change	Informed URC in 2005
2000-05: Injuries with no nature-of-injury code	No change	Informed URC in 2005

2004-05: Underlying cause and record axis fields	No change	Informed URC in 2005
2004-05: R95 due to J00	No change	Informed URC in 2005
2004-05: Refractory anemia and myelodysplastic syndrome	No change	Informed URC in 2005
2004-05: Influenza and cardiomyopathy	No change	Informed URC in 2005
2004-05: Cerebrovascular diseases and myocardial infarction	No change	Informed URC in 2005
2004-05: Accidents due to natural causes	No change	Informed URC in 2005
2004-05: Valvular diseases and myocardial infarction	No change	Informed URC in 2005

Technical Annex IV. Details on MRG Decisions For 2004-2005

"Recommendation" Issues

ISSUE: WHITE MATTER DISEASE- **URC 0315**

Background and Issues. A question was raised in the Mortality Forum about the appropriate code for white matter disease. The MRG consulted with WHO and German specialists. The German specialists stated that the term means that there are abnormal pathological imaging results and that it doesn't mean anything more informative than that. Thus, the MRG decided that R90.8, Other abnormal findings on diagnostic imaging of central nervous system, is the appropriate code.

Decision. The MRG recommends adding an inclusion term to Volume 1.

Recommendation.

Volume 1, p. 887

R90.8 Other abnormal findings on diagnostic imaging of central nervous system
Abnormal echoencephalogram
White matter disease NOS

Volume 3, p. 171

Disease, diseased – *continued*
-white blood cells D72.9
- - specified NEC D72.8
-white matter NEC R90.8
-white-spot, meaning lichen sclerosus et atrophicus L90.0

The MRG submitted this recommendation (URC recommendation 0315) to the URC in January 2005

ISSUE: SUDDEN DEATH-**URC 0316**

Background and Issues. As part of the discussion about an initiative concerning sudden deaths in adults being encouraged in the European Parliament, the MRG discussed how Rule A is applied when there are only ill-defined and trivial conditions reported on a death certificate.

Decision. The MRG recommends a slight modification of Rule A. Senility and other ill-defined conditions to clarify the instructions, and slight modifications to Volumes 1 and 3 to convey that R96.0 only includes cases in which the cause is unexplained.

Recommendation.

Volume 1, p. 890

R96.0 Instantaneous death

Sudden unexplained death in adult
Excludes: Sudden death of known aetiology (A00.0-Q99.9, V01.0-Y89.9, U04.9)

Volume 2, p. 42, section 4.1.9

Rule A. Senility and other ill-defined conditions

Where the selected cause is ill-defined and a condition classified elsewhere is reported on the certificate, reselect the cause of death as if the ill-defined condition had not been reported, except to take account of that condition it if modifies the coding. The following conditions are regarded as ill-defined: I46.9 (Cardiac arrest, unspecified); I95.9 Hypotension, unspecified); I99 (Other and unspecified disorders of circulatory system); J96.0 (Acute respiratory failure); J96.9 (Respiratory failure, unspecified); P28.5 (Respiratory failure of newborn); R00-R94 or R96-R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere

classified). Note that R95 (Sudden infant death) is not regarded as ill-defined.

If all other conditions reported on the certificate are ill-defined or trivial, the cause of death should not be reselected. That is, Rule A does not apply.

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Rule A. Senility and other ill-defined conditions

Where the selected cause is ill-defined and a condition classified elsewhere is reported on the certificate, reselect the cause of death as if the ill-defined condition had not been reported, except to take account of that condition it if modifies the coding. The following conditions are regarded as ill-defined: I46.9 (Cardiac arrest, unspecified); I95.9 Hypotension, unspecified); I99 (Other and unspecified disorders of circulatory system); J96.0 (Acute respiratory failure); J96.9 (Respiratory failure, unspecified); P28.5 (Respiratory failure of newborn); R00-R94 or R96-R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified). Note that R95 (Sudden infant death) is not regarded as ill-defined.

If all other conditions reported on the certificate are ill-defined or trivial, the cause of death should not be reselected. That is, Rule A does not apply.

Example…

Volume 3:

p. 132

Death
- Instantaneous **unexplained** R96.0
- sudden (cause unknown) **unexplained** R96.0

p. 189

Dropped
- dead, **unexplained** R96.0

p. 221

Fatal syncope, unexplained R96.0

p. 515

Sudden

- death, cause unknown R96.0

p. 518

Syncope R55

- fatal **unexplained** R96.0

The MRG submitted this recommendation (URC recommendation 0316) to the URC in January 2005

ISSUE: UNSPECIFIED GASTROENTERITIS-**URC 0317**

Background and Issues. The Note under A09 states that ''in countries where any term listed in A09 without further specification can be assumed to be of non-infectious origin, the condition should

be coded to K52.9." In practice, this means that unspecified (gastro)enteritis is coded to K52.9 in most industrialized countries. Members of the Mortality Forum have argued, however, that most cases of acute gastroenteritis are infectious, even in industrialized countries. As before, countries have the option of tabulating the code with either the infectious or non-infectious groups.

Decision. The MRG recommends deleting the country note in Volumes 1 and 3, using A09.0 for gastroenteritis specified as infectious, K52 for gastroenteritis specified as non-infectious, and A09.9 for gastroenteritis of unspecified origin.

Recommendation.

Volume 1, p. 112

A09 Other and unspecified diarrhoea and gastroenteritis of infectious origin

Excludes: due to bacterial, protozoal, viral and other specified infectious agents (A00-A08)
Noninfective diarrhoea (K52.9)
- neonatal (P78.3)

A09.0 Gastroenteritis and colitis of infectious origin

Catarrh, enteric or intestinal
Infectious or septic:
- Colitis |
- Enteritis } haemorrhagic
- Gastroenteritis |

Infectious diarrhoea **NOS**:
Diarrhoea:
- dysenteric
- epidemic
- acute bloody
- acute watery

A09.9 Gastroenteritis and colitis of unspecified origin

Acute hemorrhagic diarrhoea

p. 575-6

K52 Other noninfective gastroenteritis and colitis

K52.0 Gastroenteritis and colitis due to radiation
K52.1 Toxic gastroenteritis and colitis
Use additional external cause code (Chapter XX), if desired, to identify toxic agent.
K52.2 Allergic and dietetic gastroenteritis and colitis
Food hypersensitivity gastroenteritis or colitis
K52.8 Other specified noninfective gastroenteritis and colitis
Eosinophilic gastritis or gastroenteritis
K52.9 Noninfective gastroenteritis and colitis, unspecified
Diarrhoea |
Enteritis |
Ileitis } specified as noninfective
Jejunitis |
Sigmoiditis |
Excludes: colitis, diarrhoea, enteritis, gastroenteritis:
- infectious (A09.0)
- unspecified origin (A09.9)
functional diarrhoea (K59.1)
neonatal diarrhoea (noninfective) (P78.3)

psychogenic diarrhoea (F45.3)

In volume 3, p. 38

Allergy, allergic (reaction) T78.4
. ..
- colitis K52.2
. ..
- gastrointestinal K52.2
. ..

p.58

Arthritis, arthritic (acute) (chronic) (subacute) M13.9
- in (due to)
- - enteritis NEC **A09.9**+ M01.8*
- - - infectious A09.0+ M01.8*
- - - non-infectious K52.9+ M01.8*
...
p. 60

Arthropathy (*see also* Arthritis) M13.9
. ..
- in (due to)
. ..
- - enteropathic NEC **A09.9**+ M07.6*
- - - infectious A09.0+ M07.6*
- - - non-infectious K52.9+ M07.6*
. ..

p. 92
Cecitis K52.9
- with perforation, peritonitis, or rupture K65.8
. ..

p. 102

Colitis (acute) (catarrhal) (hemorrhagic) (*see also* Enteritis) **A09.9**
- allergic K52.2
- amebic (acute) (see also Amebiasis) A06.0
- - nondysenteric A06.2
- anthrax A22.2
- bacillary (see also Infection, Shigella) A03.9
- balantidial A07.0
- chronic (noninfective) K52.9
- coccidial A07.3
- cystica superficialis K52.8
- dietary counseling and surveillance (for)) Z71.3
- dietetic K52.2
- due to radiation K52.0
- food hypersensitivity K52.2
- giardial A07.1
- granulomatous K50.1
- infectious (*see also* Enteritis, infectious) A09.0
- ischemic K55.9
- - acute (fulminant) (subacute) K55.0
- - chronic K55.1

- - fulminant (acute) K55.0
- noninfectious K52.9
- - specified NEC K52.8
- polyposa K51.4
- protozoal A07.9
- pseudomembranous A04.7
- regional K50.1
- septic (*see also* Enteritis, infectious) A09.0
- spastic K58.9
- - with diarrhea K58.0
- toxic K52.1
- trichomonal A07.8
- tuberculous (ulcerative) A18.3+ K93.0*
- ulcerative (chronic) K51.9
- - specified NEC K51.8

...
etc.

The MRG submitted this recommendation (URC recommendation 0317) to the URC in January 2005

ISSUE: NOTE 4.2.2 (b) INFECTIONS IN A00-B99-**URC 0318**

Background and Issues. According to note (b) in section 4.2.2 of Volume 2, infections in A00-B99 may not be due to diseases outside Chapter I. There is a list of exceptions that lists infections that may be accepted as "due to" any other disease. However, some countries regard it as incomplete and feel that more conditions in Chapter I should be added. The MRG has contacted infectious disease specialists in Brazil, UK, and Sweden and discussed this extensively. The final decision is based upon input from PAHO's Unit of Communicable Diseases (CD/CPD- Area of Disease Prevention and Control).

Decision. The MRG recommends a list of conditions with specific etiologic agents or that are important to identify in statistics because of their public health consequences. These include immune preventable causes and conditions that are reportable to WHO.

This recommendation reverses the wording of the previous instruction. Now, the instruction says to accept infectious diseases as due to other conditions, except for infectious diseases that are important to identify in statistics. The ones that are important to identify in statistics have public health consequences.

Recommendation.

Volume 2, p. 67

4.2.2 Highly improbable and acceptable sequences

A. Highly improbable sequences

The expression "highly improbable" has been used since the Sixth Revision of the ICD to indicate an unacceptable causal relationship. As a guide to the acceptability of sequences in the application of the General Principle and the selection rules, the following relationships should be regarded as "highly improbable":

(a) The following infectious diseases should not be accepted as "due to" any other disease or condition, except when reported as "due to" human immunodeficiency virus [HIV] disease, malignant neoplasms and conditions impairing the immune system.

- A01-A03 (Typhoid and paratyphoid fevers, other salmonella infections, shigellosis)
- A15-A19 (Tuberculosis)

The following infectious and parasitic diseases should not be accepted as "due to" any other disease or condition (not even HIV/AIDS, malignant neoplasms or immunosuppression)

- A00 (Cholera)
- A05.1 (Botulism)
- A20-A23 (Plague, tularaemia, anthrax, brucellosis)

- A27 (Leptospirosis)
- A33-A39 (Tetanus, diphtheria, whooping cough, scarlet fever, meningococcal disease)
- A70 (Diseases due to Chlamidia psittaci)
- A75-A79 (Rickettsioses)
- A80 (Acute poliomyelitis)
- A81.0 Creutzfeldt-Jakob disease
- A81.1 Subacute sclerosing panencephalitis
- A82-A86 (Rabies, mosquito-borne viral encephalitis, tick-borne viral encephalitis, unspecified viral encephalitis)
- A91-A92 (Dengue haemorrhagic and other mosquito-borne viral fevers
- A95 (Yellow fever)
- A96.0-A96.2 (Junin and Machupo haemorrhagic fevers, Lassa fever)
- A98 (Other viral haemorrhagic fevers)
- B03-B06 (Smallpox, monkeypox, measles, rubella)
- B16-B17.1 (Acute hepatitis B and C)
- B26 (Mumps)
- B50-B57 (Malaria, leishmaniasis, Chagas' disease)
- B90 (Sequelae of tuberculosis)
- B91 (Sequelae of poliomyelitis)
- B92 (Sequelae of leprosy)
- B94.0 (Sequelae of trachoma)
- B94.1 (Sequelae of viral encephalitis)
- B94.2 (Sequelae of viral hepatitis)
- Other emerging diseases reportable to WHO (e.g., U04 SARS)

(b) a malignant neoplasm reported as "due to" any other disease, except human immunodeficiency virus (HIV) disease;
(c) haemophilia (D66, D67, D68.0-D68.2) reported as "due to" any other disease;
(d) diabetes (E10-E14) reported as "due to" any other disease except:
- haemochromatosis (E83.1),
- diseases of pancreas (K85-K86),
- pancreatic neoplasms (C25.-, D13.6, D13.7, D37.7),
- malnutrition (E40-E46);

(e) rheumatic fever (I00-I02) or rheumatic heart disease (I05-I09) reported as "due to" any disease other than scarlet fever (A38), streptococcal septicaemia (A40.0-), streptococcal sore throat (J02.0) and acute tonsillitis (J03.-);
(f) any hypertensive condition reported as "due to" any neoplasm except:
- endocrine neoplasms,
- renal neoplasms,
- carcinoid tumours;

(g) chronic ischaemic heart disease (I20, I25) reported as "due to" any neoplasm;
(h)
(1) cerebrovascular diseases (I60-I69) reported as "due to" a disease of the digestive system (K00-K92),
(2) cerebral infarction due to thrombosis of precerebral arteries (I63.0)
cerebral infarction due to unspecified occlusion of precerebral arteries (I63.2)
cerebral infarction due to thrombosis of cerebral arteries (I63.3)
cerebral infarction due to unspecified occlusion of cerebral arteries (I63.5)
cerebral infarction due to cerebral venous thrombosis, nonpyogenic (I63.6)
other cerebral infarction (I63.8)
cerebral infarction, unspecified (I63.9)
stroke, not specified as haemorrhage or infarction (I64)
other cerebrovascular diseases (I67)
sequelae of stroke, not specified as haemorrhage or infarction (I69.4)
sequelae of other and unspecified cerebrovascular diseases (I69.8)

reported as "due to" endocarditis (I05-I08, I09.1, I33-I38),
(3) occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction (I65), *except*

embolism
occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction (I66), *except* embolism
sequelae of cerebral infarction (I69.3), *except* embolism

reported as "due to" endocarditis (I05-I08, I09.1, I33-I38);

(i) any condition described as arteriosclerotic [atherosclerotic] reported as "due to" any neoplasm;
(j) influenza (J10-J11) reported as "due to" any other disease;
(k) a congenital anomaly (Q00-Q99) reported as "due to" any other disease of the individual, except for:
- a congenital anomaly reported as "due to" a chromosome abnormality or a congenital malformation syndrome,
- pulmonary hypoplasia reported as "due to" a congenital anomaly;

(l) a condition of stated date of onset "X" reported as "due to" a condition of stated date of onset "Y", when "X" predates "Y" (but see also Example 5 in section 4.1.6);
(m) accidents (V01-X59) reported as due to any other cause outside this chapter except:
(1) any accident (V01-X59) reported as due to epilepsy (G40-G41),
(2) a fall (W00-W19) due to a disorder of bone density (M80-M85),
(3) a fall (W00-W19) due to a (pathological) fracture caused by a disorder of bone density,
(4) asphyxia reported as due to aspiration of mucus, blood (W80) or vomitus (W78) as a result of disease conditions,
(5) aspiration of food (liquid or solid) of any kind (W79) reported as due to a disease which affects the ability to swallow;
(n) suicide (X60-X84) reported as "due to" any other cause.

The above list does not cover all "highly improbable" sequences, but in other cases, the General Principle should be followed unless otherwise indicated.

B. Acceptable sequences

The following are acceptable sequences:

(a) infectious diseases other than those noted in 4.2.2 A.(a) reported as "due to" other conditions;
(b) The following infectious diseases when reported as "due to" human immunodeficiency virus [HIV] disease, malignant neoplasms and conditions impairing the immune system.
- A01-A03 (Typhoid and paratyphoid fevers, other salmonella infections, shigellosis)
- A15-A19 (Tuberculosis)

(c) a malignant neoplasm reported as "due to" human immunodeficiency virus (HIV) disease;
(d) diabetes (E10-E14) reported as "due to":
- haemochromatosis (E83.1),
- diseases of pancreas (K85-K86),
- pancreatic neoplasms (C25.-, D13.6, D13.7, D37.7),
- malnutrition (E40-E46);

(e) rheumatic fever (I00-I02) or rheumatic heart disease (I05-I09) reported as "due to" scarlet fever (A38), streptococcal septicaemia (A40.0-), streptococcal sore throat (J02.0) and acute tonsillitis (J03.-);
(f) any hypertensive condition reported as "due to":
- endocrine neoplasms,
- renal neoplasms,
- carcinoid tumours;

(g) occlusion and stenosis of precerebral arteries, not resulting in embolism
occlusion and stenosis of cerebral arteries, not resulting in embolism
sequelae of cerebral infarction (I69.3), embolism

reported as "due to" endocarditis (I05-I08, I09.1, I33-I38);

(h)
(1) a congenital anomaly reported as "due to" a chromosome abnormality or a congenital malformation syndrome,

(2) pulmonary hypoplasia reported as "due to" a congenital anomaly;

(i)
(1) any accident (V01-X59) reported as due to epilepsy (G40-G41),
(2) a fall (W00-W19) due to a disorder of bone density (M80-M85),
(3) a fall (W00-W19) due to a (pathological) fracture caused by a disorder of bone density,
(4) asphyxia reported as due to aspiration of mucus, blood (W80) or vomitus (W78) as a result of disease conditions,
(5) aspiration of food (liquid or solid) of any kind (W79) reported as due to a disease which affects the ability to swallow;

(j) Acute or terminal circulatory diseases reported as due to malignant neoplasm, diabetes or asthma should be accepted as possible sequences in Part I of the certificate. The following conditions are regarded as acute or terminal circulatory diseases:

I21-I22 Acute myocardial infarction
I24.- Other acute ischaemic heart diseases
I26.- Pulmonary embolism
I30.- Acute pericarditis
I33.- Acute and subacute endocarditis
I40.- Acute myocarditis
I44.- Atrioventricular and left bundle-branch block
I45.- Other conduction disorders
I46.- Cardiac arrest
I47.- Paroxysmal tachycardia
I48 Atrial fibrillation and flutter
I49.- Other cardiac arrhythmias
I50.- Heart failure
I51.8 Other ill-defined heart diseases
I60-I68 Cerebrovascular diseases except I67.0-I67.5 and I67.9

The MRG submitted this recommendation (URC recommendation 0318) to the URC in January 2005

ISSUE: NOTE 4.2.2 (d) DIABETES DUE TO ANY OTHER DISEASE-**URC 0319**

Background and Issues. Currently, item 4.2.2 (d) states that diabetes may not be due to any other disease except haemochromatosis, diseases of pancreas, pancreatic neoplasms, and malnutrition. Most clinicians would accept other causes of diabetes than those in 4.2.2 (d).

Decision. The MRG recommends modifying the text of 4.2.2 (d) and including a more extensive list in an appendix to Volume 2. As other aspects of diabetes are considered, the MRG suggests that diabetes may eventually have a separate section in Volume 2.

Most of the additions are derived from the 1999 Expert Committee on the Diagnosis and Classification of Diabetes Mellitus etiologic classification. For example, E10, Insulin-dependent diabetes mellitus, is idiopathic or autoimmune, so the acceptable cause should only list M35.9, Systemic involvement of connective tissue, unspecified; E11, Non-insulin-dependent diabetes mellitus, is not caused by anything else.

Recommendation.

Volume 2, p. 68:

(e) diabetes (E10-E14) reported as "due to" any other disease, except for conditions causing damage to the pancreas. Note: A list of such conditions is available from the WHO Web site.

Insert new material in an appendix to Volume 2:

4.2.15 List of conditions that can cause diabetes

List of the conditions that can cause diabetes

Acceptable sequences for diabetes "due to" other diseases

Selected cause	As cause of

M35.9	E10
E40-E46	E12
	E14
B25.2	E13-E14
B26.3	
C25	
D13.6-D13.7	
D35.0	
E05- E06	
E22.0	
E24	
E80.0- E80.2	
E83.1	
E84	
E89.1	
F10.1-F10.2	"
G10	
G11.1	
G25.8	
G71.1	
K85	
K86.0- K86.1	
K86.8- K86.9	
M35.9	
O24.4	
P35.0	
Q87.1	
Q90	E13-E14
Q96	
Q98	
Q99.8	
S36.2	
T37.3	
T37.5	
T38.0- T38.1	"
T42.0	
T46.5	
T46.7	
T50.2	
X41	
X44	
X61	E13-E14
X64	
Y11	
Y14	
Y41.3	
Y41.5	
Y42.0- Y42.1	
Y46.2	
Y52.5	
Y52.7	
Y54.3	E13-E14

The MRG submitted this recommendation (URC recommendation 0319) to the URC in January 2005

ISSUE: TRANSPORT ACCIDENTS-**URC 0335**

Background and Issues. The MRG discussed that the excludes note on transport accidents for intentional self-harm currently includes X82 Intentional self-harm by crashing of motor vehicle and X83 Intentional self-harm by other specified means but does not include X81 Intentional self-harm by jumping or lying before moving objects. Likewise, Y32, Crashing of motor vehicle, undetermined intent, and Y33, Other specified events, undetermined intent, are included but not Y31 Falling, lying or running before or into moving object, undetermined intent. This does not seem to be justified.

Decision. The MRG recommends expanding the codes covered in the excludes note.

Recommendation. Volume 1, p. 1018

Transport accidents
(V01-V99)
…
Excludes:
…
event of undetermined intent (Y31-Y33)
intentional self-harm (X81-X83)

The MRG submitted this recommendation (URC recommendation 0335) to the URC in February 2005

ISSUE: VIRAL GASTRITIS-URC 0336

Background and Issues. A question was raised in the Mortality Reference Group about the appropriate code for viral gastritis which currently is not indexed to an infectious code. The MRG decided that B33.8, Other specified viral diseases, is the appropriate code.

Decision. The MRG recommends adding an index entry to Volume 3.

Recommendation. Volume 3, p. 243

Gastritis (simple) K29.7
-tuberculous A18.8 + K93.8 *
-viral B33.8

The MRG submitted this recommendation (URC recommendation 0336) to the URC in March 2005

ISSUE: SUBSEQUENT MYOCARDIAL INFARCTIONS-**URC 0337 (withdrawn URC 0198)**

Background and Issues. The MRG has been discussing if I22 should be used for all subsequent infarctions, regardless of the time elapsed since the first one or only for subsequent infarctions occurring within four weeks from the first one. The MRG got information from WHO on what was intended for I22 and background information that the content of this code reflects findings from the WHO MONICA (MONItoring or Cardiovascular diseases) study.

The code I21 should only be used for an individual's first myocardial infarction regardless of the time elapsed since the first infarction. All subsequent acute infarctions should be coded to I22.

Decision. The MRG recommends changes in Volume 1 to clarify the instructions.

Recommendation. Volume 1, p. 478-479

I21 **Acute myocardial infarction**
Includes: myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset

Excludes: certain current complications following acute myocardial infarction (I23.-)
myocardial infarction:
. old (I25.2)
. second or subsequent myocardial infarction irrespective of the interval since the previous infarction (I22.-)

. specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset (I25.8)

I22 Subsequent myocardial infarction
Includes: recurrent myocardial infarction
second or subsequent myocardial infarction irrespective of the interval since the previous infarction
Excludes: specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset (I25.8)

The MRG submitted this recommendation (URC recommendation 0337) to the URC in March 2005

ISSUE: VASCULAR PARKINSONISM-**URC 0338**

Background and Issues. The MRG discussed a question about parkinsonism and arteriosclerosis and the interrelationship of the conditions. Many neural syndromes have presenting symptoms and secondaries that are similar to parkinsonism which are eventually diagnosed to other conditions. However, there is an association between parkinsonism and arteriosclerosis.

Decision. The MRG decided to add a new fourth digit category in Volume 1 to capture vascular parkinsonism and to modify some text in Volumes 2 and 3 to direct coders to this code.

Recommendation. Volume 1, p. 399

G21 Secondary parkinsonism
…
G21.3 Postencephalitic parkinsonism
G21.4 Vascular parkinsonism
G21.8 Other secondary parkinsonism

Volume 2, pp.56-7

I67.2 Cerebral atherosclerosis

with mention of:
I60-I66 (Cerebral haemorrhage, cerebral infarction or stroke, occlusion and stenosis of precerebral and cerebral arteries), code **I60-I64**.

When reported as the originating antecedent cause of conditions in:
F03 (Unspecified dementia), code **F01.-**
G20 (Parkinson's disease), code **G21.4**
G21.9 (Secondary parkinsonism, unspecified), code **G21.4**

I70.9 Generalised and unspecified atherosclerosis

With mention of:
R02 (Gangrene, not elsewhere classified), code **I70.2**

When reported as the originating antecedent cause of:
F01 (Vascular dementia), code **F01.-**
F03 (Unspecified dementia), code **F01.-**
G20 (Parkinson's disease), code **G21.4**
G21.9 (Secondary parkinsonism, unspecified), code **G21.4**

p.64

Table 1

Selected cause	With mention of:	As cause of:	Resulting linked code
I67.2	I60-I66		I60-I64
		F03	F01.-
		G20	G21.4
		G21.9	G21.4
I70.9	R02	F03	F01.-
		G20	G21.4
		G21.9	G21.4

Volume 3, p. 427

Paralysis, paralytic (complete) (incomplete) G83.9
- agitans (see also Parkinsonism) G20
- - arteriosclerotic G21.4

p. 431

Parkinsonism (idiopathic) (primary) G20
- secondary G21.9
- - due to
- - - arteriosclerosis G21.4
- - specified NEC G21.8

The MRG submitted this recommendation (URC recommendation 0338) to the URC in March 2005

ISSUE: EXPANDING THE PNEUMONIAS LIST-**URC 0347**

Background and Issues. Several countries have asked about expanding the list of pneumonias considered obvious consequence of other serious conditions. A group of Swedish specialists suggested some additional pneumonias.

Decision. The MRG in turn recommend changes in the text of Volume 2.

Recommendation. Volume 2, p. 39

Any pneumonia in J12-J18 should be considered an obvious consequence of conditions that impair the immune system. Pneumonia in **J15.0-15.6, J15.8-J15.9, J16.8,** J18.0 and J18.2-J18.9 should be considered an obvious consequence of wasting diseases (such as malignant neoplasm and malnutrition) and diseases causing paralysis (such as cerebral haemorrhage or thrombosis), as well as serious respiratory conditions, communicable diseases, and serious injuries. Pneumonia in **J15.0-15.6, J15.8-J15.9, J16.8,** J18.0, J18.2-J18.9, J69.0, and J69.8 should also be considered an obvious consequence of conditions that affect the process of swallowing.

The MRG submitted this recommendation (URC recommendation 0347) to the URC in May 2005

ISSUE: PULMONARY OEDEMA CONSEQUENCE OF HEART DISEASE-**URC 0348**

Background and Issues. The MRG discussed a series of questions related to heart conditions and pulmonary oedema. Brazil provided data on pulmonary manifestations with and without cardiac disease which showed that pulmonary oedema is a frequent consequence of heart failure. The instructions in the volumes do not clarify which heart conditions should be linked to pulmonary oedema and if the link should be made only if the oedema is acute. Changes in the ICD could affect multiple cause data but are not anticipated to affect underlying cause to a great extent. The MRG decided upon changes to software tables that reflect changes in the ICD.

Decision. The MRG recommends changes to Volumes 1, 2, and 3 to remove mention of acute

and more explicitly state what conditions are direct consequences of the other.

Recommendation. Volume 1, p. 494

I50.1 Left ventricular failure
Oedema of lung |_ with mention of heart disease
Pulmonary oedema | NOS or heart failure
Cardiac asthma
Left heart failure

p. 540

J68.1 Pulmonary oedema due to chemicals, gases, fumes and vapours
Chemical pulmonary oedema (acute)

Volume 2, p. 39

Certain postoperative complications (pneumonia (any type), haemorrhage…

Heart failure (I50.-) and unspecified heart disease (I51.9) should be considered an obvious consequence of other heart conditions.

Pulmonary edema (J81) should be considered an obvious consequence of heart disease (including pulmonary heart disease); of conditions affecting the lung parenchyma, such as lung infections, aspiration and inhalation, respiratory distress syndrome, high altitude, and circulating toxines; of conditions causing fluid overload, such as renal failure and hypoalbuminemia; and of congenital anomalies affecting the pulmonary circulation, such as congenital stenosis of pulmonary veins. Note: a list of conditions can be obtained from the WHO Web site.

Lobar pneumonia, unspecified (J18.1) should be considered an obvious consequence of dependence syndrome due to use of alcohol (F10.2). Any pneumonia in J12-J18 should be considered an obvious consequence of conditions that impair the immune system….

Volume 3, p. 197:

Place "acute" from the entry "Edema - lung - acute" in parentheses. Reduce the number of indents accordingly.

Edema, edematous R60.9
- lung **(acute)** J81
- - with heart condition or failure (*see also* Failure, ventricular, left) I50.1

The MRG submitted this recommendation (URC recommendation 0348) to the URC in May 2005

"No Recommendation" Issues

The MRG informed the URC of thirteen issues that had been discussed and resolved without requiring a change in the ICD volumes.

Issue 1: CARDIOVASCULAR DISEASE AND HYPERCHOLESTEROLAEMIA

Background and Issues. Some countries apply Rule 3 to cardiovascular disease in Part I and hypercholesterolaemia in Part II; others do not. The MRG obtained relevant information from medical advisors to the Swedish classification service and the International Atherosclerosis Society document at http://www.athero.org/download/guidelines.pdf. The MRG decided that conditions in I20-I25, Ischaemic heart diseases, and I70, atherosclerosis (generalized and of sites) should be considered an acceptable sequence but not obvious consequence of conditions in E78.0-E78.5 and E78.8-E78.9.

Hypercholesterolaemia is a risk factor rather than a cause of atherosclerosis.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 2: SUBACUTE SCLEROSING PANENCEPHALITIS

Background and Issues. Subacute sclerosing panencephalitis is due to measles but occurs 2-20 years later. However, the sequelae code (B94.1 Sequelae of viral encephalitis) does not reflect this history because it is unspecified. The MRG agrees that the appropriate code is A81.1 (Subacute sclerosing panencephalitis) not B94.1 Sequelae of viral encephalitis, and A81.1 should be accepted as due to malignant neoplasms and compromised immune system.

Consequently, the MMDS decision tables will have the following causal relationships, for 2005 data:

Code on upper line	**Can be due to the following:**
A81.1	A81.1
A81.1	B20.0 - B24
A81.1	C00.0 - C97
A81.1	R75
A81.1	Y43.1 - Y43.4
A81.1	Y63.2
A81.1	Y84.2

Decision. No URC action necessary. (Date of decision: 2004)

Issue 3: LAENNEC'S CIRRHOSIS

Background and Issues. A question was raised about the recommended change associated with URC 0192 and URC 0205 and the situation in which an alcoholic had a non-alcoholic form of cirrhosis. The MRG decided that this would be exceptionally rare. Hence, no special instruction need to be provided.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 4: FINAL CODE FOR SARS

Background and Issues. The MRG discussed the need to assign a permanent code for SARS instead of U04.9. However, the MRG decided that the number of cases is too small to justify any action.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 5: LONGSTANDING TUBERCULOSIS

Background and Issues. The MRG was looking at the use of terms like "longstanding" and instructions for tuberculosis sequelae. Tuberculosis can remain active for a long time (e.g., 5 years), but not for extraordinary lengths of time. Tuberculosis can have disseminated effects and cause organ damage all over the body (e.g., bone, renal disease, etc.), and there might be a long interval between infection and manifested disease.

The MRG discussed coding to sequelae of tuberculosis regardless of the interval between infection and manifested disease whenever tuberculosis is reported as the cause of any of a select list of chronic conditions. However, the MRG was unable to define a list that would only be due to sequelae of tuberculosis rather than tuberculosis in its active phase. Therefore, the MRG recommends no change.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 6: INJURIES WITH NO NATURE-OF-INJURY CODE

Background and Issues. The MRG discussed an unusual situation in the software in which an external cause case gets assigned to diseases because the software did not assign a nature-of-injury code automatically. The manual instructions generally cover this situation, so no change is needed in the ICD. However, the software needs to assign some nature-of-injury codes for these particular terms.

Consequently, the MMDS decision tables will assign the following injury codes for the following terms:

	Injury code
Abandonment	T74.0
Accident, accidental	T14.9
Arson	T14.9
Assault	T14.9
Beaten	T14.9
Blow to any site	T14.9
Blunt force NOS	T14.9
Blunt impact NOS	T14.9
Conflagration	T14.9
Desertion	T74.0
Excessive heat	T67.9
Explosion	T14.9
Explosive blasts to site(s)	T14.9
Fall	T14.9
Fight	T14.9
Fire	T14.9
Flood	T14.9
Foreign body	T14.9
Heat	T67.9
Hitting any site	T14.9
Homicide, homicidal	T14.9
Hot environment	T67.9
Hot weather	T67.9
Impact	T14.9
Inhalation	T14.9
Physical violence	T14.9
Projectile	T14.9
Reaction of drug with a reported complication	T88.7
Striking any site	T14.9
Suicide, suicidal	T14.9

Decision. No URC action necessary. (Date of decision: 2004)

Issue 7: UNDERLYING CAUSE AND RECORD AXIS FIELDS

Background and Issues. The MRG discussed whether the underlying cause should always be in the record axis fields or never be in the record axis fields. Currently, it usually is, but not always. The MRG decision was that the record axis fields should start with the underlying cause followed by the other conditions in alphanumeric sort order. This can be implemented in the 2006 version of TRANSAX. No change is needed in the ICD.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 8: R95 DUE TO J00

Background and Issues. The MRG discussed the question of whether ACME should accept R95 as due to J00. The MRG agree that the certifier is probably trying to say that the death was unexpected in spite of other conditions present which he or she also reported on the death certificate. The MRG decision is to accept that R95 can be caused by other conditions. No change is needed in the ICD.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 9: REFRACTORY ANEMIA AND MYELODYSPLASTIC SYNDROME

Background and Issues. A morbidity coder raised the issue that ICD and ICD-O-3 treat these conditions differently. In ICD-10, refractory anemia goes to D46, myelodysplastic syndrome. So, both refractory anemia and myelodysplastic syndrome go to the same category. However, D46 is an unspecified behaviour category.

In ICD-O-3, the morphology for myelodysplastic syndrome is malignant. The MRG learned that the group developing ICD-O-3 created the discrepancy because they wanted this information to be collected by cancer registries, not for substantive reasons. In fact, myelodysplastic syndrome has uncertain behaviour. There seems to be some interest in changing the ICD-O-3.

The MRG decision is that the ICD is correct and no change is needed

Decision. No URC action necessary. (Date of decision: 2004)

Issue 10: INFLUENZA AND CARDIOMYOPATHY

Background and Issues. The MRG discussed the following record:

Ia) Acute heart failure
b) Myocardial degeneration
c) Influenza pneumonia

The issue is that the terminology for line b affects the influenza code that is selected, and the difference between those terms seems relatively subtle.

The MRG decided that this is a language-specific problem which is not a problem in English. No change is needed in the ICD; however, the MRG suggests that national coding instructions deal with the issue when it is a problem in their language.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 11: CEREBROVASCULAR DISEASES AND MYOCARDIAL INFARCTION

Background and Issues. The MRG was looking at the question of I21-I22 being a cause of I60-I69. The MRG agrees that I21-I22 can cause I60-I69. I21-I22 is also an acceptable final complication of a stroke. In some cases, one may be assume intervening causes (e.g., thrombolytic treatment between cerebral haemorrhage and myocardial infarction). The software needs to reflect these relationships.

Causal relationships - heart and head

Conditions in	*may be caused by*
I21.0-I22.9	I60.0-I66.9
	I69.-
I61.0-I66.9	I21.0-I22.9
I67.8-I67.9	I21.0-I22.9
	I25.-

Decision. No URC action necessary. (Date of decision: 2004)

Issue 12: ACCIDENTS DUE TO NATURAL CAUSES

Background and Issues. The MRG was asked to revisit the issue of diseases causing accidents (e.g., myocardial infarction causing car accident). Some Brazilian data was submitted on the frequency of the situation. The MRG discussed a related issue (URC 0049) several years ago and reached a consensus. It is useful to get additional information on "underlying" diseases as risk factors;

however, the MRG supports retaining the instructions on external causes due to diseases as it is. These events should continue to be coded as accidents. The MRG recommends no change in the ICD.

Decision. No URC action necessary. (Date of decision: 2004)

Issue 13: VALVULAR DISEASES AND MYOCARDIAL INFARCTION

Background and Issues. The MRG discussed the question of the acceptability of acute myocardial infarction (I21-I22) as a cause of valve disorders (I34-I38) and *vice versa*. As part of the discussion, the MRG consulted with professors of cardiology and cardiovascular epidemiology at St. George's Hospital Medical School in the UK. Medical opinion was that acute myocardial infarction can cause mitral valve prolapse and incompetence but not diseases of other valves. Valvular heart disease can cause myocardial ischaemia, through insufficient blood flow, but would rarely cause an acute myocardial infarction.

The MRG decision is to modify causal tables in the MMDS software to reflect this information as follows:

Valvular diseases and myocardial infarction

1. Valvular conditions caused by myocardial infarction

Conditions in	May be caused by
I340-I341	I210-I229
I340-I341	I258
I349	I210-I229
I349	I258
I361	I210-I229
I361	I258
I511-I512	I210-I229
I511-I512	I258

2. Ischaemic heart disease causing valvular conditions

Conditions in	May be caused by
I200-I229	I050-I069
I200-I229	I080-I083
I200-I229	I340-I359
I252-I259	I050-I069
I252-I259	I080-I083
I252-I259	I340-I359

Decision. No URC action necessary. (Date of decision: 2005)