WHO-FIC NETWORK MEETING

Tokyo, Japan
16-22 October 2005

Revision Trial of Specific Clinical Topics - Diabetes Mellitus

Australian Centre

Abstract: */*

Introduction and Background

At the WHO Family of International Classifications (WHO-FIC) Network Meeting in October 2004, Reykjavik, Iceland, it was agreed that certain collaborating centres would undertake revision of specific clinical topics. These topics were identified by the WHO-FIC Update Reference Committee (URC), as large scale clinical updating projects beyond the scope of the current terms of reference of the URC (see paper 70: http://www.nordclass.uu.se/WHOFIC/papers/reykjavik70.pdf) They included cystic fibrosis, diabetes, mental health, haematological neoplasms, external cause of injury and mitrochondrial disorders. It was recognized that this list was not exhaustive and that there are other areas of ICD-10 which require significant revision.

The Australian Centre took on the responsibility for reviewing diabetes mellitus. The National Centre for Classification in Health (NCCH) has previously done considerable work on this section of ICD-10 for the Australian modification. The changes made to ICD-10-AM were based on the international recommendations for change to the criteria and classification of diabetes mellitus (see WHO working party final report - http://whqlibdoc.who.int/hq/1999/WHO_NCD_NCS_99.2.pdf).

A modified version of these changes, URC:0019, was submitted to the WHO Update Reference Committee (URC) in 2002 (see Appendix A). There was a mixed reaction to this proposal; specific comments from the various centres may be seen at the end of this document.

Working Group

The initial meeting of the working group was held on 28th September 2005, with the following representatives present:

Associate Professor Stephen Colagiuri, Director, Department of Endocrinology and Diabetes, Prince of Wales Hospital, Randwick, NSW, Australia

Associate Professor Gordon Senator, Consultant Diabetologist/Endocrinologist, Bond and Griffith Universities, Australia

Ms Kerry Innes, Acting Director, NCCH

Ms Julie Rust, Project Officer, NCCH

Further invitations have been extended to both Australian and international experts and it is hoped that this group will expand as work is progressed.

Progress to date

The members of the working group were provided with documentation to explain the scope of the project, the work to date on diabetes undertaken by the NCCH in relation to ICD-10-AM and the feedback from the 2002 proposal to the URC. At the initial meeting the limitations in relation to the current structure, rules and conventions of ICD-10 were outlined.

As a considerable amount of work on the revision of diabetes mellitus had already been undertaken by NCCH, it was felt that the most logical approach to this work would be a two part process:

1. Review of proposal URC:0019 for level of consensus to previously submitted recommendations (see Appendix B)
2. Follow process and methodology for future work as outlined at Reykjavik in Paper 70

A number of key clinical issues relevant to the revision of diabetes mellitus were also discussed:

- Dr Stephen Colagiuri is attending a WHO meeting in Geneva on 4th, 5th and 6th November on standardizing the criteria for diagnosis of diabetes, the results of which may inform future decisions on classification
- The outcome of a draft paper on the complications of diabetes may also be helpful for future work. This is a WHO paper currently being prepared by Dr Peter Bennett, Scientist Emeritus, National Institute of Diabetes and Digestive and Kidney Diseases,Phoenix, Arizona, USA
- Review of the international classification of chronic kidney disease (CKD) and incorporate concepts and terminology into nephrology complications section of diabetes mellitus where possible

- Review of data on frequencies of E10.8 *Type 1 diabetes mellitus with unspecified complication* and E11.8 *Type 2 diabetes mellitus with unspecified complication* from ICD-10-AM to see the relevance of having a '.8 with unspecified complication' code in the classification
- There is still ongoing discussion on the criteria/diagnosis of 'metabolic syndrome', therefore this has not been included in the revision of the classification at this stage
- Review of terminology used in diabetic eye disease to bring up to date, ie 'background' retinopathy is no longer used.

Taxonomic/structural issues which need to be addressed include:

- The use of optional 5th characters for ICD-10 to provide better specificity for complications/manifestations of diabetes
- Evaluation of the dagger/asterisk convention as against the use the 'code also' notes in the diabetes section
- Consider the inclusion of internationally accepted diagnostic criteria in tabular list to assist with code selection.

It was acknowledged that longer term work in relation to ICD-11, could include:

- The possibility of a matrix of manifestations/complications with severity
- Consideration of the relationship between ICD and clinical terminologies such as SNOMED CT. As many countries have added additional characters to their respective clinical modifications of ICD (sometimes to the 7th character), there is clearly a perceived need for greater specificity in ICD. This method of representing the necessary clinical detail creates many "pre-coordinated" concepts in one code (e.g. ICD-10-CM: I69.452 *Hemiplegia and hemiparesis following stroke, not specified as haemorrhage or infarction affecting left dominant side*) which makes subsequent grouping to DRGs difficult and begs the question whether such codes are very useful for data analysis. Clinical terminologies may provide the required level of specificity, and serious consideration should be given to how the terminologies and the classification can work together to best serve the dual requirement for specificity and aggregation. Important questions to consider will be how clinical terminologies can be used for reporting clinical findings and what concepts are truly useful for statistical reporting using ICD.

The next meeting of the working group is planned for the end of 2005, following the Geneva meeting on standardizing the diagnostic criteria for diabetes mellitus.

URC Reference No: 0019 **Proposed by: Australia**

Change to Volume: I & III Type of proposal: Major

Description (term/code): Diabetes mellitus

Proposal for update:

Background

This proposal was included in the URC work for 2000. It was agreed that WHO would undertake further research. Following the 2001 HoC meeting, this work item has been handed back to the URC to progress. The original proposal has been reproduced below:

The NCCH has modified the codes for diabetes mellitus (E10-E14) for the second edition of ICD-10-AM. These changes are based on international recommendations for changes to the criteria and classification of diabetes mellitus (see WHO working party final report - http://whqlibdoc.who.int/hq/1999/WHO_NCD_NCS_99.2.pdf).

It is recommended that WHO modify E10-E14 taking these developments into account (see also the Canadian ICD-10-CA). Please note that these changes are specific to the Australian modification of ICD-10 (to the fifth character level) and as such would require modification for the WHO ICD-10.

For consideration by URC members in 2002 work program

The Australian Centre has prepared a sample of the proposed changes to ICD-10 to give URC members an idea of the scope of the

changes to be made and the issues to be considered. The changes have been prepared in line with the changes made to the ICD-10-AM Second and Third Editions (which are based on international recommendations for changes to the criteria and classification of diabetes mellitus – see WHO working party final report - http://whqlibdoc.who.int/hq/1999/WHO_NCD_NCS_99.2.pdf).

A copy of the relevant section from ICD-10-AM Third Edition has been included for members' reference at the end of this proposal.

Points to note about the restructure are:

- Category E09 *Impaired glucose regulation* can be incorporated easily into the existing structure. Changes have been made to category R73 to distinguish E09 from unspecified hyperglycaemia (R73).

- Categories E10 and E11 have been renamed *Type 1 diabetes mellitus* and *Type 2 diabetes mellitus*, respectively.

- For categories E10-E14, the proposed fourth character codes are consistent throughout.

.0 has been renamed '*with hyperosmolarity*'.

In this proposal, the logic of the classification in relation to the existing fourth character code '*with coma*' has been altered. Instead, a 'use additional code' instruction has been applied to identify any associated coma.

Alternative solutions:

- a fifth character code could be introduced – with/without coma
- a specific asterisk category could be introduced – 'coma in diabetes mellitus'

- .8 '*unspecified complication'* could be deleted, the fourth character code '*with coma*' reintroduced and the remaining fourth category codes renumbered (for example, 0 with coma, 1 with acidosis, 2 with hyperosmolarity, 3 with renal complications, and so on).

Please note that for category E10, there is no E10.0 because type 1 diabetes mellitus with hyperosmolarity is extremely rare.

.1 has been renamed '*with acidosis'*.

A 'use additional code' instruction has been applied to identify any associated coma.

Alternative solutions:

- a fifth character code could be introduced – with/without coma
- a specific asterisk category could be introduced – 'coma in diabetes mellitus'
- .8 '*unspecified complication'* could be deleted, the fourth character code '*with coma*' reintroduced and the remaining fourth category codes renumbered (for example, 0 with coma, 1 with acidosis, 2 with hyperosmolarity, 3 with renal complications, and so on).

.2 to .9 – existing descriptions have been retained.

.2 '*with renal complication*'

The existing aetiology/manifestation relationships have been retained. New terms have been introduced to the index (for example, 'diffuse glomerulosclerosis', 'diabetes mellitus with glomerular basement-membrane thickening', 'diabetes mellitus with microalbuminuria'). Difficulties arise when trying to classify new concepts to this category. For example, 'diabetes mellitus with end-stage renal disease' or 'diabetes mellitus with acute or chronic renal failure'. *N29.8 *Other disorders of kidney and ureter in other diseases classified elsewhere* is, perhaps, too general to be an appropriate manifestation code for these terms.

Alternative solutions:

- a fifth character code could be introduced for greater specificity
- a specific asterisk category or subcategory could be introduced
- a 'use additional code' instruction could be applied to identify the end-stage renal disease or acute/chronic renal failure, rather than an aetiology/manifestation relationship.

Issues to consider

The proposal does not describe the restructuring for the other complication categories (.3 ophthalmic complication, .4 neurological complication etc) because similar issues apply to these also. Of particular importance is that the detail in the .6 and .7 complication categories (specified in the ICD-10-AM) will be lost if fifth character codes cannot be introduced in the ICD-10.

Another issue for consideration is the introduction of specific asterisk categories. This will be challenging, given that there is limited scope for 'sensible' expansion within the existing structure. Existing asterisk categories may have to be utilised as a 'best fit', for example N29* could be expanded to include N29.2* *Acute renal failure in diabetes mellitus*. Or we could break with the 'asterisk category' principle and introduce specific asterisk subcategories, for example *N17.3 *Acute renal failure in diabetes mellitus*; *N18.1 *Chronic renal failure in diabetes mellitus* (includes ESRD in DM).

Finally, 'use additional code' instructions can be applied where asterisk categories cannot be developed and the existing aetiology/manifestation relationships cannot be utilised. Given the large number of terms that would be classified to these categories under this proposal (refer to the ICD-10-AM), this may mean that the tabular becomes 'cluttered' with many instructional notes. This could be confusing for the user, particularly for categories .6 and .7. The international relevance of these instructions should also be considered, particularly for those countries that apply the single-condition coding principle. The extra information (or detail) captured by multiple condition coding would be lost.

Options

The Australian Centre proposes the following four options:

Option 1: No change

Make no changes to the existing classification.

Option 2: Fifth characters

Change the fourth character categories as suggested in proposal.
Introduce fifth characters to capture concepts such as 'with coma' for category E1-.1; 'with/without gangrene' for subcategory E09.0; and to introduce a level of specificity that is required to adequately classify the complexities of diabetes mellitus.
Maintain the existing aetiology/manifestation relationships.

Option 3: New asterisk categories

Change the fourth character categories as suggested in proposal.
Develop specific asterisk categories to negate the need for fifth characters (only in instances where the existing aetiology/manifestation relationships cannot be utilised).

Option 4: New asterisk categories + 'Use additional code' convention

Change the fourth character categories as suggested in proposal.
Develop specific asterisk categories to negate the need for fifth characters (only in instances where the existing aetiology/manifestation relationships cannot be utilised).
Add 'use additional code' instructions in the tabular for all relationships that cannot be incorporated into the existing or newly developed aetiology/manifestation relationships.

Appendix A – URC 0019 Previous proposal on diabetes mellitus in 2002

When commenting on these options, can members please specifically address:

- Whether the .8 *Unspecified complication* category should be retained. Deleting this category will enable the logic of the existing classification of 'with coma' to be retained.
- How the introduction of specific asterisk categories should be handled. Are asterisk subcategories acceptable within categories that are not designated as asterisk categories now?
- The benefit of 'use additional code' instructions at the international level.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Page 43 Modify block title and code range Add category title Modify category titles	**List of three-character categories** **CHAPTER IV** **Endocrine, nutritional and metabolic diseases (E00-E90)** **Impaired glucose regulation and diabetes mellitus (E09-E14)** E09 Impaired glucose regulation E10 Type I diabetes mellitus E11 Type II diabetes mellitus	Australia (URC:0019)	Major	January 2006

Impaired glucose regulation and diabetes mellitus

(E09-E14)

Note: Diagnostic criteria:

WHO criteria for impaired glucose regulation (revised 1999):

Based on correctly conducted oral glucose tolerance test (fasting venous plasma glucose 6.1–6.9 mmol/L or 2-hour post glucose, venous plasma glucose 7.8–11.0 mmol/L)

or

fasting venous plasma glucose level 6.1–6.9 mmol/L

WHO criteria for diabetes mellitus (revised 1999):

Based on correctly conducted oral glucose tolerance test (fasting venous plasma glucose ≥ 7.0 mmol/L or 2-hour post oral glucose, venous plasma glucose ≥ 11.1 mmol/L)

or

American Diabetes Association (ADA) criteria:

Fasting venous plasma glucose level ≥ 7.0 mmol/L or classical symptoms of thirst, polyuria and a random venous plasma glucose ≥ 11.1 mmol/L

Use additional external cause code (Chapter XX), if desired, to identify drug, if drug-induced.

~~The following fourth-character subdivisions are for use with categories E10-E14:~~

~~**.0 With coma**~~

~~Diabetic:~~

~~. coma with or without ketoacidosis~~

~~. hyperosmolar coma~~

~~. hypoglycaemic coma~~

~~Hyperglycaemic coma NOS~~

~~**.1 With ketoacidosis**~~

~~Diabetic:~~

~~. acidosis) without mention of coma~~

~~. ketoacidosis)~~

~~**.2+ With renal complications**~~

~~Diabetic nephropathy (N08.3*)~~

~~Intracapillary glomerulonephrosis (N08.3*)~~

~~Kimmelstiel-Wilson syndrome (N08.3*)~~

~~**.3+ With ophthalmic complications**~~

~~Diabetic:~~

~~. cataract (H28.0*)~~

~~. retinopathy (H36.0*)~~

~~**.4+ With neurological complications**~~

~~Diabetic:~~

~~. amyotrophy (G73.0*)~~

~~. autonomic neuropathy (G99.0*)~~

~~. mononeuropathy (G59.0*)~~

~~. polyneuropathy (G63.2*)~~

~~. autonomic (G99.0*)~~

~~**.5 With peripheral circulatory complications**~~

~~Diabetic:~~

~~. gangrene~~

~~. peripheral angiopathy+ (I79.2*)~~

~~. ulcer~~

~~**.6 With other specified complications**~~

~~Diabetic arthropathy+ (M14.2*)~~

~~. neuropathic+ (M14.6*)~~

~~**.7 With multiple complications**~~

~~**.8 With unspecified complications**~~

~~**.9 Without complications**~~

E09 Impaired glucose regulation

Includes: abnormal glucose (carbohydrate):
. regulation
. tolerance
diabetes:
. chemical
. latent
impaired:
. fasting glycaemia (IFG)
. glucose (carbohydrate) tolerance (IGT)
prediabetes

Use additional code, if desired, for any underlying condition or associated genetic syndrome.

Excludes: diabetes mellitus (E10-E14)
elevated blood glucose level (R73)

E09.0 Impaired glucose regulation with peripheral angiopathy

Use additional code, if desired, to identify any associated gangrene

An alternative suggestion could be to introduce a fifth digit = with/without gangrene

E09.1 Impaired glucose regulation with features of insulin resistance

Note: This code should be assigned when the following conditions are documented with impaired glucose regulation and meet the criteria mentioned:

1. Insulin resistance is confirmed by laboratory measurements

OR

2. Increased visceral fat deposition is documented

OR

3. One (or more) of the following conditions is documented:

- Acanthosis nigricans
- Dyslipidaemia (elevated fasting tryglicerides and depressed-HDL-cholesterol)
- Hyperinsulinism
- Obesity (meeting WHO criteria)

OR

4. Hypertension is documented in addition to any of the conditions in point 3 **OR** is documented with unqualified obesity.

E09.8 Impaired glucose regulation with other complication

E09.9 Impaired glucose regulation without complication

E10 **Type 1 diabetes mellitus**

~~[See page 277 for subdivisions]~~

Includes: diabetes (mellitus):

. autoimmune

. brittle

. idiopathic

. insulin-dependent [IDDM]

. juvenile-onset

. ketosis-prone

~~. type I~~

Excludes: diabetes mellitus (due to) (in):

~~. malnutrition-related (E12.)~~

. neonatal (P70.2)

. NOS (E14.-)

. other specified (E13.-)

. pregnancy, childbirth and the puerperium (O24.-)

. Type 2 (E11.-)

glycosuria:

. NOS (R81)

. renal (E74.8)

impaired glucose regulation (E09.-)

postprocedural hypoinsulinaemia (E89.1)

In this proposal, the fourth character codes for the diabetes categories will be consistent throughout.

.0 will no longer represent 'with coma'. It will represent 'with hyperosmolarity' (the suggestion is that coma is assigned as an additional code).

For category E10, there is no E10.0 because diabetes with hyperosmolarity is extremely rare in patients with Type 1 diabetes.

E10.1 Type 1 diabetes mellitus with acidosis

Type 1 diabetes mellitus with:

. ketoacidosis

. lactic acidosis

Use additional code (R40.2), if desired, to identify associated coma

An alternative suggestion could be to introduce a fifth digit = with/without coma

E10.2 Type 1 diabetes mellitus with renal complication

Diabetic nephropathy (established) (incipient) (N08.3*)

Intracapillary glomerulonephrosis (N08.3*)

Kimmelstiel-Wilson syndrome (N08.3*)

Type 1 diabetes mellitus with:

. end-stage renal disease (N29.8*)

. renal failure (acute) (chronic) (N29.8*)

Is N29.8* an appropriate code for these manifestations? Perhaps a 'use additional code' instruction would be better?

E10.3 Type 1 diabetes mellitus with ophthalmic complication

E10.4 Type 1 diabetes mellitus with neurological complication

E10.5 Type 1 diabetes mellitus with circulatory complication

E10.6 Type 1 diabetes mellitus with other specified complication

E10.7 Type 1 diabetes mellitus with multiple complications

E10.8 Type 1 diabetes mellitus with unspecified complication

Is this .8 category useful? Are complications ever 'not specified'? E10.8 could be deleted, a category 'with coma' reintroduced, the concept of 'with hyperosmolarity' introduced and fourth character codes renumbered accordingly.

E10.9 Type 1 diabetes mellitus without complication

R73 Elevated blood glucose level

Hyperglycaemia NOS

Excludes: diabetes mellitus: ~~(E10-E14)~~

. in pregnancy, childbirth and the puerperium (O24.-)

. NOS (E10-E14)

impaired glucose regulation (E09.-)

neonatal disorders (P70.0-P70.2)

postprocedural hypoinsulinaemia (E89.1)

~~**R73.0 Abnormal glucose tolerance test**~~

~~Diabetes:~~

~~.chemical~~

~~. latent~~

~~Impaired glucose tolerance~~

~~Prediabetes~~

~~**R73.9 Hyperglycaemia, unspecified**~~

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil		We do not accept 5th digits in an official version (and for mortality). However, this proposal is acceptable for morbidity adaptations at national levels.
France		
Japan	Suspended	As for the results of the research and discussion, they have to be highly evaluated. But the judgement would be suspended because the introduction into this country requires much effort and a long time period.
NORDIC	Not supported	5th decimals are not acceptable in the official version. The changes to 4th character are not acceptable. .Decimal 0: Coma occurs in juvenile diabetes, now it has disappeared. Coma can be hyperosmolar (hyperglycemic) or hypoglycemic (hypo-osmolar). Especially in children the most usual coma is hypoglycemic but since the first aid is sugar the usual finding at admittance to hospital is hyperglycemia. In general the type of coma is not always known, it is therefore better to be unspecified. Specified etiology can be indicated with added 5th characters on national level if that is felt necessary, but it is certainly not important for international comparisons. Decimal .1: Lactic acidosis has already a code in ICD-10 E87.2 and that code does not exclude diabetes. We see no reason for a change.Decimal .1 should be reserved to ketoacidosis.

		The new code E09 cannot be differentiated from R73 which already covers the problem. The wording form WHO/NCD/NCS/99.2 is: 'The class "Impaired Glucose Tolerance" is now classified as a stage of impaired glucose regulation, since it can be observed in any hyperglycaemic disorder, and is itself not diabetes' Thus there is no need for a new code, but rather modificiation of the existing codes. The names of E10 and E11 should be changed. Although decimal .8 is possibly unnecessary and could be deleted, we don't think that it is causing any problem. Sometimes the death certificates do not specify the complication and decimal .8 is really used. We see no linkage between this question and decimal .0 which should not be changed We prefer addition of more specific manifestation code to N29*. It should however not be limited to diabetes but rather be: N29.2 Acute renal failure in other diseases classified elsewhere Manifestation codes that are specifically linked to one etiology are unnecessary and should be avoided. The etiological code always indicates the etiology in these situations. Similarly etiological codes that indicate a specific manifestation make the manifestation code unnecessary since all information is already coded. The use of 'code additional' notes is not problematic since they do not bind the user. Australian 5th decimal additions are good at .6 and .7 decimals and should be recommended for national extensions. For international statistics the current 4 character version is enough.
North America		U.S. Mortality supports Option 1, no change for mortality purposes. Would not expect terms that are coded to E09 to be reported on death certificates. In most cases, death records are coded to the .9 subcategory but there are discussions ongoing about making better use of Rule 3 to capture other existing 4th digits. The other changes seem to be making a lot of changes in detail without fundamentally changing the content; however, there may be unintended consequences of these changes. 5th digits are not used in mortality. NACC Morbidity suggests that perhaps it would be best to form a small working group to develop a consensus proposal.

		Mortality (Canada) defers to Morbidity (Canada) and concurs with their concerns. Further comment: NACC Morbidity has additional concerns regarding this proposal that were not included in our first round response. The concern is related to the movement of conditions to the new code E09 from R73, where they are currently classified. An alternative could be to expand R73.0 at the fifth digit level for national morbidity versions to include the detail that has been added at E09. This alternative would allow the capture of important information at the national level while reducing the impact on mortality changes to the classification. NACC morbidity continues to support the need for a working group of the URC to carefully review the potential impact of the suggested changes as it appears that there may be comparability issues between ICD-10-AM, ICD-10-CA and ICD-10-CM.
United Kingdom	Support option 2	The adoption of a fifth character to introduce a level of specificity is welcomed Support the decision to remove the .8 category as complications would always be specified. Support introducing fifth digit for with/without coma N92.8* - agree a 'use additional code' would be better here for greater specificity
Roberto Becker		In general, I agree with the comments from North America. Considering that E09 is not expected to appear in a death certificate (may any of the conditions/codes proposed be accepted as underlying cause of death?), maybe all the conditions proposed for a new E09 should be included in a reformulated R73? 5th digits are not accepted for regular mortality coding and all 5th offered in the official version of ICD-10 are additional or optional and for morbidity. Regarding to removing of .8 subcategory, it is not true that complications would always be specified and thus I don't agree with the removal.
Michael Schopen	Supported in part	The introduction of E09 is supported, however, the notes should be dropped as ICD contains almost no definitions of the diseases except for chapter V. Furthermore, the countries might have different definitions. With and without gangrene should be coded on the fourth character level as there is sufficient space left, e.g. E09.0 Impaired glucose regulation with peripheral angiopathy and gangrene E09.1 Impaired glucose regulation with peripheral angiopathy and without gangrene E09.2 Impaired glucose regulation with features of insulin resistance

		E09.8 Impaired glucose regulation with other complications E09.9 Impaired glucose regulation without complications E10-E14: Change of E10 and E11 to Type I and Type II diabetes is supported. Where shall LADA be classified? Changes to the fourth character level need further discussion. If .0 is changed to "with hyperosmolarity", where does hypoglycemic coma go? We strongly recommend to avoid shifts in the fourth character position, as from our experience they are the worst way to change a classification. We would prefer a fifth digit for with/without coma. If an asterisk code for coma is introduced, many other diseases should also become subject to dual classification, e.g. myxedema or Addison's disease. However, if the information about coma is to be retained on the fourth character level, fourth characters could be changed as follows to avoid shifts: .0 to .5 without changes .6 with other and unspecified complications .7 with multiple complications .8 with hyperosmolarity .9 without complications Further comment: Sorry, I forgot to give some information on LADA (late autoimmune diabetes in adults). LADA is non-insulin dependent, but shares many properties with type I diabetes.
André L'Hours	Not supported	Comments received 10/10/2002: Agree with the comments of the Nordic Centre particularly with regard to proposed category E09. A working group as proposed by the North American Center would be a reasonable way forward.

WHO-FIC NETWORK MEETING

Tokyo, Japan
16-22 October 2005

Proposed change in 2002 and subsequent revision (tracked changes)	URC opinion in 2002	Comments
Categories E10 and E11 to be renamed *Type 1 diabetes mellitus* and *Type 2 diabetes mellitus* respectively. For the classification of late autoimmune diabetes in adults (LADA) the following note is proposed: A clinical diagnosis of Type 1.5 diabetes (LADA) with positive auto-antibodies (GAD/IA2) should be assigned to E10.- *Type 1 diabetes mellitus* or without positive auto-antibodies to E14.- *Unspecified diabetes mellitus*.	General consensus, with question on where late autoimmune diabetes in adults (LADA) should be classified	See proposed note for tabular list to assis classification of LADA
The concept of 'malnutrition related diabetes' is no longer relevant and therefore category E12 *Malnutrition-related diabetes mellitus* should be inactivated.	No specific comments, but no strong objections	The reasoning for removal of this categor working party final report - http://whqlibdoc.who.int/hq/1999/WHO
Creation of new category at E09 *Impaired glucose regulation*, with the following subcatgories: .0 with peripheral angiopathy .1 with features of insulin resistance .8 with other and unspecified complication .9 without complication	There was mixed support for a separate code for IGR as some representatives felt that there was overlap and ambiguity with R73 *Elevated blood glucose level*	The clinicians in our working group feel empirical support and international criter separate category for this condition. Rece supported the importance of this distincti cause in mortality. There is also ongoing whether include further subcategories for angiopathy and gangrene' and 'with peri without gangrene'
The original proposal suggested a	There was objection to the	Ongoing discussion in the working group

change of name for the fourth character of .0 from 'with coma' to 'with hyperosmolarity' and that .0 is not a valid character for E10	suggestion of deleting '.0' for E10, so this will be reinstated.	term 'hyperosmolarity' and how coma sh
The original proposal suggested a change of name for the fourth character of .1 from 'with ketoacidosis' to 'with acidosis'	There was objection to this change of terminology	The working group will consider this issu

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