WHO-FIC NETWORK MEETING

Tokyo, Japan
16-22 October 2005

URC WORKSHEETS
RECOMMENDATIONS FOR UPDATES TO ICD-10

UPDATE REFERENCE COMMITTEE

Third round review: Tokyo HoC Meeting, September 2005

The following pages include recommendations for updates to the tabular list, instruction manual and alphabetical index of ICD-10. Each recommendation has been uniquely identified and the source indicated. Recommendations are also classified as major or minor and an implementation date suggested (subject to approval by the URC).

Where additions/changes have been suggested, these have been indicated through the use of instructions, underline and ~~strikeout.~~

Feedback is sought from members of the URC on the feasibility/desirability of accepting these changes.

For the October HoC meeting in Tokyo, this paper has been separated into sections:

Section 1 (page 3): Recommendations supported by the URC for inclusion in ICD-10

Section 2 (page 82): Recommendations for further discussion at the HoC meeting

Section 3 (page 204): Recommendations held over and include in the URC work program (0 items)

Section 4 (page 205): Recommendations not supported or withdrawn

Section 5 (page 211): Issues Discussed by MRG Not Requiring Changes to ICD-10

Section 6(page 221): Errata second edition of ICD-10

Sections 1 and 4 are to be ratified.

Section 2 is to be discussed at the HoC meeting.

Section 3, 5 and 6 are for member's information.

URC Reference No: 0204 (Addenda) Proposed by: Roberto Becker

Change to Volume: I III Type of proposal: Minor

Description (term/code): U04 Severe acute respiratory syndrome (SARS)

Proposal for update: In order to ensure that there is no confusion in the classification of this condition, a proposal is being made to incorporate the following addenda to Volumes 1 and III.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add excludes note	**B34.2 Coronavirus infection, unspecified** ***Excludes*: SARS (U04.9)**	Roberto Becker	Minor	January 2006

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	Infection, infected (opportunistic) B99	Roberto Becker	Minor	January 2006

Delete code Add subterms	– **coronavirus ~~NEC B34.2~~** **– – SARS U04.9** **– – unspecified B34.2**			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	supported	
Brazil		
France	supported	I support the modifications due to the SARS code, but I don't understand why it is a U code
Japan		
NORDIC		
North America	supported	
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob	supported	

Section 1: Recommendations supported by the URC for inclusion in ICD-10

36 work items

0220 Disorders of phosphate enzymes

0267 Hypertensive renal disease

0268 Syphilitic placenta

0272 Wood preservatives

0273 Menstruation

0276 Chromate, lead

0278 Abnormal findings

0280 Lymphadenitis

0283 Abdominal migraine

0320 West Nile Fever

0321 M94.0 Chondrocostal junction syndrome [Tietze]

0322 Complications following acute myocardial infarction

0323 Cribriform hymen

0324 Displacement, cervical intervertebral disc with neuritis

0325 Keratopathy

0329 Shoulder pain

0330 Phenazopyridine

0331 Stenosis of precerebral artery

0286 Astereognosis

0288 Sniffing

0289 Psychobiological deficiency

0300 Personality problem

0305 Erythrocytosis

0306 Fecal (faecal) occult blood

0308 Pressure ulcer

0309 Puerperal nephritis

0310 Change of index entry for renal cyst

0314 Tramadol

0316 Sudden death

0319 Note 4.2.2 (d) Diabetes due to any other disease

0333 Wallenberg's disease or syndrome

0335 Transport accidents

0338 Vascular parkinsonishm

0343 Obstruction, cardia

0345 Fahr's disease

URC Reference No: 0220 Proposed by: Germany

Change to Volume: I III Type of proposal: Major

Description (term/code): Disorders of phosphate enzymes

Proposal for update:
This proposal for change was originally tabled in 2004 and the background for the change is reproduced below:

Acid phosphatase deficiency and hypophosphatasia are not disorders of the phosphorus metabolism but disorders of the phosphatase enzymes. Hypophosphatasia means low activity of alkaline phosphatase. We are uncertain about the correct codes for these conditions, but suggest for hypophosphatasia E83.5, and for acid phosphatase deficiency E88.8.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
	E83.3 Disorders of phosphorus metabolism ~~Acid phosphatase deficiency~~ Familial hypophosphataemia ~~Hypophosphatasia~~ Vitamin-D-resistant: · osteomalacia · rickets *Excludes:* adult osteomalacia (M83.-)	Germany (URC:0220)	Major	January 2006

	osteoporosis (M80-M81)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	This proposal will need appropriate index entries/changes	Germany (URC:0220)	Major	January 2006

URC members comments 2004:

URC members	Proposal supported/ not supported	Comments
Australia		There needs to be clinical opinion about placement of codes. Are these actual morbid conditions or abnormal test results?
Brazil		We need more information
France		
Japan		As proposed by Germany, neither acid phosphatase deficiency nor hypophosphatasia should be classified in E83.3. However, hypophosphatasia is not a certain disease but means an abnormal value of serum enzyme, thus it should be included in R 74.8.
NORDIC	Supported in principle	What is the correct coding?

North America		Canada-Mortality & Canada/US Morbidity would like more information on this proposal. **Second round comment**: US Morbidity agrees with moving acid phosphatase deficiency, as recommended. On brief review of acid phosphatase deficiency on OMIM, I would agree with classifying it to E88.8 (but would be inclined to suggest that it be an index entry, rather than an inclusion term). However, hypophosphatasia does appear potentially to have some relationship to the disorders of phosphorus metabolism, even though it is actually related to a deficiency of alkaline phosphatase (a mutation in the alkaline phosphatase gene). From OMIM, there are four separate types: (1) severe perinatal ('lethal') form, (2) severe infantile form, (3) childhood form, and (4) adult form. Elevated inorganic pyrophosphate is present. Various skeletal abnormalities are found, which appear somewhat consistent with other disorders of phosphorus metabolism. The severe infantile form at least does also involve disorders of calcium metabolism, so would presumably be the reason for the suggestion to consider code E83.5. However, the adult form does not appear to involve calcium metabolism. This may need further review, to resolve.
United Kingdom		Morbidity – awaiting further clinical information
Roberto Becker		
Germany	Supported	Will also need a decision about the correct codes for acid phosphatase deficiency and for hypophosphatasia Hypophosphatasia is not only an abnormal value of a serum enzyme, it is an entity of its own. See http://www.emedicine.com/ped/topic1126.htm More information on acid phosphatase deficiency (also an entity of its own) is available here. http://www.ncbi.nlm.nih.gov/entrez/dispomim.cgi?cmd=entry&id=200950 I am still uncertain about the best codes for these conditions.
Robert Jakob		

URC decision:

There was agreement in principle that the two inclusions be removed. A decision regarding an appropriate location for the inclusions was held over for 2005.

Proposal for 2005 update:

With respect to the comments of URC members as discussed at the Reykjavik meeting, we would like to suggest a new proposal to URC reference No 0220 **Disorders of phosphate enzymes**.
Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code title	E83.3 Disorders of phosphorus metabolism and phosphatases Acid phosphatase deficiency Familial hypophosphataemia Hypophosphatasia Vitamin-D-resistant: · osteomalacia · rickets *Excludes:* adult osteomalacia (M83.-) osteoporosis (M80-M81)	Germany	Major	January 2009

URC members comments 2005:

URC members	Proposal supported/	Comments

	not supported	
Australia	Supported	
Brazil	Supported	
France	supported	But it would be better to have a special code for the disorders of phosphatasia metabolism. Maybe there is a reason why you did not propose it ?
Japan		
NORDIC	Supported	
North America	Supported, in principle	NACC Mortality defers to Morbidity.
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0267 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Hypertensive renal disease

Proposal for update:

N19 and N26 have no further subdivisions, thus .- must be deleted.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Modify inclusion term	**I12 Hypertensive renal disease** ***Includes:*** any condition in N18.–, N19.— or N26.— with any condition in I10 arteriosclerosis of kidney arteriosclerotic nephritis (chronic)(interstitial) hypertensive nephropathy nephrosclerosis ***Excludes:*** secondary hypertension (I15.–)	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	see URC-271	We supported as URC 271
France	Supported	
Japan		
NORDIC	Supported	
North America	Supported	
United Kingdom	Supported (Morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0268 Proposed by: Germany

Change to Volume: I III Type of proposal: Major

Description (term/code): Syphilitic placenta

Proposal for update:

Error correction. Compare with Syphilis, placenta.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Placenta - syphilitic ~~A52.7~~ O98.1	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America	Supported	
United Kingdom	Supported (Morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0272 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Wood preservatives

Proposal for update:

Wood preservatives are mentioned as an inclusion term at T60. An entry in section III of the Alphabetical Index is missing.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add codes	Wood preservatives T60.9 X48.- X68.- Y18.-	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	Maybe an index entry under *Preservative* is warranted as well : Preservative (nonmedicinal) .....T65.8 X49.– X69.– Y19.– – - medicinal .....T50.9 X44.– X64.– Y14.– Y57.4 - wood……T60.9 X48.- X68.- Y18.- -
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	Australian addition also reasonable
North America	Supported	**Second round comment:** NACC Morbidity and Mortality support additional indexing as proposed by Australia.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		The Australian proposal is supported.
Robert Jakob		

URC recommendations to WHO HoC:

Preservative (nonmedicinal)	T65.8	X49.–	X69.–	Y19.–	–
- medicinal	T50.9	X44.–	X64.–	Y14.–	Y57.4
- wood	T60.9	X48.-	X68.-	Y18.-	
Wood preservatives	T60.9	X48.-	X68.-	Y18.-	

URC Reference No: 0273 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Menstruation

Proposal for update:

Index entries for painful menstruation are not in line with entries for dysmenorrhea.

Menstruation

- painful (primary) (secondary) (*see also* Dysmenorrhea) N94.6

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise subterms and add codes	**Menstruation** - painful (*see also* Dysmenorrhea) N94.6 - - primary N94.4	Germany	Minor	January 2007

	- - secondary N94.5			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	Changes need to be shown in the following format: **Menstruation** - painful *(see also Dysmenorrhea)* N94.6 - - primary N94.4 - - psychogenic F45.8 - - secondary N94.5
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported as porposed by Australia	

North America	Supported	
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		The Australian proposal is supported.
Robert Jakob		

URC recommendations to WHO HoC:

Menstruation

- painful *(see also Dysmenorrhea)* N94.6

- - primary N94.4

- - psychogenic F45.8

- - secondary N94.5

URC Reference No: 0276 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Chromate, lead

Proposal for update:

Y69.- must be changed to X69.-

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Chromate** **– lead (*see also* Lead)** T56.0 X49. ~~Y69.~~ X69.- Y19.	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	Add dash to X69 in changes above
Brazil	Supported	
France		It's correct on the French version
Japan		
NORDIC	Supported	
North America	Supported	NACC (Morbidity and U.S. Mortality) support. **Second round comment:** Entry is incorrect in browser, original index and 2nd version index.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		I have corrected a typo and added .- to the code.

Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0278 Proposed by: Germany

Change to Volume: I Type of proposal: Minor

Description (term/code): Abnormal findings

Proposal for update:

There is a slight inconsistency in rendering of categories which refer to a subclassification. At some categories a note under the category title "[See before Xnn for subdivisions]" is missing and should be added. This affects chapters XVIII (all categories listed below) and also chapter XX (for reasons of space I have not listed all categories).

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add instruction	**R83** **Abnormal findings in cerebrospinal fluid** [See before R83 for subdivisions]	Germany	Minor	January 2007
Add instruction	**R84** **Abnormal findings in specimens from respiratory organs and thorax** [See before R83 for subdivisions]			

	Abnormal findings in: • bronchial washings • nasal secretions • pleural fluid • sputum • throat scrapings ***Excludes:*** blood-stained sputum (R04.2) **R85 Abnormal findings in specimens from digestive organs and abdominal cavity** [See before R83 for subdivisions]			
Add instruction	Abnormal findings in: • peritoneal fluid • saliva ***Excludes:*** faecal abnormalities (R19.5) **R86 Abnormal findings in specimens from male genital organs** [See before R83 for subdivisions]			
Add instruction	Abnormal findings in: • prostatic secretions • semen, seminal fluid Abnormal spermatozoa ***Excludes:*** azoospermia (N46) oligospermia (N46) **R87 Abnormal findings in specimens from female genital organs**			

Add instruction	[See before R83 for subdivisions] Abnormal findings in secretions and smears from: • cervix uteri • vagina • vulva ***Excludes:*** carcinoma in situ (D05~D07.3) dysplasia of: • cervix uteri (N87~.) • vagina (N89.0~N89.3) • vulva (N90.0~N90.3) **R89 Abnormal findings in specimens from other organs, systems and tissues** [See before R83 for subdivisions] Abnormal findings in: • nipple discharge • synovial fluid • wound secretions			
Add instruction				

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	There is another solution to this problem which we have implemented. We use the text boxes to denote whether a code is valid or not. A black text box indicates that the code or category requires a further character to make it valid, whereas a clear text box indicates that it is a valid code. Just a suggestion for further hard copy publications of ICD-10.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	The Finish ICD-10 version for example has opened all these codes. The extra space needed is minor compared to the discomfort caused by the back and forth searching of the book. Specially in electronic version this is not acceptable.
North America	Supported	
United Kingdom	Supported (Morbidity)	Another suggestion would be to say 'see page 885 for subdivisions'
Roberto Becker		
Germany		The Australian comment should be discussed during the URC session in 2006.
Robert Jakob		

URC recommendations to WHO HoC:

Should the wording be the same for paper copies and for electronic copies? Should the paper copies refer to a page number instead?

URC Reference No: 0280 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Lymphadenitis

Proposal for update:

As cat-scratch disease (A28.1) is a bacterial infection, we would like to suggest I88.8 as a new code in the index entry below.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Lymphadenitis - regional, nonbacterial ~~A28.1~~ I88.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France		No entry with A28.1 in the French version
Japan		
NORDIC	Supported	
North America	Supported	
United Kingdom	Supported (Morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0283 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Abdominal migraine

Proposal for update:

As abdominal migraine is a childhood periodic syndrome and a common precursor of migraine and does not include “aura”. We suggest it is better classified at G43.8.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Migraine - abdominal ~~G43.1~~ G43.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France		It's correct in the French version
Japan		
NORDIC	Suppported	
North America	Supported	
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0286 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Astereognosis

Proposal for update:

Astereognosis is coded at R41.3 Other Amnesia. As astereognosis is a special kind of agnosia, we suggest it be classified to R48.1.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Astereognosis ~~R41.3~~ R48.1	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France		We don't have this problem in the French version
Japan		
NORDIC	Supported	
North America	Supported	
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0288 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Sniffing

Proposal for update:

We are in doubt about coding sniffing. Shouldn't F18.1 be used instead as sniffing it is not identical to dependence or addiction in general? What do URC members think about this issue?

Sniffing

– glue (airplane) (addiction) F18.2

Glue

– sniffing (airplane) (dependence) F18.2

Effect, adverse NEC—*continued*

– glue (airplane) sniffing F18.1

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Delete modifier, add subterm and revise codes Delete modifier, add subterm and revise code	**Sniffing** – glue (airplane) ~~(addition) F18.2~~ F18.1 – – addiction F18.2 **Glue** – sniffing (airplane) (~~dependence) F18.2~~ F18.1 – – dependence F18.2	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	We agree that the default shouldn't be to the dependence code, but question the assignment of 'harmful use' as a default. If for instance, it has just been a one off episode, there would not necessarily be physical or mental harm, rather acute

		intoxication. We feel that the index entry should be F18.- and for the coder to assign the correct code based on the documentation. While we are making changes in this area, can we also request an index entry for 'petrol' under **Sniffing,** with the same code (F18.-). This is a common problem in parts of rural Australia.
Brazil	no opinion	
France	No opinion	
Japan		
NORDIC	Supported	F18.- as suggested by Australia is other option
North America		NACC Morbidity support. **Second round comment:** NACC Morbidity supports proposal and the modification suggested by Australia.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		The Australian proposal is supported.
Robert Jakob		
MRG		We support "Sniffing" going to F18.9, and "Sniffing - addiction" staying at F18.2, as in the German suggestion. We suggest that terms are defined for the index, so the fourth digit is shown rather than F18.- as the Australians suggest.

URC recommendations to WHO HoC:
Approved with modifications as suggested by Australia. Is the addition of an index entry for gasoline appropriate as well?

Sniffing

– gasoline F18.-

– – addiction F18.2

– glue (airplane) ~~(addition) F18.2~~ F18.-

– – addiction F18.2

– petrol F18.-

– – addiction F18.2

Glue

– sniffing (airplane) (~~dependence) F18.2~~ F18.1

– – dependence F18.2

URC Reference No: 0289 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Psychobiological deficiency

Proposal for update:

What is the meaning (usage) of psychobiological deficiency (deficient)?
Shouldn't we delete this entry?

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Delete subterm and code	Deficiency, deficient ~~**- psychobiological F60.7**~~	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	no opinion	
France		It does not exist in the French version
Japan		
NORDIC	Supported	
North America		More information is needed. **Second round comment:** More info needed. Psychobiological deficiency – question of what this means, what usage it has, and should the entry be deleted. This quoted phrase is not found on Medline or Google. It is indexed to dependent personality disorder. It may be of interest whether this entry was a literal translation from another language. Input from psychiatrists should be sought.
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0300 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Personality problem

Proposal for update:

We suggest classifying personality disorder to F69 as it is a less specific category than F61.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise Code	Problem – personality ~~F61~~ F69	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France		It doesn't exist in the French version
Japan		
NORDIC	Supported	
North America		NACC Morbidity will respond with second round review. **Second round comment:** "Personality problem" is not specific. Indexing to F69 would be more appropriate than F61. Input from psychiatry should be sought.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0305 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Minor

Description (term/code): Erythrocytosis

Proposal for update:

Erythrocytosis is defined as an increase in erythroid values (red blood cell count, haemoglobin and haematocrit) without an accompanying increase in the leukocyte or platelet values. The term polycythaemia is sometimes used to refer to an erythrocytosis. This is an incorrect use of the term. Polycythaemia implies an increase in all three myeloid cell lines in the peripheral blood (erythrocytosis, leukocytosis and thrombocytosis).

Erythrocytosis is not a disease, it is a descriptive term and usually part of some other, underlying disease process. That is, it is a 'secondary' condition.

Clinical advice given to the NCCH, Australia, supports the assertion that erythrocytosis should not be coded as a primary polycythaemia (especially D45 *Polycythaemia vera*). However, secondary erythrocytosis can be used interchangeably with secondary polycythaemia and effectively means the same thing.

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date

Revise Add inclusion term	**D75 Other diseases of blood and blood-forming organs** ***Excludes :*** enlarged lymph nodes (R59.-) hypergammaglobulinaemia NOS (D89.2) lymphadenitis: • NOS (I88.9) • acute (L04.-) • chronic (I88.1) • mesenteric (acute)(chronic) (I88.0) D75.1 Secondary polycythaemia Erythrocytosis NOS Polycythaemia: • acquired • due to: • erythropoietin • fall in plasma volume • high altitude • stress • emotional • hypoxaemic • nephrogenous • relative ***Excludes:*** polycythaemia:	Australia	Minor	January 2007

	• neonatorum (P61.1) • vera (D45)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add modifier	**Erythrocytosis** (megalosplenic)(secondary) D75.1 - familial D75.0 - oval, hereditary *(see also Elliptocytosis)* D58.1	Australia	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	This is a very good proposal!
France	Supported	The french tabular list is like the proposition of modification, but we agree with the modifications in the alphabetic index
Japan		
NORDIC	Supported	

North America	Supported	
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0306 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Minor

Description (term/code): Fecal (faecal) occult blood

Proposal for update:

The following scenario is very common in Australia. A patient does a test via local doctor which shows up positive for faecal occult blood (FOB). Referred for EGD and colonoscopy - everything is normal. The look up, via the index in ICD-10 is *Blood, in, stool* which goes to K92.1 *Malaena.* However clinicians have stressed that it is not malaena and would be better classified under R19.5 *Other faecal abnormalities* .

This proposal also raises the ongoing issue of different spelling for the alphabetic index and tabular list, ie faecal (Tab), fecal (Index).

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date
Modify Add excludes note	**K92.1 Melaena** ***Excludes***: Occult blood in faeces	Australia	Minor	January 2007

	R19.5 **Other faecal abnormalities** Abnormal stool colour Bulky stools Mucus in stools Occult blood in stools ***Excludes:*** melaena (K92.1) • neonatal (P54.1)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify Add subterm and code Add lead term and subterm	**Blood** - in - - feces *(see also Melena)* K92.1 - - - occult R19.5 - - urine *(see also Hematuria)* R31 **Melena** K92.1 - with ulcer (*see also Ulcer, by site, with hemorrhage*) K27.4 - newborn, neonatal P54.1 - - due to swallowed maternal blood P78.2 Occult - blood in feces R19.5	Australia	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	

Brazil	Supported	Really « faecal occult blood » is not « Melena »
France	Supported	But I don't understand the entry with « Occult » in the alphabetic index
Japan		
NORDIC	Supported	
North America	Supported	NACC Morbidity and Canada Mortality supports. US made this change in ICD-9-CM in 1991.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

Should a code be added at the excludes note at K92.1? (i.e. Excludes: occult blood in faeces (R19.5))
K92.1 Melena
Excludes: Occult blood in feces (R19.5)

URC Reference No: 0308 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Major

Description (term/code): Pressure ulcer

Proposal for update:

Currently pressure ulcers are coded to L89 *Decubitus ulcer*. We suggest that a breakdown of this code be provided to capture the severity (staging) of the ulcer in order to provide better clinical information.

Pressure ulcers are classified by depth of tissue damage. The staging of pressure ulcers recommended for use is consistent with the recommendations of the National Pressure Ulcer Advisory Panel (NPUAP- American organisation. We recognise that different countries may use different classification systems for pressure ulcers, however we offer this submission as a starting point for further discussion.

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date
Revise Add synonym to title and note and delete inclusion term	**L89 Decubitus [[pressure]] ulcer** Bedsore	Australia	Major	January 2009

	Plaster ulcer ~~Pressure ulcer~~ ***Note:*** For multiple sites of differing stages assign only one code indicating the highest stage. ***Excludes:*** decubitus (trophic) ulcer of cervix (uteri) (N86)			
Add code and inclusion term	**L89.0 Stage I** Decubitus [pressure] ulcer limited to erythema only ***Note:*** The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss.			
Add code and inclusion term Add code and inclusion term Add code and inclusion term	**L89.1 Stage II** Decubitus [pressure] ulcer with: •abrasion •blister •partial thickness skin loss involving epidermis and/or dermis •skin loss NOS			
Add code and inclusion term	**L89.2 Stage III** Decubitus [pressure] ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue extending to underlying fascia			

Modify exclusion note	**L89.3 Stage IV** Decubitus [pressure] ulcer with necrosis of muscle, bone or supporting structures (ie tendon or joint capsule) **L89.9 Decubitus [pressure] ulcer, unspecified** Decubitus [pressure] ulcer without mention of stage			
Modify exclusion note	**L97 Ulcer of lower limb, not elsewhere classified** ***Excludes:*** decubitus [pressure] ulcer (L89~~).~~ -) gangrene (R02) skin infections (L00–L08) specific infections classified to A00–B99 varicose ulcer (I83.0, I83.2)			
	L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified L98.4 Chronic ulcer of skin, not elsewhere classified Chronic ulcer of skin NOS Tropical ulcer NOS Ulcer of skin NOS ***Excludes:*** decubitus [pressure] ulcer (L89~~).~~ -) gangrene (R02) skin infections (L00–L08)			

	specific infections classified to A00–B99 ulcer of lower limb NEC (L97) varicose ulcer (I83.0, I83.2)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise Add subterms	**Bedsore** L89.- - stage - - I L89.0 - - II L89.1 - - III L89.2 - - IV L89.3	Australia	Major	January 2009
Add subterms	**Decubitus** (ulcer) L89.- - cervix N86 - stage - - I L89.0 - - II L89.1 - - III L89.2 - - IV L89.3			

Add subterms	**Necrosis, necrotic** (ischaemic) *(see also Gangrene)* R02 - pressure L89.2 - - stage - - - III L89.2 - - - IV L89.3 **Plaster ulcer** L89.- - stage - - I L89.0 - - II L89.1 - - III L89.2 - - IV L89.3 **Pressure** - area, skin ulcer L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3 - necrosis (chronic) (skin) L89.2			

	- - stage - - - III L89.2 - - - IV L89.3			
Add subterms	- sore (chronic) L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3 - spinal cord G95.2 - ulcer (chronic) L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3			
Add subterms	**Sore** - chiclero B55.1 - Delhi B55.1 - desert *(see also Ulcer, skin)* L98.4 - eye H57.1			

Add subterms	- Lahore B55.1 - mouth K13.7 - muscle M79.1- - Naga *(see also Ulcer, skin)* L98.4 - oriental B55.1 - pressure L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3			
Add subterms	**Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4 - cystic duct K82.8 - decubitus (skin, any site) L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3			
Add subterms	- - cervix N86 - dendritic, cornea (herpes simplex) B00.5† H19.1*			

Add subterms	- phlebitis — *see Phlebitis* - plaster L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3 - popliteal space — *see Ulcer, lower limb* - postpyloric — *see Ulcer, duodenum* - prepuce N48.1 - prepyloric — *see Ulcer, stomach* - pressure L89.- - - stage - - - I L89.0 - - - II L89.1 - - - III L89.2 - - - IV L89.3 - pyloric — *see Ulcer, stomach* - rectosigmoid K63.3 - rectum (solitary) (sphincter) K62.6 - - stercoraceous, stercoral K62.6 - - varicose — *see Varicose, ulcer, anus* - retina H30.0 - rodent (M8090/3) — *see also Neoplasm, skin, malignant*			

	- sclera H15.0 - scrofulous (tuberculous) A18.2 - scrotum N50.8 - - tuberculous A18.1† N51.8* - - varicose I86.1 - seminal vesicle N50.8 - sigmoid *(see also Ulcer, intestine)* K63.3 - skin (atrophic) (chronic) (neurogenic) (perforating) (pyogenic) (trophic) L98.4 - - with gangrene *(see also Gangrene)* R02 - - amoebic A06.7 - - decubitus L89.- - - - stage - - - - I L89.0 - - - - II L89.1 - - - - III L89.2 - - - - IV L89.3 - - lower limb L97 - - tuberculous (primary) A18.4 - - varicose — *see Ulcer, varicose* - sloughing NEC — *see Ulcer, skin*			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	This proposal is very important for morbidity
France	Supported	I agree with Brazil and we make the same proposition than the german one : start with character .1 for stage I
Japan		
NORDIC	Supported	
North America		NACC Morbidity supports in principle. Canada has added detail to ICD-10-CA. U.S. has also added to ICD-10-CM. Suggest dropping the note at L89.0; the wording seems more appropriate as a guideline. **Second round comment:** Canada Mortality defers to Morbidity.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	Germany has already added stages I – IV to its GM. Our stages are: I – erythema II – ulcer of skin III – muscles/tendons visible or involved IV – bone involved

		Furthermore, we suggest to start with the fourth character .1 to bring the fourth-character code in line with the stages.
Robert Jakob		

URC recommendations to WHO HoC:

This proposal is approved in principle, but there are multiple suggestions for adding this specificity to ICD-10. The URC has added in the additions to ICD-10-CA and ICD-10-CM as other options to consider when adding the detail pertaining to severity.

ICD-10-CA

L89 Decubitus ulcer

Includes: Bedsore

Plaster ulcer

Pressure ulcer

Excludes: decubitus (trophic) ulcer of cervix (uteri) (N86)

L89.0 Decubitus ulcer limited to erythema only [redness] without skin breakdown (Stage 1)

L89.1 Decubitus ulcer limited to breakdown of skin (Stage 2)

L89.2 Decubitus ulcer with fat layer exposed (Stage 3)

L89.3 Decubitus ulcer with depth involving muscle (Stage 4)

L89.4 Decubitus ulcer with depth involving bone (Stage 5)

L89.5 Decubitus ulcer with joint space involvement (Stage 5)

L89.8 Decubitus ulcer with necrosis involving muscle or bone (Stage X)

L89.9 Decubitus ulcer without mention of severity

Decubitus ulcer NOS

ICD-10-CM

L89.001 Decubitus ulcer of unspecified part of back limited to breakdown of the skin

L89.002 Decubitus ulcer of unspecified part of back with fat layer exposed

L89.003 Decubitus ulcer of unspecified part of back with necrosis of muscle

L89.004 Decubitus ulcer of unspecified part of back with necrosis of bone

L89.009 Decubitus ulcer of unspecified part of back with unspecified severity

URC Reference No: 0309 **Proposed by: Australian Centre**

Change to Volume: III Type of proposal: Minor

Description (term/code): Puerperal nephritis

Proposal for update:

There are currently ambiguities in the alphabetic index on the classification of puerperal nephritis. *Nephritis, complicating pregnancy, childbirth or puerperium* goes to O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium* and *Nephritis, puerperal* goes to O90.8 *Other complications of the puerperium, NEC*. Which is the correct code?

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify	**Nephritis, nephritic** N05.- Note: Where a term is indexed only at the three-character level, e.g. N00.-, reference should be made to the list of fourth-character subdivisions in Volume 1 at N00-N08. - cirrhotic *(see also Sclerosis, renal)* N26 - complicating pregnancy, childbirth or puerperium O99.8 - puerperal (postpartum) O90.8	Australia	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil	Supported	For us 090.8 is more appropriated. The title of the category 090.- includes only « puerperal complications » and for us is more specific.
France	supported	But we agree with the North American coding rules
Japan		
NORDIC		The interpretation of Canada seems reasonable. Since the alphabetical index is not used in Nordic countries, it is probable that the tabular index is interpretatded similarly. What would be the change?
North America		In Canada, we select O99.8 when the mother had pre-existing nephritis prior to the pregnancy and it is aggravated because she is pregnant either antenatally, during pregnancy or postpartum. O90.8 is selected if nephritis developed during the postpartum period (with no pre-existence prior to pregnancy). **Second round comment:** Indexing needs discussion. Excludes note at O99.8 excludes nephritis O90.8. See also Nephritis childbirth postpartum

		puerperal pregnancy
United Kingdom	Supported (morbidity)	Suggest also a note in volume 1 at O99.8 to exclude 'puerperal nephritis O90.8'
Roberto Becker		
Germany		Unable to comment.
Robert Jakob		

URC recommendations to WHO HoC:

Suggested update for this proposal:

O99.8 Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
Combination of conditions classifiable to O99.0 – O99.7
Conditions in C00–D48, H00–H95, M00–M99, N00 – N99 and Q00–Q99

Excludes: genitourinary infections in pregnancy (O23. –)
infection of genitourinary tract following pregnancy (O86.0–O86.3)
maternal care for known or suspected abnormality of maternal pelvic organs (O34. –)
postpartum acute renal failure (O90.4)
<u>postpartum nephritis (O90.8)</u>

Does the addition of the excludes note correct the ambibuity in the index?

URC Reference No: 0310 **Proposed by: Australian Centre**

Change to Volume: III Type of proposal: Major

Description (term/code): Change of index entry for renal cyst

Proposal for update:

Clinical advice received by the NCCH indicates that most renal cysts are acquired. Currently, the default in the alphabetic index of ICD-10 is to

Q61.0 *Congenital single renal cyst.* We therefore recommend the following change to the alphabetic index

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise	**Cyst** (colloid) (mucous) (retention) (simple)	Australia	Major	January 2009
Add subterms	- congenital NEC Q89.8 - - epiglottis Q31.8 - - esophagus Q39.8 - - fallopian tube Q50.4			

Revise code and modifiers Revise code and modifiers	- - kidney Q61.0 - - larynx Q31.8 - - liver Q44.7 - kidney (~~congenital~~ acquired) ~~Q61.0~~ N28.1 - - ~~acquired~~ congenital ~~N28.1~~ Q61.0 - renal (~~congenital~~ acquired) ~~Q61.0~~ N28.1 - - ~~acquired~~ congenital ~~N28.1~~ Q61.0			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	

North America	Supported	NACC Morbidity supports. Per Canada-we must verify from CAC if indeed most renal cysts are acquired. If that is true we would support this proposal – will try to get more information for second round. Per the American Academy of Family Physicians journal article.- Autopsy results have shown that approximately 50% of persons older than 50 years have one or more renal cysts. Other studies indicate that almost one third of persons in the age group have at least one renal cyst that is identifiable on CT scan. Most of these lesions are benign simple cysts that require no further evaluation, intervention or urologic consultation. **Second round comment:** NACC Morbidity and Canada Mortality supports.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		We expect feedback from our clinical experts for the second round. 2nd round: The proposal is supported by our clinicians.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0314 Proposed by: United Kingdom

Change to Volume: III Type of proposal: Major

Description (term/code): Tramadol

Proposal for update:

The United Kingdom received an enquiry regarding the codes for Tramadol suggesting this should be listed as an opioid analgesic in line with the British National Formulary. On contacting the URC advice from Dr.Bjorn Smedby was as follows,

Ms Marie Lindquist, Head of Data Management & Research and General Manager at the Uppsala Monitoring Centre (WHO Collaborating Centre for International Drug Monitoring) was involved in the preparation of the drug list for ICD-10. In the original table that was sent to WHO the codes listed below were used.

The original table sent to WHO was edited by WHO before printing. For some reason the printed version is different for Tramadol compared to the original list.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify	**Correction of error in entry in volume 3 (table of drugs and chemicals) page 735**	United Kingdom	Major	January 2009

Revise codes	**Entry should read:** Substance: Tramadol Poisoning — Chapter XIX: T40.4; Accidental: X42; Intentional self harm: X62; Undetermined intent: Y12 Adverse effect in therapeutic use: Y45.0			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		

NORDIC	Supported	Typical example of problems of keeping lists of drugs uptodate. The drugs should be coded by separate system (ATC)
North America	Supported	NACC Morbidity supports. **Second round comment:** NACC Morbidity and Mortality support
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0316 Proposed by: Mortality Reference Group

Change to Volume: I II III Type of proposal: Minor

Description (term/code): Sudden death

Proposal for update:

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. 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.

Source: MRG PS8 Q5.

Current

Volume 1, p. 890

R96.0 Instantaneous death

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.

p. 44

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 if it 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.

Example…

Volume 3:

p. 132

Death

- instantaneous R96.0
- sudden (cause unknown) R96.0

p. 189

Dropped

- dead R96.0

p. 221

Fatal syncope R96.0

p. 515

Sudden

- death, cause unknown R96.0

p. 518

Syncope R55

- fatal R96.0

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Modify	Recommended changes for 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)	MRG	Major	January 2009

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Modify	Volume 2, p. 42, section 4.1.9	MRG	Major	January 2009

Add text Modify Add text	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. <u>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.</u> Volume 2, p.44, section 4.1.10 Examples of the modification rules 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.			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify Modify subterm Modify subterm	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	MRG	Major	January 2009

	p. 518 **Syncope** R55 - fatal <u>unexplained</u> R96.0			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		Morbidity : no comments. Mortality : comments to be supplied
Brazil	Supported	We are strongly in favor! Unfortunatelly the implementation will be only in 2009!
France	No opinion	For morbidity
Japan		
NORDIC	Supported	
North America		NACC Morbidity supports. Is this truly a major proposal or could it be considered minor? **Second round comment:** NACC Morbidity and Mortality support (Is this a Major Change?)
United Kingdom		Defer to mortality colleagues
Roberto Becker		

Germany	Supported	
Robert Jakob		
MRG		**Second round comment:** We don't object to changing this to a "minor update".

URC recommendations to WHO HoC:

URC Reference No: 0319 Proposed by: Mortality Reference Group

Change to Volume: II Type of proposal: Major

Description (term/code): Note 4.2.2 (d) Diabetes due to any other disease

Proposal for update:

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). 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.

Source: MRG PS5 Q55. See Question 2001-05-02 01, and Question 1998-02-16_02 (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions.

Current Volume 2, p. 68 (d) or (e) as shown on screen 54 at http://www2.fhs.usyd.edu.au/ncch//WHO%20URC/official_WHO_updates_combined1996to2003.pdf:

(e) 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);

Suggested changes to the classification:

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Modify	Recommended changes for 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.	MRG	Major	January 2009
Add appendix	<u>Insert new material in an appendix to Volume 2:</u> <u>4.2.15 List of conditions that can cause diabetes</u>			

List of the conditions that can cause diabetes

Acceptable sequences for diabetes "due to" other diseases

Selected cause	As cause of
M35.9	E10, E14
E40-E46	E12, E14
B25.2	E13-E14
B26.3	E13-E14
C25	E13-E14
D13.6-D13.7	E13-E14
D35.0	E13 –E14
E05- E06	E13 –E14
E22.0	E13-E14
E24	E13 –E14
E80.0- E80.2	E13-E14
E83.1	E13-E14
E84	E13-E14
E89.1	E13-E14
F10.1-F10.2	E13-E14
G10	E13-E14
G11.1	E13-E14
G25.8	E13-E14
G71.1	E13-E14
K85	E13-E14
K86.0- K86.1	E13-E14
K86.8- K86.9	E13-E14
M35.9	E13-E14
O24.4	E13-E14
P35.0	E13-E14
Q87.1	E13-E14
Q90	E13-E14
Q96	E13-E14

	Q98 E13-E14 Q99.8 E13-E14 S36.2 E13-E14 T37.3 E13-E14 T37.5 E13-E14 T38.0- T38.1 E13-E14 T42.0 E13-E14 T46.5 E13-E14 T46.7 E13-E14 T50.2 E13-E14 X41 E13-E14 X44 E13-E14 X61 E13-E14 X64 E13-E14 Y11 E13-E14 Y14 E13-E14 Y41.3 E13-E14 Y41.5 E13-E14 Y42.0- Y42.1 E13-E14 Y46.2 E13-E14 Y52.5 E13 –E14 Y52.7 E13–E14 Y54.3 E13-E14			

URC members comments:

URC members	Proposal	Comments

	supported/ not supported	
Australia		Morbidity : no comments. Mortality : comments to be supplied for second round
Brazil	Supported	
France		Morbidity : no comment
Japan		
NORDIC	Supported	This proposal is related to URC 0019 case on diabetes. The list is correctly dealing mostly with E13-E14 but it is surprising that no single case is linked to E11. At least diabetes arising in pregnancy (O24.4) is epidemiologically associated with later adult type diabetes. Therefore it should rather be linked with E11 than E13-E14. For E10 other systemic connective tissue disease diagnoses thatn M35.9. should be include.They can howeve be discussed later.
North America		NACC Morbidity supports. **Second round comment:** NACC Morbidity and Mortality support.
United Kingdom		Defer to mortality colleagues
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0320 Proposed by: NACC

Change to Volume: I Type of proposal: Minor

Description (term/code): West Nile Fever

Proposal for update:

We are proposing a title change for A92.3
Our physicians feel that West Nile fever is an outdated term and the code title should read A92.3 - West Nile Virus Infection. West Nile fever may be retained as an inclusion term.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Modify code title and add inclusion	**A92.3 West Nile ~~Fever~~ virus infection** West Nile Fever	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	Is the term 'infection' necessary at the end of the code title?
Brazil	Supported	
France	No opinion	
Japan		
NORDIC	Supported	
North America	Supported	
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

Is the term 'infection' necessary at the end of the code title?

URC Reference No: 0321 Proposed by: North America

Change to Volume: I III Type of proposal: Minor

Description (term/code): M94.0 Chondrocostal junction syndrome [Tietze]

Proposal for update:

According to the dictionary of medical syndromes, 4th edition 1997 on page 791, Tietze syndrome is synonymous with costal chondritis, chondropathia tuberosa, and chondrocostal junction syndrome.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add inclusion term	**M94.0 Chondrocostal junction syndrome [Tietze]** Costochondritis	NACC	Minor	January 2007

Instruction	Alphabetic index entries	Source	Major/Minor	Suggested

			update	implementation date
Add lead term and code	***Costochondritis M94.0***	NACC	Minor	January 2007
Revise codes	***Chondritis (purulent) M94.8*** - costal ~~M94.8~~ M94.0 **Chondropathia tuberosa ~~M94.8~~ M94.0**			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported with modification	Purulent chondritis is not part of Tietzes syndrome. Therefore the second revision shoud be: ***Chondritis ~~(purulent)~~ M94.8*** - costal ~~M94.8~~ M94.0 - purulent M94.8 **Chondropathia tuberosa ~~M94.8~~ M94.0**

North America		
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

Costochondritis M94.0

Chondritis ~~(purulent)~~ M94.8

- costal ~~M94.8~~ M94.0
- purulent M94.8

Chondropathia tuberosa ~~M94.8~~ M94.0

URC Reference No: 0322 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Complications following acute myocardial infarction

Proposal for update:

There is no index entry to lead users to code I23.6 - Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterms	Complications - following - - acute myocardial infarction NEC I23.8 - - - aneurysm (false) (of cardiac wall) (of heart wall) (non-ruptured) I23.3 - - - defect - - - - septal - - - - - atrial (heart) I23.1 - - - - - ventricular (heart) I23.2 - - - haemopericardium I23.0 - - - rupture	North America	Minor	January 2007

	- - - - cardiac wall I23.3 - - - - - with haemopericardium I23.0 - - - - chordae tendineae I23.4 - - - - papillary muscle I23.5 - - - thrombosis - - - - atrium I23.6 - - - - auricular appendage I23.6 - - - - ventricle (heart) I23.6			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America		
United Kingdom	Supported (morbidity)	

Roberto Becker		
Germany	Supported	It should be checked that all complications have an entry “following acute myocardial infarction”
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0323 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Cribriform hymen

Proposal for update:

This index entry was present in ICD-9 but was missing in ICD-10.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add lead term	Cribriform hymen Q52.3	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported in principle	If Q52.3 is accepted the tabular index should be modified.
North America	Supported	Our original proposal was to add the index entry for cribriform hymen to Q52.4. Based on the following feedback from André L'Hours, we changed the proposal to Q52.3. André stated, "Microperforate, septate, stenotic, cribriform and denticulate are described as variations of imperforate hymen. I would assign this to Q52.3."
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported in principle	In the GM this condition is assigned to Q52.4, as it is not atresia.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0324 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Displacement, cervical intervertebral disc with neuritis

Proposal for update:

The index look-up for cervical disc displacement with myelopathy is missing.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterm	Displacement, displaced - intervertebral disk NEC M51.2 - - with myelopathy M51.0+G99.2* - - cervical, cervicothoracic (with) M50.2 - - - myelopathy M50.0+ G99.2* - - - neuritis, radiculitis or radiculopathy M50.1+ G55.1*	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America		
United Kingdom		
Roberto Becker		
Germany	Supported in principle	I have slightly changed the index entry to make it consistent with usual formal requirements.
Robert Jakob		

URC recommendations to WHO HoC:

Displacement, displaced
- intervertebral disk NEC M51.2
- - with myelopathy M51.0+G99.2*

- - cervical, cervicothoracic M50.2
- - - with myelopathy M50.0+ G99.2*
- - - neuritis, radiculitis or radiculopathy M50.1+ G55.1*

URC Reference No: 0325 Proposed by: North America

Change to Volume: I III Type of proposal: Minor

Description (term/code): Keratopathy

Proposal for update:

Vitreous syndrome (following cataract surgery) is the same as Bullous Aphakic (post cataract extraction) Keratopathy. We are proposing an update in the terminology of the code title.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise code title and add inclusion terms	**H59.0 - ~~Vitreous syndrome~~ Keratopathy (bullous aphakic) following cataract surgery** Vitreous (Touch) Syndrome Vitreal Corneal Syndrome	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We are currently seeking clinical advice on this proposal and will provide further comments in the second round.
Brazil	no opinion	
France	No opinion	
Japan		
NORDIC	Supported	
North America		
United Kingdom		
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0329 Proposed by: North America

Change to Volume: III Type of proposal: Major

Description (term/code): Shoulder pain

Proposal for update:

Volume III leads one to code M75.8 for pain of the shoulder. M75 classifies shoulder lesions, which are more specific than shoulder pain NOS. Pain in other joints is classified to category M25 Other joint disorders, not elsewhere classified. We are proposing that shoulder pain NOS also be classified to M25.5 Pain in joint.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Pain(s) R52.9** - shoulder ~~M75.8~~M25.5	North America	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	We have had issues with this in Australia and offer the following advice in one of our coding standards.: The classification of shoulder pain in ICD-10-AM depends on whether the pain is true articular shoulder pain (ie pain in joint) or soft tissue pain in the shoulder region. Articular shoulder joint pain is classified to M25.51 *Pain in joint, shoulder region*. Soft tissue pain in the shoulder region is classified to M75.8 *Other shoulder lesions*. A thorough check of the clinical record should reveal whether the pain is in the joint or the shoulder region. If in doubt, check with the treating clinician. We realise that this doesn't help the indexing problem in ICD-10 and therefore probably agree with changing the default to M25.5
Brazil	Supported	Really M75 is for « lesions »! M25.5 is much better for shouder pain.
France	Supported	
Japan		
NORDIC	Supported	
North America		
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0330 Proposed by: North America

Change to Volume: III Type of proposal: Major

Description (term/code): Phenazopyridine

Proposal for update:

The drug Phenazopyridine (Phenazopyridine HCl) appears to have been incorrectly classified as a systemic anti-infectives and antiparasitics instead of as an analgesic. We recommend that the codes be changed to:
nonopioid analgesics (T39.9) (X40) (X60) (Y10) (Y45.9)

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise codes	**Phenazopyridine** ~~T37.8~~ T39.9 ~~X44.-~~ X40.- ~~X64.-~~ X60.- ~~Y14.-~~ Y10.- ~~Y41.8~~ Y45.9	North America	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America		
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported in principle	I would prefer T39.8 to .9
Robert Jakob		

URC recommendations to WHO HoC:

Phenazopyridine ~~T37.8~~ T39.8 ~~X44.-~~ X40.- ~~X64.-~~ X60.- ~~Y14.-~~ Y10.- ~~Y41.8~~ Y45.9

URC Reference No: 0331 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Stenosis of precerebral artery

Proposal for update:

There currently is no index subterms for stenosis of precerebral arteries.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterm	**Stenosis (cicatricial) –*see also* Stricture** - artery I77.1 - - precerebral (see also Occlusion, artery, precerebral)	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/	Comments

	not supported	
Australia	Supported, with further suggestions	**Stenosis (cicatricial) –*see also* Stricture** - artery I77.1 - - precerebral (see also Occlusion, artery, precerebral) I65.9 - - - specified NEC I65.8 Should the various sites be indexed under 'precerebral' as well?
Brazil	Supported	
France	Supported the Australian suggestions	
Japan		
NORDIC	Supported with Australian modification	See Australian comment. Probably the other sites should be listed too.
North America		
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported in principle	If no code is listed the reference must be printed with dash instead of parentheses.
Robert Jakob		

URC recommendations to WHO HoC:

Stenosis (cicatricial) –*see also* Stricture
- artery I77.1
- - precerebral (see also Occlusion, artery, precerebral) I65.9
- - - bilateral (multiple) I65.3
- - - basilar I65.1
- - - carotid I65.2
- - - vertebral I65.0
- - - specified NEC I65.8

Are there any issues with the following additions for the various sites?

URC Reference No: 0333 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Wallenberg's disease or syndrome

Proposal for update:

There is an error in the asterisk code in the index at lead term
Wallenberg's disease or syndrome I66.3† ~~G46.4*~~ G46.3*

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Wallenberg's disease or syndrome I66.3† ~~G46.4*~~ G46.3***	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America		
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	Wallenberg's syndrome is listed among the inclusion notes of G46.3*
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0335 Proposed by: Mortality Reference Group

Change to Volume: I Type of proposal: Minor

Description (term/code): Transport accidents

Proposal for update:

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, so the MRG recommends expanding the codes covered in the excludes note.

Source: MRG PS8 Q6

Current Volume 1, p. 1018

Transport accidents

(V01-V99)

…

Excludes:

…

event of undetermined intent (Y32-Y33)

intentional self-harm (X82-X83)

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise codes	Recommended changes Volume 1, p. 1018 **Transport accidents** **(V01-V99)** … ***Excludes:*** … event of undetermined intent (~~Y32~~ Y31-Y33) intentional self-harm (~~X82~~ X81-X83)	MRG	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	No opinion	
Japan		
NORDIC	Supported	
North America		NACC Morbidity supports. **Second round comment:** NACC Morbidity and Mortality support
United Kingdom		
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0338 Proposed by: Mortality Reference Group

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

Description (term/code): Vascular parkinsonism

Proposal for update:

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. 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.

Source: MRG PS9 Q9.

Current Volume 1, p. 399

G21 Secondary parkinsonism

…

G21.3 Postencephalitic 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 **G20**

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 **G20**

p.64

Table 1

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

Volume 3, p. 427

Paralysis, paralytic (complete) (incomplete) G83.9
- agitans (see also Parkinsonism) G20
- - arteriosclerotic G21.8

p. 431

Parkinsonism (idiopathic) (primary) G20

- secondary G21.9
- - due to
- - - arteriosclerosis G21.8
- - specified NEC G21.8

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise Add code	Recommended changes Volume 1, p. 399 G21 Secondary parkinsonism … G21.3 Postencephalitic parkinsonism G21.4 Vascular parkinsonism G21.8 Other secondary parkinsonism	MRG	Major	January 2009

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Modify	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.-**	MRG	Major	January 2009

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		I70.2
		F03	F01.-
		G20	G21.4
		G21.9	G21.4

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify	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	MRG	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments

Australia	Supported	Need to show the changes in the index (strikeout G21.8 and add and underline G21.4. I would also suggest adding another index entry under **Parkinsonism** for 'vascular G21.4' and perhaps an inclusion term for 'Parkinsonism due to arteriosclerosis' under G21.4
Brazil	Supported	
France		We didn't work on this subject
Japan		
NORDIC	Supported	
North America		NACC Morbidity will respond with second round review. **Second round comment:** Support. Revision is supported by Dr. Powers of the American Academy of Neurology NACC Mortality supports
United Kingdom		The English ICD-10 index entry is A22.2 not B22.2 . A22.2 would appear to encompass everything.
Roberto Becker		
Germany	Supported	
Robert Jakob		
MRG		We agree with the suggestions from Australia. **Second round comment:** In addition to the Australian addition(s) to the index, may we also add: Parkinsonism - arteriosclerotic G21.4

URC recommendations to WHO HoC:

URC Reference No: 0343 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Obstruction, cardia

Proposal for update:

The English and French versions of the index lead to two different codes for this condition.

CIM-10

Obstruction

- cardia NCA K31.8

ICD-10

Obstruction

- cardia K22.2

As both appear to be plausible, we have not suggested changes but will defer to the members of the URC to determine which is the correct code.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Obstruction, obstructed** - cardia NEC	North America		January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We would probably favour K22.2
Brazil		In Portuguese version of ICD-10 « Obstruction- cardia » the code is K22.2. We prefer this code and not K31.8
France	No opinion	
Japan		
NORDIC	K22.2	See German comment
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		Morbidity would prefer to stick with the English code of K22.2
Roberto Becker		

Germany		As other disorders of the cardia are also coded at K22.- we are in favour of K22.2
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0345 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Fahr's disease

Proposal for update:

Fahr's disease is not classified in the English language version of ICD-10, but is indexed in the French version.

Sclerosis

- maligne de Fahr I12.9
- - avec insuffisance rénale I12.0

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add leadterm, subterm and codes	**Fahr's disease I12.9** - with - - renal insufficiency I12.0	North America	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		Is this meant to be Fahr-Volhard disease? This is the definition from Dorland's medical dictionary *: **malignant nephrosclerosis**, **malignant arteriolar nephrosclerosis**, a rare form of arteriolar nephrosclerosis affecting all the vessels of the body, especially small renal arteries and arterioles, often associated with malignant hypertension and hyperplastic arteriolosclerosis. It may occur without previous hypertension or superimposed on benign hypertension or primary renal disease, especially glomerulonephritis, benign nephrosclerosis, or pyelonephritis. Called also hyperplastic arteriolar n. and Fahr-Volhard disease.* A Snomed search on Fahr's disease points to cerebral calcification/vascular calcification.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported with modifications	See German and Australian comments. It looks like the Frech coding would refers to the disorder usually called Fahr-Volhard disease. Possibly both names should be retained in the index. The following is one of several description of Fahr's disease in the Internet: "Fahr's Disease is a rare degenerative neurological disorder characterized by the presence of abnormal calcium deposits (calcifications) and associated cell loss in certain areas of the brain (e.g., basal ganglia). The condition is often referred to as idiopathic basal ganglia calcification or IBGC because there is no apparent explanation for such calcification in these brain

		regions (idiopathic)." It looks like G23.8 'Calcification of basal ganglia' would be most accurate code for this condition. The addition to alphabetical index should therefore be: Fahr-Volhard disease (of kidney) I12.9 - with renal insufficiency I12.0 Fahr's disease (of brain) G23.8
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		
Germany	Supported in principle	In German medical language the term is ambiguous. There is Fahr's disease of the brain (non-arteriosclerotic calcification of brain vessels with dementia, also listed in Stedmann's dictionary, coded at G93.8) and Fahr's disease of the kidney (malignant nephrosclerosis, also called Fahr-Volhard's disease, coded at I12). So this proposal might need a modification like Fahr's disease - kidney I12.9 - - with renal insufficiency I12.0 - brain G93.8 I am in doubt about the G93.8 and open to better proposal from other countries.

Robert Jakob		

URC recommendations to WHO HoC:

Fahr-Volhard disease (of kidney) I12.9

- with renal insufficiency I12.0

Fahr's disease (of brain) G23.8

Section 2: Recommendations for further discussion at the HoC meeting

44 work items

0219 Thrombophilia

0221 Ulcerative colitis

0266 Glucagonoma

0269 Insulinoma, pancreas

0270 Dog Tapeworm

0271 Hypertensive renal disease – addition of inclusion

0281 Acute hepatitis NOS

0284 Synovitis/tenosynovitis

0285 Dermatitis dysmenorrhoica symmetrica

0304 Deep venous thrombosis of femoral vein

0307 Post-transfusion hepatitis/jaundice

0311 Squamous metaplasia of the cervix

0312 Usual Interstitial Pneumonia

0313 Post-polio syndrome

0315 White matter disease

0317 Unspecified gastroenteritis

0318 Note 4.2.2 (b) Infections in A00-B99

0327 Ulcerative oesphagitis

0287 Twilight and confusion caused by epilepsy

0290 Abscess of artery

0291 Prostatitis

0292 Torsion, cervix

0293 Retroversion, cervix

0294 Retraction, cervix

0295 Anteversion, cervix

0296 Displacement, cervix

0297 Caput succedaneum

0298 Sepsis, umbilical cord

0299 Congenital achalasia

0301 Benign neoplasm of prostate

0302 Cerebral artery syndrome

0303 Cortical blindness

0328 Dysplasia of prostate

0332 Systemic inflammatory response syndrome

0334 Other chemotherapy

0336 Viral gastritis

0337 Subsequent myocardial infarctions

0339 Colitis with anthrax

0340 Athropathy with dermatological disorders NEC

0341 Index directions to category ranges

0342 Hurler (Scheie) disease or syndrome

0344 Stenosis of the intervertebral foramina

0346 Hesselbach's hernia

0347 Volume 2, page 39 – Expanding the list of pneumonias considered obvious consequence of other serious conditions

0348 Pulmonary edema as direct consequence of heart disease

URC Reference No: 0219 Proposed by: Germany

Change to Volume: I III Type of proposal: Major

Description (term/code): Thrombophilia

Proposal for update:

With respect to comments or URC members, as discussed in Reykjavik meeting and with our German experts, we would like to suggest a new proposal to URC reference No 0219 Thrombophilia.

The previous proposal is shown below for reference.

Thrombophilia is an important risk factor for thrombosis and lung embolism. The incidence for activated protein C resistance in Germany is estimated to be 5 to 10 % of the population. The risk for thrombosis and lung embolism is 5 to 10 times higher in heterocygote and 50 to 100 times higher in homocygote carriers of the gene.

For basic information see

http://www.merck.com/mrkshared/mmanual_home2/sec14/ch173/ch173g.jsp

and for more detailed information see

http://www.merck.com/mrkshared/mmanual/section11/chapter132/132a.jsp

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add new code and inclusion terms Add new code and inclusion terms Add excludes note	**D68.5 Primary Thrombophilia** Activated protein C resistance [factor V Leiden mutation] Deficiency of: · antithrombin · protein C · protein S **D68.6 Other Thrombophilia** Anticardiolipin syndrome Antiphospholipid syndrome Presence of the lupus anticoagulant ***Excludes:*** disseminated intravascular coagulation (D65) hyperhomocysteinemia (E72.1)	Germany (URC:0219)	Major	January 2006

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	This proposal will need appropriate index entries/changes	Germany (URC:0219)	Major	January 2006

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported in principle	We have had a number of queries on how to code thrombophilia and some of the inclusion terms listed in the proposal, so we would welcome the changes. There will need to be a careful search of the tabular list and index, in order to cover all the necessary changes to the index. All new inclusion terms should be indexed as well.
Brazil	Supported	
France		
Japan		Protein C,S,ATIII deficiency are reported to owe 15-30% of thrombophilia cases. Since Hughes's report in 1986, APS (Antiphons phoid syndrome) has been noted as the main cause of thrombophilia even though Anticardiolip in syndrome reported first. Thrombophilia also relates to other systemic diseases, e.g. TTP (M31.1), SLE (M32.-) and SLE is very important because 5% of SLE show positive APS and higher prevalence of fulminant APS syndrome. The exclusion or inclusion notes in M30-31 is necessary. Our suggested changes are as follows: **D68.5 Primary Thrombophilia** Activated protein C resistance [factor V Leiden mutation] Deficiency of:

		· antithrombin III ← add III · protein C · protein S **D68.6 Other Thrombophilia** Anticardiolipin syndrome Antiphospholipid syndrome Presence of the lupus anticoagulant ***Excludes:*** disseminated intravascular coagulation (D65) hyperhomocysteinemia (E72.1) **D68.8 Other specified coagulation defects** ~~Presence of systemic lupus erythematosus [SLE] inhibitor~~ ←Delete **Systemic connective tissue disorders(M30-M36)** ***Includes:*** autoimmune disease: · NOS · systemic collagen (vascular) disease: · NOS · systemic ***Excludes:*** autoimmune disease, single organ or single cell-type (code to relevant condition category) · Antiphospholipid syndrome (D68.6) ←Add APS as exclusion note

NORDIC	Supported in principle	Comments from Australia and Japan need to be discussed in Reykjavik.
North America		Canada-Mortality declines comment at this time - Canada has already added several of these conditions at D68.8 at suggestion of WHO. US has added codes at D63.8. **Second round comment**: This might preferably be titled "thrombotic disorders." Cecil's Textbook of Medicine uses the term "hypercoagulable states," but on brief review of Medline, this does not appear to be as common as "thrombophilia." The last printed version of Merck used the title "thrombotic disorders," and this title is still in the more detailed version of Merck, although the online home edition has the title "thrombophilia," as referenced in the information given. If the title "thrombophilia" is kept rather than "thrombotic disorder," it would be useful to list the terms hypercoagulable state, and thrombotic disorder, as inclusion terms. An additional cause of a primary thrombotic disorder is a prothrombin gene mutation, causing a hyperprothrombinemia. According to Cecil's, this is the second most common cause of a thrombotic disorder, at least in certain white populations. This would be useful to list as an inclusion term. Cecil's describes hyperhomocysteinemia as a primary hypercoagulable state. Other causes of a primary hypercoagulable state which are more rare (but might be useful to index) include heparin cofactor II deficiency; dysfunctional thrombomodulin; fibrinolytic disorders, including hypoplasminogenemia, dysplasminogenemia, plasminogen activator deficiency, and certain dysfibrinogenemias (some of these latter cause bleeding while others cause thrombosis). Secondary hypercoagulable states can be caused by malignancy, myeloproliferative disorders, paroxysmal nocturnal hemoglobinuria, antiphospholipid antibody syndrome, pregnancy, oral contraceptives, postoperative state, and trauma. Of these, the antiphospholipid antibody syndrome is not classified elsewhere, and may be best handled by classifying to D68, as recommended. Furthermore, it appears although it is not immediately clear that the inclusion term at D68.8, "Presence of systemic lupus erythematosus [SLE] inhibitor," is intended to refer to lupus anticoagulant, one of the findings in antiphospholipid antibody syndrome. Whether it is best to have a separate code for this, rather than grouping it with the other thrombotic disorders, is not clear. Also, it is not clear what else would go to the recommended D68.6, Other thrombophilia. For secondary hypercoagulable states due to disorders classified elsewhere, an asterisk code could be considered.

		For more information, see the OMIM reference: http://www.ncbi.nlm.nih.gov/entrez/dispomim.cgi? id=176930&a=176930_AllelicVariant0009
United Kingdom	Supported	
Roberto Becker		
Germany	Supported	The Japanese suggestions are very much appreciated. Index entry should be drafted after a decision on this proposal.
Robert Jakob		

URC recommendations to WHO HoC:

For further discussion at the Reykjavik meeting in October.

Proposal for 2005 Update

Two comments from German experts to specific issues:

We should prefer “antithrombin” not “antithrombin III” as it is the preferred term in international use.

The terms “hypercoagulable state” and “thrombotic disorders” seem to be not precise enough, so they don’t recommend using them as inclusion terms.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add codes, inclusion terms and exclusions	D68.5 Primary Thrombophilia Activated protein C resistance [factor V Leiden mutation] Deficiency: · antithrombin · protein C · protein S Prothrombin gene mutation D68.6 Other Thrombophilia Anticardiolipin syndrome Antiphospholipid syndrome Presence of the lupus anticoagulant *Excludes:* disseminated intravascular coagulation (D65) hyperhomocysteinemia (E72.1)	Germany	Major	January 2007

Delete exclusion term	**D68.8 Other specified coagulation defects** ~~Presence of systemic lupus erythematosus [SLE] inhibitor~~ **Chapter XIII** **Diseases of the musculoskeletal system and connective tissue (M00-M99)** **Systemic connective tissue disorders (M30-M36)** *Includes:* autoimmune disease: · NOS · systemic collagen (vascular) disease: · NOS · systemic Add exclusion term *Excludes:* autoimmune disease, single organ or single cell-type (code to relevant condition category) Antiphospholipid syndrome (D68.6)			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We are currently seeking clinical advice on this proposal and will provide further comments in the second round. Re the last excludes note, the new inclusion term should be sequenced first.
Brazil	Supported	The comments from Germany is logic
France	supported	It seems to us that a special code for the antiphospholipid syndrome is asked more often than a code for primary thrombophilia. We agree with the exclusion under M30-M36 for the antiphospholipid syndrome
Japan		
NORDIC	Supported	
North America		NACC Morbidity will respond with second round review. NACC Mortality defers to Morbidity. **Second round comment**: NACC Morbidity has nothing further to add at this time.
United Kingdom	Supported	

	(Morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0221 Proposed by: Germany

Change to Volume: I III Type of proposal: Major

Description (term/code): Ulcerative colitis

Proposal for update:

Background: This proposal for change was originally submitted in 2004 and withdrawn. The background to the change is shown below:

We seek clarification about the use of K51.0 and K51.1. To our understanding ulcerative colitis does not affect the small intestine (except for a backwash ileitis). We feel that the terms enterocolitis and ileocolitis are not adequate. Furthermore, ulcerative enteritis NOS at K51.9 seems to be misleading.

There was some discussion about this in the URC Forum, which supports this proposal.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Delete code	**K51 Ulcerative colitis** **K51.0 Ulcerative (chronic) ~~entero~~pancolitis** **~~K51.1 Ulcerative (chronic) ileocolitis~~** **K51.2 Ulcerative (chronic) proctitis** **K51.3 Ulcerative (chronic) rectosigmoiditis**	**Germany (URC:0221)**	**Major**	**January 2006**

Delete inclusion term	**K51.4 Pseudopolyposis of colon** **K51.5 Mucosal proctocolitis** **K51.8 Other ulcerative colitis** **K51.9 Ulcerative colitis, unspecified** ~~Ulcerative enteritis NOS~~			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	This proposal will need appropriate index entries/changes	Germany (URC:0221)	Major	January 2006

URC members comments 2004:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	Research indicates that ulcerative colitis can occur, although rarely, in the terminal ileum – would this be coded to K51.8? (http://digestive.niddk.nih.gov/ddiseases/pubs/colitis/) Our national frequency data (2001/2002) shows 136 cases of K51.1 *Ulcerative ileocolitis* for principal diagnosis and 80 cases as an additional diagnosis.

Brazil	Supported	
France		
Japan		I fully agree that the terms of "enterocolitis" are not appropriate since the inflammation usually do not spread in small intestine except Backwash ileitis. Another proposal for " ulcerative enteritis NOS at K51.9 " is also understandable. However, I have comments on the suggested changes: 1. K51.3 is not appropriate for ulcerative rectosigmoiditis because our gastroenterology group classify ulcerative colitis into three groups based on the location of lesions, proctitis, left-hemicolitis and pancolitis. 2. Pseudopolyposis of colon(K51.4) is an endoscopic finding as the result of chronic inflammation. Thus, this condition cannot stand independently. 3. I do not understand why we should segregate mucosal proctocolitis(K51.5) from ulcerative proctitis(K51.2). 4. It is not clear that how " other ulcerative colitis" or " ulcerative colitis, unspecified " are categorized. It may mean the intermediate ulcerative colitis (e.g, Crohn's disease) but there still in ambiguity how "noninfective gastroenteritis and colitis, unspecified" differ from K51.9.

NORDIC	Not supported	Terminological problem that should be solved by changing the description, not the coding.
North America		Canada-Mortality would like more information on this proposal - Canada/US Morbidity may have more information in second round
United Kingdom		
Roberto Becker		
Germany	Supported	Ulcerative colitis can affect the terminal ileum only as a so-called "backwash ileitis". UC always starts in the rectum and spreads proximal without skipping areas. Thus the subcategories "proctitis", "rectosimoiditis" and "pancolitis" make sense. Backwash ileitis should be included at "pancolitis". For more information see http://www.emedicine.com/emerg/byname/inflammatory-bowel-disease.htm
Robert Jakob		

URC recommendations to WHO HoC:

Withdrawn – Germany will submit new proposal.

Proposal for 2005 update:

With respect to the comments of URC members as discussed at the Reykjavik meeting, we would like to suggest this new proposal to URC reference No 0221 for updating **K51 Ulcerative colitis**.

About coding "indeterminate ulcerative colitis" we are not yet clear. Following abstract may help when discussing that issue.

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REVIEW

Indeterminate colitis

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ABSTRACT

Indeterminate colitis (IC) originally referred to those 10–15% of cases of inflammatory bowel disease (IBD) in which there was difficulty distinguishing between ulcerative colitis (UC) and Crohn's disease (CD) in the colectomy specimen. However, IC is increasingly used when a definitive diagnosis of UC or CD cannot be made at colonoscopy, in colonic biopsies or at colectomy. The diagnostic difficulties may explain the variably reported prevalence of IC. Clinically, most patients with IC evolve to a definite diagnosis of UC or CD on follow up. The role of ancillary tests in the distinction of UC from CD is reviewed. The low sensitivity of serological markers limits their usefulness. Other tests include upper endoscopy and magnetic resonance imaging. The definition of IC may not be a purely histological one derived from resected specimens, but rather a clinicopathological one. This review offers some personal observations and viewpoints, and proposes an approach to some of the relatively more esoteric combinations of findings

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Due to incidence of indeterminate colitis (IC) we suggest a separate class for IC.

What do other URC members think about that?

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise	**K51** **Ulcerative colitis** **K51.0** **Ulcerative (chronic) ~~entero~~colitis** Includes: backwash ileitis **~~K51.1~~** **~~Ulcerative (chronic) ileocolitis~~** **K51.2** **Ulcerative (chronic) proctitis** **K51.3** **Ulcerative (chronic) rectosigmoiditis** **K51.4** **~~Pseudopolyposis of colon~~ Inflamatory polyposis [Pseudopolyposis of colon]** **~~K51.5~~** **~~Mucosal proctocolitis~~** **K51.6** **Left site colitis** **K51.7** **Indeterminate colitis** **K51.8** **Other ulcerative colitis**	Germany	Major	January 2009

	K51.9 Ulcerative colitis, unspecified ~~Ulcerative enteritis NOS~~			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We are currently seeking clinical advice on this proposal and will provide further comments in the second round. Just some comments re the proposed changes formatting : the inclusion terms at K51.0 and K54.0 need underlining (new), K51.6 and K51.7 need to be shown as new codes.
Brazil	Supported	
France	Supported the german proposition	
Japan		
NORDIC	Supported	The latest German version seems to be most logical. Deletion of 51.7 is not a deletion since it does not exist currently. I would like to see included a proposal how the deleted codes should be mapped in the new version (for continuity of statistics).

North America		NACC Morbidity will respond with second round. NACC Mortality defers to Morbidity. **Second round comment:** Title change for K51.0 Prefer earlier idea of a change to "pancolitis." As is, this would seem to overlap with K51.9. OK to delete K51.2 - Medline has only 3 times this is used, and none are for this concept. K51.4 Should at least have "of colon" in title to read "Inflammatory polyposis of colon". Not certain whether this improves clarity, or consistency with current usage (could look for specialist input). This can also occur in Crohn's disease. Deletion of K51.5 Should at least have "of colon" in title. Not certain whether this improves clarity, or consistency with current usage (could look for specialist input). This can also occur in Crohn's disease. K51.6 Was this intended to cover left hemicolitis? Unclear how useful this would be. K51.7 Indeterminate colitis- This would be a good concept to separate out, but it might go better as a new code at K52.3. The issue of where inflammatory bowel disease NOS should go is a related issue. U.S. Mortality questions where will mucosal proctocolitis be coded when it is removed from K51.5. Also, urges that all terms which will be removed are included in the index with the correct code. Lastly, questions the current correct code for proctocolitis without mucosal?
United Kingdom		
Roberto Becker		
Germany		I have modified the title for K51.4 into "Inflammatory polyps" After further discussions with our clinicians we would like to modify our proposal slightly: **K51 Ulcerative colitis** **K51.0 Ulcerative (chronic) pancolitis** Includes: backwash ileitis ~~**K51.1 Ulcerative (chronic) ileocolitis**~~

		K51.2 **Ulcerative (chronic) proctitis** **K51.3** **Ulcerative (chronic) rectosigmoiditis** ~~**K51.4** **Pseudopolyposis of colon**~~ **Inflammatory polyps** ~~**[Pseudopolyposis of colon]**~~ ~~**K51.5** **Mucosal proctocolitis**~~ **K51.6** **Left site colitis** ~~**K51.7** **Indeterminate colitis**~~ **K51.8** **Other ulcerative colitis** **K51.9** **Ulcerative colitis, unspecified** ~~Ulcerative enteritis NOS~~ Pseudopolyposis only describes a finding that may be seen in all types of ulcerative colitis coded at K51.- Indeterminate colitis should be removed from K51 to avoid it to be counted in statistics as ulcerative colitis. We suggest to introduce a new code at K52.3: **K52 Other noninfective gastroenteritis and colitis** **K52.0 Gastroenteritis and colitis due to radiation** **K52.1 Toxic gastroenteritis and colitis** **K52.2 Allergic and dietetic gastroenteritis and colitis** **K52.3 Indeterminate colitis**

		K52.8 Other specified noninfective gastroenteritis and colitis **K52.9 Noninfective gastroenteritis and colitis, unspecified**
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0266 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Glucagonoma

Proposal for update:

As this tumor is malignant in about 60 % of the cases, we would prefer D37.7

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Glucagonoma - pancreas ~~D13.7~~D37.7	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	Is this tumour malignant in about 60% of cases for the pancreas only or for all sites? If for all sites, then other entries in both the alphabetic index and morphology table will need to be changed as well.
Brazil	Supported	If this tumor is not always malignant the code D37.7 is better
France	Supported	But we regret that we have the same code for uncertain behaviour and unspecified neoplasm
Japan		
NORDIC	Not supported in this form	Since Glucagonoma can be both benign and malignant (and obviously unkown), it must be coded accordingly. Currently malignant tumors are included in C25.4 ' Malignant neoplasm of endocrine pancres', benign in D13.7 'Benign neoplasm of endocrine pancreas' and unknown or uncertain in D35.7 'Neoplasm of uncertain or unknown behaviour of other specified endocrine gland'. Glucagon excreting cells are not a digestive organ and if D37 is preferred (because C25 and D13 are pancreas codes) the rubric of D37 and exclusion of D35 should be changed.
North America	Supported	Request is consistent with ICD-O-3. NACC (Morbidity & U.S. mortality) support. **Second round comment:** U.S. Mortality cites need to change index for: Glucogonoma - unspecified site
United Kingdom		
Roberto Becker		
Germany		Taking into account the Australian comment, we would modify the proposal as follows:

		Glucagonoma (M8152/~~0~~1) - pancreas ~~D13.7~~D37.7 - specified site NEC – see Neoplasm, ~~benign~~uncertain or unknown behavior - unspecified site ~~D13.7~~D37.7 A further change is necessary in the Morphology section of Vol 1: M8152/~~0~~1 Glucagonoma
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0269 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Insulinoma, pancreas

Proposal for update:

As this tumor is malignant in about 15 % of the cases, we would prefer D37.7

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Insulinoma - pancreas ~~D13.7~~ D37.7	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	Same comments as for glucagonoma. Is this tumour malignant in about 15% of cases for the pancreas only or for all sites? If for all sites, then other entries in both the alphabetic index and morphology table will need to be changed as well.
Brazil	Supported	
France	Supported	But only for insulinoma unspecified
Japan		
NORDIC	Not supported in this form	Since Insulinoma can be both benign and malignant (and obviously unkown), it must be coded accordingly. Currently malignant tumors are included in C25.4 ' Malignang neoplasm of endocrine pancres', benign in D13.7 'Benign neoplasm of endocrine pancreas' and unknown or uncertain in D35.7 'Neoplasm of uncertain or unknown behaviour of other specified endocrine gland'. Insulin excreting cells are not a digestive organ and if D37 is preferred (because C25 and D13 are pancreas codes) the rubric of D37 and exclusion of D35 should be changed.
North America		U.S. mortality supports. NACC morbidity will respond with second round review. **Second round comment:** Conflicts with ICD-O-3 which treats this as benign U.S. Mortality cites need to change index for: Insulinoma - unspecified site
United Kingdom		
Roberto Becker		
Germany		Taking into consideration the Australian comment, we would modify our proposal as follows:

		Insulinoma (M8151/~~0~~1) - pancreas ~~D13.7~~D37.7 - specified site NEC – see Neoplasm, ~~benign~~uncertain or unknown behavior - unspecified site ~~D13.7~~D37.7 A further change is necessary in the Morphology section of Vol 1: M8151/~~0~~1 Insulinoma
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0270 Proposed by: Germany

Change to Volume: I Type of proposal: Major

Description (term/code): Dog Tapeworm

Proposal for update:

Dog tapeworm has two meanings: Echinococcus granulosus and Dipylidium caninum. Infestation with D. caninum is quite rare, whereas infestation with E. granulosus is more frequent and more important.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add inclusion term Delete inclusion term	**B67.4 *Echinococcus granulosus* infection, unspecified** Dog tapeworm (infection) **B71.1 Dipylidiasis** ~~Dog tapeworm (infection)~~	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	We would suggest deleting the inclusion term 'dog tapeworm' altogether, as it is misleading. Dipylidiasis is the tapeworm, carried by fleas, that causes tapeworm infestation in dogs and very occasionally, humans. Echinococcus granulosus causes hydatid disease in humans, and for part of its life cycle, is hosted by dogs. The term 'dog tapeworm' is not in the alphabetic index and use of this term for code assignment should be discouraged.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Not supported in current form	See Australian comment.
North America	Supported	
United Kingdom		
Roberto Becker		
Germany		I think this depends on the usage of 'dog tapeworm' in medical English. Is it frequently used? With which meaning?
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0271 Proposed by: Germany

Change to Volume: I Type of proposal: Minor

Description (term/code): Hypertensive renal disease – addition of inclusion

Proposal for update:

At N00-N08 hypertensive renal disease is excluded. The code range should be added to the inclusion note at I12 to make sure that these conditions are accepted as hypertensive renal disease.

Suggested changes to the classification:

Instruction	Tabular list entries		Source	Major/Minor update	Suggested implementation date
Modify inclusion term	**I12**	**Hypertensive renal disease**	Germany	Minor	January 2007
	Includes:	any condition in N00-N07, N18.−, N19.− or N26.− with any condition in I10			
		arteriosclerosis of kidney			
		arteriosclerotic nephritis (chronic)(interstitial)			
		hypertensive nephropathy			

	nephrosclerosis ***Excludes:*** secondary hypertension (I15.−)			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	
North America		U.S. mortality supports. NACC morbidity will respond with second round review. **Second round comment:** NACC Morbidity does not support. The glomerular disorders at N00-N07 are generally not related to hypertension, so should not be coded to I12. Renal Physician Association input might be sought, if more detailed comments were desired and time allowed. When glomerular disorders go on to cause renal failure, then a renal failure code is used; when hypertension subsequently develops, the hypertensive renal disease codes are used, even though the hypertension in such cases may be secondary to the renal disease, rather than vice versa. This makes the data misleading. This is not

		easily fixed. However, this change would make the problem worse.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0281 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Acute hepatitis NOS

Proposal for update:

As hepatitis A is never chronic, "(chronic)" should be deleted.
As hepatitis B (B16.-), C/E (B17.-) are acute, too, B15.9 seems to be not the "right" reference for all "acute".

There seems to be no class for "acute hepatitis NOS" which covers all types of acute hepatitis.
How can we handle these issues?

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Delete modifier	Hepatitis – infectious, infective (acute) (~~chronic~~) (subacute) B15.9	Germany	Minor	January 2007

	Please take a look to volume I entries, too.			

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
	B15 **Acute hepatitis A** **B15.0** **Hepatitis A with hepatic coma** **B15.9** **Hepatitis A without hepatic coma** Hepatitis A (acute)(viral) NOS **B16** **Acute hepatitis B** **B16.0** **Acute hepatitis B with delta-agent (coinfection) with hepatic coma** **B16.1** **Acute hepatitis B with delta-agent (coinfection) without hepatic coma** **B16.2** **Acute hepatitis B without delta-agent with hepatic coma** **B16.9** **Acute hepatitis B without delta-agent and without hepatic coma** Hepatitis B (acute)(viral) NOS			

	B17 **Other acute viral hepatitis** **B17.0** **Acute delta-(super)infection of hepatitis B carrier** **B17.1** **Acute hepatitis C** **B17.2** **Acute hepatitis E** **B17.8** **Other specified acute viral hepatitis** Hepatitis non-A non-B (acute)(viral) NEC **B17.9** **Acute viral hepatitis, unspecified** Acute Hepatitis NOS **B18** **Chronic viral hepatitis** **B18.0** **Chronic viral hepatitis B with delta-agent** **B18.1** **Chronic viral hepatitis B without delta-agent** Chronic (viral) hepatitis B **B18.2** **Chronic viral hepatitis C**			

Modify	**B18.8 Other chronic viral hepatitis** **B18.9 Chronic viral hepatitis, unspecified** **B19 Unspecified viral hepatitis** **B19.0 Unspecified viral hepatitis with hepatic coma** **B19.9 Unspecified viral hepatitis without hepatic coma** Viral hepatitis NOS			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We agree with the proposal that hepatitis A is never chronic, so if the default for *Hepatitis, infectious* remains at B15.9, then the NEM 'chronic' should be deleted . Are you asking for a new code for 'acute **infectious** hepatitis' NOS? The only way we can see is to change the category title of B17 to Other and unspecified acute viral hepatitis, and add a new code here , ? B17.9. The term 'hepatic' is already included in ICD-10 in the code title of B19.9.
Brazil	no opinion	
France		In the alphabetic index, we don't have to do the modification because it is correct. In the tabular list we agree with the proposition to add "hepatic" before coma
Japan		
NORDIC		There is definitely a problem. The alphabetical index indicates that all unspecified infective hepatitis are to be coded as hepatitis irrespective if acute or choronic. The former can possibly be accepted, but as hepatitis A is never chronic, the latter is obviously wrong. In the tabular list unspecified chronic hepatitis is coded to B18.9. Thus the correction in alphabetical index should be : Hepatitis – infectious, infective ~~(~~acute~~)~~ (~~chronic~~) B15.9 – infectious, infective ~~(~~chronic~~)~~ B18.9 In the tabular list the coding of unknown acute infective hepatitis is missing as the proposal indicates. If the principle that unspecified acute infections hepatitis is coded to hepatitis A, is accpeted, the tabular index needs a new inclusion:

		B15 Acute hepatitis A - Unspecified or unkonwn acute infective hepatitis The other most obvious solution is to add a new code at B17.9. This is the natural place for unspecified infective hepatitis. It is however obvious that it has been left out on purpose. Additionally, the exclusion of K73 should be modified to: viral (B18-B19) since chronic hepatitis (K73) can occur simultaneously with and is not due to acute hepatitis (B15-B17)
North America		NACC Morbidity agrees to delete term "chronic" from hepatitis A. Need to correct code title of code B19.0 so that it reads Unspecified viral hepatitis with hepatic coma. Index B19.9 and add tabular notes.
United Kingdom		
Roberto Becker		
Germany		**2nd round**: I have slightly modified the proposal as suggested by the Australian Center.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0284 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Synovitis/tenosynovitis

Proposal for update:

Crystal induced synovitis/tenosynovitis is currently classified to M11.9. We suggest it be classified to M65.8 instead.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Synovitis**—*continued* – in (due to) – – crystals ~~M11.9~~ M65.8	Germany	Major	January 2009
Revise code	Tenosynovitis **M65.9**			

	– in (due to) – – crystals ~~M11.9~~ M65.8			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	What is more important to capture clinically – the synovitis or the fact that the aetiology is crystals? Are the suggested changes because neither of these conditions should be classified to an arthropathy code. If both concepts are required, maybe a dagger asterick or code also.
Brazil	Supported	This case is « Synovitis » « Tenosynovitis » (n65) and not arthropaty (m11)
France		I agree with the australien comment
Japan		
NORDIC		See Australian comment. It seems that the point of the alphabetical index is that any crystal associated disease has always to be coded to 'crystal arthropaties'. This is impossible to understand from the tabular index and thus either an inclusion note is needed in tabular index or the alphabetical index should be modified. If alphabetical index and tabular index are in conflict, one should always regard tabular index as master version!
North America		NACC Morbidity will respond with second round review.

		Second round comment: NACC Morbidity disagrees with the suggestion to move this. I would consider M11.9 to be more specific, and an appropriate code for synovitis or tenosynovitis related to crystals. Agree in principle?
United Kingdom		
Roberto Becker		
Germany		**Second round comment:** Even if the etiology is crystals, it is not an arthropathy.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0285 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Dermatitis dysmenorrhoica symmetrica

Proposal for update:

Dermatitis dysmenorrhoica symmetrica leads to N94.6. As dermatitis it should be coded elsewhere, we suggest L98.1

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Dermatitis - dysmenorrhoica symmetrica ~~N94.1~~ L98.1	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not supported	We agree that the current code assignment is incorrect, but do not agree with L98.1 *Factitial dermatitis,* which is self-inflicted dermatitis. We would prefer L30.8 *Other specified dermatitis* which is arrived at via the look-up of 'Dermatitis, specified NEC'.
Brazil	Supported	We supported the change from N94.1 to L98 – but not .1 but .8
France		I agree with the Australian proposition
Japan		
NORDIC	Not supported	If dysmenorrhoica dermatitis is assigned to 'Dermatitis specified NEC' there is no need to include it in the alphabetical index at all. Thus it should be deleted.
North America	Not supported	NACC morbidity does not support. **Second round comment:** More information needed. Dermatitis dysmenorrhoica symmetrica ?? Is this a misspelling Dermatitis / dysmenorrheica N94.6 [may be mis-spelled, too] There are two Medline articles found on this, which are in German (from 1974 and 1958). It is not clear whether there is more a problem with dysmenorrhea, or with a dermatitis. However, the German Centre may be able to ask for more clinical detail on what this condition.
United Kingdom		
Roberto Becker		
Germany		In the German medical language this term is used for a kind of dermatitis appearing in young women with mental problems and it is due to rubbing or scratching or use of irritants. Thus we would consider it to be factitial.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0287 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Twilight and confusion caused by epilepsy

Proposal for update:

Twilight and confusion caused by epilepsy should not be coded as delirium. We suggest G40.8 (for discussion).

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Epilepsy, epileptic**—*continued* **– twilight ~~F05.8~~ G40.8**	Germany	Major	January 2009
Revise code	**Confusion, confused** R41.0 **– epileptic ~~F05.8~~ G40.8**			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	no opinion	
France		It does not exist in the french version
Japan		
NORDIC	Not supported	Since the matter is unclear, no changes should be made. Twilight and confusion are psychiatric symptoms of a problem (in this case epilepsy). There must be a possibility to register the separately from the disease (for example G40.-). Whether the correct postition is F-chapter or R-chapter is questionable.
North America		NACC Morbidity will respond with second round review. **Second round comment:** Twilight and confusion caused by epilepsy. Revision is supported by Dr. Powers of the American Academy of Neurology.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		

Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0290 **Proposed by:** **Germany**

Change to Volume: III Type of proposal: Minor

Description (term/code): Abscess of artery

Proposal for update:

Is abscess of artery classified correctly at I772 or is it more appropriately classified to I77.8?

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise code	Artery - abscess ~~I77.2~~ I77.8	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	We assume the change is requested as not all abscesses of arteries will lead to rupture. If this is the case, then perhaps 'erosion' needs to be moved as well?
Brazil		It is more appropriated the code I77.8
France	No opinion	
Japan		
NORDIC	Supported	
North America		NACC Morbidity supports. **Second round comment:** NACC supports in principle. Need more clinical input and discussion.
United Kingdom		Appears logical but would appreciate comments from clinical colleagues
Roberto Becker		
Germany		We are in favour of the Australian proposal.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0291 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Prostatitis

Proposal for update:

Abscess of prostate as a purulent process is coded at N41.2.

Suppurative prostatitis leads to N41.9. As suppurative is synonymous with purulent, is it more appropriately classified to N41.2?

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Prostatitis (congestive) (suppurative) (by) ~~N41.9~~ N41.2	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported, with changes	We agree that the current classification is not optimal and suggest the following indexing changes: **Prostatitis** (congestive) N41.9 - specified type NEC N41.8 - subacute N41.1 - suppurative N41.2 **Suppuration, suppurative** — *see also condition* - pericranial *(see also Osteomyelitis)* M86.8 - prostatitis N41.2 It may also be useful to add the inclusion term 'suppurative prostatitis' to N41.2 in the tabular list.
Brazil		For us is more appropriated the code N41.2
France	Supported the australian proposition	
Japan		
NORDIC	Support with Australian modification	See Australian comment
North America		NACC Canada Morbidity supports. NACC U.S. Morbidity will respond with second round review.

		Second round comment: More info needed. Suppurative prostatitis goes to N41.9, Inflammatory disease of prostate, unspecified. This proposal is to move it to N41.2, Abscess of prostate, with the rationale that an abscess is a purulent process, and that suppurative and purulent are synonymous. Our clinician disagrees. While these do both relate to formation of pus, he believes that in this case suppurative can just indicate that white cells are present in prostatic secretions, rather than a frank collection of pus (an abscess). Thus, he believes the indexing is appropriate. Looking at Medline, it does appear that many of the uses of this term are in translations; this might create confusion. It could be useful to get input from a urologist, or an infectious disease specialist.
United Kingdom		
Roberto Becker		
Germany		The Australian proposal is supported.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0292 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Torsion, cervix

Proposal for update:

Torsion of cervix uteri is classified to N85.4. As the category of N85 excludes cervix, we suggest it be classified to N88.8.

Volume I entry:

N85 Other noninflammatory disorders of uterus, except cervix

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Torsion **– cervix ~~(*see also* Malposition, uterus)~~ ~~N85.4~~ N88.8**	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not yet supported	These comments apply for the next four proposals as well. We are just wondering if these conditions have been coded this way as torsion, retroversion and anteversion of the cervix would also apply to the uterus as well, ie cannot occur in isolation? If this is the case, then the indexing needs to be modified to support this concept.
Brazil	Supported	It is clear that the category « N85 » excludes cervix
France	Supported	
Japan		
NORDIC	Not supported	As stated by Australia and North America (URC 0292) the malposition of cervix is part of the malposition of the uterus. The alphabetical index indicates in this way that separate malposition of cervix does not exist and therfore the code is N85.4.
North America		NACC Morbidity does not support. Is the cervix uteri not part of the uterus? **Second round comment:** Input received from the American College of Obstetricians and Gynecologists states there is no such entity as torsion of the cervix, only of the uterus. Any index entries for cervical torsion should be removed or at least left at the same code.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		**2nd round**: we have referred that back to our clinicians. Due to their feedback isolated malposition of the cervix is possible

		but very rare. I would suggest to keep all malpositions under this code and just modify the exclusion note at N85: N85 Excludes: noninflammatory disorders of cervix except malposition (n86-N88)
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0293 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Retroversion, cervix

Proposal for update:

Retroversion of cervix uteri is classified to N85.4. As the category N85 excludes cervix, we suggest it be classified to N88.8.

N85 Other noninflammatory disorders of uterus, except cervix

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Retroversion, retroverted – cervix ~~(*see also* Retroversion, uterus)~~ ~~N85.4~~ N88.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil	Supported	The same comment we did for O292
France	Supported	
Japan		
NORDIC	Not supported	As stated by Australia and North America (URC 0292) the malposition of cervix is part of the malposition of the uterus. The alphabetical index indicates in this way that separate retroversion of cervix does not exist and therfore the code is N85.4.
North America		NACC Morbidity does not support. Is the cervix uteri not part of the uterus?
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0294 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Retraction, cervix

Proposal for update:

Retraction of cervix uteri is classified to N85.4. As the category N85 excludes cervix, we suggest it be classified to N88.8.

N85 Other noninflammatory disorders of uterus, except cervix

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Retraction – cervix ~~(*see also* Retroversion, uterus)~~ ~~N85.4~~ N88.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil	Supported	See URC 292
France		
Japan		
NORDIC	Not supported	As stated by Australia and North America (URC 0292) the malposition of cervix is part of the malposition of the uterus. The alphabetical index indicates in this way that separate teraction of cervix does not exist and therfore the code is N85.4.
North America		NACC Morbidity does not support. Is the cervix uteri not part of the uterus?
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0295 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Anteversion, cervix

Proposal for update:

Anteversion of cervix uteri is classified to N85.4. As the category N85 excludes cervix, we suggest it be classified to N88.8.

N85 Other noninflammatory disorders of uterus, except cervix

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Anteversion – cervix ~~(*see also* Anteversion,)~~ ~~N85.4~~ N88.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil	Supported	see comment in URC 292
France	Supported	
Japan		
NORDIC	Not supported	As stated by Australia and North America (URC 0292) the malposition of cervix is part of the malposition of the uterus. The alphabetical index indicates in this way that there is no separate malposition of cervix in these cases and therfore the code is N85.4.
North America		NACC Morbidity does not support. Is the cervix uteri not part of the uterus?
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0296 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Displacement, cervix

Proposal for update:

Displacement of cervix uteri is classified to N85.4. As the category N85 excludes cervix, we suggest it be classified to N88.8.

N85 Other noninflammatory disorders of uterus, except cervix

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code and modifier	Displacement, displaced – cervix ~~(see also Malposition, uterus)~~ ~~N85.4~~ N88.8	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Not supported	As stated by Australia and North America (URC 0292) the malposition of cervix is part of the malposition of the uterus. The alphabetical index indicates in this way that displacement of cervix does not exist and therfore the code is N85.4.
North America		NACC Morbidity does not support. Is the cervix uteri not part of the uterus?
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0297 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Caput succedaneum

Proposal for update:

Error correction. As caput succedaneum is synonymous with chignon it should be coded as such.

P12.1 Chignon due to birth injury

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Caput - succedaneum ~~P12.8~~ P12.1	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	Changes will also be needed in the area below, for the official updates for 2005; **Conditions arising in the perinatal period** *Note* – Conditions arising in the perinatal period, even though death or morbidity occurs later, should, as far as possible, be coded to chapter XVI, which takes precedence over chapters containing codes for diseases by their anatomical site. These exclude: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) Endocrine, nutritional and metabolic diseases (E00-E99) Injury, poisoning and certain other consequences of external causes (S00-T99) Neoplasms (C00-D48) Tetanus neonatorum (A33) - caput succedaneum P12.1
Brazil	Supported	

France		I would have supported, but I agree with the North American comment
Japan		
NORDIC	Of no interest for non-english speaking countries	The NACC comment is in error since chignon is not a cephalhematoma according to several English language sources on the Internet. For example UK GPNotebook clearly defines it as 'oedematous scalp swelling … superficial to the cranial osteum' . The expression is language specific and cannot be translated. The usual meaning of chignon is some kind of hair arrangement usually used by ladies.
North America		NACC Morbidity does not support. Research by Morbidity Canada finds that Caput succedaneum is a diffuse swelling of the scalp in a newborn caused by pressure from the uterus or vaginal wall during a head-first (vertex) delivery. A caput succedaneum is caused by the mechanical trauma of the initial portion of scalp pushing through a narrowed cervix. The swelling may be on any portion of the scalp, may cross the midline (as opposed to a cephalhematoma associated with vacuum extractor usage - chignon), and may be discolored because of slight bleeding in the area. There may also be molding of the head, which is common in association with a caput succedaneum. **Second round comment:** US Morbidity believes more info needed. Reviewing this, chignon is not found in Dorlands; on Medline, it is often described as caput related to vacuum extraction. However, we are not certain if this is always the case. Caput succeaneum is often due to molding, and not related to vacuum extraction. Thus, while chignon is caput, it is not clear immediately that caput is always chignon. Input from Pediatrics should be sought.
United Kingdom		Do not think these terms are synonymous requires further clinical input.
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0298 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Sepsis, umbilical cord

Proposal for update:

We would prefer P36.9 for sepsis of umbilical (cord).

P36	Bacterial sepsis of newborn
	Includes: congenital septicaemia
P36.0	Sepsis of newborn due to streptococcus, group B
P36.1	Sepsis of newborn due to other and unspecified streptococci
P36.2	Sepsis of newborn due to Staphylococcus aureus
P36.3	Sepsis of newborn due to other and unspecified staphylococci
P36.4	Sepsis of newborn due to Escherichia coli

P36.5 Sepsis of newborn due to anaerobes

P36.8 Other bacterial sepsis of newborn

P36.9 Bacterial sepsis of newborn, unspecified

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Sepsis - umbilical, umbilical cord (newborn) (unspecified species) ~~P38~~ P36.9	Germany	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments

Australia	Not supported	We feel that this is more of a semantic problem with the use of the word 'sepsis' and how the meaning has changed over time. Sepsis more recently is used to mean the systemic response to infection whereas historically it may have meant a localised infection (eg wound sepsis). We would suggest deleting this index entry altogether as there are plenty of other accurate entries, ie infection umbilical, abscess, umbilical which assign P38 . Sepsis these days is used to reflect a more systemic infection, therefore is it correct to endorse an index entry for Sepsis of a specified site, such as umbilical cord?
Brazil	Supported	
France		It does not exist in the French version
Japan		
NORDIC	Not supported	The expression is incorrect and can only be understood as a historical relict as explained by Australia. The entry should be deleted which would result in coding of sepsis to P36 and umbilical cord infection to P38.
North America		Disagree as the axis of P36 is the type of bacterial organism causing the sepsis. Retain P38 for Sepsis, umbilical cord. **Second round comment:** Not supported - Canada Mortality opposes deletion suggested by Australia and believes it should remain as is.
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0299 **Proposed by:** **Germany**

Change to Volume: III Type of proposal: Minor

Description (term/code): Congenital achalasia

Proposal for update:

As achalasia represents missing relaxation of sphincter it doesn't fit in Q39.5.

Q39.5 Congenital dilatation of oesophagus

Achalasia (cardia) (esophagus) K22.0
– congenital Q39.5

We are not sure which is the best code, but we suggest Q39.3 or Q39.8 (preferred).

Q39	Congenital malformations of oesophagus
Q39.0	Atresia of oesophagus without fistula
	Atresia of oesophagus NOS

Q39.1 Atresia of oesophagus with tracheo-oesophageal fistula

Atresia of oesophagus with broncho-oesophageal fistula

Q39.2 Congenital tracheo-oesophageal fistula without atresia

Congenital tracheo-oesophageal fistula NOS

Q39.3 Congenital stenosis and stricture of oesophagus

Q39.4 Oesophageal web

Q39.5 Congenital dilatation of oesophagus

Q39.6 Diverticulum of oesophagus

Oesophageal pouch

Q39.8 Other congenital malformations of oesophagus

Absent } (of) oesophagus
Congenital displacement }
Duplication }

Q39.9 Congenital malformation of oesophagus, unspecified

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Achalasia (cardia) (esophagus) K22.0 – congenital ~~Q39.5~~ Q39.8	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not supported	Although not optimal, we feel that the current code assignment is the 'best fit'
Brazil	P39.3	We prefer P39.3 (and not P39.8)
France	Not supported	
Japan		
NORDIC	Not supported	See NACC comment and Australian comment. The Finish ICD-10 has divided the two types of esophageal dilatation as Q38.50 'Achalasia' and Q38.58 'Other dilatation'
North America		NACC Morbidity does not support. Disagree as achalasia is the failure of the esophagogastric sphincter to relax with swallowing, due to degeneration of ganglion cells in the wall of the organ. The thoracic esophagus also loses its normal

		peristaltic activity and becomes dilated (megaesophagus).
United Kingdom		
Roberto Becker		
Germany		
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0301 **Proposed by: Australian Centre**

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

Description (term/code): Benign neoplasm of prostate

Proposal for update:

Benign neoplasms of the prostate should logically be coded to D29.1 *Benign neoplasm of male genital organs, prostate*. These three types of benign neoplasm are currently classified to N40 *Hyperplasia of prostate.* Clinical advice received by the NCCH, Australia, notes that the code N40 includes other terms such as hyperplasia, hypertrophy, enlargement etc that are clearly not neoplastic. This is a significant problem for those who wish to count benign neoplasms as they are grouped with non-neoplastic conditions.

Suggested changes to the classification:

Instruction	Tabular List		Source	Major/Minor update	Suggested implementation date
Revise	**D29**	**Benign neoplasm of male genital organs**	Australia	Major	January 2009
		Includes: skin of male genital organs			
	D29.0	Penis			
	D29.1	Prostate			

Delete exclusion term	***Excludes:*** hyperplasia of prostate (adenomatous) (N40) prostatic: ~~• adenoma (N40)~~ • enlargement (N40) • hypertrophy (N40)			
Delete inclusion terms	**N40 Hyperplasia of prostate** Adenofibromatous hypertrophy } ~~Adenoma (benign)~~ } Enlargement (benign) } ~~Fibroadenoma~~ } of prostate Fibroma } Hypertrophy (benign) } ~~Myoma~~ } Median bar (prostate) Prostatic obstruction NOS ***Excludes:*** benign neoplasms, ~~except adenoma, fibroma and myoma~~ of prostate (D29.1)			

Instruction	Instruction manual	Source	Major/Minor	Suggested

			update	implementation date
Revise code	**4.1.7 Examples of the General Principle and selection rules** ***General Principle*** **When more than one condition is entered on the certificate, select the condition entered alone on the lowest used line of Part I only if it could have given rise to all the conditions entered above it.** *Example 8:* I (a) Cerebral haemorrhage (b) Hypertension (c) Chronic pyelonephritis (d) Prostatic adenoma Select prostatic adenoma (~~N40~~D29.1).	Australia	Major	January 2009

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	**Adenofibroma** (M9013/0) — *see also Neoplasm, benign*	Australia	Major	January 2009
Revise code	- prostate ~~N40~~ D29.1			
Revise code	**Adenoma** (M8140/0) — *see also Neoplasm, benign*			
	- prostate ~~N40~~ D29.1			
Revise code				
Revise code	**Adenomyoma** (atypical polypoid) (M8932/0) — *see also Neoplasm, benign*			
	- prostate ~~N40~~ D29.1			
Revise code				

	Fibroadenoma (M9010/0) - prostate ~~N40~~ D29.1 **Fibroma** (M8810/0) — *see also Neoplasm, connective tissue, benign* - prostate ~~N40~~ D29.1 **Myoma** (M8895/0) — *see also Neoplasm, connective tissue, benign* - malignant (M8895/3) — *see Neoplasm, connective tissue, malignant* - prostate ~~N40~~ D29.1 - uterus (cervix) (corpus) — *see Leiomyoma*			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	No opinion	
Japan		
NORDIC	Not supported	Although semantically correct in practice difficult. In addition to incorrect usage there is a problem to draw a line between

		hyperplasia and neoplasm. Even theoretically this is not selfevident. It looks most likely that because of these problems the conditions have been combined in ICD-10 on purpose to avoid problems in interpretation of statistical data.
North America		NACC Morbidity supports. **Second round comment:** NACC Morbidity and Canada Mortality support.
United Kingdom		Appears logical however will obtain advice from clinical colleagues
Roberto Becker		
Germany	Supported in principle	The problem is that the term "prostatic adenoma" is incorrectly but frequently used for "prostatic hyperplasia" – at least among German doctors.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0302 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Major

Description (term/code): Cerebral artery syndrome

Proposal for update:

We wish to expand the range of available dagger codes for cerebral artery syndromes. Often these syndromes are associated with other conditions in the category I60-I69 *Cerebrovascular diseases* and the current dagger codes listed do not cope with these pairings. As with other similar conditions, the entries in the alphabetic index will default to the least specific code within that code range, ie I67.9.

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date
Revise dagger codes	**G46* Vascular syndromes of brain in cerebrovascular diseases (I60–I67†)** G46.0* Middle cerebral artery syndrome (~~I66.0†~~ I60–I67†) G46.1* Anterior cerebral artery syndrome (~~I66.1†~~ I60–I67†) G46.2* Posterior cerebral artery syndrome (~~I66.2†~~ I60–I67†)	Australia	Major	January 2009

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise dagger codes	**Syndrome** — *see also Disease* - cerebral artery - - anterior I66.17.9† G46.1* - - middle I66.07.9† G46.0* - - posterior I66.27.9† G46.2*	Australia	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	No opinion	
Japan		
NORDIC	Not supported	Current instructions about etiological codes vary between the different G46 codes. Since the combinations can be very specific, this is a small problem. However, it is also wrong to code always I67.9, because there is more accurate information

		available. If this information is unnecessary, the specific codes should be deleted. The alphabetical part is problematic. In most cases current combinations are correct. However, we should give the coders the message that other options exist. For professional coders without knowledge about the truth nature of the patients situation/disease, the selection may be problematic. I see this as a matter that needs to be discussed in the revision process. Whether a temporary solution is useful is unclear.
North America		These are very specific dagger/asterisk relationships. We are not sure that these should be made into broader ranges. Perhaps physician input would be valuable. We have also noted that there are instances of ranges applied in the French translation of ICD-10 that do not appear in the English language version. **Second round comment**: Agree in principle?
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0303 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Minor

Description (term/code): Cortical blindness

Proposal for update:

The dictionary of eye terminology defines cortical blindness as "total loss of vision in normal-appearing eyes caused by damage to the visual area in the occipital cortex of the brain. Visually-evoked electrical response (VER) is markedly diminished."

We propose that the term "cortical blindness" be added as an inclusional term to code H47.6 *Disorders of the visual cortex*. As total loss of vision is implied in the term "cortical blindness" there is no need for an additional code from category H54 *Blindness and low vision*.

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date
Add inclusion term	**H47 Other disorders of optic [2nd] nerve and visual pathways** H47.6 Disorders of visual cortex Cortical blindness	Australia	Minor	January 2007

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterm	**Blindness** (acquired) (both eyes) (congenital) H54.0 - blast S05.8 - colour H53.5 - concussion S05.8 - cortical H47.6	Australia	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	no opinion	
France	supported	
Japan		

NORDIC	Supported	
North America		NACC Morbidity supports. **Second round comment:** More info needed. While this would be a useful term to add, and it is a disorder of the visual cortex, it is not clear that there would not be other disorders of the visual cortex which could be confused, and might not cause blindness. It may be appropriate to use a code from H54. However, if only one side is affected, there may be visual field loss on one side only (but affecting vision of both eyes). This would not make sense to code at H54, since it does not fit well with the existing codes. Input Ophthalmology should be sought.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0304 **Proposed by: Australian Centre**

Change to Volume: I III Type of proposal: Minor

Description (term/code): Deep venous thrombosis of femoral vein

Proposal for update:

We have received a number of queries on how to code a deep venous thrombosis (DVT) of the superficial femoral vein. Depending on the look up in the alphabetic index, the code assigned could be *Thrombosis, femoral* I80.1 or *Thrombosis, leg, superficial* I80.0.

A literature review has revealed that the term 'superficial femoral vein' is incorrect and should be discarded, as it is really a deep vein. Whilst this term itself is not used in ICD-10, there still appears to be confusion and ambiguity over the assignment of I80.0 and I80.1. We propose the following change to the tabular list to provide clarification. We do not propose any changes to the alphabetic index as we do not wish to endorse the use of the term 'superficial femoral vein'.

Ref: Caggiati A, Bergann JJ, Gloviczki P, janet G, Wnedell-Smith CP, Partsch H. Nomenclature of the veins of the lower limbs: an international interdisciplinary consensus statement. J Vasc Surg 2002; 36:416-422. [Medline]

Suggested changes to the classification:

Instruction	Tabular List	Source	Major/Minor update	Suggested implementation date

Revise Add excludes note	**I80 Phlebitis and thrombophlebitis** ***Includes:*** endophlebitis inflammation, vein periphlebitis suppurative phlebitis *Use additional external cause code (Chapter XX),if desired, to identify drug, if drug-induced.* ***Excludes:*** phlebitis and thrombophlebitis (of): • complicating: • abortion or ectopic or molar pregnancy (O00–O07, O08.7) • pregnancy, childbirth and the puerperium (O22.-, O87.-) • intracranial and intraspinal, septic or NOS (G08) • intracranial, nonpyogenic (I67.6) • intraspinal, nonpyogenic (G95.1) • portal (vein) (K75.1) postphlebitic syndrome (I87.0) thrombophlebitis migrans (I82.1) I80.0 Phlebitis and thrombophlebitis of superficial vessels of lower extremities ***Excludes:*** Phlebitis and thrombophlebitis of (superficial) femoral vein (I80.1) I80.1 Phlebitis and thrombophlebitis of femoral vein	Australia	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Not supported	See NACC comment
North America		NACC Morbidity does not support. This appears to be a documentation/terminology issues and should not be carried over into the classification.
United Kingdom	Supported (morbidity)	
Roberto Becker		

Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0307 **Proposed by: Australian Centre**

Change to Volume: III Type of proposal: Major

Description (term/code): Post-transfusion hepatitis/jaundice

Proposal for update:

The following clinical advice (in relation to a query on this topic) was received by our consultant haematologist:

Post-transfusion hepatitis is usually caused by a virus but the infectious agent varies from country to country and the adequacy of the donor screening. it is usually, but not always caused by hepatitis C at present. Hepatitis B has been a very uncommon cause of post-transfusion hepatitis recently as it was the first to be detectable in blood donors by testing and thus avoidable. If one is to have a default that is most likely correct it should be hepatitis C not hepatitis B.

The consultant also believes that the term 'post-transfusion hepatitis' is an archaic term that evolved because the infectious agent was not known in the past and suggests deleting this term altogether and coding the correct microbiological cause of the hepatitis. To further complicate matters, in Australia, if there was a documented causal relationship between the transfusion and the hepatitis, we would double code, ie T80.2 *Infections following infusion, transfusion and therapeutic injection*, together with a code for the specific type of hepatitis.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify	I am happy to draft changes to the alphabetic index, once there is consensus on the	Australia	Major	January 2009

	direction of change, if any.			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	But, we will prefer to keep the possibility to code the infection with an other agent ; we will propose to have, in the alphabetic index : "Post-transfusion hepatitis unspecified – see hepatitis C"
Japan		
NORDIC	Supported	Principle is OK. Transfusion hepatitis hould be coded with T80.2 in combination with B15-19 cod and Y8-group code. In acute phase T80.2 should be principle diagnosis. In chronic hepatitis a code from the B15-19 group should usually be principle diagnosis.
North America		NACC Morbidity agrees in principle. **Second round comment:** Do not support deleting term as suggested by Germany. Needs further discussion.
United Kingdom		Will forward this to appropriate clinician for comment
Roberto Becker		

Germany		I agree to delete this ambiguous term, however, the primary code should not be in chapter XIX but in chapter I and a note should be added "Use additional code (chapter XX), if desired, to identify post-transfusion hepatitis."
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0311 **Proposed by: Australian Centre**

Change to Volume: III Type of proposal: Major

Description (term/code): Squamous metaplasia of the cervix

Proposal for update:

We have received advice from clinicians that squamous metaplasia of the cervix is not the same as dysplasia of the cervix. They state that metaplasia is a normal physiologic change in the cervix which carries no sinister significance, whereas dysplasia is the earliest change which can progress to an invasive cancer. The current index entry in ICD-10 is **Metaplasia**, cervix (squamous) – see *Dysplasia, cervix*.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify Delete subterm	**Metaplasia** - apocrine (breast) N60.8 ~~- cervix (squamous) see *Dysplasia, cervix*~~	Australia	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	no opinion	
France	Supported	
Japan		
NORDIC	Not supported	The NACC reasoning is reasonable. More information is necessary before a change is accepted.
North America		Dorland's Medical Dictionary defines metaplasia as the change in the type of adult cells in a tissue to another form of adult cells that are not normal for that tissue. The diagnosis squamous metaplasia of the cervix may lead to cervical dysplasia, which is directly linked to venereal wart viruses, HPV. Perhaps for this reason the two conditions are classified under dysplasia. Are you suggesting another code for metaplasia?
United Kingdom		Will check with clinical colleagues
Roberto Becker		
Germany	Supported.	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0312 **Proposed by: Australian Centre**

Change to Volume: III Type of proposal: Major

Description (term/code): Usual Interstitial Pneumonia

Proposal for update:

Currently there is no index entry in ICD-10 for 'usual interstitial pneumonia', a diagnosis that is becoming more common in Australia. A search of medical literature indicates that this is more specifically a type of idiopathic pulmonary fibrosis. An index entry exists for *Pneumonia, interstitial*, which leads to J84.9 *Interstitial pulmonary disease, unspecified*, but this is non-specific. We suggest adding an index entry for 'usual interstitial pneumonia' which leads to J84.1 *Other interstitial pulmonary diseases with fibrosis* and perhaps adding an inclusion term in the tabular list at this code. Further clinical input on this suggestion is welcome.

Suggested changes to the classification:

Instruction	Tabular list entries		Source	Major/Minor update	Suggested implementation date
Modify	J84.1	Other interstitial pulmonary diseases with fibrosis	Australia	Major	January 2009
		Diffuse pulmonary fibrosis			
		Fibrosing alveolitis (cryptogenic)			
Add inclusion term		Hamman-Rich syndrome			

	Idiopathic pulmonary fibrosis Usual interstitial pneumonia ***Excludes:*** pulmonary fibrosis (chronic): • due to inhalation of chemicals, gases, fumes or vapours (J68.4) • following radiation (J70.1)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify Add subterm	**Pneumonia** (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9 - interstitial J84.9 - - usual J84.1	Australia	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments

Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Not supported	What is the meaning of the word "usual" in this context? Is it equivalent to "Common"? The term seems to be unclear and weak and it should not be promoted. Since J84.9 includes 'Interstitial pneumonia NOS' the term usual should be included there. Why cannot 'Idiopathic pulmonary fibrosis' be used if that is the problem patient has?
North America		NACC Morbidity will respond with second round review. **Second round comment:** Tend to support; more clinical input could be useful. Usual Interstitial pneumonia is a type of idiopathic pulmonary fibrosis. Include at J84.1.
United Kingdom		Will obtain comments from clinical colleagues
Roberto Becker		
Germany		We expect feedback from our clinical experts for the second round. 2nd round: the proposal is supported by our clinicians.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0313 Proposed by: Brazil

Change to Volume: I III Type of proposal: Major

Description (term/code): Post-polio syndrome

Proposal for update:

The proposal is to create a new code for Post-Polio Syndrome (PPS): G14

Post-Polio Syndrome (PPS)

1. Justification:

1.1 Definition

PPS is a neurological disorder characterized by a new or reoccurring muscular weakness and/or muscular fatigue abnormal in individuals who had acute poliomyelitis, many years before (DALAKAS, 1995).

Although this aggravation is a late effect of poliomyelitis, it is about a defined nosological entity, that we believe cannot be identified as a sequelae, since it characterizes itself as an evolving disease of diverse etiology and physiopathology compared to basic disease.

PPS is classified as motor neurone disease due to its histological and clinical chart being intimately related with the functions of inferior motor neurons. (DALAKAS, 1995).

1.2 Risk Factors

The risk factors to the development of PPS have not, until now, been elucidated accordingly. Based on repeated observations and epidemiological reports, however, the following factors seem to be associated with a precautious beginning of PPS: (1) New symptoms appear first, or could be firstly in the limbs previously damaged and in patients with more aggravated paralysis; (2) Precautious bulbar or respiratory difficulties occur in residual patients with loss of muscular strength of bulbar intervention and respiratory musculature; and (3) Symptoms occur precautious in patients who have acute poliomyelitis in a later age.

1.3 Physiopathology

Jubelt et al in 1999 conducted a study demonstrating the existence of 9 theories that explain the physiopathology of PPS, however the most welcome is of the "Super-training" formulated initially by Charcot, in 1875, and complimented and proven through electrophysiological studies by Dalakas et al since 1995.

In the acute infection of poliomyelitis, the virus damages the cells of the anterior medullary horn partially or totally, with denervation of some motor units through the neuronal plasticity, blossoming occurs renovating the denervated fibers although this last one depends on the number of preserved neurons after this period of recovery, we go to a period of latency, also called stability plateau. According to the theory of "super-training", thirty or forty years after the acute disease through the metabolic solicitation request from the giant motor units formed due to the neuronal recovery, there is the beginning of motor neuronal failure, mainly in the distal portions of the ***axonius***, bringing it to a new denervation known as new weakness and muscular atrophy.

1.4 Clinical Aspects

The symptoms and signals of PPS include a combination of muscular skeletal symptoms of the progressive muscular atrophy, post-poliomyelitis (AMPP) (DALAKAS, 1995).

These symptoms classified as more frequent include: new muscular weakness, new muscular atrophy with or without the presence of muscular and articular pain. There is still other symptoms although less frequent in evidence: muscular weakness of bulbar innervations, intolerance to cold, myalgia, fasciculations, new breathing difficulties, and sleep apnea.

In the research developed in UNIFESP-EPM, we have verified the presence of other forms of clinical occurrences including sleep disorders, increase of corporal weight, memory disorders, dizziness, syncope, and morning headache related to sleep disorder. Studies

conducted in diverse populations show the same characteristics having percentual as the only variation. Another important factor is the duration of the interval between the acute disease and the beginning of PPS symptoms is a determining factor with the highest rate of incidence of thirty to forty years.

1.5 Incidence and Prevalence

This may vary according to the definition of PPS, from diagnosed criteria used and also of population research undertaken.

Brazil: In depictive studies made in the Neuromuscular disease ward of Escola Paulista de Medicina UNIFESP, were found respectively 68% and 77.2% of incidents among the patients that were consulted (OLIVEIRA, 2002; QUADROS, 2004).

Japan: In a study conducted in the RECUPERATION WARD of Cosmos Hospital, Usuki city, County of Ohita, found 85% of incidents and a prevalence of PPS in Kitakyushu was of 18 cases/100,000 inhabitants (TAKEMURA, 2004).

Norway: The study in 1994 was made through national medical reports, and of social situations, and in a total of 2392 cases of poliomyelitis victims, many of whom registered in “the national association of polio victims” in Norway with a prevalence of 85% of PPS (GRELH, 1996).

Germany: A study conducted found evidence of 68.07% of PPS in patients. (TIENVOLL, 1997).

New Zealand: A loss of muscular strength was related in 47%, and it is estimated that there maybe a number of 3000-5000 polio survivors in New Zealand, that may be suffering from PPS (CHETWYND, 1993).

Australia: It is estimated that at least 20,000 – 40,000 individuals developed paralyzing poliomyelitis from 1930-1988.

Scotland: A study conducted in Edinburgh found 67% of PPS (PENTLAND, 1999).

Denmark: 54% of PPS was found (LONNBERG, 1992).

Sweden: 18.6% of PPS was found in a research (AHLSTROM, 1993).

Canada: It is estimated that 66,000 survivors exist and that approximately two thirds have or will develop PPS (URIADKA, 1997).

United Kingdom: 74,280 cases were reported and the incidence of PPS found was 77% (BRUNO, 1997).

Europe: There is nearly 250,000 patients of PPS in Europe and 20,000, 000 around the world (BOSCH, 2004).

2. Final Considerations

Considering that PPS is an evolving clinical situation irreversible and incurable, related to the progressive dysfunction of the motor units, it cannot and should not be classified as a polio sequelae. Sequelae means (see thesaurus/dictionary). In ICD-10 a poliomyelitis situation is contemplated with the codes: A-80, A-80.0, A-80.1, A-80.2, A-80.3, A-80.4, A-80.9 and B-91, being in this way not possible to characterize PPS as a nosological entity defined in these categories.

In November of 2003, a group of associations of PPS in Europe, and 20 members of the European Parliament met and agreed to create the European Union of Polio having as a goal to obtain recognition and funds of the European Parliament (BOSCH, 2004).

It becomes fundamental for post-polio syndrome to be recognized as a nosological entity and it should have a specific characterization in ICD-10 due to the relevance of the legal and social assistance.

3. References:

Bosch B. Post-polio syndrome recognized by European Parliament. The Lancet Neurology. Vol. 3. Jan 2004.

Bruno, LR, A letter to a polio survivor. Kessler institute for rehabilitation inc. 1997.

Chetwynd J, Botting C, Hogan D. Postpolio syndrome in New Zealand: a survey of 700 polio survivors. N Z Med J. 1993 Sep 22; 106(964):406 –8.

Dalakas MC. **The Post-Polio Syndrome As an Evolved Cilinical Entity**. In: The Post-Polio Syndrome: Advances in the Pathogenesis and Treatment, Annals of the New York Academy of Sciences; 68-80; 1995.

Farbu E, Rekand T, Gilhus NE. Post-polio syndrome and total health status in a prospective hospital study. Eur J Neurol. 2003 Jul;10 (4):407-13.

Grehl O, Muller-Naendrup C, Jenni W. Postpolio syndrome: retrospective study in a former polio clinic Schweiz Rundsch Med Prax. 1996 Jan 3;85 (1-2):14-20.

Jubelt B; Drucker J. Poliomyelitis and the Post-Polio Syndrome. Reprinted from Motor Disorders edited by David S. Younger. Lippincott Williams & Wilkins, Philadelphia, Cap. 34; 1999.

Oliveira, ASB. Síndrome Pós-Poliomielite: Aspectos Neurológicos. Rev Neurociências 10(1): 31-34; 2002.

Oliveira, ASB; Quadros, AAJ; Conde, MTRP. Documento Técnico da Síndrome Pós-Poliomielite; 2004. (Material não publicado).

Quadros, AAJ. Síndrome Pos-poliomielite (SPP): Uma nova doença velha. Tese de mestrado UNIFESP/EPM. 2004 (Material não publicado)

Ramlow J, Alexander M, LaPorte R, Kaufmann C, Kuller L. Epidemiology of the post-polio syndrome. Am J Epidemiol. 1992 Oct 1; 136 (7):769-86.

Takemura J, Saeki S, Hachisuka K, Aritome K. Prevalence of post-polio syndrome based on a cross-sectional survey in Kitakyushu,Japan. J Rehabil Med. 2004 Jan;36 (1):1-3.

Tjensvoll AB, Gilhus NE. The post-poliomyelitis syndrome--a real complication. A poliomyelitis material from the Haukeland hospital Tidsskr Nor Laegeforen. 1997 Feb 10; 117(4):510-3.

Uriadka C. Physiotherapy management of the late effects of polio. Post-polio clinic, West Park Hospital, Toronto, Ontario, Canada, 1997.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
	Proposal: To include the code G14 in the Chapter VI-Diseases of the nervous System, in the grouping “Systemic atrophies primary affecting the central nervous system (G10-G13)	Brazil	Major	January 2009

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	Proposal: To include the code G14 in the Chapter VI-Diseases of the nervous System, in the grouping "Systemic atrophies primary affecting the central nervous system (G10-G13)	Brazil	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil		It was our proposal
France	Supported	We agree with the North American comment
Japan		
NORDIC	Not supported	See NACC comment. It is true that B91 may be difficult to find.
North America		NACC Morbidity believes further discussion is needed regarding a need for a new code. Creation of new code would seem to invalidate B91. As stated in the proposal the disorder is characterized by new or reoccurring weakness. Would B91 be used for reoccurring weakness and the suggested new code be used for new weakness? For easier data retrieval perhaps consideration should be to keep all instances at existing B91.

		Second round comment: Canada Mortality suggests expanding B91 (B91.0 for post-polio syndrome and B91.9, Other and unspecified).
United Kingdom		
Roberto Becker		
Germany	Supported	We also had a few inquiries regarding the coding of PPS.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0315 Proposed by: Mortality Reference Group

Change to Volume: I III Type of proposal: Minor

Description (term/code): White matter disease

Proposal for update:

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

Source: MRG PS6 Q18: See MF 2002-03-18_03 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions.

Current Volume 1, p. 887

R90.8 Other abnormal findings on diagnostic imaging of central nervous system

Abnormal echoencephalogram

Volume 3, p. 171

Disease, diseased – *continued*

-white blood cells D72.9

- - specified NEC D72.8

-white-spot, meaning lichen sclerosus et atrophicus L90.0

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Modify Add inclusion term	Recommended changes for Volume 1, p. 887 **R90.8 Other abnormal findings on diagnostic imaging of central nervous system** Abnormal echoencephalogram White matter disease NOS	MRG	Minor	January 2007

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date

Modify Add subterm	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	MRG	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	But we think that it is going to give a good reason for hundreds of abnormal findings on diagnostic imaging to be introduced in ICD
Japan		
NORDIC	Supported with modification	The recommendation of Robert Jakob was originally G98 'Other disorders of nervous system, not elsewhere classified' which includes 'Nervous system disorder NOS'. Although the usage of this expression really means that not much is known about the patient, specfially it's usage in a death certificate must mean more than just abnormal finding. As the term used in the

		proposal indicates the patient must have a disease, not just finding. The usage of this very unclear term should of course not be encouraged but Robert's original proposal seems to be most correct. Whether the term should at all be added to ICD is questionable.
North America		NACC Morbidity supports. **Second round comment:** NACC Morbidity and Mortality support
United Kingdom		Defer to mortality colleagues
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0317 **Proposed by:** **Mortality Reference Group**

Change to Volume: I III Type of proposal: Major

Description (term/code): Unspecified gastroenteritis

Proposal for update:

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.

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.

Source: MRG PS5 Q24: See Question 1997-12-12 01 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Delete text	**A09 Other diarrhoea and gastroenteritis of infectious and unspecified origin** ~~***Note*: In countries where any term listed in A09 without further specification can be assumed to be of non-infectious origin, the condition should be classified to K52.9~~ ~~Catarrh, enteric or intestinal~~ ~~Colitis | NOS~~ ~~Enteritis } haemorrhagic~~ ~~Gastroenteritis | septic~~ ~~Diarrhoea:~~ ~~- NOS~~ ~~- dysenteric~~ ~~- epidemic~~ ~~- Infectious diarrhoeal disease NOS~~	MRG	Major	January 2009
Add code and inclusion terms	*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:			

Add code and inclusion term	- 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			
Modify inclusion terms	p. 575-6 **K52 Other noninfective gastroenteritis and colitis**			
Modify exclusion note and add revised codes	**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, ~~or NOS in countries where the~~ Jejunitis | ~~conditions can be presumed to be of non-infectious origin~~ Sigmoiditis | ***Excludes***: colitis, diarrhoea, enteritis, gastroenteritis: - infectious (A09.0) - unspecified ~~in countries where the condition can be presumed to be of infectious origin (A09)~~ origin (A09.9) functional diarrhoea (K59.1) neonatal diarrhoea (noninfective) (P78.3) psychogenic diarrhoea (F45.3)			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterms and revised codes	p.58 **Arthritis, arthritic (acute) (chronic) (subacute)** M13.9 - in (due to) - - enteritis NEC A09.9+ M01.8*	MRG	Major	January 2009

	- - - infectious A09.0+ M01.8* - - - non-infectious K52.9+ M01.8* ... p. 60			
Add subterms and revised codes	**Arthropathy** (*see also* Arthritis) M13.9 . .. - in (due to) . .. - - enteropathic NEC ~~K52.9+~~ **A09.9**+ M07.6* - - - infectious A09.0+ M07.6* - - - non-infectious K52.9+ M07.6* p. 102			
Revise modifiers and add revised codes	**Colitis (acute) (catarrhal) (hemorrhagic) (~~presumed infectious~~)** (*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			
Revise code	- granulomatous K50.1			
	- infectious (*see also* Enteritis, infectious) A09.0			
	- ischemic K55.9			
	- - acute (fulminant) (subacute) K55.0			
	- - chronic K55.1			
Modify term	- - fulminant (acute) K55.0			
	- ~~noninfective~~ noninfectious K52.9			
	- - specified NEC K52.8			
Delete text	- polyposa K51.4			
	~~- presumed noninfective K52.9~~			
	- protozoal A07.9			
	- pseudomembranous A04.7			
Revise code	- 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 ... p. 158			
Revise modifiers and add revised codes	**Diarrhea, diarrheal (disease) (~~endemic~~) (infantile) ~~(presumed infectious) (summer) (~~** *~~see also~~* **~~Note at category A09) A09~~** **A09.9** - achlorhydric K31.8 - acute A09.9 - - bloody A09.0 - - hemorrhagic A09.9 - - watery A09.0 - allergic K52.2 - amebic (see also Amebiasis) A06.0- - - with abscess - see Abscess, amebic - - acute A06.0 - - chronic A06.1 - - nondysenteric A06.2 - and vomiting, epidemic A08.1 - bacillary - see Dysentery, bacillary - balantidial A07.0			

	- cachectic NEC K52.8 - *Chilomastix* A07.8 - chronic (noninfective) K52.9 - coccidial A07.3 - Cochin-China B78.0 - *Dientamoeba* A07.8 - dietetic K52.2 - due to - - bacteria A04.9 - - - specified NEC A04.8 - - *Campylobacter* A04.5 - - *Clostridium perfringens* (C) (F) A04.8 - - *Cryptosporidium* A07.2 - - *Escherichia coli* A04.4 - - - enteroaggregative A04.4 - - - enterohemorrhagic A04.3 - - - enteroinvasive A04.2 - - - enteropathogenic A04.0 - - - enterotoxigenic A04.1 - - - specified NEC A04.4 - - food hypersensitivity K52.2 - - specified organism NEC A08.5 - - - bacterial A04.8 - - - viral A08.3			

	- - *Staphylococcus* A04.8			
Revise codes	- - virus (see also Eteritis, viral) A08.4			
Add subterm	- - Yersinia enterocolitica A04.6			
	- dysenteric A09.0			
	- endemic A09.0			
	- epidemic A09.0			
	- flagellate A07.9			
	- functional K59.1			
	- - following gastrointestinal surgery K91.8			
	- - psychogenic F45.3			
	- *Giardia lamblia* A07.1			
Revise codes and add subterms	- giardial A07.1			
	- infectious A09.0			
	- inflammatory ~~A09~~ A09.9			
	- - infectious A09.0			
	- - noninfectious K52.9			
	- mycotic NEC B49+ K93.8*			
Revise text	- neonatal (noninfective) P78.3			
Delete text	- nervous F45.3			
	- noninfectious K52.9			
	~~- presumed noninfectious K52.9~~			
	- protozoal A07.9			
	- - specified NEC A07.8			
	- psychogenic F45.3			

	- specified - - bacterium NEC A04.8 - - virus NEC A08.3 - strongyloidiasis B78.0 - toxic K52.1 - trichomonal A07.8 - tropical K90.1 - tuberculous A18.3+ K93.0* - viral (*see also* Enteritis, viral) A08.4 .. .			
Revise code	p. 161 **Disease, diseased** - *see also* Syndrome - diarrheal, infectious NEC ~~A09~~ A09.0 ...			
Revise code and subterms	p. 191 **Dysentery, dysenteric (catarrhal) (diarrhea) (epidemic) (hemorrhagic) (infectious) (sporadic) (tropical)** ~~A09~~ A09.0 - amebic (*see also* Amebiasis) A06.0 - - with abscess - see Abscess, amebic - - acute A06.0			

	- - chronic A06.1 - arthritis A09.9+ M01.8* - - bacillary A03.9+ M01.3* - - infectious A09.0+ M01.8* - - noninfectious K52.9+ M01.8* - bacillary A03.9 - - arthritis A03.9+ M01.3* - - Boyd A03.2 - - Flexner A03.1 - - Schmitz(-Stutzer) A03.0 - - Shiga(-Kruse) A03.0 - - *Shigella* A03.9 - - - *boydii* A03.2 - - - *dysenteriae* A03.0 - - - *flexneri* A03.1 - - - group A A03.0 - - - group B A03.1 - - - group C A03.2 - - - group D A03.3 - - - *sonnei* A03.3 - - - specified type NEC A03.8 - - Sonne A03.3 - - specified type NEC A03.8 - balantidial A07.0			

	- *Balantidium coli* A07.0 - Boyd's A03.2 - candidal B37.8 - *Chilomastix* A07.8 - coccidial A07.3 - *Dientamoeba (fragilis)* A07.8 - *Embadomonas* A07.8 - *Entamoeba,* entamebic - *see* Dysentery, amebic - Flexner's A03.1 - *Giardia lamblia* A07.1 - Hiss-Russell A03.1 - *Lamblia* A07.1 - leishmanial B55.0 - metazoal B82.0 - monilial B37.8 - protozoal A07.9 - Salmonella A02.0 - schistosomal B65.1 - Schmitz(-Stutzer) A03.0 - Shiga(-Kruse) A03.0 - *Shigella* NEC (*see also* Dysentery, bacillary) A03.9 - Sonne A03.3 - strongyloidiasis B78.0 - trichomonal A07.8			

	- viral (*see also* Enteritis, viral) A08.4 .. .			
Revise modifiers and code	p.208 **Enteritis (acute) (diarrheal) (~~epidemic~~) (hemorrhagic) (~~presumed infectious)~~ ~~(septic) (~~*~~see also~~* **~~Note at category A09) A09~~** **A09.9** - allergic K52.2 - amebic (see also Amebiasis) A06.0 - - acute A06.0 - - - with abscess - see Abscess, amebic - - - nondysenteric A06.2 - - chronic A06.1 - - - with abscess - see Abscess, amebic - - - nondysenteric A06.2 - - nondysenteric A06.2 - bacillary NEC A03.9 - bacterial A04.9 - - specified NEC A04.8 - candidal B37.8 - *Chilomastix* A07.8 - chronic (noninfective) K52.9 - - ulcerative K51.9 - coccidial A07.3			

Add subterm and revise codes	- dietetic K52.2 - due to - - food hypersensitivity K52.2 - - infectious organism (bacterial) (viral) - *see* Enteritis, infectious - - *Yersinia enterocolitica* A04.6 - eltor A00.1 - epidemic A09.0 - gangrenous (*see also* Enteritis, infectious) A09.0 - giardial A07.1 - infectious NEC A09.0 - - due to - - - adenovirus A08.2 - - - *Aerobacter aerogenes* A04.8 - - - Arizona (bacillus) A02.0 - - - bacteria NEC A04.9 - - - - specified NEC A04.8 - - - *Campylobacter* A04.5 - - - *Clostridium perfringens* A04.8 - - - *Enterobacter aerogenes* A04.8 - - - enterovirus A08.3 - - - *Escherichia coli* A04.4 - - - - enteroaggregative A04.4 - - - - enterohemorrhagic A04.3 - - - - enteroinvasive A04.2			

	- - - - enteropathogenic A04.0 - - - - enterotoxigenic A04.1 - - - - specified NEC A04.4 - - - specified - - - - bacteria NEC A04.8 - - - - virus NEC A08.3 - - - *Staphylococcus* A04.8 - - - virus NEC A08.4 - - - - specified type NEC A08.3 - - - *Yersinia enterocolitica* A04.6 - - specified organism NEC A08.5 - influenzal (specific virus not identified) J11.8 - - influenza virus identified J10.8 - ischemic K55.9 - - acute K55.0 - - chronic K55.1 - microsporidial A07.8 - mucomembranous, myxomembranous - *see* Syndrome, irritable bowel - mucous - *see* Syndrome, irritable bowel - necroticans A05.2			
Revise subterm	- necrotizing of fetus or newborn P77 - neurogenic - *see* Syndrome, irritable bowel			
Delete text	- noninfectious K52.9 - parasitic NEC B82.9			

	- paratyphoid (fever) (*see also* Fever, paratyphoid) A01.4 ~~- presumed noninfectious K52.9~~ - protozoal A07.9 - - specified NEC A07.8 - regional (of) K50.9 - - intestine K50.9 - - - large (colon or rectum) K50.1 - - - - with small intestine K50.8 - - - small (duodenum, ileum or jejunum) K50.0 - - - - with large intestine K50.8 - rotaviral A08.0			
Add subterm	- *Salmonella*, salmonellosis (*arizonae*) (*cholerae-suis*) (*enteritidis*) (*typhimurium*) A02.0 - segmental K50.9 - <u>septic A09.0</u> - *Shigella* (see also Infection, Shigella) A03.9 - spasmodic, spastic - *see* Syndrome, irritable bowel - staphylococcal A04.8 - toxic K52.1 - trichomonal A07.8 - tuberculous (*see also* Tuberculosis) A18.3+ K93.0* - typhosa A01.0 - ulcerative (chronic) K51.9 - - specified NEC K51.8			

Revise code	- viral A08.4 - - adenovirus A08.2 - - enterovirus A08.3 - - *Rotavirus* A08.0 - - small round structured A08.1 - - virus specified NEC A08.3 . ..			
Add subterm and code	**Enterocolitis** (*see also* Enteritis) ~~A09~~ **A09.9** - due to *Clostridium difficile* A04.7 - fulminant ischemic K55.0 - hemorrhagic (acute) K55.0 - infectious NEC A09.0 - ischemic K55.9			
Add subterm and code	- necrotizing - - due to *Clostridium difficile* A04.7 - - fetus or newborn P77 - noninfectious NEC K52.9 - ulcerative (chronic) K51.0 . ..			
Revise modifiers and code	p. 244 **Gastroenteritis (acute)** ~~**(epidemic) (presumed infectious) (see also Note at**~~			

	~~**category A09) A09**~~ (*see also* Enteritis) **A09.9**			
	- allergic K52.2			
	- chronic (noninfective) K52.9			
	- dietetic K52.2			
	- due to			
Add subterm	- - *Cryptosporidium* A07.2			
	- - food poisoning (*see also* Intoxication, foodborne) A05.9			
	- - radiation K52.0			
	- eosinophilic K52.8			
Revise subterm	- epidemic A09.0			
	- food hypersensitivity K52.2			
	- infectious (*see also* Enteritis, infectious) A09.0			
	- nonbacterial, of infancy A08.5			
Add subterm	- noninfectious K52.9			
	- - specified NEC K52.8			
	- rotaviral A08.0			
	- salmonella A02.0			
	- septic A09.0			
	- toxic K52.1			
	- viral A08.4			
	- - acute infectious A08.3			
	- - epidemic A08.1			
	- - - type Norwalk A08.1			
	- - infantile (acute) A08.3			

Revise code and add subterms	- - Norwalk agent A08.1 - - rotaviral A08.0 - - severe, of infants A08.3 - - specified type NEC A08.3			
Revise modifiers	**Gastroenteropathy** (*see also* Gastroenteritis) ~~A09~~ **A09.9** - acute, due to Norwalk agent A08.1 - infectious A09.0 - noninfectious K52.9 . ..			
Revise code and add subterms	**Gastrojejunitis, noninfective ~~(presumed)~~** (*see also* Enteritis ~~and note at category A09~~) K52.9 . ..			
Revise code and add subterms	p. 284 **Ileitis** (*see also* Enteritis) ~~A09~~ A09.9 - infectious A09.0 - noninfectious K52.9 - regional or terminal (ulcerative) K50.0			
Revise codes	**Ileocolitis** (*see also* Enteritis) ~~A09~~ A09.9 - infectious A09.0 - noninfectious K52.9 - ulcerative (chronic) K51.1			

Revise code and add subterms Add code and subterm Delete non-essential modifier	. .. p. 290 **Infection, infected (opportunistic)** B99 . .. - alimentary canal NEC (*see also* Enteritis, infectious) ~~A09~~ A09.0 . .. . .. - colon (*see also* Enteritis, infectious) ~~A09~~ A09.0 . .. - enteric (*see also* Enteritis, infectious) ~~A09~~ A09.0 . .. - gastrointestinal (*see also* Enteritis, infectious) ~~A09~~ A09.0 . .. - intestine, intestinal (*see also* Enteritis, infectious) ~~A09~~ A09.0 . .. p. 304 **Inflammation, inflamed, inflammatory (with exudation)** . .. - ileum (*see also* Enteritis) ~~A09~~ A09.9 - - infectious A09.0 - - noninfectious K52.9 . ..			

Revise code and add subterm Delete non-essential modifier	p. 322 **Jejunitis** - *see also* Enteritis **A09.9** - infectious A09.0 - noninfectious ~~(presumed)~~ K52.9 . ..			
Revise code	p. 499 **Sigmoiditis** (*see also* Enteritis) ~~A09~~ **A09.9** - infectious A09.0 - noninfectious ~~(presumed)~~ K52.9 . .. p. 553 **Ulcer, ulcerated, ulcerating, ulceration, ulcerative** L98.4 . .. - dysenteric NEC ~~A09~~ A09.9 . ..			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported in principle	We have made a number of corrections and changes to the suggested changes area within the document, as they were too hard to list here. 1. What is the difference between acute bloody diarrhea and acute hemorrhagic diarrhea? 2. Is it necessary to change the subterms 'noninfective' to 'noninfectious'?
Brazil	Supported	This is, for us, a very important proposal
France		We didn't have time to work on this question
Japan		
NORDIC	Supported with hesitation	The original point that in all countries most cases of unclear diarrhoea are of infectious origin is correct. That has created a problem especially in morbidity statistics and it should be corrected. However, adding a new code is questionable. We are dealing with following situations : Gastroenteritits with known infectious etiology — Current: A00-A08 — Proposed: A00-A08 Gastroenterits with (presumably) infectious but unknown etiology — Current: A09 — Proposed: A09.0 Gastroenteritis with unknown but presumably infectious etiology (most usual clinical situation) — Current: A09 — Proposed: A09.9 Gastroenterits with unknown (presumably) non-infectious etiology — Current: K52.9 — Proposed: K52.9

		Gastroenterits with known non-infectious etiology K52.0-K52.8 K52.0-K52.8 At least following points need to be discussed. 1. If A09.0 is added, the exact text has to be considered. The German proposal is most appealing. 2. The new group A09.9 '**Gastroenteritis and colitis of unspecified origin'** is a rest group and the problem is, if it can be distinguished from other groups at issue. 3. The term septic should be used with caution. In many languages it is mixed with septicaemia although it possibly here means 'purulent' i.e. with pus. Possibly another word should be selected.
North America		NACC Morbidity support as is. Amend title to read as original. **Second round comment:** NACC Morbidity and Mortality support as is.
United Kingdom		
Roberto Becker		
Germany	Supported	I wonder whether the title of A09.0 should better read "Other and unspecified gastroenteritis and colitis of infectious origin".
Robert Jakob		
MRG		Change the suggested indexing concerning arthritis and arthropathy: Arthritis, arthritic (acute)(chronic)(subacute) M13.9 - in (due to) - - enteritis NEC A09.9+ M14.8* - - - infectious NEC A09.0+ M14.8*

		- - - non-infectious NEC K52.9+ M14.8* ... Arthropathy (see also Arthritis) M13.9 - in (due to) - - enteritis NEC A09.9+ M14.8* - - - infectious NEC A09.0+ M14.8* - - - non-infectious NEC K52.9+ M14.8* Also change the indexing of Enteritis ... - with septicemia NEC A09.9 ... and of Gastroenteritis ... - with septicemia NEC A09.9 ...

		We agree with the suggestion from Germany on the title of A09.0.

URC recommendations to WHO HoC:

URC Reference No: 0318 Proposed by: Mortality Reference Group

Change to Volume: II Type of proposal: Major

Description (term/code): Note 4.2.2 (b) Infections in A00-B99

Proposal for update:

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).

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.

Source: MRG PS2 Q1 (PS7 Q4)

Current Volume 2, section 4.2.2 for 2006 implementation
(http://www3.fhs.usyd.edu.au/ncch/downloads/official_WHO_updates_combined%201996%20to%202003.pdf)

4.2.2 Interpretation of "highly improbable"

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) any infectious disease may be accepted as "due to" disorders of the immune mechanism such as human immunodeficiency virus [HIV] disease or AIDS;

(b) an infectious or parasitic disease (A00-B99) reported as "due to" any disease outside this chapter, except that:

- diarrhoea and gastroenteritis of presumed infectious origin (A09))
- septicaemia (A40-A41))
- erysipelas (A46)) may be accepted as "due to"
- gas gangrene (A48.0)) any other disease,
- Vincent's angina (A69.1))
- mycoses (B35-B49))
- any infectious disease may be accepted as "due to" immunosuppression by chemicals (chemotherapy) and radiation.
- any infectious disease classified to A00-B19 or B25-B64 reported as "due to" a malignant neoplasm will also be an acceptable sequence,
- varicella and zoster infections (B01-B02) may be accepted as "due to" diabetes, tuberculosis and lymphoproliferative neoplasms;

(c) a malignant neoplasm reported as "due to" any other disease, except human immunodeficiency virus (HIV) disease;

(d) haemophilia (D66, D67, D68.0-D68.2) reported as "due to" any other disease;

(e) 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);

(f) 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.-);

(g) any hypertensive condition reported as "due to" any neoplasm except:

- endocrine neoplasms,
- renal neoplasms,
- carcinoid tumours;

(h) chronic ischaemic heart disease (I20, I25) reported as "due to" any neoplasm;

(i)

(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);

(j) any condition described as arteriosclerotic [atherosclerotic] reported as "due to" any neoplasm;

(k) influenza (J10-J11) reported as "due to" any other disease;

(l) 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;

(m) 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);

(n) 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;

(o) 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.

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

Suggested changes to the classification:

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Modify Delete text	Volume 2, p. 67 ~~**4.2.2 Interpretation of "highly improbable"**~~ ~~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) any infectious disease may be accepted as "due to" disorders of the immune mechanism such as human immunodeficiency virus [HIV] disease or AIDS;~~ ~~(b) an infectious or parasitic disease (A00-B99) reported as "due to" any disease outside this chapter, except that:~~ ~~• diarrhoea and gastroenteritis of presumed infectious origin (A09)~~ ~~• septicaemia (A40-A41)~~ ~~• erysipelas (A46)~~ ~~may be accepted as "due to" any~~	MRG	Major	January 2009

Add text	~~• gas gangrene (A48.0)) disease~~ ~~• Vincent's angina (A69.1))~~ ~~• mycoses (B35-B49))~~ ~~• any infectious disease may be accepted as "due to" immunosuppression by chemicals (chemotherapy) and radiation;~~ ~~• any infectious disease classified to A00-B19 or B25-B64 reported as "due to" a malignant neoplasm will also be an acceptable sequence;~~ ~~• varicella and zoster infections (B01-B02) may be accepted as "due to" diabetes, tuberculosis and lymphoproliferative neoplasms;~~ **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 Chlamydia 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) ~~(c)~~ (b) a malignant neoplasm reported as "due to" any other disease, except human immunodeficiency virus (HIV) disease; (d) (c) haemophilia (D66, D67, D68.0-D68.2) reported as "due to" any other			

	disease; ~~(e)~~ (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); ~~(f)~~ (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.-); ~~(g)~~ (f) any hypertensive condition reported as "due to" any neoplasm except: • endocrine neoplasms, • renal neoplasms, • carcinoid tumours; ~~(h)~~ (g) chronic ischaemic heart disease (I20, I25) reported as "due to" any neoplasm; ~~(i)~~ (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);

~~(j)~~ (i) any condition described as arteriosclerotic [atherosclerotic] reported as "due to" any neoplasm;

~~(k)~~ (j) influenza (J10-J11) reported as "due to" any other disease;

~~(l)~~ (k) a congenital anomaly (Q00-Q99) reported as "due to" any other disease of the individual, ~~including immaturity~~ 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;

~~(m)~~ (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);

~~(n)~~ (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; ~~(o)~~ (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			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		Morbidity : no comments. Mortality : comments to be forwarded for second round.
Brazil		With this proposal we will have a very good orientation for the interpretation of « Highly improbable and acceptable sequences ». Very good for the coders!
France		Morbidity : no comment
Japan		
NORDIC	Supported with slight modification	There is small spelling problem. Because the structure of the part dealing with infectious diseases is changed the points after infections get very difficut to understand. Therefore the text should be modified as follows : 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 rules about "highly improbable" should be applied**: ….. ~~(c)~~ (b) **A** malignant neoplasm **is highly improble** "due to" any other disease, except human immunodeficiency virus (HIV) disease; (d) (c) **H**aemophilia (D66, D67, D68.0-D68.2) **is highly improbable** "due to" any other disease; ~~(e)~~ (d) **D**iabetes (E10-E14) **is highly improbable** "due to" any other disease except **etc** Although this expression is a few characters longer, it is much more user friendly, because each item is understandable without

		looking backwards to the beginning of the list.
North America		NACC Morbidity supports. **Second round comment:** NACC Morbidity and Mortality support
United Kingdom		Defer to mortality colleagues
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0327 Proposed by: North America

Change to Volume: I Type of proposal: Minor

Description (term/code): Ulcerative oesphagitis

Proposal for update:

Ulcerative esophagitis is an acceptable alternate term for ulcer of the esophagus.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add inclusion term	K22.1 Ulcer of oesophagus Erosion of oesophagus Ulcer of oesophagus: • NOS • Due to ingestion of: • Chemicals • drugs and medicaments	North America	Minor	January 2007

	• fungal • peptic Ulcerative oesophagitis Use additional external cause code (Chapter XX), if desired, to identify cause.			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not supported	We feel that K22.1 *Ulcer of oesophagus* relates to single discrete ulcers and diagnoses such as drug-induced ulcer, malignant ulcer, foreign body-induced ulcer. Our clinicians prefer the assignment of K21.0 *Gastro-oesophageal reflux disease with oesophagitis* for ulcerative oesophagitis.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Suported	Among the existing entries are situations which clearly cause multiple ulcerations.
North America		
United Kingdom		
Roberto Becker		

Germany	Supported	Index entry is necessary.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0328 Proposed by: North America

Change to Volume: I III Type of proposal: Major

Description (term/code): Dysplasia of prostate

Proposal for update:

Physicians in Canada agree that better understanding or progression of PIN to Ca prostate suggests it should be clearly identified for both clinical statistical reasons. Index entries will be added if proposal is accepted.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add code, inclusion notes and exclusions	**N42.3 Dysplasia of prostate** Low grade (mild) (moderate) dysplasia of prostate Prostatic intraepithelial neoplasia I (PIN I) Prostatic intraepithelial neoplasia II (PIN II) *Excludes*: prostatic intraepithelial neoplasia III (PIN III) (D07.5) high grade (severe) dysplasia of prostate (D07.5)	North America	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	It is very good and necessary this new sub-category N42.3
France	Supported	
Japan		
NORDIC	Not supported	This is related to URC case n:o 0301 and they should probably be discussed together. In this case the question is why these neoplasias should not be coded as neoplasms i.e either in D07.5 'In situ neoplasm of prostate' , D40 'Neoplasm of uncertain or unknown behaviour of prostate'. or D29.1 'Benign neoplasm of prostate'.
North America		
United Kingdom	Supported(morbidity)	Suggest separate 4th characters for PIN 1 and PIN 11
Roberto Becker		
Germany	Supported in principle	High grade dysplasia usually comprises PIN II and PIN III. Thus, in the GM we have assigned PIN II and III to D07.5 and only PIN I to chapter XIV. I suggest that to be verified by other countries.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0332 Proposed by: North America

Change to Volume: I III Type of proposal: Major

Description (term/code): Systemic inflammatory response syndrome

Proposal for update:

Systemic Inflammatory Response Syndrome (SIRS) is a clinical response to an insult, infection or trauma, that includes systemic inflammation, elevated or reduced temperature, rapid heart rate and respiration and elevated white blood count. The medical community recognizes SIRS as a major complication of infection or trauma. SIRS is a condition frequently associated with stays in the Intensive Care Unit (ICU). For patients admitted to the intensive care unit with septicemia, the symptoms of SIRS are generally present. The non-infectious etiologies of SIRS include trauma, burns, bleeding, adrenal insufficiency, anaphylaxis, cardiac tamponade, dissecting or ruptured aortic aneurysm, drug overdose, myocardial infarction, post-cardiopulmonary bypass syndrome and pulmonary embolism.[1]

An insult to the body produces signs and symptoms (e.g. fever and leukocytosis) of a *systemic inflammatory response syndrome* (SIRS), when infection is the underlying cause of SIRS, the condition is called *sepsis*. When sepsis is accompanied by dysfunction in one or more vital organs, the condition is called *severe sepsis*. When severe sepsis is accompanied by hypotension that is refractory to volume infusion, the condition is called *septic shock*.[2]

[1] Gorbach, Sherwood L., Falagas, Matthew, 5-Minute Infectious Diseases Consult, 1st. Edition.
[2] Marino, Paul L., ICU Book, 2nd. Edition,

Our research shows that as many as 50% of patients in critical care units in Canadian hospitals may suffer from SIRS. Canadian physicians state that SIRS is now quite well defined and that there are well-defined criteria to separate SIRS from sepsis and other causes as noted above. There is currently no method of classifying this syndrome in ICD-10. It appears that since the diagnosis of SIRS depends on the presence of certain signs and symptoms, it may be classified under Chapter XVIII - Signs and Symptoms, using additional codes to identify any related organ failure. However, till agreement can be reached we propose category U05 for SIRS.

Index entries will be added if proposal is accepted.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add	**U05 Systemic inflammatory response syndrome [SIRS]**	North America	Major	January 2009

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	We provide general definitions such as above in our coding standards for SIRS and with the current classification, the

		following is the best we can do : SIRS should be coded as follows: • SIRS due to infection is coded according to the appropriate index entry at *Sepsis*. • SIRS due to trauma is coded according to the type of trauma. • SIRS due to clinical insult other than infection is coded to the type of insult (eg pancreatitis, ischaemia). We would welcome a new, unique code for this condition.
Brazil	Supported	Taking in account that SIRS currently is a very well described syndrome we are against to code it in the chapter XVIII. Till a further discussion for us UO5 is a appropriated code!
France	Supported a new code	We agree with the german proposition
Japan		
NORDIC	Supported	See German comments
North America		US Morbidity says it may be useful to add usage notes as was done in U.S. and German clinical modifications. **Second round comment:** Canada Mortality supports the classification of SIRS pending resolution of the comments made by Brazil and Germany.
United Kingdom		
Roberto Becker		
Germany	Supported in principle	SIRS was included into the GM for 2005 at R65 as follows: R65 SIRS

		R65.0 SIRS of infectious origin without organ failure R65.1 SIRS of infectious origin with organ failure R65.2 SIRS of non-infectious origin without organ failure R65.3 SIRS of non-infectious origin with organ failure R65.9 SIRS, unspecied The problem with the inclusion of SIRS is the overlap with the codes for sepsis. In the GM the coding instructions say: • The SIRS codes must not be used for primary coding. The condition leading to SIRS must be coded first, i.e. one of the sepsis codes or any other condition leading to SIRS. That makes sure that the underlying condition is coded and the sepsis codes are used. The additional "infectious SIRS" codes make sure that severe cases can be distinguished from less severe cases. The "non-infectious SIRS" codes make sure that the condition can be coded at all. • Additional codes have to be used to identify the kind of organ failure. We know that this solution is not yet satisfactory and are open to proposals from other countries to improve the situation.
Robert Jakob		
MRG		We support the suggestion from Germany. It is important that the cause of the SIRS is always coded when known.

URC recommendations to WHO HoC:

URC Reference No: 0334 Proposed by: North America

Change to Volume: I Type of proposal: Minor

Description (term/code): Other chemotherapy

Proposal for update:

The term chemotherapy is often restricted to drugs used to treat neoplasms. We propose that the title of code Z51.2 Other chemotherapy be changed to say pharmacotherapy as this term is more universal.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Revise code title Add inclusion term	Z51.2 Other ~~chemotherapy~~ pharmacotherapy Antibiotic therapy Maintenance chemotherapy NOS Excludes: prophylactic chemotherapy for immunization purposes (Z23-Z27, Z29.-)	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	We have introduced this terminology into our procedure classification, so would agree with the proposed changes in ICD-10.
Brazil	not supported	For us the term « chemotherapy » is used and is not necessary to change to « pharmacolotherapy »
France	Not supported	We agree with the german comment
Japan		
NORDIC	Something is needed	It is obvious already from this discussion that the term chemotherapy is understood in several ways. It should be made clear what it actually is supposed to mean.
North America		US Morbidity will respond with second round review. **Second round comment:** Canada Mortality defers to NACC Morbidity for response in second round review.
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Not supported	This proposal changes the meaning of Z51.2. To our opinion this code is intended for anti-infectious chemotherapy, not for pharmacotherapy in general, see e.g.the index entry Therapy - intravenous (IV) without reported diagnosis Z51.8
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0336 **Proposed by:** **Mortality Reference Group**

Change to Volume: III Type of proposal: Minor

Description (term/code): Viral gastritis

Proposal for update:

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

Source: MRG PS8 Q12 (MRG-MMDS 2004-06-08): See MF 2004-05-25_01 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions.

Current Volume 3, p. 243

Gastritis (simple) K29.7

-tuberculous A18.8 + K93.8 *

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add subterm and code	Recommended changes for Volume 3, p. 243 **Gastritis (simple)** K29.7 -tuberculous A18.8 + K93.8 * -viral B33.8	MRG	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not yet supported	Why should gastroentertitis, viral go to A08.4 and gastritis, viral, go to B33.8. Is there clinically a great difference between these conditions?
Brazil	Supported	
France	Not supported	We don't think that B33.8 is a good choice to describe viral gastritis. We prefer A08.4 or A09
Japan		
NORDIC	Not supported	It is unclear what viral gastritis actually means. Viral gastroenteritis may be manifested as only vomiting and possibly that is called 'viral gastritis'. The 3 main symptoms of a fully developed gastroenteritis are vomiting, diarrhea and fever. The same

		infection may in different persons and in different phases of the disease manifest with any of these symptoms and the disease may be limited to one of these symptoms. The disussion on mortality forum was based on a rather unusual case with fatal outcome in a 91 years old woman. Gastroenteritis limited to gastric symptoms is a very usual clinical situation that needs to be coded together with other gastroenterits. A08.4 includes already gastroenteritis and if necessary it should be modified to cover viral gastritis also. If the rubric of the group A00-A09 stating 'intestinal' is a problem, it should be changed to 'gastrointestinal'
North America		NACC Morbidity supports.
United Kingdom	Not supported (morbidity)	
Roberto Becker		
Germany	Not yet supported	The Australian comment should be considered.
Robert Jakob		
MRG		The MRG suggests a code in Chapter I, since infections are generally excluded from Chapter XI. We do not think that "gastritis" belongs in the block A00-A09, however. This block is for intestinal conditions and strictly speaking the stomach is not a part of the intestinal tract. Since "gastroenteritis" involves both stomach and intestines that term does not show the correct code for "gastritis".

URC recommendations to WHO HoC:

URC Reference No: 0337 Proposed by: Mortality Reference Group

Change to Volume: I Type of proposal: Major

Description (term/code): Subsequent myocardial infarctions

Proposal for update:

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

Source: MRG PS5 Q28 (withdrawn URC 0198): See Question 1999-10-04_03 (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related discussion in the Mortality Forum.

Current 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)
- Specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset (I25.8)
- Subsequent (I22.-)

Postmyocardial infarction syndrome (I24.1)

I22 Subsequent myocardial infarction

Includes: recurrent myocardial infarction

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

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Modify	Recommended changes for 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	MRG	Major	January 2009

Add exclusion note		Excludes: certain current complications following acute yocardial 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)			
Add inclusion note	**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)			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	International standardisation of this definition is welcomed. There is still the issue that Canada raised via the URC forum on how to classify 'extended MI'. This terminology is used in Australia as well.
Brazil	Supported	
France		We didn't had time to work on this subject
Japan		
NORDIC	Unclear position	There is a disagreement on the usage of coding of subsequent myocardial infarctions in Nordic countries. The Finnish ICD-10 is very close to the interpretation in this proposal. The Swedish translation has added the time limit of 4 weeks. Following is the Swedish view that Finnish side would not accept. « There is clinical disagreement on this proposal. For morbidity coding in routine clinical work, an acute myocardial infarction should be coded I21.- regardless of how many previous AMIs the patient has had. If there is a subsequent infarction within 28 days, this is important clinical information that should be coded I22.- Information on a historical myocardial infarction (Previous myocardial infarction more than 28 days earlier than the present) is best captured by I25.2

		It seems that the MONICA study is not relevant for clinicians' need for logical coding. » It seems that even though the official version would be changed this would not be accepted by all countries. In practice the only way to standardize international statistics is to combine I21 and I22 in all calculations. This problem should be solved in the revision to ICD-11 where the translations should be better controlled.
North America		NACC Morbidity will respond with second round review. **Second round comment:** NACC Mortality supports NACC Morbidity believes more discussion needed
United Kingdom	Supported (morbidity)	
Roberto Becker		
Germany	Supported in principle	It should be checked whether an additional code for "subsequent subendocardial myocardial infarction" is needed for morbidity purposes.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0339 Proposed by: North America

Change to Volume: II Type of proposal: Minor

Description (term/code): Colitis with anthrax

Proposal for update:

A review of the volume III of ICD-10 and CIM-10 has uncovered what appear to be discrepancies in the code directions between the English and French language versions of the index. These differences are brought to the URC to determine which index is correct.

ICD-10 index:

Colitis (acute)(catarrhal)(hemorrhagic)(presumed infectious)(see also Enteritis, and note at category A09) A09

- anthrax A22.2

CIM-10 index

Colite(aiguë)(exsudative)(gangréneuse)(hémorragique)(infectieuse)

(nécrotique)(phlegmoneuse)(septique) (due à) A09

- charbonneuse (B.anthracis) A22.2† K93.8*

Suggested changes to the classification:

Changes will be suggested to the appropriate classification following decision of the members of the URC.

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		I am assuming that the B22.2 in the ICD-10 index should be A22.2 (just a typo here). We would support the English version – the addition of K93.8 adds no further information.
Brazil	no opinion	These is not « Colitis » with « anthrax » or « charbonneuse (B.anthracis) in the Portuguese version of the Volume III
France		We think that the french version is correct, but we have no opinion for K93.8. When I worked on the French alphabetic index of the CIM 10, I asked several times André about the oportunity of adding an asterisk code and it was not so easy to have a clear rule on this point. As we use the asterisk code as a principal diagnosis in the French DRG's system, I probably add too much asterisk codes.
Japan		
NORDIC	A22.2	Agree with Australia
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		
Germany		We assume that B22.2 is a typo and have corrected that. As K93.8* does not really add information we are in favour of A22.2

Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0340 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Athropathy with dermatological disorders NEC

Proposal for update:

The French version of the index provides a general look-up for arthropathy with dermatological disorders not elsewhere classified that does not appear in the English index. The excerpt from CIM-10 appears below:

Arthropathie (à)(de)(*voir aussi* Arthrite) M13.9

- associée à, au cours de, due à (*voir aussi* Arthropathie, réactionelle) M02.9
- - affection(s)
- - dermatologiques NCA L98.9† M14.8*

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
ICD -10 index	**Arthropathy (*see also* Arthritis) M13.9** - reactive M02.9	North America	Minor	January 2007

	- - dermatological disorders NEC L98.9† M14.8*			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	The reason is explain under URC reference N° 339
Japan		
NORDIC	Supported	This is typical example of both good and bad sides of dagger-asterisk system. For the alphabetical index this is very complicated, because the number of specific reasonable combination is high. On general level we get very unclear examples like the one given here. Compaired with M13.9 the pair only adds the information that the arthropathy is related to a skin disease. In most cases it would be possible to combine M14.9. with a more specific code like L51.9 'Arthropathy in erythema: multiforme' or L52.9 'Arthropathy in erythema: nodosum'.
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		

Germany	Not supported	The unspecific dagger code is not really helpful.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0341 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Index directions to category ranges

Proposal for update:

There are multiple lead terms within the French version of the index where the user is directed to a range of categories from which to select the appropriate dagger code. In the English version, the index directs the user to a specific dagger code and the statement to *see also* has not been added. Should the English index have the ranges added? Examples of where these occur in the French index are shown below:

Arthropathie (à)(de)(*voir aussi* Arthrite) M13.9

- associée à, au cours de, due à (*voir aussi* Arthropathie, réactionelle) M02.9
- - hémophilie (*voir aussi* rubriques D66-D68) D66† M36.2*
- - hépatite virale (*voir aussi* rubriques B15 – B19) B19.9† M03.2*
- - leucémie (M9800/3) (*voir aussi* rubriques C91-C95) C95.9† M36.1*
- - mycose NCA (*voir aussi* rubriques B35-B49) B49† M01.6*
- - troubles hématologiques NCA (voir aussi D50-D77) D75.9† M36.3*

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add see also notes	**Arthritis, arthritic (acute)(chronic)(subacute)** M13.9 - in (due to) - - hematological disorder NEC (see also categories D50-D77) D75.9† M36.3* - - mycosis (see also categories B35-B49) B49† M01.6* **Arthropathy (*see also* Arthritis) M13.9** - in (due to) - - hemophilia NEC (*see also* categories D66-D68) D66† M36.2* - - leukemia NEC (M9800/3) (see also categories C91-C95) C95.9† M36.1* - - viral hepatitis (postinfectious) NEC (see also categories B15 –B19) B19.9† M03.2* - -	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Partially supported	We have no major objections to these changes, however this appears to be a general convention in ICD-10, which occurs in many other instances in the alphabetic index. We always advise our coders that if they have more detailed information, eg the type of leukaemia, then assign that code as the 'dagger' code.
Brazil	Supported	

France	Supported	Supported
Japan		
NORDIC	Supported	Agree with Australian comment. The additional information of the unspecific dagger code is not great but still something. The see also instruction should be useful.
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		
Germany	Not supported	Again we think that the unspecific dagger codes are not really helpful.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0342 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Hurler (Scheie) disease or syndrome E76.0

Proposal for update:

The French version of the ICD-10 index directs the user to a dagger/asterisk combination for this condition at the lead term Dégénérescence. This direction does not appear in the English version of the index.

CIM-10 reads as follows:

Dégénérescence

- cerveau (corticale)(diffuse)(parenchymateuse)(progressive) G31.9
- - au cours de
- - - maladie ou syndrome de
- - - - Hurler E76.0† G32.8

Assuming that the translation for the English index would be to Degeneration as a lead term, we propose the following update to the ICD-10 index.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Add subterms and codes	***Degeneration, degenerative*** - brain (cortical)(progressive) G31.9 - - in Hurler (Scheie) disease or syndrome E76.0† G32.8	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Not supported	Since Mucopolysaccharidosis, type I (Hurler-Scheie) always results in degenerative changes of brain, the asterisk code is really not adding any information. Irrispective if the pari is listed in the index or not this is a valid coding that may be used if for example in the local statistics the nervous system diseases should be found with G-codes. This will never work as an international standard.

North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		
Germany	Not supported	We have added the missing asterisk to the index entry. Again we think that the unspecific asterisk code is not helpful.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0344 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Stenosis of the intervertebral foramina

Proposal for update:

The French and English versions of the index lead to different codes for this condition:

CIM-10 index

Rétrécissement

- espace intervertébral (par)(voir aussi Détérioration, disque) M51.3
- - ossification M99.6
- - subluxation M99.6
- - tissu conjonctif et discal M99.7

ICD-10 index

Stenosis (cicatricial) *see also* Stricture

- intervertebral foramina M99.8
- - connective tissue M99.7

- - disk M99.7
- - osseous M99.6
- - subluxation M99.6

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
	Stenosis (cicatrical) see also Stricture We have not proposed changes at this time but defer to the URC for direction.	North America		

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We are seeking clinical advice on this issue. Should stenosis of this area be classified as a type of degeneration?
Brazil		Portuguese version of Volume III is similar to the French index

France		The use of M99.- is not realy clear for us. When I asked André about it, I understood that those codes were created for osteopath (but maybe I am wrong). That's why I probably made a mistake, though there is no code for "rétressissement du canal rachidien sans precision (unspecified)" under M99.- and your proposition is to code "Other biomechanical lesions" which is not a good description.
Japan		
NORDIC		Clinically narrowing of the spinal canal, nerve root canals, or intervertebral foramina due to spondylosis and degenerative disk disease seem to referred combined as spinal stenosis. Since this is an increasing problem, it is not acceptable that a very unspecific code like M99.8 would be used for it. M51.3 is neither correct because the etiology is not always intervertebral disc degeneration. Perhaps more correct code would be M48.0 'Spinal stenosis'?
North America		Language issues? **Second round comment:** Canada Mortality supports the use of the single ICD-10 code.
United Kingdom		
Roberto Becker		
Germany		As M51.3 assumes that the stenosis is due to the intervertebral disc we would prefer M99.8
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0346 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Hesselbach's hernia

Proposal for update:

There seems to be a discrepancy in the index for Hesselbach's hernia that is dependent on the lead term used.

Hernia, hernial

- Hesselbach's - *see* Hernia, femoral by site

Hesselbach's hernia - *see* Hernia, abdomen, specified site NEC

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date

	We have not posed suggested changes at this time as we defer to the members of the URC to help determine which index entry is correct.	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		ICD-9 classified this hernia to abdominal, via both the above index entries. Perhaps the 'femoral, by site' was an error.
Brazil		In the Portuguese version of Volume III we have « Hesselbach's hernia – see Hernia, abdomen, specified site NEC »
France	No opinion	
Japan		
NORDIC		Hesselbachs hernia = A hernia with diverticula through the cribriform fascia, presenting a lobular outline Cribriform fascia or Hesselbach's fascia Description: The cribriform fascia covering the femoral canal. As stated by Germany this is a femoral hernia which should be coded with K41.-. No reference with 'see' is needed.
North America		NACC Morbidity will respond with second round review. **Second round comment:** Support clarifying the indexing. Still to resolve how best to do this. Hesselbach's hernia. Schwartz's Principles of Surgery, 8th Ed. (2005), has a table indicating that Hesselbach's is a synonym for an external femoral hernia. However, Sabiston's Textbook of Surgery, 15th Ed. (1997), identifies Hesselbach's triangle as being bounded by the inferior epigastric vessels, the rectus muscle, and the inguinal ligament below; this is the site of direct inguinal hernias.

		It also notes that originally in 1814, Hesselbach's triangle was bounded below by Cooper's ligament (thus it appears it may have included the site of at least some femoral hernias). Schwartz Principles of Surgery, 7th Ed. (1999), also describes that direct inguinal hernias go through Hesselbach's triangle. It also states that femoral hernias are usually considered a separate entity but are actually a form of direct inguinal herniation. Canada Mortality supports the need for consistency between ICD-10 and CIM-10 for this cause, deferring to URC for resolution.
United Kingdom		
Roberto Becker		
Germany		In German medical language Hesselbach's hernia is a synonym for a lateral fermoral hernia, also called Cooper's hernia. Thus we are in favour of "see Hernia, femoral by site".
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0347 Proposed by: MRG

Change to Volume: II Type of proposal: Minor

Description (term/code): Volume 2, page 39 – Expanding the list of pneumonias considered obvious consequence of other serious conditions

Proposal for update:

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.

Suggested changes to the classification:

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Add text	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.	MRG	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil		
France		
Japan		
NORDIC	Supported	
North America		US Mortality supports
United Kingdom		
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0348 Proposed by: MRG

Change to Volume: I II III Type of proposal: Minor

Description (term/code): Pulmonary edema as direct consequence of heart disease

Proposal for update:

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. 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.

Source: MRG PS5 Q54, PS6 Q25. See MF 1997-04-14_02-03 at http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm for related discussion in the Mortality Forum.

Suggested changes to the classification:

Instruction	Tabular list entries	Source	Major/Minor update	Suggested implementation date
Delete text	**I50.1 Left ventricular failure**	MRG	Minor	January 2007

Delete text	~~Acute~~ oedema of lung |_ with mention of heart disease ~~Acute~~ pulmonary oedema | NOS or heart failure Cardiac asthma Left heart failure **J68.1 ~~Acute~~ pulmonary oedema due to chemicals, gases, fumes and vapours** Chemical pulmonary oedema (acute)			

Instruction	Instruction manual entries	Source	Major/ Minor update	Suggested implementation date
Add text	Certain postoperative complications (pneumonia (any type), haemorrhage… <u>Heart failure (I50.-) and unspecified heart disease (I51.9) should be considered an obvious consequence of other heart conditions.</u> 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	MRG	Minor	January 2007

	that impair the immune system….			

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify text – place "acute" in parentheses and reduce number of indents accordingly	Edema, edematous R60.9 - lung **(acute)** J81 - - with heart condition or failure (*see also* Failure, ventricular, left) I50.1	MRG	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		
Brazil		
France		
Japan		

NORDIC	Supported	
North America		US Mortality supports
United Kingdom		
Roberto Becker		
Germany	Supported	
Robert Jakob		

URC recommendations to WHO HoC:

Section 3: Recommendations held over and include in the URC work program

0 work items

Section 4: Recommendations not supported or withdrawn

3 work items

0279 Polyneuropathy

0282 Neoplasia of nervous system

0326 Hamartoma

URC Reference No: 0279 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Polyneuropathy

Proposal for update:

There is a discrepancy between Volume I and Volume III for tuberculous polyneuropathy.

G63.0* Polyneuropathy in infectious and parasitic diseases classified elsewhere

Polyneuropathy (in):
· diphtheria (A36.8+)
· infectious mononucleosis (B27.-+)
· leprosy (A30.-+)
· Lyme disease (A69.2+)
· mumps (B26.8+)
· postherpetic (B02.2+)
· syphilis, late (A52.1+)
· congenital syphilis, late (A50.4+)
· tuberculosus (A17.8+)

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Polyneuropathy - tuberculosus A17.8+ ~~G05.0*~~ G63.0*	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		We cannot find the index entry that you are referring to.
Brazil	Supported	
France		It's correct in the French version
Japan		
NORDIC		See Australian comment
North America		This may be a German clinical modification issue. Index entries in the original ICD-10 and the new browser version show

		A17.8 and G63.0.
United Kingdom	Not supported (morbidity)	The index entry in the UK version is correct ; Polyneuropathy -in - - tuberculosis A17.8† G63.0 *
Roberto Becker		
Germany		I have corrected a typo and added the missing dagger code. **2nd round**: This proposal is retracted. It refers to an error in the German edition only. Sorry for the confusion.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0282 Proposed by: Germany

Change to Volume: III Type of proposal: Major

Description (term/code): Neoplasia of nervous system

Proposal for update:

Error correction. Entries belonging to neoplasia of nervus(i) olfactorius(i) in volume I and ICD-O-3 are leading to C72.2 but they don't in volume III.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Neuroepithelioma (M9503/3) - olfactory (M9523/3) ~~C30.0~~ C72.2	Germany	Major	January 2009
Revise code	Neuroblastoma (M9500/3) - olfactory (M9522/3) ~~C30.0~~ C72.2			

Revise code	Tumor - neurogenic olfactory (M9520/3) ~~C30.0~~ C72.2			

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Not supported	We can't find any evidence in ICD-0-3 for this change. In our version of the publication, all of the above tumours are linked to C30.0.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported	C72.2 includes both olfactory nerve and olfactory bulb. Since all mentioned situations are of neural origin, it is obvious that they belong to this group.
North America	Supported	
United Kingdom		
Roberto Becker		
Germany		**Second round comment:** We would like to retract this proposal. If really necessary, we will come out with a new one for 2007.

Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0326 Proposed by: North America

Change to Volume: III Type of proposal: Minor

Description (term/code): Hamartoma

Proposal for update:

Morphology code missing in ICD-10

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Add morphology code	Hamartoma -lung (M8251/0) D14.3	North America	Minor	January 2007

URC members comments:

URC members	Proposal supported/	Comments

	not supported	
Australia		There is currently no subterm at all for lung under **Hamartoma.** ICD-0-3 refers to SNOMED
Brazil	Supported	
France	Not supported	The SNOMED code is M755500 witch is not in the tabular list of ICD 10
Japan		
NORDIC	Supported	A simple search in the Internt indicates that hamartomas occur in addition to lungs in hypothlamus, skin and spleen at least. Should they be also added?
North America		
United Kingdom		Unable to find this in original or 2000 index.
Roberto Becker		
Germany	Not yet supported	I am uncertain whether the morphology code is correct. M8251/0 stands for alveolar adenoma.
Robert Jakob		

URC recommendations to WHO HoC:

Section 5: Issues Discussed by MRG Not Requiring Changes to ICD-10

13 items

Issue 1: Cardiovascular disease and hypercholesterolaemia

Issue 2: Subacute sclerosing panencephalitis

Issue 3: Laennec's cirrhosis

Issue 4: Final code for SARS

Issue 5: Longstanding tuberculosis

Issue 6: Injuries with no nature-of-injury code

Issue 7: Underlying cause and record axis fields

Issue 8: R95 due to J00

Issue 9: Refractory anemia and myelodysplastic syndrome

Issue 10: Influenza and cardiomyopathy

Issue 11: Cerebrovascular diseases and myocardial infarction

Issue 12: Accidents due to natural causes

Issue 13: Valvular diseases and myocardial infarction

For URC Members' Information

Following is a list of questions that the MRG has discussed to date but for which the MRG decided not to make any recommendations for change. The MRG decided that URC members would benefit from knowing the MRG's decisions.

Issue 1: Cardiovascular disease and hypercholesterolaemia

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS6 Q27.

Date of decision: 2004

Issue 2: Subacute sclerosing panencephalitis

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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

Source: MRG PS7 Q4. See MF 2003-09-23_04 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions.

Date of decision: 2004

Issue 3: Laennec's cirrhosis

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS8 Q4 and PS6 Q33. URC 0192 and URC 0205.

Date of decision: 2004

Issue 4: Final code for SARS

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS8 Q7, URC 0204

Date of decision: 2004

Issue 5: Longstanding tuberculosis

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS5 Q27: See MF 2000-05-08_02 and 2001-04-23_03 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions..

Date of decision: 2004

Issue 6: Injuries with no nature-of-injury code

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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

Source: MRG PS3 Q4.

Date of decision: 2004

Issue 7: Underlying cause and record axis fields

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS9 Q11 (MRG-MMDS 2004-09-09).

Date of decision: 2004

Issue 8: R95 due to J00

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS9 Q5.

Date of decision: 2004

Issue 9: Refractory anemia and myelodysplastic syndrome

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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

Source: MRG PS9 Q12.

Date of decision: 2004

Issue 10: Influenza and cardiomyopathy

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS9 Q14.

Date of decision: 2004

Issue 11: Cerebrovascular diseases and myocardial infarction

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.-

Source: MRG PS8 Q1.

Date of decision: 2004

Issue 12: Accidents due to natural causes

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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.

Source: MRG PS9 Q6 (URC 0049): See MF 1997-11-16_04-05,07 at (http://www.pubcare.uu.se/nordwho/verksam/mortforum/mortindex.htm) for related Mortality Forum discussions..

Date of decision: 2004

Issue 13: Valvular diseases and myocardial infarction

Recommendation: No action necessary.

Please describe the reason(s) for decision and attach any supporting documentation.

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

Source: MRG PS8 Q2.

Date of decision: 2005

Section 6: Errata second edition of ICD-10

3 work items

0274 Von Recklinghausen's

0275 Neoplasm, laryngopharynx

0277 Cleaner, paint or varnish

URC Reference No: 0274 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Von Recklinghausen's

Proposal for update:

Error in the morphology code.

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify morphology code	**Von Recklinghausen's** - disease (neurofibromatosis) (M95401) Q85.0 Change M95401 into M9540/1	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia		The inclusion of this morphology code was an official update in 1997 for 1999. The forward slash in the code appears in the official update document and in the ICD-10 eBook. Is this an error in ICD-10 Second Edition, hard copy? We have not received our alphabetic index of this edition yet, so this may be the problem.
Brazil	Supported	
France	Supported	
Japan		
NORDIC	Supported if not corrected already	
North America		NACC (Morbidity and U.S. Mortality) support. **Second round comment:** This is not an update, it's an Errata. Entry is correct on browser and original ICD10 index but is incorrect in 2nd print version.
United Kingdom	Not supported (morbidity)	This has already been corrected in the 2000 edition that Morbidity use in the UK, the change was agreed in 1997 for implementation in 1999 (listed in the cumulative updates for 2003)
Roberto Becker		
Germany		This proposal is retracted. It refers to an error in the German edition only. Sorry for the confusion.
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0275 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Neoplasm, laryngopharynx

Proposal for update:

C14.1 must be changed to C13.9 (code was deleted)

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Modify	Neoplasm, neoplastic – **laryngopharynx** C13.9 C79.8 D00.0 D10.9 D37.0	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	
Brazil	Supported	
France		It's correct on the French version
Japan		
NORDIC	Supported	
North America		NACC Morbidity supports replacing C14.1 with C13.9 (code was deleted). **Second round comment:** U.S. Mortality notes that this is confusing. C14.1 was deleted in the original version of ICD-10. The index entry is correct in the English version. Is this a problem with the German version? 7/19 This is not an update, it's an Errata. Entry is correct on browser and original ICD10 index but is incorrect in 2nd print version.
United Kingdom	Not supported	C14.1 was deleted in the original corrigenda, the existing neoplasm table is correct which reads as C13.9

	(morbidity)	C79.9 ,D00.0 ,D10.9 and D37.0
Roberto Becker		
Germany		I have corrected a typo – instead of C14.1 read C13.9
Robert Jakob		

URC recommendations to WHO HoC:

URC Reference No: 0277 Proposed by: Germany

Change to Volume: III Type of proposal: Minor

Description (term/code): Cleaner, paint or varnish

Proposal for update:

Y66.- must be changed to X66.-

Suggested changes to the classification:

Instruction	Alphabetic index entries	Source	Major/Minor update	Suggested implementation date
Revise code	Cleaner, cleansing agent NEC **– of paint or varnish** T52.9 X46. ~~Y66.~~ X66.- Y16.	Germany	Minor	January 2007

URC members comments:

URC members	Proposal supported/ not supported	Comments
Australia	Supported	This was an official change in 1997 for 1999.
Brazil	Supported	
France		It's correct on the French version
Japan		
NORDIC	Supported	
North America	Supported	NACC (Morbidity and U.S. Mortality) support **Second round comment:** Error in 2nd edition index, correct in browser, incorrect in original index but corrected in 1997.
United Kingdom	Not supported (Morbidity)	This correction was agreed in 1997 for implementation in 1999 and has been published in the 2000 reprints used by UK (Morbidity) Listed in the cumulative updates for 2003
Roberto Becker		
Germany		I have corrected a typo and added the dash.

		Second round comment: This official change has so far been missing in the hardcopy and in the master files. It will be present in the 2006 files.
Robert Jakob		

URC recommendations to WHO HoC: