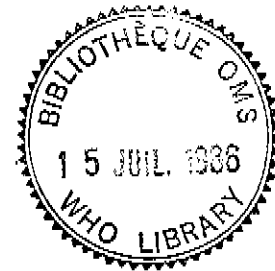




MEETING OF HEADS OF WHO COLLABORATING  
CENTRES FOR THE CLASSIFICATION OF DISEASES

Tokyo, Japan  
22 - 30 April 1986



REPORT

1. Introduction

Dr K. Kupka, Chief Medical Officer, Development of Epidemiological and Health Statistical Services (DES Unit), formally opened the meeting on behalf of the Regional Director and Director-General of WHO. Dr K. Hasegawa welcomed the participants on behalf of the Ministry of Health and Welfare, Japan. All those attending the meeting were also welcomed by Dr A. Tanaka, Chairman of the Japanese Committee on Statistical Classification of Diseases, Injuries and Deaths, Ministry of Health and Welfare, who had been involved in the deliberations in preparing the Ninth Revision. The importance of the activity on the Tenth Revision was emphasized.

Dr A. Tanaka was elected Chairman of the meeting and Dr G. Cerkovnyi Vice-Chairman. Dr M.R. Alderson and Mr R.A. Israel were elected joint Rapporteurs.

Dr Cerkovnyi, who was chairing the meeting on behalf of Dr Tanaka, proposed that the agenda be adopted and this was accepted by the meeting.

It was pointed out that the main function of the meeting was to assist in the preparation of the second draft proposals for the Tenth Revision, at the four-character level, for circulation to all member countries prior to the Expert Committee Meeting in 1987. It was considered important that the meeting clarify some particular areas where special discussion was required prior to circulation of the chapter proposals.

2. Reports of activities of WHO Collaborating Centres for the Classification of Diseases

The report of the Centre for North America (WHO/DES/ICD/C/86.4) drew particular attention to the arrangements that would be made in the United States for reviewing the proposals on the Tenth Revision. It had apparently been suggested that inadequate discussion was held prior to the Ninth Revision. A much more extensive programme of consultation had been initiated. This was likely to generate conflicting ideas; the US Committee on Vital and Health Statistics would have to adjudicate and resolve any controversy. It was also indicated how time-consuming discussions of the AIDS coding issues had been; the coding procedure invoked for this would be discussed later in the meeting.

Next, the report for the Sao Paulo Centre (WHO/DES/ICD/C/86.10) was presented. Again there was emphasis that the majority of the Centre's time had been spent on the ICD-10 proposals. The report also indicated that the International Classification of Primary Care (ICPC) had been translated into Portuguese prior to the consultation on primary care classifications held in Geneva from 11 to 15 November 1985.

In the report of the Paris Centre (WHO/DES/ICD/C/86.13), attention was drawn to the education of coders, an attempt to improve the coding of certain causes of death, and the issue of regionalization of coding death certificates. Tables on preliminary results of the examination of violent deaths were attached to the report, together with an analysis of the use of the Classification of Impairments, Disabilities, and Handicaps.

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The report for the London Centre (WHO/DES/ICD/C/86.11), particularly drew attention to curtailment of funding of work, the problem occasioned by detailed consultation and the impact this had both upon timeliness of response and resolution of conflicting views. The increased coding queries that had resulted from implementation of multiple-cause coding of death certificates were also mentioned. In further discussion of the report, it was indicated that the mortality emphasis was on use of combined codes, whilst morbidity coding would predominantly utilize manifestation where two codes were available for a complex condition. The present UK procedures require every term mentioned on the certificate to be coded. Therefore others stressed the desirability of exchanging information on guidance for multiple-cause coding.

The Moscow Centre report (WHO/DES/ICD/C/86.16), emphasized that efforts had been concentrated on the proposals on the Tenth Revision, with a Committee chaired by the First Deputy Minister of Health, and involving chairmen of national societies in the fields of medicine and directors of specialized institutes. In answer to a question, it was agreed that the report on coding of certain causes of death would be sent to DES Unit who would arrange translation and circulation. Adaptation of the terminology used in Volume 2 of the English-language version of ICD-9 to identify appropriate phrases for use in the Russian language had been necessary.

The report for the Beijing Centre (WHO/DES/ICD/C/86.15) described the development of the index to ICD-9 as an essential step towards the enhanced use of ICD in China. The workshop on the certification of death was the first in China, and further courses would be run when the Volume 2 was available. In answer to a request from DES Unit, the Centre agreed to produce a paper on the country view of the requirements for ICD-10 short lists.

The Nordic Medico-Statistical Committee (NOMESCO) report (WHO/DES/ICD/C/86.12), described the areas of work covered by the different working groups, particularly that involved in classification within the health statistics field. It was confirmed that Iceland had introduced ICD-9 a few years ago, Finland, Norway and Sweden would do so for 1987 events, and Denmark may not implement that revision. The possibility of creating a Centre for Classification in the Nordic countries was being explored.

Dr Hideko Yoshimura was welcomed as the new Chief of the Office of ICD; she presented the report on ICD related activities in Japan (WHO/DES/ICD/C/86.17). An appreciable section of the report related to the issue of impairments, which would be discussed later in the meeting. The Office of ICD agreed to present details on the revised definitions for fetal death which were likely to be introduced in Japan.

### 3. ICD-training material

The material on training that had been circulated was briefly introduced (WHO/DES/ICD/C/86.7, WHO/DES/ICD/C/86.9, and the final appendix to WHO/DES/ICD/C/86.11). A lot of the material related to reorientation courses that had been used in the past. It was emphasized that there was also a need for (1) basic training material that was not revision specific, and was suitable for coders whether they were going to handle mortality or morbidity material; (2) advanced training that would be specific to either mortality or morbidity coding, and would include detail on rules. Basic training material had recently been tried out on a ten-day course in Sri Lanka and indicated what was required for countries with no past coding experience. It was commented that material was also required to introduce clinicians to the usage of coded material. There was some discussion on the difficulty of maintaining a training programme for national or regional coding centres which only have one or two coders. DES Unit requested the other Centres to send in an inventory of any material that was available in their country, including that on media other than written documents (e.g. slides, tapes, etc.).

### 4. Chapter proposals for ICD-10

DES Unit indicated that there were some general problems which required resolution, and applied to several or all of the chapters of the ICD-10 proposals. The general issues were:

- (1) The heading for each chapter should be made consistent using the term disease or disorder.
- (2) The Ninth Revision contained some inconsistencies in the allocation of asterisks to manifestations, and there was no clear principle in the allocation of dagger and asterisk categories for ICD-10. Guidance on this was required.
- (3) Contrary to the recommendation of the first Expert Committee on ICD-10, the second draft proposal retained post-surgical syndromes in the system chapters.
- (4) Proposals had been made for the inclusion of fifth-digits for certain chapters in spite of the Expert Committee recommendation not to go beyond four characters.
- (5) There was a wide range of potential uses of the ICD and it was not clear whether the ICD-10 should basically be utilized for mortality with more extensive classifications for morbidity and other specific usage. Aligned to this issue was whether the three-character level presently allocated was correctly balanced between the different chapters, and also guidelines were required on where the ICD basic classification stopped and where the family of classifications started.
- (6) There were conflicting proposals for blood and immunity disorders.
- (7) The Council for International Organizations of Medical Sciences (CIOMS) had provided a nomenclature for certain diseases, but this was not available for all chapters. Even for some of the chapters covered by the CIOMS nomenclature there were likely to be conflicting views (for example, where rickettsioses should be allocated in ICD-10).

The Chairman pointed out that it had been agreed at earlier meetings that the dagger and asterisk system was to be utilized, the classification should be equally suitable for mortality and morbidity; and there should be a three-character code with a fourth-character for additional detail.

After a lengthy discussion, each Centre was invited to comment about their view on continuation of the dagger and asterisk system: the Beijing Centre wanted to keep the system, provided good guidelines were developed; the Sao Paulo Centre and the Office of the ICD, Japan agreed with this view as did the North American Centre which also wanted the system to be limited in scope; NOMESCO said a system was required to fulfil the present functions of the current dagger/asterisk system; the Paris Centre objected to a system which allows the coding of the same condition in more than one place in the classification and preferred to do without the dagger/asterisk system; and the London Centre could implement this system but was concerned about having redundant codes in the classification and also whether it did make the coding work hard for some countries without sophisticated computer systems; the Moscow Centre agreed with the previous decision to implement the system and said that either the dagger/asterisk or an equivalent approach was required to retrieve etiology and manifestation. The WHO Regional Office for the Western Pacific reported that some countries in the region might find it very hard to implement the dagger/asterisk system. After further discussion, it was agreed that the North American Centre would provide draft guidelines by June 1986, particularly focusing on the essential structure for the system.

There was a general comment about the suitability of the classification for different purposes and it was emphasized that there should be a general manual of the ICD codes, with different sets of instructions to facilitate quite different applications. The idea of producing different versions of ICD each containing the same basic classification scheme but with different instructions for each application was rejected unanimously.

#### INFECTIOUS AND PARASITIC DISEASES (WHO/DES/ICD/C/86.01)

This proposal was examined in relation to the WHO paper RSD/85/25. The following points were made:

- (1) There was a separation of viral and bacterial diseases, and the CIOMS recommendations had been used in grouping certain agents such as Rickettsia and Chlamydia with the bacteria. A new section had been created grouping infections with a predominantly sexual mode of transmission.
- (2) For tuberculosis there had been upgrading to the three-character level of information formerly classified at the fifth-digit level, though the space allocated in the draft conflicted with that in the RSD/85/25 paper with one less code for tuberculosis being used.
- (3) Other changes related to leprosy and other mycobacteria, zoonoses, tetanus neonatorum, the handling of toxic shock syndrome, AIDS, the addition of liver fluke in helminthiasis, the ability to code infection of uncertain cause, and the handling of late effects.
- (4) In certain sections other and unspecified infections were given a three-character level code.
- (5) The subclassification of viral hepatitis.

The meeting suggested that there might be too much detail in the tuberculosis section, and that inactive tuberculosis might be transferred to the chapter on Factors influencing health status and contact with health services. Trichomoniasis (A60.2) needed to be expanded as for gonococcal infection; Plasmodium falciparum malaria (A80) should indicate drug resistance; sarcoidosis (B85) might move to another chapter; uro-genital herpes might require more detailed specification of site.

There was a request that nosocomial infections should be separately identified, but others considered these might go to the chapter on External causes of morbidity and mortality.

Bacteraemia could be diagnosed without the agent involved being known and this should be coded even if symptomless. There was some discussion as to whether bacteria in certain diseases should be identified with double codes.

The proposed classification of tuberculosis was considered to be a major innovation, though it had been argued for on the grounds of epidemiological value. It was suggested that tuberculosis and leprosy were very different conditions and should not remain in the same group.

There was a question on the appropriate title and content of the chapter and it was confirmed that these should relate to infections that could affect multi-systems.

#### NEOPLASMS (WHO/DES/ICD/C/86.02)

The revision of this chapter was presented by IARC. It was pointed out that Annex III of the document was the current version recommended, though it was still subject to change from comments presently being submitted. It was an expanded and revised version of that circulated previously, and its structure was hybrid (using anatomy, histology, and tissue axes). Attention was drawn to the various changes that had been introduced in relation to ICD-9, and particularly the expansion for non-Hodgkin lymphoma and associated conditions.

It was mentioned that ICD-0, which had met with wide acceptance, now required an update. It was anticipated that this would be circulated by the end of 1986.

Further detail was then presented on the classifications of Hodgkin and non-Hodgkin lymphoma. It was pointed out that for mortality a relatively limited range of codes was satisfactory, but for interest in morbidity, there was increasing demand to meet the needs of specialists. The new proposal in Annex III was such that different classifications could be coded using these proposals. The codes would also separate the lymphomas arising in lymph nodes from the extra-nodal lymphomas; with the ICD-9 structure, no such distinction was made. Lymphomas of unspecified site would be allocated to lymph nodes on the balance of probability.

The proposals were in general welcomed by the Heads of Centres. There was support for separate classification of mesothelioma, the amalgamation of male and female breast cancer, and the detail on the lymphomas. There was some discussion on the need for the use of .7 as the fourth character in the codes for other specified sites. It was suggested that wherever possible .8 be used for overlapping lesions only; it was agreed that where appropriate and on a practicable basis this might be utilized.

DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM (WHO/DES/ICD/C/86.03)

DES Unit asked for further guidance about the handling of disorders involving the immune mechanism (D80-D87) and whether the asterisk codes provided were appropriate.

It was suggested that the sickle-cell anaemia (D58.3) should be considered sickle-cell disease, which was not necessarily appropriately placed within the anaemia section.

ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES (WHO/DES/ICD/C/86.04)

The immune deficiencies had been moved to the previous chapter, diabetes had been revised but it needed confirmation that this was appropriate, the asterisk categories remained as in the Ninth Revision, there was also a need to consider whether hypothyroidism should distinguish between congenital thyroid deficiency and cretinism; there have been very few comments from the bodies consulted, and it was felt that there might be other areas for possible change that needed to be identified.

It was pointed out that carcinoid syndrome (E32.0) could only occur with malignant carcinoid syndrome and it was therefore a manifestation. If the condition was mentioned without the primary condition it was not clear how this should be coded.

MENTAL DISORDERS (WHO/DES/ICD/C/86.05)

The DES Unit introduction informed that there were many more subdivisions than in the Ninth Revision. The problems were: the need for definitions and a glossary, which was in draft and would be much more extensive than before; there was also some overlap between certain codes and other chapters (for example psychological distress related to the menstrual cycle (F53) and premenstrual tension syndrome (N94.0)). Homosexuality if resulting in disturbance was coded within psychological and behavioural problems associated with sexuality (F67). There had been an attempt to align the classification with DSM III. It was reported that those responsible for the proposals on mental disorders and the authors of DSM III had achieved major alignment and the two groups were continuing to work together.

The Chairman suggested that in general the meeting would follow the views of experts. There was a question about the use of the expression recurrent depression, and it was accepted that this identified a very different syndrome in comparison with the recurrence of other conditions coded in chapters on physical disease.

It was suggested that drug dependence (F15) should be handled with the same sub-structure as combined alcohol and drug dependence (F18).

It was stated that in some countries unspecified mental disorder was a relatively frequent diagnosis and therefore needed to be identified in the classification. No immediate solution to this was found.

DISEASES OF THE NERVOUS SYSTEM (WHO/DES/ICD/C/86.06)

DES Unit drew attention to the frequent use of the asterisk, and the mixture of anatomy and designated disorder. For epilepsy, quite different approaches had been suggested. Advice would be requested to see whether the recommendation of the International League Against Epilepsy had general support.

There was considerable concern about the frequent identification of manifestations, which might be acceptable if they were not covered in adequate detail elsewhere in the classification - there was a strong opposition to asterisk categories where these duplicated other diagnostic rubrics.

It was suggested that parasitic infections of the central nervous system in diseases classified elsewhere (G09\*) might be removed; there was no clear identification of Reye syndrome which might go to cerebral degenerations (G20); hereditary, motor and/or sensory neuropathy (G60) was not clear; and other disorders of the nervous system in diseases classified elsewhere (G90\*) was not necessarily appropriately placed.

#### DISORDERS OF THE EYE AND ADNEXA (WHO/DES/ICD/C/86.07)

The different use of the terms disease and disorder in this chapter and the chapter of Diseases of the ear and mastoid process, and the fact that there were no "blocks" of categories in these chapters was drawn to the attention of participants.

It was agreed that the overall title of the ICD implied disease, that certain chapters warranted the expression disorder (for example the mental chapter), but in the above mentioned chapters there was some mixture of disease and disorder and this might be avoided in the category titles by only mentioning the site to which the title applied.

#### DISEASES OF THE EAR AND MASTOID PROCESS (WHO/DES/ICD/C/86.08)

DES Unit identified the presence of symptoms and queried whether these should be left as in the Ninth Revision.

Again there was objection to the use of asterisk categories which duplicated the information contained in primary codes.

#### DISEASES OF THE CIRCULATORY SYSTEM (WHO/DES/ICD/C/86.09)

DES pointed out that this chapter required careful study. In particular: the grouping of rheumatic heart disease had been changed; hypertensive diseases were not provided with a combination code for other heart diseases, though it has been requested by many countries; acute myocardial infarction (I22) had been changed, including combination of ICD-9 codes 410 and 411; pulmonary heart disease and other forms of heart diseases had been changed; a new rubric had been provided for sudden cardiac death syndrome, as it was thought that some such deaths in the Ninth Revision went into the symptom chapter as sudden deaths of unknown cause.

There was considerable discussion about the sudden cardiac death syndrome; one query was how to code a patient who had a sudden cardiac event but did not die; another issue was the introduction of diagnostic factors, or certainty of diagnosis (for example acute myocardial infarction (I22) and sudden cardiac death syndrome (I46)).

There was a query about the terminology of right heart failure rather than congestive heart failure, and also arrhythmia versus dysrhythmia (CIOMS nomenclature had been followed). As far as sudden death was concerned, it was suggested that certain cerebrovascular deaths might also be uniquely identified.

In comparing sudden cardiac death syndrome (I46) and acute myocardial infarction (I22) there was a need for change or possible suppression of the fourth-character detail. Centres were asked to consult experts on this.

Insufficiency and failure were distinct terms in the English language, but were synonymous in French and Portuguese. Careful translation was required.

Others supported the concept of pre-infarction syndrome, conduction disorders (I44) and cardiac dysrhythmias (I45), seem reminiscent of the Ninth Revision, though DES Unit confirmed it had been changed, while there was a suggestion that cardiac arrest (I45.6) might be used for cases with insufficient precision.

It was felt that cerebrovascular diseases (I60-I69), though changed a lot, still presented difficulty, particularly with late effects. A query was raised about when one started counting an interval for hospital patients; was this admission or discharge?

There appeared to be no appropriate code for cerebral or cranial aneurysm that was unruptured, though this presented medical problems.

The Chairman concluded that DES Unit would consult with the WHO Cardiovascular Diseases Unit prior to circulating the second draft proposal for ICD-10. Individual centres would consider the above points in particular at the next round of consultation.

#### DISEASES OF THE RESPIRATORY SYSTEM (WHO/DES/ICD/C/86.010)

Not all the recommendations contained in the associated expert paper RSD/85/25 had been implemented. In particular that expert group was not familiar with the chronic respiratory diseases and further attention was warranted on these aspects (such as coding for pneumoconiosis, asthma, etc.). Further proposals would be welcomed. Hypersensitivity pneumonitis due to organic dust (J87) involved a change in title and terminology; there was a request to include smoking as an agent (different views were expressed as to whether this should be included in this chapter, or dealt with in the chapters on External causes of morbidity and mortality or on Factors influencing health status and contact with health services). There was a suggestion that the age limit for bronchitis that was considered acute might be increased to 15 years and this would particularly be suitable for certain countries where the assumption was valid.

Other requests were that chronic bronchitis and chronic obstructive pulmonary diseases might be separated; acute pulmonary oedema, unspecified (J68) was usually due to cardiac cause, and guidance was required as to whether this should go to the cardiovascular chapter, and the particular circumstances in which it was relevant to respiratory diseases. Pleural plaques were of increasing concern in addition to other problems with asbestosis and may warrant a specific code.

#### DISEASES OF THE DIGESTIVE SYSTEM (WHO/DES/ICD/C/86.011)

There had been an extension of some groups, e.g. for the oral cavity; some conditions had been moved to symptoms (constipation and haemorrhage); and hernias had been completely rearranged.

Alcoholic liver disease (K72) should identify chronic alcoholic hepatitis, and biliary cirrhosis needed to be split into primary and secondary. There was also a request to separate regional ileitis and Crohn disease, and also diverticulosis and diverticulitis. Irritable bowel syndrome (K57) might be changed to irritable colon, and there was a need to separate some of the conditions in abscess of anal and rectal region (K61) and anal and rectal polyp (K62) at the four-character level. It was pointed out that schistosomiasis causes fibrosis instead of cirrhosis.

#### DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE (WHO/DES/ICD/C/86.012)

DES asked for comments by the end of the year, particularly on whether lichen planus-like eruptions [graft versus host disease] (L26) was clear or required appreciable change, and whether decubitus ulcer (L56) warranted classification at the three-character level.

The United States had a proposal which would be compatible with SNODERM; it appeared to be too detailed and contained conditions which were coded to other chapters in ICD. However, the organization concerned might be prepared to develop a special version if this was considered appropriate.

#### DISEASES OF THE MUSCULOSKELETAL SYSTEM (WHO/DES/ICD/C/86.013)

This draft stemmed from the work of an expert, and with advice from the International League Against Rheumatism. DES Unit emphasized that it was an extremely detailed chapter,

had provision for extensive fifth-digit detail, and had a major use of asterisk categories. An important point was whether the chapter could be condensed appreciably prior to circulation. After extensive discussion, it was suggested that DES Unit might remove the fifth-digits, perhaps by transferring this to the four-character level and omitting a lot of the present four-character detail. Such a simpler and shorter draft chapter would be suitable to circulate, with the specialist groups being invited to finalize a more detailed extension for their own use. It was not clear whether time was available to do this in conjunction with expert advice. DES Unit should inform the appropriate nongovernmental organization accordingly.

Other points discussed were: acquired deformities (as included in the Seventh to Ninth Revisions) were not in the present draft, though it was not clear what was their relationship to ICDH; the title of M67 (rupture of synovium and tendon, non-traumatic) appeared to be inappropriate; there was a need to consider the growth areas relevant to this chapter and ensure that codes for these were retained; the use of the word pathological in M88 (other pathological fracture) was inappropriate to non-union or malunion of a fracture.

#### DISEASES OF THE GENITOURINARY SYSTEM (WHO/DES/ICD/C/86.014)

DES Unit pointed out that there were only limited changes involving nephritis and nephrotic syndrome and diseases of female genital tract. It had been suggested that there might be an alternative classification of nephritis, though no such classification has been referred to DES Unit.

The meeting had no specific comments about the chapter.

#### PREGNANCY, CHILDBIRTH AND THE PUERPERIUM (WHO/DES/ICD/C/86.015)

DES Unit referred to the very different views on hypertensive disorders in relation to pregnancy. The Organisation Gestosis (Society for the study of pathophysiology in pregnancy) favoured less emphasis on hypertension but desired inclusion of proteinuria and oedema in the group of hypertensive disorders. Deliveries including procedures were included in the chapter which changed the recommendation of the Expert Committee. There was a need to distinguish conditions of pregnancy only, and deal separately with conditions of the puerperium; threatened labour (040) and premature delivery (060) appeared to deal differently with threatened labour. It was thought that there was a need for a glossary, though this has yet to be prepared.

The following comments were made: failed attempted induced abortion (006) should be moved so that it was not in the group with the outcome of abortion; hypertensive conditions not specific to pregnancy (010) required to be coded elsewhere (the meeting agreed that this would probably be in the cardiovascular chapter); indications for maternal care in pregnancy, related to possible delivery problems to the fetus and the amniotic cavity (030-046) needed an improved title; abnormalities of organs or soft tissues of maternal pelvis, identified in pregnancy (033) required tumour of the cervix (perhaps by combining other fourth-digits; hydatidiform mole (001) required an exclusion note as in the Ninth Revision to deal with chorionepithelioma; when referring to cancer of the cervix consideration of cervical intra-epithelial neoplasia (CIN) was emphasized; multiple gestation and associated problems (030) was not in the ideal order, as papyraceous fetus (030.3) came in between the progression of high ordered pregnancies. It was considered that it might still be logical to leave this within this section as it was more likely to be diagnosed in the presence of multiple conception, though there was no unanimity.

#### CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD (WHO/DES/ICD/C/86.016)

It was felt that the title needed to be altered to remove the expression "period", though it was accepted that the conditions involved were those that occurred throughout the pre-natal period or during the first week of life. Perhaps the sub-heading on the inclusion note of the title required amplification, though no acceptable wording was provided.

Tetanus neonatorum had been moved to the chapter on Infectious and parasitic diseases; heart failure (P30.2) and sleep apnoea (P30.3) could occur in adults and the index must make this clear; fetus or newborn affected by noxious influences transmitted via placenta or breast milk (P04) might be replaced by an abnormality affecting the child rather than the cause of this; congenital hydrocele (P82) seemed inappropriately allocated here as a congenital malformation (some conditions where it was not clear whether or not this was congenital were coded in the system chapter rather than in the congenital chapter - but this could not apply to a first week condition which must be congenital); drug reactions and intoxications specific to newborn (P93) required expansion to include other substances given to the mother.

#### CONGENITAL MALFORMATIONS AND CHROMOSOMAL ABNORMALITIES (WHO/DES/ICD/C/86.017)

Chapter sub-headings had been introduced and attention was given to unspecified anomalies of specified sites, but there was still an unresolved issue over the correct chapter title. The meeting questioned whether the word anomaly should be used instead of malformation and if chromosomal abnormalities should remain as a part of the title.

There were two specific points of detail; polycystic kidney should be identified at four-character level with cystic kidney disease (Q66); in congenital cardiac murmur (Q29.4) a murmur may be present but without any anomaly.

#### SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS NOT ELSEWHERE CLASSIFIED (WHO/DES/ICD/C/86.018)

DES pointed out that the genito-urinary symptoms had been transferred to the system chapter; the order of ill-defined symptoms had been changed; some other system chapters did not have sub-headings in this chapter, as in the Ninth Revision; it was not clear whether the ordering of ill-defined/symptoms/abnormal findings was suitable for the coders; those working in primary care had criticized an early version, but had not provided an alternative; it was not clear whether atypical symptoms should be included in the chapter.

It was confirmed that WONCA had been invited to comment on this chapter. It was suggested that all non-pathognomonic conditions should be classified here.

A subgroup of the meeting, formed to discuss this chapter pointed out that there had been difficulty in interpreting the word pathognomonic. In addition they had supported the majority of changes, felt the format was improved, wished ill-defined to have a changed heading, thought that laboratory findings might overlap, and queried the term "undiagnosed death". Sudden infant death syndrome (R20) required an additional code for a "near-miss".

It was argued that the resolution from the 1984 Heads of Centres and Expert Committee Meetings should be followed. This had strongly recommended that reversion of symptoms from many of the chapters back to the symptom chapter should occur. Each Centre representative was asked to comment. Two did not feel that it was necessary to directly implement these prior resolutions; all other national representatives agreed to the prior resolutions. It was agreed that the North American Centre would review the position, and advise DES by the end of June 1986.

#### CONSEQUENCES OF EXTERNAL CAUSES (WHO/DES/ICD/C/86.019)

DES stated that this had been restructured on the basis of recommendations made at the Heads of Centres Meeting in Sao Paulo and the relevant document presented at the San Francisco meeting. It was not clear whether retrieval of data would be adequate to provide continuity of statistics. The system required double coding for open fractures; the system was better for handling multiple fractures. A revision had recently been incorporated which dealt with earlier queries on injury to nerves.

A subgroup of the meeting was formed to discuss this chapter in more detail. The subgroup welcomed the topographic approach and the better detail provided by the fourth-character. They were satisfied the system could handle multiple fractures. Though some reservation was expressed about lack of continuity, it was pointed out that most time series statistics only use a broad cause group and this should be available with the new proposal.

#### EXTERNAL CAUSES OF MORBIDITY AND MORTALITY (WHO/DES/ICD/C/86.020)

There were two proposals and a decision was required as to which should be used. Both placed greater emphasis on the victim rather than the event. There was also a decision to be made as to the number of alpha characters that could be used.

There was general concern that many different environmental factors that influence health were not covered in this chapter which still placed emphasis on traditional causes of accidents and injuries.

The subgroup of the meeting which formed to discuss this chapter considered that the best from the two proposals should be merged into a revision, that would only utilize three alpha characters but was completed down to the fourth-character level. It was hoped that those involved in preparing the two proposals would be able to reach agreement, helped by some of the other Centres. The intention was that this would be completed and reach DES by 10 September 1986. This new revision would be circulated to all countries some time after the other chapters; therefore it would only be back as a third draft shortly before the June 1987 Heads of Centres meeting.

#### FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES (WHO/DES/ICD/C/86.021)

More information on personal history and some medical reasons for contact had been inserted, room for alteration should remain within the structure.

Outcome of delivery had not been detailed as in the Ninth Revision, but the pregnant state was now coded at the three-character level; sub-categories on communicable diseases had been extended; perhaps more space for counselling was required.

There was some discussion about the need to handle smoking and other factors either as risk factors or as external causes of disease.

The subgroup which was formed to discuss this chapter stressed the need to consult national experts. There was also a need for guidance at the beginning of the chapter that such codes should not be used for underlying cause of death.

A number of specific points were mentioned: personal history of other dependence on machines (Z17) needed clarification; personal history of unhealthy lifestyle and other risk factors (Z18-Z21) were accepted in general, even when not causal; separate codes were required for outcome of delivery and healthy liveborn infants according to type of birth, including information on place of birth; pregnant state NOS (Z32) at the three-character level was welcomed; titles of categories relating to contacts with, carriers of and screening for acquired immunodeficiency syndrome (AIDS) (Z50.6, Z51.5 and Z90.2) should be changed to HTLV-III/LAV infections; greater detail was required for counselling than was included in Z81 (other persons seeking consultation without complaint or sickness); venous catheter should be added to the category of attention to artificial openings (Z65).

The subgroup also suggested that the notes to Z50.0 (contact with or exposure to intestinal infectious diseases) and Z50.8 (contact with or exposure to other communicable diseases) should be deleted.

5. Definitions related to maternal and child health

The meeting discussed problems related to maternal and child health, using as a background document material prepared by DES Unit (WHO/DES/ICD/C/86.19). It was pointed out that there were two major areas of disagreement arising from the report of the Consultation on Definitions and Standards Related to Maternal and Child Health held in Geneva in 1984 (ICD/PE/84.1). These areas of disagreement were the change of concept from "fetal death" to the new concept "dead-birth" and the definition of numerators and denominators for calculation of rates such as perinatal and maternal mortality rates. In addition, it was pointed out that there were a number of questions related to definitions of maternal mortality and the associated 42 day reference period.

In view of the importance of these topics, the expressed interest of many countries, and the concerns of the UN Statistical Office especially on behalf of developing countries, it was recommended that WHO call a special meeting with broad representation devoted to problems of nomenclature, definitions and standards for maternal and child health.

6. International death certificate study - Neoplasms

A presentation was made of Part II of the International Death Certificate Study (WHO/DES/ICD/C/86.18). In Part I, only US death certificates had been circulated for comparative coding analyses but this produced some biases so participating countries were asked to submit about 100 certificates of their own where cancer was mentioned and there were problems in coding. The difference and discrepancies in underlying causes of death were analysed. One of the main problems noted in this phase of the study was in the area of coding multiple sites of cancer. As a result of this international comparative study in cancer coding it was noted that nosologists from the various countries would profit from periodic international meetings to discuss problems of mutual interest. It was further suggested that any new rules and new codes based on ICD-10 could be tested on these same death certificates used for the study; this would assist in evaluating the impact of ICD-10 changes on cancer codes before implementation of ICD-10.

7. Morbidity coding in the United States

Since the procedures used in the United States for coding morbidity data were somewhat different from those recommended in ICD-9 and were based on the US adaptation, ICD-9-CM, the North American Centre explained the methods used in US hospitals. These were presented in WHO/DES/ICD/C/86.5. A definition of "principal diagnosis" was given. It was noted that dagger and asterisk codes of ICD-9 had been replaced with specific notes for required additional codes in ICD-9-CM, and specific coding rules to produce hospital morbidity statistics were described. A question was raised regarding the rule for coding multiple comparative diagnoses and while the rule might be considered inconsistent with the rule for coding questionable diagnoses, it was noted that it would not be feasible to change a rule at this time.

8. Study of the effect of changing ICD guidelines for improbable sequences in mortality coding

The North American Centre reported on possible effects of changing the ICD guidelines for improbable sequences in selecting underlying causes of death (WHO/DES/ICD/C/86.8). A study based on 1.4 million deaths disclosed major effects on underlying cause of death statistics based on the application of improbable sequence guidelines and concluded that it was important for ICD-10 to develop more assistance to coders on an international basis in applying this principle. The Brazilian Centre reminded the meeting that similar findings and recommendations were reported at the Heads of Centres meeting in Caracas (WHO/ICD/C/82.11). It was also reported that a NOMESCO committee was working on the concepts of underlying cause of death, multiple cause of death, and the necessary supporting rules.

The meeting agreed that, in general, the question of international rules and guidelines for ICD-10 needs further discussion and, because of its importance it should be on the agendas of the next two Centre Heads meetings.

## 9. International Classification of Impairments, Disabilities and Handicaps

The topic of impairments, disabilities and handicaps was introduced by DES Unit, referring to the report of a Meeting of Principal Investigators for Testing the Classification of Impairments, Disabilities, and Handicaps (ICIDH) in Voorburg, Netherlands, in June 1985 (DES/ICIDH/85.23).

In that report, a number of recommendations were presented, and several questions raised. One major issue was whether the impairments portion of ICIDH should be moved to ICD; if so, should they be distributed among the chapters or concentrated in one chapter. Another major concern was that the nature and severity of handicaps were often dependent on the society in which they occurred; therefore if impairments were relocated to ICD a revised form of ICIDH might be restricted only to disabilities. The Paris Centre reported that they were using the rubric titles of ICIDH to describe problems since the subdivisions of the rubrics were too detailed and difficult to apply. The group which met in Voorburg was planning to meet again and would appreciate hearing through DES Unit about the experiences of other countries in the use of ICIDH. It was also reported that there was a possibility of establishing a WHO Collaborating Centre for Disabilities, Impairments and Handicaps in the Netherlands to assist with this work.

Dr Satoshi Ueda, Professor of Rehabilitation Medicine, School of Medicine, University of Tokyo, representing the Japanese Expert Committee on the Classification of Impairments, Disabilities and Handicaps, reported on a feasibility study of ICIDH which was carried out in Japan and reported in a 92 page Japanese-language document in December 1985. The report given to the meeting was a condensed version of the summary of the original report. It was felt that ICIDH was a worthwhile and notable effort but some serious difficulties arose when coding individual cases. Some of the problems were related to inexperience in the use of the classification. However, even after gaining some experience, some difficulties persisted. It was hard to find appropriate items to correctly describe disabilities since one case could have many codes. One rheumatoid arthritis case was cited as requiring 100 disability codes and eight impairment codes. The classification should be simplified if it was to be useful in application. The report concluded that further work to develop, adapt, and utilize this classification, especially for international use, should be carried out.

## 10. Consultation on Primary Care Classifications

The meeting learned of the conclusions of the Consultation on Primary Care Classifications which took place in Geneva in November 1985 (DES/PHC/85.7). Apart from the draft ICPC, the consultation also discussed a number of aspects including Information Needs of the Managerial Process for National Health Development, and the WHO International Classifications in the fields of Diseases, Procedures in Medicine, and Impairments, Disabilities, and Handicaps. The Centre Heads were informed of the conclusions and recommendations of the consultation which included several points particularly relevant to their deliberations.

- (1) The draft classification had been using the name "International Classification of Primary Care". Because this title incorrectly implied certain attributes, it was suggested that the title be changed to reflect the provisional nature of the classification and its relation to general medicine rather than primary care.
- (2) This classification could not replace ICD but could supplement it.
- (3) WONCA or a similar group should consider publication, with proper acknowledgement to WHO, in order to further develop and evaluate the classification; WHO should continue to collaborate in this testing.
- (4) There remained an unmet need in developing countries for a classification for primary health care for the management and evaluation of health programmes related to the Health for All strategies.

The Moscow Centre then reported on the results of an experimental trial of the so-called International Classification for Primary Care (WHO/DES/ICD/C/86.14). It was found that the classification in its present form was not useful in USSR; it was necessary to significantly modify it. It was felt that the concept behind the classification was a good one but the adaptation either needed further testing or should be replaced with a better international version.

#### 11. HTLV-III/LAV infections and Brazilian purpuric fever

The Centre Heads heard two presentations on coding problems associated with newly emergent conditions: HTLV-III/LAV infections reported by the North American Centre (WHO/DES/ICD/C/86.6) and Brazilian purpuric fever reported by the Sao Paulo Centre (WHO/DES/ICD/C/86.10).

The material on HTLV-III/LAV infections was described in two parts. First, three three-digit rubrics with fourth-digit subdivisions utilizing the now vacant ICD-9 codes 042, 043, and 044 were presented; these are to be implemented in the United States to code mortality and morbidity from these infections and the possible resultant acquired immunodeficiency syndrome (AIDS). Second, the North American Centre reported that the definitions and procedures to be implemented to code HTLV-III/LAV infections would be reviewed in one year's time and recommendations regarding an appropriate classification for ICD-10 could be made at that time. There was concern expressed by the meeting that the codes might be too detailed and the definitions of the proposed rubrics might represent departures from usual ICD concepts. However, it was agreed that Centres and DES Unit would be kept informed of experiences in the US and in other countries in the coding of HTLV-III/LAV infections and that a specific ICD-10 proposal could be deferred until next year.

The problems encountered in Brazil with Brazilian purpuric fever (WHO/DES/ICD/C/86.10) were similar in principle to those experienced in the United States. Both Centres found it necessary to introduce modifications to ICD-9 to accommodate these newly-emerging conditions and were so informing DES Unit and the other Centres of their interim solutions. In neither case was there sufficient knowledge or experience to prepare firm recommendations for ICD-10 at this time.

#### 12. Future activities related to ICD

DES Unit reported an interest in information regarding automated translation capabilities which might assist in the timely production of different language versions of ICD-10. While the meeting was not aware of any process that was capable of adequately translating diagnoses from one language to another, it was acknowledged that automated non-medical translation had progressed in recent years and that new computer procedures and "artificial intelligence" were rapidly growing fields; anyone learning of information to assist WHO in the translation of ICD into other languages was requested to advise DES Unit.

There was some discussion on further action related to the second draft proposal. It was emphasized that any further comments must reach DES by 15 May 1986 in order for them to be incorporated in the second draft proposals to be mailed out by 15 July 1986 (which would be sent to all Member States and also Heads of Centres). To keep to the timetable, it was essential that replies to the second draft should be received back in DES Unit by 15 January 1987 at the latest. This would permit revised proposals to be prepared and circulated by 30 March 1987, preparatory to the discussion of the June 1987 Heads of Centres meeting.

With uncertainties in available resources for future years, DES Unit was unable at this time to indicate whether ICD-related activities other than the currently scheduled Centre Heads meetings would be planned.

In regard to the forthcoming meetings of Centre Heads, the Moscow Centre had agreed to plan the next meeting in Leningrad to be held from 2 to 9 June 1987.

NOMESCO had volunteered to host the Centre Heads Meeting in 1988, most likely in Uppsala or Stockholm, Sweden, with the probable dates from 7 to 13 June.

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