
Donna L. Hoyert and Lars Age Johansson
National Center for Health Statistics, CCHS, Centers for Disease Control and Prevention, Hyattsville, MD, USA, and EPC, National Board of Health and Welfare, Stockholm, Sweden

Abstract

This paper presents the activities and status of the WHO Mortality Reference Group for 2005-2006. The WHO created the MRG as a component of the ICD updating process. Comprised of members from Collaborating Centres and regional offices, the MRG meets largely in person to review problems encountered in the application of ICD-10 to mortality. In its eighth year of work, the MRG deliberated about 80 problems and has made recommendations to the Update and Revision Committee for further action. Many issues are still under review. The MRG is also currently working on improving the availability of additional information on the issues that the MRG discusses.

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Introduction

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

In its first seven years, the MRG dealt with more than 250 issues related to updating and clarifying ICD-10 as it applies to mortality classification and coding. The MRG settled about 177 questions selected largely from the Mortality Forum and submitted recommendations to the Update and Revision Committee (URC) for consideration.

This report describes the background of the MRG, the problems decided in the eighth year, and the problems presently under consideration. The report includes three appendices: Appendix I is the Terms of Reference and work plan for the MRG, Appendix II is a list of the members of the MRG, Appendix III lists the topics decided since 1998, and Appendix IV provides details for each of the issues the MRG reached closure on in 2005-2006.

Basis for the MRG

Provisions for the MRG are described in two documents: the WHO long-term strategy document (WHO/HST/ICD/C/97.39) and the Centre Heads’ Report for 1997 (WHO/HST/ICD/C/97.65). Briefly, for updating the ICD, WHO- - working with the Centre Heads- - established two separate bodies: one being the MRG, which can make decisions regarding the application and interpretation of ICD to mortality and which makes recommendations on ICD updates and changes. The MRG discusses issues raised in the Mortality Forum or those referred from other sources including the Centre Heads and WHO. WHO designated membership of the MRG and the Chair in 1998, based on nominations from Collaborating Centres. Lars Age Johansson succeeded Harry M. Rosenberg as chair of the MRG in February 2002. In 2005-2006, membership remained similar with the addition of a Co-Chair, Donna Hoyert (formerly Secretariat).

Decisions during the first seven years

In the first seven years (1998-2005), the MRG reached 177 decisions: forwarding 146 decisions to the Update and Revision Committee (URC): 93 recommendations for changes in the ICD and informing the URC that the MRG had discussed but decided against recommending any change for 53 issues (see Table 1). The URC referred six issues back for additional work, and the MRG withdrew three recommendations to do further work during the first seven years. The MRG discussions on other issues were not complete at the end of the seventh year.
Decisions during the eighth year

In the eighth year, the MRG met in Alexandria, Virginia, USA May 9-10, 2006, Tunis, Tunisia October 26-27, 2006, and a small group met in Geneva, Switzerland June 28-29, 2006. The MRG relied on e-mail communication to carry forward discussions and action between face-to-face meetings.

The MRG discussed about 80 issues this year. The MRG (Table 1) forwarded twenty-six decisions to the URC for further action; 9 decisions that involved no recommended change to the ICD were also forwarded for the URC’s information. The MRG reached closure on 9 other issues after the URC submission date and is approaching a resolution on more than 25 issues.

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

<table>
<thead>
<tr>
<th>Year</th>
<th>MRG reached decision</th>
<th>MRG submitted recommendations to URC</th>
<th>URC approved major or minor</th>
<th>MRG withdrew or URC referred back</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Major (substantive change)</td>
<td>Minor (clarification)</td>
<td>No change to ICD</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2000</td>
<td>8</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2001</td>
<td>6</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>2002</td>
<td>33</td>
<td>17</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>2003</td>
<td>57</td>
<td>76</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>2004</td>
<td>25</td>
<td>14</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2005</td>
<td>46</td>
<td>24</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>2006</td>
<td>44</td>
<td>35</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>181</td>
<td>54</td>
<td>65</td>
</tr>
</tbody>
</table>

... Not applicable

Each of the recommendations is described in terms of background, issues, and the decision made by the MRG (see Appendix IV). The additional issues that were not submitted to the URC were resolved at the Alexandria meeting which was after the deadline for submission of recommendations to the URC. The MRG continues to work on new issues as well as issues held over from previous years. Increasingly, the ongoing issues are complex and more difficult to resolve quickly.

The 26 recommendations for change address a number of situations including
clarifications of instructions (e.g., succession of accidents) and appropriate codes (e.g., tsunami victims).

The 9 issues for which decisions entailed no recommended change to the ICD include incorporating international consensus into decision tables used in automated software (e.g., cerebral infarction and valvular diseases); resolution of variations in interpreting instructions (e.g., cerebrovascular lesion due to Parkinson’s disease); improvement of the MMDS as an international tool (e.g., identifying nosocomial infections); and reaffirming current practices (e.g., unspecified diabetes and age of onset).

**Issues under review by the MRG**

Approximately 60 other specific issues and general topics related to improving data quality are under active review by the MRG. To improve the dissemination of information on the discussions and background of MRG decisions, a small group of MRG members met in Geneva in June to develop a basic design for a WHO mortality-classification Web page, resolve how decision tables would be presented on the Web page, and to develop a database of the work done by the MRG. Significant advances were made on each of these issues. The problems, background, and current status of the MRG issues are available on request to the Chair of the MRG.

**Procedural considerations**

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

**Conclusion**

In the eighth year, the MRG met twice in person, communicated extensively by e-mail, did considerable work on a number of problems outside the committee meetings, circulated documentation for issues under consideration; and comprehensively documented its activities. During the eighth year, a total of about 80 problems were reviewed by the MRG. For 44 of these, closure was reached. Twenty-six recommendations for change were made to the URC in 2006 including topics resolved in 2005. The decisions on the 9 issues did not involve changes in the ICD and the remaining recommendations were not drafted in time to submit in 2006.
Appendix I: Mortality Reference Group Terms of Reference

Purpose:

The objective of the Mortality Reference Group (MRG) is to improve international comparability of mortality data by establishing standardized application of the ICD-10.

Functions:

1. To identify and solve problems related to the interpretation and application of ICD-10 to coding and classification of mortality.

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

3. To develop recommendations for ICD-10 updates through a democratic process which attempts to achieve consensus.

4. To submit annual recommendations to the Update and Revision Committee by the end of April.

5. To provide documentation of discussions and decisions in a database.

Structure and working methods

The MRG will endeavour to ensure that its membership reflects the widest possible representation from centres and WHO regional offices.

The chair and co-chair are elected by the MRG for terms of two years. The election is submitted to the Secretariat for confirmation.

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

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

Decisions from the MRG which are endorsed by the URC and the Centre Heads should be available from the WHO ICD-10 home page.

**Workplan 2006-2007**

1. Continue to hold periodic meetings: one face-to-face meeting at WHO-FIC Network annual meeting and one roughly 6 months later, and telephone conferences as needed (2006 and 2007)
2. Prioritise issues and problems for review (2006 and 2007)
3. Make recommendations to the Update and Revision Committee (by April 2007)
4. Prepare annual report for WHO-FIC Network meeting (August 1, 2007)
5. Respond to URC requests to review material on URC platform (2006 and 2007)
7. Contribute to development of list of causes eligible to be leading causes of death
### Appendix II: Mortality Reference Group Membership

**Brazilian Centre**

- **Professor Caetana Maria Bocchella**
  - School of Public Health
  - University of Sao Paulo
  - Sao Paulo 05508-900 BRAZIL

- **Professor Ruy Laurenti**
  - School of Public Health
  - University of Sao Paulo
  - Sao Paulo 05508-900 BRAZIL

**North American Centre**

- **Dr. Donna Glaser** (Co-Chair)
  - Division of Vital Statistics
  - National Center for Health Statistics (NCHS)
  - Center for Disease Control and Prevention (CDC)
  - Atlanta, GA 30333 USA

- **Ms. Demetriaa Pickert MPH MHA**
  - Medical Information Administrator
  - Office of the Director
  - NCHS, CDC
  - Hyattsville, MD 20782 USA

- **Dr. Robert N. Anderson**
  - Division of Vital Statistics
  - National Center for Health Statistics (NCHS)
  - Center for Disease Control and Prevention (CDC)
  - Atlanta, GA 30333 USA

- **Ms. J. B. Baynac**
  - Division of Vital Statistics
  - NCHS, CDC
  - Research Triangle Park, NC 27709 USA

**Australian Centre**

- **Dr. Robert Jackson**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

- **Dr. Kenji Shiny**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

- **Dr. Kenji Shiny**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

**Japanese Centre**

- **Dr. Kenji Shiny**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

- **Dr. Kenji Shiny**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

- **Dr. Kenji Shiny**
  - Classification, Assessment, Survey and
t  - Epidemiology
  - Department of Health
  - Government of South Australia
  - Adelaide, SA 5000 AUSTRALIA

**Nordic Centre**

- **Lars Aage Johansen** (Chair)
  - Bjørg, National Institute of Health and Welfare
  - Oslo, Norway

- **Dr. Jeanne Carlsen-Salier**
  - Coordinating of the Statistical Unit
  - Office of Health Analytic and Information Services
  - Pan American Health Organization
  - Washington, DC 20057-2890 USA

- **Dr. Jeanne Carlsen-Salier**
  - Coordinating of the Statistical Unit
  - Office of Health Analytic and Information Services
  - Pan American Health Organization
  - Washington, DC 20057-2890 USA

**German Centre**

- **Dr. Christian Rose**
  - Medical Informationist
  - Office for National Statistics (OES)
  - London SW1Y 5JY UK

- **Ms. Elaine Towner**
  - Systemic, Office of Death Records
  - ONS
  - London SW1Y 5JY UK

**French Centre**

- **Dr. Susan Cole**
  - General Register Office for Scotland
  - Edinburgh EH2 2PQ SCOTLAND

- **Dr. Rafael Lazano**
  - Director General of Information and Performance Assessment
  - Health Ministry
  - Reforma 69, 11° Torre, Colonia Condesa
  - Mexico City, Mexico 06000
## Appendix III: Decisions Made by the WHO Mortality Reference Group

<table>
<thead>
<tr>
<th>Year Discussed and Topic</th>
<th>Type of Change</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-99: Rule A</td>
<td>Substantive change</td>
<td>Recommended to URC in 1999 and approved by URC</td>
</tr>
<tr>
<td>1998-99: Coding maternal conditions (revived in 2000-2002)</td>
<td>No change</td>
<td>No change in 1999 not communicated; recommended change in 2001 was withdrawn; Informed URC in 2002 of no change decision</td>
</tr>
<tr>
<td>1999-2000: Applying Rule 3 for pneumonia</td>
<td>Substantive change</td>
<td>Recommended to URC in 2000 and approved by URC in 2000</td>
</tr>
<tr>
<td>1999-2000: Rule A, additional condition</td>
<td>Substantive change</td>
<td>Recommended to URC in 2000 and approved by URC in 2000</td>
</tr>
<tr>
<td>1999-2000: Coding perinatal conditions</td>
<td>Clarification, and recommended changes in Alphabetical Index</td>
<td>Recommended to URC in 2001 and approved in principle by URC in 2001 (URC/MRG working on details in 2002 and URC approved in 2002)</td>
</tr>
<tr>
<td>1999-2000: Highly Improbable: Angina due to Bronchitis</td>
<td>No change</td>
<td>Informed URC in 2002</td>
</tr>
<tr>
<td>1999-2001: HIV due to blood transfusion</td>
<td>Substantive change</td>
<td>Recommended to URC in 2001 and approved by URC in 2001</td>
</tr>
<tr>
<td>1999-2001: Trivial list</td>
<td>Substantive change</td>
<td>Recommended to URC in 2001 and approved by URC in 2001</td>
</tr>
<tr>
<td>2000-2001: Forced list</td>
<td>Substantive change</td>
<td>Recommended to URC in 2001 and approved by URC in 2001</td>
</tr>
<tr>
<td>2001: List distribution</td>
<td>Substantive change</td>
<td>Recommended to URC in 2001 (folded into other initiatives)</td>
</tr>
<tr>
<td>2001: Congenital anomalies</td>
<td>Substantive change</td>
<td>Recommended to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02: Restore consolidated section of recommendations</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02 Trivial rule</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02 Intestinal obstruction</td>
<td>Clarification</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02 Intoxication</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02 Poisoning</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>1999-2002 Embolism due to digestive diseases</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2001-02 Transitory conditions</td>
<td>Substantive change</td>
<td>Submitted to URC in 2002 and approved by URC in 2002</td>
</tr>
<tr>
<td>2000-02 Drug treatment</td>
<td>No change</td>
<td>Informed URC in 2002</td>
</tr>
<tr>
<td>Topic</td>
<td>Change</td>
<td>Year</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>2001-02 SIDS detail</td>
<td>No change</td>
<td>2002</td>
</tr>
<tr>
<td>2001-02 Peripheral vascular disease causes</td>
<td>No change</td>
<td>2002</td>
</tr>
<tr>
<td>1999-2002 Ischaemic due to pulmonary conditions</td>
<td>No change</td>
<td>2002</td>
</tr>
<tr>
<td>2000-02 Newborn/neonatal terms</td>
<td>No change</td>
<td>2002</td>
</tr>
<tr>
<td>2001-02 Circulatory insufficiency</td>
<td>No change</td>
<td>2002</td>
</tr>
<tr>
<td>2002: Literal or liberal interpretation of ICD</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Recent complications caused by past surgery</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: I20. - (Angina pectoris) more specific than I25.9</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: J21 Apply the same linkages for acute bronchitis (J20) and acute bronchiolitis (J21)?</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Insufficiency vs. failure codes</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Code for &quot;narcotism&quot;</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Accident assumed cause of injury</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Different expressions for the same time limit</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Cerebral haemorrhage an obvious consequence of Waldenstrom=s macroglobulinaemia?</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Wording: Can be- may- should.....</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Cases when Rule 3 should not be applied</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: D84.9 (Immunodeficiency, unspecified) due to D45 (Polycythaemia vera) sequence</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Acute or terminal circulatory diseases due to diabetes</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: 177.6 (Arteritis, unspecified) due to 164 (Stroke)</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Cardiac arrhythmia, unspecified and Cardiac arrest, unspecified linkage</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Conditions in Part I regarded as a part of the natural history of a disease reported in Part II</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: May an ill-defined condition block the application of Rule 3</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: Renal failure- obvious consequence of urinary infection?</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002: K74.6 (Cirrhosis of liver) due to D73.5 (Infarction of spleen) sequence</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2002-03: Indexing of &quot;coronary disease&quot; and &quot;coronary heart disease&quot;</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2003: Code for euthanasia</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>2003: Code for stillborn due to maternal diabetes</td>
<td>No change</td>
<td>2003</td>
</tr>
<tr>
<td>Year</td>
<td>Description</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>2003</td>
<td>Hemiplegia due to hypertension—assume and code cerebrovascular disease</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Dilated cardiomyopathy reported as due to any other disease</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Exposure to substances (Agent Orange, asbestos, dust, pesticide) resulting in disease</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Other diseases of pharynx due to Degenerative disease of the nervous system, unspecified, an acceptable sequence</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Assume an unspecified infarction to be transmural</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2003</td>
<td>Aspiration a direct consequence of poisonings and intoxication</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2003</td>
<td>Pancreatitis an obvious consequence of alcoholism</td>
<td>No change, Informed URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Vascular dementia</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Cardiac categories with priority over atherosclerosis</td>
<td>Substantive change, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Persons repairing transport vehicles (2 related recommendations)</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Legal intervention</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-04</td>
<td>Priority between adverse &amp; abnormal incidents &amp; reactions and misadventure</td>
<td>Clarification, Submitted to URC in 2003 (URC 0155); Held over for MRG to provide more clarification and resubmitted in 2004; Approved by URC in 2004</td>
</tr>
<tr>
<td>2002-03</td>
<td>Embolic conditions</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Reapply Rule 3 after Rule D</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2000-03</td>
<td>Should Chapter XV be used for all maternal conditions</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2000-03</td>
<td>Puerperal sepsis</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>F10 and K70 coding</td>
<td>Substantive change, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Unspecified self-inflicted poisoning</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Underlying cause in face of multiple chronic lower respiratory diseases</td>
<td>Substantive change, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>Priorities in stroke span</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>No reason for surgery and therapeutic misadventure</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-03</td>
<td>(Acute) pseudomembranous colitis</td>
<td>Substantive change, Submitted to URC in 2003; Approved by URC in 2003</td>
</tr>
<tr>
<td>2002-04</td>
<td>Bacterial hepatitis</td>
<td>Substantive change, Submitted to URC in 2003 (URC 0166); Held over to address comments and resubmitted in 2004; Approved by URC in 2004</td>
</tr>
<tr>
<td>2002-03</td>
<td>Food-borne intoxication due to Clostridium difficile</td>
<td>Clarification, Submitted to URC in 2003; Approved by URC in 2003</td>
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<tr>
<td>Year</td>
<td>Description</td>
<td>Type</td>
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<tr>
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<td>2002-03</td>
<td>Sequelae of TB link with pneumoconiosis</td>
<td>Clarification</td>
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<tr>
<td>2002-03</td>
<td>Dementia, anemia, &amp; malnutrition</td>
<td>Clarification</td>
</tr>
<tr>
<td>2002-03</td>
<td>Arteriosclerotic chronic nephritis - how many lines</td>
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<td>2002-03</td>
<td>Malignant pleural effusion, NOS</td>
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<td>2002-03</td>
<td>Hypoxic ischaemic encephalopathy of newborn</td>
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<td>2002-03</td>
<td>Hepatitis with reported complications</td>
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<td>2002-03</td>
<td>Fractures and osteoporosis</td>
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<td>2002-03</td>
<td>Dementia, subtypes</td>
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<td>2002-04+</td>
<td>Value of combination codes</td>
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<td>2002-03</td>
<td>Term motor vehicle</td>
<td>Clarification</td>
</tr>
<tr>
<td>2002-04+</td>
<td>Multiple neoplasm sites in Part II</td>
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<td>2002-03</td>
<td>Neuro-endocrine neoplasm</td>
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<td>2002-03</td>
<td>Thrombosis or embolism and atrial fibrillation</td>
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<td>2002-03</td>
<td>Renal failure and urinary infections</td>
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<td>2002-03</td>
<td>Meconium ileus</td>
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<td>1999-2004+</td>
<td>Postoperative complications</td>
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<td>Alcoholic and non-Alcoholic cirrhosis</td>
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<td>Drug combinations</td>
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<td>2003</td>
<td>Fournier’s syndrome- females</td>
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<td>What is I22?</td>
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<td>Multiple valvular conditions</td>
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<td>Hepatitis C not specified as acute or chronic</td>
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<td>2002-03</td>
<td>Fractures of unspecified cause and E887</td>
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<td>2002-03</td>
<td>Unspecified HIV and ill-defined conditions</td>
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<td>Lewy body disease</td>
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<td>Heroin vapour leukencephalopathy</td>
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<td>2003-04</td>
<td>Lobar pneumonia in alcoholism</td>
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<td>2002-04</td>
<td>Changes to Rule 3</td>
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<td>2002-04</td>
<td>Old/healed myocardial infarction</td>
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<td>2003-04</td>
<td>Intracerebral haemorrhage &amp; warfarin use</td>
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<td>Chronic respiratory failure</td>
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<td>Note 4.2.2 (b) Infections in A00-B99</td>
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<td>Note 4.2.2 (d) Diabetes due to any other disease</td>
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<td>Transport accidents</td>
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<td>Viral gastritis</td>
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<td>Expanding the list for pneumonia</td>
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<td>Pulmonary oedema consequence of heart disease</td>
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<td>Cardiovascular disease and hypercholesterolaemia</td>
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<td>Injuries with no nature-of-injury code</td>
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<td>2004-05:</td>
<td>Underlying cause and record axis fields</td>
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<td>2004-05:</td>
<td>R95 due to J00</td>
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<td>2004-05:</td>
<td>Refractory anemia and myelodysplastic syndrome</td>
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<td>Influenza and cardiomyopathy</td>
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<td>2004-05:</td>
<td>Cerebrovascular diseases and myocardial infarction</td>
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<td>Accidents due to natural causes</td>
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<td>2004-05:</td>
<td>Valvular diseases and myocardial infarction</td>
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<td>2000-04:</td>
<td>Multiple drug combination deaths</td>
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<td>2003-05:</td>
<td>Modification of 3 cancer codes</td>
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<td>2004-05:</td>
<td>Self neglect</td>
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<td>2004-05:</td>
<td>Exacerbation of respiratory disease</td>
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<td>2004-05:</td>
<td>Inclusion body myositis</td>
<td>Substantive change</td>
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<td>2004-05:</td>
<td>Immaturity vs respiratory failure in newborn</td>
<td>Clarification</td>
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<td>2004-05:</td>
<td>C22 code</td>
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<td>2003-04:</td>
<td>Acute alcoholic pancreatitis and use of alcohol</td>
<td>Clarification</td>
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<td>2005:</td>
<td>C-section as cause of death</td>
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<td>2005:</td>
<td>Code for ischaemic heart failure</td>
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<td>2005:</td>
<td>Subarachnoid haemorrhage due to aneurysm of basilar artery</td>
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<td>2005:</td>
<td>Hypostatic pneumonia</td>
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<td>2005:</td>
<td>Code for immobility</td>
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<td>2005:</td>
<td>Can cerebral haemorrhage be due to liver disease</td>
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<td>2005:</td>
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<td>2005:</td>
<td>Code for sclerosing mesenteritis</td>
<td>Substantive change</td>
</tr>
<tr>
<td>2005:</td>
<td>Code for multiple system atrophy</td>
<td>Substantive change</td>
</tr>
</tbody>
</table>
### Appendix IV: Details on MRG Decisions for 2005-2006

#### “Recommendation” Issues

**ISSUE: TSUNAMI VICTIMS - UR C ID 16**

**Background and Issues.** Questions have arisen regarding how to code victims of the December 2004 tsunami. First, some argument exists about coding the initial earthquake or the tsunami as the cause of injury or death. Second, what is the appropriate code for tsunami? The MRG referred to a variety of English dictionaries for the distinction between tsunami and terms used in the ICD. The decisions were 1) that the earthquake did not directly affect the victims, so the focus should be on the tsunami and not the initial earthquake, and 2) the code including “tidal wave” now should be used.

**Decision.** The MRG recommends adding an inclusion term to Volume 1 and an index entry in Volume 3 to clarify that “tsunami” should be coded to X39 Exposure to other and unspecified forces of nature.

**Recommendation.**

Volume 1, p 1081 (ICD-10 1st edition)

**X39 Exposure to other and unspecified forces of nature**

<table>
<thead>
<tr>
<th>2005: Code for mesenteric arterial occlusive disease</th>
<th>Substantive change</th>
<th>Submitted to URC in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005: Fall in tub, not resulting in drowning</td>
<td>Substantive change</td>
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</tr>
<tr>
<td>2005: Code for cerebrovascular hemorrhagic infarction</td>
<td>Clarification</td>
<td>Submitted to URC in 2006</td>
</tr>
<tr>
<td>2005: Code for hip infection</td>
<td>Substantive change</td>
<td>Submitted to URC in 2006</td>
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<tr>
<td>2005: Tsunami victims</td>
<td>Clarification</td>
<td>Submitted to URC in 2006</td>
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<td>2005: Succession of accidents</td>
<td>Clarification</td>
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<td>2003-05: Cerebrovascular lesion due to Parkinson’s disease</td>
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<td>Informed URC in 2006</td>
</tr>
<tr>
<td>2003-05: Malignant neuroleptic syndrome</td>
<td>No change</td>
<td>Informed URC in 2006</td>
</tr>
<tr>
<td>2005: Cerebral infarction and valvular diseases</td>
<td>No change</td>
<td>Informed URC in 2006</td>
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<tr>
<td>2005: Neoplastic disease and mastectomy</td>
<td>No change</td>
<td>Informed URC in 2006</td>
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<td>2005: Water intoxication</td>
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<tr>
<td>2005: Identifying nosocomial infections</td>
<td>No change</td>
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<td>2005: Food allergy</td>
<td>No change</td>
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</tr>
<tr>
<td>2005: Unspecified diabetes and age of onset</td>
<td>No change</td>
<td>Informed URC in 2006</td>
</tr>
<tr>
<td>2005: Toxic shock syndrome</td>
<td>No change</td>
<td>Informed URC in 2006</td>
</tr>
</tbody>
</table>
Includes: natural radiation NOS
    tidal wave NOS
    tsunami NOS
Excludes: exposure NOS (X59.9)

Volume 3, p. 620 (ICD-10 1st edition)

Tripping
  - over
  ...
  - - with fall W03.-
Tsunami (any injury) NEC X39.-
Twisted by person(s)(accidentally) W50.-

The MRG submitted this recommendation (URC recommendation 16) to the URC in 2006

ISSUE: CODE FOR IMMUNE COMPROMISED- URC ID 17

Background and Issues. The initial question that led to this recommendation was about coding “immune compromised” as HIV for countries where HIV is not reported because of sensitivity concerns. The MRG discussed some available data from different countries. The MRG rejected the idea of coding something different than what was reported on the death certificate. However, when a country is publishing statistics, they may wish to take account of local customs and combine codes into a broader category.

Decision. The MRG recommends adding the term immune compromised to ICD volume 3 to clarify that the appropriate code is D89.9 (Disorder involving the immune mechanism, unspecified).

Recommendation.
Volume 3, p. 112 (ICD-10 1st edition)

Compression
  ...
  -vena cava (inferior)(superior) I87.1
Compromised immune (system) D89.9
Compulsion, compulsive
  p. 285

Immobility syndrome (paraplegic) M62.3
Imune compromised D89.9
Immunization (see also Vaccination) Z26.9
  ...

The MRG submitted this recommendation (URC recommendation 17) to the URC in 2006

ISSUE: CODE FOR SCLEROSING MESENTERITIS- URC ID 19

Background and Issues. Questions were raised in the MRG about the appropriate code for “sclerosing mesenteritis” and whether sclerosing mesenteritis would be a chronic condition for which it would be appropriate to separate from conditions in K65.9 (Peritonitis, unspecified). The German Centre has indexed “mesenteritis” to K65.9 but has not indexed “sclerosing mesenteritis”. The MRG decided that K65.8 (Other peritonitis) is the appropriate code.

Decision. The MRG recommends adding the term “sclerosing mesenteritis” under “mesenteritis” to ICD volume 3 to clarify how to appropriately code the terms.

Recommendation.
**Mesenchymoma** (M8990/1) – *see also*

**Mesentery, mesenteric* - *see condition*

**Mesenteritis** K65.9
- sclerosing K65.8

The MRG submitted this recommendation (URC recommendation 19) to the URC in 2006

**ISSUE: CODE FOR MULTIPLE SYSTEM ATROPHY - URC ID 20**

**Background and Issues.** A question was raised about the appropriate code for “multiple system atrophy.” The MRG discussed several seemingly vague terms and Shy-Drager syndrome, but decided that neurologists use the term “multiple system atrophy” to refer to different parts of the brain rather than multiple organs. Thus, G90.3 (Multi-system degeneration) is the appropriate code for this term.

**Decision.** The MRG recommends adding the terms “multiple system atrophy” and “multiple organ failure” to the index to clarify the appropriate codes.

**Recommendation.**

**Atrophy, atrophic** – *continued*

- macular (dermatological) L90.8

- multiple system G90.3
- muscle, muscular M62.5

**Failure, failed** – *continued*

- mitral I05.8
- multiple organ R68.8
- myocardial, myocardium (see also Failure, heart) I50.9

**System, systemic** – *see also condition*

- atrophy
- - multiple G90.3
- disease, combined – *see Degeneration, combined*
- lupus erythematosus M32.9
- - inhibitor present D68.86

The MRG submitted this recommendation (URC recommendation 20) to the URC in 2006

**ISSUE: CODE FOR MESENTERIC ARTERIAL OCCLUSIVE DISEASE - URC ID 21**

**Background and Issues.** A question was raised about the appropriate code for “mesenteric arterial occlusive disease.” The MRG discussed the following International Nomenclature of Diseases text:
K55.0 (Acute vascular disorders of intestine) includes ischaemia that is usually caused by thrombosis or embolism of the superior mesenteric artery and can result in partial or complete necrosis of the part of the intestine supplied by the artery. It is most often seen in elderly patients with cardiovascular disease. Onset of symptoms is usually acute with severe colicky abdominal pain that becomes diffuse and constant, abdominal distension, vomiting, anorexia and diarrhoea (usually with bloody stools). If intestinal necrosis is complete, approximately 24-72 hours after onset of symptoms, there is gangrene with peritonitis, sepsis and shock.

Synonyms: acute mesenteric ischaemia; acute small-intestinal ischaemia; haemorrhagic infarction of the intestine; mesenteric infarction; small intestinal infarction; transmural infarction of the intestine.

K55.1 (Chronic vascular disorders of intestine) relates to a form of ischaemia that is generally caused by partial mesenteric vascular occlusion and chronic arterial insufficiency. It is manifested by postprandial pain (15-60 minutes after eating) and weight loss due to decreased food intake because of fear of pain. The disorder may cause mucosal damage, fibrotic narrowing of the lumen, and malabsorption and may ultimately progress to infarction of the intestine.

The MRG discussed the distinction between chronic and acute blockages and whether it is more important to keep the detail on the case involving mesenteric arteries than getting how complete the occlusion is. The MRG decision is that K55.1 is the appropriate code unless specified as acute. In the acute case, K55.0 would be the appropriate code.

Decision. The MRG recommends adding terms to the index to clarify which code should be used.

Recommendation.

Volume 3, p. 161 (ICD-10 1st edition)

Disease, diseased – see also Syndrome

... arterial I77.9
- - - occlusive
- - - mesenteric (chronic) K55.1
- - - acute K55.0

The MRG submitted this recommendation (URC recommendation 21) to the URC in 2006

ISSUE: INCLUSION BODY MYOSITIS- URC ID 22

Background and Issues. A question was raised in the MRG about how to code "inclusion body myositis." Robert Jakob provided the MRG with the following research on medical terminology, specifically related to the terms "inclusion body myositis" and "inflammatory myopathy."

1 (Primary) (idiopathic) inflammatory myopathies
As a result on the web search and the usage in scientific publications the term "myopathy" is a synonym to "muscle disease". The term myositis may include infectious and other causes for muscular inflammation in Anglo-Saxon countries. This is not the case in German. Here "inflammatory myopathies" and "myositis" are used as synonyms. The technical term "inflammatory myopathies" is frequently combined with "primary" or "idiopathic" meaning just "of unknown origin". This term relates to a group of currently four diseases. Depending on medical school, local practice and scientific workgroup, but apparently mainly on terminological accuracy, sometimes the term of "inflammatory myopathy" might be used to indicate one particular disease of the group. The terminology of ICD-10 derives from 1987. At this time "Dermatology", M33, was used to group diseases now scientifically grouped under the more generic term "Inflammatory myopathies". They are all due to autoimmune mechanisms and independent and not to be confused with myopathies within other rheumatic diseases.

1.1 Dermatomyositis (DM),
DM inflammation damages both muscle fibres and skin. Like PM, you develop muscle weakness, pain and fatigue. In addition, you have a distinctive patchy, reddish rash on the eyelids, cheeks, bridge of the nose, back or upper chest, elbows, knees and knuckles. In some cases, you may develop hardened bumps under the skin.

1.2 Polymyositis (PM)
PM inflames and weakens muscles in many parts of the body, especially those closest to the trunk (proximal). Dysphagia is common, as is fatigue and pain in the joints and muscles.

1.3 Inclusion Body Myositis (IBM).
Symptoms of IBM typically begin after age 50 with very gradual weakening of muscles throughout the body. You may develop dysphagia, weak wrists or fingers and atrophy of the forearms and/or thigh muscles. Unlike other forms of myositis, IBM occurs more often in men than in women and, unfortunately, there are no effective treatments known for IBM.

1.4 Juvenile Myositis (JM):
Although some children develop juvenile forms of PM and IBM, children usually get juvenile DM with symptoms of muscle weakness, skin rash and dysphagia.

The MRG decided that "inclusion body myositis" should be coded to M33.1 and "juvenile myositis" to M33.0.

**Decision.** The MRG recommends additions to the index to clarify what the appropriate codes are.

**Recommendation.**

Volume 3, p. 365 (ICD-10 1st edition)

**Myositis**
- in (due to)
- trichinellosis B75+ M63.1 *
- inclusion body (IBM) M33.1
- infective M60.0
- interstitial M60.1
- juvenile M33.0
- multiple – see Polymyositis

The MRG submitted this recommendation (URC recommendation 22) to the URC in 2006

**ISSUE: MULTIPLE DRUG COMBINATION DEATHS- URC ID 23**

**Background and Issues.** In addition to the drug poisoning issue included in the 2003 recommendations (URC 193), the MRG has discussed other multiple drug combination deaths (e.g., decedent was dependent on both alcohol and heroin or dependent on both heroin and sedatives). The F10-F19 codes cover a range of types of drugs. If Dependence syndrome, multiple drug use (F19.2) is assigned, then the drugs involved in multi-drug deaths cannot be identified from the underlying cause. According to the WHO data, the code F19.2 is being used to code up to 30% of all the deaths in the categories F10-F19 in individual countries. The MRG agreed on the principle of applying the same priorities to drugs in F10-F19 as used for poisoning involving multiple drugs to retain more detail in the underlying cause.

**Decision.** The MRG recommends changes to the text on pages 52 and 87 of Volume 2 to clarify this instruction. The proposed change will bring more specificity to the underlying drug; however, the impact will vary by country.

**Recommendation.**

Volume 2, p. 85 (ICD-10 1st edition)

**Insert new section**

- 19 -
4.2.8 **Involvement of multiple types of substance use**

If a condition classifiable to F10-F19 or F55 is selected as underlying cause, and one or more other conditions also classified to F10-F19 or F55 are mentioned on the death certificate, proceed as follows:

i) If one condition is specified as the cause of death, code to that condition.

ii) When no single condition is specified as the main cause of death, clarification should be sought from the certifier.

iii) When no such clarification can be obtained, select the underlying cause in the following order of priority:

1) Mental and behavioural disorders due to use of opioids (F11)
2) Mental and behavioural disorders due to use of cocaine (F14)
3) Mental and behavioural disorders due to use of other stimulants, including caffeine (F15)
4) Mental and behavioural disorders due to use of synthetic narcotics, in F19
5) Abuse of antidepressants and non-opioid analgesics, in F55
6) Mental and behavioural disorders due to use of cannabinoids (F12), Mental and behavioural disorders due to use of sedatives and hypnotics (F13), Mental and behavioural disorders due to use of hallucinogens (F16), Mental and behavioural disorders due to use of tobacco (F17), Mental and behavioural disorders due to use of substances other than synthetic narcotics classified to F19, Abuse of non-dependence-producing substances other than antidepressants and non-opioid analgesics classified to F55.
7) Mental and behavioural disorders due to use of alcohol (F10)

If the death certificate reports more than one mental and behavioural disorder in the same priority group, code to first mentioned.

4.2.9 **Rheumatic fever with heart involvement**

Renumber remaining sections
(screenshot 100-102 at [http://www.who.int/classifications/committees/ICDCombinedUpdates.pdf](http://www.who.int/classifications/committees/ICDCombinedUpdates.pdf))

4.2.11 **Poisoning by drugs, medicaments and biological substances**

When combinations of medicinal agents classified differently are involved, proceed as follows:

A) Selection of the underlying cause of death

i) If one component of the combination is specified as the cause of death, code to that component.

Ex.: I(a) Poisoning by amphetamine
II Toxic levels of heroin and flunitrazepam

Code to accidental poisoning by amphetamine (X41). By placing amphetamine poisoning alone in Part I and reporting the other substances as contributing causes of death in Part II, the certifier has identified amphetamine as the most important substance in bringing about the death.

Ex.:  I(a) Poisoning by alcohol
       II Toxic levels of heroin and flunitrazepam

Code to accidental poisoning by alcohol (X45). By placing alcohol poisoning alone in Part I and reporting the other substances as contributing causes of death in Part II, the certifier has identified alcohol as the most important substance in bringing about the death.

Ex.:  I(a) Poisoning by heroin
       II Toxic levels of alcohol and flunitrazepam

Code to accidental poisoning by heroin (X42). By placing heroin poisoning alone in Part I and reporting the other substances as contributing causes of death, the certifier has identified heroin as the most important substance in bringing about the death.

ii) When no component is specified as the main cause of death, clarification should be sought from the certifier.

iii) When no such clarification can be obtained, code combinations of alcohol with a drug to the drug. For other multi-drug deaths, code to the appropriate category for “Other”.

iv) When F10-F19 is reported on the same record with a poisoning, proceed as follows:

F10-F19 Mental and behavioural disorders due to psychoactive substance use

with mention of:
X40-X49 Accidental poisoning by and exposure to noxious substances, code X40-X49
X60-X69 Intentional self-poisoning by and exposure to noxious substances, code X60-X69
X85-X90 Assault by noxious substances, code X85-X90
Y10-Y19 Poisoning by and exposure to drugs, chemicals and noxious substances, code Y10-Y19

Fourth character .0 (Acute intoxication), code X40-X49, X60-X69, X85-X90 or Y10-Y19

Refer to section 4.1.11 when multiple conditions classified to F10-F19 are reported on the same record.

B) Identifying the most dangerous drug
To provide useful statistics on multiple drug deaths, it is of utmost importance that the most dangerous drug is identifiable in addition to the underlying cause (see also Nature of injury, pp 86-87). When selecting the code for the most dangerous drug, apply the following instructions.

If one component of the combination is specified as the cause of death, code to that component. If no single component is indicated as the cause of death, code combinations of alcohol with a drug to the drug. When the classification provides a specific category for a combination of drugs, e.g. mixed antiepileptics (T42.5), code to that category. If no appropriate combination category is available, select the main injury code in the following order of priority:

1. Opioids (T40.0-T40.2)
   Combinations including opioids classifiable to more than one fourth-character subcategory in T40.0-T40.2: Code to T40.2
2. Cocaine (T40.5)
3. Psychostimulants with abuse potential (T43.6)
   Includes: Amphetamine and derivates
4. Synthetic narcotics and other and unspecified narcotics (T40.3-T40.4, T40.6)
   Combinations including synthetic narcotics classifiable to more than one fourth-character subcategory in T40.3-T40.4: Code to T40.4
   Combinations including synthetic narcotics classifiable to more than one fourth-character subcategory in T40.3-T40.4 with other and unspecified narcotics classifiable to T40.6: Code to T40.6
5. Antidepressants (T43.0-T43.2)
   Combinations including antidepressants classifiable to more than one fourth-character subcategory in T43.0-T43.2: Code to T43.2
6. Non-opioid analgesics (T39.-)
   Combinations including non-opioid analgesics classifiable to more than one fourth-character subcategory in T39.0-T39.4: Code to T39.8
7. Drugs and substances not listed above
   If the death certificate reports more than one such drug, code to the first mentioned.

If there is more than one drug in the same priority group, code to the first mentioned.

The MRG submitted this recommendation (URC recommendation 23) to the URC in 2006

**ISSUE:** CODE FOR ISCHAEMIC HEART FAILURE- URC ID 24

**Background and Issues.** A question was raised in the MRG about the appropriate code for “ischaemic heart failure.” The MRG discussed the codes that different countries currently use (I50.9 Heart failure, unspecified, and I25.9 Chronic ischaemic heart disease, unspecified). The MRG decision is that I25.9 is the more informative code.

**Decision.** The MRG recommends adding terms to the index to clarify which code should be used.
Recommendation.
Volume 3, p. 219 (ICD-10 1st edition)

Failure, failed

... - Heart (acute) (sudden) I50.9
... - hypertensive (see also Hypertension, heart) I11.0
- - with renal disease I13.0
- - - with renal failure I13.2
- - - - ischemic I25.9
- - left (ventricular) (see also Failure, ventricular, left) I50.1

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Ischemia, ischemic I99

... - heart (chronic or with a stated duration of over 4 weeks) I25.9
- - acute or with a stated duration of 4 weeks or less I24.9

The MRG submitted this recommendation (URC recommendation 24) to the URC in 2006

ISSUE: SUBARACHNOID HAEMORRHAGE DUE TO ANEURYSM OF BASILAR ARTERY - URC ID 25

Background and Issues. A question was raised in the MRG about the appropriate codes and underlying cause for records such as the following:

1a) Subarachnoid Haemorrhage
b) Aneurysm of Basilar Artery
II Ischaemic Heart Disease

The MRG discussed current coding practices in countries, the acceptability of the causal sequence, and where haemorrhaging could occur. We relied on MRG member's medical training.

Decision. The MRG decision is that changes in Volume 1 and 3 are needed to clarify this issue.

Recommendation.
Volume 1, p. 499 (ICD-10 1st edition)

I67.1 Cerebral aneurysm, nonruptured

... Excludes: congenital cerebral aneurysm, nonruptured (Q28.-)
ruptured cerebral aneurysm (I60.-)

Volume 3, p. 46 (ICD-10 1st edition)

Aneurysm

... - brain I67.1
- - arteriosclerotic I67.1
- - - ruptured (see also Hemorrhage, subarachnoid) I60.9
- - - arteriovenous (congenital) (nonruptured) Q28.2
- - - acquired I67.1
- - - - ruptured I60.8
- - - ruptured I60.8
- - berry (nonruptured) I67.1
The MRG submitted this recommendation (URC recommendation 25) to the URC in 2006

ISSUE: IMMATURE VERSUS RESPIRATORY FAILURE IN NEWBORN - URC ID 26

  Background and Issues. A question was raised in the MRG about preferring immaturity over respiratory failure and about different countries’ practices concerning assuming prematurity when respiratory failure in perinatal deaths is reported. The MRG made no decision about assuming a condition that is not reported on the certificate. However, if two conditions are on the certificate, code prematurity if the other conditions reported are also ill-defined.

  Decision. The MRG recommends reinforcing the note on p. 61 of Volume 2 to reflect that P28.5, which is ill-defined, should not be preferred to P07-P08.

  Recommendation.

Volume 2, section 4.1.11, p. 61 (ICD-10 1st edition)

P07.- Disorders related to short gestation and low birth weight, not elsewhere classified
P08.- Disorders related to long gestation and high birth weight

Not to be used if any other cause of perinatal mortality is reported. This does not apply if the only other cause of perinatal mortality reported is respiratory failure of newborn (P28.5).

The MRG submitted this recommendation (URC recommendation 26) to the URC in 2006

ISSUE: CODE FOR LONG QT SYNDROME- URC ID 27

  Background and Issues. A question was raised in Forum-CIE about how to code “long QT syndrome” and circulated in several forums including the Mortality Forum before coming before the MRG. Long QT syndrome is a conduction disorder rather than an arrhythmia. The MRG relied primarily on the medical experts in the group. The MRG decided that I45.8 Other specified conduction disorders is appropriate.

  Decision. The MRG recommends an additional entry in Volume 3 to clarify the appropriate code.

  Recommendation.

Volume 3, p. 521 (ICD-10 1st edition)

Syndrome- continued
- lobotomy F07.0
- long QT I45.8
- low
...
- prolonged QT I45.8

The MRG submitted this recommendation (URC recommendation 27) to the URC in 2006

ISSUE: FALL IN TUB, NOT RESULTING IN DROWNING - URC ID 33
**Background and Issues.** The question raised in the MRG was how to code the external cause for fall in tub when the nature of injury is not drowning. The MRG decided that if there is no mention of slipping, then the appropriate code would be W18 Fall on same level.

**Decision.** The MRG recommends adding an entry in the index to clarify the appropriate code.

**Recommendation.**

Volume 3, p. 598 (ICD-10 1st edition)

**Fall, falling- continued**

- in, on
- - aircraft NEC V97.0
- - - with accident to aircraft V97.0
- - - while boarding or alighting V97.1
- - bath(tub) W18
- - - escalator
- - - transport vehicle after collision - see Accident, transport, by type of vehicle, collision
- - - tub W18
- - - into

The MRG submitted this recommendation (URC recommendation 33) to the URC in 2006

**ISSUE: CODE FOR HIP INFECTION - URC ID 34**

**Background and Issues.** A question was raised about hip infection in the MRG. Our UK colleagues were wondering about the distinction between bedsore, infection in the joint, and indeterminate skin or joint problem in the hip area when the term “hip infection” is used. The MRG discussed querying and looking at other conditions on the record to disentangle cases that might be bedsores and so on. However, the MRG decided that “hip infection” would generally mean “infection of the hip joint” and M00.9 is the appropriate code.

**Decision.** The MRG recommends implementing this decision by adding a term to the index.

**Recommendation.**

Volume 3, p. 321 (ICD-10 2nd edition)

**Infection, infected**

- - Heterophyes (heterophyes) B66.8
- - hip (joint) M00.9
- - Histoplasma (see also Histoplasmosis) B39.9

The MRG submitted this recommendation (URC recommendation 34) to the URC in 2006

**ISSUE: EXACERBATION OF RESPIRATORY DISEASE - URC ID 35**

**Background and Issues.** A question was raised in the MRG by Scotland about coding of a record with exacerbation of chronic obstructive airways disease. The first issue was how exacerbation is coded. In the US data the term was used on 230 records, about 70% with chronic obstructive pulmonary disease and 8% with each asthma and congestive heart failure. The MMDS does not combine J44.9 with exacerbation unless “acute” is also specified. The MRG decided that “exacerbation” should be considered acute whether it is specified or not. For the specific situation, the MRG resolved that lower respiratory infections in J44.0 should include those coded to J12-J22.

**Decision.** The MRG recommends adding non-essential modifiers to the index and clarifying the linkage between chronic obstructive airways disease and pneumonia and other infections in Volume 2.

**Recommendation.**
Volume 2, p. 62 (ICD-10 2nd edition)

J43.- Emphysema

... J44.8-J44.9 Other and unspecified chronic obstructive pulmonary disease

With mention of:
J12-J18 (Pneumonia), code J44.0
J20-J22 (Other acute lower respiratory infections), code J44.0

J45.- Asthma

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Selected cause With mention of: As cause of: Resulting lined code
J43.- J40 J44.-
...
J44.8-J44.9 J12-J18 J44.0
J20-J22 J44.0

J60-J64

Volume 3, p. 175 (ICD-10 2nd edition)

Disease, diseased

... - airway, obstructive, chronic J44.9
  - - due to
  - - - cotton dust J66.0
  - - - specific organic dusts NEC J66.8
  - - with
  - - - exacerbation (acute) NEC J44.1
  - - - lower respiratory infection (except influenza) J44.0
  ... 

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Disease, diseased

... - lung J98.4
- - obstructive (chronic) J44.9
- - with
- - - acute
- - - - exacerbation NEC (acute) J44.1
- - - - lower respiratory infection (except influenza) J44.0
... 
- - - emphysema J44.-
- - - - exacerbation (acute) J44.1

The MRG submitted this recommendation (URC recommendation 35 to the URC in 2006

ISSUE: HYPOSTATIC PNEUMONIA- URC ID 36

Background and Issues. A question was raised in the MRG about coding of a record that had bronchopneumonia and immobility on it but the immobility was not in a due to position. The MRG thinks that if immobility or other terms equivalent to immobility are reported anywhere on the record,
the condition should be coded as hypostatic.

**Decision.** The MRG recommends clarifying the instructions in Volume 2 to provide better instructions on this situation adding an inclusion term to Volume 1 and an index entry in Volume 3.

**Recommendation.**

Volume 2, section 4.1.7, Rule 3 (ICD-10, 2006 edition ~p. 43)

Lobar pneumonia, unspecified (J18.1) should be considered an obvious consequence of dependence syndrome due to use of alcohol (F10.2). Any pneumonia in J12-J18 should be considered an obvious consequence of conditions that impair the immune system. Pneumonia in 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 J18.0 and J18.2-J18.9, J69.0, and J69.8 should also be considered an obvious consequence of conditions that affect the process of swallowing. **Pneumonia in J18.- (except lobar pneumonia) reported with immobility or reduced mobility should be coded to J18.2.** Other common secondary conditions (such as pulmonary embolism, decubitus ulcer, and cystitis) should be considered an obvious consequence of wasting diseases (such as malignant neoplasms and malnutrition) and diseases causing paralysis (such as cerebral haemorrhage or thrombosis) as well as communicable diseases, and serious injuries. However, such secondary conditions should not be considered an obvious consequence of respiratory conditions.

The MRG submitted this recommendation (URC recommendation 36) to the URC in 2006

**ISSUE: CODE FOR IMMOBILITY- URC ID 37**

**Background and Issues.** A question was raised in the MRG about how immobility can affect the coding of the record and that the MMDS does not make full use of this information. Currently, coders in different countries deal with mentions of immobility in a variety of ways. The MRG felt that it was important that M62.3 not be used for this, but it should be possible to capture mentions of immobility with ICD codes. The MRG finally concluded that using Z74.0 in multiple cause mortality coding was the best solution.

**Decision.** The MRG recommends additions to Volumes 2 and 3 to clarify how to code situations involving immobility.

**Recommendation.**

Volume 2, p. 61 (ICD-10 2nd edition)

J06.- Acute upper respiratory infections of multiple and unspecified sites

... 

J18.- Pneumonia, organism unspecified

**With mention of:**

Z74.0 (Reduced mobility), code to J18.2

J20.- Acute bronchitis

Volume 3, p. 311 (ICD-10 2nd edition)

**Immersion** T75.1

- foot or hand T69.0

**Immobility** Z74.0

**Immobility syndrome (paraplegic)** M62.3

The MRG submitted this recommendation (URC recommendation 37) to the URC in 2006
**ISSUE:** CAN CEREBRAL HAEMORRHAGE BE DUE TO LIVER DISEASE - **URC ID 38**

**Background and Issues.** The MRG discussed the issue of cerebral hemorrhage due to liver disease. If I61.- is reported to be due to K70-K76 in Part I, this is an acceptable sequence, and any severe liver disease can affect clotting.

**Decision.** The MRG recommends one change in Volume 2 to clarify the coding.

**Recommendation.**

Volume 2 (ICD-10, 2006 edition~p.72)

(i) (1) cerebrovascular diseases (I60-I69) reported as “due to” a disease of the digestive system (K00-K92), except Cerebral haemorrhage (I61.-) due to Diseases of liver (K70-K76)

(2) cerebral infarction due to thrombosis of precerebral arteries (I63.0)

(3) cerebral infarction due to unspecified occlusion of precerebral arteries (I63.2)

(4) cerebral infarction due to thrombosis of cerebral arteries (I63.3)

The MRG submitted this recommendation (URC recommendation 38) to the URC in 2006

**ISSUE:** C-SECTION AS CAUSE OF DEATH - **URC ID 61**

**Background and Issues.** A question was raised about coding death certificates with Caesarian section mentioned. The MRG decided that C-sections should be coded like other operations, that is, code to the cause of the C-section if the reason is known. If not, or if the C-section is performed for 'trivial reasons', use 075.4 Other complications of obstetric surgery and procedures as the underlying cause (equivalent to Y83.-). The codes about delivery would be appropriate for multiple cause coding. This clarification requires modification of a note in Volume 1 and instructions in Volume 2.

**Decision.** The MRG recommends modifying the note in Volume 1 to clarify that these codes can be used for multiple cause coding and add examples to the operation notes in Volume 2.

**Recommendation.**

Volume 1, p. 727 (ICD-10 2nd edition)

Delivery

(O80-O84)

**Note:** Codes O80-O84 are provided for morbidity coding purposes. Codes from this block should be used for primary morbidity coding only if no other condition classifiable to Chapter XV is recorded. For use of these categories reference should be made to the mortality and morbidity coding rules and guidelines in Volume 2.


**4.2.6 Operations**

If an operation appears on the certificate as the cause of death without mention of the condition for which it was performed or of the findings at operation, and the alphabetical index does not provide a specific code for the operation, code to the residual category for the organ or site indicated by the name of the operation (e.g. code "nephrectomy” to N28.9). If the operation does not indicate an organ or site, e.g. "laparotomy", code to "Other ill-defined and unspecified causes of mortality” (R99), unless there is a mention of a therapeutic misadventure classifiable to Y60-Y84 or a postoperative complication. If there is mention of a misadventure at the time of the procedure, code to Y60-Y69. If there is a mention of an abnormal reaction of the patient, without mention of misadventure at the time of the procedure, code to Y83-Y84.
Example: I (a) Pulmonary embolism
(b) Appendectomy
Code to unspecified disease of appendix (K38.9)

Example: I (a) Accidental puncture of aorta
(b) Laparotomy
Code to unintentional puncture during surgical operation (Y60.)

Code complications of obstetrical surgery to the reason for the surgery. If no reason for the obstetrical surgery is stated, code to O75.4.

Example: I (a) Postoperative haemorrhage
(b) Caesarean section
(c) Prolonged labour
Code to long labour, unspecified (O63.9)

Example: I (a) Amniotic fluid embolism
(b) Caesarean section
Code to other complications of obstetric surgery and procedures (O75.4)

The MRG submitted this recommendation (URC recommendation 61) to the URC in 2006

**ISSUE: CODE FOR CEREBROVASCULAR HEMORRHAGIC INFARCTION- URC ID 62**

**Background and Issues.** A question was raised by the UK about coding the term “cerebrovascular haemorrhagic infarction.” Different countries dealt with term differently: some sought medical opinion of how the haemorrhage and infarction would occur, some coded multiple terms, and some set up rules for determining what should be coded when a term has more than one modifier. According to medical input, the infarction weakens the walls of the arteries and then haemorrhage results.

**Decision.** The MRG recommends changes in the index to clarify how this term should be coded.

**Recommendation.**
Volume 3, p. 316 (ICD-10 2nd edition)

**Infarct, infarction**

- cerebral (hemorrhagic) I63.9
  - - due to
    - - embolism (hemorrhagic)
    - - thrombosis (hemorrhagic)

The MRG submitted this recommendation (URC recommendation 62) to the URC in 2006

**ISSUE: SUCCESSION OF ACCIDENTS- URC ID 63**
Background and Issues. A question was raised about how far to trace a sequence of external events. The MRG discussion was that if there is a known sequence, then it is consistent with the General Principle to follow the trail back in time to the first event that directly affected the decedent. So, apply selection rules as usual, that is, any sequence that is not highly improbable should be accepted.

Decision. The MRG recommends some additional text for Volume 2 to provide this clarification.


4.2.12 External causes

The codes for external causes (V01-Y89) should be used as the primary codes for single-condition coding and tabulation of the underlying cause when, and only when, the morbid condition is classifiable to Chapter XIX (Injury, poisoning and certain other consequences of external causes).

When the morbid condition is classified to Chapters I-XVIII, the morbid condition itself should be coded as the underlying cause and categories from the chapter for external causes may be used, if desired, as supplementary codes.

When a sequence of external events is reported, apply the General Principle and the selection rules in the normal way, and select the first external event that affected the decedent.

Example: I (a) Third degree burns
        (b) Fell from ladder, hit kerosene stove that overturned, extensive burns from escaping kerosene

        Code to fall from ladder (W11)

The MRG submitted this recommendation (URC recommendation 63) to the URC in 2006

ISSUE: C22 CODE- URC ID 64

Background and Issues. A question was raised about coding primary malignant liver neoplasms for which the morphology has not been specified. The MRG reviewed Swedish data which could distinguish which C22.9 Liver, unspecified records were primary malignant neoplasm of liver, unspecified morphology and which were malignant neoplasm of liver, unspecified. About a third of the records were stated to be primary. The MRG decided that it is important to retain this information.

Decision. The MRG recommends creating a separate code for records stated to be primary malignant neoplasm of liver but do not specify the morphological type.

Recommendation. Volume 1, p. 177 (ICD-10 2nd edition)

C22.4 Other sarcomas of liver
C22.5 Other primary malignant neoplasm of liver stated to be primary, not elsewhere classified

        Malignant neoplasm of liver stated to be primary, but of unspecified morphology

C22.7 Other specified carcinomas of liver

Volume 3, p. 385 (ICD-10 2nd edition)

Melanoma

- site classification
- - liver (primary) C22.9
-- stated to be primary C22.5

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<tr>
<th>Neoplasm</th>
<th>Malignant</th>
<th>Secondary</th>
<th>In situ</th>
<th>Benign</th>
<th>Uncertain or unknown behaviour</th>
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- liver
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<td>D13.4</td>
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</tbody>
</table>

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Sarcoma
- leptomeningeal (M9530/3) - see Neoplasm, meninges, malignant
- liver C22.9
- stated to be primary NEC C22.4
- Lymphangioendothelial (M9170/3) C49.9

The MRG submitted this recommendation (URC recommendation 64) to the URC in 2006

**ISSUE: ACUTE ALCOHOLIC PANCREATITIS AND USE OF ALCOHOL - URC ID 65**

**Background and Issues.** The original recommendation for URC 0203 included some recommended changes related to linking F10 to acute alcoholic pancreatitis. We do not think there was any disagreement about this aspect of the proposal; however, this part of the recommendation was left off the final version of the recommendation. We suppose this was an oversight.

**Decision.** The MRG recommends several changes in Volume 2 to provide guidance on coding records with mention of both F10 and K85.

**Recommendation.**
Volume 2 (p. 70, 2005 version)
F10.- Mental and behavioural disorders due to use of alcohol with mention of:

K76.9 (Liver disease, unspecified), code K70.9

K85.2 (Alcohol-induced acute pancreatitis), code K85.2

K86.0 (Alcohol-induced chronic pancreatitis), code K86.0

**K85.9 Acute pancreatitis, unspecified**

with mention of:

F10.- (Mental and behavioural disorders due to use of alcohol), code K85.2
Table 1. Summary of linkages by code number

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<tr>
<th>Selected cause</th>
<th>With mention of:</th>
<th>As cause of:</th>
<th>Resulting linked code</th>
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The MRG submitted this recommendation (URC recommendation 65) to the URC in 2006

**ISSUE: MODIFICATION OF 3 CANCER CODES- URC ID 66**

**Background and Issues.** The MRG is working on improving the instructions for coding malignant neoplasms and has changes for three codes to provide more detail. First, the usefulness of C97, Malignant neoplasms of independent (primary) multiple sites, as an underlying cause has been questioned. The MRG found that many cancer registries do not use the code and the ICD-O(3) has removed the code. Thus, the MRG recommends making C97 invalid as an underlying cause. Second, there has been concern about the variety of terms that all get assigned to the code C80, Malignant neoplasm without specification of site. The MRG recommend new fourth digits to C80 to distinguish between unknown primary and cancer, not otherwise specified. Third, the MRG recommends that metastases, secondary malignant neoplasms, and similar terms be coded to a new C79.9, Secondary malignant neoplasm, unspecified, instead of C80.

**Decision.** The MRG recommends adding fourth digits to C79 and C80 in Volume 1, note about C97 in section 4.1.11 of Volume 2, and change the codes shown in Volume 3 to reflect the additional fourth digits.

**Recommendation.**

Volume 1 (2nd edition), p. 198

**C79.8** Secondary malignant neoplasm of other specified sites

**C79.9** Secondary malignant neoplasm, unspecified

**C80** Malignant neoplasm without specification of site
Cancer
Carcinoma
Carcinomatosis
Generalized:
  • cancer
  • malignancy
Malignancy
Multiple cancer

Malignant cachexia
Primary site unknown

**C80.0 Malignant neoplasm, primary site unknown, so stated**

**C80.9 Malignant neoplasm NOS**

Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81-C96)

Vol 2 (2nd edition), pp. 54-55

B95-B97  Bacterial, viral and other infectious agents

Not to be used for underlying cause mortality coding.

C97  Malignant neoplasms of independent (primary) multiple sites

Not to be used for underlying cause mortality coding. When multiple but independent malignant neoplasms are reported on the death certificate, select the underlying cause by applying the Selection and Modification Rules in the normal way.

D50-D89  Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism

as the cause of:

B20-B24  Human immunodeficiency virus [HIV] disease and where the certificate indicates that the HIV disease is a result of a blood transfusion given as treatment for the originating condition, code B20-B24

p. 70

**Table 2. Summary of codes not to be used in underlying cause mortality coding**

<table>
<thead>
<tr>
<th>Codes not to be used for underlying cause mortality coding (code to item in parentheses; if no code is indicated, code to R99)</th>
<th>Not to be used if the underlying cause is known</th>
</tr>
</thead>
</table>

- 33 -
Cachexia R64
- cancerous (M8000/3) C80.C80.9
  . . .
  - malignant (M8000/3) C80.C80.9

p. 92
Carcinoid (tumor) (M8240/3) – see also Neoplasm, malignant
  . . .
  - goblet cell (M8243/3) C80.C80.9

p. 97
Carcinomatosis
  . . .
  - unspecified site (M8010/6) C80.C80.9

p. 169
Dermatofibrosarcoma (M8832/3) – see also Neoplasm, skin, malignant
  . . .
  - pigmented (M8833/3) C80.C80.9

p. 182
Disease, diseased—continued
  . . .
  - neoplastic (malignant), generalized (M8000/6) C80.C80.9

p. 213
Eaton-Lambert syndrome C80.C80.9† G73.1*

p. 360
**Lambert-Eaton syndrome**  \(\text{C80.9}^{+}\) G73.1*

---

**Melanoma**—continued

- metastatic
  - specified site NEC (M8720/6) \(\text{C79.8}\)
  - unspecified site (M8720/6) \(\text{C80C79.9}\)

---

**Metastasis, metastatic**

...  
- cancer or neoplasm (M8000/6) \(\text{C80 C79.9}\)

---

**Myasthenia, myasthenic** \(\text{G70.9}\)

...  
- malignant neoplasm NEC (M8000/3) (*see also* Neoplasm, malignant) \(\text{C80C80.9}^{+}\) G73.2*

---

**Myopathy**—continued

...  
- malignant neoplasm NEC (M8000/3) (*see also* Neoplasm, malignant) \(\text{C80C80.9}^{+}\) M63.8*

---

**Neoplasm, neoplastic**

<table>
<thead>
<tr>
<th>Malignant</th>
<th>Uncertain or unknown behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>In situ</td>
<td></td>
</tr>
</tbody>
</table>

\(\text{C80C80.9}\) \(\text{C80C79.9}\) \(\text{D09.9}\) \(\text{D36.9}\) \(\text{D48.9}\)

- stated to be unknown primary site \(\text{C80.0}\) \(\text{C79.9}\)

---

**Neoplasm, neoplastic**—continued

- disseminated  \(\text{C80C80.9}\)
p. 415
- generalized $C80C80.9$

p. 422
- metastatic, primary site unknown $C80C79.9$
  (multiple)

p. 441
**Neuropathy, neuropathic**--continued

- carcinomatous $C80C80.9^\dagger G13.0^*$

p. 487
**Polyneuropathy**--continued
- in--continued

- malignant neoplasm NEC (M8000/3) (see also Neoplasm, malignant) $C80C80.9^\dagger G63.1^*$

p. 528
**Sarcomatosis**

- unspecified site (M8800/6) $C80C80.9$

p. 565
**Syndrome**--continued

- generalized, neoplastic (malignant) $C80C80.9$

p. 597
**Tumor**--continued

- germ cell (M9064/3) - see also Neoplasm, malignant
  - mixed (M9085/3) $C80C80.9$

p. 598
**Tumor**--continued

- malignant (M8000/3) - see also Neoplasm, malignant
  - fusiform cell (type) (M8004/3) $C80C80.9$
  - giant cell (type) (M8003/3) $C80C80.9$
  - mixed NEC (M8940/3) $C80C80.9$
The MRG submitted this recommendation (URC recommendation 66) to the URC in 2006

**ISSUE:** SELF NEGLECT- URC ID 99

**Background and Issues.** Questions were raised in the MRG about the issue of self neglect and how it should be coded. The MRG discussed that self neglect is more likely to be a symptom than a description of an external event. Therefore, self neglect should not be regarded as an accident, but should be coded somewhere in Chapter XVIII. If there is a disease reported that could cause self neglect, then Rule A would allow the disease to be selected as the underlying cause. If reported alone, then the underlying cause would stay with the R-code.

**Decision.** The MRG recommends creating a new code R63.6 for self neglect involving starvation and adding terms to the index to assist in coding different terms related to self neglect.

**Recommendation.**

Volume 1, (ICD-10, 2nd edition)

p. 839

**R46.8 Other symptoms and signs involving appearance and behaviours**

*Includes:* self neglect NOS

*Excludes:* insufficient intake of food and water due to self neglect (R63.6)

p. 847

**R63 Symptoms and signs concerning food and fluid intake**

... **R63.5 Abnormal weight gain**

*Excludes:* excessive weight gain in pregnancy (O26.0) obesity (E66.-)

**R63.6 Insufficient intake of food and water due to self neglect**

*Excludes:* starvation due to anorexia (R63.0) starvation due to privation of food (X53) self neglect NOS (R46.8)

**R63.8 Other symptoms and signs concerning food and fluid intake**

p. 1050

**X53 Lack of food**

*Includes:*

- inanition
- insufficient nourishment
- starvation

*Excludes:*

- neglect or abandonment by others (Y06.-)
- insufficient intake of food and water due to self neglect (R63.6)
- self neglect NOS (R46.8)

Volume 3, p. 534
Self neglect R46.8
- causing insufficient intake of food and water R63.6

p. 550

Starvation X53.-
- due to abandonment or neglect (see also Abandonment) Y06.9
- due to self neglect R63.6

The MRG submitted this recommendation (URC recommendation 99) to the URC in 2006

“No Recommendation” Issues

The MRG informed the URC that nine issues that had been discussed and resolved without requiring a change in the ICD volumes. Details of these issues are presented in their entirety for the first time in the following pages.

Issue 1: UNSPECIFIED DIABETES AND AGE OF ONSET

Background and Issues. Historically, diabetes type has been age-related. Consequently, at least one country has assigned type for unspecified diabetes based upon age. Other countries and the MMDS make no assumption about type based upon age. The MRG decided that the MMDS operates correctly currently, particularly, given changes in age of onset for diabetes in recent years. No change is needed in the ICD volumes, nor no change in the MMDS.

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

Issue 2: FOOD ALLERGY

Background and Issues. The nature-of-injury codes related to food allergies are better in ICD-10 than ICD-9; however, there is ambiguity about what external code to use. The MRG believes that future revisions should consider addressing allergy and autoimmune diseases and immunological reactions in the disease chapters. For ICD-10, X58 (Exposure to other specified factors) is the appropriate code. No change is needed for ICD-10 volumes, but the MMDS needs to assign X58 instead of X59.

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

Issue 3: IDENTIFYING NOSOCOMIAL INFECTIONS

Background and Issues. The MRG discussed that there is an increasing demand for differentiation between hospital acquired and community acquired infections; however, it’s difficult to separate care as the cause since many of those acquiring an infection start with vulnerable health profiles. One of the countries suggested using Y95 nosocomial condition as a multiple cause data item to capture information that the condition was acquired in the hospital; the MRG agrees. Changes expected in the MMDS in 2006 will allow countries to use Y95 for this purpose. No changes are needed in ICD-10.

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

Issue 4: MALIGNANT NEUROLEPTIC SYNDROME
Background and Issues. A question was raised regarding the appropriate code for malignant neuroleptic syndrome while the MRG was discussing another MRG issue. It is associated with R29.8 (Other and unspecified symptoms and signs involving the nervous and musculoskeletal systems) in the MMDS dictionary. However, the MRG decided that G21.0 (Malignant neuroleptic syndrome) would be a more appropriate code. No change is needed in the ICD volumes.

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

Issue 5: CEREBROVASCULAR LESION DUE TO PARKINSON’S DISEASE

Background and Issues. In comparing Swedish manual coding to automated coding results, some differences were identified in accepted causal sequences between stroke and degenerative conditions. The MRG developed a revised list of conditions that can cause I60-I67. Testing of this proposal resulted in increases in cerebrovascular disease and decreases in Parkinson’s disease (e.g., largest absolute increases in I64 and decreases in G30.9 and G20 although the percent change was small for these). No change is needed in the ICD volumes.

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

Issue 6: WATER INTOXICATION

Background and Issues. The MRG discussed a case in which a person went to a life mastery course, intentionally drank excessive amounts of water, and died. Water intoxication is indexed to E87.7, but the question was whether it would be appropriate to have an external cause code. The MRG agreed that this was an interesting question; however, the external codes have less detail and no nature-of-injury code is available. Unless accidental but self-induced water intoxication events become much more common so that it would be important to track these deaths for public health purposes, the MRG does not feel that there is sufficient justification to create the new codes that would be needed to use external codes. Thus, the appropriate code is E87.7 (Fluid overload) where water intoxication is presently coded.

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

Issue 7: NEOPLASTIC DISEASE AND MASTECTOMY

Background and Issues. Michael Schopen asked if neoplastic disease and mastectomy are reported together, should the record be interpreted as breast cancer. The MRG thought the best solution is to query this record. If no further information can be obtained, then it is reasonable to assume that “neoplastic disease” is being used synonymously with “neoplasm.” The MRG decision for this case is that the code for neoplastic disease should be D48.9 Neoplasm of uncertain or unknown behaviour, unspecified. However, the MRG felt that this was a very specific case and that we did not want to create an instruction for such a specific situation.

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

Issue 8: TOXIC SHOCK SYNDROME

Background and Issues. The issue raised at a Nordic mortality meeting was whether A48.3 (Toxic shock syndrome) should have the same causal relationships as A41.9 (Septicemia). The MRG consulted Swedish clinicians about the issue and changes in the use of the terms over time. The MRG decision for this case is that toxic shock syndrome and septicemia should have the same causal relationships. This decision will need to be implemented in the MMDS.

Decision. No URC action necessary. (Date of decision: 2005)
**Issue 9: Cerebral Infarction and Valvular Diseases**

**Background and Issues.** The issue raised as a result of comparing Finnish manual coding to automated coding was whether cerebral infarction could be due to valvular diseases? The MRG agrees that it should. The changes in Volume 2 made with previous recommendations such as URC 0188 provide sufficient instructions. However, the MMDS needs some updates to the decision tables on embolism to bring it in alignment with this decision.

**Suggested causal tables**

1. *Arterial embolism, except pulmonary*

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>E236</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>G951</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>H340</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>H342</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>I210</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>I219</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>I240</td>
<td>M Embolism only</td>
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<td><strong>I630</strong></td>
<td><strong>I64</strong></td>
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<td><strong>I694</strong></td>
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<tr>
<td>I740</td>
<td>I749</td>
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<tr>
<td>I788</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>K550</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>N280</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>N488</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>O032</td>
<td>M Not pulmonary embolism</td>
</tr>
<tr>
<td>O037</td>
<td>M Not pulmonary embolism</td>
</tr>
<tr>
<td>O042</td>
<td>M Not pulmonary embolism</td>
</tr>
<tr>
<td>O047</td>
<td>M Not pulmonary embolism</td>
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<tr>
<td>O052</td>
<td>M Not pulmonary embolism</td>
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<tr>
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<td>M Not pulmonary embolism</td>
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<tr>
<td>O062</td>
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<td>O067</td>
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<tr>
<td>O072</td>
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<tr>
<td>O077</td>
<td>M Not pulmonary embolism</td>
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<tr>
<td>O082</td>
<td>M Not pulmonary embolism</td>
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<tr>
<td>O882</td>
<td>M Not pulmonary embolism</td>
</tr>
<tr>
<td>T801</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>T817</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>T828</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>T838</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>T848</td>
<td>M Embolism only</td>
</tr>
<tr>
<td>T858</td>
<td>M Embolism only</td>
</tr>
</tbody>
</table>
are due to
I011
I020
I050  I069
I080  I089
I091
I330  I339  M  Of mitral or aortic valve, or NOS
I340  I359
I38
I423
I424
I48  I499
I513  M  Left heart or NOS
I700
I741  M  Ascending or NOS
I800  I809  M  If with cardiac septal defect
I821  I823  M  If with cardiac septal defect
I828  I829  M  If with cardiac septal defect
O033  M  Thrombosis of left heart, aorta or main arteries
O038  M  Thrombosis of left heart, aorta or main arteries
O043  M  Thrombosis of left heart, aorta or main arteries
O048  M  Thrombosis of left heart, aorta or main arteries
O053  M  Thrombosis of left heart, aorta or main arteries
O058  M  Thrombosis of left heart, aorta or main arteries
O063  M  Thrombosis of left heart, aorta or main arteries
O068  M  Thrombosis of left heart, aorta or main arteries
O073  M  Thrombosis of left heart, aorta or main arteries
O078  M  Thrombosis of left heart, aorta or main arteries
O087  M  Thrombosis of left heart, aorta or main arteries
O223  M  If with cardiac septal defect
O229  M  If with cardiac septal defect
O60  O849
O871  M  If with cardiac septal defect
O879  M  If with cardiac septal defect
O994  M  Thrombosis of left heart, aorta or main arteries
T801  M  Thrombosis of left heart, aorta or main arteries
T817  M  Thrombosis of left heart, aorta or main arteries
T828  M  Thrombosis of left heart, aorta or main arteries
T838  M  Thrombosis of left heart, aorta or main arteries
T848  M  Thrombosis of left heart, aorta or main arteries
T858  M  Thrombosis of left heart, aorta or main arteries
Y600  Y849
2. Cerebral embolism

Conditions in
I630 I64
I650 I669
I693 I694

can also be due to
I650
I652

3. Lower body embolism

Conditions in
I743 I745
K550 M Embolism only
N280 M Embolism only
N488 M Embolism only
O032 M If of lower body artery
O037 M If of lower body artery
O042 M If of lower body artery
O047 M If of lower body artery
O052 M If of lower body artery
O057 M If of lower body artery
O062 M If of lower body artery
O067 M If of lower body artery
O072 M If of lower body artery
O077 M If of lower body artery
O082 M If of lower body artery
O882 M If of lower body artery
T801 M If embolism of lower body artery
T817 M If embolism of lower body artery
T828 M If embolism of lower body artery
T838 M If embolism of lower body artery
T848 M If embolism of lower body artery
T858 M If embolism of lower body artery

can also be due to
I740, Embolism and thrombosis of abdominal aorta

4. Pulmonary embolism

Conditions in
can be due to

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I011</td>
<td>M Of pulmonary or tricuspid valve, of unspecified valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I020</td>
<td>M Of pulmonary or tricuspid valve, of unspecified valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I050</td>
<td>M If a cardiac septal defect is present</td>
</tr>
<tr>
<td>I070</td>
<td>M If a cardiac septal defect is present</td>
</tr>
<tr>
<td>I080</td>
<td>M If a cardiac septal defect is present</td>
</tr>
<tr>
<td>I081</td>
<td>M When involving tricuspid or pulmonary valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I088</td>
<td>M When involving tricuspid or pulmonary valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I089</td>
<td>M When involving tricuspid or pulmonary valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I091</td>
<td>M When involving tricuspid or pulmonary valve, or unspecified valve, or if a cardiac septal defect is present</td>
</tr>
<tr>
<td>I148</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1499</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1513</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1800</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1821</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1822</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1823</td>
<td>M Of right heart or unspecified</td>
</tr>
<tr>
<td>I1828</td>
<td>M Of right heart or unspecified</td>
</tr>
</tbody>
</table>
Suggested "Direct Sequel" (Rule 3) tables

1. Arterial embolism, except pulmonary

Conditions in

E236      M      Embolism only
G951      M      Embolism only
H340      H342   M      Embolism only
I219      M      Embolism only
I240      M      Embolism only
I630      I64
I650      I669
I693      I694
I740      I749
I788      M      Embolism only
K550      M      Embolism only
N280      M      Embolism only
N488      M      Embolism only
<table>
<thead>
<tr>
<th>Code</th>
<th>Sex</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>O032</td>
<td>M</td>
<td>Not pulmonary embolism</td>
</tr>
<tr>
<td>O037</td>
<td>M</td>
<td>Not pulmonary embolism</td>
</tr>
<tr>
<td>O042</td>
<td>M</td>
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<tr>
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</tr>
<tr>
<td>T858</td>
<td>M</td>
<td>Embolism only</td>
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</table>

are an obvious consequence of conditions in

<table>
<thead>
<tr>
<th>Code</th>
<th>Sex</th>
<th>Diagnosis</th>
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<tbody>
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<td>I069</td>
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</tr>
<tr>
<td>I080</td>
<td>I089</td>
<td></td>
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<tr>
<td>I091</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I330</td>
<td>I339</td>
<td>M Left heart or NOS</td>
</tr>
<tr>
<td>I340</td>
<td>I359</td>
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<td>I48</td>
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<td>O073</td>
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<td></td>
</tr>
<tr>
<td>O849</td>
<td></td>
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</tr>
</tbody>
</table>
2. Cerebral embolism

Conditions in

I630  I64
I650  I669
I693  I694

are also an obvious consequence of conditions in

I650
I652

3. Lower body embolism

Conditions in

I743  I745

K550  M  Embolism only
N280  M  Embolism only
N488  M  Embolism only
O032  M  If of lower body artery
O037  M  If of lower body artery
O042  M  If of lower body artery
O047  M  If of lower body artery
O052  M  If of lower body artery
O057  M  If of lower body artery
O062  M  If of lower body artery
O067  M  If of lower body artery
O072  M  If of lower body artery
O077  M  If of lower body artery
O082  M  If of lower body artery
O882  M  If of lower body artery
T801  M  If embolism of lower body artery
T817  M  If embolism of lower body artery
T828  M  If embolism of lower body artery
T838  M  If embolism of lower body artery
T848  M  If embolism of lower body artery
4. Pulmonary embolism

<table>
<thead>
<tr>
<th>Conditions in</th>
<th>M</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>I260 I269</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O032</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O037</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O042</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O047</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O052</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O057</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O062</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O067</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O072</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O077</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O082</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>O882</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>T801</td>
<td>M</td>
<td>Pulmonary embolism only</td>
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<tr>
<td>T838</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>T848</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
<tr>
<td>T858</td>
<td>M</td>
<td>Pulmonary embolism only</td>
</tr>
</tbody>
</table>

are also an obvious consequence of conditions in
I070 I079
I081 I083
I088 M When involving tricuspid or pulmonary valve
I089
I091

When involving tricuspid or pulmonary valve, or unspecified valve

I330 I339 M Of right heart or unspecified
I360 I38
I513 M
I800 I809
I821
I822
I823
I828
I829
O033 M  If venous thrombosis/phlebitis
O038 M  If venous thrombosis/phlebitis
O043 M  If venous thrombosis/phlebitis
O048 M  If venous thrombosis/phlebitis
O053 M  If venous thrombosis/phlebitis
O058 M  If venous thrombosis/phlebitis
O063 M  If venous thrombosis/phlebitis
O068 M  If venous thrombosis/phlebitis
O073 M  If venous thrombosis/phlebitis
O078 M  If venous thrombosis/phlebitis
O087 M  If thrombosis/phlebitis
O223
O229
O60 O849
O871
O879
O994 M  If thrombosis/phlebitis
T801 M  If thrombosis
T817 M  If thrombosis
T828 M  If thrombosis
T838 M  If thrombosis
T848 M  If thrombosis
T858 M  If thrombosis
Y600 Y849

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