was short of resources.

Prof. Sugano said that the proposals from the IM-TAG had been incorporated into the ICD Alpha draft and that the group should look at the Alpha draft. Some different inputs from the submitted proposal were observed in the list and each WG now should look at the Alpha draft for such different information.

Ms. Cottler made a remark that it was not easy to see the whole structure of iCAT for verification of inputs and that she could make the print version available. The proposals are on the SharePoint site and the printed tabular list will be mailed to WG chairs.

Dr. Ogawa asked Ms. Cottler to send the updated list of all TAG members.

Asked about funding for editorial manager, Dr. Takimura answered she was making preparation for it and said that the groups should now find a candidate for the managing editor.

Prof. Sugano added that two groups, Respiratory and Endocrinology WGs, had not made any progress.

Asked for the progress of these two groups, Dr. Takimura replied that a supporting group was formed for the Endocrinology WG and that Dr. Shimatsu had circulated proposals to the international members of the group but the Ministry had not received their Alpha draft yet. For the Respiratory WG, the Ministry did not receive any information from Dr. Ingbar so far.

Prof. Sugano said that more information should be given from Japanese supporters of this group in a similar manner as the Cardiovascular and Gastroenterology WGs.

Ms. Cottler asked members to send email or call her mobile phone if they have any concern or question.

Dr. Sugano said that alignment is missing between TAGs and WGs and any conflict between groups should be resolved. To facilitate resolution Ms. Cottler will organize teleconference between WGs and TAGs. If anybody wishes to have teleconference for this purpose, he/she should call Ms. Cottler for arrangement.

8. Closing

To close the meeting, Prof. Sugano thanked participants and said that in the next teleconference the feedback from iCAMP will be discussed.

End

平成 22 年度　第 2 回電話会議の概要

Date:24/09/2010

Participants:

IM-TAG:	
Gastroenterology WG:	N/A
Hepatology and Pancreatobiliary WG:	N/A
Nephrology WG:	N/A
Cardiovascular WG:	N/A
Respiratory WG:	N/A
Hematology WG:	N/A
Endocrinology WG:	N/A
Rheumatology WG:	N/A
WHO:	N/A
IM-TAG managing editor:	Julie Rust
IM-TAG secretariats :	Kayo Takimura, Toshio Ogawa

Agenda

1. Return of Ms. Rust to the IM-TAG
2. Morbidity TAG
3. Karyn Chen
4. Funds for Ms. Rust
5. Proposals from the Rheumatology TAG
6. Summary

Minutes of Meeting

1. Return of Ms. Rust to the IM-TAG

Dr. Ogawa thanked Ms. Rust for talking to Dr. Fibbe and explained that the idea of Dr. Fibbe's groups on managing editor is to finalize the Alpha draft first and then to have a managing editor to change the contents in the Beta phase and asked Ms. Rust if she could accept this idea.

Ms. Rust said that that idea was sensible. In her impression at the WHO in May or June, it seemed that the WHO wanted to enter the data centrally at the WHO.

Dr. Ogawa wanted to define the role of managing editor and asked Ms. Rust who enters the data in iCAT.

Ms. Rust was not sure but said there were two people at the WHO working on structural change, while the WHO expects groups to enter the data for the contents.

Dr. Ogawa asked to confirm the idea of Dr. Fibbe that he does not need a managing editor until the Beta phase.

Ms. Rust said that every TAG wanted to have a managing editor but it was not

going to happen in terms of time and money. Dr. Fibbe had done a lot of good work and the group needed tidying up and the hematology is not a big problem.

Dr. Ogawa asked Ms. Rust if he could tell Dr. Sugano that Ms. Rust is joining again and Ms. Rust gave a positive answer, adding that she already had contact with Dr. Sugano although she only said to Dr. Sugano that there would be a discussion on the subject. Dr. Ogawa will email to Dr. Sugano to confirm that Ms. Rust will join the TAG again. Ms. Rust was not able to join the iCAMP this time but Dr. Sugano was attending it and the IM-TAG will have a teleconference early October and Ms. Rust will be invited to that teleconference.

2. Morbidity TAG

Dr. Takimura wanted to know how the Morbidity TAG will work with the IM-TAG.

Ms. Rust said that the Morbidity TAG will be formed in Toronto in the October meeting and the Morbidity Reference Group will go into sort of hibernation and some of them will move to the Morbidity TAG, some as full-time members and some as observers. The Morbidity TAG will be a group of classification reviewers and they receive proposals and review them from the viewpoint of classification experts, as far as Ms. Rust understood. Ms. Rust, however, was not sure how the group will work in practice. Ms. Rust has a list of members of the Morbidity TAG and she will send it to Dr. Ogawa. The Morbidity TAG will be working on overlapping areas with TAGs, such as Rare Disease TAG which had overlapping issues with many TAGs. Dr. Ogawa pointed out that the WHO should make sure of the ownership to avoid overlapping issues.

3. Proposals from the Rheumatology TAG

Ms. Rust said that proposals from the Rheumatology TAG had been sent to the WHO, adding that she would confirm that. Dr. Ogawa said that Dr. Jonathan Kay had asked him the situation and probably the Rheumatology TAG did not yet receive the Alpha draft. Ms. Rust said that she knew some people at the WHO and according to these people not much activities were made during summer due to the holiday season but now iCAMP will be held and they can be pushed.

4. Summary

Before concluding the meeting Ms. Rust pointed out the actions she will take as follows:

- Ms. Rust will send Dr. Ogawa information on people, in particular Megan who is more available.
- Ms. Rust will make a rough estimate for the cost required.
- Ms. Rust will send a list of people who belong to Morbidity TAG.
- Ms. Oikawa will inform Dr. Sugano of return of Ms. Rust to the TAG.

Ms. Rust added that if Ms. Oikawa is attending iCAMP, she could raise an inquiry about channeling the money through the WHO. When Ms. Rust was in Tokyo in April,

she talked to Dr. Üstün and he had said that kind of arrangement was possible. But the WHO might only pay people who have medical qualifications and therefore it remains to be seen.

Dr. Ogawa will give Ms. Rust any additional information if he receives.

End.

平成 22 年度　第 3 回電話会議の概要

Date: 17/01/2011

Participants:

IM-TAG:	Kentaro Sugano
Gastroenterology WG:	Peter Malfertheiner, Junichi Akiyama
Hepatology and Pancreatobiliary WG:	N/A
Nephrology WG:	Yasuhiko Iino
Cardiovascular WG:	Takahide Kohro
Respiratory WG:	N/A
Hematology WG:	Willem Fibbe
Endocrinology WG:	N/A
Rheumatology WG:	Jonathan Kay, Masayoshi Harigai
WHO:	Sara Cottler
IM-TAG managing editor:	Julie Rust, Megan Cumerlato
IM-TAG secretariats:	Kayo Takimura,　Toshio Ogawa

Agenda

1. Taking Attendance
2. Introduction
3. Confirmation of the Working Group Members of IM-TAG
   3.1 Confirmation by WHO (letter of the acknowledgement)
4. Proposal of the structure
   4.1 WGs update (by Julie)
   4.2 Due date of the proposal (by the end of February, 2011)
   4.3 Discussion with other WGs and TAGs about the overlapped and underlapped area by the end of March, 2011.
5. The RSG meeting in Geneva (from 11 to 14 April, 2011)
6. The Face-to-face meeting of IM-TAG in Tokyo (from 18 to 19 April, 2011)
   6.1 Participation
   6.2 Finalize structural changes and input
   6.3 Contents input
7. Next teleconference schedule
8. Closing

4. Proposal of the structure

4.1 WGs update

With respect to Endocrinology and Metabolism WG, Dr. Takimura explained that due to the unfortunate passing last year of Dr. Saudek, who was the co-chair, Dr. Naoko Tajima had been recommended to WHO to succeed Dr. Saudek as the co-chair. Ms. Cottler said approval on Dr. Tajima serving as co-chair would be discussed later that day.

On Hepatology WG, Ms. Rust reported that proposals on structural changes, some of which had already been reviewed by WHO, would be put into the iCAT within the next

several days.

With regard to Gastroenterology WG, Prof. Sugano reported that the WG had almost completed their proposals for structural changes. Ms. Rust added that she and Ms. Cumerlato would be reviewing feedback from WHO and provide their comments to Prof. Miura and Dr. Malfertheiner.

As an overarching conceptual issue, Ms. Rust asked whether after receiving feedback from WHO and reviewing the proposals, any further process was necessary before putting the proposals into the iCAT. Ms. Cottler replied that it was not necessary and proposals should be put into the iCAT. It was agreed that sooner the proposals went into the iCAT the better, and that changes could be made on the iCAT.

As for Cardiovascular WG, Dr. Takimura reported that Dr. Kohro was in the process of sorting out proposals by Japanese cardiovascular societies and sending them to Ms. Rust and Ms. Cumerlato by end of January. Ms. Rust commented that European societies had done substantial work on congenital and pediatric section of cardiology and Dr. Franklin, a Cardiovascular WG member, was expected to send information on the work done.

With regard to Rheumatology WG, Dr. Kay reported that Ms. Rust was in the process of inputting codes and recommended the entire IM-TAG to consider coding proposals by organ sites. Ms. Rust agreed that an agreement on the overarching structure was needed to secure consistency on site codes, including organs and anatomical sites. Dr. Kay pointed out the need for securing funding for managing editors. Dr. Harigai commented that Japan society of rheumatology was willing to provide some funding. Ms. Rust asked how overlap with Musculoskeletal TAG was being addressed. Dr. Kay replied that Rheumatology WG essentially had dominance over rheumatology codes within Musculoskeletal TAG.

As for Respiratory WG, Ms. Cottler reported that it had too many members, particularly with three additional members from the United States. However, it was agreed that work efficiency should have priority over number of members so that the WG's work could be finished by end of May. Dr. Takimura explained that the Japanese Respiratory Society (JRS) had prepared the proposals for structural changes and that once they were approved by the JRS board, they would be circulated among WG members.

For Hematology WG, Dr. Fibbe reported that the proposals would be completed in the next few weeks. The WG consisted of members from three major hematology societies of Japan, the United States, and Europe, with representation from all six WHO regions. It was waiting membership approval from WHO. With respect to overlaps with Neoplasm TAG and ICD-O (IARC), the WG was having discussions to reach an agreement on the contents with a WG member who was also a member of ICD-O. Dr. Fibbe did not expect difficulties dealing with overlaps with Rare Diseases TAG. Dr. Fibbe further explained that the WG would seek funding from the three major hematology societies to partially pay for the managing editors. Ms. Cottler noted that WHO approval on the WG members was forthcoming.

As for Nephrology WG, Dr. Iino reported that the WG met in November for discussion

and identified an area of overlap. The WG would look for a managing editor.

Prof. Sugano commented that he hoped to see the progress of all WGs' work aligned by end of May as some WGs were very slow in their progress.

5. The RSG meeting in Geneva (from 11 to 14 April, 2011)

Ms. Cottler explained that the RSG meeting would be held from 11th to 14th April with the participation of the chairs of all TAGs, including Mortality, Morbidity, and Quality and Safety TAGs. Moreover, it was agreed at the last iCAMP in September 2010 to invite chairs of all WGs of IM-TAG to the RSG meeting, as it would allow boundary issues to be solved more efficiently and WG chairs to know what was happening at other TAGs. Prof. Sugano noted that he had requested WHO to provide funding for travel and accommodation of WG chairs for the meeting but he still had not received a response from WHO.

6. The Face-to-face meeting of IM-TAG in Tokyo (from 18 to 19 April, 2011)

Dr. Takimura explained that a face-to-face meeting of IM-TAG in Tokyo, sponsored by the Japanese Society of Internal Medicine, would be held from 18th to 19th April, and WG chairs and managing editors would be invited. Funding for travel expenses was still being worked out with respective societies, with the exception of the Japanese Society of Gastroenterology, which had agreed to support in providing travel expenses for their WG chairs. Prof. Sugano noted that funding for Ms. Rust and Ms. Cumerlato was available. Prof. Sugano commented that there was a lot of work to be done until May when the Alpha draft phase would come to an end and that the meeting was essential to discuss the final stage of Alpha draft organization. Information about the meeting would be distributed soon.

7. Next teleconference schedule

Dr. Ogawa explained that he would discuss with the Japanese Ministry of Health, Labor and Welfare about the funding of the next teleconference and look into the possibility of having it in February. Prof. Sugano noted that there were three WGs that had not done any work and that were not participating in IM-TAG teleconferences either and pointed out that teleconferences without them would be inefficient. He said they should be asked to attend the teleconference or have them send reports about their progress. Dr. Ogawa suggested that holding separate teleconferences with the chairs of particular WGs might be useful. It was agreed to push the WGs that were slow in their work. Dr. Ogawa said he would distribute information about the next teleconference.

8. Closing

Prof. Sugano thanked all the participants to the teleconference and closed the meeting.

End.

平成 22 年度　第 4 回電話会議の概要

Date: Monday, February 21, 2011 (23 p.m. GMT)

Participants:

IM TAG:	Kentaro Sugano, Rodney Franklin
Gastroenterology WG:	N/A
Hepatology and Pancreatobiliary WG:	E. B. Keeffe
Nephrology WG:	N/A
Cardiovascular WG:	N/A
Respiratory WG:	N/A
Hematology WG:	N/A
Endocrinology WG:	Akira Shimatsu
Rheumatology WG:	Jonathan Kay
IM-TAG managing editor:	Megan Cumerlato
IM-TAG secretariats	Emiko Oikawa, Toshio Ogawa

1. WGs update

1.1 Hepatology and Pancreaticobiliary WG

Ms. Cumerlato explained that Ms. Rust was entering the structural changes for the Hepatology and Pancreaticobiliary WG into the iCAT. Professor Keeffe noted that there were some overlaps in the pediatric area but the issue had been resolved with Dr. Chang from Taiwan.

1.2 Gastroenterology WG

Ms. Cumerlato reported that Ms. Rust was entering the changes for the Gastroenterology WG into the iCAT and that Ms. Rust would send out feedback documents for outstanding issues that needed to be resolved. She explained that although the workload was considerable, the work was on track.

1.3 Cardiovascular WG

Dr. Ogawa reported that he received e-mail from Dr. Kohro on the current state of the Cardiovascular WG. According to Dr. Kohro, the WG was drafting the alpha draft within the Japanese cardiovascular societies, after which the WG would ask international cardiovascular societies for review of the proposals. Prof. Sugano noted that the Japanese societies would likely complete the drafting by end of March. Dr. Ogawa said he would contact Dr. Kohro to confirm.

1.4 Endocrinology WG

Dr. Shimatsu reported that Prof. Tajima worked hard on the alpha drafting with a particular focus on achieving logical classification for clinical practice for the diabetes section and that the WG needed comments on diabetes caused by genetic disorders. He expected the alpha draft to be completed by the end of the current week, which would

then be circulated within the international WG for approval and input into the iCAT. Prof. Sugano commented that metabolic diseases were a subject of intense focus from other groups, such as Nephrology WG, Ophthalmology TAG, and Neurology TAG, and it was particularly important to finalize the drafting for this section.

1.5 Rheumatology WG

Dr. Kay reported that the basic structure of the rheumatology section had been completed and that a number of organ- and disease-specific associations were showing interest in providing their input into the classification and fine tune the alpha draft based on their expertise in a Wiki-like process. He also mentioned that in terms of infrastructure, a U.S. rheumatology association was willing to consider supporting the managing editors and that a European rheumatology association would provide some funding.

1.6 Respiratory WG

Ms. Cumerlato explained that some of the structural changes were being put into the iCAT. She also sent feedback documents to Dr. Ingbar, who might have further changes.

2. Issues Discussed

2.1 Definition Layers

Questions were asked about the timeline regarding the work on the definition layers. Prof. Sugano pointed out that only after finalizing the ICD-11 structure in the alpha draft phase could the definition layers be added, which would be in the beta draft phase scheduled to start in May.

2.2 Eponyms

Dr. Kay asked how eponyms should be dealt with in ICD-11. Ms. Cumerlato replied that it was the stance of WHO to discourage the use of eponyms and to use more clinical terms instead, as indicated in WHO's content manual document.

2.3 Anatomical Sites

Dr. Kay remarked that an anatomical or organ coding system, which would link a diagnosis with specific anatomical sites or organs (ex. systemic lupus erythematosus to kidney or other organs), should be incorporated into ICD-11. Ms. Cumerlato replied that there was discussion at WHO on creating a separate chapter on all anatomical sites within ICD-11, which, if realized, would enable such a coding system. Prof. Sugano mentioned that there was also a move within WHO to create a multi-system disease chapter, which might have relevance to the Rheumatology WG.

2.4 Pediatric TAG

Dr. Franklin asked whether there would be a separate chapter on congenital malformation. Prof. Sugano replied that the Pediatric TAG was working on the congenital diseases section of ICD-11. Apart from that, no other information was available. Dr.

Franklin, who was also on the Pediatric TAG, requested to identify pediatric representatives in each IM-TAG WG for possible interactions between the two TAGs. Dr. Ogawa agreed to confirm the identities of those pediatricians not yet known.

3. The Next Face-to-Face Meeting

Ms. Oikawa explained that the next face-to-face meeting of IM-TAG would be held from April 18 (Mon.) to 19 (Tue.), 2011, in Tokyo, and that all WG chairs were invited. Funding to cover the travel expenses for Ms. Rust and Ms. Cumerlato was being worked out. Dr. Teramoto, Director of the Japanese Society of Internal Medicine, was expected to address the opening session, and a reception was planned on April 18. The invitations would be sent shortly.

4. Closing

Prof. Sugano thanked all the participants to the teleconference and closed the meeting.

平成 22 年度　第 5 回電話会議の概要

Date: Tuesday, February 22, 2011 (6:10 a.m. GMT)

Participants:

IM TAG:	Kentaro Sugano
Gastroenterology WG:	N/A
Hepatology and Pancreatobiliary WG:	N/A
Nephrology WG:	Yasuhiko Iino
Cardiovascular WG:	N/A
Respiratory WG:	N/A
Hematology WG:	Willem Fibbe
Endocrinology WG:	Naoko Tajima
Rheumatology WG:	N/A
IM-TAG managing editor:	Megan Cumerlato
IM-TAG secretariats	Emiko Oikawa, Toshio Ogawa, Tomomi Sano

Minutes of Meeting

1. WGs update

1.1 Hematology WG

Prof. Fibbe reported that the U.S., European, and Japanese hematology associations were working on the revision of the proposals made and that the Hematology WG was aiming to have the structural changes put into the iCAT before the next face-to-face meeting in April. He noted that the WG was working with the ICD-O group with the objective of having proposals that were in complete harmonization with ICD-O and resolving overlap issues. On the subject of overlap with Rare Diseases TAG, he said that the WG was in contact with the Rare Diseases TAG and that he saw no major problem concerning the issue as the Rare Diseases TAG had indicated that they would follow the lead of the work already completed by the Hematology WG. He expected the issue of allocation of rare diseases within the ICD-11 structure could be solved at the WG level.

1.2 Endocrinology WG

Prof. Tajima, who was now officially approved by WHO as the co-chair of Endocrinology WG, introduced herself as Endocrinology WG co-chair responsible for the diabetes and metabolism section, and thanked the other IM-TAG members for their support. She reported that the WG would check the provisional alpha draft on matters of transparency and grammar before sending it to Ms. Rust by the end of the current week. She said that as for diabetes, the WG made changes to the hierarchy according to etiological classification but retained the original coding hierarchy as mush as possible. Prof. Sugano stressed the importance of completing the draft for the diabetes and metabolism section as it concerned other groups, such as Nephrology WG, Dermatology TAG, and

Ophthalmology TAG. He also requested the Endocrinology WG to examine nutritional deficiency diseases and related conditions, as this area was important from the WHO perspective in terms of the worldwide use of ICD-11, because two thirds of the world population were in a state of nutritional deficiency.

1.3 Nephrology WG

Dr. Iino and Ms. Cumerlato explained that a part of the proposals from the Nephrology WG were now in the iCAT and the work of completing the alpha draft was on track. Dr. Iino said that the WG would meet at an international conference on nephrology on April 8–9, 2011.

2. Issues Discussed

2.1 Timeline

Prof. Tajima asked by when the input into the iCAT should be completed. Prof. Sugano explained that the work had to be completed by end of April before the start of the beta phase set by WHO in May but that it was preferable to have the work completed before the IM-TAG face-to-face meeting in mid-April so there could be discussion on the iCAT platform at the meeting. Prof. Sugano further pointed out that the filling out of the definition layers would only begin in the beta phase after the structural base was solidified and agreed upon in the alpha phase.

2.2 Synonyms and Eponyms

Prof. Sugano mentioned that the handling of synonyms and eponyms would be one of the subjects that would be discussed at the face-to-face meeting in April.

2.3 Pediatric TAG

Prof. Sugano touched on the subject of the pediatric representation in each IM-TAG WG, which was discussed in the first session of the teleconference. Dr. Fibbe confirmed that Hematology WG had at least two pediatricians in the group.

2.4 Multi-System Disease Chapter

Prof. Sugano indicated that WHO was proposing establishing a multi-system disease chapter in ICD-11 and that the IM-TAG would discuss this issue at the face-to-face meeting in April, as many diseases covered by the TAG were linked to the multi-system disease chapter, particularly rheumatology. Prof. Tajima remarked that although the idea of having a multi-system disease chapter might complicate the situation and discussions were needed among the related groups, the idea was an excellent one.

2.5 iCAT Platform and Training Tool

Dr. Iino inquired about the password to the iCAT platform. Ms. Cumerlato replied that she would check and that she would also make sure that WG chairs without access to the platform would have one. Ms. Cumerlato further reported that WHO had released the training video tool for the iCAT and content model. She would send e-mail with a link to

the training tool to all WG chairs and managing editors. Dr. Ogawa agreed to provide an instruction manual to WG chairs and managing editors.

3. The Next Face-to-Face Meeting

Prof. Sugano said that the venue, agenda, and other details of the next face-to-face meeting in Tokyo on April 18 (Mon.) and 19 (Tue.), 2011, would be sent out shortly.

4. Closing

Prof. Sugano thanked all the participants to the teleconference and closed the meeting.

αドラフト

循環器分野

New classification

Hypertensive diseases
(I10–I15)
Excludes: complicating pregnancy, childbirth and the puerperium (O10–O11, O13–O16)
involving coronary vessels (I20–I25)
neonatal hypertension (P29.2)
pulmonary hypertension (I27.0)

I10 Essential (primary) hypertension
High blood pressure
Hypertension (arterial)(benign)(essential)(primary)(systemic)
Includes: Systolic and Diastolic hypertension
Systolic hypertension
Excludes: involving vessels of:
· brain (I60–I69)
· eye (H35.0)

I11 Hypertensive heart disease
Includes: any condition in I50.–, I51.4–I51.9 due to hypertension
I11.0 Hypertensive heart disease with (congestive) heart failure
Hypertensive heart failure
I11.9 Hypertensive heart disease without (congestive) heart failure
Hypertensive heart disease NOS

I12 Hypertensive renal disease
Includes: any condition in N00–N07, N18.–, N19.–or N26.–due to hypertension
arteriosclerosis of kidney
arteriosclerotic nephritis (chronic)(interstitial)
hypertensive nephropathy
nephrosclerosis
Excludes: secondary hypertension (I15.–)
I12.0 Hypertensive renal disease with renal failure
Hypertensive renal failure
I12.9 Hypertensive renal disease without renal failure
Hypertensive renal disease NOS

I13 Hypertensive heart and renal disease
Includes: any condition in I11.– with any condition in I12.disease:
· cardiorenal
· cardiovascular renal
I13.0 Hypertensive heart and renal disease with (congestive) heart failure
I13.1 Hypertensive heart and renal disease with renal failure
I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
I13.9 Hypertensive heart and renal disease, unspecified

I14 Hypertensive crisis
Excludes: Severe hypertension with
· cerebral infarction
· intracranial hemorrhage
· subarachnoid hemorrhage
· acute aortic dissection
· acute heart failure
· acute glomerulonephritis or acute renal crisis
· excessive circulating cathecholamines (pheochromocytoma, cocaine use etc.)
· eclampsia
I14.0 Accelerated–malignant hypetension with papilledema
I14.1 Hypertensive encephalopathy

I15 Secondary hypertension
Excludes: involving vessels of:
· brain (I60–I69)
· eye (H35.0)
I15.0 Renovascular hypertension
I15.1 Hypertension secondary to other renal disorders
renal parenchymal disease, renin–producinf tumors, renoprival, primary sodium retention

ICD-10 classification

Hypertensive diseases
(I10–I15)
Excludes: complicating pregnancy, childbirth and the puerperium (O10–O11, O13–O16)
involving coronary vessels (I20–I25)
neonatal hypertension (P29.2)
pulmonary hypertension (I27.0)

I10 Essential (primary) hypertension
High blood pressure
Hypertension (arterial)(benign)(essential)(malignant)(primary)(systemic)

Excludes: involving vessels of:
· brain (I60–I69)
· eye (H35.0)

I11 Hypertensive heart disease
Includes: any condition in I50.–, I51.4–I51.9 due to hypertension
I11.0 Hypertensive heart disease with (congestive) heart failure
Hypertensive heart failure
I11.9 Hypertensive heart disease without (congestive) heart failure
Hypertensive heart disease NOS

I12 Hypertensive renal disease
Includes: any condition in N00–N07, N18.–, N19.–or N26.–due to hypertension
arteriosclerosis of kidney
arteriosclerotic nephritis (chronic)(interstitial)
hypertensive nephropathy
nephrosclerosis
Excludes: secondary hypertension (I15.–)
I12.0 Hypertensive renal disease with renal failure
Hypertensive renal failure
I12.9 Hypertensive renal disease without renal failure
Hypertensive renal disease NOS

I13 Hypertensive heart and renal disease
Includes: any condition in I11.– with any condition in I12.disease:
· cardiorenal
· cardiovascular renal
I13.0 Hypertensive heart and renal disease with (congestive) heart failure
I13.1 Hypertensive heart and renal disease with renal failure
I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
I13.9 Hypertensive heart and renal disease, unspecified

I15 Secondary hypertension
Excludes: involving vessels of:
· brain (I60–I69)
· eye (H35.0)
I15.0 Renovascular hypertension
I15.1 Hypertension secondary to other renal disorders

I15.2 **Hypertension secondary to endocrine disorders**
acromagaly, hypothyroidism, hyperthyroidism, hypercalcemia, adrenal, extraadrenal chromaffin tumors, carcinoid, exogenous hormonse

I15.8 **Other secondary hypertension**
neurological dfisorder, alcohol and drug use

I15.9 **Secondary hypertension, unspecified**

Ischaemic heart diseases
(I20–I25)
Note: For morbidity, duration as used in categories I21, I22, I24 and I25 refers to the interval elapsing between onset of the ischaemic episode and admission to care. For mortality, duration refers to the interval elapsing between onset and death.
Includes: with mention of hypertension (I10–I15)
Use additional code, if desired, to identify presence of hypertension.

I20 Angina pectoris

I20.0 **Unstable angina**
Angina:
· crescendo
· de novo effort
· worsening effort
Intermediate coronary syndrome
Preinfarction syndrome

I20.1 **Angina pectoris with documented spasm**
Angina:
· angiospastic
· Prinzmetal
· spasm-induced
· variant

I20.2 **Stable angina**
Angina:
· effort, no worsening

I20.8 **Other forms of angina pectoris**
Stenocardia

I20.9 **Angina pectoris, unspecified**
Angina:
· NOS
· cardiac
Anginal syndrome
Ischaemic chest pain

I21 Acute myocardial infarction

Includes: myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset
Excludes: certain current complications following acute myocardial infarction (I23.–)
myocardial infarction:
· old (I25.2)
· specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset (I25.8)
· subsequent (I22.–)
postmyocardial infarction syndrome (I24.1)

I21.0 **Acute transmural myocardial infarction of anterior wall**
Transmural infarction (acute)(of):
· anterior (wall) NOS
· anteroapical
· anterolateral
· anteroseptal

I21.1 **Acute transmural myocardial infarction of inferior wall**
Transmural infarction (acute)(of):
· diaphragmatic wall
· inferior (wall) NOS
· inferolateral
· inferoposterior

I21.2 **Acute transmural myocardial infarction of other sites**
Transmural infarction (acute)(of):
· apical-lateral
· basal-lateral
· high lateral
· lateral (wall) NOS

I15.2 **Hypertension secondary to endocrine disorders**

I15.8 **Other secondary hypertension**

I15.9 **Secondary hypertension, unspecified**

Ischaemic heart diseases
(I20–I25)
Note: For morbidity, duration as used in categories I21, I22, I24 and I25 refers to the interval elapsing between onset of the ischaemic episode and admission to care. For mortality, duration refers to the interval elapsing between onset and death.
Includes: with mention of hypertension (I10–I15)
Use additional code, if desired, to identify presence of hypertension.

I20 Angina pectoris

I20.0 **Unstable angina**
Angina:
· crescendo
· de novo effort
· worsening effort
Intermediate coronary syndrome
Preinfarction syndrome

I20.1 **Angina pectoris with documented spasm**
Angina:
· angiospastic
· Prinzmetal
· spasm-induced
· variant

I20.8 **Other forms of angina pectoris**
Angina of effort
Coronary slow flow syndrome
Stenocardia

I20.9 **Angina pectoris, unspecified**
Angina:
· NOS
· cardiac
Anginal syndrome
Ischaemic chest pain

I21 Acute myocardial infarction

Includes: myocardial infarction specified as acute or with a stated duration of 4 weeks (28 days) or less from onset
Excludes: certain current complications following acute myocardial infarction (I23.–)
myocardial infarction:
· old (I25.2)
· specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset (I25.8)
· subsequent (I22.–)
postmyocardial infarction syndrome (I24.1)

I21.0 **Acute transmural myocardial infarction of anterior wall**
Transmural infarction (acute)(of):
· anterior (wall) NOS
· anteroapical
· anterolateral
· anteroseptal

I21.1 **Acute transmural myocardial infarction of inferior wall**
Transmural infarction (acute)(of):
· diaphragmatic wall
· inferior (wall) NOS
· inferolateral
· inferoposterior

I21.2 **Acute transmural myocardial infarction of other sites**
Transmural infarction (acute)(of):
· apical-lateral
· basal-lateral
· high lateral
· lateral (wall) NOS

- posterior (true)
- posterobasal
- posterolateral
- posteroseptal
- septal NOS

I21.3 **Acute transmural myocardial infarction of unspecified site**
Transmural myocardial infarction NOS

I21.4 **Acute subendocardial myocardial infarction**
Nontransmural myocardial infarction NOS

I21.9 **Acute myocardial infarction, unspecified**

I22 Recent myocardial infarction

Includes: myocardial infarction:
- extension
- recurrent
- reinfarction

Note: For morbidity coding, this category should be assigned for infarction of any myocardial site, occurring within 4 weeks (28 days) from onset of a previous infarction

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

I22.0 **Recent myocardial infarction of anterior wall**
Recent infarction (acute)(of):
- anterior (wall) NOS
- anteroapical
- anterolateral
- anteroseptal

I22.1 **Recent myocardial infarction of inferior wall**
Recent infarction (acute)(of):
- diaphragmatic wall
- inferior (wall) NOS
- inferolateral
- inferoposterior

I22.8 **Recent myocardial infarction of other sites**
Recent myocardial infarction (acute)(of):
- apical-lateral
- basal-lateral
- high lateral
- lateral (wall) NOS
- posterior (true)
- posterobasal
- posterolateral
- posteroseptal
- septal NOS

I22.9 **Recent myocardial infarction of unspecified site**

I2A **Old myocardial infarction**
Includes: myocardial infarction:
- extension
- recurrent
- reinfarction

Note: For morbidity coding, this category should be assigned for infarction of any myocardial site, occurring within 4 weeks (28 days) from onset of a previous infarction

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

I2A.0 **Old myocardial infarction of anterior wall**
Old infarction (acute)(of):
- anterior (wall) NOS
- anteroapical
- anterolateral
- anteroseptal

I2A.1 **Old myocardial infarction of inferior wall**
Old infarction (acute)(of):
- diaphragmatic wall
- inferior (wall) NOS
- inferolateral
- inferoposterior

I2A.8 **Old myocardial infarction of other sites**

- posterior (true)
- posterobasal
- posterolateral
- posteroseptal
- septal NOS

I21.3 **Acute transmural myocardial infarction of unspecified site**
Transmural myocardial infarction NOS

I21.4 **Acute subendocardial myocardial infarction**
Nontransmural myocardial infarction NOS

I21.9 **Acute myocardial infarction, unspecified**
Myocardial infarction (acute) NOS

I22 Subsequent myocardial infarction

Includes: myocardial infarction:
- extension
- recurrent
- reinfarction

Note: For morbidity coding, this category should be assigned for infarction of any myocardial site, occurring within 4 weeks (28 days) from onset of a previous infarction

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

I22.0 **Subsequent myocardial infarction of anterior wall**
Subsequent infarction (acute)(of):
- anterior (wall) NOS
- anteroapical
- anterolateral
- anteroseptal

I22.1 **Subsequent myocardial infarction of inferior wall**
Subsequent infarction (acute)(of):
- diaphragmatic wall
- inferior (wall) NOS
- inferolateral
- inferoposterior

I22.8 **Subsequent myocardial infarction of other sites**
Subsequent myocardial infarction (acute)(of):
- apical-lateral
- basal-lateral
- high lateral
- lateral (wall) NOS
- posterior (true)
- posterobasal
- posterolateral
- posteroseptal
- septal NOS

I22.9 **Subsequent myocardial infarction of unspecified site**

Old myocardial infarction (acute)(of):
- apical-lateral
- basal-lateral
- high lateral
- lateral (wall) NOS
- posterior (true)
- posterobasal
- posterolateral
- posteroseptal
- septal NOS

12A.9 **Old myocardial infarction of unspecified site**

I23 Certain current complications following acute myocardial infarction

Excludes: the listed conditions, when:
- concurrent with acute myocardial infarction (I21–I22)
- not specified as current complications following acute myocardial infarction (I31.–, I51.–)

I23.0 **Haemopericardium as current complication following acute myocardial infarction**

I23.1 **Atrial septal defect as current complication following acute myocardial infarction**

I23.2 **Ventricular septal defect as current complication following acute myocardial infarction**

I23.3 **Rupture of cardiac wall without haemopericardium as current complication following acute myocardial infarction**

Excludes: with haemopericardium (I23.0)

I23.4 **Rupture of chordae tendineae as current complication following acute myocardial infarction**

I23.5 **Rupture of papillary muscle as current complication following acute myocardial infarction**

I23.6 **Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction**

I23.7 **Dressler's syndrome**

Postmyocardial infarction syndrome

I23.8 **Other current complications following acute myocardial infarction**

I24 Other acute ischaemic heart diseases

Excludes: angina pectoris (I20.–)
transient myocardial ischaemia of newborn (P29.4)

I24.0 **Coronary thrombosis not resulting in myocardial infarction**

Coronary (artery)(vein):
- embolism
- occlusion
- thromboembolism

} not resulting in myocardial infarction

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

I24.8 **Other forms of acute ischaemic heart disease**

Coronary:
- failure
- insufficiency

I24.9 **Acute ischaemic heart disease, unspecified**

Excludes: ischaemic heart disease (chronic) NOS (I25.9)

I25 Chronic coronary heart disease

Excludes: cardiovascular disease NOS (I51.6)

I25.0 **Diseases of the coronary artery**

I25.0.1 **Coronary Atherosclerosis without significant ischemia**

Atherosclerotic heart disease
Coronary (artery):
- atheroma
- atherosclerosis
- disease
- sclerosis

I25.0.2 **Coronary artery aneurysm**

Coronary arteriovenous fistula, acquired
Excludes: congenital coronary (artery) aneurysm (Q24.5)

I25.1 **Chronic ischemia of the myocardium**

I25.1.1 **Ischaemic cardiomyopathy**

I25.1.2 **Silent myocardial ischaemia**

I25.1.3 **Aneurysm of heart following myocardial infarction**

Aneurysm:
- mural
- ventricular

I25.8 **Other forms of chronic ischaemic heart disease**

Any condition in I21–I22 and I24.–specified as chronic or with a stated duration of more than 4 weeks

I23 Certain current complications following acute myocardial infarction

Excludes: the listed conditions, when:
- concurrent with acute myocardial infarction (I21–I22)
- not specified as current complications following acute myocardial infarction (I31.–, I51.–)

I23.0 **Haemopericardium as current complication following acute myocardial infarction**

I23.1 **Atrial septal defect as current complication following acute myocardial infarction**

I23.2 **Ventricular septal defect as current complication following acute myocardial infarction**

I23.3 **Rupture of cardiac wall without haemopericardium as current complication following acute myocardial infarction**

Excludes: with haemopericardium (I23.0)

I23.4 **Rupture of chordae tendineae as current complication following acute myocardial infarction**

I23.5 **Rupture of papillary muscle as current complication following acute myocardial infarction**

I23.6 **Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction**

I23.8 **Other current complications following acute myocardial infarction**

I24 Other acute ischaemic heart diseases

Excludes: angina pectoris (I20.–)
transient myocardial ischaemia of newborn (P29.4)

I24.0 **Coronary thrombosis not resulting in myocardial infarction**

Coronary (artery)(vein):
- embolism
- occlusion
- thromboembolism

} not resulting in myocardial infarction

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

I24.1 **Dressler's syndrome**

Postmyocardial infarction syndrome

I24.8 **Other forms of acute ischaemic heart disease**

Coronary:
- failure
- insufficiency

I24.9 **Acute ischaemic heart disease, unspecified**

Excludes: ischaemic heart disease (chronic) NOS (I25.9)

I25 Chronic ischaemic heart disease

Excludes: cardiovascular disease NOS (I51.6)

I25.0 **Atherosclerotic cardiovascular disease, so described**

I25.1 **Atherosclerotic heart disease**

Coronary (artery):
- atheroma
- atherosclerosis
- disease
- sclerosis

I25.2 **Old myocardial infarction**

Healed myocardial infarction
Past myocardial infarction diagnosed by ECG or other special investigation, but currently presenting no symptoms

I25.3 **Aneurysm of heart**

Aneurysm:
- mural
- ventricular

I25.4 **Coronary artery aneurysm**

Coronary arteriovenous fistula, acquired
Excludes: congenital coronary (artery) aneurysm (Q24.5)

I25.5 **Ischaemic cardiomyopathy**

I25.6 **Silent myocardial ischaemia**

(more than 28 days) from onset

I25.9 **Chronic ischaemic heart disease, unspecified**
Ischaemic heart disease (chronic) NOS

Pulmonary heart disease and diseases of pulmonary circulation
(I26–I28)

I26 **Pulmonary thromboembolism**

Includes: pulmonary (artery)(vein):
- infarction
- thromboembolism
- thrombosis

Excludes: complicating:
- abortion or ectopic or molar pregnancy (O00–O07, O08.2)
- pregnancy, childbirth and the puerperium (O88.–)

I26.0 **Acute pulmonary thromboembolism**
Acute pulmonary thromboembolism with pulmonary hypertension
Acute pulmonary thromboembolism without pulmonary hypertension

I26.1 **Chronic pulmonary thromboembolism without pulmonary hypertension**

I26.2 **Chronic thromboembolic pulmonary hypertension**

I27 **Other pulmonary hypertension**

I27.0 **Pulmonary arterial hypertension**
Idiopathic pulmonary arterial hypertension
Heritable pulmonary arterial hypertension
Portopulmonary hypertension
Persistent pulmonary hypertension of the newborn
Pulmonary veno-occlusive disease／Pulmonary capillary hemangiomatosis

I27.2 **Other secondary pulmonary hypertension**
Drug- or toxin-induced pulmonary arterial hypertension
Pulmonary arterial hypertension associated with connective tissue disease
Pulmonary arterial hypertension associated with HIV infection
Pulmonary arterial hypertension associated with Congenital heart diseases
Pulmonary arterial hypertension associated with Schistosomiasis
Pulmonary arterial hypertension associated with Chronic hemolytic anemia
Pulmonary hypertension owing to lung disease and/or hypoxemia
Pulmonary arterial hypertension associated with sleep-disordered breathing
Pulmonary arterial hypertension associated with prolonged residence at high altitude
Use additional code, if desired, to identify the underlying disease

I27.8 **Other specified pulmonary heart diseases**
Excludes: Eisenmenger's defect (Q21.8)

I27.9 **Pulmonary heart disease, unspecified**
Chronic cardiopulmonary disease
Cor pulmonale (chronic) NOS

I28 **Other diseases of pulmonary vessels**

I28.0 **Arteriovenous fistula of pulmonary vessels**

I28.1 **Aneurysm of pulmonary artery**

I28.8 **Other specified diseases of pulmonary vessels**
Rupture, Stenosis, Stricture } of pulmonary vessel

I28.9 **Disease of pulmonary vessels, unspecified**

Pericarditis
(I30–I32)

I30 **Pericarditis, acute pericarditis, pericardial effusion**
Includes: acute pericardial effusion
Excludes: rheumatic pericarditis (acute) (I01.0)

I30.0 **Acute nonspecific idiopathic pericarditis**

I30.1 **Infective pericarditis**
Pericarditis, Pyopericarditis, Purulent pericarditis:
- bacterial
- yuberculous

rickettsial, spirochetal, spirillum, mycoplasma pneumoniae, infectious mononucleosis, leptospira, listeria, lymphogranuloma venereum, psittacosis(chlamydiaceae)

I25.8 **Other forms of chronic ischaemic heart disease**
Any condition in I21–I22 and I24.–specified as chronic or with a stated duration of more than 4 weeks (more than 28 days) from onset

I25.9 **Chronic ischaemic heart disease, unspecified**
Ischaemic heart disease (chronic) NOS

I26 **Pulmonary embolism**

Includes: pulmonary (artery)(vein):
- infarction
- thromboembolism
- thrombosis

Excludes: complicating:
- abortion or ectopic or molar pregnancy (O00–O07, O08.2)
- pregnancy, childbirth and the puerperium (O88.–)

I26.0 **Pulmonary embolism with mention of acute cor pulmonale**
Acute cor pulmonale NOS

I26.9 **Pulmonary embolism without mention of acute cor pulmonale**
Pulmonary embolism NOS

I27 **Other pulmonary heart diseases**

I27.0 **Primary pulmonary hypertension**

I27.1 **Kyphoscoliotic heart disease**

I27.2 **Other secondary pulmonary hypertension**

Use additional code, if desired, to identify the underlying disease

I27.8 **Other specified pulmonary heart diseases**
Excludes: Eisenmenger's defect (Q21.8)

I27.9 **Pulmonary heart disease, unspecified**
Chronic cardiopulmonary disease
Cor pulmonale (chronic) NOS

I28 **Other diseases of pulmonary vessels**

I28.0 **Arteriovenous fistula of pulmonary vessels**

I28.1 **Aneurysm of pulmonary artery**

I28.8 **Other specified diseases of pulmonary vessels**
Rupture, Stenosis, Stricture } of pulmonary vessel

I28.9 **Disease of pulmonary vessels, unspecified**

Pericarditis
(I30–I32)

I30 **Acute pericarditis**

Includes: acute pericardial effusion
Excludes: rheumatic pericarditis (acute) (I01.0)

I30.0 **Acute nonspecific idiopathic pericarditis**

I30.1 **Infective pericarditis**
Pericarditis:
- pneumococcal