STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS

FIFTH EDITION

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and
ADALINE C. HAYDEN, C.R.L., ASSOCIATE EDITOR

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STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS

PREFACE

The purpose of the system of classifying disease employed in this book is to present a logical clinical nomenclature. Work on this Nomenclature was initiated by invitation of the New York Academy of Medicine, March 22, 1928; and at that time the National Conference on Nomenclature of Disease was formed with a membership representing most of the leading medical and public health organizations in the country. Dr. George Baehr served as chairman of the steering committee of this conference, prepared the plan for a dual topographical, etiological classification in accordance with the library coding system, did much of the work in preparing the schema, enlisted the cooperation of national societies, and stimulated development of proper financing for the Nomenclature. The Commonwealth Fund was responsible for a large share of the financial support for this undertaking. A number of individuals, special funds, insurance companies, and medical organizations also contributed to the support of the work. The major credit for completing the book is due to Dr. H. B. Logie, the executive secretary of the National Conference.

The basic plan was adopted officially at the second National Conference on November 24, 1930. The first printing appeared in 1932, the first edition in 1933, and the second edition in 1935. Obviously a nomenclature of this kind must be kept constantly abreast of the progress of medicine, and the responsibility for its periodic revision was therefore taken over by the American Medical Association in 1937. In connection with the third edition, planned after this change in control, a fourth National Conference on Medical Nomenclature was held under the auspices of the American Medical Association in Chicago on March 1, 1940 with Dr. Haven Emerson of New York serving as chairman. About sixty delegates from interested organizations and institutions attended that conference. Abstracts of the conference were published in the *Journal of the American Medical Association.*

The third edition, edited by Dr. Edwin P. Jordan, was published in June, 1942. The fifth National Conference on medical nomenclature was held under the auspices of the American Medical Association in Chicago on June 23, 1948. At this time publication of a new edition was considered and decided upon. Subsequently, on October 1, 1948 the Board of Trustees of the American Medical Association appointed for the fourth edition a new editorial advisory board consisting of Dr. George Baehr, Chairman, New York; Dr. Selwyn D. Collins, Washington; Dr. James R. Miller, Hartford, Conn.; Dr. Halbert L. Dunn, Washington; Dr. Edward T. Thompson, Washington; Dr. Edwin L. Crosby, Baltimore; Dr. Morris Fishbein, Chicago; Dr. R. J. Plunkett, Chicago; and Mrs. Adaline C. Hayden, C.R.L., Chicago.

The editorial advisory board met on December 4, 1948 at the American Medical Association, Chicago. General plans for a new revision were discussed, and individual committees were appointed to consider revision of each section of the Nomenclature. Dr. R. J. Plunkett was designated as editor and Mrs. Adaline C. Hayden, C.R.L., was designated as associate editor for the fourth edition. The fourth edition was published in 1952. Immediately following the publication of the fourth edition, the Editorial Advisory Board was reconstituted under the chairmanship of Dr. George Baehr with the following membership: Dr. Austin Smith, Chicago; Dr. Selwyn D. Collins (deceased), Washington; Dr. Edward T. Thompson, Washington; Dr. Edwin L. Crosby, Chicago; Dr. Richard J. Plunkett, Chicago; and Mrs. Adaline C. Hayden, C.R.L., Chicago. In 1957 Drs. Edwin Jordan and Kenneth Babcock were appointed as additional members of the Editorial Advisory Board.

In December, 1955 Dr. Richard Plunkett resigned as editor of the Nomenclature to assume the position of Associate Director of Administration, Joint Commission of Mental Illness and Health. In February, 1956 the Board of Trustees appointed Dr. Edward T. Thompson, Coordinator of Professional Services, Division of Hospital Facilities, Public Health Service, Washington, editor of the Standard Nomenclature of Diseases and Operations. Dr. Thompson had served as a member of the Editorial Advisory Board since 1948.

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The chairman of each Standard Nomenclature committee was empowered to appoint such additional consultants as were needed for the work of his committee and to collaborate fully with standing committees on nomenclature of other national medical and scientific associations.

Several changes have been made in the general arrangement of this edition to increase the usefulness of the book and to bring about a closer integration of the material presented.

A growing body of scientific knowledge of recent years has required many changes in the scientific material presented. In this revision changes include complete revision of the Neurology, Ophthalmology, and Obstetric and Newborn sections.

The topography and surgery sections have been considerably expanded.

Revision of the other sections of the book has been kept as much as possible to a minimum. Nevertheless, approximately 6,000 changes represented as additions, deletions, or corrections have been required in this edition to compensate for needed consistency changes, advances in knowledge, and new scientific concepts since publication of the fourth edition.

Dr. George Baehr, chairman, and the members of the Editorial Advisory Board express sincere appreciation to the chairmen, committee members, and consultants who have so freely contributed much of their time and effort toward this revision.

EDWARD T. THOMPSON, M.D., *Editor*
ADALINE C. HAYDEN, C.R.L., *Associate Editor*

INTRODUCTION

The Standard Nomenclature attempts to include every disease which is clinically recognizable and to avoid repetition and overlapping. English terms in good usage are employed whenever possible in preference to Latin or Greek terms, although numerous exceptions occur, especially under diseases of the skin and of the eye. This Nomenclature clarifies the distinction between a disease and its manifestations (Supplementary Terms). It has been designed primarily for use by clinicians, as the clinical diagnosis is a most important source of information on prevalence and distribution of disease.

The method of classification is based on two elements: the portion of the body concerned (topographic) and the cause of the disorder (etiologic). These two elements are designated by code numbers separated from each other by a hyphen. The first three digits describe the topographic site; the last three, following the hyphen, describe the etiologic agent. Combined they form a complete diagnostic code number.

TOPOGRAPHIC CLASSIFICATION

The main topographic systems are:

0– Body as a whole (including the psyche and the body generally) not a particular system exclusively
1– Integumentary system (including subcutaneous areolar tissue, mucous membranes of orifices and the breast)
2– Musculoskeletal system
3– Respiratory system
4– Cardiovascular system
5– Hemic and lymphatic systems
6– Digestive system
7– Urogenital system
8– Endocrine system
9– Nervous system
x– Organs of special sense

These major groups are further divided in order to specify a definite organ or part of an organ. Thus, for example, the digestive system is designated by 6. The fourth organ listed in the system being stomach, the digits for the stomach are 64. The pylorus which according to arrangement is the fifth structure under stomach therefore receives the code number 645–. Thus if a lesion involves the whole alimentary tract, it will receive the topographic classification 600–; if the disease involves all of the stomach, it will receive the number 640–; and if it can be positively identified as involving the pylorus, it receives the number 645–.

ETIOLOGIC CLASSIFICATION

A similar system of numbering the causes of disease constitutes the second element of the classification. Thirteen major etiologic categories are included:

–0 Diseases due to prenatal influence
–1 Diseases due to a lower plant or animal parasite
–2 Diseases due to a higher plant or animal parasite
–3 Diseases due to intoxication
–4 Diseases due to trauma or physical agent
–50 Diseases secondary to circulatory disturbance
–55 Diseases secondary to disturbance of innervation or of psychic control

–6 Diseases due to or consisting of static mechanical abnormality (obstruction, calculus, displacement, or gross change in form) due to unknown cause
–7 Diseases due to disorder of metabolism, growth or nutrition
–8 New growths
–9 Diseases due to unknown or uncertain cause with the structural reaction (degenerative, infiltrative, inflammatory, proliferative, sclerotic, or reparative) manifest; hereditary and familial diseases of this nature
–x Diseases due to unknown or uncertain cause with the functional reaction alone manifest; hereditary and familial diseases of this nature
–y Diseases of undetermined cause

As in the topographic classification, these major groups are further subdivided to specify particular etiologic agents. For example, a causative agent identified as poison, but with its exact nature undetermined or unspecified, receives the number –300. If identified as a metallic poison, but with the exact metal undetermined, it will receive the number –310. If the metal can be identified as a heavy metal, for example, it will receive the number –311, and if identifiable as mercury, it receives the number –3111, thus indicating the specific etiologic agent. In certain of the etiologic groups it is necessary to insert an added decimal digit to indicate the anatomic or functional disturbance produced by the etiologic agent. If one wishes to indicate that mercury has produced degeneration, the code number assigned would be –3111.9. The digit following the decimal point indicates the resultant degeneration. Similarly, ankylosis of knee due to infection would receive the number 248–100.4; the digit following the decimal represents the ankylosis. The 248– is the topographic number for knee, while –100 indicates infection, generally. More specifically, if the ankylosis was due to tuberculosis, the code would be 248–123.4.

Secondary Diagnoses—The determination of which of two or more diagnoses is primary and which is secondary is influenced by the interpretation of the individual coders. No universal rule can be stated since a diagnosis which is primary in one situation may be secondary in another. This fact invalidates the statistics of primary and secondary diagnoses. Recognition of these facts has influenced many institutions to stop the cross-indexing of primary and secondary diagnoses and to record all conditions, whether primary, secondary, or associated on the appropriate disease-classification card without reference to their relationship.

If an institution wishes to attempt a distinction between primary and secondary diagnoses, this may be done as follows: The secondary diagnoses may be entered with a different color ink or may be placed, if desired, on different color cards.

Symptoms, Manifestations, or *Supplementary Terms*—For the indication of symptoms this edition includes, under the section on Supplementary Terms, code numbers for the coding of symptoms or other manifestations of disease for each of which special cards may be employed if desired. The Supplementary Terms have been grouped in sections that follow the pattern of the sections in the body of the book, i.e., Body as a Whole, Regional and General Diseases, Skin, etc. The terms are listed under the system classification in which they most commonly occur as symptoms or manifestations; however,

any of the terms listed in the entire Supplementary Classification may be used if desired as supplements to any of the diagnoses listed in the Nomenclature of Diseases section of the book. This list is probably not complete. Needed additions may be arranged by communication to the editors.

Incomplete Diagnoses—The Use of y—If information for an accurate diagnosis is insufficient, that fact may be indicated at the point in the diagnostic code where the information is lacking. Thus it is possible to code "undiagnosed disease of the heart." This would receive the topographic designation for heart, generally, 410–, and the etiologic code of –y00, signifying an undetermined cause. A lesion known merely to involve an unidentified portion of the digestive tract would receive the topographic code number 6y0–. Similarly, the lesion in an unidentified portion of the stomach but not involving all the stomach would be designated 64y. Therefore y00–y00 would indicate complete ignorance of the nature of a disease both as to location and cause. For similar "nondiagnostic terms for hospital record," see page 481.

Suspected Diagnoses—There is one other purpose for employing y and that is to designate diagnoses which the physician wishes to show are merely suspected. The name and digits of the diagnosis are to be entered as usual, and y is added at the end of the code.

Punch Cards—The system of coding of the Standard Nomenclature is readily adaptable to the use of punch cards.

Eponyms—Eponyms have been avoided in the body of the book as much as possible particularly when an adequate descriptive topographic-etiologic title is available. The common eponymic diseases that appeared in a table in the third edition have been combined with the Disease Index in this edition. The eponyms will now be found in the Disease Index listed in their proper alphabetic sequence with a direct reference to their proper descriptive title as it appears in the Nomenclature.

Index—The index is designed to help the users of this Nomenclature to identify the proper diagnosis. It includes a great many commonly used terms which do not represent acceptable diagnoses. The index is to be used to identify and determine the proper diagnostic title and may not be used as a substitute classification or as an alphabetic nomenclature. The use of the Nomenclature will be simplified if clinicians adapt their thinking to the topographic-etiologic relationship on which the classification is based. An effort has been made whenever possible, to refer the user directly to the page containing the specific diagnosis. Diagnostic cards should be filed in hospital files by strict numeric sequence according to the topographic code number and not by organ arrangement or alphabetical arrangement as the diagnoses occur in the body of the book.

Diseases Occurring in Pregnant State—Any of the diseases of the female genital organs which occur in the pregnant state may be indicated by changing the code approximately, e.g., change 782, Nonpregnant uterus, to 7x2, Pregnant uterus. Vaginitis, acute in pregnant state, would be coded 7x1–100 *Specify organism when known* and not 781–100.

Inactive Tuberculosis—Inactive tuberculosis may be indicated by the addition of the digit 7 to the etiologic code –123.

General—For diagnoses which are not found listed or for which specific provision for coding has not been made, e.g., as in the Regional Classification, it is requested that the user communicate with the editors. Please do not try to improvise new code numbers or titles.

Abridged Statistical Classification for Clinical Indexing Based on Standard Nomenclature of Diseases and Operations—Abridged Statistical Classification Codes have been placed in italics to the right of the diagnosis in the body of the book and in the Appendix as a cross-reference to the Standard code numbers. For use of these numbers, see instructions at the beginning of the Appendix.

EDWARD T. THOMPSON, M.D., *Editor*
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INSTRUCTIONS TO MEDICAL RECORD LIBRARIANS FOR INSTALLATION OF STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS

The installation of Standard Nomenclature of Diseases and Operations need not be a task beyond the capabilities of the average medical record librarian.

Of prime importance is an understanding of the nomenclature, its principles, its arrangement, and its contents.

A definite installation date must be set. In the interest of harmony of administration it is considered advisable that the date of the installation be determined by the administrator, the medical staff, and the medical record librarian.

The next decision to be made is the determination of the extensiveness of the coding. This should be a joint decision of the administration and the clinic staff.

The success of an installation must be measured by the ease with which clinicians and others may gain access to cases in order to compile an accurate group of cases for study, review, and research.

The classification may be as elaborate or as simple as desired. Consideration must be given the size of the institution, i.e., the number of clinical records to be classified annually and how the records are to be used.

The majority of institutions will find the three digit code both for topographic and etiology satisfactory. This type of installation should meet the needs of all institutions except those using the records for extensive research and group study. These institutions often require a more detailed classification which may be obtained by expending the topographic and etiologic codes to the fourth and fifth position.

Grouping, which is a collection of codes having some mutual relation or dependence, is recommended but extreme care must be exercised in the use of group codes. If you are not conversant with the codes that can be grouped, write the Standard Nomenclature office for the recommended list. No open end, master, or division codes are to be used in your card captions.

Next, a determination must be made of the information, both type and quantity, to be recorded in the indexes. It is advisable to prepare cards only as diagnoses are received by the medical record department. With either visible or vertical equipment, cards must be filed in strict numerical sequence according to topography and not according to book arrangement.

VISIBLE CARD FILING METHOD

Visible card filing cabinet units consist of a number of trays containing individual holders from which cards are suspended. The cards lie flat in the trays, overlapping one another so that the bottom of each is exposed. The exposed portion of each card must bear the classification number and diagnosis. As a tray is pulled forward from the cabinet, the titles of all the cards are plainly visible. With cards arranged in numerical sequence according to code numbers one can instantly locate any particular card. One may then refer, or post, to that card by "lifting" the card above without removing it from its holder.

Cards should be neatly typed, particular care being given to alignment of typing on all cards. This not only improves the appearance of the file but permits faster finding, posting, and reference. Figure 1 illustrates visible record forms correctly and incorrectly typed.

The card filing cabinet should be divided into eleven sections, representing the eleven major topographic classifications. The cards in each section (0 to X) should be arranged in proper numerical sequence.

Incorrectly typed	
000–x90	Mental deficiency
014–190	Septicemia, puerperal
x05–388	Eclampsia
085–322	Sulfuric acid burn of hand

Correctly typed	
000–x90	Mental deficiency
014–190	Septicemia, puerperal
015–388	Eclampsia
085–322	Sulfuric acid burn of hand

Fig. 1

VERTICAL CARD FILING METHOD

The vertical card filing method requires the conventional card index cabinet drawers. Standard cabinets provided for the purpose may be obtained.

To facilitate the filing and finding of individual diagnostic cards, a suitable set of Standard Nomenclature of Disease index guides should be provided. These guides are available in sizes 8 by 5, 6 by 4, and 5 by 3 inches. A set consists of major subdivision guides for topographic classifications, supplemented with subdivision guides for etiologic classifications. It is suggested that in the beginning only the topographic guides be placed in the cabinet drawer.

As individual cards are made out for each different diagnosis these cards should be filed behind the proper topographic classification index guides. As the accumulation of cards in a particular topographic classification increases, it should be subdivided by inserting suitable etiologic classification index guides. For example, if behind the 330– topographic index guide there are five, six, or more cards accumulated for the –400 etiologic classification (e.g., –401, –441, –496, etc.), a –400 etiologic index guide should be inserted for ease in finding.

Cards for the vertical filing method should have code numbers and diagnoses typed at the extreme top edge of the card, the typing beginning about five spaces from the left edge of the card. Care should be taken to maintain the alignment on all cards.

The cards should be filed strictly by code number, regardless of where the diagnosis is found in the book. For example, diseases of the abdomen, 040–; of the peritoneum, 060–; and of the omentum, 067–, are found in the body of the book under 6– Digestive System; but when the cards are filed, they should be filed in the 0– section.

Recording of Secondary Diagnoses—There are no preferred methods of differentiating between primary and secondary diagnoses. When this differentiation is attempted, however, the use of different color cards is recommended.

Another suggested method is to use only one card but to enter the secondary diagnosis in ink of a different color. The recording of primary and secondary diagnoses is not generally advocated.

Recording of Supplementary Terms—Supplementary Terms may be recorded in one of two ways. A column may be provided for this purpose on the diagnostic card, or each separate supplementary term may have a separate card. When separate cards are used, they should be filed strictly by code number; and a column should be provided on each card for the code number of the primary diagnosis.

Questions—Specific questions should be addressed to Standard Nomenclature of Diseases and Operations, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

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SCHEMA OF CLASSIFICATION

TOPOGRAPHIC CLASSIFICATION