There is a great deal of interest in being able to capture information on disease recurrence as an intermediate outcome indicator of cancer. This comes from Scottish Government, the National Cancer Quality Steering Group (a subgroup of the Scottish Cancer Taskforce) and local clinicians. It is particularly relevant to diseases such as breast cancer, which now have relatively high levels of survival, so that it may be necessary to wait for up to ten years after diagnosis to have a meaningful survival outcome. As surgical techniques are modified, local and/or regional recurrence serves as an earlier warning of potentially unfavourable effects of changes in surgical management.

Clinically, recurrences are described as:

**local** – essentially at, or closely associated with, the anatomical site of the primary tumour

**regional** – this refers to cancer found in the group(s) of lymph nodes draining the primary site

**distant** – this refers to metastasis to non-regional lymph nodes and/or to other organs.

However this clinical terminology might not find its way through to coders. For example, regional and distant recurrence might be described as “positive nodes” following biopsy/sampling/excision of a particular lymph node group, or as “metastasis” in a particular organ, respectively.

**Coding regional and distant recurrence** Codes for regional and distant recurrence already exist in ICD10. These are the codes for ‘secondary malignant neoplasm’ in categories C77 – C79. If the coder has been given clear information about regional and/or distant recurrence, however it is phrased, such information should be recorded using codes C77 – C79 according to normal coding rules and standards.

However these secondary malignant neoplasm codes will not in themselves allow distinction between known metastasis present at the same time as the original primary (which would not be described as recurrence) and regional and distant recurrence which appears only after the primary has been treated. To distinguish these two cases, linked data will be used.
Local recurrence and ‘recurrent NOS’ National coding rules state that malignancies described by the clinician as “recurrent” should be coded with the appropriate primary malignancy code. Unfortunately this approach cannot distinguish between the statements ‘local recurrence’ (which has a specific clinical meaning) and ‘recurrent’ (which is non-specific and could mean any or all of local, regional and distant recurrence).

To allow this distinction to be made, Scottish 5th digits should be added to appropriate primary malignancy codes as follows:

<table>
<thead>
<tr>
<th>5th digit</th>
<th>meaning of 5th digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>‘Local recurrence’, ‘locally recurrent’</td>
</tr>
<tr>
<td>9</td>
<td>‘Recurrent’ NOS</td>
</tr>
</tbody>
</table>

**NOTE** that these 5th digits should be applied **ONLY** to the ICD10 codes for breast cancer, colorectal cancer and melanoma of skin:

- C18.- Malignant Neoplasm of Colon
- C19.X Malignant Neoplasm of Rectosigmoid Junction
- C20.X Malignant Neoplasm of Rectum
- C43.- Malignant Melanoma of Skin
- C50.- Malignant Neoplasm of Breast

For example:
- the statement ‘recurrent rectal cancer’ would be coded as C20.X9
- the statement ‘locally recurrent breast cancer’ would be coded as C50.91

**Cystic Fibrosis with Manifestations**

When cystic fibrosis is documented with a manifestation(s), an additional code or codes identifying the manifestation(s) must be assigned *immediately after* a code from category E84.- *Cystic fibrosis*, where doing so adds further information about the specific manifestation(s).

Multiple codes from category E84.- must be used where multiple manifestations are present.

**Examples**

- Cystic fibrosis related pseudomonas aeruginosa lower respiratory tract infection
- E84.0 Cystic fibrosis with pulmonary manifestations
- B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters

Cystic fibrosis related meconium ileus, cirrhosis of the liver, chronic pancreatitis and osteopenia

**E84.1D** Cystic fibrosis with intestinal manifestations
- Meconium ileus in cystic fibrosis D (P75A)

**P75.XA** Meconium ileus in cystic fibrosis (E84.1D)

**E84.8** Cystic fibrosis with other manifestations

**K74.6** Other and unspecified cirrhosis of liver
SECONDARY NEOPLASMS OR METASTASES FROM HAEMATOLOGICAL MALIGNANCIES

Codes in the range C77-C79 must never be assigned to indicate a secondary neoplasm due to/from a haematological malignancy (codes in C81-C96).

Diagnostic statements indicating that metastases are the result of a haematological malignancy (e.g. “Lymphoma with bone metastases”) must be referred back to the responsible consultant to clarify that this is spread of the haematological malignancy. If this is confirmed, only the code from C81-C96 is assigned.

Haematological malignancies are systemic diseases and the involvement of additional sites is expected as part of the disease. This process of disease spread in haematological malignancies is not the same as that of solid tumours, and as such the recording of “secondary” or “metastatic” tumours is not appropriate.

STROKE WITH HEMIPLEGIA, DYSPHAGIA AND DYSPHASIA

On emergency admission for strokes, the code for stroke must be assigned in the primary position.

As indicated by the note at category G81; Hemiplegia (G81) when due to stroke that is currently being treated, must be coded in a secondary position to the stroke.

Symptoms of stroke such as dysphagia and dysphasia that are classified in chapter XVIII, must only be coded when they have been treated as a problem in their own right, in a secondary position.

On further admissions following treatment of the stroke if the hemiplegia is still present it will be appropriate to record the hemiplegia as a sequela (late effect) of a stroke. Other conditions occurring as a result of a stroke, such as dysphagia and dysphasia, must be treated in the same way.

SCOTTISH CLINICAL CODING STANDARDS – OPCS4

INSERTION OF A THERAPEUTIC JOINT SPACER IN THE FIRST STAGE OF A TWO STAGE REVISION OF AN INFECTED HIP OR KNEE PROSTHETIC JOINT REPLACEMENT.

Please note that when coding the first stage of a two stage revision of an infected hip or knee prosthetic joint replacement, the insertion of an antibiotic-impregnated cement joint spacer must be coded if this has been carried out as part of the procedure. Code W81.7, Insertion of therapeutic spacer into joint, should be assigned in addition to the code for the excision arthroplasty.
This is an addition to the coding guideline issued in 2004 by the Scottish Arthroplasty Project in collaboration with Terminology Services (then known as the Scottish Clinical Coding Centre) regarding the coding of two stage revision of an infected hip or knee prosthetic joint replacement.

Example

Patient with infected knee joint prosthesis is admitted for the first stage of a two stage revision of the total knee replacement. The infected joint replacement is removed and debridement and insertion of a joint spacer are performed. Code as follows.

W57.4 Conversion to excision arthroplasty of joint + Z84.6 Knee joint
W81.7 Insertion of therapeutic spacer into joint + Z84.6 Knee joint

**Intraoperative Cell Salvage (ICS)**

ICS is an intraoperative procedure that collects blood lost during surgery and reinfuses it into the patient, with the intention of reducing or avoiding the use of donor red blood cells. Information on the use of ICS nationally is important to the Scottish National Blood Transfusion Service (SNBTS). For example, it will help SNBTS identify areas of good transfusion practice.

ICS can be recorded using two codes introduced in OPCS4.7 -

X36.4 Autologous blood salvage and
X33.7 Autologous transfusion of red blood cells.

When coders have information that ICS has been used in an operation they are coding, it should be recorded as follows:

**Scenario 1** – The coder knows that blood lost during surgery was salvaged, but for one reason or another it was not reinfused into the patient.

Code **X36.4 Autologous blood salvage only.**

**Scenario 2** - The coder knows that blood lost during surgery was salvaged and was reinfused into the patient in the same SMR01 episode

Code **X33.7 Autologous transfusion of red blood cells only.**

**Scenario 3** – If cell salvage occurred in theatre but the harvested blood was not reinfused until a subsequent SMR01 episode, code X36.4 in the theatre episode and X33.7 in the subsequent episode.

**Scenario 4** - The coder has only a statement such as ‘ICS’ or ‘cell salvage’, without any further detail – i.e. cell salvage NOS.

Code **X33.7 Autologous transfusion of red blood cells only, as a default.**

**Note that**

a) this is an exception to the coding standard *Non-operative interventions*, last published in SCCS7, July 2014.

b) coders should only code ICS as indicated above IF THERE IS SPACE TO RECORD IT in the SMR01. In other words, codes required to record the actual operation should always take precedence over the codes for ICS.
GENERAL INFORMATION

CERTIFICATE IN TECHNICAL COMPETENCE CLINICAL CODING (SCOTLAND)

Following on from a questionnaire to all health boards and a subsequent Steering Group meeting, ISD and the Health Boards are working together to produce a CTC – Certificate of Technical Competence in Clinical Coding (CTCCC). This is a work based practical assessment similar to the CTC created for Health Records staff.

It is envisaged that the project will take no more than a year to develop training and assessment materials, with one or two sites piloting the process shortly after that.

Successful candidates will, on completion of their work, be awarded the CTCCC by the Institute of Health Records and Information Management (IHRIM).

Some of the benefits we foresee from the award are:

- Clearer and more structured evaluation of the learning process for clinical coders
- Set a foundation level in order that Boards can be assured their staff have the necessary coding skills
- Supporting the professional standards of clinical coding within Scotland
- Develop a training and development pathway for coders in support of Continuing Professional Development
- Improve the quality of clinical coding training within Scotland
- Coders would have a written record of their achievements and work progress
- Standardisation of initial on-site training
- Assisting Boards to meet Information Governance standards
- Help coding staff feel supported and engaged
- Raise the confidence and profile of coding staff
- Help to improve the quality of coding
- Support the quality of analytical output for better healthcare decision making for NHS Scotland

Development has begun on the training materials, involving representatives from two health boards and ISD. These 6 individuals make up the Short Life Working Group (SLWG), which is scheduled to meet on a monthly basis until further notice. Between meetings, work has to be progressed and reported back to the SLWG to create a final draft.

Members of Clinical Coding and Health Records departments make up the Steering Group which will then review and approve the draft materials. However, it would be helpful to have more boards represented in creating the workbooks. If you would be interested in joining the SLWG at this stage, contact Liz Williamson, Clinical Coding Tutor, ISD. Email address - lizwilliamson@nhs.net or please feel free to call on 0131-275-7082 should you wish further information. We look forward to bringing you updates on the progress of the award.

IMPLEMENTATION OF LATEST REVISION TO THE INTERNATIONAL CLASSIFICATION OF DISEASES ICD10 VERSION 5

The latest edition of ICD10 (V5) has been approved for use in Scotland and in keeping with NHS England, is to be implemented in Scotland in April 2016. The new codes should be used with effect from April 1st 2016, for all discharges on or after that date. ISD will provide the new ICD10 V5 reference files by April 1st 2016.

The World Health Organisation carry out annual updates to the classification and when they deem it necessary, order a reprint of the books. Although the Summary of Changes document
shows what would appear to be a relatively small number of amendments (71 new codes, 48 amendments to codes and 21 deletions), it is changes to notes and index trails which render a manual update of current books unworkable.

As there are some major changes involved in this update, it is essential that Clinical Coders and other staff involved in selecting or analysing codes have access to the new version of the ICD10 prior to the implementation date.

The Health and Social Care Information Centre (HSCIC) in England is currently working on an electronic version of ICD10, with the same functions as the OPCS eViewer. If sites wish to use this instead of, or in addition to, having books, the software will be available, free of charge, via download from the Technology Reference data Update Distribution site (TRUD). It is envisaged that the software will be available in V4 towards the end of this year. Link to TRUD: https://isd.hscic.gov.uk/trud3/user/guest/group/0/home. Please note, the eBook is supplied and maintained by HSCIC. Any queries regarding the download, supply and maintenance of the product should be directed to HSCIC.

The books will also be available for purchase through The Stationery Office. Details required for ordering are available from our website:

http://www.isdscotland.org/Products-and-Services/Terminology-Services/Classification-and-Terminology-Tools/

ISD have notified Simplecode and Medicode of the plan to move to V5 and as they are involved in NHS England, they do not foresee any problems in having the Scottish version of the encoders available for NHS Scotland. However, sites should make contact with their encoder and PAS/PMS suppliers as soon as possible to ensure the correct interfacing is in place for the implementation date.

Should you have any questions regarding the implementation of ICD10 V5, please contact Liz Williamson, Clinical Coding Tutor, Terminology Services, ISD or lizwilliamson@nhs.net.

INITIATIVE TO IMPROVE HEART FAILURE INFORMATION FOR CODING

The Scottish Heart Failure Hub is a sub-group of the National Advisory Committee for Heart Disease. One of the remits of the Hub is to improve current discharge documentation content and consistency and to help improve the accuracy of coding, enabling accurate coding to be more easily undertaken in the community. The Scottish Heart Failure Hub is being led by consultant cardiologists Dr Mark Petrie and Dr Martin Denvir. A coding and information subgroup consisting of medical, pharmacy and specialist nursing staff (Dr Martin Denvir, Mr Paul Forsyth, Dr Pardeep Jhund, Dr Ninian Lang, Ms Jill Nicholls) has been established which also includes representation from clinical coding through our team member Tim Varley from PHI Terminology Services. This initiative will be much welcomed by coding and information teams throughout NHS Scotland. Please contact Tim with any comments and suggestions and he can raise these with the group (tim.varley@nhs.net). If any clinical colleagues wish to know more about the work of this group they can contact Dr Pardeep Jhund (Pardeep.Jhund@glasgow.ac.uk) for further information.

PLEASE NOTE THAT CLINICAL CODING STANDARDS IN THIS EDITION APPLY TO ALL DISCHARGES ON AND AFTER 1ST OCTOBER 2015.

Scottish Clinical Coding Standards is the new title for Coding Guidelines. This is to reflect the fact that the standards published herein are coding rules which apply in Scotland.

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