



SNOMED Clinical Terms Editorial Guidelines

Content Inclusion Principles and Process

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Purpose of this document

This document addresses the question of what content belongs and does not belong in SNOMED CT. Its primary purpose is to guide the decisions of those individuals charged with triaging and incorporating new content as it is submitted via any channel. Its secondary purpose is to provide guidelines for submission of new content.

Status

The document is a working draft.

Review Date

This Editorial Policy will be formally reviewed in December 2008. Minor amendments may be made before that time which will be highlighted when a new version is posted. Comments and suggestions on the policy are welcomed. Please send to ksp@ihtsdo.org.



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1 Content Inclusion - Problem Statement

The basic problem to be addressed is that of deciding whether new content should be added to SNOMED CT, and if so, should it be in the international release or in an extension. This document attempts to provide basic principles and specific guidelines and examples, as well as a process that can be followed to resolve difficult or contested decisions.

1.1 What general types of content may be in scope for SNOMED CT?

The range of concepts, terms, and other components in SNOMED CT is extremely broad in order to support the terminological needs of information systems that support the health and health care of individuals. Nevertheless, within this broad scope there are items for which some groups or individuals may want to have a “code”, but which are ruled as unacceptable for SNOMED CT. This document aims to identify some rules and mechanisms by which unacceptable content can be identified.

1.2 What is the “core”?

The word “core” has been used with several different meanings and therefore should not be used without qualification. In this document we will address the question of whether content should be included in SNOMED at all, and also the question of whether it should be in the “core” international release. This is the content that is maintained and distributed by IHTSDO.

1.3 What is an extension?

A SNOMED CT extension has two main defining characteristics. First, it consists of SNOMED CT components that are identified by SCTIDs that have a unique identifying namespace, which is the namespace identifier of the extension. Second, the extension and its SCTID namespace are controlled and managed by a single organization that has the responsibility of maintaining the extension and following certain rules associated with the creation and distribution of the identifiers and other SNOMED CT compatible structures in the extension.

It is important to emphasize that this definition of “extension” is a narrow one. There will almost certainly be other types of electronic information artefacts that might be called add-ons, enhancements, or expansions that may have the purpose of increasing the usefulness of SNOMED CT in various application domains, but for the purposes of this document we will not refer to them as “extensions” unless they fit the narrow definition given here.

2 Basic principles: Does it belong in SNOMED?

Not every possible term or code that is related to health care belongs in SNOMED. Some content should be excluded. There has been significant debate about what does and does not belong; these



debates are healthy and should continue. This document only attempts to ground the debate in some specific principles that can guide the decisions about what to include and what to exclude.

SNOMED is intended to be as reusable as possible, and this generates a tension between being all things to all purposes, versus being custom-fit to a particular purpose. The most general statement that can be made is that SNOMED is designed to foster semantic interoperability of electronic health applications.

2.1 Creation and maintenance of semantic interoperability

The most basic principle for determining whether content belongs in SNOMED is that it must create and sustain semantic interoperability of clinical information. This ability in turn depends on a reproducible and consistent approach to the incorporation of terminology into electronic records.

2.1.1 Understandable – Reproducible – Useful

Beginning in 1996 with the development of SNOMED RT, the SNOMED modelers began to follow three basic operational criteria that help determine whether new content is following the principle of creating and sustaining semantic interoperability. These tests were summarized with the acronym “URU”, standing for:

Understandable: The meaning must be able to be communicated to understood by an average health care provider without reference to inaccessible, hidden or private meanings

Reproducible: It is not enough for one individual to say they think they understand a meaning. It must be shown that multiple people understand and use the meaning in the same way.

Useful: The meaning must have some demonstrable use or applicability to health or health care.

2.2 Coordination with and exposure of information architecture components

The overall semantic interoperability of electronic health records is derived from the combined functioning of an information architecture and the terminology that populates it. Yet SNOMED itself does not produce – and does not dictate the choice of – the information architecture. The best we can do is to make explicit those elements of SNOMED that would be possible to represent in some alternative ways using the information architecture.

2.2.1 SNOMED codes name classes of things

A basic principle that has regrettably been overlooked in the past is that the name “SNOMED” includes the word “nomenclature”, defined as a systematic way of naming. With reference to the semiotic triangle, the codes should be considered symbols that refer to classes or categories of real things. New content should be rejected if it consists of full sentences and statements rather than names that can be used in statements.

New content that refers to, or contains references to, a particular instance, should also be rejected. For example, “Doctor Jones’ pre-operative order set” can be rejected on the grounds that Doctor Jones is an instance (individual) and not a class.



2.2.2 Clinical statements are made using codes within the information architecture

There is a tension between the purity of a nomenclature and the needs of information system implementers. Many system implementers are working with impoverished information models, and to deny them certain coded content is to prevent their use of SNOMED at all. In the past we have acknowledged this fact and attempted to maximize usefulness while minimizing the pre-coordination of all possible clinical statements.

2.3 Comprehensiveness of domain coverage

Within the content currently in SNOMED, there are some areas that are covered with a great deal of completeness, and others that are not. It is a goal of SNOMED, and one of the main features of any good clinical terminology, to be comprehensive in those areas that it chooses to cover.

Decisions about inclusion of an individual piece of content should therefore be made on the basis of whether the domain to which it belongs is one that is being comprehensively supported in SNOMED CT. For example "organisms affecting human and veterinary health" would be an example of a domain which we have previously decided to include in the core. An organism meeting this criterion can therefore be judged as belonging.

A draft list of domains currently being maintained is included in appendix A.

Even within a particular broad domain, there may be sub-domains that should be added comprehensively rather than piecemeal. For example, there are many new genetic tests not currently included in SNOMED CT. The general approach to addition should be to add these as a large batch that is quality assured and reviewed for overlaps and gaps and inconsistencies. They should not be added one or two at a time, because this would be more inefficient and more error-prone and would not serve users needs well.

3 Principles for accepting content into the international release

The fundamental statement of the scope of the international release is that it includes content necessary for international conformance and interoperability.

Content that is defined as being within the scope of the international release is restricted to the international release and may not be modified or replaced by an extension, unless explicitly permitted by IHTSDO. For content that is within scope for SNOMED CT, other criteria must be met in order to require that it must be included in the international release:

Is the concept necessary for health information conformance and interoperability?

Multi-national – Is it useful in more than one national healthcare system?

Conformance – Does it need to be understandable in health information systems within more than one national healthcare system?

Interoperable – Does it need to be shared so that information systems can use it in a reproducible manner beyond a patient's national healthcare system, if a patient were to travel or relocate to a different country?



3.1 Principles for determining extension content

The fundamental statement of the scope of a National Extension is that it includes content outside of the scope of the international release, but is necessary for national conformance and interoperability. The interpretation and application of this fundamental scope will depend on the specifics of each member-state's national healthcare system and is left for each member-state to determine for itself.

Criteria to determine if concepts should be included in the National Extension terminology include:

Is the concept outside the scope of the international release but necessary for national conformance and interoperability?

National – Is it useful throughout the national healthcare system?

Conformance – Does it need to be understandable throughout the national healthcare system?

Interoperable – Does it need to be shared in a reproducible manner within the national healthcare system?

If so, then the concept may be eligible for the National Extension terminology. However, the final decision on inclusion of concepts within a National Extension lies with each member-state.

4 Guidelines for submission of new content

It would be impossible to provide specific rules to apply to every case where new content must be assessed, but it is helpful to list some of the recurring decisions in order to provide consistency and full explanations for the reasons that some content submissions are rejected.

New content should optimally be submitted with fully specified names (FSN's), and these should conform to the editorial guidelines for terms, including spelling, language, and term style guidelines. New content should also be submitted with a "parent" code to show where in the hierarchies it belongs. Assignment of this parent should be according to the editorial policy guidelines (see the other style guide documents for details).

Some common errors in past submissions include misspelled words, words submitted in the FSN that use abbreviations or acronyms, or are spelled using British spelling instead of US spelling, FSNs in plural instead of singular form, procedure FSNs in past tense instead of present tense, FSNs containing short forms with hyphens instead of fully unambiguous phrases, mismatch of the FSN tag and the submitted parent code hierarchy, terms that already exist (duplicates), terms containing "or", terms with precoordinated numeric ranges, and FSNs that are ambiguous and not fully specified.

Here we add guidelines for content submission that address issues other than the concept model or term style, but must also be considered and can be grounds for rejection of submitted content.

4.1 Usefulness

Content submitted to the international release shall be required to pass a test for "usefulness." The usefulness test can be passed in more than one way. At least one of the following must be satisfied:

- 1) Content that is used by more than one major user (a national release center such as NHS, a vendor/supplier of clinical information systems with international scope, or a large intra-national system user such as VA or Kaiser) will be considered to have passed the "usefulness" criterion.



- 2) Data demonstrating significant frequency of use, or frequency of need, by a single user (single national center, or single vendor, or single health care system) can also be used as evidence in support of “usefulness”.

Additional means of passing the usefulness test may be added in the future. Submissions that pass the usefulness criterion must also pass understandability and reproducibility tests, and conform to style rules.

4.2 Classification-derived phrases

4.2.1 Phrases meaningless outside the classification use case

New concept submissions that contain certain classification-derived phrases in their FSN shall be rejected because they fail the basic tests of understandability, reproducibility and usefulness when removed from the narrow constraints of the classification use case. Some such classification-derived phrases are:

- NOS (not otherwise specified)
- NEC (not elsewhere classified)
- Not mentioned
- With or without

The basic reason for rejection of these phrases is that they are meaningless within a clinical terminology that assumes a use case based on primary clinical documentation that allows multiple overlapping entries, rather than coding of a pre-existing record into a single best class.

The classification phrases assume that a health care record already exists, and therefore it is meaningful to have codes that depend on what has been specified or mentioned in that record. Likewise the classification phrases assume that there is a fixed set of classes into which the existing record should be placed, and therefore it is meaningful to have codes that depend on what has been classified elsewhere in the system. Lastly, the classifications must have a class for every case, and therefore they provide additional codes for categorizing a case that hasn't been properly captured by any other code – sometimes called “catch bins”.

SNOMED assumes that the physician or health care provider may be in the process of documenting observations about a patient, and in this setting anything that has fidelity to the clinical situation may be stated and coded. It also assumes that the entire range of reproducible and useful meanings is available to be used to faithfully document the health and health care of the individual, and codes may be selected at any and all levels of specificity if desired. There is no single best code that must be selected, and using one code does not require the exclusion of another code with overlapping meaning. Finally, there are no “catch-bins”, but there are multiple codes at a variety of levels of generality that may be used, and a rich set of qualifiers for refining the meaning of an existing code.

4.2.2 Phrases that go beyond naming to making full statements or sentences

There are many phrases in classification systems that make statements. These phrases are in a borderline area for acceptance into SNOMED. In an ideal world, the information model would provide the mechanism for making these statements and there would be no pressure to pre-coordinate them into SNOMED. In the practical world, many users of existing systems are attempting to migrate from ICD-9-CM or similar coding systems towards SNOMED CT, and in the process they require maximum



possible concurrence between the codes they are currently using and the codes to which they are migrating.

Nevertheless, SNOMED requires that when such concepts are included, they must have a fully specified name that omits all classification-style phrases and meets URU criteria. This may be difficult to achieve because of the idiosyncratic nature of some classification additions.

4.2.2.1 Example: episode of care and pregnancy complications

For example, ICD-9-CM adds a series of complicated “episode of care” phrases to several of the categories of disorders affecting pregnancy and delivery. Here is the full set of “fifth digit” modifiers for complications related to pregnancy:

The following fifth-digit subclassification is for use with categories 640-649 to denote the current episode of care:

- 0 unspecified as to episode of care or not applicable
- 1 delivered, with or without mention of antepartum condition
 - Antepartum condition with delivery
 - Delivery NOS (with mention of antepartum complication during current episode of care)
 - Intrapartum obstetric condition (with mention of antepartum complication during current episode of care)
 - Pregnancy, delivered (with mention of antepartum complication during current episode of care)
- 2 delivered, with mention of postpartum complication
 - Delivery with mention of puerperal complication during current episode of care
- 3 antepartum condition or complication
 - Antepartum obstetric condition, not delivered during the current episode of care
- 4 postpartum condition or complication
 - Postpartum or puerperal obstetric condition or complication following delivery that occurred:
 - during previous episode of care
 - outside hospital, with subsequent admission for observation or care

The first task is to strip away all “mention of” and “unspecified” phrases, and then determine whether there is still a URU meaning. A fifth digit of “0” generates no special meaning for SNOMED and the phrase “unspecified as to episode of care” would be rejected as invalid for an FSN. Therefore SNOMED cannot incorporate any code that corresponds to the “0” fifth digit here.

A fifth digit of “1” means that the current episode of care involved delivery and the complication finding was antepartum. Some submitters might want to have a short phrase that says something like “finding X, delivered”, where the finding occurred antepartum and the mother was delivered during the current episode of care. This constitutes two statements and our recommendation would be to place each statement in the patient record separately. However, given the request for a single pre-coordinated code that captures both meanings, it is possible to use the SNOMED CT context model, with two role groups, to capture the two statements.

A specific code, 641.91, would carry the ICD-9-CM phrase “Unspecified antepartum hemorrhage, delivered, with or without mention of antepartum condition”.

Obviously there is a great deal of revision required to make this acceptable (even marginally) to SNOMED. The “unspecified” and “with or without mention of” phrases must be dropped. Clarification must be added to indicate whether it is the mother or fetus who is the subject of the record. The “episode of care” meaning is hard to capture in SNOMED and would be largely unrepresentable. This process might result in an FSN that says “history of antepartum hemorrhage, mother delivered (situation)”, which could be defined as:

Situation, {associated-finding = antepartum hemorrhage, temporal-context = past},
{associated -finding = mother delivered, temporal-context = current or specified}



This expression does not completely capture all the subtle meanings associated with the ICD-9-CM code 641.91, but it is perhaps as close as we can come without major changes.

In general, pre-coordination of such codes is to be denigrated and discouraged because of the false sense of completeness it gives to those seeking to link SNOMED and ICD-9-CM (the meanings are **not** the same and **cannot be**), and because of the added complexity such compositional expressions may present to decision support algorithms, particularly those that require automated processing of temporal relationships. In the example given, a statement in a patient record using this code cannot tell us when the antepartum hemorrhage took place. It only tells us that it was sometime in the past – prior to delivery. The expression as given actually matches cases where the antepartum hemorrhage took place in a prior pregnancy. This temporal linkage problem would be avoided by using two statements with two time stamps, one coding the complication (and recording the time when it occurred) and the other one for the delivery.

4.2.3 Disjunctive aggregates

Frequently classifications employ disjunction (and/or) to group and aggregate related disorders or procedures. For example, a procedure classification might have a term for “total abdominal hysterectomy with unilateral or bilateral oophorectomy”. From a procedure classification standpoint it may be appropriate to lump these all together; but from a patient standpoint, a unilateral oophorectomy leaves estrogen-producing capacity while a bilateral does not, and this is very important to the patient and to their health care.

The general rule is that a FSN should be capable of being stated without and/or. There are occasional exceptions. The first exception is where the *referent* is a single thing but there is no *name* for it. These occur in anatomy. For example, “head and neck” is really a single anatomical structure that can be defined as the body above the level of the shoulders. We don’t have a name and so we use disjunction to name this body part. The second exception is where the term is an intentional navigational aggregate term. For example, we might want to group together disorders that relate to life up to the end of the neonatal period, and group them using a term such as “fetal or perinatal or neonatal disorders”. But outside these broad navigational aggregate terms, it is advisable to reject disjunctive terms and instead create separate terms to be more specific about what a particular disorder is, or what particular procedure was performed.

It requires some judgment to identify the allowable exceptions, but the general rule is that FSNs should not contain disjunctions.

4.2.4 Excessive pre-coordination

It has not been possible to clearly define what “excessive” pre-coordination is. Instead, we rely on the rules for usefulness to avoid this.

4.3 Numeric ranges

Categories that depend on numeric ranges are almost always inappropriate for pre-coordination. For example, a finding of the number of lesions might be split up into ranges of 1, 2 to 5, and greater than 5. But in another context it might as easily be split into ranges of 1-2, 3 to 10, and greater than 10. It is obvious that there are literally infinite possibilities (in theory) and practically far too many possibilities to consider pre-coordinations of this type.



Rare exceptions may be made when a fixed standard uses numeric ranges and there are no reasonable alternatives. For example, some histologic scoring systems give a score of “1” when there are 0 to 5 mitoses per high power field, and a score of “2” when there are 6 to 10, etc. In these cases, where the range is really an explanation or definition of the score, it may be reasonable to make an exception.

On the other hand, it is important to avoid pre-coordination of knowledge that should reside external to SNOMED terms. For example, the serum sodium concentration is in the “normal range” when between 135 and 145 mEq/L, but for low sodium SNOMED should not use the phrase “serum sodium less than 135 mEq/L”, but instead should use a phrase such as “serum sodium concentration low”, and not attempt to include the definition of the lower limit of the reference range. The reason for this should be obvious – that is, sometimes reference ranges change, and sometimes systems of units change and it would cause unnecessary disruption if the SNOMED terms were dependent on those external factors. It should be forbidden to pre-coordinate these kinds of numeric ranges into SNOMED terms where it is not absolutely necessary.

4.4 Procedures categorized by complexity

Procedure concepts that include modifiers that represent procedure complexity based on the amount of effort required, or based on realm-specific definitions, are not to be added to the international release.

Examples of prohibited concepts:

Simple arthrodesis, simple repair, complex repair.

This policy does not proscribe the additions of procedures that use the words “simple” or “complex” which are defined by reproducible meanings based on what is done to or for the patient, rather than how much effort is expended in doing it.

Example of acceptable definition:

Simple mastectomy: Reproducibly defined as the removal of all breast tissue without removal of axillary contents. Differentiated from modified radical, radical, skin-sparing, and subcutaneous variants of mastectomy.

4.5 Counts of the number of procedures done

Many procedure classifications focus on the amount of resource required to carry out a procedure in order to support use cases involving reimbursement or tracking of resource expenditures. For this reason there may be a desire to pre-coordinate different codes for different counts of a procedure. For example, consider “placement of one stent” vs “placement of two stents”.

The general advice is that the counts of number of procedures done should be handled by the information model of the patient record, and should not be pre-coordinated into SNOMED codes.

4.6 Acronyms

Here we reiterate the prohibition of acronyms in fully specified names. Acronyms can be misinterpreted because they are not fully spelled out. It is a mistake to assume that everyone will know



what an acronym means. Therefore acronyms may not be used in fully specified names when the fully spelled out name is available. An exception may be where a sequence of letters started as an acronym but has now become a word in its own right, understood without expansion to its original full form. A common example would be “laser”. Evidence that it is a word in its own right is that it is included in dictionaries in lower case, and the fully spelled-out meaning has become a trivia question. An example of an acronym that may *not* be included in an FSN is “CT” for “computed tomography”. While those involved in imaging and radiology may regard “CT” as a word (pronounced “see tee”), it does not pass the test of being unambiguous, of appearing in a dictionary in lower case, or of its component words being a trivia question.

4.7 Eponyms and proprietary names

4.7.1 Eponyms

Eponyms are names that are derived from a proper name, usually the name of a person who discovered or described the thing originally. They are commonly found in a wide variety of names in health terminology, ranging across diverse areas such as anatomic structures, morphologic abnormalities, blood groups, diseases, findings, and procedures. Examples include Rutherford Morrison’s pouch, vein of Galen, Aschoff body, Kell blood group, Down syndrome, Moro reflex, and Whipple procedure.

It is neither desirable nor indeed possible to completely avoid the use of eponyms in a health terminology. Nevertheless, FSNs should avoid including eponyms wherever possible in order to improve clarity of meaning and to facilitate translation to other languages. The full description should be used as the FSN, and the eponymous term can be added as a synonym. For example, the FSN for “Moro reflex” should use the phrase “infant startle reflex.”

Exceptions are allowed when the full description is exceptionally long and unwieldy. An example of allowed exception is “Hemi-Fontan operation (procedure).” This operation is defined as a “bidirectional Glenn shunt with end-to-side anastomosis of proximal superior vena cava to right pulmonary artery with isolation from right atrium”. The resulting FSN would be too long and unwieldy, so the eponym is allowed in the FSN in this case. Such exceptions require careful attention to the possibility that the acronym’s meaning may change over time.

Exceptions are also allowed for concepts where the eponym is the only precise clinically relevant name available, and where an artificially constructed non-eponymous name would necessarily be vague or subject to significant misinterpretation. Examples include “Hodgkin lymphoma” and “Burkitt lymphoma.”

It is permitted and encouraged to include eponyms as designations (non-FSN terms) whenever they are understandable, reproducible and useful in a given context. For example, the preferred term for “infant startle reflex” may be “Moro reflex.”

4.7.2 Proprietary names

Proprietary names are the proper names that have been assigned to products, usually drugs and devices, by their corporate producers. It is both necessary and useful to include proprietary names in a health terminology, subject to the following criteria:



4.7.2.1 Proprietary names belong in national extensions

When needed in health terminology, the names and codes for proprietary products (drugs, devices, and other products including foods etc.) should be included in national extensions and not in the international release. This is not only because the same proprietary name may refer to an entirely different product in a different country, but also because there are differences in the process of production, including rules and regulations related to safety, packaging, labeling, and so forth, that make the meaning of proprietary product names dependent on the country or jurisdiction in which the product is approved for sale or distribution.

4.7.2.2 Exception for brand names that have become eponyms

An exception may be made for brand names that have become eponyms. In this case, some brand names have come to stand for a category of product and not the particular brand itself. (Examples in US English include kleenex, band aid, coke, popsicle, jello, velcro, etc). These “proprietary eponyms” may be included in the international release as designations (non-FSN terms). Their FSNs should follow the rules for eponyms (above), and avoid the inclusion of the eponym in the FSN wherever possible. For example, the FSN for “jello” should use the phrase “fruit flavored gelatin”, and the FSN for “band aid” should use the phrase “plastic adhesive bandage strip”.

4.8 Hyphens and the word “of”

Hyphens should be avoided in FSNs, with rare exceptions. For example, the phrase “disability – all limbs” should be changed to say “disability of all limbs”. The rare exceptions occur in places such as the morphology hierarchy, where we need to distinguish categories from specific subtypes (see the editorial guidelines for the morphology hierarchy for explanation). In those circumstances, we may allow phrases such as “glioma – category” to differentiate the category term that includes all gliomas from a specific morphology of “glioma” as specified by ICD-O.

5 Process for adjudication (DRAFT – skeleton)

Assessment by submitters

Review by editorial staff

Rejections and deferrals appealed to chief terminologist, backup by Content Committee

Editorial staff will appeal both **Rejections** and **Deferrals** to the chief terminologist. For Rejections, there should be a way for the submitter to have a voice in the appeal process. Deferrals arise where the editorial staff needs clarity around modeling rules before proceeding (e.g. “in remission”). Resolution of deferrals may require an issue document, committee discussion, management board decision, etc. Simpler issues can hopefully be resolved more expeditiously – e.g. by a ruling of the chief terminologist, subject to being challenged by the Content Committee.

Principles, process and rules to be approved by management board



Appendix A Domains being maintained in SNOMED CT

Terminology domains currently covered by SNOMED include:

- Clinical findings, including disorders
- Procedures, broadly defined as including all health related activities such as history taking, physical examination, testing, imaging, surgical procedures, disease-specific training and education, counseling, and so forth.
- Observable entities which, when given a value, provide a specific finding or assertion about health related information. Examples include the names of lab tests, physical exam tests, dates of significant events, and so forth.
- Anatomy, morphology, and other body structures
- Chemicals and other substances of relevance to health and health care, including generic drug ingredient names, generic drug products (virtual medicinal products)
- Generic physical devices relevant to health care, or to broad categories of injury or accident
- Organisms relevant to health and health care of humans and animals
- Other etiologies of disease, including external forces, harmful events, accidents, genetic abnormalities,
- Functions and activities
- Social contexts relevant to health, including general categories of status of employment, education, housing, care provision, family relationships, and so forth.
- Types of clinical records, documents, certificates and other records and record components relevant to health care.
- Staging, scales, classifications, and other miscellaneous health information
- Attributes and values necessary to organize and structure the terminology