2017-10-17 Editorial Advisory Group Face-to-face meeting, Bratislava

Zoom Meeting Details

SNOMED Int'l Editorial Advisory group

SNOMED International - Editorial advisory group conference call
UTC

Please join my meeting from your computer, tablet or smartphone.

https://snomed.zoom.us/j/680315399

Date 20171017

0700-1500 UTC

0900-1700 Bratislava time

0500-1300 Eastern Daylight Time

Attendees

Chair:

- Jim Case

AG Members

- Keith Campbell
- Guillermo Reynoso
- Bruce Goldberg
- Paul Amos
- Jeremy Rogers

Observers:

- Monica Harry
- Krista Lilly
- Maria Braithwaite
- Donna Morgan
- Maggie Lau
- Ismat Mohd Sulaiman
- Toni Morrison
- Eric Rose
- Cathy Richardson
- Elze de Groot
- Katrien Scheerlinck
- Nicola Ingram
- Regis Charlot
- Phuong Skovgaard
- Gary Dickinson
- Timothy Williams
- Emma Melhuish
- Alejandro Lopez Osornio
- Matt Cordell
- Penni Hernandez
- Candy Barth
- Rita Barsoum
- Corey Smith
- Scott Campbell
- Mary Kennedy
- Raj Dash
- James R. Campbell

Apologies

- Jeff Pierson

Meeting Files

Sepsis models.pptx

Complications and sequelae update.pptx

Allergy Topics.pptx

2017 KDIGO Update

Meeting recording

The folder containing the meeting recordings is located **here.**

Objectives

- Obtain consensus on agenda items

Discussion items

Item	Description	Owner	Notes	Discus
1	Call to order and role call	JCA		
2	Conflicts of interest Approval of minutes 20170928	JCA		
3	Continued from 20170928: Change of name for genetic diseases	JCA	Based on requests from UKTC: The concepts are 726018006|Autosomal dominant medullary cystic kidney disease (disorder)| 723373006|Autosomal dominant medullary cystic kidney disease with hyperuricemia (disorder)| 726017001|Autosomal dominant medullary cystic kidney disease without hyperuricemia (disorder)| The FSN for these concepts align with Orphanet, OMIM and Genetics Home Reference. The request from the UKTC is *All terms should ideally be replaced by autosomal dominant tubulointerstitial kidney disease (ADTKD) (see KDIGO report). The above terms are not necessarily the same and don't really reflect the improved clinical descriptions of the disease based on genetics. ADTKD reflects the inheritance, common phenotype caused by different mutations and can be used for suspected cases. This is well described in the KDIGO report. They also make the point it is a simple term to use and that MCKD is frankly inaccurate!* *As above. I would favour not using these terms MCKD 1 and 2 even though they may be commonly used at present. ADTKD-UMOD or ADTKD-MUC1 would be the preferred names. The list of genes is also increasing making a single term more appropriate.* *ADTKD would be the parent and the children would be ADTKD associated with UMOD mutations and ADTKD associated with MUC1 mutations.* It is anticipated that this type of request will become more frequent as the move towards genomics continues. **Question**: Do we go with the current naming convention to align with Orphanet (our current "Source of truth") or try to keep pace with the evolving nature of content in this area? **10/6/2017:** Response from Orphanet After checking, I confirm the proposed modification of nomenclature from your contact. These modifications don't change the concepts nor the current mappings. To sum up, here is the new configuration: ORPHA34149 Autosomal dominant tubulointerstitial kidney disease (Disease) ORPHA88949 MUC1-related autosomal dominant tubulointerstitial kidney disease (Clinical subtype) (formerly MCKD1) ORPHA88950 UMOD-related autosomal dominant tubulointerstitial kidney disease (Clinical subtype) (formerly MCKD2) ORPHA217330 REN-related autosomal dominant tubulointerstitial kidney disease (Clinical subtype) (formerly FJHN type 2) **Question:** Do we change the FSN or inactivate and replace? In this case it is clear from the response that the "meaning" of the concept is unchanged. For organisms, we have adopted the policy that when taxonomic names change, it is not the organism that changes, but the term representing the organism, thus we rename the FSN for the concept and retain the "older" term as a historical synonym as the naming transition for searching convenience. Should we adopt the same policy for disorders, or does this constitute a substantive change compelling us to inactivate and replace?	**Summar past discussi** • Up cy fo re l s pr a ch fo SN D cu • In on co fo "m FS ch cr a l ch wi ad va Cl on su ve ch sti re • Sh SN D a s so of fo sp he do

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**10/17/201
Discussi**

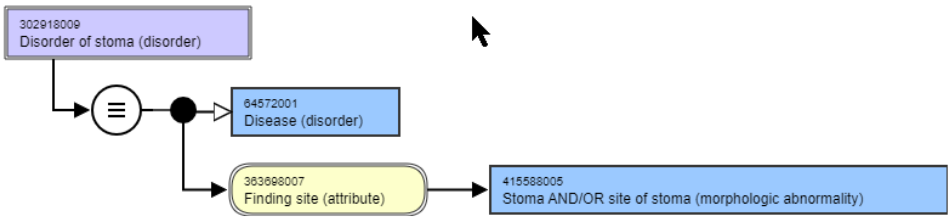
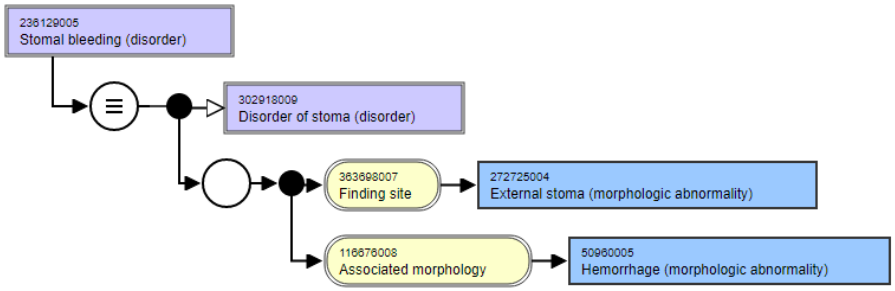
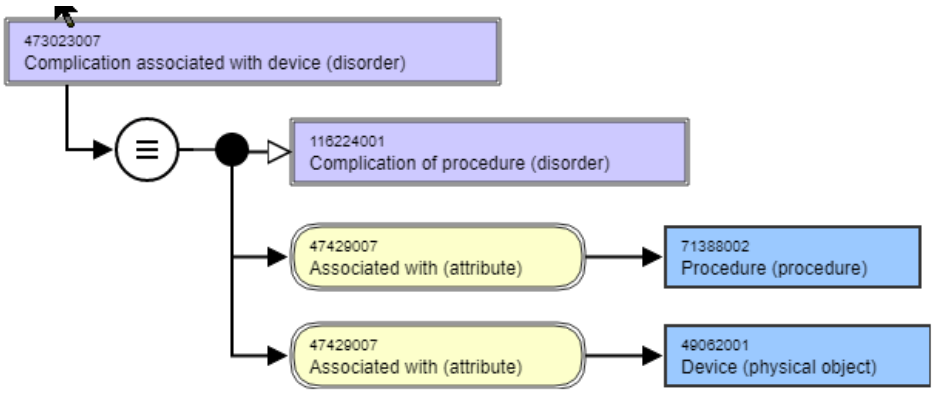
				Suggeste we need specific w guidance what cons "change meaning" that time, safest thi do is to re and repla Also sugg that the o term be retained a descriptio associate the new concept. The exam the policy for organi name cha was pres but this is primitive hierarchy cases discussed there is n change to underlyin modeling a name c Terms tha inherently vague or ambiguou are clarifi name cha or additio relationsh would ma inactivatio replacem Additiona documen http://ped aappublic org/conte /2016/04/ /peds.201 0590 Do we ne new inact status tha reflects th inactivatio to a chan understar of the cor i.e. refine knowledg
4	**Demo:** Batch structural changes to existing content	GRE		Brief demonstr of the too that will b to revised inconsiste identified structure SNOMED content. Examples types of patterns t will be addresse be found ://qa.snor org/

5	ECE Update	BGO	• **Sepsis/Sepsis-associated organ dysfunction.** The third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) published in 2016 state sepsis is a multi organ dysfunction syndrome due to an infection or more specifically due to an dysregulated host response to infection. Current model places sepsis as a subtype of SIRS and infectious disease which is not consistent with Sepsis-3 definition. Proposed model: IsA Multiple organ dysfunction syndrome due to infection. Discussion by ECE Sepsis models.pptx **Question:** Would a new pathological process of dysregulated host response be required in order to fully define sepsis?	BGO pres the discus form the E meeting t previous See slide Sepsis m pptx attta Is the shif meaning the curre represent in SNOM going to issues for if we char Agreeme the curre modeling wrong? Discussio to the nee the new pathologi process, i does it ac value to t definition' Suggeste there is a for anothe PATHOL L PROCE "Abnorma immune response' GRE Brou up the his the inconsiste use of PATHOL PROCES This lead severe restriction range. Discussio expandin range an the editor guidance be tighter ensure consisten Group ag that Seps should be remodele according new defin GRE mer with the introducti multiple sufficient we can su the transi
6	Findings related to skin wounds	JCA	A number of requests related to findings related to surgical skin wounds and pressure injury findings reveal an issue with current structure. Most of the requested terms are Findings related to skin wounds, but currently 262526004 |Wound of skin (disorder)|is a disorder, so cannot be used as a parent for findings related to skin wounds. There is currently 225552003 |Wound finding (finding)|, but it is not specific to skin. 262526004 |Wound of skin (disorder)|currently has 65 immediate subtypes, many of which could reasonably be viewed as findings (e.g. "Abrasion of X"). Need to make a determination of whether observations related to wounds (i.e. color, discharge, odor) should be placed in a subhierarchy different from the "Wound (disorder)" itself.	Agreed th wounds a disorders and findir about wo should be classified wound fin
7	Specimen from subjects other than the patient	JCA	Currently we have many concepts in the specimen hierarchy that include "from patient"as well as those that do not include it as an ancestor. Since the subject of record is the default for specimens, we would like to retire these apparent duplicates, but then we run into the problem of specimens derived from other sources such as donors or normal control patients. They cannot be subtypes if the intended meaning is "subject of record"..or can they, since the context is implied? How do we structure the specimen hierarchy to account for this? What are the analytical implications of having different sources for specimens as subtypes of one another?	

				The "soft default of specimen originatin the patier where the problem l Currently organizat the value SPECIME SOURCE causes sc specimen patients t classify u the group term "Spe from patie Suggestic make a m general te "Patient fi specimen donor", bu would onl address t the SPEC SOURCE KCA men the many issues wi "soft defa For the m part, thes specimen used as c from the patient. However, the FSN t need to b changed reflect tha these are the patier Does the need to re explicitly comes fro patient? Should ev Specimen the SPEC SOURCE explicitly defined? this conte comes fro where the concept is within the record. TI history of terms ma provide s the reaso as to why terms wer created. F example, restriction where co could be in earlier versions v2 (i.e. pr v2.5) mea there was place to p additional informatic around th specimen suggeste these the segregate a module that they eventuall segregate away fron core.

				Non-patie oriented specimen the major now and of the use cases still the older transport structure, meaning need pre- coordinat content. What are requireme for the ad of these t and what major fun of the cor address t requireme More mod transport mechanis such as F do not ne level of pr coordinat Comment IMO indic that most of the terminolo not suffici sophistica use either terminolo model ba post- coordinat The long- standing practice o using unspecifie Specimen provides substantia challenge revising th make it ea as it woul result in a number o changes may impa implemen

8	WAS-A Inactivation redux	JCA	Concerns have been expressed about the impending inactivation of existing WAS-A relationships: "This topic has consulted with the CMAG and UKTC. The feedback from CMAG was that this should not be a priority. The size and efforts are small for content maintenance. The potential impact could be high if we make changes. The feedback from UKTC was to delay the changes until 2018 when they move to RF2. Furthermore, they still think it would be useful to provide information for WAS A by technical means centrally. " See additional discussion	Jeremy R presentec use case these terr within the UKTC. Guillermo Reynoso Describec history of A relation The obse was mad these relationsh have not updated f number o years so represent full scope inactivatic relationsh The WAS relationsh no longer available was prim used to m "limited" concepts, were mac inactive ir The abilit segregate from the using a m approach also sugg Also sugg that these moved ba the UK extension that they full contro how to us them as t are not ne by other extension It was suggeste if there is need to h access to A relation for transit closure, t complete these can reconstru from the f files. whic would be complete the curren There wa discussio about the ambiguity REPLACI BY, which also no lo used.

9	Morphologic abnormalities as values for FINDING SITE	JCA	This arose during a review of "Disorder of stoma (disorder)" Currently there are 16 disorders and 23 findings that have a value of 245857005 |Stoma (morphologic abnormality)|. As the stoma is a morphologic structure within a body structure, is it legitimate to allow this as a finding site? For the most part the terms that use this value are nonspecific to the site of the stoma.  Additionally, it is unclear what the use of 91241007 |Stoma site (morphologic abnormality)|, given that the site of a stoma can be values using any anatomical site. **Questions:** • Is 302918009 |Disorder of stoma (disorder)| a useful clinical term other than as a grouper term? • There are 403 disorders and 433 Clinical findings with morphologic abnormalities as values for FINDING SITE. Should these be remodeled to a normal anatomy finding site with an ASSOCIATED MORPHOLOGY. • How does one model generic terms such as "Hemorrhage of stoma"? currently modeled:  • Current editorial guidance and MRCM rules allow for the use of morphologic abnormality concepts as values for FINDING SITE. Should this guidance be tightened?	Suggestic that a sto not a morpholo is an "Acc body stru The curre descende "acquired structure" include a number o morpholo abnormal concepts. is cleanu needed ir subhierar There are number o surgical structures procedura structures have bee given the semantic "morpholo abnormal these wer cleaned u then they be used a values for FINDING more clea Proposed review th existing concepts use morpholo abnormal as the val FINDING to determ whether t can be ac as subtyp "acquired structure" Those tha appropria have the semantic changed "body stru The MRC need to b revised to disallow "morpholo abnormal from bein value of FINDING
10	What is an "infected prosthesis"	JCA	We have a number of terms, both disorder and procedure that deal with "infected prosthesis". In general, prostheses themselves are not infected, but the surrounding soft (or bone) tissue adjacent to the prosthesis can become infected. This infection often does not have a demonstrable causal or temporal relationship to the procedure. Currently these are modeled with an ASSOCIATED WITH relationship:  **Question:** How do we best represent the true nature of the infection? This is especially important when we deal with "Removal of prosthesis due to infection" and concepts such as "Infection of implanted cardiac device (disorder)".? Based on previous discussions regarding "causal chain", should this be a DUE TO relationship since the infections would not have occurred if the procedure had not been done?	A prosthe can be inf (e.g. vege on a pros heart valv The need associate procedure these wo unnecess and in ma cases inc The use DUE TO relationsh not appro Currently involved concepts ASSOCIA WITH = Procedur the paren "Complica associate device", v should nc this relati There are timing asp that are n represent these terr which ma them mor vague.

				The asso problem i need for a definition what is m by "infect device". I view the presence device as another acquired structure, these ma be complicat The timin the infecti relation to procedure be the rea to classify somethin Complica a procedu e. within a certain nu of days). The two approach "close to reality", w multi-dimensio and challe to determ "simplifie model" th describes is certain. determina whether somethin complicat not is ofte unknown. testing wi to be don see the in of applyin simplified model. If not meet needs fro classifica standpoin a more co model wil needed. This argu the use o ASSOCIA WITH as relationsh devices. For the procedure such as "Removal prosthesis to infectio possibility use of HA FOCUS. There are guideline the evalu of patient to implant where pre existing infection cause ab of the procedure Clarificati the curren understan of Complica can be fo re.
11	“Acquired” disorders vs. Congenital disorders	JCA		There are "Acquired disorders SNOMED The vast majority a primitive.

- There are existing "Acquired X (morphologic abnormality)" concepts, but these are very much analogous to the "Congenital X" morphologies that we are trying hard to get rid of.
- "Acquired" and "Congenital" are not morphologies, but timeframes. We do not have a way of denoting "All periods of life after birth" like we do for "Congenital". If we did, then we could create a fully defined concept grouper of "Acquired disorder", which would subsume all concepts that had any OCCURRENCE value later than "At birth", but then it would require that all acquired disorders have a valid OCCURRENCE relationship.
- This approach might also open the door that all disorders that are not specifically “Congenital” have an OCCURRENCE relationship stating that it is required, which seems to be “overmodeling”. While we can use the "Acquired deformity" morphology concepts currently, due to the lack of many useful subtypes of "Acquired X" morphologies, it would only be a partial solution.
- The HoT is not in favor of recreating the problem in "Acquired" concepts that would mimic the type of concepts we are trying to inactivate in the Congenital space. However, the current guidance related to “Congenital” is not totally correct, because there are many conditions that can ONLY be congenital, even if the FSN does not state it (For example, aplasias or supernumerary structures). So the guidance does need to be updated.
- One potential solution is to create a primitive grouper of "Acquired disorder" and then using that as the proximal primitive parent, adding the necessary relationships to make acquired disorders defined. It is a kludge, but it would allow for full definition.

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12	Update of EAG Workplan	JCA	Review and revision of current workplan	Continue next call lack of tim

13	Use of the Oxford comma in FSNs	JCA	The Oxford comma is a comma added after the penultimate term in a list, e.g. For example "Disorder of head, neck, and shoulders". The purpose if its use is to make explicit the fact that the terms are part of a list. The editorial guide is silent about its use, but the example provided does not use the Oxford comma. There are currently 347 FSNs in SNOMED CT that use the Oxford comma. Most of these are terms obtained from other terminology, such as ICD and nursing. There are 2500 FSNs that contain comma delimited lists, but do not use the Oxford comma. **Question:** Should SNOMED CT be consistent in the use of this grammar mark or maintain fidelity to the original source of the terms that do use it?	KCA expr support fo Oxford co The ques being wh there sho a retroact applicatio FSNs. It d not chang meaning would not considere requireme inactivatio replacem JRO was favor of u the Oxfor comma w does not value. Th challenge provide e guidance what the condition that requi use or no

14	AoB	Group	Placement of "conditions" and "predispositions" as clinical findings as opposed to disorders. - BGO Device disorder vs. device failure	Bruce Go presentec issues fro ECE mee that requi additional Complica and sequ update.pp **Device** **complica** Problems the devic should be finding ar a disorde would allc some rearrange of the cur device pr findings. modleing structure be to use INTERPR /HAS INTERPR ON pair t define the findings. Should al create a r specific " failure" to segregate general e equipmer failure. desire to more exa for each three patt **Hyperse** **y conditi** **remodeli** **finding:** **Allergy T** **pptx** Predispos are not disorders as they d have a pathologi process. Proposed move a la number o concepts under dis to finding Because proposal simply ch the sema tag within same hie would not require inactivatio recreation these con The distin between findings a diseases brought u problems associate this distin and the duplicatio terms as findings a disorders discussec asked to list of thes duplicates

15	Future meetings	JCA		Next conferenc TBD