

# ICPC-2

## The International Classification of Primary Care , an introduction

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### ICPC-2: The Classification

The members of the WONCA INTERNATIONAL CLASSIFICATION COMMITTEE are very proud to announce you the publication of the book International Classification of Primary Care second edition. ( ICPC-2)

ICPC-2 is the fruit of experience and efforts of all the members of the committee since 5 years.

From 92 to 97, with meetings all over the world, members from nearly 30 different countries have discussed chapters, rubrics, inclusion and exclusion criteria and ICD-10 cross mapping, with the determination to elaborate a tool for all the general practitioners and family doctors of the world.

This second edition of ICPC has been prepared for two main reasons; to relate it to the 10th edition of ICD, ICD-10, published by WHO in 1992, and to add inclusion criteria and cross referencing for many of the rubrics. In the interests of stability and consistency, very few changes to the classification have been made, though many have been suggested, and will be the subject of ongoing work by the WONCA Classification Committee.

ICPC-2 has been carefully mapped to ICD-10 so that conversion systems can be used. ICPC-2/ICD-10 conversion file are included in the book in printing form. Extensive use of ICPC has confirmed that it and ICD are complementary rather than in competition.

### ICPC-2: The Book

At the same time this second edition of the book includes information about new developments in the conceptual basis of understanding general/family practice which have arisen in large part from the use of a classification appropriate to the discipline. The book is based on the use of standard terminology as defined in the international glossary published by the WONCA Classification Committee in 1995.

The book also includes information about a number of new initiatives related to classification. The Duke/WONCA severity of illness checklist enables either individual health problems, or the combined health problems of the patient, to be graded in terms of severity. The COOP/WONCA functional status assessment charts allow assessment of functional status of the patient independent of any particular reason for encounter or health problem

### ICPC-2 : Translations

WONCA is an international organization and wishes to promote translation of ICPC into languages other than English, which is the working language of the Classification Committee. ICPC has already been translated into 19 languages, and has been published as a book in some of these. ICPC-2 is already being translated in French and shall be published as the [Classification Internationale des Soins Primaires, deuxième édition \(CISP-2\)](#). The

Committee encourages anyone wishing to promote, undertake, or assist with translations of ICPC-2 to contact them to arrange cooperative work. Please feel free to contact the Committee.

## **ICPC-2 : Major changes**

### **A. Modifications to the classification itself ;**

Only major changes are listed here; additions, change in meaning of the rubric, or transfer or deletion of a rubric. There are many other changes of detail to the titles of the rubrics which do not change the meaning, and are not listed here.

- **23 changes of the rubric title**
- **14 suppressions of rubric, inclusions in a pre-existent one or code change**
- **17 new rubrics for new problems :**
  - **risk factors**
  - **health maintenance**
  - **concern about appearance**
  - **other new problems**

[Click here for futher information on ICPC-2 changes](#)

### **B. New layout for the ICPC-2 rubrics in components 1 and 7 ;**

**Main rubrics are set out in the following format ;**

- **ICPC-2 code and title of the rubric followed by ICD-10 code(s)**
- **incl: terms included**
- **excl: terms excluded, with their ICPC codes**
- **criteria: criteria for inclusion in this rubric**
- **consider: rubrics to be considered if the criteria are not met**

[Click here for futher information on ICPC-2 layout changes](#)

### **C. The inclusion criteria in ICPC-2 ;**

The underlying principle used was to provide :

**THE MOST CONCISE INCLUSION CRITERIA POSSIBLE  
WHICH WOULD MINIMISE VARIABILITY IN CODING.**

Adherence to this principle led to the use of minimal inclusion criteria for each rubric. Inclusion criteria are not the same as definitions. They should be considered in relation to their purpose, to improve consistency of coding, rather than as definitions for delineating health problems

Attempts were made to specify the minimum number of necessary criteria in order to

reduce the complexity of coding and thus minimise miscoding. In addition, criteria should have sufficient discriminatory value to distinguish one rubric from another with which it might be confused

It is important to understand several things which the criteria are NOT intended to do.

1. They do not serve as a guide to diagnosis.
2. They do not set standards for care.
3. They do not act as a guide for therapy.

#### D. Theoretical framework for assignment of inclusion criteria ;

The theoretical framework used to assign inclusion criteria in this classification is based on the presence of four general categories of diagnosis in primary care: aetiological and pathological disease entities, pathophysiological conditions, nosological diagnoses (syndromes), and symptom diagnoses.

Four general categories of diagnosis in primary care :

1. **aetiological and pathological:** the diagnosis has proven pathology or aetiology;  
Examples: appendicitis, acute myocardial infarction
2. **pathophysiological:** the diagnosis has a proven pathophysiological substrate;  
Examples: presbycusis, hypertension
3. **nosological:** the diagnosis depends on a symptom complex based on consensus between physicians  
Examples: depression, irritable bowel syndrome
4. **symptom:** a symptom or complaint is the best medical label for the episode.  
Examples: fatigue, eye pain

#### E. ICPC-2 and ICD-10 cross mapping ;

ICPC-2 has been carefully mapped to ICD-10 so that conversion systems can be used (Chapter 11). Extensive use of ICPC has confirmed that it and ICD are complementary rather than in competition. Each rubric has a three digit code number, a title of limited length, and the codes of the corresponding ICD-10 rubrics. In Components 1 and 7 the corresponding ICD-10 codes are listed for each rubric. Sometimes these are an exact one-to-one match, but more often there are several ICD codes for an ICPC-2 rubric, and sometimes there are several ICPC-2 codes for a single ICD-10 rubric. A full conversion structure is given in Chapter 10.

#### ICPC-2 : Examples

**K86 ..... HYPERTENSION, UNCOMPLICATED ..... ICD-10 code: I10**

**incl :** essential hypertension; hypertension NOS; idiopathic hypertension

**excl :** hypertension with complications K87, in pregnancy W81

**criteria :** either two or more readings per encounter, taken at two or more encounters, with blood pressures that average over 95 mmHg diastolic or over 160 mm Hg systolic in adult patients; or two or more readings at a

single encounter with an average diastolic blood pressure of 120 mm Hg or more; plus absence of evidence of secondary involvement of heart, kidney, eye, or brain.

**consider** : elevated blood pressure K85

**notes** :

1. For children, consult appropriate paediatric blood pressure tables
2. If secondary hypertension, code also the underlying cause

**B25** ..... **FEAR OF AIDS** ..... **ICD-10 codes:**  
**Z71.1, Z71.7**

**excl** : if patient has the disease code the disease

**criteria** : concern or fear of AIDS or HIV in a patient without the disease or until the diagnosis is proven

**P74** ..... **ANXIETY DISORDER/ANXIETY STATE**  
..... **ICD-10 codes:**  
.....**F41.0,F41.1**  
**,F41.3 to F41.9**

**incl** : anxiety neurosis, panic disorder

**excl** : anxiety with depression P76, anxiety NOS P01

**criteria** : clinically significant anxiety that is not restricted to any particular environmental situation. It manifests as a panic disorder (recurrent attacks of severe anxiety not restricted to any particular situation, with or without physical symptoms) or as a disorder in which generalised and persistent anxiety, not related to any particular situation, occurs with variable physical symptoms

**consider** : feeling anxious, nervous, tense P01

**Z14** ..... **PARTNER ILLNESS**  
**PROBLEM** ..... **ICD-10 codes: Z63.6**

**Note:** The diagnosis of problems arising from one or both family partners being ill requires the patient's agreement on the existence of the problem and desire for help.