Inpatient Diagnosis Clusters: Analyzing Hospital Care in Family Practice

Roger A. Rosenblatt, MD, MPH, Ronald Schneeweiss, MB, Daniel C. Cherkin, PhD, and L. Gary Hart Seattle, Washington

Hospital care is an important component of family practice in the United States, but the study of this area has been impeded by the lack of a simple and clinically meaningful method of categorizing the diagnostic problems that make up the inpatient workload. This paper extends the method of diagnosis clusters—first used in the analysis of ambulatory care—to the hospital setting. Using the University of Southern California Medical Activities and Manpower Study of office-based general and family physicians, 52 clinically discrete diagnosis clusters were developed that include 78 percent of all principal diagnoses recorded in the hospital during the study interval. Fifty percent of all hospital encounters can be incorporated in only 15 clusters.

Data clustered using this technique demonstrate that clinical problems such as ischemic heart disease and malignant neoplasms represent a major part of the family physician's hospital workload, a fact that has important implications for training and practice. Diagnosis clustering should facilitate further study of the hospital activities of primary care physicians.

This article presents a classification scheme for analyzing the content of hospital care, building upon the recent development of diagnosis clusters as a tool for handling diagnostic data in the ambulatory setting.¹ The clustering method facilitates logical and efficient manipulation of the large number of individual coding rubrics used in the medical system, and has been useful in previous studies of family practice.² In addition, clustering tends to reduce the extent to which idiosyncratic labeling and coding behavior on the part of providers and medical records technicians blurs the analysis of the medical care process.

Until 1979 the coding scheme used almost universally for hospital diagnoses in the United States was the eighth revision of the International Classification of Diseases, generally known as ICDA-8; the version adapted for use in the United States includes more than 3,000 discrete diagnostic categories.³ Subsequent revisions of this classification

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From the Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington. Requests for reprints should be addressed to Dr. Roger A. Rosenblatt, Department of Family Medicine, RF-30, School of Medicine, University of Washington, Seattle, WA 98195.

scheme, such as ICD-9⁴ and ICD-9-CM,⁵ are based on a hierarchical structure similar to ICDA-8, with an even larger number of available diagnostic rubrics. This complex coding scheme allows precision in the assignment of diagnostic labels to the clinical conditions presented by hospital patients. Although this specificity is a useful characteristic when indexing the medical record, retrieving specific diagnoses, or reimbursing hospitals and physicians, it becomes a liability when attempting to describe the content of medical care. It is particularly cumbersome when analyzing the inpatient experiences of a physician or group of physicians or in comparing the hospital role of different groups of physicians.

One method being widely adopted for the classification of inpatient conditions is that of diagnosis-related groups (DRGs).⁶ The major purpose of the DRGs is to control for variations in case mix and intensity of services in order to improve prospective reimbursement of hospitals. Although the DRG approach appears to be promising for reimbursement, the extensive data requirements of the technique (eg, whether a procedure was performed or whether a co-morbid condition is present) limit its utility when dealing with existing data sources. Moreover, the relatively large number of discrete categories (more than 400 in the most recent revision) make it unwieldy for descriptive purposes.

The diagnosis-clustering approach was developed in response to these limitations. The objective of diagnosis clusters is to construct a classification method that is simple, clinically relevant, and compatible with the ICD coding scheme and its derivative applications. Diagnosis clusters have been designed to be used with existing encounter data that are routinely recorded in most medical settings without requiring additional data, sophisticated equipment, or highly trained personnel. The ambulatory diagnosis clusters were derived using the National Ambulatory Medical Care Survey (NAMCS) data7 and can be applied to any of the 28 medical specialties sampled in that ongoing survey. The clusters themselves and the techniques used to derive them have been published separately.1

This paper extends the diagnosis-clustering approach to inpatient problems, using a data set that captures the hospital workload of a national sample of general and family physicians. In doing so,

this paper presents an intermediate step in the development of an all-purpose inpatient set of diagnosis clusters. Unlike the ambulatory clusters. which were derived from a data base that incorporated virtually all types of physicians in ambulatory clinical practice, the classification scheme presented here was derived from a national sample of general and family physicians. As NAMCS does not include information on hospitalized patients, it was impossible to use that source as a vehicle for creating inpatient clusters. Focusing on the hospital experience of general and family practice as the foundation for inpatient clusters is a rational first step because this discipline represents the largest group of physicians by specialty and because the diagnostic spectrum of this group of physicians is very broad. The relative frequency of the individual clusters is therefore applicable only to general and family physicians, although the clusters themselves should be meaningful in other contexts as well. Further development of the clusters, however, should be geared to encompass other specialty groups and thereby facilitate interspecialty comparisons. It is to be expected that each specialty will have its own characteristic profile of inpatient diagnoses, similar to the dramatic differences that are apparent when the ambulatory diagnosis clusters are applied in the ambulatory setting.8

Materials and Methods

The data for the inpatient clusters were derived from the University of Southern California Medical Activities and Manpower Study (MAMP) performed in 1977.⁹ Like NAMCS, the MAMP study was based on a multistage probability sample of physicians in the United States. MAMP differs from NAMCS in that inpatient activities were also recorded by the participating physicians, using log-diary encounter forms that were completed by each participating physician following each encounter with a hospitalized patient.

The data for the construction of the diagnosis clusters come from 651 office-based general and family physicians and involve 7,830 separate hospital encounters, of which 7,720 were usable in constructing these clusters. For each hospital encounter the diagnosis was coded to the fourth digit using ICDA-8; a total of 721 distinct codes were used to describe the principal inpatient diagnoses recorded by the general and family physicians during the study period. These diagnoses formed the raw data from which the inpatient diagnosis clusters were constructed. Further information about the MAMP study has been published elsewhere.^{9,10}

The following criteria were used in constructing the individual diagnosis clusters

1. Each cluster is clinically homogeneous, bringing together individual diagnostic rubrics that tend to generate similar cognitive processes and clinical responses on the part of clinicians. Thus each cluster includes diagnoses that share common pathophysiological etiologies and expressions.

2. The clusters are broad enough to encompass most discrete diagnostic rubrics that are used in hospital practice yet precise enough so that they do not blur clinically meaningful distinctions.

3. The clusters are designed to decrease the confounding effects of idiosyncratic labeling or coding patterns of individual health care providers or medical records technicians by grouping clinically related conditions into unitary diagnostic entities.

These criteria were applied to the 721 discrete diagnostic inpatient codes recorded in the sample of physicians, and a preliminary roster of clinically coherent clusters was constructed. The entire list of codes was then re-examined to ensure that no major single diagnosis was excluded from the provisional clusters. The list of clusters was then subjected to the scrutiny of a group of family phy-. sicians who were asked to examine the clusters for clinical consistency and utility. The clusters were then modified in accordance with the suggestions of the peer-review panel. All discrete diagnoses and clusters with a frequency greater than 0.1 percent were included in the final list.

Results

Table 1 presents the 52 most common inpatient clusters ranked according to their frequency of occurrence in the MAMP general and family practitioner files. As can be seen from this table, 78.1 percent of all principal inpatient diagnoses recorded by a population-based sample of general and family physicians were captured with the use of 52 clusters. Fifty percent of all hospital encounters can be identified with the use of only 15 clusters.

The utility of the clustering method is apparent from a review of this first table. The second most frequent group of diagnostic conditions encountered by family physicians in the hospital is malignant neoplasms, a fact that has been rarely appreciated when considering the hospital workload of this specialty. One reason for this apparent oversight is that this cluster is composed of a very large number of individual diagnostic codes. In a list of hospital diagnoses in individuals treated by family physicians, any individual neoplasm occurs infrequently. Only when the individual diagnoses are grouped does it become evident that family physicians devote a considerable portion of their hospital work to the care of patients with cancer. This finding has obvious implications for residency training and continuing medical education.

Another interesting observation is that the nine most frequent conditions for which general and family physicians render hospital care are medical and obstetric, as opposed to surgical, diagnoses. The most common surgical diagnosis is appendicitis/appendectomy. One limitation of the data that emerges from this sort of analysis is that it is not possible to know whether a specific procedure was performed in relation to any given diagnosis or whether that procedure was performed by the admitting physician or a consultant. It is likely that the majority of patients with the diagnosis of benign diseases of the uterus (cluster 16) underwent hysterectomies and most of those with abnormal menstrual bleeding (cluster 25) were treated with dilation and curettage, although this must remain speculation. This limitation derives from the limited amount of information that can be encapsulated within any given diagnostic rubric and is part of the reality of most data bases available to researchers. Although a more complex and detailed list could be generated, it would destroy one of the most attractive features of this approach, namely its independence from additional data requirements.

Clusters were constructed for all principal diagnoses that had a combined frequency of more than 0.1 percent of all the principal diagnoses recorded. It would be possible to extend this list further for specific research applications, particularly in dealing with uncommon diseases or entities. A com-

Cluster Rank	Cluster Title	Percent				Percent	
		Fre- quency	Cumulative Frequency	Cluster Rank	Cluster Title	Fre- quency	Cumulative Frequency
1	Ischemic heart disease	7.9	7.9	24	Essential benign hypertension	1.1	63.3
	(including myocardial infarction)			25	Abnormal menstrual bleeding	1.0	64.3
2	Malignant neoplasm	6.2	14.1	26	Pyogenic infections of skin and	0.9	65.2
3	Pregnancy-normal and complicated	4.4	18.5		subcutaneous tissue		
4	Back pain, radiculopathy	4.3	22.8	27	Diverticulitis of colon	0.9	66.1
5	Cerebrovascular disease	4.0	26.8	28	Pelvic inflammatory disease	0.8	66.9
6	Pneumonia	3.1	29.9	29	Gastrointestinal obstruction	0.8	67.7
7	Diabetes mellitus	3.1	33.0	30	Arthritis	0.8	68.5
8	Congestive heart failure	2.7	35.7	31	Anemia	0.7	69.2
9	Chronic obstructive pulmonary	2.7	38.4	32	Abdominal pain	0.7	69.9
	disease			33	Gangrene not otherwise specified	0.7	70.6
10	Appendicitis/appendectomy	2.3	40.7	34	Asthma	0.7	71.3
11	Fractures and dislocations (excluding femur, skull, and all	2.3	43.0	35	Lacerations and multiple trauma (excluding all late effects)	0.6	71.9
	late effects)			36	Anxiety and depression	0.6	72.5
12	Surgical aftercare	2.0	45.0	37	Alcoholism	0.5	73.0
13	Cholecystitis	1.9	46.9	38	Head injury (not	0.5	73.5
14	Peptic ulcer disease	1.9	48.8		associated with multiple trauma)		
	(without hemorrhage)			39	Poisoning	0.5	74.0
15	Well-child care	1.8	50.6	40	Gastrointestinal bleeding	0.4	74.4
16	Benign disease of uterus	1.7	52.3	41	Bronchitis	0.4	74.8
17	Fracture of femur	1.6	53.9	42	Pulmonary embolism and infarction	0.4	75.2
	(excluding late effects)			43	Burns—all	0.4	75.6
18	Diarrheal disease	1.6	55.5		(excluding late effects)		
19	External hernias of abdomen	1.4	56.9	44	Syncope	0.4	76.0
	(including with complications)			45	Cardiac arrhythmias	0.4	76.4
20	Kidney stone	1.4	58.3	46	Seizure disorder	0.3	76.7
21	Disease of urinary tract—	1.4	59.7	47	Abortion—all	0.3	77.0
	ill defined			48	Chest pain	0.3	77.3
22	Diseases of intestine and	1.3	61.0	49	Ectopic pregnancy	0.3	77.6
	peritoneum			50	Pancreatitis	0.2	77.8
23	Upper respiratory tract infection	12	62.2	51	Hemorrhoids	0.2	78.0
	(including influenza)		UL.L	52	Headache	0.1	78.1

plete list of the 52 most common clusters and their component diagnostic titles and codes derived from ICDA-8 and ICD-9-CM is presented in the Appendix. It is important to note that ICD-9-CM codes do not correspond exactly to the adjacent ICDA-8 rubrics, although the cluster content is identical.

Discussion

The hospital occupies a central position in the health care delivery system. Despite the importance of inpatient care, relatively little is known about the process of care in hospitals, and even simple descriptive data about which physician groups are responsible for the care of specific types of illnesses or what differences exist among various subgroups of physicians are lacking. A major limitation to the expansion of knowledge in this area has been the inability to make ready use of the secondary data available about patterns of hospitalization in this country.

In this paper, the method of diagnostic clustering originally developed for use in the ambulatory setting is extended to inpatient diagnoses. By bringing together diagnoses with similar pathophysiological etiologies that require similar diagnostic and clinical decisions on the part of physicians, it is possible to reduce some of the complexity inherent in standard coding schemes with their thousands of distinct rubrics. The basic purpose of this method is to allow investigators a straightforward, conceptually appealing tool with which to manipulate or aggregate data about hospital diagnoses recorded by different groups of physicians.

There are some important limitations to the classification scheme presented here. The actual clusters emerge from a national study of only one physician discipline-family practice. Although family physicians have a fairly wide hospital practice, touching on most areas of medicine, there are definitely major areas with which they have little contact. To the extent that the family physicians in this sample did not record diagnoses in specific areas, there will be important inpatient problems that are not captured in these clusters. Examples of such problems are neurosurgical procedures and rehabilitation medicine diagnoses.

A more definitive list of diagnosis clusters requires a data base that involves all types of physicians who admit patients to hospitals. Unfortunately, there is no inpatient data base that is analogous to the National Ambulatory Medical Care Survey. In the absence of a more inclusive data set, the clusters presented here represent a first step toward the efficient and meaningful analysis of inpatient data and should facilitate study of the hospital activities of primary care physicians.

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Appendix

Inpatient Diagnosis Clusters for Family and General Physicians, Based on the University of Southern California Medical Activities and Manpower Project (MAMP)

	ICDA-8	ICD-9-CM*		ICDA-8	ICD-9-CM*
1. Ischemic Heart Disease			9. Chronic Obstructive Pulmonary Disease		
(including myocardial infarction)			Chronic bronchitis	491	491, 492
Acute myocardial infarction	410	410-414	Emphysema	492	494, 496
Other acute and subacute forms of ischemic	411		Bronchiectasis	518	
heart disease			10. Appendicitis/Appendectomy		
Chronic ischemic heart disease	412		Acute appendicitis	540-542	540-542
Angina pectoris	413		11. Fractures and Dislocations	805-808	805-809
Asymptomatic ischemic heart disease	414		(excluding femur, skull, and all .9	810-819	810-819
2. Malignant Neoplasm			late effects)	822-838	822-829
Of lip	140	140-208		839.0-	830-839
Of oral cavity and pharynx	141-149			839.8	
Of digestive organs and peritoneum	150-159		12. Surgical Aftercare	Y-10	V51-V58
Of respiratory system	160-163				V67
Of bone, connective tissue	170-171		13. Cholecystitis		
Of breast	174		Cholelithiasis with cholecystitis	574.0-	574.0
Of genitourinary organs	180-189			574.1	574.1
Of other and unspecified sites	190-199		Other and unspecified cholelithiasis	574.9	574.3
Of lymphatic and hematopoietic tissue	200-209		Cholecystitis and cholangitis	575	574.4
Malignant melanoma	172				575.0
Other malignant neoplasms of skin	173				575.1
3. Pregnancy—Normal and Complicated					576.1
Hemorrhage of pregnancy	632	640-641	14. Peptic Ulcer Disease (without hemorrhage)		
(including threatened abortion)		650	Esophagitis	530.1	530.1
Delivery without complication	650	651-654	Ulcer of stomach	531.1	531.1
Delivery complicated by placenta previa and		656-659		531.9	531.3
antepartum hemorrhage	651	660-669	Ulcer of duodenum	532.1	531.5
Delivery complicated by retained placenta	652	V22, V23		532.9	531.7
Delivery complicated by postpartum hemorrhage	653	V24	Peptic ulcer not otherwise specified	533	531.9
Delivery complicated by abnormality of pelvis	654		Gastrojejunal ulcer	534.1	532.1
Delivery complicated by cephalopelvic	655			534.9	532.3
disproportion				535	532.5
Delivery complicated by malpresentation	656				532.7
Delivery complicated by prolonged labor	657				532.9
Delivery with laceration of perineum	658				533.1
Rupture of uterus	659				533.3
Other obstetric trauma	660				533.5
Delivery with other complications	661				533.7
Prenatal care	Y6				533.9
Postnatal care	Y7				534.1

4. Back Pain, Radiculopathy					E24.2
Sciatica	353	720.1-			534.5
Osteoarthritis of spine	713.1	720.9			534.5
Lumbago	717.0	721, 722			534.7
Displacement of intervertebral disc-all sites	725	724, 846			534.9
Lumbalgia	728.7	847			539
Backache not otherwise specified	728.9		15. Well-Child Care	1/0 F	100 100
Sprains and strains of other and unspecified parts of back	847		Well-baby and well-child care Classification of liveborn infants and	Y0.5 Y20-Y30.2	V20, V30- V39
5. Cerebrovascular Disease			fetal death		
Malignant hypertension with cerebrovascular	400.2	430-438	16. Benign Diseases of Uterus	210	210 210
involvement			Uterine fibroma	210	210, 219
Subarachnoid hemorrhage	430		Other benign neoplasm of uterus	219	018
Cerebral hemorrhage	431		Uterovaginal prolapse	623	000 001
Occlusion of precerebral arteries	432		17. Fracture of Femur (excluding .9 late effects)	820-821	820-821
Cerebral thrombosis	433		18. Diarrheal Disease	000 000	001 000
Cerebral embolism	434		Intestinal infectious disease	800-000	001-009
Transient cerebral ischemia	435		Diarrheal disease	009	
Acute but ill-defined cerebrovascular disease	436		19. External Hernias of Abdomen		
Generalized ischemic cerebrovascular disease	437		(including with complications)		
Other and ill-defined cerebrovascular disease	438		Inguinal hernia	550	550
6. Pneumonia		and the second second	Femoral, umbilical, and ventral hernias	551.0-	551.0-
Viral pneumonia	480	480-486		551.2	551.2
Pneumococcal pneumonia	481	487.0	Inguinal hernia with complication	552	552.0-
Other bacterial pneumonia	482		Femoral, umbilical, and ventral hernia	553.0-	552.2
Other specified organism eq. mycoplasma	483		with complication	553.2	553.0-
Acute interstitial pneumonia	484				553.2
Bronchonneumonia unspecified	485		20. Kidney Stone		
Pneumonia unspecified	486		Renal calculi	592	592
7. Diabetes Mellitus	250	250	Pain referable to urinary system	786.0	788.0
8. Congestive Heart Failure	100	100	21 Diseases of Urinary Tract—III Defined**		
Hypertensive heart disease with failure	402	428	Psychogenic genitourinary disorders	305.6	306.5
Congestive heart failure	427.0	402.01	Other urinary tract disease	599	599
Left ventricular failure	427.1	402.11	Symptoms referable to genitourinary system	786.1-	788.19
Acute heart failure	/82.4	402.91	Symptoms release to genitodiniary system	786.9	

*ICD-9-CM codes do not correspond exactly to the adjacent specific ICDA-8 rubrics, although the cluster content is identical **This cluster, although ill defined, included rubrics with a high reported frequency and was therefore included

Appendix (Continued)

Inpatient Diagnosis Clusters for Family and General Physicians, Based on the University of Southern California Medical Activities and Manpower Project (MAMP)

22. Diseases of Intestine and Peritoneum (not elsewhere classified)** Multiple dislocations, simple 839.7 (not elsewhere classified)** 569 563.1 Multiple dislocations, compound 839.8 (including proctitis, prolapse of rectum, other rectal disease, fistula of intestine, perforation of intestine, and other diseases) 569 563.1 and trunk 870.878 23. Upper Respiratory Tractal diseases) 569.4 and trunk 870.878 and trunk Streptococcal sore throat 034.0 034, 460 and trunk 800.897 Lacerations and open wounds of limbs 800.897 266.0 286.288 Acute paryingitis 462 464, 465 Involutional melancholia 296.0 286.288 Acute paryinglisis 462 464, 465 Involutional melancholia 296.0 286.8 Acute paryinglisis 462 464, 465 Depressive psychosis 296.8 300.4 Acute paryinglisis 462 464.465 Depressive psychosis 296.8 300.4 Acute paryinglisis 462 464.465 A87 296.8 300.4 Acute paryinglisis 462 464.465 A87 296.8 300.4 <th></th> <th>ICDA-8</th> <th>ICD-9-CM*</th> <th></th> <th>ICDA-8</th> <th>ICD-9-CM*</th>		ICDA-8	ICD-9-CM*		ICDA-8	ICD-9-CM*
(not deswhere classified)** S33.8 Other disease of intestines and peritoneum other intestine, perforation of intestine, and other diseases) 569.1 23. Upper Respiratory Tract Infection (including influenza) 569.81 23. Upper Respiratory Tract Infection (including influenza) 802.837 Catte to scient for the formation of intestine, and other diseases) 460 462, 463 Streptococcal sore throat 034.0 034.460 36.Amiety and Depression Acute name/paryingitis 460 462, 463 Multiple discretions (including melancholia) 296.0 296.298 Acute to paryingitis 460 462 464.487 Psychotic reactive depression 298.0 300.4 Acute to paryingitis/tachelitis 464 487 Psychotic reactive depression 298.0 300.4 Acute upper respiratory infection 465 Malcoholis psychosis (including delirum tremens) 291.303 303.4 Abormal menstruel bleeding 626.0 626 Alcoholis psychosis (including delirum tremens) 571.04 Vaginal bleeding 626.3 626.4 526.4 S64.4 566.4 566.4 Sybuctanceux Tissue 626.3 626.4 566.6	22. Diseases of Intestine and Peritoneum			Multiple dislocations, simple	839.7	
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23. Upper Respiratory Tract Infection (including influenza) Lacerations and open wounds of limbs 880-897 Streptococcal sore throat 034, 0 034, 460 36. Anxiety and Depression 900-907 Acute nasopharyngitis 460 462, 463 Involutional melancholia 296, 0 296-298 Acute pharyngitis 463 487 296, 1 300, 4 Acute tonsilitis 464 487 296, 1 300, 4 Acute paryngitis/trachetis 464 487 296, 3 300, 4 Acute paryngitis/trachetis 464 487 Psychotic reactive depression 296, 2 300, 4 Acute paryngitis/trachetis 464 487 Psychotic reactive depression 296, 2 300, 4 Acute paryngitis/trachetis 464 464 Psychotic reactive depression 296, 2 30, 4 Acute paryngitis/trachetis 464 470 Alcoholism 30, 4 291, 303 25, Ahormal Menstrual Bleeding 62, 62, 62 37, Alcoholism 30, 2 291, 303 26, Progenic Infections of Skin and 622, 5 38, Head Injury 571, 0 80, 803 26, Progenic Infections of Skin and 526, 4 526, 4 526, 4 90, 803 26, Progenic Infections of Jaws 566	perforation of intestine, and other diseases)			Multiple lacerations of head, neck, and trunk	879	
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Acquired nemolytic263Paroxystrial atrial tachyclatitia427.5Aplastic284Ventricular fibrillation/flutter427.6Other and unspecified285Other and unspecified disorders of rhythm427.932. Abdominal Pain785.5789.046. Seizure disorder33. Gangrene (not otherwise specified)445785.4Epilepsy34. Asthma493493Convulsions not otherwise specified780.235. Lacerations and Multiple Trauma640-64563(excluding all .9 late effects)804Precordial pain782.0Multiple fracture of skull or face with other bones80981749. Ectopic Pregnancy631Multiple fracture of trunk Multiple fracture of hand bones81782.750. Pancreatitis577.0-Multiple fracture of upper limb818839.89577.0-57Multiple fracture of upper limb818839.89577.0-57	A new state stat	202		Atrial infinitation/inducer	127.5	
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34. Asthma493493493Convulsions not otherwise specified780.27835. Lacerations and Multiple Trauma493493493Convulsions not otherwise specified780.27835. Lacerations and Multiple Trauma49349349349347. Abortion—All640-64563(excluding all .9 late effects)804804Precordial pain782.078Multiple fracture of skull or face with other bones80981749. Ectopic Pregnancy631633Multiple fracture of trunk Multiple fracture of hand bones81782750. Pancreatitis577.0-577.0-Multiple fracture of upper limb8188398.9.9577.1455455	33. Gangrene (not otherwise specified)	445	/85.4	Epilepsy	345	345
35. Lacerations and Multiple Trauma47. Abortion—All640-645 </td <td>34. Asthma</td> <td>493</td> <td>493</td> <td>Convulsions not otherwise specified</td> <td>780.2</td> <td>780.3</td>	34. Asthma	493	493	Convulsions not otherwise specified	780.2	780.3
(excluding all .9 late effects)48. Chest PainMultiple fracture of skull or face with other bones804Precordial pain782.078Multiple fracture of trunk809817Pleuritic pain783.7Multiple fracture of trunk80981749. Ectopic Pregnancy63163Multiple fracture of hand bones81782750. Pancreatitis577.0-57Multiple fracture of upper limb818839.89577.15757	35. Lacerations and Multiple Trauma			47. Abortion—All	640-645	634-638
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Multiple fracture of hand bones81782750. Pancreatitis577.0-57Multiple fracture of upper limb818839.89577.1Multiple fracture of upper limb818839.89577.1	Multiple fracture of trunk	809	817	49. Ectopic Pregnancy	631	633
Multiple fracture of upper limb 818 839.89 577.1	Multiple fracture of hand bones	817	827	50. Pancreatitis	577.0-	577.01
	Multiple fracture of upper limb	818	839.89		577.1	
Multiple fracture of upper limb and other bones 819 860-869 51. Hemorrhoids 455 45	Multiple fracture of upper limb and other bones	819	860-869	51. Hemorrhoids	455	455
Multiple fracture of lower limb 827 870-897 52. Headache	Multiple fracture of lower limb	827	870-897	52. Headache		
Multiple fracture of lower limbs and 828 Cephalalgia (including tension headache) 306.8 30	Multiple fracture of lower limbs and	828		Cephalalgia (including tension headache)	306.8	307.81
other bones Migraine 346 34	other bones			Migraine	346	346
Headache not otherwise specified 791 78				Headache not otherwise specified	791	784.0

*ICD-9-CM codes do not correspond exactly to the adjacent specific ICDA-8 rubrics, although the cluster content is identical **This cluster, although ill defined, included rubrics with a high reported frequency and was therefore included