

## Scottish Renal Registry

### Notes for pathologists coding renal biopsies for the Scottish Renal Biopsy Registry

When reporting a renal biopsy for the Renal Biopsy Registry, do your report in the usual way in your usual format. For the purposes of the Registry we need a few lines at the end of the report giving 3 items of information.

1. Number of glomeruli (NOG)
2. Pathological diagnosis (SM1, SM2 ....)

These should be recorded at the end of the report in this format.

NOG, x  
SM1, 181414000  
SM2, xxxxxxxx  
SM3, tttttttttt

Explanatory notes:

1. The number of glomeruli. This should include both viable and obsolescent glomeruli. It should be recorded as 'NOG, x'

The spreadsheet containing the SNOMED CT codes can be downloaded from the [Scottish Renal Registry website](#)

Pathological diagnosis should be recorded as a number of codes and up to 4 would be allowed per case. The first code SM1 is the code for kidney (181414000). The attached codes are based on the SNOMED CT coding system (the most recent one). Each condition you diagnose would have two codes, one giving the histological pattern of damage and the second giving the underlying cause. For instance, for mesangiocapillary pattern glomerulonephritis, the code would be SM2, 80321008 and if it was secondary to Hepatitis C infection it would also be SM3, 50711007 or if it was due to lupus nephritis it would be SM3, 36402006. The codes are formatted like this to allow automatic computer recognition that these are the codes. Likewise diabetic nephropathy would be recorded as expansion of the mesangium SM2, 263806003 and diabetes SM3, 127013003 but expansion of the mesangium due to amyloidosis would be SM3, 17602002. Only separate diagnoses should be coded separately e.g. if you see some interstitial inflammation but you feel it is secondary to a glomerulonephritis don't give it a second pair of codes. However if you feel that there is glomerular disease plus tubulointerstitial disease then it deserves two separate sets of codes.

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