Clinical coding: a collective responsibility

Sir,
Clinical coding is fundamental to healthcare management. Imprecision can have significant implications for all secondary uses of coding datasets, including epidemiology, clinical audit and financial reimbursement.

Coding is notoriously prone to error; accuracy is dependent on both clinicians and coders. Coding awareness and engagement among clinicians is low (Naran et al, 2014), thus the clinical documentation that is used for coding often contains errors that inhibit code assignment. Examples include inconsistent diagnosis reporting, minimal information on disease interactions and a lack of sufficient detail to allow conditions or interventions to be coded to the highest degree of specificity. Sources of coder error are well reported and include a lack of experience, misspecification and misinterpretation of medical terminology (O'Malley et al, 2005).

The author engaged in a series of clinician-based coding audits, within general paediatrics, between November 2015 and April 2016. Inpatient records and coding reports were reviewed jointly by a consultant and a clinical coder on a monthly basis. Identified documentation and coding errors were corrected and quantified before the trust coding deadlines.

Of the 1315 hospital spells audited, 104 required coding amendments which resulted in an increase of £72 997.07 in gross financial reimbursement. This demonstrates that avoidable errors can result in significant financial losses and that clinical engagement in coding is vital to uphold the reliability of coding data and its suitability for secondary uses.

To maintain a high degree of accuracy multi-professional coding reviews should be established across all specialities within a hospital setting. Designating a clinician to act as a coding advocate and educating clinical teams on the importance of audit would allow for the planned provision of resources and ensure sustainability. Communication, education and audit are essential for maintaining the usefulness of coding datasets for clinical and statistical purposes.

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Naran S, Hudovsky A, Antscherl J, Howells S, Nouraei SAR (2014) Audit of accuracy of clinical coding in oral surgery. *Br J Oral Maxillofacial Surg* **52**(8): 735–9 (doi: 10.1016/j.bjoms.2014.01.026)

O'Malley KJ, Cook KF, Price MD, Wildes KR, Hurdle JF, Ashton CM (2005) Measuring diagnoses: ICD code accuracy. *Health Serv Res* **40**(5p2): 1620–39 (doi: 10.1111/j.1475-6773.2005.00444.x)

Digital clubbing: forms, associations and pathophysiology

Sir,
The excellent review by Dr Dubrey and colleagues (vol 77(7), 2016, p. 403) describes the pathophysiology of clubbing, but this is more diverse and complex than is suggested (Shneerson, 1981).

The proposal that hypoxia causes clubbing in those with patent ductus arteriosus and cystic fibrosis is unlikely. Clubbing is not a feature of chronic respiratory failure in which hypoxia is a central feature. Clubbing in these disorders is probably caused by shunting of blood either within the heart or lungs, allowing mediators such as those described by the authors to bypass the filtering function of the lungs and thereby to increase the blood flow, blood volume and vascular tissue in the digits which are the hallmarks of clubbing. The same mechanism also explains the clubbing seen in patients with inflammatory bowel disease.

Second, in contrast to what is stated, there is no evidence for a neurological cause for acquired clubbing except when this forms part of hypertrophic osteoarthropathy. Vagotomy does relieve the symptoms of this condition, implying an affluent neurological link to the brain, but with an unknown 'efferent' mechanism which might involve one or more of the mediators listed by the authors.

Clubbing is a feature of many different disorders, each with its own pathophysiology, and care is needed before generalizing about these.

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Shneerson JM (1981) Digital clubbing and hypertrophic osteoarthropathy: the underlying mechanisms. *Br J Dis Chest* **75**: 113–31

ERRATA

The first two authors of the article *Interventional oncology* (vol 77(8), 2016, p. C114, doi: 10.12968/hmed.2016.77.8.C114), Dr Edward W Johnston and Dr Conrad von Stempel, should have been listed as joint first authors.

Professor C Fotopoulou, Consultant in Gynaecological Oncology, Imperial College Healthcare NHS Trust, London, should have been included as an author of the article *Cervical intraepithelial neoplasia: screening and management* (vol 77(8), 2016, p. C118, doi: 10.12968/hmed.2016.77.8.C118).