

TRANSITION FROM ICD-10 TO ICD-11 IN DIABETES MELLITUS: IMPLICATIONS FOR CLINICAL DOCUMENTATION, COMPLICATION CODING, AND ENDOCRINE CARE*

Ö. Sarı¹, M. Polat²

¹*Yenimahalle Training and Research Hospital, Ankara, Turkey*

²*Karabuk Training and Research Hospital, Karabuk, Turkey*
oznurure@yahoo.com

Diabetes mellitus is one of the chronic diseases that have the highest documentation in the health systems today. Its clinical care covers primary care, endocrinology and nephrology specialist care, cardiology, ophthalmology, podiatry and acute care in many cases over decades. Proper disease classification is independent to not only patient care but also quality measurement, payment, research, as well as population-wide monitoring. The functions are supported by International Classification of Diseases (ICD) codes, which convert clinical stories into data that is structured to make informed decisions at health systems.

The international standard to move in ICD 10 to ICD 11 is the biggest revision of disease classification in the last three decades. ICD-11 adds the digital-first architecture, increased (clinical) granularity, and new post-coordination mechanisms that fundamentally transform the representation of the diagnoses [1]. In the case of diabetes mellitus, alterations are observed in disease type, complications, severity,

and time associations encoding. Though ICD-11 will be more clinical expressive, it will also heighten the dependency on good quality clinical documentation to facilitate proper coding.

In most health systems, documentation practises have been changed in order to meet the requirements of ICD-10. These practises tend to focus on adequate coding minimums as opposed to overall clinical specificity. Consequently, there have always been typical trends like the unspecified type of diabetes, incomplete correlation between diabetes and complications or the unspecified stage of chronic kidney disease [2]. These habits not fit into the framework of ICD-11, which presupposes a definite record of causal relations, attributes of diseases and modifiers of severity.

Damaging effects of the lack of compliance between documentation and classification can be exceptionally recreational in the area of diabetes care. Poor and inconsistent coding misrepresent or miscalculate prevalence rates of complications, compromise quality measures,

* The study was initiated by the authors.

The authors declared that this study received no financial support.

The authors guarantee full responsibility for all the information published herein.

The authors guarantee absence of competing interests and their own financial interest when carrying out the research and writing the article.

The manuscript was received by the editorial staff 13.04.2026.



This work is licensed under a Creative Commons Attribution 4.0 International License.



influence reimbursement, and hide actual disease burden [3]. With the onset of the ICD-11 system in health systems, the question of how it affects the documentation of diabetes and endocrine care is a pressing informatics and clinical governance problem.

This paper is a synthesis of secondary evidence on the ICD-10 to ICD-11 transition when used in diabetes mellitus. It also discusses the impacts of changes in classification, clinical documentation, coding of complication, design of electronic health record, (and new data governance) alongside workforce readiness, with practical endocrine care implications taken into account.

ICD-10 versus ICD-11: Practical Changes in Disease Classification

ICD-11 was created to overcome some of the weaknesses that were identified in the previous updates, especially the difficulty of remaining

relevant in a more data-driven and digital healthcare landscape. In contrast to ICD-10 which was mainly built as a fixed classification to facilitate statistical reporting, ICD-11 was designed as a dynamic digital classification system. The architecture makes it able to be updated more frequently, be machine-readable, and consistent with other terminologies [4].

Among the more important practical modifications presented by ICD-11, there is the increased application of post-coordination. ICD-11 is not based on pre-existing codes, as it allows to integrate several clusters of codes to elaborate on a clinical concept. This method allows the clear depiction of disease characteristics like the severity, anatomic location, laterality and causation. Although this flexibility adds to expressiveness, it puts the burden of responsibility on clinicians and coders to make sure that documentation has the required detail.

Table 1

Key structural differences between ICD-10 and ICD-11 and their implications for diabetes documentation and coding

Domain	ICD-10 Structure	ICD-11 Structure	Practical Implication for Diabetes Care
Classification Model	Primarily pre-coordinated combination codes	Foundation component with post-coordination (code clustering)	Requires explicit documentation of causal relationships between diabetes and complications
Digital Integration	Designed for statistical reporting; limited native digital tools	Digital-first design with browser, API access, and coding tool integration	Increased reliance on structured, point-of-care documentation
Complication Representation	Combination codes link diabetes and specific complications	Post-coordinated clusters allow detailed specification of organ involvement and attributes	Greater granularity but reduced tolerance for ambiguous documentation
Severity and Attributes	Limited representation of severity, laterality, and timing within single codes	Extension codes enable staging, laterality, severity, and temporal status	Documentation must include stage, laterality, and episode details
Causal Linkage	Often inferred through combination codes	Explicit causal linkage required in coding cluster	Clinicians must clearly state when complications are attributable to diabetes
Update Mechanism	Periodic static revisions	Continuous digital updating model	Governance processes must monitor version control and classification updates
Analytical Use	Primarily statistical and reimbursement focused	Enhanced semantic interoperability and data analytics capability	Improved population health analysis if documentation supports granularity

The implication to the clinicians especially the endocrinologists is that the narrative documentation should be more explicit [5]. ICD-11 presupposes that causal relationships, including diabetes as the predetermining factor of nephropathy or neuropathy, are explicitly indicated. In ICD-10 such relationships were usually deduced or accommodated by combination codes. In the case of ICD-11, the ambiguity of documentation is directly converted into incomplete or incorrect code clusters [6].

The other viable contrast is the fact that ICD-11 is implemented with electronic tools. The classification is made to be accessed by browsers, application programming interface and coding tools incorporated within electronic health records. The design is more digital-first and opens possibilities on the way of providing real-time coding help, at the same time revealing the lack of documentation in a shorter time. In areas where the ICD-10 coding can be subjectively determined by skilled coders, ICD-11 is increasingly depending on structured, point-of-care information capture. The structural contrasts between ICD-10 and ICD-11 that are particularly relevant to diabetes mellitus are summarized in Table 1.

Diabetes Mellitus Coding Landscape in ICD-10

In the ICD-10, the diabetes mellitus coding is classification based on the type of disease

and occurrence of complications. Codes distinguish between type 1, type 2, other specified and unspecified diabetes with extra characters used to show complications to other organ systems of kidneys, eyes, nerves and circulatory system [7]. The use of long-term insulin and poor glycaemic control are included with supplementary codes.

Regardless of this design, diabetes coding in the real world based on ICD-10 has been typified by inconsistency and variability. A large number of the records have unspecified diabetes codes despite the clinical notes that are explicit on type of disease. Patients with more than one comorbidity often have their complications coded without a specific record of being causally related to diabetes [8]. The staging of chronic kidney disease is frequently imprecise, and information on laterality of retinopathy or depth of ulcer of diabetic foot disease can be neglected.

These documentation lapses are not administrative concerns. They impact the risk stratification, quality measures, and clinical analytics. Experienced coders were at times allowed under ICD-10 to make up vague documentation by applying conventional rules. The use of explicit relationships in ICD-11, however, limits the extent to which such an interpretation can be used and puts more emphasis on documentation accuracy at the point of care.

MATERIALS AND METHODS

This paper assumed a secondary research design that used narrative and thematic synthesis to discuss the implication of switching between ICD-10 and ICD-11 in diabetes mellitus. A narrative methodology was chosen because it enables the incorporation of a wide range of evidence, such as informatics research, clinical reviews, and reports of implementation, and international guidelines, which not be readily conducive to quantitative synthesis [9].

In order to have a medical, health services, and informatics perspective, literature searches were carried out in PubMed, Scopus, and IEEE Xplore. Search strategies were used to combine words that linked to ICD-11, ICD-10, diabetes mellitus, clinical documentation, coding, electronic health records and health in-

formation management [6]. The searches were restricted to the English language publications of 2018–2025 to show the recent development and initial implementation of ICD-11.

Those articles that were reviewed by peers, articles that comprised a systematic or narrative review, implementation studies, and authoritative reports were included based on inclusion criteria as they discussed ICD-11 adoption, diabetes coding practices, documentation quality, and health informatics implications [1]. The exclusion criteria were mainly limited to those code lists which are merely technical without any discussion of the implications of clinical and documentation, editorials without substantive analysis and studies that do not relate to diabetes or chronic disease management.

RESULTS AND THEIR DISCUSSION

Thematic Synthesis

Theme A:

Clinical Documentation Changes in Diabetes Care

Through the literature reviewed, insufficient specificity in documentation was identified as a root cause of the inefficiency of ICD-11 implementation in diabetes management. The structure of ICD-11 involves that clinicians make clear records of connexons between diabetes and its complications, and severity, stage, and laterality attributes. As a matter of fact, most of the endocrine clinic reports are still geared towards glycemic measurements and therapeutic regimes, and little is being done to formally associate complications with diabetes [10]. The essential documentation elements required to support accurate ICD-11 coding in diabetes mellitus are outlined in Table 2.

As an illustration, the recording of chronic kidney disease stage 3 without including diabetic nephropathy as a cause does not allow building precise ICD-11 code clusters. Equally, the mention of retinopathy without laterality or severity limits the accuracy of coding. In ICD-11, these omissions are hard to deal with in the coding process and lead to less informative data.

The synthesis implies that documentation needs to transform the problem-focused summaries into more formal narratives, which anticipates the coding needs. This is not to say that it is too much administration but instead focused understanding in the areas of causality, progression and disease characteristics [11]. This can be in endocrine care, where one directly mentions whether complications are due to diabetes, their present status and their development during time.

Table 2

**Core documentation elements required to support accurate
ICD-11 coding in diabetes mellitus**

Clinical Domain	Required Documentation Element	Risk if Omitted Under ICD-11	Impact on Data Quality
Diabetes Type	Explicit classification as type 1, type 2, secondary, or other specified	Default to unspecified category	Reduced case-mix accuracy
Glycemic Status	Indication of control status or metabolic decompensation	Incomplete representation of disease severity	Impaired risk stratification
Renal Complications	Clear statement of diabetic nephropathy and CKD stage	Inability to cluster causal relationship and stage	Distorted renal complication prevalence
Ophthalmic Complications	Specification of diabetic retinopathy type and laterality	Loss of laterality and severity detail	Reduced analytical precision
Neurological Complications	Explicit linkage between neuropathy and diabetes	Misclassification as non-diabetic neuropathy	Inaccurate complication burden estimates
Peripheral Vascular/Foot Disease	Documentation of ulcer depth, infection status, and relation to diabetes	Under-specification in post-coordination	Compromised quality metrics
Cardiovascular Disease	Clarification whether macrovascular disease is diabetes-related	Ambiguity in clustering codes	Inconsistent registry data
Temporal Status	Indication of acute, chronic, active, or resolved condition	Incomplete timing modifiers	Impaired longitudinal tracking
Encounter Context	Distinction between primary diagnosis and comorbid condition	Misinterpretation of main condition	Distortion of admission statistics

Theme B: Complication Coding and Case-Mix Integrity

One consistent issue that is revealed in the literature is the risk of apparent trend breaks within the data of diabetes complications when switching to ICD-11. The meeting or breaking of coding regulations and classification can result in artificial gains or losses to the recorded complication prevalence with no regard to actual clinical alteration [12]. Such distortions are very dangerous to health systems that use longitudinal data to enhance quality or reimbursement.

At ICD-11, more detailed coding can potentially lead to reduced complication rates recorded in the first few years as long as the documentation does not require inserting the detailed code clusters. On the other hand, a better specificity exaggerates apparent severity profiles relative to past ICD-10 data [6]. Such changes make it difficult to benchmark, risk adjust and evaluate performance.

Thematic analysis indicates the significance of active auditing and cooperation between coders and clinicians in the process of transition. Training should not focus on new codes only, but also on the documentation behaviors that should be maintained to sustain case-mix integrity.

Theme C: Electronic Health Record Templates and Clinical Decision Support

ICD-11 transition has a direct impact on the design of the electronic health record. Current templates which are optimized to ICD-10 documentation not reflect the data elements required to code to ICD-11. Reviewed studies highlight the importance of the use of structured templates to aid the quality of documentation without overloading clinicians.

Redesigned templates are used in diabetes care, suggesting clinicians to note the linkage, stage, and laterality of complications when making regular visits. EHRs can also have clinical decision support mechanisms that can assist clinicians in real-time, including reminding them to indicate chronic kidney disease stage when renal involvement has been brought up [11]. The tools are useful in achieving the

clinical and informatics goals as they enhance both the quality of data and completeness of care.

Excessive alerting has also found its way in the literature as potentially one of the causes of fatigue among clinicians. Effective implementations strike a balance between organized data collection and narrative flexibility and support documentation with clinical processes instead of having hard requirements.

Theme D: Data Governance, Reporting, and Quality Measurement

Internal representation of the ICD-11 adoption goes beyond the twenty-first-line documentation impacting bottom-up peri-data regulation and disclosure procedures. During transition periods, health systems have to deal with parallel coding systems, version control and transparency in the way data is interpreted as time goes by [13]. This is specifically applicable in diabetes care in terms of pay-for-performance schemes, population health reporting, and datasets.

Thematic synthesis discloses that the governance structures should explicitly speak up of the mapping strategies amid ICD-10 and ICD-11 acknowledging that it is not always possible to bring out one-to-one equivalences. Coding regulations, transfer schedule, and adjustments of the analysis used to maintain the continuity of the data should be documented clearly. In the absence of this form of governance the comparisons between periods are misleading.

Theme E: Workforce Readiness and Implementation Strategies

Lastly, the workforce preparedness was identified as a key factor to successful ICD-11 implementation. Clinicians as well as coding professionals need education more than that provided by knowledge of coding to include conceptual shifts in the representation of disease. In the case of endocrinologists, this means the interpretation of optimal documentation options regarding the quality of data and the clinical analytics [4]. In the case of coders, it involves expertise in post-coordination and clinical teamwork.

It has been shown that phased implementation plans like pilot tests in specific services like diabetes clinics are a way of learning and accommodating change. Constant tracking and feedback mechanisms will allow recognizing gaps in documentation and identified education. Interdisciplinary training will enable the health systems to reap the benefits of ICD-11 and reduce disruption.

The results of this secondary synthesis prove that the shift between ICD-10 to ICD-11 in diabetes mellitus is the fundamental change in the organization, communication, and operationalization of clinical information in health systems [14]. Instead of being a mere update of diagnostic codes, ICD-11 proposes a re-organization of the interaction between clinical documentation and coding practice and the subsequent use of data. This transformation, in the case of diabetes care, where diagnoses are assumed to be longitudinal, and complications change across a variety of organ systems, increases the possible benefits but the risk of implementation of the classification change.

Among the most significant findings of the analysis, the primary contribution of documentation quality to the success of the adoption of the ICD-11 can be highlighted. The post-coordination framework and increased granularity of the ICD-11 relies on clear clinical statements about the type of disease, causation, severity, and the status of the disease [9]. The structure of documentation in diabetes management, however, has traditionally taken priority away from diagnostic description in favour of glycaemic intervention alerts and treatment responsibility. Such a mismatch poses a serious weakness as documentation practices developed with ICD-10 can be too unsatisfactory to enable true ICD-11 code clustering. Unless specific modifications are made to the way in which clinicians code complications like nephropathy, neuropathy, or retinopathy with respect to diabetes, ICD-11 will produce fragmented or under-specified data sets which are not reflective of the clinical reality [4].

The synthesis also brings out the fact that poor documentation under ICD-11 has far reaching implications beyond accuracy in the code. The information concerning diabetes forms the basis of quality measures, reimbursement

patterns, population health monitoring, and clinical studies. The apparent changes in the prevalence of complications, their severity distributions and case-mix indices in the transition period can result from disruptions in documentation fidelity and not necessarily indicate a real change in epidemiological process [13]. This is especially problematic in health systems which depend on longitudinal diabetes registries or performance-based financing systems where continuity and comparability of data is required.

An informatics approach to ICD-11 transition requires re-assessment of the electronic health record design. The numerous existing documentation templates and workflows were streamlined to record the minimum ICD-10 requirements and not encourage clinicians to document the specificity that the ICD-11 requires. The analysis of evidence indicates that there should be no passive dependence on awareness of clinicians. Rather, endocrine clinic models need to be integrated with the practice of documentation support in the form of context-dependent prompts and redesigned templates of ICD-11 compatibility in order to embed the results into everyday care. These tools should be incorporated in such a manner they facilitate clinical logic as opposed to adding administrative overhead since excessive of too many prompts or improperly designed prompts lead to clinician burnout and opposition.

Another area of critical ICD-11 transition in diabetes care is data governance. The presence of ICD-10 and ICD-11 simultaneously in the phases of implementation creates complexity in data interpretation, reporting and audit. Governance models should be clear about mapping plans, version control as well as analytical adaptations so that trends in diabetes outcomes and complications are decoded in a proper way [7]. The inability to develop clear governance systems can destroy confidence in data deliverables and decision-making on both organizational and policy levels.

Lastly, the workforce preparedness is an influential factor in the issuance of ICD-11 intended benefits. The synthesis suggests that successful transition involves interdisciplinary interaction, which is the association of clinicians, coders, informaticians, and data ana-

lysts. In the case of the endocrinologists, it is the appreciation of documentation as a clinical and analytical process and not as an administrative one. To the professionals in coding, it involves the understanding of the conceptual model of ICD-11 and can work with clinicians to help them in eliminating ambiguity. Unless training programmers are designed so as to consider both the code mechanics and the underlying principles of documentation, there are low chances of a lasting improvement [14].

CONCLUSION

The ICD-10 to ICD-11 change is a critical step towards the development of diabetes mellitus and its complications in the classification and description of their presence. Although ICD-11 provides significant improvements in clinical granularity, digitalization and analytical capabilities, the improvements are not achievable without a parallel adjustment in the documentation habit, in the information infrastructure, and organizational preparation. The dangers of classification and documentation being at variance in diabetes care are especially acute, because correct representation of type of disease, burden of complications and disease progression is the key to effective management.

This synthesis illustrates that the implementation of ICD-11 cannot be successful only through the implementation of the technical codes. It necessitates a focused transition to explicit, structured, and clinically based doc-

umentation; doing a redesign of electronic health record templates and decision support tools to support codability; having strong data governance to maintain continuity and interpretability of longitudinal data; and high-quality workforce training to establish a clinical-informatics bridge. Proactive systems that consider these dimensions are more prone to integrity of data throughout transition, safeguard the integrity of quality and reimbursement measures, and employ ICD-11 to produce significant insights into the delivery and care results of diabetes.

Finally, ICD-11 must not be perceived as a goal but as an instrument of better clinical communication and population health knowledge. In diabetes mellitus, a matching of classification and clinical reality constitutes a chance to empower the endocrine care, assuming that the implementation should be introduced as a system-wide change.

REFERENCES

1. Nikiema JN, Thiam D, Bayani A, et al. *J Am Med Inform Assoc* 2024;31(6): 1219-1226. <http://doi.org/10.1093/jamia/ocae046>.
2. Ooi ECW, Md Isa Z, Abdul Manaf MR, et al. *Sci Rep* 2024;14(9926). <http://doi.org/10.1038/s41598-024-60439-2>.
3. Drösler SE, Weber S, Chute CG. *BMC Med Inform Decis Mak* 2021;21(6): 278. <http://doi.org/10.1186/s12911-021-01635-2>.
4. Sundararajan V, Le Pogam MA, Southern DA, et al. *BMC Med Inform Decis Mak* 2021;21: 382. <http://doi.org/10.1186/s12911-022-01990-8>.
5. Fung KW, Xu J, Weng C. *J Am Med Inform Assoc* 2020; 27(5): 738-746. <http://doi.org/10.1093/jamia/ocaa030>.
6. Lee H, et al. *Health Info Manage J* 2023;52(2): 102-112. <http://doi.org/10.1177/18333583221095147>.
7. Harb H, Sinno S, Hourani H, Rady A. *East Mediterr Health J* 2026;32(1): 19-28. <http://doi.org/10.26719/2026.32.1.19>.
8. Golpira R, Azadmanjir Z, Zarei J, et al. *Inform Med Unlocked* 2021;25: 100668. <http://doi.org/10.1016/j.imu.2021.100668>.
9. Reed GM, First MB, Kogan CS, et al. *World Psychiatry* 2019;18(1): 3-19. <http://doi.org/10.1002/wps.20611>.
10. Eastwood CA, Southern DA, Doktorchik C, et al. *Health Info Manage J* 2023;52(2): 92-100. <http://doi.org/10.1177/18333583211038633>.

11. Quan H, Steinum O, Southern DA, et al. *BMC Med Inform Decis Mak* 2021;21:387. <http://doi.org/10.1186/s12911-025-03069-6>.
12. Zhang M, Wang Y, Jakob R, et al. *J Am Med Inform Assoc* 2024;31(5): 1084-1092. <http://doi.org/10.1093/jamia/ocae031>.
13. WHO. ICD-11 Implementation: transition and guidance. 2025, available at: <https://www.who.int/standards/classifications/frequently-asked-questions/icd-11-implementation>.
14. WHO. International Classification of Diseases 11th Revision (ICD-11) Fact Sheet. 2022, available at: <https://www.who.int/news-room/fact-sheets/detail/icd-11>.

TRANSITION FROM ICD-10 TO ICD-11 IN DIABETES MELLITUS: IMPLICATIONS FOR CLINICAL DOCUMENTATION, COMPLICATION CODING, AND ENDOCRINE CARE

Ö. Sarı¹, M. Polat²

¹ Yenimahalle Training and Research Hospital, Ankara, Turkey

² Karabuk Training and Research Hospital, Karabuk, Turkey
oznurure@yahoo.com

Background. Diabetes mellitus is a chronic, multisystem disease, which needs appropriate clinical records and coding to facilitate safe patient management, quality of measurement, payment, and population health observation. The international change in classification of diseases, Tenth Revision (ICD-10) to the Eleventh Revision (ICD-11) is a significant structural and conceptual move in the classification of diseases, specifically diabetes because of its complicated complication archetypes and longitudinal care pathways. The ICD-10 influenced documentation practices not be sufficient to promote the greater granularity and digit-first architecture of ICD-11.

Objective. This paper will seek to put together the available secondary literature on changes in ICD-10 to ICD-11 in diabetes mellitus with respect to its clinical documentation, coding of complications, endocrine work-flows, and health informatics systems implications.

Materials and methods. It used narrative secondary research design, which entailed thematic synthesis. The types of literature used include peer-reviewed, international guidance documents and publications of health informatics studies without older than 2018 and 2025, selected by using PubMed, Scopus and IEEE Xplore. Sources that are related to ICD-11 implementation, coding of diabetes, clinical documentation, electronic health records, and data governance were incorporated. The thematic synthezation of findings was aimed at determining repeated implications on practice and informatics.

Results. Five connected themes were found, which include changing documentation needs in diabetes care, endangering the accuracy of complication coding and case-mix integrity, requiring reformed electronic health record templates and clinical decision support, facing difficulties in data governance, reporting, and quality measurement, and workforce preparedness to adopt ICD-11. In all themes, poor documentation specificity was identified as the key risk to effective implementation of ICD-11.

Conclusions. ICD-11 transition has considerable implications in diabetes care beyond the level of the replacement of technical codes. Failure to change documentary practice in a systematic fashion, informatics infrastructure, and training of workforce will likely undermine data quality and clinical insight by ICD-11 adoption. Active synchronization of endocrine record, EHRS, and governance structure is needed in order to achieve the clinical and analytical advantages of ICD-11.

Key words: ICD-11; ICD-10; diabetes mellitus; clinical language; coding of complications; endocrinology; electronic health records; health informatics; data governance, review.

ПЕРЕХІД ВІД МКХ-10 ДО МКХ-11 ПРИ ЦУКРОВОМУ ДІАБЕТІ: НАСЛІДКИ ДЛЯ КЛІНІЧНОЇ ДОКУМЕНТАЦІЇ, КОДУВАННЯ УСКЛАДНЕНЬ ТА ЕНДОКРИННОЇ ДОПОМОГИ

Сари О.¹, Полат М.²

¹ Навчально-дослідна лікарня Єнімахалле, м. Анкара, Туреччина;

² Навчально-дослідна лікарня Карабюк, м. Карабюк, Туреччина
oznurure@yahoo.com

Цукровий діабет — це хронічне мультисистемне захворювання, яке потребує належного ведення клінічних записів та кодування для забезпечення коректного ведення пацієнтів, якості вимірювань, оплати та спостереження за здоров'ям населення. Міжнародна зміна класифікації хвороб Десятого перегляду (МКХ-10) на Одинадцятий перегляд (МКХ-11) є значним структурним та концептуальним кроком у класифікації хвороб, зокрема діабету, через його складні архетипові ускладнення та подовжні шляхи надання медичної допомоги. Практика документування, що вплинула на МКХ-10, не є достатньою для сприяння більшій деталізації та архітектурі МКХ-11, що базується на принципі «спочатку цифра».

Мета. У цій статті зібрано доступну вторинну літературу щодо змін від МКХ-10 до МКХ-11 при цукровому діабеті з точки зору клінічної документації, кодування ускладнень, ендокринних процесів та наслідків для систем медичної інформатики.

Матеріали та методи. Використовувався наративний дизайн вторинного дослідження, який передбачав тематичний синтез. Використана література включає рецензовані міжнародні керівні документи та публікації досліджень з медичної інформатики, не старіші за 2018-2025 роки, відібрані за допомогою PubMed, Scopus та IEEE Xplore. Були включені джерела, пов'язані з впровадженням МКХ-11, кодуванням діабету, клінічною документацією, електронними медичними картками та управлінням даними. Тематичний синтез результатів мав на меті визначити повторювані наслідки для практики та інформатики.

Результати. Було виявлено п'ять пов'язаних тем, серед яких зміна потреб у документації в догляді за діабетом, загроза точності кодування ускладнень та цілісності комплексу випадків, потреба в реформованих шаблонах електронних медичних записів та підтримці клінічних рішень, труднощі в управлінні даними, звітності та вимірюванні якості, а також готовність персоналу до впровадження МКХ-11. У всіх темах низька специфіка документації була визначена як ключовий ризик для ефективного впровадження МКХ-11.

Висновок. Перехід на МКХ-11 має значні наслідки для лікування діабету, що виходять за рамки простої заміни технічних кодів. Нездатність систематично змінити практику документування, інформаційну інфраструктуру та навчання персоналу, ймовірно, підірве якість даних та клінічне розуміння через впровадження МКХ-11. Для досягнення клінічних та аналітичних переваг МКХ-11 необхідна активна синхронізація ендокринних записів, електронних медичних карток та структури управління.

Ключові слова: МКХ-11; МКХ-10; цукровий діабет; клінічна мова; кодування ускладнень; ендокринологія; електронні медичні записи; медична інформатика; управління даними; огляд.