While end users do not need to know the technical details of SNOMED CT, it is useful to understand some of the commonly used terms. This fact sheet aims to give an overview to some of those terms.

SNOMED is known as a terminology: i.e. it provides the technical or special terms used in healthcare. In addition to the terms, SNOMED also provides a logical structure. Currently there are over 800,000 clinical terms within the UK Edition of SNOMED.

A terminology is different to a classification such as ICD-10 and OPCS-4. A classification provides mutually exclusive categories that enable an episode of care to be allocated to the appropriate code(s).

SNOMED consists of 3 basic building blocks:

- concepts,
- descriptions and
- relationships.

**Concepts** are the foundation of the terminology and represent the clinical terms – a concept is that clinical thought to be conveyed to others such as blood pressure, obese, CBT. The Concept Id is the code the computer uses to identify the concept.

We use text to describe a concept; these are the **descriptions** in SNOMED and a concept can have more than one description, just as we use chicken pox and varicella to refer to the same clinical concept.

Concepts are linked to other concepts which help to clearly define the meaning of a concept. These links are known as **relationships**. Relationships also provide the logical organisation of the concepts.

The is-a relationship helps to define what a concept is: for example Alzheimer’s disease is-a type of dementia; depression is-a type of mood disorder. These are used to write searches in systems. The is-a relationships organise the terminology into what are known as **hierarchies**.

For example, all interventions and procedures are in the Procedure hierarchy.

The attribute (or has-a) relationship defines further clinical links: for example dementia has-a finding site of brain structure; viral pneumonia has-a causative agent of virus and has-a associated morphology of inflammation and consolidation. These can also be used in more advanced systems to write searches.

### Each concept has at least two descriptions:

- the Fully Specified Name (FSN): The FSN is unique and aims to clearly describe the concept, as such it includes the type of concept it is in brackets;
- the Preferred Term (PT): The PT is the commonly used clinical description.

For example, Dementia has an FSN of Dementia (disorder) and a PT of Dementia.

A concept can have multiple descriptions as some concepts can be referred to using a variety of clinical phrases; these are known as synonyms.
Example

The concept that is conveyed when we talk about ‘bipolar disorder’.

- Has a concept id of 13746004
- Has an FSN of Bipolar disorder (disorder)
- Is in the Clinical Findings hierarchy within the disorder sub-hierarchy – this contains all the Diagnoses.
- Has a PT of Bipolar disorder
- Has a number of synonyms: Bipolar affective disorder, MDI – Manic Depressive illness, Manic-depressive disorder, Manic-depressive psychosis.

By providing synonyms for concepts, users can generally find the concept they need to record in the electronic patient record. A synonym may be provided for a commonly used abbreviation – note you will not find the abbreviation on its own, but it will have the full definition alongside – see MDI above. This is to ensure that as data flows between systems it cannot be mis-interpreted.

Some systems only allow or guide users to enter a PT; this means visually it’s easier to pick up instances where the same clinical concept is recorded.

The creation of the phrases in SNOMED is governed by national and international Editorial Principles. These are published on the NHS Digital website. This helps to ensure that phrases are written in a consistent way, which means the more you use the terminology the more familiar the principles become – for example you will note in the above example there are no spaces before or after the hyphen.

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