Testicular Cancer

Data Definitions for the National Minimum Core Data Set to support the introduction of Testicular Cancer Quality Performance Indicators

Definitions developed by ISD Scotland in Collaboration with the Testicular Quality Performance Indicator Development Group

Version 2.0: July 2015

To be used in conjunction with:

1. Testicular Clinical Quality Performance Indicators V1.0 (April 2014)
2. Testicular QPI Dataset Validations (Latest Published Version).
3. Testicular Measurability of Quality Performance Indicators (Latest Published Version)
**DOCUMENT CONTROL SHEET**

**Key Information**

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Testicular – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs)</th>
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<td><strong>Date Published/Issued</strong></td>
<td>July 2015</td>
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<td>Final</td>
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<td>NHS staff involved in implementing and recording Testicular Quality Performance Indicators.</td>
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| **Cross References** | Testicular Quality Performance Indicators  
Testicular Measurability of Quality Performance Indicators |
| **Author** | Information Services Division of NHS National Services Scotland |

**Revision History**

<table>
<thead>
<tr>
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<th><strong>Summary of Changes</strong></th>
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<td>V1.1</td>
<td>Jan 2015</td>
<td>Changes agreed out with review during validation QA to support data collection.</td>
<td>Jane Garrett</td>
<td>See page iii</td>
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<td>V1.2</td>
<td>July 2015</td>
<td>Changes agreed at 9 month review</td>
<td>Charlotte Anthony</td>
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<td>July 2015</td>
<td>Changes agreed at 9 month review. Changes to take effect for patients diagnosed from 1st October 2015</td>
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Definitions for the National Minimum Core Data Set for Testicular Cancer. Developed by ISD Scotland, 2014
PREFACE

Following the publication of Better Cancer Care: An Action Plan in October 2008, the Scottish Government established the Scottish Cancer Taskforce to oversee its implementation. The NHS Scotland Healthcare Quality Strategy in 2010 expands on this by articulating quality ambitions. A quality measurement framework has been developed setting out measures and targets which will be used to monitor, challenge, manage and report progress. Part of this strategy is the development of quality performance indicators (QPIs) to drive quality improvement in cancer care throughout NHS Scotland.

As high quality data are required to enable comparisons over time and between regions, it is important that national data definitions are used to facilitate consistent data collection. National data definitions already in use have been used as much as possible to allow electronic data capture, thereby minimising duplication of data collection. Where national data definitions do not already exist, definitions used in other systems have been incorporated.

To ensure that findings are comparable across Scotland, the national dataset and data definitions in conjunction with the final quality performance indicators were agreed through public engagement and are now ready for implementation for patients diagnosed from 1st October 2014.
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with testicular cancer on or after 1st October 2015, who are eligible for inclusion in the testicular cancer audit.

Changes to definitions fall into the following categories:

- to address problems with ongoing audit and standardise data definitions, where feasible, between different cancer sites
- to address problems with existing definitions
- to allow Quality Performance Indicators to be measured and reported against

If you have difficulties in using individual definitions within this document please contact

General Enquiries on the Collection of the Minimum Core Data Set
If you have any comments on the attached data definitions ISD would welcome your feedback. Please contact:

NSS.ISDCANCERAUDIT@NHS.NET

CONVENTIONS

The layout for each item is standard as shown below where it is applicable:

Common Name(s):
Main Source of Data Item Standard:
Definition:
Field Name:
Field Type:
Field Length:
Notes for Users:
Codes and Values:
Related Data Item(s):

In addition the following two conventions have been used in the document:

- {curly brackets} - definition relates to one specific named data set
- ‘described elsewhere’ - indicates there is a definition for the named item within this document
REVISIONS TO DATASET
The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 1st October 2015

REVISIONS TO DATASET FROM 9 MONTH REVIEW (July 2015)

Criteria for Inclusion of Patients in Audit – insert under include “Multiple independent primary tumours should be recorded separately.”

Location of Diagnosis {Testicular Cancer} – removed X1010=Not applicable.

Date of Diagnosis – replaced “of the first investigative procedure that confirms a diagnosis of testicular cancer” with “of the earliest relevant investigation that raised the suspicion of cancer (which was subsequently confirmed)” in definition and notes for users.

Date of Ultrasound Diagnosis {Testicular Cancer} – remove ‘first’ from notes for users.

Date SACT Discussed by Care Team (MDT) – replace ‘treat’ with ‘recommend’ and inserted ‘be treated’

Tumour Size {Testicular Cancer} – inserted (mm) in definition and ‘The unit of measurement for tumours is mm.’ removed ‘there is’ from notes for users

Vascular Invasion {Testicular Cancer} - Where “lymphovascular invasion” is noted within a pathology report record as 01 yes as terms are used interchangeably.

TNM Tumour Classification (Final) {Testicular Cancer} removed ‘p’ from codes within codes and values table. Removed the following text from notes for users “T – primary tumour: Except for pT4, where radical orchidectomy is not always necessary for classification purposes, the extent of the primary tumour is classified after radical orchidectomy. In other circumstances, pTX is used if no radical orchidectomy has been performed.”

TNM Nodal Classification (Final) {Testicular Cancer} removed ‘p’ from codes within codes and values table. Removed the following text from notes for users ‘in the pathology report’ and ‘Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.’

TNM Metastasis Classification (Final) {Testicular Cancer} removed ‘p’ from codes within codes and values table. Removed the following text from notes for users ‘in the pathology report’ and ‘Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.’

Stage Grouping {Testicular Cancer} – inserted the following text in notes for users “Where RMH staging is used this can be recorded where this system corresponds to UICC staging (Stage I and II), otherwise clarify with the relevant clinician.”

Definitions for the National Minimum Core Data Set for Testicular Cancer. 
Developed by ISD Scotland, 2014
REVISIONS TO DATASET:

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/04/2014.

Dataset:

Morphology of Tumour {Testicular Cancer} spelling mistake corrected 9080/3: teratoblastoma
Patient Entered into Clinical Trial {Cancer} field type changed to characters from character

Dataset Specification:

CHI Number field type changed to characters from character
Date of Serum Tumour Markers Test (Pre-SACT) field name corrected to STMDATE
Patient Entered into Clinical Trial {Cancer} field type changed to characters from character
CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT

To facilitate national comparisons the same patients must be audited throughout Scotland. The following eligibility criteria have been documented for this purpose.

Include:
- All patients with a confirmed new primary invasive cancer of the testis (ICD-10 C62)
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
- Multiple independent primary tumours should be recorded separately.

Exclude:
- Patients where the origin of the primary is uncertain
- Patients with tumour type sarcoma or lymphoma
- Patients with recurrent disease (as opposed to a new primary)
- Patients with metastases in the testis originating from another primary site.
- Patients with malignant mesothelioma of the tunica vaginalis, non-invasive tumours or dysplasia
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.

NB:
- Only treatments as part of the initial treatment plan should be recorded.
- Patients treated within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.
DOWNLOAD FORMAT
To assist with downloading data to ISD for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

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<th>Field Type</th>
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**Section 5: Oncology**

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**Section 6: Clinical Trials**

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**Section 7: Follow Up and Death Details**

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</tbody>
</table>

*Definitions for the National Minimum Core Data Set for Testicular Cancer.*  
*Developed by ISD Scotland, 2014*
Section 1: Demographic Items
Person Family Name (at Diagnosis)

**Common Name(s):** Surname, Family name

**Main Source of Data Item Standard:** Government Data Standards Catalogue

**Definition:**
That part of a person's name which is used to describe family, clan, tribal group, or marital association at the time of diagnosis.

**Field Name:** PATSNAME
**Field Type:** Characters
**Field Length:** 35

**Notes for Users:**
Main Source of Standard: Government Data Standards Catalogue
The surname of a person represents that part of the name of a person indicating the family group of which the person is part. It should be noted that in Western culture this is normally the latter part of the name of a person. However, this is not necessarily true of all cultures. This will, of course, give rise to some problems in the representation of the name. This is resolved by including the data item Name Element Position in the structured name indicating the order of the name elements.

From SMR Definitions and Codes

**Notes by Users:**
Person Given Name

**Common Name(s):** Forename, Given Name, Personal Name

**Main Source of Data Item Standard of Standard:** Government Data Standards Catalogue

**Definition:** The forename or given name of a person.

**Field Name:** PATFNAME
**Field Type:** Characters
**Field Length:** 35

**Notes for Users:**
Main Source of Standard: Government Data Standards Catalogue
The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

Where the person's preferred forename is not the first forename, the related data item 'Preferred Forename' should be used to indicate this.

**Related Data Item(s):**

**Notes by Users:**
Patient Postcode at Diagnosis

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition: Postcode of patient's usual place of residence on the date of diagnosis

Field Name: PATPCODE
Field Type: Characters
Field Length: Maximum 8

Notes for Users:
Postcode is included in BS7666 Address (GDSC) but there is also a separate Post Code standard which will be populated from BS7666 Address Post Code.

This item can be derived from the date of diagnosis and patient address at that time

Related Data Item(s):
Date of Diagnosis

Notes by Users:
**Date of Birth**

**Main source of Data Item Standard:** Government Data Standards Catalogue

**Definition:** The date on which a person was born or is officially deemed to have been born, as recorded on the Birth Certificate.

**Field Name:** DOB  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

**Notes for Users:**
If the patient's date of birth is recorded differently on different occasions, the most frequently used or latest date should be recorded.

The patient's full date of birth inclusive of the century should be recorded. The format should be DD/MM/CCYY e.g. 01/02/2011.

**Related Data Item(s):**
CHI Number

**Notes by Users:**
CHI Number

Main Source of Data Item Standard of Standard: Scottish Executive Health Department.

Definition: The Community Health Index (CHI) is a population register, which is used in Scotland for health care purposes. The CHI number uniquely identifies a person on the index.

Field Name: CHINUM
Field Type: Characters
Field Length: 10

Notes for Users:
The Community Health Index (CHI) is a computer based population index whose main function at present is to support primary care services. CHI contains details of all Scottish residents registered with a General Practitioner and was originally envisaged and implemented as a population-based index to help assess the success of immunisation and screening programmes. It is therefore closely integrated with systems for child health, cervical cytology and breast screening call and recall...It is intended that this number, the Scottish equivalent of the new NHS number in England and Wales, should become the Unique Patient Identifier throughout the NHS in Scotland.
From Designed to Care - Scottish Office

The CHI number is a unique numeric identifier, allocated to each patient on first registration with the system. The CHI number is a 10-character code consisting of the 6-digit date of birth (DDMMYY), two digits, a 9th digit which is always even for females and odd for males and an arithmetical check digit.
(ISD, Information Services, NHS National Services Scotland)

The CHI number should always be used to identify a patient. However, Health record identifiers, such as hospital numbers in Patient Administration Systems (PAS), may be used locally, in conjunction with the CHI number or in the absence of the CHI number, to track patients and their records.

Although there may be no number when a patient presents for treatment, there must be an allocation at some point in the episode of care as CHI is mandatory on all clinical communications.

Non-Scottish patients and other temporary residents can have a CHI number allocated if required but it is envisaged that future development may allow the identifying number used in other UK countries to be used in Scotland.

Related Data Item(s):
Date of Birth

Notes by Users:
Section 2: Pre-treatment Imaging & Staging Investigations
Location of Diagnosis {Testicular Cancer}

Main Source of Data Item Standard: The National Audit Cancer Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The patient's hospital of investigation in which the diagnosis of cancer was first made.

Field Name: HOSP
Field Type: Characters
Field Length: 5

Notes for Users: Required for analysis purposes and clarifying responsibility for data collection.

Details of location codes for hospitals can be found in the "Definitions and Codes for the NHS in Scotland" manual produced by ISD Scotland.

Location codes for hospitals are five character codes maintained by ISD Scotland and the General Register Office (Scotland). The first character denotes the health board, the next three are assigned and the fifth denotes the type of location (H=hospital) e.g.

A111H=Crosshouse Hospital
G107H=Glasgow Royal Infirmary
X9999=Not recorded

If a patient was provisionally diagnosed at one hospital but transferred to another for confirmation of the diagnosis only e.g. biopsy, then returns to the original hospital, the first hospital should be recorded as the Location of diagnosis.

Codes and Values:

Related Data Items: Date of Diagnosis {Testicular Cancer}

Notes by Users:
Date of Diagnosis {Testicular Cancer}

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The date on which the suspicion of cancer was first raised by the earliest relevant investigation whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods (which was subsequently confirmed).

Field Name: DIAGDATE
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI(s): 9

The date recorded is the date of the earliest relevant investigative procedure that raises a suspicion of testicular cancer whether done clinically, radiologically or histologically (which is subsequently confirmed).

If the exact date is not documented, record as 09/09/0909.

The date recorded is the date the procedure was performed, not the date the report was issued.

Related Data Items:
Location of Diagnosis {Testicular Cancer}

Notes by Users:
### Date of Ultrasound Diagnosis {Testicular Cancer}

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** The date on which testicular cancer was diagnosed by ultrasound.

**Field Name:** DUSS  
**Field Type:** Date (DD/MM/CCYY)  
**Field length:** 10

**Notes for Users:** Required for QPI(s): 3

The date recorded is the date of the ultrasound that lead to a diagnosis of testicular cancer. If the date is unclear then clarify with the relevant clinician.

If the exact date is not documented, record as 09/09/0909.

If no ultrasound was performed record as 10/10/1010 (Not applicable).

The date recorded is the date the procedure was performed, not the date the report was issued.

This may be the same date as recorded in ‘Date of Diagnosis’.

**Related Data Items:**  
Location of Diagnosis {Testicular Cancer}

**Notes by Users:**
**Date CT Scan Completed**

**Main Source of Data Item Standard:** The National Audit Cancer Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** The date chest, abdomen and pelvis imaging investigations were completed by computed tomography (CT) of the chest, abdomen and pelvis.

**Field Name:** CTDATE  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

**Notes for Users:** Required for QPI(s): 1, 9

As a minimum a CT of the chest, abdomen AND pelvis should be completed. Several investigations may be undertaken prior to staging. It is the date of the FIRST COMPLETE SET of CT scans carried out which should be recorded for this item.

These investigations may be done separately and at different times. Record the date that ALL items are complete, e.g. if CT chest and CT abdomen and pelvis were done on separate days then record the final date.

If CT chest, abdomen and pelvis was not completed or if only some components were completed then record as not applicable (10/10/1010).

If the exact date is not documented, record as (09/09/0909).

**Related data item(s):**  
Date Surveillance CT Scan 1-2

**Notes by Users:**
Pre-Operative Assessment

**Main Source of Data Item Standard:** The National Audit Cancer Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** Denotes whether a pre-operative assessment was completed prior to surgery.

**Field Name:** PREOP  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 2

Several investigations may be undertaken prior to surgery. As a minimum a testicular ultrasound and a check of serum tumour markers (STMs) must be completed before surgery.

These investigations (ultrasound and STMs) may be done separately and at different times.

Serum tumour markers (STMs) are:  
- Alpha Feta Protein (AFP)  
- Human Chorionic Gonadotrophin (HCG)  
- Lactate Dehydrogenase (LDH)

If only one component (i.e. testicular ultrasound) or not all parts of STMs done then record as 02 (No).

If pre-operative assessment is not documented, record as 99 (Not recorded).

If the patient is a non-surgical patient then record as 96 (Not applicable).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td>Testicular ultrasound completed and STMs</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td>E.g. Only one component completed</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused pre-operative assessment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Non-surgical patient</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related data item(s):**

**Notes by Users:**
WHO/ ECOG Performance Status

Main Source of Data Item Standard: WHO (World Health Organisation) and ECOG (Eastern Cooperative Oncology Group)


Field Name: PSTATUS
Field Type: Integer
Field length: 1

Notes for Users: Required for national survival analysis and national comparative analysis.

The WHO/ECOG performance status is a grade on a five point scale (range 0 to 4) at the time of investigation in which '0' denotes normal activity and '4' a patient who is 100% bedridden. If it is not documented do not deduce from other information and record as 'Not recorded'.

This item may occur more than once throughout a patient’s record however, it is the initial WHO/ECOG performance status which should be recorded.

If the performance status falls between two scores, record the higher value i.e. the worst performance status.

Codes and values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light housework, office work</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of self care but unable to carry out any work activities: up and about more than 50% of waking hours</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self care, confined to bed or chair more than 50% of waking hours</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled, cannot carry on any self care, totally confined to bed or chair</td>
</tr>
<tr>
<td>9</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Discussed by Care Team (MDT)

Common name: Date discussed by multidisciplinary team (MDT) {Cancer}

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: This denotes the date the care team meeting was held to discuss the management of the patient’s care.

Field Name: MDTDATE
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users: Required for QPI(s): 4

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, physiotherapists and others relevant to the treatment of a specific cancer. The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first MDT meeting date post-orchidectomy should be recorded. If the patient has not had an orchidectomy then record the first MDT.

If the patient has not been discussed by the MDT record as 10/10/1010 (Not applicable).

If the date of the MDT meeting is unknown record as 09/09/0909 (Not recorded)

Related data Item(s):
Date SACT Discussed by Care Team (MDT)

**Common name**: Date discussed by multidisciplinary team (MDT) (Cancer)

**Main Source of Data Item Standard**: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition**: This denotes the date the care team meeting was held to discuss whether the patient should be treated with systemic anti-cancer therapy (SACT).

**Field Name**: SMDTDATE
**Field Type**: Date (DD/MM/CCYY)
**Field Length**: 10

**Notes for Users**: Required for QPI(s): 8

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, physiotherapists and others relevant to the treatment of a specific cancer. The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first MDT meeting date where the decision to recommend the patient be treated with SACT should be recorded. This could be pre or post orchidectomy.

If the patient has not been discussed by the MDT for SACT then record as 10/10/1010 (Not applicable).

If the date of the MDT meeting is unknown record as 09/09/0909 (Not recorded)

**Related data Item(s):**
Type of First Cancer Treatment

**Common name:** Mode of first treatment

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** This denotes the first specific treatment modality administered to a patient.

**Field Name:** FIRSTTREATMODE  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for national survival analysis and national comparative analysis.

For any particular modality it is the first treatment and not specifically the definitive treatment i.e. this does not include purely diagnostic biopsies such as incisional biopsies, needle biopsies or core biopsies.

Record patients as having ‘supportive care only’ if a decision was taken not to give the patient any active treatment as part of their primary therapy. No active treatment includes watchful waiting and supportive care but not palliative chemotherapy and/or radiotherapy.

Steroids etc should not be recorded as first treatment if more substantive treatment such as radiotherapy, chemotherapy or surgery is given. If no further treatment is given, then record as supportive care.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>10</td>
<td>Active Surveillance</td>
<td>Scheduled follow-up including repeat clinic visits, tests and biopsies after an</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interval until the disease progresses or the grade of the tumour changes</td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all</td>
<td></td>
</tr>
<tr>
<td></td>
<td>therapies</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date of First Cancer Treatment
Date of First Cancer Treatment

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: This denotes the date the type of first cancer treatment was given to the patient.

Field Name: FIRSTTREATDATE
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users: Required for national survival analysis and national comparative analysis.

This field should be recorded for all patients including those with supportive care only (‘No active treatment’) (see below).

If type of first cancer treatment is ‘supportive care only’, the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

The date recorded should be that of the first type of cancer treatment.

If the exact date is not documented, record as 09/09/0909 (Not recorded).

If the patient died before treatment or the patient refused treatment, record as 10/10/1010 (Not applicable).

Related Data Item(s):
Type of First Cancer Treatment
Section 3: Surgery
Location Code {Cancer Surgery}

**Common Name(s):** Location, Location of Contact.


**Definition:** This is the reference number of any building or set of buildings where events pertinent to NHS Scotland take place. Locations include hospitals, health centres, GP surgeries, clinics, NHS board offices, nursing homes, schools and patient/client’s home.

**Field Name:** HOSPSURG  
**Field Type:** Characters  
**Field Length:** 5

**Notes for Users:** Required for national survival analysis and national comparative analysis.

This is the hospital of the **main definitive surgery** which removes the primary tumour. This may be a planned excision even if close margins are found and further surgery is required. On occasion, this result will be achieved by excision biopsy. This should be included as site of first definitive surgery.

Each location has a location code, which is maintained jointly by ISD and General Register Office (Scotland). [http://www.show.scot.nhs.uk/smrfiles/information.html](http://www.show.scot.nhs.uk/smrfiles/information.html) – datafiles.

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at ISD is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate. [http://www.show.scot.nhs.uk/smrfiles](http://www.show.scot.nhs.uk/smrfiles)

Information about location should be electronically stored, managed and transferred using the relevant location code. IT systems should allow the recording and display of locations on the user interface as the relevant location name and associated address, etc.

If the location code is not documented, record as X9999.
If surgery has not been performed or the patient has refused surgery, record as inapplicable, X1010.

Examples of codes are given below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>A111H</td>
<td>CROSSHOUSE HOSPITAL</td>
</tr>
<tr>
<td>C418H</td>
<td>ROYAL ALEXANDRA HOSPITAL</td>
</tr>
<tr>
<td>F704H</td>
<td>VICTORIA HOSPITAL, KIRKCALDY</td>
</tr>
<tr>
<td>G107H</td>
<td>GLASGOW ROYAL INFIRMARY</td>
</tr>
<tr>
<td>G405H</td>
<td>SOUTHERN GENERAL HOSPITAL, GLASGOW</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Final Definitive (or Only) Surgery Performed (Surgery) [Testicular Cancer]
Contralateral Biopsy of Testis{Testicular Cancer}

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by the Information Services.

**Definition:** A record to determine whether the patient had a contralateral biopsy of the testis.

**Field Name:** CONTRABIOP  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for national survival analysis and national comparative analysis.

If contralateral biopsy of testis is not recorded record as ‘99’ or if there is no surgery has been undertaken record as ‘96’ not applicable.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Date of Surgery

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: This is the date the main (definitive) surgery was performed.

Field Name: DSURG
Field Type: Date (DD/MM/CCYY).
Field Length: 10

Notes for Users: Required for QPI(s): 1, 2, 3, 4, 6, 10

This is the date of tumour resection and not the date of any diagnostic surgical procedures.

If the exact date of surgery is not known, record as 09/09/0909 (Not recorded).

If no surgery was performed, record as 10/10/1010 (Not applicable).

All treatments given as part of the initial treatment plan.

Related Data Items:
Location Code {Cancer Surgery}
Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer}

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** This is the main (definitive) or only operation performed for treatment of testicular cancer.

**Field Name:** OPCODE1
             OPCODE2

**Field Type:** Characters

**Field Length:** 5

**Notes for Users:** Required for QPI(s): 1, 2, 3, 4, 5, 6, 10

Where OPCS codes have been recorded in the patient notes by the surgeon, this code should be used. Where no OPCS code has been recorded, the table below should be used. For queries or issues regarding recording OPCS please contact NSS.terminologyhelp@nhs.net.

Operation is coded to the 4-digit code according to the Fourth Revision of the OPCS Classification of Surgical Operations (OPCS4).

Coding instructions and a full list of codes are included in the OPCS4 manual. It should be noted that it may be necessary to record two codes in order to fully specify the operation.

**Key = NEC – Not elsewhere classified**

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N05.2</td>
<td>Bilateral orchidectomy</td>
<td></td>
</tr>
<tr>
<td>N05.3</td>
<td>Bilateral inguinal orchidectomy</td>
<td></td>
</tr>
<tr>
<td>N06.2</td>
<td>Excision of aberrant testis</td>
<td></td>
</tr>
<tr>
<td>N06.3</td>
<td>Orchidectomy NEC</td>
<td></td>
</tr>
<tr>
<td>N06.6</td>
<td>Inguinal orchidectomy NEC</td>
<td></td>
</tr>
<tr>
<td>N07.1</td>
<td>Excision of lesion of testis</td>
<td></td>
</tr>
<tr>
<td>N07.2</td>
<td>Destruction of lesion of testis</td>
<td></td>
</tr>
<tr>
<td>N10.1</td>
<td>Insertion of prosthetic replacement for testis</td>
<td></td>
</tr>
<tr>
<td>T85.8</td>
<td>Other specified block dissection of lymph nodes</td>
<td>Includes - retroperitoneal</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.G. non-surgical patient</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Evidence in patient record that surgery was received but details of the type of surgery is not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**

Location Code {Cancer Surgery}
Section 4: Pathological Details
Tumour Size {Testicular Cancer}

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by the Information Services.

Definition: This is the maximum diameter (mm) of the tumour.

Field Name: TSIZE
Field Type: Integer
Field Length: 4

Notes for Users: Required for QPI(s): 5

If there is more than one lesion the size of the largest tumour should be recorded. The unit of measurement for tumours is mm.

If size of the tumour is not recorded record as ‘9999’ or if no surgery has been undertaken record as ‘1010’ not applicable.

Related Data Items:
Vascular Invasion {Testicular Cancer}
Rete Stromal Invasion {Testicular Cancer}
Vascular Invasion {Testicular Cancer}

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by the Information Services.

Definition: A record to determine whether there has been vascular invasion.

Field Name: VASCINV
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 5

Where "lymphovascular invasion" is noted within a pathology report record as 01 yes as terms are used interchangeably.

If vascular invasion is not recorded record as ‘99’ or if there is no surgery has been undertaken record as ‘96’ not applicable.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>98</td>
<td>Cannot be assessed</td>
<td>E.g. technical failure</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Tumour Size {Testicular Cancer}
Rete Stromal Invasion {Testicular Cancer}
Rete Stromal Invasion {Testicular Cancer}

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by the Information Services.

**Definition:** A record to determine whether there has been rete stromal invasion.

**Field Name:** RSINV  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 5

If rete stromal invasion is not recorded record as ‘99’ or if there is no surgery has been undertaken record as ‘96’ not applicable.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>98</td>
<td>Cannot be assessed</td>
<td>E.g. technical failure</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**

Tumour Size {Testicular Cancer}  
Vascular Invasion {Testicular Cancer}
TNM Tumour Classification (Final) {Testicular Cancer}


**Definition:** A record of the size and extent of the tumour of the testis.

**Field Name:** FINALT  
**Field Type:** Characters  
**Field length:** 3

**Notes for Users:** Required for national survival analysis and national comparative analysis.

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as ‘not recorded’.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed</td>
<td>See note above</td>
</tr>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td>E.g. histological scar in testis</td>
</tr>
<tr>
<td>T1</td>
<td>Tumour limited to testis and epididymis without vascular/lymphatic invasion; tumour may invade tunica albuginea but not tunica vaginalis</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour limited to testis and epididymis with vascular/lymphatic invasion, or tumour extending through tunica albuginea with involvement of tunica vaginalis</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades spermatic cord with or without vascular/lymphatic invasion</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour invades scrotum with or without vascular/lymphatic invasion</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- TNM Nodal Classification (Final) {Testicular Cancer}
- TNM Metastasis Classification (Final) {Testicular Cancer}
- S Category {Testicular Cancer}
TNM Nodal Classification (Final) {Testicular Cancer}


Definition: A record of the extent of regional lymph node involvement of the testis following resection of the primary cancer.

Field Name: FINALN
Field Type: Characters
Field length: 3

Notes for Users: Required for national survival analysis and national comparative analysis.

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as 'not recorded'.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis with a lymph node mass 2cm or less in greatest dimension or 5 or fewer positive nodes, none more than 2cm in greatest dimension</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis with a lymph node mass more than 2cm but not more than 5cm in greatest dimension; or more than 5 nodes positive, none more than 5cm; or evidence of extranodal extension of tumour</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis with a lymph node mass more than 5cm in greatest dimension</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:

TNM Tumour Classification (Final) {Testicular Cancer}
TNM Metastasis Classification (Final) {Testicular Cancer}
S Category {Testicular Cancer}
TNM Metastasis Classification (Final) {Testicular Cancer}

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**Definition:** A record of the extent of metastatic spread of the tumour of the testis following resection of the primary cancer.

**Field Name:** FINALM  
**Field Type:** Characters  
**Field length:** 3

**Notes for Users:** Required for national survival analysis and national comparative analysis.

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as ‘not recorded’.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1a</td>
<td>Non-regional lymph node(s) or lung metastasis</td>
<td></td>
</tr>
<tr>
<td>M1b</td>
<td>Distant metastasis other than non-regional lymph nodes and lung</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

- TNM Tumour Classification (Final) {Testicular Cancer}
- TNM Nodal Classification (Final) {Testicular Cancer}
- S Category {Testicular Cancer}
S Category {Testicular Cancer}

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**Definition:** This denotes the nadir levels as obtained after orchidectomy.

**Field Name:** SERUM  
**Field Type:** Characters  
**Field length:** 2

**Notes for Users:** Required for national survival analysis and national comparative analysis.

If elevated after orchidectomy, markers should be performed serially according to the normal decay of AFP (half-life 7 days) and hCG (half-life 3 days) to assess for serum tumour marker elevation. The S classification is based on the nadir value of hCG and AFP after orchidectomy. The serum level of LDH (but not its half-life levels) has prognostic value in patients with metastatic disease and is included for staging.

N indicates the upper limit of normal for the LDH assay.

This must not be calculated and should only be recorded if actually documented in the casenotes.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sx</td>
<td>Serum markers not available</td>
<td></td>
</tr>
<tr>
<td>S0</td>
<td>Serum marker study levels within reference range</td>
<td>E.g. Negative, normal limits</td>
</tr>
<tr>
<td>S1</td>
<td>LDH &lt;1.5 * N and hCG &lt;5,000(mIU/ml) and AFP &lt; 1000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>LDH 1.5-10* N or hCG 5,000 – 50,000 (mIU/ml) or AFP 1,000 -10,000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>LDH &gt;10 * N or hCG &gt;50,000(mIU/ml) or AFP &gt;10,000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. S category not assessed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

- TNM Tumour Classification (Final) {Testicular Cancer}
- TNM Nodal Classification (Final) {Testicular Cancer}
- TNM Metastasis Classification (Final) {Testicular Cancer}
Stage Grouping {Testicular Cancer}


Definition: This describes the extent of cancer in a patient’s body according to the TNM pathological classification.

Field Name: STAGE
Field Type: Characters
Field length: 4

Notes for Users: Required for QPI(s): 6, 7, 8, 9

If TNMS is not documented in the pathology report or MDT then clarify with relevant clinician, do not deduce from other information.

Where RMH staging is used this can be recorded where this system corresponds to UICC staging (Stage I and II), otherwise clarify with the relevant clinician.

Codes and Values:

<table>
<thead>
<tr>
<th>Stage</th>
<th>T</th>
<th>N</th>
<th>M</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>T1-T4</td>
<td>N0</td>
<td>M0</td>
<td>SX</td>
</tr>
<tr>
<td>IA</td>
<td>T1</td>
<td>N0</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IB</td>
<td>T2-T4</td>
<td>N0</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IS</td>
<td>Any pT/TX</td>
<td>N0</td>
<td>M0</td>
<td>S1-S3</td>
</tr>
<tr>
<td>II</td>
<td>Any pT/TX</td>
<td>N1-N3</td>
<td>M0</td>
<td>SX</td>
</tr>
<tr>
<td>IIA</td>
<td>Any pT/TX</td>
<td>N1</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>N1</td>
<td>M0</td>
<td>S1</td>
</tr>
<tr>
<td>IIB</td>
<td>Any pT/TX</td>
<td>N2</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>N2</td>
<td>M0</td>
<td>S1</td>
</tr>
<tr>
<td>IIC</td>
<td>Any pT/TX</td>
<td>N3</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>N3</td>
<td>M0</td>
<td>S1</td>
</tr>
<tr>
<td>III</td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>SX</td>
</tr>
<tr>
<td>IIIA</td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>S0</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>S1</td>
</tr>
<tr>
<td>IIIB</td>
<td>Any pT/TX</td>
<td>N1-N3</td>
<td>M0</td>
<td>S2</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>S2</td>
</tr>
<tr>
<td>IIIC</td>
<td>Any pT/TX</td>
<td>N1-N3</td>
<td>M0</td>
<td>S3</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>S3</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1b</td>
<td>Any S</td>
</tr>
<tr>
<td>99</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

Related Data Items:
Morphology of Tumour {Testicular Cancer}

**Main Source of Data Item Standard:** Pathology and Genetics of Tumours of the Digestive System, WHO Histological Classification of Tumours 2007.

**Definition:** This is the morphology of the tumour according to the International Classification of Diseases for Oncology (ICD-O(3)).

**Field Name:** MORPHOL  
**Field Type:** Characters  
**Field Length:** 6

**Notes for Users:** Required for QPI(s): 5, 6, 9

If surgical resection has not been performed morphology of the tumour can be determined from biopsy.

The morphology terms have five-digit code numbers which run from 8000/0 to 9989/1; the first four digits indicate the specific histologic terms and the fifth digit, after the slash, is a behaviour code.

If material supplied cannot be assessed code to ‘not assessable’ (1111/1).

If not recorded, record as 9999/9 (Not recorded).

If the pathology report is negative code to 8888/8.

If no invasive diagnostic procedures were undertaken record as inapplicable (1010/0).

Morphology codes are shown below. This list is not exhaustive and if a code is not on the list please contact - NSS.isdCANCERAUDIT@nhs.net for advice.
### Morphology codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>9061/3</td>
<td>Seminoma, classical</td>
</tr>
<tr>
<td>9063/3</td>
<td>Spermatocytic seminoma; spermatocytoma</td>
</tr>
<tr>
<td>9065/3</td>
<td>Germ cell tumour, nonseminomatous</td>
</tr>
<tr>
<td>9070/3</td>
<td>Embryonal carcinoma; embryonal adenocarcinoma</td>
</tr>
<tr>
<td>9080/3</td>
<td>Teratoma malignant, NOS; embryonal teratoma; teratoblastoma, malignant; immature teratoma, malignant; immature teratoma, NOS</td>
</tr>
<tr>
<td>9071/3</td>
<td>Yolk sac tumour; endosermal sinus tumour; polyvesivular vitelline tumour; orchioblastoma; embryonal carcinoma, infantile; hepatoid yolk sac tumour</td>
</tr>
<tr>
<td>9081/3</td>
<td>Teratocarcinoma; mixed embryonal carcinoma and teratoma</td>
</tr>
<tr>
<td>9085/3</td>
<td>Mixed germ cell tumour; mixed teratoma and seminoma</td>
</tr>
<tr>
<td>9100/3</td>
<td>Choriocarcinoma; chorionepithelioma; chorioepithelioma</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
</tr>
<tr>
<td>8888/8</td>
<td>Negative Pathology</td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Related Data Items:

Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014
Section 5: Oncology
Radiotherapy Course Type (Testicular Cancer)

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** The type of course of external beam radiotherapy administered for the treatment of the cancer.

**Field Name:** RADIO  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for national survival analysis and national comparative analysis.

Combined treatments may be administered concurrently/synchronously e.g. chemotherapy and radiotherapy, intra-operative radiotherapy.

For patients undergoing chemoradiotherapy the radiotherapy element should be recorded as code ‘6’ and recorded also in SACT under code ‘5’.

All treatments given as part of the initial treatment plan

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery.</td>
</tr>
<tr>
<td>03</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>04</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
<tr>
<td>05</td>
<td>Neo-adjuvant</td>
<td>It is given before potentially curative surgery.</td>
</tr>
<tr>
<td>06</td>
<td>Chemoradiotherapy</td>
<td>Radical radiotherapy given in combination with chemotherapy, either concurrently or sequentially. Chemotherapy element of this combined treatment should be recorded separately in field Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date Treatment Started (Testicular Cancer) (Radiotherapy)  
Date Treatment Completed (Testicular Cancer) (Radiotherapy)
Date Treatment Started \{Testicular Cancer\} (Radiotherapy)

**Main Source of Data Item Standard:** The National Audit Cancer Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** The date cancer treatment course commenced.

**Field Name:** RADDATE  
**Field Type:** Date (DD/MM/CCYY)  
**Field length:** 10

**Notes for Users:** Required for national survival analysis and national comparative analysis.

This is the first fraction of a course of radiotherapy.

Up to three courses may be recorded.

For the purposes of national audit, only radiotherapy given as part of the primary treatment plan should be recorded. Palliative radiotherapy to other (metastatic) sites is only recorded if part of the initial treatment plan.

If the date radiotherapy started is unknown, record as 09/09/0909 (Not recorded).

If radiotherapy has not been given or the patient has refused radiotherapy, record as 10/10/1010 (not applicable).

**Related Data Items:**  
Date Treatment Completed \{Testicular Cancer\} (Radiotherapy)  
Radiotherapy Course Type \{Testicular Cancer\}
Date Treatment Completed \{Testicular Cancer\} (Radiotherapy)

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services

**Definition:** The date cancer treatment course ended.

**Field Name:** RCOMPDATE  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

**Notes for Users:** Required for QPI(s): 10

This is the last fraction of a course of radiotherapy.

It should be noted this can be the same day as the day the therapy started.

If the date treatment completed is unknown, record as 09/09/0909 (Not recorded).

If treatment has not been given, record as 10/10/1010 (Not applicable).

**Related Data Item(s):**
Date Treatment Started \{Testicular Cancer\} (Radiotherapy)  
Radiotherapy Course Type \{Testicular Cancer\}
Date of Serum Tumour Markers Test (Pre-SACT)

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: This is the date the Serum Tumour Markers (STMs) test was performed prior to commencing SACT.

Field Name: STMDATE
Field Type: Date (DD/MM/CCYY).
Field Length: 10

Notes for Users: Required for QPI(s): 7

It is beneficial to measure STMs to allow for appropriate treatment planning.

Serum tumour markers (STMs) are:

- Alpha Feta Protein (AFP)
- Human Chorionic Gonadotrophin (HCG)
- Lactate Dehydrogenase (LDH)

If the STMs test was done on more than one occasion prior to the commencement of SACT then record the most recent one pre-SACT.

If the exact date of the STMs test is not known, record as 09/09/0909 (Not recorded).

If no STMs test was performed record as 10/10/1010 (Not applicable).

Related Data Items:
Calculation of Renal Function

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** This denotes the method used in the calculation of renal function.

**Field Name:** CALC  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for QPI(s): 6

This should only be recorded for patients receiving Carboplatin otherwise 96 (not applicable) should be recorded.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>EDTA</td>
<td>Eethylenediaminetetraacetic acid</td>
</tr>
<tr>
<td>02</td>
<td>Other</td>
<td>E.g. Blood, urine</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. not assessed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Type of Systemic Anti-Cancer Therapy (SACT) 1-3

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The type of course of cytotoxic or biological drugs administered for the treatment of the cancer. Cytotoxic drugs are drugs which destroy cells.

Field Name: CHEMTYPE1
CHEMTYPE2
CHEMTYPE3
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 1, 2, 3, 6, 7, 8, 9

Patients may have ongoing systemic therapy both before and after surgery. These patients should be recorded under neo-adjuvant Type. Some patients may have separate completion chemotherapy post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

Systemic therapy must be treatment received for initial management and not treatment for recurrence or relapse.

For patients undergoing chemoradiotherapy the chemotherapy element should be recorded as code ‘5’ and recorded also in ‘Radiotherapy Course Type) under code ‘6’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to radiotherapy or first definitive surgery to reduce tumour size.</td>
</tr>
<tr>
<td>02</td>
<td>Adjuvant</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis.</td>
</tr>
<tr>
<td>05</td>
<td>Chemoradiotherapy</td>
<td>Can be sequential or concurrent. Radiotherapy element of this combined treatment should be recorded separately in field Radiotherapy Course Type (1-3)</td>
</tr>
<tr>
<td>07</td>
<td>Biological Therapy</td>
<td></td>
</tr>
<tr>
<td>08</td>
<td>Adjuvant Single Agent Therapy - Carboplatin AUC 7</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Systemic therapy not given as primary part of therapy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE2
CHEMDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI(s): 1, 2, 3, 7, 8

This is the first dose of the first cycle of a course of chemotherapy or biological therapy.

If the date SACT started is unknown, record as 09/09/0909 (Not recorded).

If SACT has not been given or the patient has refused SACT, record as 10/10/1010 (not applicable).

Related data items:
Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The date cancer treatment course ended.

Field Name: CHEMENDATE1
          CHEMENDATE2
          CHEMENDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI(s): 10

This is the first day of the last cycle of a course of chemotherapy, or biological therapy.

It should be noted this can be the same day as the day the therapy started.

If the date treatment started is unknown, record as 09/09/0909 (Not recorded).

If SACT has not been given or the patient has refused SACT, record as 10/10/1010 (Not applicable).

Related data items:
Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Section 6: Clinical Trials
Patient Entered into Clinical Trial

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** An indication of whether or not the patient received treatment within the context of a clinical trial.

**Field Name:** TRIAL  
**Field Type:** Characters  
**Field Length:** 3

**Notes for Users:** Required for QPI(s): 8, 9

This relates only to participation in clinical trials which may be national or international multi-centred trials.

The majority of non-commercial multi-centred trials available in Scotland are NCRN badged or equivalent.

Some academic and university units may have ongoing local trials which should not be included here. These can be recorded on local trials databases.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01A</td>
<td>Yes – Chemotherapy trial</td>
</tr>
<tr>
<td>01B</td>
<td>Yes – Other trial</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Section 7: Follow Up and Death Details
Main Source of Data Item Standard: The National Audit Cancer Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: The date surveillance abdomen +/- chest and pelvis imaging investigations were completed by computed tomography (CT)

Field Name: SURVCTDATE1
SURVCTDATE2
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users: Required for QPI(s): 9

Record each date a CT of the abdomen +/- chest and pelvis was completed subsequent to the initial CT scan.

Surveillance CT scan’s are generally done at 3 and 12 months following pathological diagnosis and confirmed staging (i.e. post orchidectomy).

If CT abdomen +/- chest and pelvis was not completed then record as not applicable (10/10/1010).

If the exact date is not documented, record as (09/09/0909).

Related data item(s):
Date CT Scan Completed
Date of Death

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** This is the certified date of death as recorded by the General Register Office (Scotland) (GRO(S)).

**Field Name:** DOD  
**Field Type:** Date (DD/MM/CCYY).  
**Field Length:** 10

**Notes for Users:** Required for QPI(s): 10
If the exact date is not documented, record as 09/09/0909 (Not recorded).
If the patient is alive use the code 10/10/1010 (Not applicable).

**Related Data Items:**