Bladder Cancer

Data Definitions for the National Minimum Core Dataset to Support the Introduction of Bladder Cancer Quality Performance Indicators

Definitions developed by PHS Scotland in Collaboration with the Bladder Quality Performance Indicator Development Group

Version 3.2 May 2020

To be used in conjunction with:

1. Bladder Cancer Quality Performance Indicators
2. Bladder QPI Dataset Validations (Latest published version)
3. Bladder Measurability of Quality Performance Indicators (Latest published version)
## Key Information

| Title | Bladder Cancer – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs) |
|-------|-------------------------------------------------------------------------------------------------
| Date Published/Issued | May 2020 |
| Date Effective From | 1<sup>st</sup> April 2018 (TNM 8 changes effective from 1<sup>st</sup> April 2018) |
| Version/Issue Number | V3.2 |
| Document Type | Guidance |
| Document Status | Final Version |
| Standard Audience | NHS staff involved in implementing and recording Bladder Cancer Quality Performance Indicators. |
| Cross References | Bladder Quality Performance Indicators  
Bladder Cancer Measurability of Quality Performance Indicators |
| Author | Information Services Division of NHS National Services Scotland |

## Revision History

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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 April 2014.
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with Bladder cancer on or after 1st April 2015, who are eligible for inclusion in the Bladder 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 PHS would welcome your feedback. Please contact: phs.canceraudit@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.

Addition to dataset during COVID 19 Pandemic (May 2020)

Database Specification

**Date of Referral** - add new Data item, Field Name: REFERDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

**COVID 19 Impact** - add new Data item, Field Name: COVID, Field Type: Integer, Field Length: 2

Dataset

**Date of Referral** - add new data item - implement from 1 March 2020

**COVID 19 Impact** - add new Data item – implemented from 1 April 2019

Revisions to Dataset Outwith Review (May2020)

Inclusion criteria - remove 'urothelial'

**Date of Definitive Treatment {Bladder Cancer}** - Notes for Users add 'The date recorded is the date of confirmation of muscle invasive bladder cancer prior to definitive treatment.'. Add 'If the patient does not have a diagnosis of MIBC prior to definitive treatment record as 10/10/1900 (Not applicable)'.

**Complete Resection at TURBT 1-2 (NMIBC & MIBC)** - Notes for Users add 'Where completeness of resection is documented as uncertain 'Record as 02-No'.

**Tumour Grade 1973 Classification (NMIBC & MIBC)** - Notes for Users amend 'All non-urothelial cancers should be recorded as 96 - not applicable to 'For morphologies other than urothelial carcinoma/transitional cell carcinoma, record as 96 - not applicable'

**Tumour Grade 2004 Classification (NMIBC & MIBC) (TGRADE2004)** - Notes for Users amend 'All non-urothelial cancers should be recorded as 96 - not applicable to 'For morphologies other than urothelial carcinoma/transitional cell carcinoma, record as 96 - not applicable'

Revisions to Dataset Outwith Review (April 2019)

**Date of Diagnosis {Cancer}** – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’

**Date of Histological Diagnosis** - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

**Date Discussed by Care Team** - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’
Date of First Cancer Treatment - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Definitive Treatment (Bladder Cancer) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Diagnosis MIBC - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of TURBT 1-2 (NMIBC & MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Cystectomy (NMIBC & MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Other Procedure (NMIBC & MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Seen by Oncologist (MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Started (NMIBC & MIBC) (Radiotherapy) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed (NMIBC & MIBC) (Radiotherapy) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment started Systemic Anti-Cancer Therapy (SACT) (NMIBC & MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (NMIBC & MIBC) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Death - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Changes Agreed at Formal Review (November 2018)

DATABASE SPECIFICATION

Bladder Diverticular Tumour – add new data item, Field Name ‘DIVERT’, Field Type ‘Integer,’ Field Length ‘2’

Date of Histological Diagnosis - add new data item, Field Name ‘HISTDATE’, Field Type ‘Date (DD/MM/CCYY),’ Field Length ‘10’
Early Cystectomy (NMIBC & MIBC) - add new data item, Field Name ‘EARLYCYST’, Field Type ‘Integer,’ Field Length ‘2’

Pelvic Lymph Node Dissection (NMIBC & MIBC) - add new data item, Field Name ‘LNLEVEL’, Field Type ‘Integer,’ Field Length ‘2’

Dataset

Bladder Diverticular Tumour – add new data item

Date of Histological Diagnosis – add new data item

Date Discussed by Care Team (MDT) – Notes for Users amend ‘initial TURBT’ to ‘histological confirmation’

Date of First Cancer Treatment – Notes for Users add ‘Where this has been subsequently been confirmed at MDT, the date of the MDT should be recorded’.

Date of Definitive Treatment (Bladder Cancer) – Notes for Users amend ‘Required for QPI: 3’ to ‘Required for QPI: 1’, add ‘Where this has been subsequently been confirmed at MDT, the date of the MDT should be recorded’, amend ‘unless the patient was given palliative chemotherapy and/or radiotherapy in which case’ to ‘If the patient has been given palliative chemotherapy and/or radiotherapy’

Date of Diagnosis of MIBC – Notes for Users add Required for QPIs ‘1, 4, 9, 10’

TURBT 1 (NMIBC & MIBC) - Notes for Users remove Required for QPI ‘11’

Date of TURBT 1-2 (NMIBC & MIBC) - Notes for Users remove Required for QPI ‘11’

Tumour Size at TURBT 1-2 (Clinical) (NMIBC & MIBC) - Notes for Users add Required for QPI ‘4’, amend ‘should’ to ‘may’

Number of Tumours at TURBT 1-2 (NMIBC & MIBC) - Notes for Users add Required for QPI ‘4’, amend ‘should’ to ‘may’

Bladder Diagram at TURBT 1-2 (NMIBC & MIBC) (BDIAG) - Notes for Users amend ‘should’ to ‘may’

Tumour Appearance at TURBT 1-2 (NMIBC & MIBC) (TAPPEAR) - Notes for Users amend ‘should’ to ‘may’

Bladder Perforation at TURBT 1-2 (NMIBC & MIBC) - Notes for Users remove Required for QPIs ‘3, 4’

Complete Resection at TURBT 1-2 (NMIBC & MIBC) - Notes for Users amend Required for QPIs ‘2’ to ‘4’

Intent of Surgery – Cystectomy (NMIBC & MIBC) - Notes for Users remove Required for QPI ‘1’, Codes and Values table add ‘code 03 – Salvage’, Explanatory Notes remove ‘salvage’
Operative Procedure - Notes for Users remove Required for QPIs ‘1, 8’

Date of Cystectomy (NMIBC & MIBC) - Notes for Users remove Required for QPIs ‘6, 8, 11’

Early Cystectomy (NMIBC & MIBC) - add new data item

TNM Tumour Classification (Pathological) (NMIBC & MIBC) - Notes for Users amend Required for QPIs ‘10’ to ‘1, 3, 4’

TNM Metastases Classification (Pathological) (MIBC) – Notes for Users add Required for QPI ‘4’

Associated Carcinoma In Situ (NMIBC & MIBC) - Notes for Users add Required for QPI ‘4’

Total Number of Lymph Nodes Examined Microscopically (NMIBC & MIBC) - Notes for Users remove Required for QPI ‘6’

Pelvic Lymph Node Dissection (NMIBC & MIBC) – add new data item

Radiotherapy Course Type 1-2 (NMIBC & MIBC) - Notes for Users amend Required for QPIs ‘9’ to ‘11’

Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC) - Notes for Users amend Required for QPIs ‘9’ to ‘11’

Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC) - Notes for Users delete Required for QPI ‘7’

Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC) - Notes for Users add Required for QPI ‘7’

Change Outwith Review (April 2018)

Person Family Name (at Diagnosis) – link updated

Person Given Name – link updated

Patient Postcode at Diagnosis {Cancer} – link updated

Date of Birth – link updated

Intent of Surgery 1-2 (NMIBC & MIBC) - Definition changed from 'as defined by Multidisciplinary Team (MDT)' to 'as documented in the Clinical Record/Post op MDT'; Notes for Users delete 'Record the intent pre-operatively'

Tumour Size at TURBT 1-2 (Clinical) (NMIBC & MIBC) - Definition Remove 'invasive'

Tumour Grade 1973 Classification (NMIBC & MIBC) - Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology
report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'. 'For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

**Tumour Grade 2004 Classification (NMIBC & MIBC)** – Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'. ' to 'For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

**Morphology of Tumour (NMIBC & MIBC)** - Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'. ' to 'For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

**Associated Carcinoma In Situ (NMIBC & MIBC)** - Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'. ' to 'For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

**Margin Status (Microscopic) (Muscle Invasive Bladder Cancer)** - Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'. ' to 'For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

**Intent of Surgery - Cystectomy (NMIBC & MIBC)** - Definition changed from 'as defined by Multidisciplinary Team (MDT)' to 'as documented in the Clinical Record/Post op MDT', Notes for Users delete 'Record the intent pre-operatively'.

**TNM Tumour Classification (Clinical) (NMIBC & MIBC)** - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017; Code T2, T2a and T2b change 'muscle' to 'muscularis propria'; Add code TX - Primary tumour cannot be assessed.

**TNM Nodal Classification (Clinical) (NMIBC & MIBC)** - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017; Code N2 add 'regional'.

**TNM Metastases Classification (Clinical) (NMIBC & MIBC)** - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017; Delete code M1 - Distant Metastasis; Add code M1a - Non-regional lymph nodes and code M1b - Other distant metastasis.
TNM Tumour Classification (Pathological) (NMIBC & MIBC) - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017; Code T2, T2a and T2b change ‘muscle’ to ‘muscularis propria’; Add code TX - Primary tumour cannot be assessed
Notes for Users delete 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.


Notes for Users change 'For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'.

Change Outwith Review (July 2017)

Tumour Grade 1973 Classification (NMIBC & MIBC) and Tumour Grade 2004 Classification (NMIBC & MIBC)
Changes to field names;
From 1973TGRADE1 to TGRADE19731
From 1973TGRADE2 to TGRADE19732
From 2004TGRADE1 to TGRADE20041
From 2004TGRADE2 to TGRADE20042

Change Outwith Review (November 2016)

Date Discussed by Care Team (MDT) (MDTDATE) – (Query 1325) amend from 'The first MDT meeting date will be recorded’ to 'The first MDT meeting date will be recorded except for NMIBC patients discussed both before and after initial transurethral resection of bladder tumour (TURBT), in which case the date of the first MDT following initial TURBT should be recorded'.

Tumour Grade 2004 Classification (NMIBC & MIBC) - (2004TGRADE1-2) – (Query 928) Add ‘includes pTis’ to the Explanatory Notes for code 96 Not Applicable in the table of Codes and Values.

Associated Carcinoma In Situ (NMIBC & MIBC) Codes and Values table add 'includes pTis' to the Explanatory Notes for code 96 Not Applicable

Amendments to Baseline Review Changes (October 2016)

Date of Diagnosis {Cancer} - update Notes for User with ‘the date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat.

Data Definitions for the National Minimum Core Dataset for Bladder Cancer.
Developed by ISD Scotland
2014
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Bladder Diagram at TURBT 1-2 (NMIBC & MIBC) - Insert text ‘Use of a bladder diagram or a detailed description with documentation of tumour location, size, number and appearance’.

TNM Tumour Classification (Pathological) (NMIBC & MIBC) - Notes for Users: add text ‘Record as ‘not applicable’ where only pathology is from biopsy rather than formal TURBT.’

Baseline Review Changes (August 2016)

Date of Diagnosis of MIBC - Insert text - The date recorded is the date the report was issued and not the date the procedure was performed.

TURBT 1 (NMIBC & MIBC) – remove reference to TURBT 2

TURBT 2 (NMIBC & MIBC) (TURBT2) – new data item for TURBT 2

Date of TURBT 1-2 (NMIBC & MIBC) (TURBTDATE1-2) - Insert text - or cystoscopy

Insert text to each of the bulleted list below - For cystectomy specimens, pT0 tumours, or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as ‘not applicable’

- TNM Tumour Classification (Pathological) (NMIBC & MIBC) (pTTURBT and pTCYST)
- TNM Metastases Classification (Pathological) (MIBC) (pM)
- Tumour Grade 1973 Classification (NMIBC & MIBC) (1973TGRADE1 - 1973TGRADE2)
- Tumour Grade 2004 Classification (NMIBC & MIBC) (2004TGRADE1 - 2004TGRADE2)
- Morphology of Tumour (NMIBC & MIBC) (MORPHOL1 - MORPHOL2)
- Associated Carcinoma In Situ (NMIBC & MIBC) (ASSCIS1 – 2)
- Margin Status (Microscopic) (Muscle Invasive Bladder Cancer) (MICROMARGIN)

Lymphovascular Invasion (NMIBC & MIBC) (LYMPINV1 - LYMPINV2)

Insert text - For pTa or pTis tumours, lymphatic vascular invasion should be recorded as Not applicable (96).

Margin Status (Macroscopic) (NMIBC & MIBC) (MACROMARGIN)

Notes for Users: Remove text – required for QPI 5.

Tumour Size (Pathological) (NMIBC & MIBC) (TSIZE)

Notes for Users: Remove text - required for QPI 5.

Changes outwith review (July 2016)

Date of Definitive Treatment – removed “For patients undergoing no active treatment (e.g. 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. This will therefore be the same date as the First Treatment Date for these patients." Insert “For patients not receiving radical treatment for MIBC the date recorded should be the date the decision was taken not to give the patient radical treatment as part of their primary therapy unless the patient was given palliative chemotherapy and/or radiotherapy in which case the date this treatment started should be recorded”

**Changes outwith review (July 2015)**

**Criteria for Inclusion of Patients in Audit** - Remove ‘urothelial’ from inclusion criteria

**TNM Tumour Classification** – created 2 field names pTTURBT and pTCYST. In field pTTURBT added to the TURBT text within notes for users. In field pTCYST added to the cystectomy text within notes for users. Insert code pT0 No evidence of primary tumour, cystectomy specimen;

**Tumour Grade 1973 Classification (NMIBC & MIBC)** – created 2 field names 1973TGRADE1 and 1973TGRADE2. in field 1973TGRADE1 added to the TURBT text within notes for users. In field 1973TGRADE 2 added to the cystectomy text within notes for users. All non-urothelial cancers should be recorded as not applicable – added to notes for users.

**Tumour Grade 2004 Classification (NMIBC & MIBC)** – created 2 2004TGRADE field names 2004TGRADE1 and 2004TGRADE2. . . in field 2004TGRADE 1 added to the TURBT text within notes for users. In field 2004TGRADE 2 added to the cystectomy text within notes for users. All non-urothelial cancers should be recorded as not applicable – added to notes for users.

**Morphology of Tumour (NMIBC & MIBC)** – created 2 field names MORPHOL1 and MORPHOL2. . . in field MORPHOL 1 added to the TURBT text within notes for users. In field MORPHOL 2 added to the cystectomy text within notes for users.

**Lymphovascular Invasion (NMIBC & MIBC)** – created 2 field names LYMPINV1 and LYMPINV2. . . in field LYMPINV 1 added to the TURBT text within notes for users. In field LYMPINV 2 added to the cystectomy text within notes for users.

**Amendments to revisions following 9 month review (July 2015)**

**Intent of Surgery 1-2 (NMIBC & MIBC)** - The following text has been added to notes for users – “TURBTINTENT2 is optional and can be used for recording locally.”

**TURBT 1-2 (NMIBC & MIBC) (TURBT1 & TURBT2)** – removed following text from notes for users - “TURBT2 is optional and can be used for recording locally.”

**Date of TURBT 1-2 (NMIBC & MIBC)** - removed following text from notes for users - “TURBT2 is optional and can be used for recording locally.”

**Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC)** - The following text has been added to notes for users – “DEMUSC2 is optional and can be used for recording locally.”
Bladder Diagram at TURBT 1-2 (NMIBC & MIBC) - The following text has been added to notes for users – “BDIAG2 is optional and can be used for recording locally.”

Tumour Size at TURBT 1-2 (Clinical) (NMIBC & MIBC) - The following text has been added to notes for users – “CTSIZE2 is optional and can be used for recording locally.”

Number of Tumours at TURBT 1-2 (NMIBC & MIBC) - The following text has been added to notes for users – “MULTIPLE2 is optional and can be used for recording locally.”

Tumour Appearance at TURBT 1-2 (NMIBC & MIBC) - The following text has been added to notes for users – “TAPPEAR2 is optional and can be used for recording locally.”

Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer) - The following text has been added to notes for users – “INTRAV2 is optional and can be used for recording locally.”

Date of Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer) - The following text has been added to notes for users – “INTRAVDATE2 is optional and can be used for recording locally.”

Bladder Perforation at TURBT 1-2 (NMIBC & MIBC) - The following text has been added to notes for users – “PERFTURBT2 is optional and can be used for recording locally.”

Complete Resection at TURBT 1-2 (NMIBC & MIBC) - The following text has been added to notes for users – “RESECCOMP2 is optional and can be used for recording locally.”

Revisions to dataset following 9 month review (March 2015)

Site of Origin of Primary Tumour {Cancer} - If the site of origin of the tumour is not specific then it should be classified as subcategory C67.9. add to notes for users.

Type of First Cancer Treatment – removed Complete and (tumours <5mm) from the explanatory notes of code 05 – Endoscopic

Location Code – TURBT 1-2 {Cancer Surgery} (NMIBC & MIBC) – removed the following text from notes for users “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.”

Intent of Surgery 1-2 (NMIBC & MIBC) – Inserted a new code 03 – Diagnostic Biopsy

TURBT 1-2 (NMIBC & MIBC) (TURBT1 & TURBT2) Field type changed from Characters to Integer; Field size changed from 5 to 2. The following text has been added to notes for users – “TURBT2 is optional and can be used for recording locally.”
Date of TURBT 1-2 (NMIBC & MIBC) – under TURBTDATE1 in notes for users changed diagnostic to first. And added “TURBT2 is optional and can be used for recording locally” to the end of notes for users.

Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC) code 96 Inapplicable changed to Not applicable

Bladder Diagram at TURBT 1-2 (NMIBC & MIBC) code 96 Inapplicable changed to Not applicable

Tumour Appearance at TURBT 1-2 (NMIBC & MIBC) – removed pathology states from explanatory notes of code 03 Mixed.

Date of Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer) replaced TURBT with MMC Instillation in notes for users.

Bladder Perforation at TURBT 1-2 (NMIBC & MIBC) inserted “or op note” into notes for users; added new code 04 – Perforation not specified

Complete Resection at TURBT 1-2 (NMIBC & MIBC) - inserted “or op note” into notes for users

Location Code – Cystectomy {Cancer Surgery} (NMIBC & MIBC) – removed the following text from notes for users “This is the hospital where cystectomy took place which removes the primary tumour. This may be a planned excision even if close margins are found and further surgery is required. This should be included as site of first definitive surgery.”

Operative Procedure – Cystectomy (NMIBC & MIBC) – removed the following text from notes for users “Where OPCS codes have been recorded in the patient notes by the surgeon, this code should be used. Where no opc code has been recorded, the table below should be used. For queries or issues regarding recording OPCS please contact phs.canceraudit@nhs.net” and “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 e.g. double bypass could be recorded as:”

Other Procedures (NMIBC & MIBC) – “Cystodiathermy” added to the explanatory notes of code M42.2


Lymphatic Vascular Invasion (NMIBC & MIBC) – name changed to Lymphovascular Invasion (NMIBC & MIBC); text changed in definition to reflect title change.

Associated Carcinoma In Situ (NMIBC & MIBC) – created 2 field names ASSCIS1 and ASSCIS2. in field ASSCIS1 added to the TURBT text within notes for users. In field ASSCIS2 added to the cystectomy text within notes for users.

Margin Status (Macroscopic) (NMIBC & MIBC) Code 99 – Not known changed to Not recorded
Margin Status (Microscopic) (Muscle Invasive Bladder Cancer) Code 99 – Not known changed to Not recorded

Date Seen by Oncologist (NMIBC & MIBC) – NMIBC removed from title; the following text added to notes for users under not applicable “, NMIBC or not seen by an oncologist......”

Radiotherapy Course Type 1-3 (NMIBC & MIBC) – the following text has been removed from the explanatory notes of code 03 radical “Refers to chemo given concurrently with radiotherapy. Recorded as concurrent or sequential. There are exceptions, for example; a patient may get 4 cycles of neoadjuvant chemo followed by 4 weeks of radiotherapy bt without concurrent chemo at same time as radiotherapy, this should not count as chemoradiotherapy.”; CHEM2 or CHEM3 added to explanatory notes of code 07 – Chemoradiotherapy.

Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC) - the following text has been removed from the explanatory notes of code 07 Chemoradiotherapy “Refers to chemo given concurrently with radiotherapy. Recorded as concurrent or sequential. There are exceptions, for example; a patient may get 4 cycles of neoadjuvant chemo followed by 4 weeks of radiotherapy bt without concurrent chemo at same time as radiotherapy, this should not count as chemoradiotherapy. Radiotherapy element of this combined treatment should be recorded separately in fields ‘Radio1’ ‘Radio2’ and ‘Radio3’” and replaced with Chemotherapy given in combination with radical radiotherapy, either concurrently or sequentially. Radiotherapy element of this combined treatment should be recorded separately in fields RADIO1, RADIO2 or RADIO3

Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC) – changed last dose to first dose in notes for users.

Database Specification:

TURBT 1-2 (NMIBC & MIBC) (TURBT1 & TURBT2) Field type changed from Characters to Integer; Field size changed from 5 to 2

Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC) Field name changed from DEMUSC1 to DEMUSC2

TNM Tumour Classification (Pathological) (NMIBC & MIBC) Field name changed from PT to pT

TNM Nodal Classification (Pathological) (NMIBC & MIBC) Field name changed from PN to pN

TNM Metastases Classification (Pathological) (NMIBC & MIBC) Field name changed from PM to pM

Lymphatic Vascular Invasion (NMIBC & MIBC) title changed to Lymphovascular Invasion (NMIBC & MIBC)
Associated Carcinoma In Situ (NMIBC & MIBC) inserted additional Field Name now ASSCIS1 and ASSCIS2

Date Seen by Oncologist (NMIBC & MIBC) NMIBC removed from title.

Revisions to Dataset (July 2014)

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

Date of Definitive Treatment {Bladder Cancer} – insert new data item

Database Specification:

Date of Definitive Treatment {Bladder Cancer} data item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.
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 and non-invasive cancer of the bladder (ICD-10 C67 and ≥ pTa).
- All patients with carcinoma in-situ
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

A separate record should be entered for each tumour of distinct origin. This is in line with BAUS. However, if there are multiple tumours within the bladder, which have the same histology, record this as one tumour.

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 bladder originating from another primary site.
- Patients with PUNLMP (papillary urothelial neoplasia of low malignant potential) or dysplasia.
- Patients with neuroendocrine tumours
- 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 can be recorded.
DOWNLOAD FORMAT
To assist with downloading data to PHS 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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Data Definitions for the National Minimum Core Dataset for Bladder Cancer. Developed by ISD Scotland 2014 xvi
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**Section 3b: Cystectomy**

| Location Code - Cystectomy (Cancer Surgery) (NMIBC & MIBC) | HOSPCYST | Characters | 5 | 42 |

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Developed by ISD Scotland
2014
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<td>Integer</td>
<td>4</td>
</tr>
<tr>
<td>Pelvic Lymph Node Dissection (NMIBC &amp; MIBC)</td>
<td>LNLEVEL</td>
<td>Integer</td>
<td>2</td>
</tr>
<tr>
<td>Number of Positive Lymph Nodes (NMIBC &amp; MIBC)</td>
<td>POSLN</td>
<td>Integer</td>
<td>4</td>
</tr>
<tr>
<td>Tumour Size (Pathological) (NMIBC &amp; MIBC)</td>
<td>TSIZE</td>
<td>Integer</td>
<td>4</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>---</td>
</tr>
</tbody>
</table>

### Section 5: Oncology

<table>
<thead>
<tr>
<th>Date Seen by Oncologist (MIBC)</th>
<th>ONCDATE</th>
<th>Date (DD/MM/CCYY)</th>
<th>10</th>
<th>69</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy Course Type 1-3 (NMIBC &amp; MIBC)</td>
<td>RADIO1</td>
<td>Integer</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Radiotherapy Course Type 1-3 (NMIBC &amp; MIBC)</td>
<td>RADIO2</td>
<td>Integer</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Radiotherapy Course Type 1-3 (NMIBC &amp; MIBC)</td>
<td>RADIO3</td>
<td>Integer</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>Date Treatment Started 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RADDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Date Treatment Started 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RADDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Date Treatment Started 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RADDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Date Treatment Completed 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RCOMPDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Date Treatment Completed 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RCOMPDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Date Treatment Completed 1-3 (NMIBC &amp; MIBC) (Radiotherapy)</td>
<td>RCOMPDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEM1</td>
<td>Integer</td>
<td>2</td>
<td>73</td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEM2</td>
<td>Integer</td>
<td>2</td>
<td>73</td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEM3</td>
<td>Integer</td>
<td>2</td>
<td>73</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>74</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>74</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>74</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMENDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMENDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC &amp; MIBC)</td>
<td>CHEMENDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>75</td>
</tr>
</tbody>
</table>

### Section 6: Clinical Trials

| Patient Entered into Clinical Trial | TRIAL | Integer | 2 | 77 |

### Section 7: Death Details
<table>
<thead>
<tr>
<th>Date of Death</th>
<th>DOD</th>
<th>Date (DD/MM/CCYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>79</td>
</tr>
</tbody>
</table>

Data Definitions for the National Minimum Core Dataset for Bladder 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
**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.
**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
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
**Person Sex at Birth**

**Common Name(s):** Sex at Birth

**Main Source of Data Item Standard of Standard:** Derived from the nearest equivalent Government Data Standards Catalogue standard ‘Person Gender at Registration’

**Definition:** This is a factual statement, as far as is known, about the phenotypic (biological) sex of the person at birth

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

**Notes for Users:**
A person’s sex has clinical implications, both in terms of the individual’s health and the health care provided to them.

In the majority of cases, the phenotypic (biological) sex and genotypic sex are the same and the phenotypic sex is usually easily determined. In a small number of cases, accurate determination of genotype may be required

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Not specified/Indeterminate</td>
<td>Where it has not been possible to determine if the person is male or female at birth, e.g. intersex / hermaphrodite.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

*Data Definitions for the National Minimum Core Dataset for Bladder Cancer.*
*Developed by ISD Scotland*
*2014*
**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.

*(PHS, 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,  
Person Sex at Birth.
Section 2: Pre-treatment Imaging & Staging Investigations
Date of Referral

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 patient referral to secondary care for the investigation and / or treatment of Bladder cancer was received.

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

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

The referral date is the date of receipt of initial referral into secondary care.

Where referral is through a screening programme, referral date is the date a request for further diagnostic intervention is received.

Where presentation is via A & E or other direct referral to hospital the referral date is the date the patient presents to hospital.

If the exact date is not documented, record as 09/09/1900.

Notes by Users:
Location of Diagnosis {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 PHS.

Location codes for hospitals are five character codes maintained by PHS 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 {Cancer}
Date of Diagnosis {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 cancer was first diagnosed whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods.

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

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

The date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat.

If the exact date is not documented, record as 09/09/1900.

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

Codes and Values:

Related Data Items:
Location of Diagnosis {Cancer}
**Site of Origin of Primary Tumour (Cancer)**

**Main Source of Data Item Standard:** The World Health Organisation (WHO) and the Cancer Registration New Data definitions for Socrates (August 1999 Version 8.0).

**Definition:** The anatomical site of origin of the primary tumour according to the International Classification of Diseases of Oncology Third Edition, World Health Organisation classification (ICD-O (3)).

**Field Name:** SITE  
**Field Type:** Characters ICD-O (3)  
**Field length:** 5

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

For ICD-10, tumours should be assigned to the subcategory that includes the point of origin of the tumour. A tumour that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified as subcategory ‘C67.8’. It should be noted that this subcategory should only be used where it is impossible to identify the specific site of origin of the tumour.

If the site of origin of the tumour is not specific then it should be classified as subcategory C67.9.

**Codes and Values:**

<table>
<thead>
<tr>
<th>ICD-O(3) Code</th>
<th>Value</th>
<th>Notes on Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>C67.0</td>
<td>Trigone of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.1</td>
<td>Dome of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.2</td>
<td>Lateral wall of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.3</td>
<td>Anterior wall of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.4</td>
<td>Posterior wall of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.5</td>
<td>Bladder neck</td>
<td>Includes Internal urethral orifice</td>
</tr>
<tr>
<td>C67.6</td>
<td>Ureteric orifice</td>
<td></td>
</tr>
<tr>
<td>C67.7</td>
<td>Urachus</td>
<td></td>
</tr>
<tr>
<td>C67.8</td>
<td>Overlapping lesion of bladder</td>
<td></td>
</tr>
<tr>
<td>C67.9</td>
<td>Bladder, NOS</td>
<td>Includes Bladder wall, NOS and Urinary bladder, NOS</td>
</tr>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Bladder Diverticular Tumour

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

Definition: A record of whether the patient has a bladder diverticular tumour (arising within a diverticulum).

Field Name: DIVERT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 2

This information may be found within the clinical notes / TURBT pro-forma.

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Date of Histological Diagnosis (Bladder 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 date that the histological/cytological microscopic examination of the specimen to determine the presence of malignancy and the confirmation of bladder cancer was performed.

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

Notes for Users: Required for QPI: 1 and for National survival analysis / national comparative analysis.

If there is a discrepancy between reports of cytology and histology, the histology date should be recorded as the definitive date.

If no cytological or histological diagnosis was made, record as 10/10/1900 (Not applicable).

If the exact date is not documented, record as 09/09/1900 (Not recorded).

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

Codes and Values:

Related Data Items:
**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 first 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: 1  
May be used for analysis of QPI relating to MDT meetings.

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, speech language therapists, 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 will be recorded except for NMIBC patients discussed both before and after initial transurethral resection of bladder tumour (TURBT), in which case the date of the first MDT following histological confirmation should be recorded.

If the patient has not been discussed by the MDT record as 10/10/1900 (Not applicable).

If the date of the MDT meeting is unknown record as 09/09/1900 (Not recorded)

**Related Data Items:**
COVID 19 Impact

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

Definition: A record of whether COVID 19 has impacted on treatment decisions.

Field Name: COVID
Field Type: Integer
Field Length: 2

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

The COVID 19 pandemic will have an impact on the patient pathways of some patients, potentially affecting the treatment they will receive. This may affect treatment decisions from the outset or plans may change part way through treatment. MDTs will record when the recommendations of the MDT for management are made on the basis of emergency COVID 19 management guideline and differ from what would otherwise be advised.

Where there is a record of a patients treatment being amended due to the emergency COVID 19 management guidelines elsewhere, for example amendments to treatment after MDT discussion, then this can also be recorded under ‘Yes – other’, however it is acknowledged that this information may not be complete.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes - plan developed by MDT</td>
<td>MDT record treatment as determined by emergency COVID 19 management guidelines from the outset</td>
</tr>
<tr>
<td>2</td>
<td>Yes - plan amended by MDT</td>
<td>MDT record amendment to existing treatment plan due to emergency COVID 19 management guidelines</td>
</tr>
<tr>
<td>3</td>
<td>Yes – Other</td>
<td>Other record of amendment to treatment due to emergency COVID 19 management guidelines e.g. clinic letter about alteration of treatment plan</td>
</tr>
<tr>
<td>4</td>
<td>No</td>
<td>No evidence of patient treatment being affected by COVID 19</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Where documentation of part of the patient pathway is unavailable, e.g. for patients diagnosed outwith NHS Scotland, or where the patient moves away while treatment is still ongoing</td>
</tr>
</tbody>
</table>
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 survival 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.

This field relates to pre-treatment performance status i.e. at the time of the MDT closest to actual treatment.

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</td>
</tr>
<tr>
<td>9</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
**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 QPI: 1

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.

Dilatation without other treatment is not considered as active treatment.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Endoscopic</td>
<td>TURBT, cystodiathermy</td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td>Immunotherapy</td>
</tr>
<tr>
<td>7</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all 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 QPI: 1

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. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

It should be noted that for patients with non-muscle invasive bladder cancer, MDT discussion will take place following initial transurethral resection of bladder tumour (TURBT).

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

If the exact date is not documented, record as 09/09/1900 (Not recorded).

If the patient died before treatment or the patient refused treatment, record as 10/10/1900 (Not applicable).

**Related Data Item(s):**  
Type of First Cancer Treatment
**Date of Definitive Treatment (Bladder 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 definitive cancer treatment was given to the patient.

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

**Notes for Users:** Required for QPI: 1

For patients with muscle invasive bladder cancer (MIBC) definitive treatment will be either:

- Neo adjuvant SACT;
- Radical Cystectomy; or
- Radiotherapy.

For patients with non muscle invasive bladder cancer (NMIBC) definitive treatment will be TURBT. The date recorded is the date of confirmation of muscle invasive bladder cancer prior to definitive treatment.

It is the date of this treatment that should be recorded.

If a patient receives more than one of the treatments listed it is the first which should be recorded.

For patients not receiving radical treatment for MIBC the date recorded should be the date the decision was taken not to give the patient radical treatment as part of their primary therapy. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. If the patient has been given palliative chemotherapy and/or radiotherapy the date this treatment started should be recorded.

If the exact date is not documented, record as 09/09/1900 (Not recorded).

If the patient died before treatment, the patient refused treatment or if the patient does not have a diagnosis of MIBC prior to definitive treatment record as 10/10/1900 (Not applicable).

**Related Data Item(s):**
**TNM Tumour Classification (Clinical) (NMIBC & MIBC)**

**Common name:** Clinical TNM Tumour Classification (Bladder Cancer)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, UICC, 2017).

**Definition:** The size and extent of the tumour as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

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

Clinical TNM is derived from clinical examination, radiological investigation and histology from biopsy or transurethral resection. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is as defined by the Multidisciplinary Team Meeting (MDT) based on best knowledge at any MDT meeting after initial TURBT and prior to other treatment. If no MDT has taken place and clinical TNM has been recorded in clinical letters or staging investigations for example, then this may be recorded.

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table for T2, T3 and T4 tumours is recommended.

**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></td>
</tr>
<tr>
<td>Ta</td>
<td>Non-invasive papillary carcinoma</td>
<td></td>
</tr>
<tr>
<td>Tis</td>
<td>Carcinoma In Situ “flat tumour”</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Tumour invades subepithelial connective tissue</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>T2a</td>
<td>Invades superficial muscularis propria (inner half)</td>
<td></td>
</tr>
<tr>
<td>T2b</td>
<td>Invades deep muscularis propria (outer half)</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades perivesical tissue</td>
<td></td>
</tr>
<tr>
<td>T3a</td>
<td>Microscopically</td>
<td></td>
</tr>
<tr>
<td>T3b</td>
<td>Macroscopically (extravesical mass)</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall or abdominal wall</td>
<td></td>
</tr>
<tr>
<td>T4a</td>
<td>Invades prostate stroma, seminal vesicles, uterus or</td>
<td></td>
</tr>
<tr>
<td>T4b</td>
<td>Invades pelvic wall or abdominal wall</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 (Clinical) (NMIBC & MIBC)  
TNM Metastases Classification (Clinical) (NMIBC & MIBC)
TNM Nodal Classification (Clinical) (NMIBC & MIBC)

Common name: Clinical TNM Nodal Classification (Bladder Cancer).


Definition: The extent of regional lymph node metastases as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

Field Name: CN
Field Type: Characters
Field length: 2

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

Clinical TNM is derived from clinical examination, radiological investigation and histology from biopsy or transurethral resection. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is as defined by the Multidisciplinary Team Meeting (MDT) based on best knowledge at any MDT meeting after initial TURBT and prior to other treatment. If no MDT has taken place and clinical TNM has been recorded in clinical letters or staging investigations for example, then this may be 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 in a single lymph node in the true pelvis (hypogastric, obturator, external iliac, or presacral).</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in multiple regional lymph nodes in the true pelvis (hypogastric, obturator, external iliac, or presacral).</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in a common iliac lymph node(s).</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 (Clinical) (NMIBC & MIBC)
TNM Metastases Classification (Clinical) (NMIBC & MIBC)
**TNM Metastases Classification (Clinical) (NMIBC & MIBC)**

**Common name:** Clinical TNM Metastases Classification (Bladder Cancer).

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, UICC, 2017).

**Definition:** The extent of metastatic spread of the tumour as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

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

Clinical TNM is derived from clinical examination, radiological investigation and histology from biopsy or transurethral resection. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is as defined by the Multidisciplinary Team Meeting (MDT) based on best knowledge at any MDT meeting after initial TURBT and prior to other treatment. If no MDT has taken place and clinical TNM has been recorded in clinical letters or staging investigations for example, then this may be 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>M1a</td>
<td>Non-regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>M1b</td>
<td>Other distant metastasis</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>

**E.g. M status not assessed.**

**Related Data Items:**
TNM Tumour Classification (Clinical) (NMIBC & MIBC)
TNM Nodal Classification (Clinical) (NMIBC & MIBC)
**Date of Diagnosis of MIBC**

**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 Muscle Invasive Bladder Cancer was diagnosed.

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

**Notes for Users:** Required for QPI(s): 1, 4, 7, 9, 10

The date recorded is the date of confirmation of muscle invasive bladder cancer. Confirmation may be obtained at TURBT 1 or 2 or from imaging.

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

Muscle invasive bladder cancer (MIBC) is where the tumour has spread to the muscle layer of the bladder, or right through the wall of the bladder.

Non-muscle invasive bladder cancer (NMIBC) is where the tumour is confined to the inner lining, or just below the inner lining, of the bladder.

This is for patients who initially present with a diagnosis of MIBC and not patients that have progressed from NMIBC at a later stage.

If the patient does not have a diagnosis of MIBC record as 10/10/1900 (Not applicable).

If the exact date is not documented, record as 09/09/1900.

**Codes and Values:**

**Related Data Items:**
- Location of Diagnosis (Cancer)
- Date of Cystectomy (NMIBC & MIBC)
- Date Treatment Started 1-3 (NMIBC & MIBC) (Radiotherapy)
- Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
- Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
- TNM Tumour Classification (Pathological) (NMIBC & MIBC)
Section 3: Surgery

Section 3a – TURBT 1 & 2
Section 3b – Cystectomy
Section 3c – Other Procedures
Section 3a: TURBT1 & TURBT2

Please note: All fields in this section marked 1-2 are linked and should be paired together i.e. All data related to TURBT1 should be recorded in field 1
Location Code – TURBT 1-2 (Cancer Surgery) (NMIBC & MIBC)

**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:** HOSPTURBT1, HOSPTURBT2

**Field Type:** Characters

**Field Length:** 5

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

This is the hospital where TURBT took place.

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland)

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.

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):**

Intent of Surgery 1-2 (NMIBC & MIBC)
TURBT 1 (NMIBC & MIBC)
TURBT 2 (NMIBC & MIBC)
**Intent of Surgery 1-2 (NMIBC & MIBC)**

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

**Definition:** Final assessment of intent of surgery as documented in the Clinical Record/Post operative Multidisciplinary Team (MDT).

**Field Name:** TURBTINTENT1  
TURBTINTENT2

**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 2, 4

TURBTINTENT2 is optional and can be used for recording locally

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Curative</td>
</tr>
<tr>
<td>2</td>
<td>Palliative</td>
</tr>
<tr>
<td>3</td>
<td>Diagnostic Biopsy</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Location Code – TURBT 1-2 (Cancer Surgery) (NMIBC & MIBC)  
TURBT 1 (NMIBC & MIBC)  
TURBT 2 (NMIBC & MIBC)
**TURBT 1 (NMIBC & MIBC)**

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

**Definition:** This denotes whether the patient underwent a transurethral resection of bladder tumour procedure(s) for investigation and / or treatment of bladder cancer.

**Field Name:** TURBT1

**Field Type:** Integer

**Field Length:** 2

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

Both Transurethral Resection of Bladder Tumour (TURBT) for purposes of diagnosis (MIBC) and treatment (NMIBC) should be recorded in this field.

**Cystectomy procedures should be recorded in Section 3b.**

Where TURBT1 is recorded, Detrusor Muscle Sampled (Bladder Cancer) DEMUSC1 must be recorded.

**Codes and Values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>TURBT – M42.1</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>Other procedure</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 Item(s):**
Location Code – TURBT 1-2 (Cancer Surgery) (NMIBC & MIBC)
Intent of Surgery 1-2 (NMIBC & MIBC)
Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC)
TURBT 2 (NMIBC & MIBC)
TURBT 2 (NMIBC & MIBC)

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

Definition: This denotes whether the patient underwent a transurethral resection of bladder tumour procedure(s) for investigation and / or treatment of bladder cancer.

Field Name: TURBT2
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 4

Both Transurethral Resection of Bladder Tumour (TURBT) for purposes of diagnosis (MIBC) and treatment (NMIBC) should be recorded in this field.

Cystectomy procedures should be recorded in Section 3b.

Where TURBT2 is recorded, Detrusor Muscle Sampled (Bladder Cancer) DEMUSC2 must be recorded.

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TURBT</td>
<td>TURBT – M42.1</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>No other procedures performed</td>
</tr>
<tr>
<td>3</td>
<td>Cystoscopy with biopsy</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Cystoscopy only</td>
<td></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 Item(s):
Location Code – TURBT 1-2 (Cancer Surgery) (NMIBC & MIBC)
Intent of Surgery 1-2 (NMIBC & MIBC)
Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC)
TURBT 1 (NMIBC & MIBC)
**Date of TURBT 1-2 (NMIBC & MIBC)**

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

**Definition:** The date a surgical procedure was performed for the investigation and/or treatment of bladder cancer.

**Field Name:** TURBTDATE1  
TURBTDATE2

**Field Type:** Date (DD/MM/CCYY).

**Field Length:** 10

**Notes for Users:** Required for QPI(s): 3, 4

TURBTDATE1 - Date of the first Transurethral Resection of Bladder Tumour (TURBT) should be recorded here.

TURBTDATE2 - Date of the second Transurethral Resection of Bladder Tumour (TURBT) or cystoscopy should be recorded here, if applicable.

If the exact date of surgery is not known, record as 09/09/1900 (Not recorded).

If no surgery was performed, record as 10/10/1900 (Not applicable).

All treatments given as part of the initial treatment plan.

**Related Data Items:**
Location Code – TURBT 1-2 (Cancer Surgery) (NMIBC & MIBC)
Intent of Surgery 1-2 (NMIBC & MIBC)
TURBT 1 (NMIBC & MIBC)
Detrusor Muscle Sampled at TURBT 1-2 (NMIBC & MIBC)

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

Definition: A record to determine if Detrusor Muscle was included in the specimen sent for pathological evaluation for patients undergoing surgical resection (Transurethral Resection of Bladder Tumour (TURBT))

Field Name: DEMUSC1
DEMUSC2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI(s): 2, 4, 5
This field is linked to TURBT 1 – 2 fields. Where DEMUSC1-2 is recorded, TURBT1-2 must be recorded in the same sequence.

If insufficient muscle is sampled the field should still be coded as 01 Yes DEMUSC2 is optional and can be used for recording locally

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>Insufficient muscle sample should be recorded as ‘Yes’</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>For patients not undergoing a surgical resection (TURBT)</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
TURBT 1 (NMIBC & MIBC)
Bladder Diagram at TURBT 1-2 (NMIBC & MIBC)

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

Definition: A record to determine if a bladder diagram* was used for patients undergoing Transurethral Resection of Bladder Tumour (TURBT), either for diagnostic or treatment purposes.

Field Name: BDIAG1
BDIAG2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 2

This information may be obtained from the operation notes (TURBT pro-forma) for patients undergoing TURBT and should not be deduced.

*Use of a bladder diagram or a detailed description with documentation of tumour location, size, number and appearance.

BDIAG2 is optional and can be used for recording locally

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>For patients not undergoing a surgical resection (TURBT)</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
TURBT 1 (NMIBC & MIBC)
**Tumour Size at TURBT 1-2 (Clinical) (NMIBC & MIBC)**

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

**Definition:** The size of the largest tumour (measured in millimetres) as determined by the surgeon for patients undergoing Transurethral Resection of Bladder Tumour (TURBT), either for diagnostic or treatment purposes.

**Field Name:** CTSIZE1  
CTSIZE2  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 2, 4, 5

This information may be obtained from the operation notes (TURBT pro-forma) for patients undergoing TURBT

CTSIZE2 is optional and can be used for recording locally

<table>
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<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≤5mm</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6-10mm</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>11-30mm</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>&gt;30mm</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No TURBT carried out</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
TURBT 1 (NMIBC & MIBC)
**Number of Tumours at TURBT 1-2 (NMIBC & MIBC)**

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

**Definition:** The number of tumours as detected by the surgeon for patients undergoing Transurethral Resection of Bladder Tumour (TURBT), either for diagnostic or treatment purposes.

**Field Name:** MULTIPLE1  
**Field Name:** MULTIPLE2  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 2, 4

This information may be obtained from the operation notes (TURBT pro-forma) for patients undergoing TURBT

MULTIPLE2 is optional and can be used for recording locally

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>&gt;3</td>
<td>TURBT not performed</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>TURBT not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
TURBT 1 (NMIBC & MIBC)
**Tumour Appearance at TURBT 1-2 (NMIBC & MIBC)**

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

**Definition:** The appearance of the bladder tumour as detected by the surgeon for patients undergoing Transurethral Resection of Bladder Tumour (TURBT), either for diagnostic or treatment purposes.

**Field Name:** TAPPEAR1  
TAPPEAR2  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for QPI: 2

This information may be obtained from the operation notes (TURBT pro-forma) for patients undergoing TURBT

TAPPEAR2 is optional and can be used for recording locally

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Papillary</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Solid</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mixed</td>
<td>E.g. papillary and solid</td>
</tr>
<tr>
<td>4</td>
<td>Red patch</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>TURBT not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

TURBT 1 (NMIBC & MIBC)
Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer)

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

Definition: Confirmation that a single intravesical instillation of mitomycin C was performed for patients with NMIBC undergoing Transurethral Resection of Bladder Tumour (TURBT).

Field Name: INTRAV1
INTRAV2
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 3

INTRAV1 relates to TURBT1 and INTRAV2 relates to TURBT2.

INTRAV2 is optional and can be used for recording locally

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>MIBC Suspected</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>TURBT not performed, or patient has MIBC</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 Item(s):
TURBT 1 (NMIBC & MIBC)
Date of Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer)
TNM Tumour Classification (Pathological) (NMIBC & MIBC)
**Date of Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder 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 a single intravesical instillation of mitomycin C was performed for patients with NMIBC undergoing Transurethral Resection of Bladder Tumour (TURBT).

**Field Name:** INTRAVDATE1  
INTRAVDATE2  

**Field Type:** Date (DD/MM/CCYY).  

**Field Length:** 10  

**Notes for Users:** Required for QPI: 3  

If no TURBT was performed or the patient has MIBC, record as 10/10/1900 (Not applicable).  

If the exact date of MMC instillation is not known, record as 09/09/1900 (Not recorded).  

All treatments given as part of the initial treatment plan.  

INTRAVDATE2 is optional and can be used for recording locally

**Related Data Item(s):**  
TURBT 1 (NMIBC & MIBC)  
Intravesical Instillation of Mitomycin C 1-2 (Non Muscle Invasive Bladder Cancer)
Bladder Perforation at TURBT 1-2 (NMIBC & MIBC)

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

Definition: A record if either intra-or-extraperitoneal perforation occurred when performing an initial Transurethral Resection of Bladder Tumour (TURBT).

Field Name: PERFTURBT1
   PERFTURBT2
Field Type: Integer
Field length: 2

Notes for Users:

TURBT pro-forma or op-note must be used to complete this item and it must not be deduced from the clinical notes. If no perforation stated then '99 – not recorded' must be recorded.

Intraperitoneal perforation – perforation of the bladder within the peritoneal cavity.
Extraperitoneal perforation – perforation of the bladder outwith the peritoneum.

PERFTURBT2 is optional and can be used for recording locally

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intraperitoneal perforation</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Extraperitoneal</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Perforation not specified</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>

TURBT not performed

Related Data Item(s):
TURBT 1 (NMIBC & MIBC)
Complete Resection at TURBT 1-2 (NMIBC & MIBC)

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

Definition: A record to determine if a complete resection was carried out when performing Transurethral Resection of Bladder Tumour (TURBT)

Field Name: RESECCOMP1
             RESECCOMP2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 4

TURBT pro-forma or op-note must be used to complete this item and it must not be deduced from the clinical notes. If not stated then '99 – not recorded' must be recorded.

Where completeness of resection is documented as uncertain 'Record as 02-No.'

RESECCOMP2 is optional and can be used for recording locally

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>TURBT not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>TURBT not performed</td>
</tr>
</tbody>
</table>

Related Data Item(s):
TURBT 1 (NMIBC & MIBC)
Section 3b: Cystectomy
**Location Code - Cystectomy (Cancer Surgery) (NMIBC & MIBC)**

**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:** HOSPCYST  
**Field Type:** Characters  
**Field Length:** 5

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

This is the hospital where cystectomy took place which removes the primary tumour. Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland) [http://www.show.scot.nhs.uk/smrfiles/information.html](http://www.show.scot.nhs.uk/smrfiles/information.html) – data files.

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 PHS 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>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):**
- Intent of Surgery - Cystectomy (NMIBC & MIBC)
- Operating Surgeon 1-2 (NMIBC & MIBC)
- Operative Procedure – Cystectomy (NMIBC & MIBC)
- Date of Cystectomy (NMIBC & MIBC)
Intent of Surgery - Cystectomy (NMIBC & MIBC)

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

Definition: Final assessment of intent of surgery as documented in the Clinical Record/Post operative Multidisciplinary Team (MDT).

Field Name: CYSTOPINTENT
Field Type: Integer
Field Length: 2

Notes for Users: Required QPI(s): 6, 7, 8, 9, 11

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Curative</td>
<td>E.g. Radical</td>
</tr>
<tr>
<td>2</td>
<td>Palliative</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Salvage</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:
Location Code - Cystectomy (Cancer Surgery) (NMIBC & MIBC)
Operating Surgeon 1-2 (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)
Date of Cystectomy (NMIBC & MIBC)
**Operating Surgeon 1-2 (NMIBC & MIBC)**

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

**Definition:** The surgeon who performed the Cystectomy.

**Field Name:** CYSTOPSURG1
  CYSTOPSURG2

**Field Type:** Characters

**Field Length:** 20

**Notes for Users:** Required for QPI: 8

The surname and forename of each consultant should be recorded to distinguish between surgeons with common surnames. Consultants names should be stored in databases as General Medical Council (GMC) number. If two consultant surgeons share an operation each operating surgeon code should be recorded.

If the patient is operated on by a clinician who is working as a locum consultant, record only that the clinician is a locum consultant, “LOCUM”,

If the operating surgeon is not a consultant record as non-consultant grade ,8889 regardless of whether the surgeon was a locum or not. If the clinician’s name is not recorded code as 9999. If no surgery was performed record as inapplicable (1010).

**Related Data Item(s):**
- Location Code - Cystectomy (Cancer Surgery) (NMIBC & MIBC)
- Intent of Surgery - Cystectomy (NMIBC & MIBC)
- Operative Procedure – Cystectomy (NMIBC & MIBC)
- Date of Cystectomy (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)

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 surgical procedure(s) performed for treatment of bladder cancer.

Field Name: CYSTOP
Field Type: Characters
Field Length: 5

Notes for Users: Required for QPI(s): 5, 6, 7, 9, 11

Transurethral Resection of Bladder Tumour (TURBT) for purposes of diagnosis (MIBC) and treatment (NMIBC) should be recorded in Section 3a

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

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>M34.1</td>
<td>Cystoprostatectomy</td>
<td></td>
</tr>
<tr>
<td>M34.2</td>
<td>Cystourethrectomy</td>
<td></td>
</tr>
<tr>
<td>M34.3</td>
<td>Cystectomy NEC</td>
<td></td>
</tr>
<tr>
<td>X14.2</td>
<td>Clearance of pelvis - Anterior exenteration</td>
<td></td>
</tr>
<tr>
<td>M35.1</td>
<td>Diverticulectomy of bladder</td>
<td></td>
</tr>
<tr>
<td>M35.9</td>
<td>Partial cystectomy</td>
<td></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, abandoned procedure</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 Item(s):
Location Code - Cystectomy {Cancer Surgery} (NMIBC & MIBC)
Intent of Surgery - Cystectomy (NMIBC & MIBC)
Operating Surgeon 1-2 (NMIBC & MIBC)
Date of Cystectomy (NMIBC & MIBC)
**Date of Cystectomy (NMIBC & MIBC)**

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

**Definition:** The date a surgical procedure was performed for the treatment of bladder cancer.

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

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

If no Cystectomy was performed, record as 10/10/1900 (Not applicable).

If the exact date of surgery is not known, record as 09/09/1900 (Not recorded).

**Related Data Items:**
- Location Code - Cystectomy {Cancer Surgery} (NMIBC & MIBC)
- Intent of Surgery - Cystectomy (NMIBC & MIBC)
- Operating Surgeon 1-2 (NMIBC & MIBC)
- Operative Procedure – Cystectomy (NMIBC & MIBC)
**Early Cystectomy (NMIBC & MIBC)**

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

**Definition:** A record to determine whether the patient has undergone early cystectomy.

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

**Notes for Users:** Required for QPI: 4

An early cystectomy may be performed in someone with high risk NMIBC instead of the usual Re-TURBT. This would may be documented as part of the MDT outcome following TURBT1.

If not stated then ‘99 – not recorded’ must be recorded.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Cystectomy not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Section 3c: Other Procedures
Other Procedures (NMIBC & MIBC)

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 surgical procedure(s) performed for treatment of bladder cancer.

Field Name: OPROC
Field Type: Characters
Field Length: 5

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

These procedures are in addition to any recorded in the fields TURBT 1-2 (NMIBC & MIBC) or Operative Procedure – Cystectomy (NMIBC & MIBC)

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M41.4</td>
<td>Open biopsy of lesion of bladder</td>
<td></td>
</tr>
<tr>
<td>M42.2</td>
<td>Endoscopic cauterisation of lesion of bladder</td>
<td>Cystodiathermy</td>
</tr>
<tr>
<td>M42.3</td>
<td>Endoscopic destruction of lesion of bladder NEC</td>
<td></td>
</tr>
<tr>
<td>M45.1</td>
<td>Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder</td>
<td></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:
Date of Other Procedure (NMIBC & MIBC)
TURBT 1 (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)
Date of Other Procedure (NMIBC & MIBC)

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

Definition: The date a surgical procedure was performed for the treatment of bladder cancer.

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

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

If no other procedure was performed, record as 10/10/1900 (Not applicable).
If the exact date of surgery is not known, record as 09/09/1900 (Not recorded).

Related Data Items:
Other Procedures (NMIBC & MIBC)
Section 4: Pathological Details
### TNM Tumour Classification (Pathological) (NMIBC & MIBC)

**Common name:** Pathological TNM Tumour Classification (Bladder Cancer)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, UICC, 2017).

**Definition:** A record of the size and extent of the tumour of the bladder following resection of the primary cancer.

**Field Name:** pTTURBT  
**Field Type:** Characters  
**Field length:** 4

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

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field pTTURBT.

Record as ‘not applicable’ where only pathology is from biopsy rather than formal TURBT.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy in field pTCYST.

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

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table is recommended.

Pathology taken within 6 months of a patient initially refusing further investigation can also be recorded.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pTX</td>
<td>Primary tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>pTa</td>
<td>Non-invasive papillary carcinoma</td>
<td></td>
</tr>
<tr>
<td>pTis</td>
<td>Carcinoma In Situ “flat tumour”</td>
<td></td>
</tr>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
<td>cystectomy</td>
</tr>
<tr>
<td>pT1</td>
<td>Tumour invades subepithelial connective tissue</td>
<td></td>
</tr>
<tr>
<td>pT2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>pT2a</td>
<td>Invades superficial muscularis propria (inner half)</td>
<td></td>
</tr>
<tr>
<td>pT2b</td>
<td>Invades deep muscularis propria (outer half)</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour invades perivesical tissue</td>
<td></td>
</tr>
<tr>
<td>pT3a</td>
<td>Microscopically</td>
<td></td>
</tr>
<tr>
<td>pT3b</td>
<td>Macroscopically (extravesical mass)</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall or abdominal</td>
<td></td>
</tr>
<tr>
<td>pT4a</td>
<td>Invades prostate stroma, seminal vesicles, uterus or vagina.</td>
<td></td>
</tr>
<tr>
<td>pT4b</td>
<td>Invades pelvic wall or abdominal wall</td>
<td></td>
</tr>
</tbody>
</table>
Related Data Items:
TNM Nodal Classification (Pathological) (NMIBC & MIBC)
TNM Metastases Classification (Pathological) (MIBC)
TURBT 1 (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)
TNM Nodal Classification (Pathological) (NMIBC & MIBC)

Common name: Pathological TNM Nodal Classification (Bladder Cancer).


Definition: A record of the extent of metastatic spread of the tumour as detected by microscopy.

Field Name: pN
Field Type: Characters
Field length: 3

Notes for Users: Required for QPI: 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pNX as regional lymph nodes cannot be assessed until a cystectomy has been performed.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy.

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

Pathology taken within 6 months of a patient initially refusing further investigation can also be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pNX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>pN0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>pN1</td>
<td>Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac, or presacral).</td>
<td></td>
</tr>
<tr>
<td>pN2</td>
<td>Metastasis in multiple regional lymph nodes in the true pelvis (hypogastric, obturator, external iliac, or presacral).</td>
<td></td>
</tr>
<tr>
<td>pN3</td>
<td>Metastasis in a common iliac lymph node(s).</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 (Pathological) (NMIBC & MIBC)
TNM Metastases Classification (Pathological) (MIBC)
TURBT 1 (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)
**TNM Metastases Classification (Pathological) (MIBC)**

**Common name:** Pathological TNM Metastases Classification (Bladder Cancer).

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, UICC, 2017).

**Definition:** The extent of metastatic spread of the tumour as detected by microscopy.

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

**Notes for Users:** Required for QPI: 4, 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record 96 (not applicable).

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy.

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as ‘not applicable’

Pathology taken within 6 months of a patient initially refusing further investigation can also be recorded.

Where the M status has not been assessed then record as 96 (Not applicable).

Where the M status has been assessed and no distant metastasis identified then record as 96 (Not applicable).

Where the M status had been assessed and the outcome not recorded then record as 99 (Not recoded).

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pM1</td>
<td>Distant Metastasis</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. M status not assessed, no sample to analyse, no metastatic disease biopsied/resected, no metastasis identified</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. Sample analysed but outcome not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**

- TNM Tumour Classification (Pathological) (NMIBC & MIBC)
- TNM Nodal Classification (Pathological) (NMIBC & MIBC)
- TURBT 1 (NMIBC & MIBC)
- Operative Procedure – Cystectomy (NMIBC & MIBC)
Tumour Grade 1973 Classification (NMIBC & MIBC)

Main Source of Data Item Standard: WHO Classification 1973

Definition: The histopathological grading of the tumour as detected by microscopy.

Field Name: TGRADE19731  
TGRADE19732
Field Type: Characters
Field length: 2

Notes for Users: Require for QPI(s): 4, 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field TGRADE19731.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy in field TGRADE19732.

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'
If grade is not documented in the pathology report do not deduce from other information and record as 'not recorded'.

Pathology taken within 6 months of a patient initially refusing further treatment can also be recorded.

For morphologies other than urothelial carcinoma/transitional cell carcinoma, 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>G1</td>
<td>Well differentiated</td>
<td>Have an existing papillary architecture, fine chromatin, and a little indication of nucleoli or mitoses</td>
</tr>
<tr>
<td>G2</td>
<td>Moderately differentiated</td>
<td>Usually have a papillary architecture, granular chromatin, and a stronger indication of nucleoli and mitoses</td>
</tr>
<tr>
<td>G3</td>
<td>Poorly differentiated</td>
<td>Least likely to have a papillary architecture, have coarse chromatin, and have many examples of nucleoli and mitoses</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:
Tumour Grade 2004 Classification (NMIBC & MIBC)

Main Source of Data Item Standard: WHO/ISUP 2004

Definition: The histopathological grading of the tumour as detected by microscopy.

Field Name: TGRADE20041  
          TGRADE20042

Field Type: Integer

Field length: 2

Notes for Users: Require for QPI(s): 4, 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field TGRADE20041.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy in field TGRADE20042.

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'

If grade is not documented in the pathology report do not deduce from other information and record as 'not recorded'.

Pathology taken within 6 months of a patient initially refusing further treatment can also be recorded.

For morphologies other than urothelial carcinoma/transitional cell carcinoma, 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>1</td>
<td>Low grade</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>High grade</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>includes pTis</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Morphology of Tumour (NMIBC & MIBC)

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: MORPHOL1
          MORPHOL2
Field Type: Characters
Field Length: 6

Notes for Users: Required for QPI: 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field MORPHOL1.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy record pathology from the Cystectomy in field MORPHOL2.

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'
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 - phs.canceraudit@nhs.net for advice.
**Morphology codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>8000/3</td>
<td>Neoplasm, malignant, Tumour, malignant, NOS, Malignancy, Cancer, Unclassified tumour, malignant, Blastoma, NOS</td>
</tr>
<tr>
<td>8001/3</td>
<td>Tumour cells, malignant</td>
</tr>
<tr>
<td>8010/2</td>
<td>Carcinoma in situ, NOS, Intraepithelial carcinoma, NOS</td>
</tr>
<tr>
<td>8010/3</td>
<td>Carcinoma, NOS, Epithelial tumor, malignant</td>
</tr>
<tr>
<td>8020/3</td>
<td>Carcinoma, undifferentiated, NOS</td>
</tr>
<tr>
<td>8033/3</td>
<td>Pseudosarcomatous carcinoma, Sarcomatoid carcinoma</td>
</tr>
<tr>
<td>8041/3</td>
<td>Small cell carcinoma, NOS, Reserve cell carcinoma, Round cell carcinoma, Small cell neuroendocrine carcinoma</td>
</tr>
<tr>
<td>8050/3</td>
<td>Papillary carcinoma, NOS</td>
</tr>
<tr>
<td>8070/2</td>
<td>Squamous cell carcinoma in situ, NOS, Epidermoid carcinoma in situ, NOS, Intraepidermal carcinoma, NOS, Intraepithelial squamous cell carcinoma</td>
</tr>
<tr>
<td>8070/3</td>
<td>Squamous cell carcinoma, NOS, Epidermoid carcinoma, NOS, Squamous carcinoma, Squamous cell epithelioma</td>
</tr>
<tr>
<td>8071/3</td>
<td>Squamous cell carcinoma, keratinizing, NOS, Squamous cell carcinoma, large cell, keratinizing, Epidermoid carcinoma, keratinizing</td>
</tr>
<tr>
<td>8072/3</td>
<td>Squamous cell carcinoma, large cell, nonkeratinizing, NOS, Squamous cell carcinoma, nonkeratinizing, NOS, Epidermoid carcinoma, large cell, nonkeratinizing</td>
</tr>
<tr>
<td>8073/3</td>
<td>Squamous cell carcinoma, small cell, nonkeratinizing, Epidermoid carcinoma, small cell, nonkeratinizing</td>
</tr>
<tr>
<td>8074/3</td>
<td>Squamous cell carcinoma, spindle cell, Epidermoid carcinoma, spindle cell, Squamous cell carcinoma, sarcomatoid</td>
</tr>
<tr>
<td>8120/2</td>
<td>Transitional cell carcinoma in situ, Urothelial carcinoma in situ</td>
</tr>
<tr>
<td>8120/3</td>
<td>Transitional cell carcinoma, NOS, Urothelial carcinoma, NOS, Transitional carcinoma</td>
</tr>
<tr>
<td>8122/3</td>
<td>Transitional cell carcinoma, spindle cell, Transitional cell carcinoma, sarcomatoid</td>
</tr>
<tr>
<td>8130/2</td>
<td>Papillary transitional cell carcinoma, non-invasive, Papillary urothelial carcinoma, non-invasive</td>
</tr>
<tr>
<td>8130/3</td>
<td>Papillary transitional cell carcinoma, Papillary urothelial carcinoma</td>
</tr>
<tr>
<td>8140/2</td>
<td>Adenocarcinoma in situ, NOS</td>
</tr>
<tr>
<td>8140/3</td>
<td>Adenocarcinoma, NOS</td>
</tr>
<tr>
<td>8260/3</td>
<td>Papillary adenocarcinoma, NOS, Papillary carcinoma of thyroid, Papillary renal cell carcinoma</td>
</tr>
<tr>
<td>8310/3</td>
<td>Clear cell adenocarcinoma, NOS, Clear cell carcinoma, mesonephroid</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:**

*Data Definitions for the National Minimum Core Dataset for Bladder Cancer.*
*Developed by ISD Scotland*
*2014*
**Lymphovascular Invasion (NMIBC & MIBC)**

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

**Definition:** A record if lymphovascular invasion was present in the tumour specimen obtained following surgical resection (Transurethral Resection of Bladder Tumour (TURBT or Cystectomy).

**Field Name:** LYMPINV1
**Field Type:** Integer
**Field Length:** 2

**Notes for Users:** Required for QPI: 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field LYMPINV1.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy in field LYMPINV2.

For pTa or pTis tumours, lymphatic vascular invasion should be recorded as Not applicable (96).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Patient did not have surgery, not identified etc</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

TNM Tumour Classification (Pathological) (NMIBC & MIBC)
**Associated Carcinoma In Situ (NMIBC & MIBC)**

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

**Definition:** A record to determine if associated carcinoma in situ (CIS) was present in the tumour specimen obtained following surgical resection (Transurethral Resection of Bladder Tumour (TURBT) or Cystectomy).

**Field Name:** ASSCIS1, ASSCIS2

**Field Type:** Integer

**Field Length:** 2

**Notes for Users:** Required for QPI(s): 4, 5

For patients who only have Transurethral Resection of Bladder Tumour (TURBT) record pathology from TURBT in field ASSCIS1.

For patients who have Transurethral Resection of Bladder Tumour (TURBT) for diagnostic purposes followed by a Cystectomy, record pathology from the Cystectomy in field ASSCIS2.

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as 'not applicable'

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Present</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Absent</td>
<td></td>
</tr>
<tr>
<td>93</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>includes pTis</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

TNM Tumour Classification (Pathological) (NMIBC & MIBC)
TURBT 1 (NMIBC & MIBC)
Operative Procedure – Cystectomy (NMIBC & MIBC)
Margin Status (Macroscopic) (NMIBC & MIBC)

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

**Definition:** A record to determine if there was macroscopic margin involvement present in the tumour specimen obtained following cystectomy.

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

**Notes for Users:**

Only for Cystectomy

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>Tumour present at the surgical margin.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>Tumour not present at the surgical margin.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. cystectomy not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

Operative Procedure – Cystectomy (NMIBC & MIBC)
**Margin Status (Microscopic) (Muscle Invasive Bladder Cancer)**

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

**Definition:** A record to determine if there was microscopic margin involvement present in the tumour specimen obtained following cystectomy.

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

**Notes for Users:** Required for QPI: 5  
Only for Cystectomy

For cystectomy specimens staged pT0 or those where the microscopic pathology report does not give a TNM stage but states that no viable tumour is present record as ‘not applicable’

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>Tumour present at the surgical margin.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>Tumour not present at the surgical margin.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. cystectomy not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
TNM Tumour Classification (Pathological) (NMIBC & MIBC)  
Operative Procedure – Cystectomy (NMIBC & MIBC)
**Total Number of Lymph Nodes Examined Microscopically (NMIBC & MIBC)**

**Main Source of Data Item Standard:** Derived from the Royal College of Pathologists standards and datasets for reporting cancers.

**Definition:** A record of the total number of lymph nodes examined microscopically following Cystectomy.

**Field Name:** LNEXAMINE  
**Field Type:** Integer  
**Field Length:** 4

**Notes for Users:** Required for QPI: 5  
Only for cystectomy.

If cystectomy is not performed record, as ‘1010’ not applicable.

If the total number examined is not known, record as 9999 (Not recorded)

**Related Data Items:**  
Operative Procedure – Cystectomy (NMIBC & MIBC)
Pelvic Lymph Node Dissection (NMIBC & MIBC)

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

Definition: A record of whether level 2 pelvic lymph node dissection has been undertaken (to the middle of the common iliac artery or level of the crossing of the ureter).

Field Name: LNLEVEL
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 6

The extent of pelvic lymph node dissection will be recorded in the operation note. Where it has been documented that the dissection has been level 2, or mid common iliac, or mid level crossing this should be recorded as 01, Yes

Bilateral lymph node dissection should be undertaken as standard.

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. cystectomy not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
**Number of Positive Lymph Nodes (NMIBC & MIBC)**

**Main source of standard:** Derived from the Royal College of Pathologists standards and minimum datasets for reporting cancers.

**Definition:** The number of lymph nodes reported as positive for the presence of tumour metastases by microscopy.

**Field Name:** POSLN  
**Field Type:** Integer  
**Field Length:** 4

**Notes for Users:** Required for QPI: 5

**Only for cystectomy.**

If no lymph nodes examined, record as ‘1010’ (Not applicable)

If the total number examined is not known, record as 9999 (Not recorded).

**Related Data Items:**
**Tumour Size (Pathological) (NMIBC & MIBC)**

**Main Source of Data Item Standard:** Derived from the Royal College of Pathologists standards and datasets for reporting cancers.

**Definition:** The maximum size of the tumour as determined by a pathologist following Cystectomy.

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

**Notes for Users:**

**Only for cystectomy.**

If no cystectomy is performed code as ‘1010’, not applicable.

Size should be recorded to the nearest Integer (mm).

If the maximum size is not known or not recorded, code as 9999.

**Related Data Items:**  
Operative Procedure – Cystectomy (NMIBC & MIBC)
Section 5: Oncology
**Date Seen by Oncologist (MIBC)**

**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 patient was first seen by an oncologist to discuss all treatment options prior to surgery for bladder cancer.

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

**Notes for Users:** Required for QPI: 9

For patients not undergoing surgery, NMIBC or not seen by an oncologist, record as 10/10/1900 (Not applicable).

If the exact date is not documented, record as 09/09/1900 (Not recorded).

**Related data items:**
Radiotherapy Course Type 1-3 (NMIBC & MIBC)

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: RADIO1
RADIO2
RADIO3
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI(s): 7, 10, 11

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 7.

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>3</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
<tr>
<td>7</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 fields CHEM1, CHEM2 or CHEM3</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 1-3 (NMIBC & MIBC) (Radiotherapy)
Date Treatment Completed 1-3 (NMIBC & MIBC) (Radiotherapy)
**Date Treatment Started 1-3 (NMIBC & MIBC) (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:** RADDATE1  
RADDATE2  
RADDATE3  
**Field Type:** Date (DD/MM/CCYY)  
**Field length:** 10

**Notes for Users:** Required for QPI: 7

This is the first fraction of a course of radiotherapy.

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 09/09/1900 (Not recorded).

If radiotherapy has not been given or the patient has refused radiotherapy, record as 10/10/1900 (not applicable).

**Related Data Items:**  
Radiotherapy Course Type 1-3 (NMIBC & MIBC)  
Date Treatment Completed 1-3 (NMIBC & MIBC)(Radiotherapy)
**Date Treatment Completed 1-3 (NMIBC & MIBC)(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:** RCOMPDATE1
RCOMPDATE2
RCOMPDATE3

**Field Type:** Date (DD/MM/CCYY)

**Field Length:** 10

**Notes for Users:** Required for QPI: 11

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 09/09/1900 (Not recorded).

If treatment has not been given, record as 10/10/1900 (Not applicable).

**Related Data Item(s):**
Radiotherapy Course Type 1-3 (NMIBC & MIBC)
Date Treatment Started 1-3 (NMIBC & MIBC) (Radiotherapy)
Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)

**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:** CHEM1
CHEM2
CHEM3

**Field Type:** Integer

**Field Length:** 2

**Notes for Users:** Required for QPI(s): 7, 11

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 07 and recorded in Radiotherapy Course Type [RADIO1, RADIO2 and RADIO3].

Intravesical Mitomycin C/BCG should **not** be recorded here.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant</td>
<td>Given after radical surgery</td>
</tr>
<tr>
<td>2</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to radical radiotherapy or first definitive surgery to reduce tumour size/ eradicate micrometastastic</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of</td>
</tr>
<tr>
<td>7</td>
<td>Chemoradiotherapy</td>
<td>Chemotherapy given in combination with radical radiotherapy, either concurrently or sequentially. Radiotherapy element of this combined treatment should be recorded separately in fields RADIO1, RADIO2 or RADIO3.</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 1-3 (SACT) (NMIBC & MIBC)
- Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
**Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)**

**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:**

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 09/09/1900 (Not recorded).

If SACT has not been given or the patient has refused SACT, record as 10/10/1900 (not applicable).

**Related data items:**
Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)  
Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
**Date Treatment Completed Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)**

**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): 7, 11

This is the first dose 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 09/09/1900 (Not recorded).

If SACT has not been given or the patient has refused SACT, record as 10/10/1900 (Not applicable).

**Related data items:**
Type of Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
Date Treatment Started Systemic Anti-Cancer Therapy 1-3 (SACT) (NMIBC & MIBC)
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:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI: 10

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>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related data items:**
Section 7: Death Details
**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 national survival analysis and national comparative analysis.

If the exact date is not documented, record as 09/09/1900 (Not recorded).

If the patient is alive use the code 10/10/1900 (Not applicable).

**Related data items:**