Brain/CNS Cancer

Data Definitions for the National Minimum Core Dataset to support the introduction of Brain/CNS Quality Performance Indicators

Definitions developed by ISD Scotland in Collaboration with the Brain/CNS Quality Performance Indicators Development Group

Version 1.4: April 2015

To be used in conjunction with:

1. Brain/CNS Clinical Quality Performance Indicators
2. Brain/CNS QPI Dataset Validations (Latest published version (v1))
3. Brain/CNS Measurability of Quality Performance Indicators (Latest published version (v1))
**Title**: Brain/CNS Cancer – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs)

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**Cross References**: Brain/CNS Cancer Quality Performance Indicators, Brain/CNS Cancer Measurability of Quality Performance Indicators

**Author**: Information Services Division of NHS National Services Scotland

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<td>1.2</td>
<td>11/07/14</td>
<td>Changes agreed out with review to support data collection.</td>
<td>Jane Garrett ISD</td>
<td>See page iii.</td>
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<td>1.4</td>
<td>04/2015</td>
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<td>Jane Garrett ISD</td>
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Data Definitions for the National Minimum Core Data Set for Brain/CNS Cancer.
Developed by ISD Scotland 2014
Page ii
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 1 January 2014.
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with Brain/CNS cancer on or after 1 January 2014, who are eligible for inclusion in the Brain/CNS 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 Improvement Indicators to be measured and reported against

Please email NSS.ISDCANCERAUDIT@nhs.net for enquiries regarding definitions and collection of the minimum core dataset.

CONVENTIONS

In the following definitions the layout for each item is standard. Two conventions have been used in the document as follows:

- {curly brackets} - definition relates to one specific named data set
- ‘described elsewhere’ - indicates there is a definition for the named item within this document
REVISIONS TO DATASET:

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

Revisions (04/2015):

Dataset Specification:

Date of Birth - Field type incorrect change to Date (DD/MM/CCYY)
CHI Number – Field type changed to Integer
Date of MRI SCAN (Pre-treatment) - Field type incorrect change to Date (DD/MM/CCYY)
Date of WHO/ECOG Performance Status - Field type incorrect change to Date (DD/MM/CCYY)
Date of Diagnosis (Cancer) - Field type incorrect change to Date (DD/MM/CCYY)
Date Discussed by Care Team (MDT) - Field type incorrect change to Date (DD/MM/CCYY)
Date of First Cancer Treatment (Brain/CNS Cancer) - Field type incorrect change to Date (DD/MM/CCYY)
Date of Definitive Treatment (Brain/CNS Cancer) - Field type incorrect change to Date (DD/MM/CCYY)
Date of Definitive Surgery - Field type incorrect change to Date (DD/MM/CCYY)
Date of Post Surgical MRI SCAN - Field type incorrect change to Date (DD/MM/CCYY)
Date of 1P/19Q Tissue Analysis (Brain/CNS Cancer) - Field type incorrect change to Date (DD/MM/CCYY)
Date of MGMT Tissue Analysis - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Started (Cancer) (Radiotherapy) 1 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Started (Cancer) (Radiotherapy) 2 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Completed (Cancer) (Radiotherapy) 1 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Completed (Cancer) (Radiotherapy) 2 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 2 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1 - Field type incorrect change to Date (DD/MM/CCYY)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 2 - Field type incorrect change to Date (DD/MM/CCYY)
Date of Death - Field type incorrect change to Date (DD/MM/CCYY)

Dataset:

CHI Number – Field type changed to Integer
Site of Origin of Primary Tumour (Brain/CNS Cancer) 1-4 - Incorrect page reference change to
[See note 5 on page 166 ICD-10]
Post Surgical MRI SCAN – remove explanatory note for code ‘98’
Date of Post Surgical MRI SCAN - Incorrect Related Data Item change to WHO Grade
MGMT Tissue Analysis - Spelling mistake change to For patients who do not have a glioblastoma
Histopathology Report Complete (Brain/CNS Cancer) - Incorrect Related Data Item delete Error!
Reference source not found.
Revisions (07/2014):

Dataset:

Page 13: ‘Seizure Presentation’ code 96 removed
Page 22: ‘Type of First Cancer Treatment {Brain/CNS Cancer}’ new data item added
Page 23: ‘Date of First Cancer Treatment {Brain/CNS Cancer}’ new data item added
Page 24: ‘Date of Definitive Treatment {Brain/CNS Cancer}’ new data item added
Page 31: ‘Reduction in Tumour Volume’ addition to Notes for Users
Page 32: ‘Post Surgical MRI SCAN’ amendment to Notes for Users and Explanatory Note removed for Code 01
Page 36: ‘1P/19Q Tissue Analysis {Brain/CNS Cancer}’ amendment to Codes and Values and change of field name
Page 38: ‘MGMT Tissue Analysis’ amendments to Codes and Values
Page 45: ‘Seen by Specialist Neuro-oncologist’ addition to Notes for Users

Dataset Specification:

Type of First Cancer Treatment {Brain/CNS Cancer} data item added: Field Name: FIRSTTREATTYPE, Field Type: Integer, Field Length 2.

Date of First Cancer Treatment {Brain/CNS Cancer} data item added: Field Name: FIRSTTREATDATE, Field Type: Date, Field Length: 10.

Date of Definitive Treatment {Brain/CNS Cancer} data item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.

1P/19Q Tissue Analysis {Brain/CNS Cancer} field name amended

Date of 1P/19Q Tissue Analysis {Brain/CNS Cancer} field name amended
CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT

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

**Include:**
- All patients with a confirmed new primary invasive cancer of the Brain/CNS (ICD-10 C70-C72 and C75.2 or C75.3).
- Patients with gliosarcoma
- All patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Multiple independent primary tumours should be recorded separately.

**Exclude:**
- Patients where the origin of the primary is uncertain.
- Patients with non-intrinsic Brain/CNS tumours
- Patients with recurrent disease (as opposed to a new primary).
- Patients with metastases in the brain or CNS originating from another primary site.
- Patients with tumour type sarcoma (other than gliosarcoma state above) or lymphoma.
- Patients with 'benign' tumours/cysts or tumours of uncertain/borderline behaviour.
- 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.
DOWNLOAD FORMAT
To assist with downloading data to ISD for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
<th>Page</th>
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<tbody>
<tr>
<td><strong>Section 1: Demographic Items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Person Family Name (at Diagnosis)</td>
<td>PATSNAME</td>
<td>Characters</td>
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<tr>
<td>Person Given Name</td>
<td>PATFNAME</td>
<td>Characters</td>
<td>35</td>
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<tr>
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<td>PATPCODE</td>
<td>Characters</td>
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<td>4</td>
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<tr>
<td>Date of Birth</td>
<td>DOB</td>
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<td>10</td>
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<tr>
<td>Person Sex at Birth</td>
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<td>CHI Number</td>
<td>CHINUM</td>
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<td><strong>Section 2: Pre-treatment Imaging &amp; Staging Investigations</strong></td>
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<tr>
<td>MRI SCAN (Pre-treatment)</td>
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<td>DIAGDATE</td>
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<td>Characters</td>
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</tr>
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<td>OPSURG3</td>
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<td>Post Surgical MRI SCAN</td>
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</table>

**Section 4: Pathology Details**

| WHO Grade | GRADE | Integer | 2 | 35 |
| 1P/19Q Tissue Analysis (Brain/CNS Cancer) | SAMP1P | Integer | 2 | 36 |
| Date of 1P/19Q Tissue Analysis (Brain/CNS Cancer) | SAMP1PDATE | Date (DD/MM/CCYY) | 10 | 37 |
| MGMT Tissue Analysis | MGMTSAMP | Integer | 2 | 38 |
| Date of MGMT Tissue Analysis | MGMTSAMPDATE | Date (DD/MM/CCYY) | 10 | 39 |
| Morphology of Tumour | MORPHOL | Characters | 6 | 40 |
| Histopathology Report Complete (Brain/CNS Cancer) | PATHCOMPL | Integer | 2 | 42 |

**Section 5: Oncological Treatment**

<p>| Specialist Neuro-oncologist (Brain/CNS Cancer) | NEUROCONGMC | Characters | 20 | 44 |
| Seen by Specialist Neuro-oncologist (Brain/CNS Cancer) | SPECNEURO | Integer | 2 | 45 |
| MRI Fusion in Radiotherapy Planning (Brain/CNS Cancer) | MRIFUS | Integer | 2 | 46 |
| Radiotherapy Course Type (Brain/CNS Cancer) 1-2 | RADIO1 | Integer | 2 | 47 |
| Radiotherapy Course Type (Brain/CNS Cancer) 1-2 | RADIO2 | Integer | 2 | 47 |
| Date Treatment Started (Cancer) (Radiotherapy) 1-2 | RADDATE1 | Date (DD/MM/CCYY) | 10 | 48 |
| Date Treatment Started (Cancer) (Radiotherapy) 1-2 | RADDATE2 | Date (DD/MM/CCYY) | 10 | 48 |
| Date Treatment Completed (Cancer) (Radiotherapy) 1-2 | RCOMPDATE1 | Date (DD/MM/CCYY) | 10 | 49 |
| Date Treatment Completed (Cancer) (Radiotherapy) 1-2 | RCOMPDATE2 | Date (DD/MM/CCYY) | 10 | 49 |
| Type of Systemic Anti-Cancer Therapy (SACT) (Brain/CNS Cancer) 1-2 | CHEMTYPE1 | Integer | 2 | 50 |</p>
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<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-2</td>
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<td>CHEMENDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>52</td>
</tr>
</tbody>
</table>

**Section 6: Clinical Trial Entry**

| Patient Entered into Clinical Trial (Cancer) | TRIAL | Integer | 2 | 54 |

**Section 7: Death Details**

| Date of Death | DOD | Date (DD/MM/CCYY) | 10 | 56 |
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:**
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

**Codes and Values:**

**Related Data Items:**
**Person Given Name**

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

**Main Source of Data Item 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:**  
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.

**Codes and Values:**

**Related Data Items:**
Patient Postcode at Diagnosis {Cancer}

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

Codes and Values: N/A

Related Data Items: Date of Diagnosis {Cancer}
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.

Codes and Values: N/A

Related Data Items:
CHI Number
Person Sex at Birth

Common Name(s): Sex at Birth

Main Source of Data Item 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>01</td>
<td>Male</td>
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</tr>
<tr>
<td>02</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>09</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 Items:
CHI Number
CHI Number

Main Source of Data Item 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: Integer
Field Length: 10

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

From Designed to Care - Scottish Office

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

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

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

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

Codes and values: N/A

Related Data Items:
Date of Birth
Person Sex at Birth
Section 2: Pre-treatment Imaging & Staging Investigations
MRI SCAN (Pre-treatment)

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

Definition: A record to determine if a MRI was carried out prior to treatment

Field Name: MRI
Field Type: Integer
Field Length: 2

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

The pre – treatment contrast MRI scan should only be recorded when relating to the patients first line treatment.

The pre-treatment contrast MRI scan should be within 6-weeks of decision to treat.

Codes and values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patients undergoing biopsy only</td>
</tr>
<tr>
<td>97</td>
<td>Contraindication to intravenous contrast medium</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td>Patient not suitable e.g. MRI incompatible implanted device, cerebral aneurysm clip, metal in eye, co-morbidities etc</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items
Date of MRI SCAN (Pre-treatment)
Date of MRI SCAN (Pre-treatment)

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

Definition: The date the pre-treatment MRI scan investigation was carried out.

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

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

The pre-treatment MRI scan should only be recorded when relating to the patient’s first line treatment.

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

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

Related Data Items
MRI SCAN (Pre-treatment)
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 QPI 1 and 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>
<th>Karnofsky Performance Status (KPS) Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction</td>
<td>100</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>
<td>70-90</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>
<td>50-60</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>
<td>30-40</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled, cannot carry on any self care, totally confined to bed or chair</td>
<td>10-20</td>
</tr>
<tr>
<td>9</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
**Date of (WHO/ECOG ) Performance Status**

**Main Source of Data Item Standard:** WHO Classification

**Definition:** The date of assessment to determine the patients WHO performance status.

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

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

Date of assessment must be on the same day or prior to the first MDT date.

If the exact date is not documented or if no assessment was carried out, record as 09/09/0909 (Not recorded)

**Related Data Items:**
WHO/ ECOG Performance Status  
Date Discussed by Care Team (MDT)
Seizure Presentation

**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 the patient has presented with seizures at the time of diagnosis.

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date of Diagnosis {Cancer}
Seen by Neurologist and/or nurse with expertise in Epilepsy management {Brain/CNS 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 the patient was seen by a Neurologist and/or Epilepsy Specialist Nurse.

Field Name: EPILNESN
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI(s): 11

The patient may be seen by the Neurologist and/or nurse with expertise in Epilepsy management at anytime during the patient pathway.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Nurse with expertise in epilepsy management</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Neurologist</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Seen by both (nurse with expertise in epilepsy management and Neurologist)</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:
Seizure Presentation
Location 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 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 clarifying responsibility for data collection and national comparative analysis.

This may also be a GP surgery code if a biopsy was taken by a GP. This will be the hospital/GP surgery where the sample was taken or the hospital at which the patient was managed when the diagnosis was made.

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). [http://www.natref.scot.nhs.uk/](http://www.natref.scot.nhs.uk/)

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.  

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

If a patient was diagnosed through imaging at one hospital but transferred to another for confirmation of the diagnosis, the first hospital should be recorded as the Location of diagnosis.

**Related Data Item(s):**  
Date of Diagnosis {Cancer}
**Date 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 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 of the first investigative procedure that confirms a diagnosis of Brain/CNS cancer whether done radiologically or histologically.

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

The date of diagnosis may not relate to ‘Most Valid Basis of Diagnosis’.

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

**Related Data Item(s):**  
Date of Birth  
Location of Diagnosis {Cancer}
Most Valid Basis of Diagnosis {Cancer}


Definition: The best evidence in support of the diagnosis of cancer.

Field Name: VALID
Field Type: Integer
Field Length: 2

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

The conclusion of a diagnosis of cancer may be based on one or several procedures; clinical findings or as a report on the death certificate. Histological confirmation is considered as the most valid basis of diagnosis.

The methods of diagnosis from 1-8 are listed in essentially ascending order of validity, microscopic methods having greater validity than non-microscopic methods.

NB: With the emergence of molecular markers etc., there are plans to review the definition of this variable in the context of updating the IARC monograph, Cancer Registration Principles and Methods.

The most valid basis of diagnosis may not relate to date of diagnosis.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Clinical only</td>
<td>The diagnosis is based solely on clinical findings (history and/or physical examination). This is made before death but without the benefit of the following:</td>
</tr>
<tr>
<td>02</td>
<td>Clinical investigation</td>
<td>The diagnosis is supported by investigations such as x-ray, CT scan, ultrasound etc.</td>
</tr>
<tr>
<td>03</td>
<td>Exploratory surgery@endoscopy/autopsy (without concurrent or previous histology)</td>
<td>The tumour has been visualised or palpated but there is no confirmatory microscopic evidence</td>
</tr>
<tr>
<td>04</td>
<td>Tumour specific markers (biochemical/immunological tests)</td>
<td>The diagnosis is supported by specific tests</td>
</tr>
<tr>
<td>05</td>
<td>Cytology</td>
<td>The diagnosis is supported by cytology (the examination of cells whether from a primary or secondary site).</td>
</tr>
<tr>
<td>06</td>
<td>Histology of metastasis</td>
<td>The diagnosis is based on the history of a metastasis (secondary deposit), e.g. resulting from a lymph node biopsy</td>
</tr>
<tr>
<td>07</td>
<td>Histology of primary</td>
<td>The diagnosis is based on the histology of the primary either resulting from a biopsy or from complete resection of the tumour.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
**Site of Origin of Primary Tumour {Brain/CNS Cancer} 1-4**

**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 (ICD-10)

**Field Name:** ICDSITE1  
ICDSITE2  
ICDSITE3  
ICDSITE4  
**Field Type:** Characters  
**Field length:** 5

**Notes for Users:** Required for QPI(s): 1-10

Where the tumour is multi-focal e.g. fronto-parietal, tempo-parietal etc then record each site individually.

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 .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. [See note 5 on page 166 ICD-10]

If only one site is required then leave ICDSITE 2-4 blank.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C70.0</td>
<td>Cerebral Meninges</td>
<td>Cranial dura mater; Cranial meninges; Cranial pia mater; Falx Cerebeli; Falx cerebri; Falx NOS; Intracranial arachnoid; Intracranial meninges; Tentorium cerebelli; Tentorium NOS.</td>
</tr>
<tr>
<td>C70.1</td>
<td>Spinal Meninges</td>
<td>Spinal arachnoid; Spinal dura mater; Spinal pia mater.</td>
</tr>
<tr>
<td>C70.9</td>
<td>Meninges NOS</td>
<td>Arachnoid NOS; Dura NOS; Dura mater NOS; Pia mater NOS.</td>
</tr>
<tr>
<td>C71.0</td>
<td>Cerebrum</td>
<td>Basal ganglia; Central white matter; Cerebral cortex; Cerebral hemisphere; Corpus striatum; Globus pallidus; Hypothalamus; Insula; Internal capsule; Island of Reil; Operculum; Pallium; Putamen; Rhinecephalon; Supratentorial brain NOS; Thalamus.</td>
</tr>
<tr>
<td>C71.1</td>
<td>Frontal Lobe</td>
<td>Frontal pole</td>
</tr>
<tr>
<td>C71.2</td>
<td>Temporal Lobe</td>
<td>Hippocampus; Uncus</td>
</tr>
<tr>
<td>C71.3</td>
<td>Parietal Lobe</td>
<td></td>
</tr>
<tr>
<td>C71.4</td>
<td>Occipital Lobe</td>
<td>Occipital pole.</td>
</tr>
<tr>
<td>C71.5</td>
<td>Ventricle NOS</td>
<td>Cerebral ventricle; Choroid plexus NOS; Choroid plexus of lateral ventricle; Choroid plexus of third ventricle; Ependyma; Lateral ventricle NOS; Third ventricle NOS.</td>
</tr>
<tr>
<td>C71.6</td>
<td>Cerebellum NOS</td>
<td>Cerebellar peduncle; Basis pedunculi; Choroid plexus of fourth ventricle; Fourth ventricle NOS; Infratentorial brain NOS; Medulla oblongata; Midbrain; Olive; Pons; Pyramid.</td>
</tr>
<tr>
<td>C71.7</td>
<td>Brain Stem</td>
<td></td>
</tr>
</tbody>
</table>
### Data Definitions for the National Minimum Core Data Set for Brain/CNS Cancer

*Developed by ISD Scotland 2014*

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#### C71.8 Overlapping Lesion of Brain
Corpus callosum; Tapetum

#### C71.9 Brain NOS
Intracranial site; Cranial fossa NOS; Anterior cranial fossa; Middle cranial fossa; Posterior cranial fossa; Suprasellar.

### Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>C72.0</td>
<td>Spinal Cord</td>
<td>Cervical cord; Conus medullaris; Filum terminale; Lumbar cord; Sacral cord; Thoracic cord.</td>
</tr>
<tr>
<td>C72.1</td>
<td>Cauda Equina</td>
<td></td>
</tr>
<tr>
<td>C72.2</td>
<td>Olfactory Nerve</td>
<td></td>
</tr>
<tr>
<td>C72.3</td>
<td>Optic Nerve</td>
<td>Optic chiasm; Optic tract</td>
</tr>
<tr>
<td>C72.4</td>
<td>Acoustic Nerve</td>
<td></td>
</tr>
<tr>
<td>C72.5</td>
<td>Cranial Nerve NOS</td>
<td>Abducens nerve; Accessory nerve NOS; Spinal accessory nerve; Facial nerve; Glossopharyngeal nerve; Hypoglossal nerve; Oculomotor nerve; Trigeminal nerve; Trochlear nerve; Vagus nerve.</td>
</tr>
<tr>
<td>C72.8</td>
<td>Overlapping Lesion of Brain and Central Nervous System</td>
<td>Neoplasms whose point of origin cannot be assigned to any of the categories C70 to C725</td>
</tr>
<tr>
<td>C72.9</td>
<td>Nervous System NOS</td>
<td>Central nervous system; Epidural; Extradural; Parasellar.</td>
</tr>
</tbody>
</table>

### Endocrine Glands and Related Structures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C75.2</td>
<td>Craniopharyngeal Duct</td>
</tr>
<tr>
<td>C75.3</td>
<td>Pineal Gland</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

---

**Related Data Item(s):**
- Histopathology Report Complete {Brain/CNS Cancer}
- Laterality of Origin of Primary Tumour {Brain/CNS Cancer}
Laterality of Origin of Primary Tumour {Brain/CNS Cancer}

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

Definition: The anatomical side (laterality) of origin of the primary tumour.

Field Name: LATSITE
Field Type: Integer
Field Length: 2

Notes for Users: Required to allow local sub analysis.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Left</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Midline</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Both left and right</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Site of Origin of Primary Tumour {Brain/CNS Cancer} 1-4
Date Discussed by Care Team (MDT)

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

**Main source of data standard:** The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

**Definition:** This denotes the date the care team meeting (also known as the multidisciplinary team) was held to discuss the management of the patient's care.

**Field Name:** MDTDATE

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

**Field Length:** 10

**Notes for Users:** Required for QPI(s): 1, 2

The first MDT meeting should be recorded.

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.

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

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

**Related Data Item(s):**
Type of First Cancer Treatment {Brain/CNS Cancer}

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: FIRSTTREATTYPE
Field Type: Integer
Field length: 2

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

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td>Excludes biological therapy as part of combined treatment</td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td>Includes biological therapy as part of combined treatment</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 {Brain/CNS 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 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(s): 2

This field should be recorded for all patients including those with supportive care only ('No active treatment') (see below).
If type of first cancer treatment is 'supportive care only', the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

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

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

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

Related Data Item(s):
Date of First Cancer Treatment {Brain/CNS Cancer}
**Date of Definitive Treatment {Brain/CNS 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: 2

For patients with brain/CNS cancer definitive treatment will be either:

- Surgery;
- Radiotherapy; or
- Systemic Anti Cancer Therapy.

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 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.

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

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

**Related Data Item(s):**
Section 3: Surgery
Location Code {Cancer Surgery}

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

Main Source of Data Item Standard: Derived from SMR data standards.

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

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

Notes for Users: Required sub and survival analysis

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

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). [http://www.natref.scot.nhs.uk/](http://www.natref.scot.nhs.uk/)

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

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

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 Not applicable, X1010.

Related Data Item(s):
Operating Surgeon
Main Type of Definitive Surgery {Brain/CNS Cancer}
Date of Definitive Surgery
Operating Surgeon

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

**Definition:** The surgeon performing the definitive surgery as described elsewhere.

**Field Name:** OPSURG1
OPSURG2
OPSURG3

**Field Type:** Characters

**Field Length:** 20

**Notes for Users:** Required to allow local sub and survival analysis

Where more than one surgeon is involved in a joint operation then record each in a separate field.

The surname and forename of each surgeon (including locum) should be recorded to distinguish between surgeons with common surnames. Surgeon’s names should be stored in databases as General Medical Council (GMC) number.

If the clinician’s name is unknown, code as 9999 (Not recorded).

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

**Related Data Item(s):**
Location Code {Cancer Surgery}
Main Type of Definitive Surgery {Brain/CNS Cancer}
Date of Definitive Surgery
Main Type of Definitive Surgery {Brain/CNS Cancer}

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

Definition: This is the main (definitive) surgery performed on the patient for treatment of Brain/CNS cancer.

Field Name: OPCODE1
OPCODE2
OPCODE3
OPCODE4

Field Type: Characters
Field Length: 5
Notes for Users: Required for QPI(s): 5, 6, 7, 9

Each operation can have one, two or more codes. Up to four procedures may be recorded here as part of the definitive operation. The Main Operation/Procedure should be recorded in OPCODE1 with subsidiary procedures being recorded in OPCODE2-4.

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

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

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

Codes and Values

<table>
<thead>
<tr>
<th>OPCS</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A02.1</td>
<td>Craniotomy for lesion of frontal lobe</td>
<td></td>
</tr>
<tr>
<td>A02.2</td>
<td>Craniotomy for lesion of temporal lobe</td>
<td></td>
</tr>
<tr>
<td>A02.3</td>
<td>Craniotomy for lesion of parietal lobe</td>
<td></td>
</tr>
<tr>
<td>A02.4</td>
<td>Craniotomy for lesion of occipital lobe</td>
<td></td>
</tr>
<tr>
<td>A02.5</td>
<td>Craniotomy for lesion of cerebellum</td>
<td></td>
</tr>
<tr>
<td>A02.8</td>
<td>Craniotomy for lesion of brain tissue - other site</td>
<td></td>
</tr>
<tr>
<td>A10.6</td>
<td>Insertion of carmustine wafers in neoplasm of tissue of brain</td>
<td></td>
</tr>
<tr>
<td>A12.4</td>
<td>Insertion of ventriculoperitoneal shunt</td>
<td></td>
</tr>
<tr>
<td>A14.2</td>
<td>Revision/maintenance of cerebroventricular shunt</td>
<td></td>
</tr>
<tr>
<td>A14.3</td>
<td>Removal of cerebroventricular shunt</td>
<td></td>
</tr>
<tr>
<td>A12.5</td>
<td>Insertion of Omaya reservoir</td>
<td></td>
</tr>
<tr>
<td>A14.8</td>
<td>Other CSF drainage/shunt procedure</td>
<td></td>
</tr>
<tr>
<td>A20.1</td>
<td>Insertion of external ventricular drain</td>
<td></td>
</tr>
<tr>
<td>A20.3</td>
<td>ICP monitoring</td>
<td></td>
</tr>
<tr>
<td>A48.8</td>
<td>Spinal cord procedure- not elsewhere coded</td>
<td></td>
</tr>
<tr>
<td>Y46.5</td>
<td>Supratentorial open approach to contents of</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Y46.6</td>
<td>Infratentorial open approach to contents of cranium</td>
<td></td>
</tr>
<tr>
<td>Y46.9</td>
<td>Open approach to contents of cranium, Unspecified</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></td>
</tr>
<tr>
<td>98</td>
<td>Biopsy only</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related data items:
Location Code {Cancer Surgery}
Operating Surgeon
Date of Definitive Surgery

Evidence in patient record that surgery was received but details of the type of surgery is not recorded
Date of Definitive Surgery

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

Definition: This is the date of the operative procedure described elsewhere.

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

Notes for Users: Required for QPI(s): 3, 7, 9

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

If no surgical procedure is carried out, code as 10/10/1010 (Not applicable).

Codes and values: N/A

Related data items:  
Location Code (Cancer Surgery)  
Operating Surgeon
Reduction in Tumour Volume {Brain/CNS Cancer}

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

Definition: The estimated percentage reduction volume achieved during surgical resection of a tumour as determined by radiology.

Field Name: REDUCT  
Field Type: Integer  
Field Length: 2

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

This should be determined by comparing pre and post operation MRI scans and documented by the radiologist.

Reduction volume percentage should be clearly documented on the post-operative MDT notes as defined by the radiologist and not deduced by audit staff. If it is not documented then discuss with the relevant clinician.

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>&lt;50%</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>50-89%</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>90-99%</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>100%</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 Item(s):  
WHO/ ECOG Performance Status  
MRI SCAN (Pre-treatment)  
Post Surgical MRI SCAN
Post Surgical MRI SCAN

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

Definition: A record to determine if a MRI was carried out after surgery.

Field Name: POSTMRI
Field Type: Integer
Field Length: 2

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

Codes and values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patients undergoing biopsy only.</td>
</tr>
<tr>
<td>97</td>
<td>Contraindication to intravenous contrast medium</td>
<td>Patient not suitable e.g. MRI incompatible implanted device, cerebral aneurysm clip, metal in eye etc.</td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items
**Date of Post Surgical MRI SCAN**

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

**Definition:** The date the MRI scan investigation was carried out following surgery.

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

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

The post-surgical MRI scan may be performed within 3 days (72 hours) of surgery however, due to other factors it may occur out with 3 days. The MRI scan date should be recorded regardless.

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

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

**Related Data Items**  
Post Surgical MRI SCAN  
WHO Grade  
Date of Definitive Surgery
Section 4: Pathology Details
WHO Grade

Main source of data standard: WHO Classification

Definition: This is a malignancy scale to determine the aggressiveness of tumours and to estimate the prognosis.

Field Name: GRADE
Field Type: Integer
Field Length: 2

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

If two different grades (e.g. from scanning & pathology) are recorded in the notes then always record the higher grade.

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Grade I</td>
<td>Tumours with a low proliferative potential, a frequently discrete nature and a possibility of cure following surgical resection alone.</td>
</tr>
<tr>
<td>02</td>
<td>Grade II</td>
<td>Generally infiltrating tumours low in mitotic activity but with a potential to recur. Some tumour types tend to progress to lesions with higher grades of malignancy (e.g. diffuse astrocytomas, oligodendrogliomas and ependymomas).</td>
</tr>
<tr>
<td>03</td>
<td>Grade III</td>
<td>Histological evidence of malignancy, generally in the form of mitotic activity, clearly expressed infiltrative capabilities and anaplasia.</td>
</tr>
<tr>
<td>04</td>
<td>Grade IV</td>
<td>Mitotically active, necrosis-prone neoplasms, generally associated with a rapid pre- and post-operative evolution of the disease.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. no sample for pathology</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Histopathology Report Complete {Brain/CNS Cancer}
Date of (WHO/ECOG) Performance Status
1P/19Q Tissue Analysis {Brain/CNS 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 of the outcome of 1p and 19q analysis carried out for patients with glioma with an oligodendroglial component.

**Field Name:** SAMP1P  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 3
Can be determined from biopsy or surgical resection.
Where the patient does not have an oligodendroglial component then record 96 – Not Applicable.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>1p - 19q - Not co-deleted</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>1p - 19q - Co-deleted</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Insufficient sample</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>For patients who do not have an oligodendroglial component</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date of 1P/19Q Tissue Analysis {Brain/CNS Cancer}
Date of 1P/19Q Tissue Analysis {Brain/CNS 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 of the date that analysis of 1p and 19q was carried out for patients with glioma with an oligodendroglial component.

Field Name: SAMP1PDATE
Field Type: Date (DD/MM/CCYY)
Field Length: 10

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

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

If no analysis is carried out, record as 10/10/1010 (Not applicable).

Where the patient does not have an oligodendroglial component, record as 10/10/1010 (Not applicable).

Related Data Items:
1P/19Q Tissue Analysis {Brain/CNS Cancer}
MGMT Tissue Analysis

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

Definition:  The result of tissue sample analysis to assess for MGMT promoter hypermethylation status for patients with glioblastoma.

Field Name:  MGMTSAMP  
Field Type:  Integer  
Field Length:  2  

Notes for Users:  Required for QPI(s):  3  
Can be determined from biopsy or surgical resection.  If the result is not clear from the notes then pathology should be contacted to provide clarity.

Where the patient does not have a glioblastoma then record 96 – Not Applicable.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Methylated</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Unmethylated</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Insufficient sample</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>For patients who do not have a glioblastoma</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:  
Date of MGMT Tissue Analysis
Data Definitions for the National Minimum Core Data Set for Brain/CNS Cancer.
Developed by ISD Scotland 2014
Page 39

Date of MGMT Tissue Analysis

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 the date that tissue sample analysis was done to assess for MGMT promoter hypermethylation status in patients with glioblastomas.

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

Notes for Users: Required for QPI(s): 3
If the exact date is not documented, record as 09/09/0909 (Not recorded).
If no analysis is carried out, record as 10/10/1010 (Not applicable).
Where the patient does not have a glioblastoma, record as 10/10/1010 (Not applicable).

Related Data Items:
MGMT Tissue Analysis
Morphology of Tumour

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

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

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

Notes for Users: Required for QPI(s): 3, 6, 7, 9.

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 the pathology report is negative code to 8888/8.

If not recorded code to 9999/9.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>9380/3</td>
<td>Glioma malignant</td>
</tr>
<tr>
<td>9381/3</td>
<td>Gliomatosis Cerebri</td>
</tr>
<tr>
<td>9431/3</td>
<td>Angiocentric Glioma</td>
</tr>
<tr>
<td>9400/3</td>
<td>Low Grade Astrocytoma</td>
</tr>
<tr>
<td>9424/3</td>
<td>Pleomorphic Xanthoastrocytoma</td>
</tr>
<tr>
<td>9401/3</td>
<td>Anaplastic Astrocytoma</td>
</tr>
<tr>
<td>9410/3</td>
<td>Protoplasmic Astrocytima</td>
</tr>
<tr>
<td>9440/3</td>
<td>Glioblastoma</td>
</tr>
<tr>
<td>9441/3</td>
<td>Giant Cell Glioblastoma</td>
</tr>
<tr>
<td>9411/3</td>
<td>Gemistocytic Astrocytoma</td>
</tr>
<tr>
<td>9420/3</td>
<td>Fibrillary Astrocytoma</td>
</tr>
<tr>
<td>9423/3</td>
<td>Polar Spongioblastoma</td>
</tr>
<tr>
<td>9425/3</td>
<td>Pilomyxoid Astrocytoma</td>
</tr>
<tr>
<td>9430/3</td>
<td>Astroblastoma</td>
</tr>
<tr>
<td>9442/3</td>
<td>Gliosarcoma (Glioblastoma with Sarcomatous Component)</td>
</tr>
</tbody>
</table>

Oligodendrogliomas

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>9450/3</td>
<td>Low Grade Oligodendroglioma</td>
</tr>
<tr>
<td>9451/3</td>
<td>Anaplastic Oligodendroglioma</td>
</tr>
<tr>
<td>9382/3</td>
<td>Low Grade Oligoastrocytoma</td>
</tr>
<tr>
<td>9382/3</td>
<td>Anaplastic Oligoastrocytoma</td>
</tr>
</tbody>
</table>
### Ependymal Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9391/3</td>
<td>Low Grade Ependymoma</td>
</tr>
<tr>
<td>9392/3</td>
<td>Anaplastic Ependymoma</td>
</tr>
<tr>
<td>9393/3</td>
<td>Papillary Ependymoma</td>
</tr>
</tbody>
</table>

### Choroid Plexus Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9390/3</td>
<td>Choroid Plexus Carcinoma</td>
</tr>
</tbody>
</table>

### Neuronal/Glial Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9490/3</td>
<td>Ganglioneuroblastoma</td>
</tr>
<tr>
<td>9505/3</td>
<td>Anaplastic Ganglioglioma</td>
</tr>
</tbody>
</table>

### Pineal Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9362/3</td>
<td>Pineal Parenchymal Tumour of Intermediate Differentiation</td>
</tr>
<tr>
<td>9362/3</td>
<td>Pineoblastoma</td>
</tr>
<tr>
<td>9395/3</td>
<td>Papillary Tumour of Pineal Region</td>
</tr>
</tbody>
</table>

### Embryonal Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9470/3</td>
<td>Medulloblastoma</td>
</tr>
<tr>
<td>9471/3</td>
<td>Desmoplastic Nodular Medulloblastoma; Medulloblastoma with Extensive Nodularity</td>
</tr>
<tr>
<td>9472/3</td>
<td>Medullomyoblastoma</td>
</tr>
<tr>
<td>9473/3</td>
<td>Primitive Neuroectodermal Tumour (PNET)</td>
</tr>
<tr>
<td>9474/3</td>
<td>Large Cell Medulloblastoma; Anaplastic Medulloblastoma</td>
</tr>
<tr>
<td>9501/3</td>
<td>Medulloepithelioma</td>
</tr>
<tr>
<td>9500/3</td>
<td>Neuroblastoma</td>
</tr>
<tr>
<td>9392/3</td>
<td>Ependymoblastoma</td>
</tr>
</tbody>
</table>

### Cranial and Spinal Nerve Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9540/3</td>
<td>Malignant Peripheral Nerve Sheath Tumour</td>
</tr>
<tr>
<td>9561/3</td>
<td>Malignant Peripheral Nerve Sheath Tumour with Rhabdomyoblastic Differentiation</td>
</tr>
<tr>
<td>9571/3</td>
<td>Perienurioma, Malignant</td>
</tr>
</tbody>
</table>

### Meningeal Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9530/3</td>
<td>Anaplastic Meningioma</td>
</tr>
<tr>
<td>9538/3</td>
<td>Papillary Meningioma (Rhabdoid Meningioma)</td>
</tr>
<tr>
<td>9150/3</td>
<td>Hemangiopericytoma</td>
</tr>
<tr>
<td>9539/3</td>
<td>Meningeal Sarcomatosis</td>
</tr>
</tbody>
</table>

### Miscellaneous Tumours

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9503/3</td>
<td>Euroepithelioma</td>
</tr>
<tr>
<td>9504/3</td>
<td>Spongioneuroblastoma</td>
</tr>
<tr>
<td>9508/3</td>
<td>Atypical Teratoid/Rhabdoid Tumour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1010/0</td>
<td>Not applicable</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>
</tbody>
</table>

**Related Data Items:**
Histopathology Report Complete {Brain/CNS Cancer}
Histopathology Report Complete {Brain/CNS Cancer}

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

Definition: A record to determine if all information required in the pathology report is complete.

Field Name: PATHCOMPL
Field Type: Integer
Field Length: 2

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

Full Information Required:
(As defined by the Royal College of Pathology CNS Dataset)

Clinical:
Site of origin of tumour
Type of procedure

Macroscopic items:
Estimate tumour size in three dimensions or the volume of tumour tissue if submitted piecemeal, or provide the tumour weight.

There may be no information available for the macroscopic data items however if the pathologist has noted this then it can be deemed to be completed.

Microscopic items:
Tumour type.
Tumour sub-type relevant for grading and prognosis.
Tumour grade (WHO 2007).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Not complete</td>
<td>Not all data items recorded.</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):
Site of Origin of Primary Tumour {Brain/CNS Cancer}
Morphology of Tumour
Section 5: Oncological Treatment
Specialist Neuro-oncologist {Brain/CNS Cancer}

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

**Definition:** The Specialist Neuro-oncologist managing a patient undergoing oncological treatment as described elsewhere.

**Field Name:** NEUROCONGMC  
**Field Type:** Characters  
**Field Length:** 20

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

The surname and forename of the consultant (including locum) should be recorded to distinguish between Neuro-oncologist with common surnames. Consultants’ names should be stored in databases as General Medical Council (GMC) number.

A specialist neuro-oncologist can be defined as:
- Having an interest in brain/ CNS cancer,
- Attends at least 50% of weekly neuro-oncology MDT meetings
- Is a member of SANON
- Attends at least one national or international neuro-oncology conference every two years

If the Specialist Neuro-oncologist name is not recorded, code as 9999.

If no oncological treatment was performed record as not applicable (1010).

**Related Data Item(s):**  
Seen by Specialist Neuro-oncologist {Brain/CNS Cancer}
Seen by Specialist Neuro-oncologist \{Brain/CNS 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 the patient was seen by a Specialist Neuro-oncologist.

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

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

A specialist Oncologist can be defined as:
- Having an interest in brain/ CNS cancer,
- Attends at least 50% of weekly neuro-oncology MDT meetings
- Is a member of SANON
- Attends at least one national or international neuro-oncology conference every two years

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Specialist Neuro-oncologist \{Brain/CNS Cancer\}
MRI Fusion in Radiotherapy Planning {Brain/CNS Cancer}

Main source of data standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by Information Services.

Definition: A record to determine if patients with primary brain/CNS cancer had MRI fusion included when radical radiotherapy planning was carried out.

Field Name: MRIFUS
Field Type: Integer
Field Length: 2

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

Codes and Values

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes – MRI fusion included</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>Contraindication to intravenous contrast medium</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td>Patient not suitable e.g. MRI incompatible implanted device, cerebral aneurysm clip, metal in eye, co-morbidities etc</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Radiotherapy Course Type \{Brain/CNS Cancer\} 1-2

**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  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for QPI(s): 5, 8, 9, 10

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

All treatments given as part of the initial treatment plan.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery.</td>
</tr>
<tr>
<td>02</td>
<td>Neo-adjuvant</td>
<td>It is given before potentially curative surgery.</td>
</tr>
<tr>
<td>03</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>04</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
</tbody>
</table>
| 07   | Chemoradiotherapy         | Radical radiotherapy given in combination with chemotherapy, either concurrently or sequentially.  
                                          | Chemotherapy element of this combined treatment should be recorded separately in fields CHEMTYPE1-3. |
| 94   | Patient died before radiotherapy treatment |  |
| 95   | Patient refused radiotherapy treatment |  |
| 96   | Not applicable            | e.g. no radiotherapy given.                                                       |
| 99   | Not recorded              |  |

**Related Data Items:**

Date Treatment Started \{Cancer\} (Radiotherapy) 1-2  
Date Treatment Completed \{Cancer\} (Radiotherapy) 1-2
Date Treatment Started {Cancer} (Radiotherapy) 1-2

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

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

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 09/09/0909 (Not recorded).

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

Related Data Items:
Specialist Neuro-oncologist {Brain/CNS Cancer}  
Radiotherapy Course Type {Brain/CNS Cancer} 1-2  
Date Treatment Completed {Cancer} (Radiotherapy) 1-2
Date Treatment Completed {Cancer} (Radiotherapy) 1-2

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: RCOMPDAT1
            RCOMPDAT2
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users: Required to support survival analysis

This is the last fraction of a course of radiotherapy.

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

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

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

Related Data Item(s):
Radiotherapy Course Type {Brain/CNS Cancer} 1-2
Date Treatment Started {Cancer} (Radiotherapy) 1-2
Type of Systemic Anti-Cancer Therapy (SACT) (Brain/CNS Cancer) 1-2

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

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

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

Notes for Users: Required for QPI(s): 5, 8, 9

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Adjuvant</td>
<td>Chemotherapy given after surgery.</td>
</tr>
<tr>
<td>02</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to radiotherapy or first definitive surgery to reduce tumour size.</td>
</tr>
<tr>
<td>04</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis.</td>
</tr>
<tr>
<td>05</td>
<td>Chemoradiotherapy</td>
<td>For curative/radical treatment. Can be sequential or concurrent with radiotherapy. Radiotherapy element of this combined treatment should be recorded separately in fields RADIO1-2.</td>
</tr>
<tr>
<td>07</td>
<td>Biological Therapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Systemic therapy not given as primary part of therapy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-2
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-2

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

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

This is the first dose of the first cycle of a course of SACT.

Some patients may have separate completion chemotherapy post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

If the patient’s type of first treatment was ‘supportive care only’, then subsequently proceeds to active treatment at a later date, only record if systemic therapy occurs within 6-months of diagnosis.

If the date of SACT treatment started is not known or not documented, record as 09/09/0909 (Not recorded).

If SACT treatment is not carried out, record (10/10/1010) (Not applicable).

Related Data Items(s):
Type of Systemic Anti-Cancer Therapy (SACT) (Brain/CNS Cancer) 1-
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-2
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-2

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

Notes for Users: Required to support survival analysis.

This is the first day of the last cycle of a course of therapy.

Some patients may have separate completion chemotherapy post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

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

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

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

Related Data Item(s):
Type of Systemic Anti-Cancer Therapy (SACT) (Brain/CNS Cancer) 1-2
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-2
Section 6: Clinical Trial Entry
**Patient Entered into Clinical Trial {Cancer}**

**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 generic QPIs.

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 National Cancer Research Network (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>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Section 7: 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 generic QPIs:

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

If the patient is alive use the code 10/10/1010 (Not applicable).

Codes and Values: N/A

Related Data Items: