Breast Cancer

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

Definitions developed by ISD Scotland in collaboration with the
Breast Quality Performance Indicator Development Group

Version 4.6: July 2022

To be used in conjunction with:

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Breast Cancer – Data Definitions for the National Minimum Core Dataset to support the introduction of Breast Quality Performance Indicators (QPIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Published/Issued</td>
<td>July 2022</td>
</tr>
<tr>
<td>Date Effective From</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; January 2019</td>
</tr>
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<td>Version/Issue Number</td>
<td>V4.6</td>
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<td>NHS staff involved in implementing and recording Breast Cancer Quality Performance Indicators.</td>
</tr>
</tbody>
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| Cross References | Breast Cancer Quality Performance Indicators  
Breast Cancer Measurability of Quality Performance Indicators |
| Author | Public Health Scotland (PHS) |

## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of Changes</th>
<th>Name</th>
<th>Changes Marked</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2.0</td>
<td>September 2013</td>
<td>Changes agreed at 9 month review. To be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; January 2014.</td>
<td>David Early,</td>
<td>See page xi</td>
</tr>
<tr>
<td>V2.1</td>
<td>September 2014</td>
<td>Changes following baseline review. To be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; January 2014</td>
<td>Charlotte Anthony</td>
<td>See page xi</td>
</tr>
<tr>
<td>V2.2</td>
<td>October 2014</td>
<td>Additional change following baseline review. To be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; January 2014</td>
<td>Charlotte Anthony</td>
<td>See page xi</td>
</tr>
<tr>
<td>V2.3</td>
<td>October 2014</td>
<td>Additional change following baseline review. To be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; January 2014</td>
<td>Charlotte Anthony</td>
<td>See page xi</td>
</tr>
<tr>
<td>V2.4</td>
<td>October 2014</td>
<td>Changes agreed outwith review. To be applied for patients</td>
<td>Charlotte Anthony</td>
<td>See page xi</td>
</tr>
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<tr>
<td>V2.5</td>
<td>December 2014</td>
<td>Changes agreed outwith review To be applied for patients diagnosed from 1st January 2014</td>
<td>Charlotte Anthony</td>
<td>See page x</td>
</tr>
<tr>
<td>V2.6</td>
<td>June 2015</td>
<td>Changes agreed outwith review To be applied for patients diagnosed from 1st January 2014</td>
<td>Charlotte Anthony</td>
<td>See page x</td>
</tr>
<tr>
<td>V3.0</td>
<td>August 2016</td>
<td>Changes following Formal Review. To be applied for patients diagnosed from 1st January 2014</td>
<td>Karen Heatlie</td>
<td>See page viii</td>
</tr>
<tr>
<td>V3.1</td>
<td>July 2017</td>
<td>Changes outwith review</td>
<td>Charlotte Anthony</td>
<td>See page viii</td>
</tr>
<tr>
<td>V3.2</td>
<td>September 2017</td>
<td>Changes outwith review</td>
<td>Karen Heatlie</td>
<td>See page viii</td>
</tr>
<tr>
<td>V3.3</td>
<td>January 2018</td>
<td>Changes outwith review</td>
<td>Jane Garrett</td>
<td>See page vii</td>
</tr>
<tr>
<td>V3.4</td>
<td>July 2018</td>
<td>Changes outwith review</td>
<td>Ashleigh Morrissey</td>
<td>See page vii</td>
</tr>
<tr>
<td>V4.0</td>
<td>August 2019</td>
<td>Changes following Formal Review.</td>
<td>Jane Garrett</td>
<td>See page iv</td>
</tr>
<tr>
<td>V4.1</td>
<td>May 2020</td>
<td>Addition to dataset during COVID 19 Pandemic and changes outwith review</td>
<td>Jane Garrett</td>
<td>See page iii</td>
</tr>
<tr>
<td>V4.2</td>
<td>February 2021</td>
<td>Changes outwith review and Rebranding Updates</td>
<td>Caroline Dawson</td>
<td>Throughout Document</td>
</tr>
<tr>
<td>V4.3</td>
<td>July 2021</td>
<td>Changes outwith review</td>
<td>Grant Callahan</td>
<td>See page iii</td>
</tr>
<tr>
<td>V4.4</td>
<td>September 2021</td>
<td>Changes outwith review</td>
<td>Grant Callahan</td>
<td>See page iii</td>
</tr>
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<td>Grant Callahan</td>
<td>See page iii</td>
</tr>
</tbody>
</table>
PREFACE

Breast cancer services were among the earliest adopters of audit due to the rigorous quality assurance established for Breast Screening services. While some Breast Units have been collecting audit data since the mid 1990s, it has been widespread for the last decade.

The SIGN treatment guidelines were published in 1998 and recommended that a core dataset be established. This was provided by the former Scottish Cancer Therapy Network (SCTN) in 1999.

The strongest recommendations from the SIGN guidelines were used to form the basis for the first Clinical Standards Board (CSBS) standards which were produced in 2000. All Scottish breast units were visited by multidisciplinary peer teams in 2001 and a national report published in March 2002. At that time several units were identified that still did not have regular prospective audit in place.

Under the auspices of NHS Quality Improvement Scotland (QIS), the standards were updated and revised in 2007 (final version published in 2008). The cancer data set was developed by ISD in collaboration with the three cancer networks.

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 national cancer 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 and the accompanying measurability document were agreed in public engagement and are now ready for implementation for patients diagnosed from 01/01/2012.

Mr Matthew Barber, Consultant Surgeon
Ms Alison Lannigan, Consultant Breast Surgeon
Dr Ruth Adamson, Consultant Pathologist
Dr Hilary Dobson, Clinical Director, WoS Breast Screening Service
Dr John Dewar, Consultant Clinical Oncologist

Breast Cancer QPI Development Group Subgroup Lead Clinicians
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with breast cancer on or after 1st January 2014, who are eligible for inclusion in the breast 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

General enquiries on the collection of the National Minimum Core Dataset:

If you have any difficulties in using individual definitions within this document, or any comments on the data definitions, Public Health Scotland would welcome your feedback.

Please contact: phs.canceraudit@phs.scot

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):
Notes by Users:

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

Changes to dataset outwith review June 2022

CHI number CHINUM – changed from integer to character

Changes outwith Review (December 2021)

Final Axillary Surgery - Codes and Values: added code 6 - Targeted Axillary Dissection

Changes outwith Review (September 2021)

Date of Referral - Notes for user updated – see table

First Axillary Surgery - Codes and Values: added code 6 - Targeted Axillary Dissection

Changes outwith Review July 2021 (should be implemented for cases diagnosed from January 2021)

Database specification

Type of immediate Breast Reconstruction – add new data item Field Name: TYPERECON, Field Type: Integer, Field Length: 2

Dataset

Type of Immediate Breast Reconstruction - Added data item

Changes outwith Review and rebranding (February 2021) (implementation date for patients from 1st January 2020)

Key Information – Author amended from Information Services Division (ISD) to Public Health Scotland

Database Specification:

Date of Definitive Treatment {Breast Cancer} – Data item removed

Dataset:

Date of Mastectomy Decision - Due to the dataset being incorrectly updated in May 2020 the Notes for users have been amended to remove the notes regarding neoadjuvant hormone therapy as this is not an exclusion in QPI 6, clarification has
also been added to show these are only QPI 6ii exclusions and if the date is readily available for excluded patients it can still be recorded for local purposes.

**Date of Definitive Treatment {Breast Cancer}** – Data item removed

**Genetics Referral** - Codes and Values table updated explanatory notes for code 3 to “No documented evidence that the patient was referred” and code 96 to “Not Applicable Patient is already known to Genetics and referral is not required, or patient died before a referral was made”

**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 January 2019

**Changes outwith Review (May 2020)**

**Database Specification:**

**Date of Mastectomy and Immediate Reconstruction** - add new data item, Field Name: MASTIMRDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

**Dataset:**

**Date of Mastectomy and Immediate Reconstruction** - add new data item

**Genomic Test Performed** - Codes and Values table remove leading ‘0’

**Genetics Referral** - Codes and Values table remove leading ‘0’, Update explanatory notes for Code 3 – No can only be used if there is documented evidence there was family history etc but the patient was not referred. Code 96 – Not applicable should only be used where there is documented evidence of no family history etc therefore no reason to refer. Code 99 – Not recorded should only be used where there is no documented evidence of whether the patient was referred or not.

**Type of First Cancer Treatment** - update explanatory notes code 11 – e.g. Large Volume Biopsy
% Predicted Survival Benefit (PREDICT) - Notes for Users add Patients who have had neo-adjuvant chemotherapy, Peri-operative hormone therapy, neo-adjuvant hormone therapy, patients who have in situ disease only and patients with M1 disease should all be recorded as ‘Not Applicable’

Date of Mastectomy Decision - Notes for Users add Add For patients not included in QPI 6, record 10/10/1900. i.e. Patients having neoadjuvant chemotherapy or neoadjuvant hormones, Patients having mastectomy without immediate reconstruction, Patients not having mastectomy, Males, Patients with M1 disease.

Revisions to Dataset agreed at Formal Review (August 2019)

Database Specification:
Date of Mastectomy Decision - add new data item, Field Name: MASTDECDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Lymphovascular Invasion {Breast Cancer} - add new data item, Field Name: LYMPINV, Field Type: Integer, Field Length: 2

Pathological Complete Response - add new data item, Field Name: PATHRESP, Field Type: Integer, Field Length: 2

Deep Inspiratory Breath Hold (DIBH) Radiotherapy - add new data item, Field Name: DIBH, Field Type: Integer, Field Length: 2

Partial Breast Irradiation (PBI) - add new data item Field Name: PBI, Field Type: Integer, Field Length: 2

Location Code {Radiotherapy Treatment} – add new data item Field Name: HOSPRADIO, Field Type: Characters, Field Length: 5

Location Code {SACT Treatment} - add new data item Field Name: HOSPSACT, Field Type: Characters, Field Length: 5

Dataset:
Date of First Clinic - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Ultrasound Findings (Axilla) {Breast Cancer} - Notes for Users Remove Required for QPI(s) ‘3’

Nodal Cytology of Axilla Results - Notes for Users Remove Required for QPI(s) ‘3’

Date Nodal Cytology of Axilla Performed - Notes for Users Remove Required for QPI(s) ‘3’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’
Histological Opinion (Breast Biopsy) - Notes for Users Remove Required for QPI(s) ‘2’

Date Breast Biopsy Performed - Notes for Users Remove Required for QPI(s) ‘2’; amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Histological Opinion (Nodal Biopsy) - Notes for Users Remove Required for QPI(s) ‘2’

Date Nodal Biopsy Performed - Notes for Users Remove Required for QPI(s) ‘2, 3’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

TNM Tumour Classification (Pre-operative) {Breast Cancer} - Notes for Users add ‘QPI(s): 18 and for’, remove ‘and’

TNM Nodal Classification (Pre-operative) {Breast Cancer} - Notes for Users add ‘QPI(s): 18 and for’, remove ‘and’

TNM Metastasis Classification (Pre-operative) {Breast Cancer} - Notes for Users Required for QPI(s) remove ‘10’, ‘12’, add ‘18’

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

Laterality {Cancer} - Notes for Users add ‘Required for QPI: 19’

Date Discussed by Care Team - Notes for Users remove ‘Required for QPI(s): 1’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Type of First Cancer Treatment - Notes for Users remove ‘QPI(s): 1,’

Date of First Cancer Treatment - Notes for Users remove ‘QPI(s): 12 and’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Date of Definitive Treatment {Breast Cancer} - Notes for Users remove ‘Required for QPI(s): 1’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer} - Notes for Users remove Required for QPI(s): ‘3, 4, 5,’

Reason for Mastectomy - Notes for Users remove Required for QPI(s): ‘4’

Date of Mastectomy Decision - add new data item

Date of First Definitive Breast Surgery {Breast Cancer} - Notes for Users remove Required for QPI(s): ‘2, 3, 4’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’
Date of Final Definitive (or Only) Surgery Performed to Breast or Axilla {Breast Cancer} - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

First Axillary Surgery {Breast Cancer} - Notes for Users remove Required for QPI(s) ‘7’

Final Axillary Surgery {Breast Cancer} - Notes for Users remove Required for QPI(s) ‘7’

Type of Tumour {Breast Cancer} - Notes for Users remove Required for QPI(s): ‘1, 2, 3, 5, 11’ add ‘18’

Tumour Grade {Breast Cancer} - Notes for Users add ‘QPI: 10 and for’, remove ‘and’

Distance from Final Radial Excision Margin {Breast Cancer} - Notes for Users amend Required for QPI ‘5’ to ‘10’

Maximum Invasive Pathological Diameter {Breast Cancer} - Notes for Users amend Required for QPI ‘12’ to ‘10’

Maximum Microscopic Whole Tumour Diameter {Cancer} - Notes for Users remove Required for QPI ‘4’

Total Number of Lymph Nodes Involved {Cancer} - Notes for Users amend Required for QPI(s) ‘7, 11, 12’ to ‘10, 17’

Tumour Extent {Breast Cancer} - Notes for Users remove Required for QPI ‘4’

Oestrogen Receptor (ER) Status {Breast Cancer} - Notes for Users add Required for QPI(s) ‘10, 11, 17, 18’

Progesterone Receptor (PR) Status {Breast Cancer} - Notes for Users add Required for QPI(s) ‘11, 18’

Date of HER2 Reporting - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Breast Cancer} - Notes for Users amend Required for QPI(s) ‘12’ to ‘10, 11, 17, 18’

Lymphovascular Invasion {Breast Cancer} - add new data item

Pathological Complete Response - add new data item

Location Code {Radiotherapy Treatment} – add new data item

Radiotherapy Course Type (1-2) - Notes for Users add Required for QPI(s) ‘10, 19’
Site of External Beam Radiotherapy - Notes for Users remove ‘Required for QPI(s) 10’

Date Treatment Started {Cancer} (Radiotherapy) (1-2) - amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Deep Inspiratory Breath Hold (DIBH) Radiotherapy - add new data item

Partial Breast Irradiation (PBI) - add new data item

Type of Hormonal Therapy {Breast Cancer} - Notes for Users amend Required for QPI(s) ‘4, 7’ to ‘10, 17’

Date Hormonal Therapy Started {Breast Cancer} - Notes for Users remove ‘Required for QPI(s) 4, 7’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

% Predicted Survival Benefit - Notes for Users amend Required for QPI(s) ‘4, 7’ to ‘11, 17’, add ‘As a guide for clinicians it has been agreed that PREDICT version 2.1 should be used and third generation chemotherapy should be selected as default for the purpose of consistency, however this does not require to be evidenced for individual patients. Where a score has been documented this should be recorded as per table below’, amend ‘not ‘to ‘is not the tool that’

Location Code {SACT Treatment} - add new data item

Type of Chemotherapy {Cancer} (1-2) - Notes for Users amend Required for QPI(s) ‘4, 7, 15’ to ‘17, 18’

Date Treatment Started {Cancer} (Chemotherapy) (1-2) - Notes for Users remove ‘Required for QPI(s) ‘4, 7’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Date Treatment Completed {Cancer} (Chemotherapy) (1-2) - Notes for Users remove ‘Required for QPI(s) ‘4, 7, 15’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Biological Agent {Breast Cancer} - Notes for Users remove ‘Required for QPI(s) ‘12’

Date Treatment Started {Cancer} (Biological Therapy) - Notes for Users remove ‘Required for QPI(s) 12’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Genomic Test Performed - Notes for Users add ‘QPI(s): 17 and for’

Date of Genomic Test Result - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Recurrence Score (Oncotype DX) - Notes for Users add ‘QPI: 11 and for’
**Genetics Referral** - Notes for Users add ‘e.g.’

**Date Referred for Genetic Testing** - Notes for Users add ‘e.g.’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

**Patient Entered into Clinical Trial {Breast Cancer}** - Notes for Users add Required for QPI(s) ‘17’,

**Follow-up Date** - Notes for Users add ‘e.g.’, amend ‘09/09/0909’ to ‘09/09/1900’

**Date of First Local Recurrence {Breast Cancer}** - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

**Date of First Regional Recurrence {Breast Cancer}** - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

**Date of First Distant Recurrence** - Notes for Users amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

**Date of Death** - Notes for Users remove ‘QPI(s): 15 and’, amend 10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Revisions to Dataset out with review (July 2018)

**Database Specification:**

**Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer}** - Field Name amended from SURBRST to SURGBRST

Revisions to Dataset outwith review (January 2018)

**TNM Tumour Classification (Pre-operative) {Breast Cancer}** - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

**TNM Nodal Classification (Pre-operative) {Breast Cancer}** - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

**TNM Metastasis Classification (Pre-operative) {Breast Cancer}** - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

**Date of First Cancer Treatment** - Notes for Users add ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.'
Date of Definitive Treatment {Breast Cancer} - Notes for Users add ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.’

Revisions to Dataset outwith review (September 2017)
NB: Changes to take effect for patients diagnosed from 01/01/2017.

Recurrence Score (Oncotype DX) - Notes for Users amend to allow the Oncotype recurrence score to be between 0 and 100.

% Predicted Survival Benefit – Table of Codes and Values code 3 changed to >5.

Patient Entered into Clinical Trial {Breast Cancer} – Table of Codes and Values added Code 1I Yes – Other (Entered into a clinical trial involving a therapy or therapies which does not include radiotherapy, chemotherapy, biological therapy or hormone therapy).

Person Family Name (at Diagnosis) – link updated

Person Given Name – link updated

Patient Postcode at Diagnosis {Cancer} – link updated

Date of Birth (DOB) – link updated

Revisions to Dataset outwith review (July 2017)
NB: Changes to take effect for patients diagnosed from 01/01/2017.

First Axillary Surgery {Breast Cancer} – Table of Codes and Values added code: 3A/ Combined dye/isotope, 3B/ Blue dye alone, 3C/ Isotope alone: 3D/ Other/Without either blue die or isotope.

Revisions to Dataset following Formal Review (August 2016)

Date of Birth – Notes for Users Required for QPI(s): now ‘12, 14’

Person Sex at Birth – Notes for Users Add ‘Required for QPI(s): 4, 6’ to Notes for Users.

Source of Cancer Referral – Notes for Users Required for QPI(s) now states ‘Required for national survival analysis and national comparative analysis.’

Date Breast Biopsy Performed – Notes for Users Required for QPI(s): add ‘, 9’

Date Nodal Biopsy Performed – Notes for Users Required for QPI(s): add ‘, 9’
TNM Tumour Classification (Pre-operative) {Breast Cancer} – Notes for Users now states ‘Required for national survival analysis and national comparative analysis.’

TNM Nodal Classification (Pre-operative) {Breast Cancer} – Notes for Users now states ‘Required for national survival analysis and national comparative analysis.’

TNM Metastasis Classification (Pre-operative) {Breast Cancer} – Notes for Users now states ‘Required for national survival analysis and national comparative analysis.’

Date of Diagnosis {Breast Cancer} – Notes for Users now states ‘Required for national survival analysis and national comparative analysis.’

Most Valid Basis of Diagnosis {Cancer} – Notes for Users now states ‘Required for national survival analysis and national comparative analysis.’

Date Discussed by Care Team – Definition add ‘Audit staff should refer to the relevant MDT guideline for their region for clarity on the membership required to constitute an MDT if required’ and ‘hospital’. Notes for Users add ‘If the patient has only been discussed at the screening centre MDT, record as not applicable (10/10/1010)’

Type of First Cancer Treatment Required – Notes for Users now states ‘for national survival analysis and national comparative analysis.’

Date of First Cancer Treatment – Notes for Users Required for QPI(s): add ‘and national survival analysis.’

First Definitive Surgery Performed to Breast {Breast Cancer} – add new data item

Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer} – Notes for Users Required for QPI(s): add ‘13’

Reason for Mastectomy – add new data item

Date of First Definitive Breast Surgery {Breast Cancer} – Notes for Users Required for QPI(s): delete 1 and 7

Date of Final Definitive (or Only) Surgery Performed to Breast or Axilla {Breast Cancer} – Notes for Users ‘Required for QPI (s): 6’

Type of Tumour {Breast Cancer} – Notes for Users Required for QPI(s): remove ‘4’ and add ‘, 13’

Tumour Grade {Breast Cancer} – Notes for Users now ‘national survival analysis and national comparative analysis.’

Maximum Microscopic Whole Tumour Diameter {Cancer} – Notes for Users Required for QPI(s): delete ‘11’
Oestrogen Receptor (ER) Status {Breast Cancer} - Notes for Users ‘Required for QPI(s): 14’

Progesterone Receptor (PR) Status {Breast Cancer} – add new data item

Date of HER2 Reporting - Definition added ‘(as detected by immunohistochemistry (IHC) and/or FISH analysis).’ Notes for users added ‘Required for QPI(s): 9’ to Notes for Users.

Human Epidermal Growth Factor Receptor-2 (HER2) Status Available at Pre-treatment MDT {Breast Cancer} – Archive data item

Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Breast Cancer} – Notes for Users Required for QPI(s): ‘14’ added.

Date Hormonal Therapy Started {Breast Cancer} – Notes for Users Required for QPI(s) remove‘1’

% Predicted Survival Benefit – add new data item

Type of Chemotherapy {Cancer} (1-2) – Notes for Users Required for QPI(s) add ‘15’ added

Date Treatment Started {Cancer} (Chemotherapy) (1-2) – Notes for Users Required for QPI(s) delete ‘1’

Date Treatment Completed {Cancer} (Chemotherapy) (1-2) - Notes of Users Required for QPI(s): add ‘15’

Date Treatment Started {Cancer} (Biological Therapy) - Notes for Users Required for QPI(s) delete 1

Genomic Test Performed – add new data item

Date of Genomic Test Result - add new data item

Recurrence Score (Oncotype DX) – add new data item

Genetics Referral – add new data item

Date Referred for Genetic Testing – add new Data item

Follow-up Date – Notes for Users add ‘Required for national survival analysis and national comparative analysis’ to Required for QPI(s):

Follow-up Status – Notes for users now ‘Required for national survival analysis and national comparative analysis.’
Data Definitions for the National Minimum Core Dataset for Breast Cancer.
Developed by ISD Scotland, 2013

Date of Death – Notes for Users Required for QPI(s) add ‘15 and national survival analysis.’ To

Revisions to Dataset outwith review (June 2015)

Hospital of Diagnosis – Notes for Users remove X1010 Not applicable

Revisions to Dataset outwith review (December 2014)

TNM Tumour Classification (Pre-operative) {Breast Cancer} – Codes and Values Table amended spelling error of carcinoma – T4d.

Date Discussed by Care Team (MDT pre-treatment) – Title remove ‘pre treatment’

Date of First Definitive Breast Surgery {Breast Cancer} – Notes for Users Add "If patient has axillary surgery alone this is the date which should be recorded"

Human Epidermal Growth Factor 2 (HER2) Status Available at Pre-treatment MDT {Breast Cancer} – Definition remove the word initial. Notes for Users remove the word initial. Notes for Users add ‘If the IHC is inconclusive and the HER2 FISH status is available at pre-treatment MDT, the FISH status would then be recorded’

Revisions to Dataset outwith review (November 2014)

Date of Definitive Treatment {Breast Cancer} – Notes for Users Required QPI(s) amend from 3 to 1.

Date of First Cancer Treatment – Notes for Users Required QPI(s) remove ‘1’

Additional Revision to Dataset Following Baseline Review (October 2014)

The following changes have been made following the Baseline review of Breast Cancer Data Definitions for the National Minimum Core Dataset. Changes to take effect for patients diagnosed from 01/01/2014.

Dataset:

Date of HER2 Reporting – add new Data Item

Database Specifications:

Date of HER2 Reporting - add new data item: Field Name: HER2REPORT, Field Type: Date, Field Length: 10.

Revisions to Dataset Following Baseline Review (September 2014)
The following changes have been made following the Baseline review of Breast Cancer Data Definitions for the National Minimum Core Dataset. Changes to take effect for patients diagnosed from 01/01/2014.

Dataset:

Date of Definitive Treatment {Breast Cancer} – add new Data Item

Database Specifications:

Date of Definitive Treatment {Breast Cancer} – add new data item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.

Revisions to Dataset Following 9-Month Review (September 2013)

The following changes have been made following the 9-month review of Breast Cancer Data Definitions for the National Minimum Core Dataset. Changes to take effect for patients diagnosed from 01/01/2014.

Criteria for Inclusion of Patients in Audit - Inclusion criteria removed:
- Multiple independent primary tumours should be recorded separately
- Patients diagnosed within NHS Scotland but who have received any part of their treatment privately or outwith Scotland
- All patients aged 16 years and over

Exclusion criteria added:
- Patients with other tumour types, such as sarcoma or lymphoma
- Patients where the only record of their cancer is from a death certificate (DCO)
- Patients with metastases in the breast originating from another primary site.
- Applicable ICD-10 codes for cancer relating to skin of breast.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith Scotland’

Exclusion criteria removed:
- Patients diagnosed in the private sector
- Death Certificate Only (DCO) cases

Hospital of Diagnosis – add new data item

Ultrasound Examination of Axilla (Pre-operative) {Breast Cancer} – Archive Data Item

Database Specification:

Hospital of Diagnosis - add New Data Item: Field Name: HOSPDIAG, Field Type: Character, Field Length: 5

Ultrasound Examination of Axilla – Archive Data Item Field Name: ULTRAXIL, Field Type: Integer, Field Length: 2.
Dataset:

**Person Sex at Birth** – Table of Coders and Values amended code '99: Not known' to '99: Not recorded'

**Source of Cancer Referral** – Table of Coders and Values amended code '99: Not known' to '99: Not recorded',

**Ultrasound Findings (Axilla) {Breast Cancer}** – Title amend data item name, adding '(axilla)' for clarity on what is being recorded. Table of Codes and Values amended code '99: Not known' to '99: Not recorded'

**Nodal Cytology of Axilla Results** – Table of Codes and Values amended code '99: Not known' to '99: Not recorded, explanatory notes added code '2: Benign' to explain that this includes normal results.

**Date Nodal Cytology of Axilla Performed** – Notes for Users add 'If more than one FNA or other cytological procedure is carried out on the lymph nodes, record the date of the procedure with the most significant abnormality.'

**Histological Opinion (Breast Biopsy)** - Title remove 'core', Notes for Users add 'If more than one breast biopsy is performed, record the result of the procedure with the most significant abnormality.' Explanatory notes add code 'B3: Atypia' to include lobular neoplasia. Table of Codes and Values amended code '99: Not known' to '99: Not recorded'.

**Date Breast Biopsy Performed** – Title remove 'core', definition add 'or vacuum-assisted needle biopsy of the breast was performed'.

**Histological Opinion (Nodal Biopsy)** – Title removed ‘core’ from data item name. Notes for Users add 'If more than one nodal core biopsy or vacuum assisted needle biopsy of the axilla is carried out, record the result of the procedure with the most significant abnormality.'

**Date Nodal Biopsy Performed** – Title remove ‘core’ from data item. If more than one nodal core biopsy or vacuum assisted needle biopsy of the axilla is carried out, record the date of the procedure with the most significant abnormality.'

**TNM Tumour Classification (Pre-operative) {Breast Cancer}** - Notes for Users add 'This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.'

Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.'
Notes for Users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

Codes and Values Table amended code ‘99: Not known’ to ‘99: Not recorded’.

**TNM Nodal Classification (Pre-operative) {Breast Cancer}** – Notes for Users add ‘This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.’

Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.’

Notes for Users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

Table of Codes and Values amended code ‘99: Not known’ to ‘99: Not recorded’.

**TNM Metastasis Classification (Pre-operative) {Breast Cancer}** – Notes for Users add ‘This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.’

Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.’

Notes for Users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

Table of Codes and Values amended code ‘99: Not known’ to ‘99: Not recorded’.

**Most Valid Basis of Diagnosis {Cancer}** – Table of Codes and Values removed code ‘10: Death Certificate Only’ and amended code ‘99: Not known’ to ‘99: Not recorded’.

**Laterality** - Table of Code and Values amended code ‘99: Not known’ to ‘99

**Date Discussed by Care Team (MDT Pre-treatment)** – Definition Revised: ‘This denotes the date of the first multidisciplinary care team meeting to discuss the management of the patient. Notes for Users amended to reflect updated numbering in latest QPIs.

Notes for Users to remove requirement for MDT date to be before date of first treatment for this to be recorded.

Related data item remove ‘Human Epidermal Growth Factor Receptor-2 (HER2) Status Available at Initial MDT {Breast Cancer}.

**Type of First Cancer Treatment** – Table of Codes and Values amend ‘99: Not known’ to ‘99: Not recorded’.

**Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer}** – Table of Codes and Values Amended code ‘99: Not known’ to ‘99: Not recorded’.
First Axillary Surgery {Breast Cancer} - Explanatory note to code ‘3: Sentinel node biopsy (isotope +blue dye)’ in table of codes and values: ‘Sentinel node biopsy can only be recorded when isotope colloid and blue dye have been used to localise the sentinel node. If node positive, may be followed by clearance.’ Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’.

Final Axillary Surgery {Breast Cancer}: Table of Codes and Values add explanatory note to code ‘3: Sentinel node biopsy can only be recorded when isotope colloid and blue dye have been used to localise the sentinel node. If node positive, may be followed by clearance’ and amended code ’99: Not known’ to ’99: Not recorded’.

First Axillary Surgery {Breast Cancer} – Table of Codes and Values add explanatory note to code ‘3: Sentinel node biopsy (isotope +blue dye)’ in table of codes and values: ‘Sentinel node biopsy can only be recorded when isotope colloid and blue dye have been used to localise the sentinel node. If node positive, may be followed by clearance.’ and amended code ’99: Not known’ to ’99: Not recorded’.

Type of Tumour {Breast Cancer} - Table of Codes and Values add ‘23:Malignant cells on cytology, not otherwise specified’ and add code ‘24:Occult invasive, with positive nodes on histology’ to table of codes and values, amend amended code ’99: Not known’ to ’99: Not recorded’.


Distance from Final Radial Excision Margin - Table of Codes and Values amend code ’99: Not known’ to ’99: Not recorded’.

Tumour Extent {Breast Cancer} - Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’.

Oestrogen Receptor (ER) Status {Breast Cancer} – Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’.

Human Epidermal Growth Factor Receptor-2 (HER2) Status Available at Pre-treatment MDT {Breast Cancer} – Title Revised data item ‘from initial MDT to pre-treatment MDT’.
Definition add ‘...is available, and recorded at initial pre-treatment multidisciplinary team (MDT) meeting.’
Notes for Users add ‘HER2 status available at initial pre-treatment MDT. This may not be the date the patient is first discussed.’ Table of Codes and Values amend ’99: Not known’ to ’99: Not recorded’, Related Data Items remove ‘Data Discussed by Care Team (MDT) Pre-treatment’ from ‘Related Data Items.

Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Breast Cancer} – Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’,
Radiotherapy Course Type (1-2) – Filed Type amended include two fields for entering two courses of radiotherapy (RADIO and RADIO2). Title revised to include ‘(1-2)’.
Notes for Users add ‘For patients undergoing chemoradiotherapy, the radiotherapy element should be recorded as code ‘10’ and recorded additionally in Systemic Anti-Cancer Therapy under code ‘10’.
Table of Codes and Values add ‘7’ Intraoperative Radiation Therapy (IORT)’ and explanatory notes to table of codes and values.
Table of Codes and Values add ’10: Chemoradiotherapy’, Table of Codes and Values amended code ‘99: Not known’ to ‘99: Not recorded’,

Site of External Beam Radiotherapy {Breast Cancer} (1-5) – Notes for Users add ‘Radiotherapy fields refer to the area of the body exposed to radiation. There may be more than one field if targeting the tumour from different angles.’ Table of Codes and Values amend ’99: Not known’ to ‘99: Not recorded’ amend ‘Related Data Item(s)’.

Date Treatment Started {Cancer} (Radiotherapy) 1-2 Field - Type amended to include fields for two dates to permit recording of two courses of radiotherapy (RADDATE1 and RADDATE2), amended Related Data Items

Type of Hormonal Therapy {Breast Cancer} – Table of Codes and Values amend ’99: Not known’ to ’99: Not recorded’.

Type of Chemotherapy {Cancer} (1-2) – Notes for Users add to notes for Users: ‘For patients undergoing chemoradiotherapy, the chemotherapy element should be recorded as code ‘10’ and recorded additionally in Radiotherapy Course Type under code ‘10’.
And ‘If chemotherapy was not given as part of primary therapy, code as ‘8 (A/B/C/D)’, as applicable. Table of Codes and Values add ‘10: Chemoradiotherapy’ and amended code ’99: Not known’ to ’99: Not recorded’.

Date Treatment Completed {Cancer} (Chemotherapy) (1-2) – Notes for Users amend ‘inapplicable’ to ‘not applicable’

Biological Agent {Breast Cancer} – Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’,

Patient Entered into Clinical Trial {Breast Cancer} - Table of Codes and Values amend code ’99: Not known’ to ’99: Not recorded’,

Follow-up Status – Table of Codes and Values amended code ’99: Not known’ to ’99: Not recorded’,

Date of First Local Recurrence {Breast Cancer} – Notes for Users amended ‘inapplicable’ to ‘not applicable’.

Date of First Regional Recurrence {Breast Cancer} – Notes for Users amended ‘inapplicable’ to ‘not applicable’.

Data Definitions for the National Minimum Core Dataset for Breast Cancer.
Developed by ISD Scotland, 2013
Page xviii
**Date of First Distant Recurrence** – Notes for Users amend ‘inapplicable’ to ‘not applicable’

**Date of Death** – Notes for Users Amend ‘inapplicable’ to ‘not applicable’.
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 female and male patients with a confirmed new primary cancer of the breast with invasive or in situ disease, ICD10 codes C50 and D05 (these codes include connective tissue of the breast but exclude skin, and lymphomas which are recorded separately).
- This includes all patients with Paget’s disease and patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
  - In cases where there are multiple tumours, the tumour with the worst prognosis should be recorded.

Exclude

- Patients where the origin of the primary is uncertain.
- Patients with other tumour types of the breast, such as sarcoma, lymphoma or phyllodes.
- Patients with recurrent disease (as opposed to a new primary).
- Applicable ICD-10 codes for cancer relating to skin of breast.
- Patients with metastases in the breast originating from another primary site.
- 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 out with Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.
DOWNLOAD FORMAT
To assist with downloading data to PHS for the National Quality Assurance Programme and other agreed activities, all sites should be able to export data according to the following specification.

DATABASE SPECIFICATION

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**Section 5: Pathology Details**

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**Section 6: Radiotherapy**

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<td>Location Code (Radiotherapy Treatment)</td>
<td>HOSPRADIO</td>
<td>Characters</td>
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<td>Radiotherapy Course Type (1-2)</td>
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<td>Field name</td>
<td>Field type</td>
<td>Size</td>
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</tr>
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</tr>
<tr>
<td>Site of External Beam Radiotherapy (Breast Cancer) (1-5)</td>
<td>RADSITE1, RADSITE2, RADSITE3, RADSITE4, RADSITE5</td>
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<tr>
<td>Date Treatment Started (Cancer) (Radiotherapy) (1-2)</td>
<td>RADDATE1, RADDATE2</td>
<td>Date</td>
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<td>Deep Inspiratory Breath Hold (DIBH) Radiotherapy</td>
<td>DIBH</td>
<td>Integer</td>
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<tr>
<td>Partial Breast Irradiation (PBI)</td>
<td>PBI</td>
<td>Integer</td>
<td>2</td>
<td>72</td>
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<tr>
<td><strong>Section 7: Systemic Therapy</strong></td>
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<tr>
<td>Location Code (SACT Treatment)</td>
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<tr>
<td>Type of Hormonal Therapy (Breast Cancer)</td>
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<tr>
<td>Date Hormonal Therapy Started (Breast Cancer)</td>
<td>HORMDATE</td>
<td>Date</td>
<td>10</td>
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<tr>
<td>% Predicted Survival Benefit</td>
<td>PREDICT</td>
<td>Integer</td>
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<tr>
<td>Type of Chemotherapy (Cancer) (1-2)</td>
<td>CHEM1, CHEM2</td>
<td>Characters</td>
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<td>Date Treatment Started (Chemotherapy) (1-2)</td>
<td>CHEMDATE1, CHEMDATE2</td>
<td>Date</td>
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<td>Date Treatment Completed (Cancer) (Chemotherapy) (1-2)</td>
<td>CHEMENDATE1, CHEMENDATE2</td>
<td>Date</td>
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<td>Biological Agent (Breast Cancer) – Other, specify</td>
<td>BIOAGENT, BIOAGENT8</td>
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<td>Biological Agent (Breast Cancer)</td>
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<td>Characters</td>
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<td>83</td>
</tr>
<tr>
<td>Date Treatment Started (Cancer) (Biological Therapy)</td>
<td>BIODATE</td>
<td>Date</td>
<td>10</td>
<td>84</td>
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<td>Genomic Test Performed</td>
<td>GENTEST</td>
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<tr>
<td>Date of Genomic Test Result</td>
<td>GENREPORT</td>
<td>Date</td>
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</tr>
<tr>
<td>Recurrence Score (Oncotype DX)</td>
<td>ONCSCORE</td>
<td>Integer</td>
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<tr>
<td><strong>Section 8: Genetic Testing</strong></td>
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<tr>
<td>Genetics Referral</td>
<td>GENETICS</td>
<td>Integer</td>
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<td>89</td>
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<tr>
<td>Date Referred for Genetic Testing</td>
<td>GENETICDATE</td>
<td>Integer</td>
<td>2</td>
<td>90</td>
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<tr>
<td><strong>Section 9: Clinical Trial Entry</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Patient Entered into Clinical Trial (Breast Cancer)</td>
<td>TRIAL</td>
<td>Characters</td>
<td>2</td>
<td>92</td>
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<tr>
<td><strong>Section 10: Follow-up and Death Details</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Follow-up Date</td>
<td>FUDATE</td>
<td>Date</td>
<td>10</td>
<td>94</td>
</tr>
<tr>
<td>Follow-up Status</td>
<td>FUSTATUS</td>
<td>Integer</td>
<td>2</td>
<td>95</td>
</tr>
<tr>
<td>Date of First Local Recurrence (Breast Cancer)</td>
<td>FLOCDATE</td>
<td>Date</td>
<td>10</td>
<td>96</td>
</tr>
<tr>
<td>Date of First Regional Recurrence (Breast Cancer)</td>
<td>FREGDATE</td>
<td>Date</td>
<td>10</td>
<td>97</td>
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<tr>
<td>Date of First Distant Recurrence</td>
<td>FDISTDATE</td>
<td>Date</td>
<td>10</td>
<td>98</td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date</td>
<td>10</td>
<td>99</td>
</tr>
</tbody>
</table>
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: Required for national comparative analysis.

The surname of a person represents that part of the name of a person indicating the family group of which the person is part.

It should be noted that in Western culture this is normally the latter part of the name of a person. However, this is not necessarily true of all cultures. This will, of course, give rise to some problems in the representation of the name. This is resolved by including the data item Name Element Position in the structured name indicating the order of the name elements.

From SMR Definitions and Codes

Notes by Users:
Person Given Name

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

Main Source of Data Item Standard: [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: Required for national comparative analysis.

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.

Notes by Users:
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: Required for national comparative analysis.

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
Field Length: 10

Notes for Users: Required for QPI(s): 10, 12, 14,

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

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

Related Data Item(s):
CHI Number

Notes by Users:
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:** Required for QPI: 6

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

**Notes by Users:**
**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:** Characters  
**Field Length:** 10

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

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, Public Health 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

**Notes by Users:**
Hospital of Audit

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

Definition: This will be the hospital of audit responsibility and will usually be the main hospital responsible for the patient’s overall care.

Field Name: HOSPAUD
Field Type: Characters
Field Length: 5

Notes for Users: Required for national comparative analysis.

This is the main hospital for audit responsibility of the patient’s pathway.

Regional arrangements of how this works locally apply.

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

Codes and Values:
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
X1010=Not applicable
X9999=Not recorded

Notes by Users:
Section 2: Presentation and Referral Details
Date of Referral

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

Definition: The date on which the patient referral to secondary care for the investigation and/or treatment of breast 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.

See Table overleaf:
<table>
<thead>
<tr>
<th>Referral Mode</th>
<th>Guidance on date of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care clinician (Dentist, GP, Nurse practitioner)</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Screening service</td>
<td>Record the date on which the referral from screening was received by the hospital. If a Screening referrals has not been stamped with the date the referral was received and the exact date cannot be found, the earliest available date should be used. The referral date is the date that the letter for the assessment centre is generated to request recall to an assessment centre for further diagnostic intervention.</td>
</tr>
<tr>
<td>Incidental finding / Secondary Care</td>
<td>For patients who are incidentally found or suspected of having a cancer (and a new cancer is subsequently confirmed), the date the patient was referred to a specialist for further investigation and treatment should be used. If no referral is required, the date of the investigation that led to the suspicion of cancer should be used. For example, if a patient was having a mammogram for follow up of a previously diagnosed breast cancer, and a new breast cancer is picked up, an onward referral may not be necessary and the date of the mammogram should be used.</td>
</tr>
<tr>
<td>Review clinic</td>
<td>For patients who attend for routine review either for follow up of a previous cancer (and a new cancer is found) or, patients who attend for follow up for benign disease (and a new cancer is found), the date the patient was referred to a specialist for further investigation and treatment should be used. If no referral is required, the date of the investigation that led to the suspicion of cancer should be used. For example, if a patient was having a mammogram for follow up of a previously diagnosed breast cancer, and a new breast cancer is picked up, an onward referral may not be necessary and the date of the mammogram should be used.</td>
</tr>
<tr>
<td>Cancer genetic clinic</td>
<td>Record the date the referral for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Self-referral to A&amp;E</td>
<td>Record the date the patient self presents to A&amp;E.</td>
</tr>
<tr>
<td>GP referral directly to hospital</td>
<td>Record the date the patient presents to hospital (A&amp;E or other) following referral by their GP (usually the same date as referral).</td>
</tr>
<tr>
<td>Previous GP referral but subsequently admitted to hospital</td>
<td>If the previous GP referral was made due to the same or similar symptoms that led to the patient presenting at A&amp;E, record the date the initial GP referral was received. If the previous referral made by the GP was due to different symptoms, record the patient as self-referral to A&amp;E or GP referral directly to hospital, whichever is appropriate.</td>
</tr>
<tr>
<td>Primary care clinician (dental)</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Referral from private healthcare</td>
<td>Record the date on which the patient referral from a private healthcare provider for the investigation and / or treatment of cancer was received by the NHS hospital.</td>
</tr>
<tr>
<td>Other</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Not recorded</td>
<td>If the exact date is not documented, record as 09/09/1900.</td>
</tr>
</tbody>
</table>

**Notes by Users:**
Hospital of Diagnosis

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

Definition: This denotes the hospital location in which the definitive diagnosis of breast cancer was first made. This may be the Breast Screening Service.

Field Name: HOSPDIAG
Field Type: Characters
Field Length: 5

Notes for Users: Required for national comparative analysis.

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

See data item ‘Date of Diagnosis’ described elsewhere for details of definitive diagnosis.

Codes and Values:
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

Notes by Users:
Source of Cancer Referral

Main Source of Data Item Standard: The National Cancer Datasets developed by the Cancer Networks supported by PHS from SEHD guidance issued 13 April 2005.

Definition: This denotes the route by which the patient was referred to the breast cancer team for investigation and/or treatment of breast cancer.

Field Name: MREFER
Field Type: Integer
Field Length: 2

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

A primary care clinician will usually be a general practitioner (GP) but may be any member of the primary care team e.g. practice nurse.

After attending for routine screening in a Screening Programme a patient may be referred for further investigation, 2 (screening service).

Some patients may be attending or referred to hospital for investigation or treatment of a condition unrelated to their cancer and a tumour is diagnosed (incidental finding), or may present at A&E before being referred on to the specialist team. These should be recorded as 14 (Secondary Care)

Patients may attend an outpatient cancer clinic as they are being followed up for benign disease or a previous cancer of the same site as diagnosed (4 review clinic) or because of a strong family history of cancer (15 Increased Risk Clinic).

13 (Other) includes following a domiciliary visit by a hospital clinician.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary Care Clinician (GP, Nurse practitioner)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Screening Service</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Secondary Care</td>
<td>Includes emergency admissions to A&amp;E</td>
</tr>
<tr>
<td>4</td>
<td>Review Clinic</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Increased Risk Clinic; Family History Clinic; Radiotherapy Exposure etc.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Referral from private healthcare</td>
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</tr>
<tr>
<td>13</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Consultant in Charge

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

Definition: This is the name of the consultant who is in overall charge of the patient's care/management. This will normally be the breast surgeon but for patients with metastatic disease at diagnosis it may be an oncologist.

Field Name: CONS
Field Type: Characters
Field Length: 20

Notes for Users: Required to assist local analysis.

The surname and forename of the consultant should be recorded to distinguish between consultants with common surnames.
NB: On the database, the consultant's name will be stored as a GMC number.

If the clinician's name is not recorded code as 9999.

If the patient is managed by a team rather than with a consultant in overall charge, record as Not applicable, 1010.

Notes by Users:
Date of First Clinic

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

Definition: The date on which a consultant clinician, (or one of his/her team), first sees a patient for investigation or management of breast cancer following referral from primary or secondary healthcare.

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

Notes for Users: Required to continue with NHS QIS standards.

This does not refer to assessment clinics within the screening service as these are covered by NHS QIS Breast Screening standards.

Screening patients should be recorded as Not applicable (10/10/1900).

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

Codes and Values: N/A

Notes by Users:
Section 3: Pre-treatment Investigations
Ultrasound Findings (Axilla) {Breast Cancer}

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

Definition: The findings from ultrasound examination of the axilla in a patient suspected of having breast cancer.

Field Name: ULTRA
Field Type: Characters
Field Length: 2

Notes for Users: Required for national comparative analysis.

An ultrasound scanner uses sound waves to scan an organ or area of the body. It does not use ionising radiation or a contrast agent.

Used to determine if ultrasound of the axilla is performed.

The ultrasound score may be based on a combination of breast and axillary ultrasound. Where breast and axilla ultrasound are reported separately it is the axilla suspicion score which should be recorded.

A score of U3 or above would warrant FNA/core biopsy of the axilla, as detailed within explanatory notes below.

If there are multiple investigations or reports, record the one with the highest score.

In the case of bilateral disease, record the side with the worst prognosis.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Normal</td>
<td>No requirement for FNA/biopsy of axilla</td>
</tr>
<tr>
<td>U2</td>
<td>Benign</td>
<td>Normal - No requirement for FNA/biopsy of axilla</td>
</tr>
<tr>
<td>U3</td>
<td>Indeterminate</td>
<td>Abnormal – should go on to axillary FNA/biopsy</td>
</tr>
<tr>
<td>U4</td>
<td>Suspicious</td>
<td>Abnormal – should go on to axillary FNA/biopsy</td>
</tr>
<tr>
<td>U5</td>
<td>Malignant</td>
<td>Abnormal – should go on to axillary FNA/biopsy</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Includes not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

Related Data Items:
Ultrasound Examination of Axilla {Breast Cancer}
Laterality {Cancer}

Notes by Users:
Nodal Cytology of Axilla Results

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

Definition: The appearance of the cells obtained by fine needle aspiration (FNA) or other cytological procedure.

Field Name: NODECYTOLOGY
Field Type: Integer
Field length: 2

Notes for Users: Required for national comparative analysis.

If more than one FNA or other cytological procedure is carried out on the lymph nodes record the most significant abnormality. If the procedure is repeated and the result is malignant, code as malignant.

In the case of bilateral disease, record the side with the worst prognosis.

NB: Screening patients should be included.

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-diagnostic</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Benign</td>
<td>Includes normal.</td>
</tr>
<tr>
<td>3</td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Suspicious</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Malignant Breast</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Malignant Other</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Malignant Not known</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):
Date Nodal Cytology of Axilla Performed

Notes by Users:
Date Nodal Cytology of Axilla Performed

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

Definition: The date nodal cytology of the axilla was performed.

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

Notes for Users: Required for national comparative analysis.

This should be before date of surgery.

If more than one FNA or other cytological procedure is carried out on the lymph nodes, record the date of the procedure with the most significant abnormality.

If no nodal cytology of the axilla is carried out, code as 10/10/1900 (Not applicable). If the exact date is not documented, record as 09/09/1900.

Related Data Item(s):
Nodal Cytology of Axilla Results

Notes by Users:
Histological Opinion (Breast Biopsy)

**Main Source of Data Item Standard:** The Royal College of Pathologists, Pathology Reporting for Breast Disease, January 2005.

**Definition:** The histological appearance as assessed by the pathologist in a breast core biopsy or vacuum assisted needle biopsy.

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

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

If more than one breast biopsy is performed, record the result of the procedure with the most significant abnormality.

Screening patients should be included.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1</td>
<td>Non-diagnostic</td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td>Benign</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>Atypia</td>
<td>Inc.lobular neoplasia/LCIS</td>
</tr>
<tr>
<td>B4</td>
<td>Suspicious</td>
<td></td>
</tr>
<tr>
<td>B5a</td>
<td>Malignant In-situ</td>
<td></td>
</tr>
<tr>
<td>B5b</td>
<td>Malignant Invasive</td>
<td></td>
</tr>
<tr>
<td>B5</td>
<td>Malignant Not assessable</td>
<td>If not possible to clarify whether invasive or non-invasive on biopsy.</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):**  
Date Breast Biopsy Performed

**Notes by Users:**
**Date Breast Biopsy Performed**

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

**Definition:** The date the core biopsy of the breast or vacuum-assisted needle biopsy of the breast was performed.

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

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

This should be before date of surgery.

If more than one breast biopsy is performed, record the date of the procedure with the most significant abnormality.

If no breast biopsy is carried out, code as 10/10/1900 (Not applicable).  
If the exact date is not documented, record as 09/09/1900.

**Related Data Item(s):**  
Histological Opinion (Breast Biopsy)

**Notes by Users:**
Histological Opinion (Nodal Biopsy)

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

Definition: The histological appearance as assessed by the pathologist in a nodal core biopsy or vacuum assisted needle biopsy of the axilla.

Field Name: NODEBIO
Field Type: Integer
Field length: 2

Notes for Users: Required for national comparative analysis

If more than one nodal core biopsy or vacuum assisted needle biopsy of the axilla is carried out, record the result of the procedure with the most significant abnormality.

Screening patients should be included.

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-diagnostic</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Benign</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Atypia</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Suspicious</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Malignant Breast</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Malignant Other, specify</td>
<td>e.g. Lymphoma</td>
</tr>
<tr>
<td>7</td>
<td>Malignant Not Known</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:
Date Nodal Biopsy Performed.

Notes by Users:
Date Nodal Biopsy Performed

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

**Definition:** The date the core biopsy of the axillary lymph nodes was performed.

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

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

This should be before date of surgery.

If more than one nodal core biopsy or vacuum assisted needle biopsy of the axilla is carried out, record the date of the procedure with the most significant abnormality.

If no nodal biopsy of the axilla is carried out, code as 10/10/1900 (Not applicable).  
If the exact date is not documented, record as 09/09/1900.

**Related Data Item(s):**  
Histological Opinion (Nodal Biopsy)

**Notes by Users:**
TNM Tumour Classification (Pre-operative) {Breast Cancer}


Definition: A record of the size and extent of the tumour of the breast as agreed at the multidisciplinary team (MDT) meeting according to TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

Field Name: cT
Field Type: Characters
Field Length: 4

Notes for Users: Required for QPI: 18 and for national survival analysis / national comparative analysis.

This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
</tr>
<tr>
<td>Tis</td>
<td>Carcinoma in situ (CIS)</td>
</tr>
<tr>
<td>TisA</td>
<td>Ductal Carcinoma in situ (DCIS)</td>
</tr>
<tr>
<td>TisB</td>
<td>Lobular Carcinoma in situ (LCIS)</td>
</tr>
<tr>
<td>TisC</td>
<td>Paget disease of the nipple not associated with invasive carcinoma and/or carcinoma in-situ (DCIS/ LCIS) in the underlying breast parenchyma. Carcinomas in the breast parenchyma associated with Paget disease are categorized based on the size and characteristics of the parenchymal disease, although the presence of Paget disease should still be noted.</td>
</tr>
<tr>
<td>T1</td>
<td>Tumour up to 2cm</td>
</tr>
<tr>
<td>T1mi</td>
<td>Microinvasion 0.1cm or less</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour &gt; 0.1cm but ≤ 0.5 cm</td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour &gt; 0.5 cm but ≤ 1 cm</td>
</tr>
<tr>
<td>T1c</td>
<td>Tumour &gt; 1 cm but ≤ 2 cm.</td>
</tr>
<tr>
<td>T2</td>
<td>Tumour &gt;2 cm but ≤5 cm</td>
</tr>
<tr>
<td>T3</td>
<td>Tumour &gt;5 cm</td>
</tr>
<tr>
<td>T4</td>
<td>Tumour of any size with direct extension to chest wall and/or to skin (ulceration or skin nodules)</td>
</tr>
<tr>
<td>T4a</td>
<td>Extension to chest wall (does not include pectoralis muscle invasion only).</td>
</tr>
<tr>
<td>T4b</td>
<td>Ulceration, ipsilateral satellite skin nodules, or skin oedema (including peau d’orange).</td>
</tr>
<tr>
<td>T4c</td>
<td>Both 4a and 4b above</td>
</tr>
<tr>
<td>T4d</td>
<td>Inflammatory carcinoma</td>
</tr>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

### Related Data Item(s):

TNM Nodal Classification (Pre-operative) {Breast Cancer}
TNM Metastasis Classification (Pre-operative) {Breast Cancer}

### Notes by Users:
TNM Nodal Classification (Pre-operative) {Breast Cancer}


**Definition:** The size and position of nodes in the axilla as agreed at the multidisciplinary team (MDT) meeting according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

**Notes for Users:** Required for QPI: 18 and for national survival analysis / national comparative analysis.

This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. **N.B. Pathological classification for this data item refers to those made from biopsies only.**

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.
<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph nodes metastasis</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis to movable ipsilateral Level I, II axillary lymph node(s)</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in ipsilateral Level I, II axillary lymph node(s) that are clinically fixed or matted, or in clinically detected* ipsilateral internal mammary lymph node(s) in the absence of clinically evident axillary lymph node metastasis.</td>
<td>Fixed nodal metastasis. * Detected by clinical examination or by imaging studies (excluding lymphoscintigraphy) and having characteristics highly suspicious for malignancy or a presumed pathological macrometastasis based on fine-needle aspiration biopsy with cytological examination.</td>
</tr>
<tr>
<td>N2a</td>
<td>Metastasis in axillary lymph node(s) fixed to one another (matted) or to other structures.</td>
<td></td>
</tr>
<tr>
<td>N2b</td>
<td>Metastasis only in clinically detected* internal mammary lymph node(s) and in the absence of clinically detected axillary lymph node metastasis.</td>
<td>* Detected by clinical examination or by imaging studies (excluding lymphoscintigraphy) and having characteristics highly suspicious for malignancy or a presumed pathological macrometastasis based on fine-needle aspiration biopsy with cytological examination.</td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in ipsilateral infraclavicular (Level III axillary) lymph node(s), with or without Level I, II axillary lymph node involvement, or in clinically detected* ipsilateral internal mammary lymph node(s) with clinically evident Level I, II axillary lymph node metastasis, or metastasis in ipsilateral supraclavicular lymph node(s), with or without axillary or internal mammary lymph node involvement.</td>
<td>Nodal metastasis above the clavicle. * Detected by clinical examination or by imaging studies (excluding lymphoscintigraphy) and having characteristics highly suspicious for malignancy or a presumed pathological macrometastasis based on fine-needle aspiration biopsy with cytological examination.</td>
</tr>
<tr>
<td>N3a</td>
<td>Metastasis in infraclavicular lymph node(s)</td>
<td></td>
</tr>
<tr>
<td>N3b</td>
<td>Metastasis in internal mammary and axillary lymph node(s)</td>
<td></td>
</tr>
<tr>
<td>N3c</td>
<td>Metastasis in supraclavicular lymph node(s)</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed)</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
TNM Metastasis Classification (Pre-operative) {Breast Cancer}


Definition: The extent of the spread of the disease outwith the breast and axilla as agreed at the multidisciplinary team (MDT) meeting 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 QPI(s): 6, 11, 18 and for national survival analysis.

This is a pre/non-operative classification as defined by the multidisciplinary team (MDT) meeting, based on best knowledge. This may be at any MDT up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as ‘not recorded’.

Includes patients discovered to have metastatic disease during the initial pathway or treatment normally within three months of diagnosis.

When there is no suspicion of metastasis record as M0.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No evidence of distant metastasis</td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis present</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):
TNM Tumour Classification (Pre-operative) {Breast Cancer}
TNM Nodal Classification (Pre-operative) {Breast Cancer}

Notes by Users:
Date of Diagnosis {Breast Cancer}

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

Definition: The date of diagnosis is the date on which there was confirmation of the diagnosis of breast cancer whether by histology, cytology or clinical 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 the procedure was performed, not the date the report was issued.

If multiple histological or cytological findings have been carried out, the date of the first procedure that confirmed a positive diagnosis of breast cancer is taken.

If no histological or cytological procedures were undertaken, the date of diagnosis will be the date of any imaging procedure performed that confirmed a diagnosis of breast cancer, otherwise the date will be based on clinical findings and will be the first date upon which the clinician concludes a diagnosis of breast cancer.

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

Notes by Users:
**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 national survival analysis and national comparative analysis.

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.

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.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</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>2</td>
<td>Clinical investigation</td>
<td>The diagnosis is supported by investigations such as x-ray, CT scan, ultrasound etc.</td>
</tr>
<tr>
<td>3</td>
<td>Exploratory surgery/endoscopy/autopsy</td>
<td>The tumour has been visualised or palpated but there is no confirmatory microscopic evidence</td>
</tr>
<tr>
<td></td>
<td>(without concurrent or previous histology)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Tumour specific markers (biochemical/immunological tests)</td>
<td>The diagnosis is supported by specific tests</td>
</tr>
<tr>
<td>5</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>6</td>
<td>Histology of metastasis</td>
<td>The diagnosis is based on the histology of a metastasis (secondary deposit), e.g. resulting from a lymph node biopsy</td>
</tr>
<tr>
<td>7</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>8</td>
<td>Autopsy (with histology)</td>
<td>The diagnosis is based on the findings at autopsy supported by concurrent or previous histology.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Notes by Users:**

*Data Definitions for the National Minimum Core Dataset for Breast Cancer.*
*Developed by ISD Scotland, 2013*
Laterality {Cancer}


Definition: Side or laterality (i.e. left or right) of the body in which the tumour is located.

Field Name: SIDE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 19

Clinically relevant data item which can influence treatment decisions and prognosis. Required for sub-group analysis as incidence and survival may be associated with laterality.

If there are bilateral tumours at the time of initial diagnosis, the subsequent data items relate to the tumour with the worst prognosis e.g. highest tumour stage as classified according to the TNM Classification.

In case of unilateral axillary lymphadenopathy but no detectable primary, then laterality of the primary can be assumed to be the same side as that of the lymphadenopathy providing the pathology is consistent with a breast primary.

For patients who present with metastatic disease without identification of the breast primary, record as ‘Not recorded’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Left</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Bilateral</td>
<td>At the time of the initial diagnosis</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Ultrasound Examination of Axilla Results {Breast Cancer}
Total Number of Lymph Nodes Involved {Cancer}

Notes by Users:
Date Discussed by Care Team

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

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

**Definition:** This denotes the date of the first hospital multidisciplinary care team meeting to discuss the management of the patient.

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

**Notes for Users:** Required for national comparative analysis

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.

Audit staff should refer to the relevant MDT guideline for their region for clarity on the membership required to constitute an MDT if required.

The first hospital MDT meeting date will be recorded.

**NB:** Where screening patients have been discussed initially at a screening centre MDT meeting, then subsequently discussed at a hospital MDT meeting, record the latter. If the patient has only been discussed at the screening centre MDT, record as Not applicable (10/10/1900).

If the patient was not discussed at the MDT, record as Not applicable (10/10/1900).

If the date of the MDT meeting is unknown record as (09/09/1900).

**Related Data Item(s):**

**Notes by Users:**
COVID 19 Impact

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

**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>
Type of First Cancer Treatment

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

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

Field Name: FIRSTTREATMODE
Field Type: Integer.
Field Length: 2

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

For any particular modality it is the first treatment and not specifically the definitive treatment i.e. this does not include purely diagnostic biopsies such as incisional biopsies, needle biopsies or core biopsies. Some biopsies, such as excisional biopsies may be included as these may have some therapeutic benefits i.e. the removal of the tumour.

Patients receiving peri-operative endocrine treatment (or placebo) as part of current trials or for logistical reasons should have their first treatment recorded as hormone therapy but are not subject to later exclusions based on neo-adjuvant treatment. Record patients as having 'no active treatment' if a decision was taken not to give the patient treatment as part of their primary therapy (some patients that have 'no active treatment' may subsequently have treatment when symptoms develop but this is not primary therapy). No active treatment includes watchful waiting and supportive care but not palliative chemotherapy and/or radiotherapy. Radiotherapy includes teletherapy (external beam radiotherapy) and brachytherapy.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Hormone therapy</td>
<td>e.g. Letrozole</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Includes peri-operative endocrine treatment</td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>e.g. Herceptin</td>
</tr>
<tr>
<td>15</td>
<td>Biological therapy</td>
<td>e.g. Herceptin</td>
</tr>
<tr>
<td>7</td>
<td>No active treatment</td>
<td>e.g. Bisphosphonates</td>
</tr>
<tr>
<td></td>
<td>(Supportive care)</td>
<td>May include terminal care patients.</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td>e.g. Large Volume Biopsy</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>
<tr>
<td>14</td>
<td>Patient died before treatment</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 Audit Cancer Datasets developed by the regional Cancer Networks supported by PHS.

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

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

Notes for Users: Required for national survival analysis.

This field should be recorded for all patients including those with 'no active treatment' (see below).

If type of first cancer treatment is 'no active treatment', 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.

If hormone therapy is the first treatment, it is not always clearly documented when hormone therapy starts. In the patient discharge or clinic letter the clinician may ask the GP to prescribe hormone therapy, in this case, record the date as two days from the day the discharge letter or clinic letter was typed.

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

If the patient died before treatment or the patient refused treatment, record as 10/10/1900.

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

Related Data Item(s):
Type of First Cancer Treatment

Notes by Users:
Section 4: Surgery
First Definitive Surgery Performed to Breast {Breast Cancer}

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

Definition: This is the first operation performed on the patient for primary treatment of the breast cancer.

Field Name: FSURGBRST  
Field Type: Integer  
Field Length: 2

Notes for Users: Required for QPI: 13

This field should only be completed if the patient has undergone more than one operation for the primary treatment of the breast cancer. Where the patient only undergoes one procedure, code as 96 (not applicable) and enter this procedure in ‘Final (or only) Definitive Surgery Performed to Breast’.

If the definitive diagnosis is made clinically or by imaging techniques only (i.e. no surgery is undertaken), code 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>11</td>
<td>Localising or excision biopsy</td>
<td>Removal of the tumour at biopsy without requirement for further surgery.</td>
</tr>
<tr>
<td>12</td>
<td>Conservation surgery</td>
<td>Removal of tumour with surrounding normal tissue without the removal of the whole breast. Wide local excision and re-excision are included in this category as are segmentectomy and quadrantectomy.</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Therapeutic Mammoplasty</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>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Final Definitive (or Only) Surgery Performed to Breast or Axilla {Breast Cancer}

Notes by Users:
Final Definitive (or Only) Surgery Performed to Breast (Breast Cancer)

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

**Definition:** This is the final (or only) operation performed on the patient for primary treatment of the breast cancer.

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

**Notes for Users:** Required for QPI(s): 6, 10, 13.

If the definitive diagnosis is made clinically or by imaging techniques only (i.e. no surgery is undertaken), code 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>11</td>
<td>Localising or excision biopsy</td>
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<tr>
<td>12</td>
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<td>Removal of tumour with surrounding normal tissue without the removal of the whole breast. Wide local excision and re-excision are included in this category as are segmentectomy and quadrantectomy.</td>
</tr>
<tr>
<td>4</td>
<td>Mastectomy</td>
<td>Removal of the breast.</td>
</tr>
<tr>
<td>7</td>
<td>Mastectomy + Immediate Reconstruction</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Axillary surgery alone</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Therapeutic Mammoplasty</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>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date of Final Definitive (or Only) Surgery Performed to Breast or Axilla (Breast Cancer)

**Notes by Users:**
Reason for Mastectomy

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

**Definition:** The reason why a mastectomy was performed.

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

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

Only the most dominant reason should be recorded.

If no mastectomy is undertaken, code 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>Size (tumour relative to breast)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Multifocal Disease</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Central Position</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Patient Choice</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>High Risk Patient</td>
<td>Patients who have tested positive for BRCA1 or BRCA2 genes, or as agreed by MDT</td>
</tr>
<tr>
<td>6</td>
<td>Widespread Ductal Carcinoma In-situ</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Co-morbidity</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Patients who have had previous</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other, specify</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:**

**Notes by Users:**
Date of Mastectomy Decision

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

Definition: This is the date on which mastectomy was agreed as the treatment plan between the patient and clinician.

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

Notes for Users: Required for QPI: 6ii

This is the date that the mastectomy is agreed as the treatment option by consultation between the patient and the breast surgeon (or delegate). This usually follows MDT discussion.

For patients not included in QPI 6(ii), record 10/10/1900.

i.e.
Patients having neoadjuvant chemotherapy
Patients having mastectomy without immediate reconstruction
Patients not having mastectomy
Males
Patients with M1 disease.

If a patient is excluded from QPI 6ii as detailed above but the date of mastectomy decision is readily available, it can be recorded for local use.

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

If no mastectomy is carried out, code as 10/10/1900 (Not applicable).

Related Data Item(s):
Date of Mastectomy and Immediate Reconstruction

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

Definition: This is the date of the mastectomy and immediate reconstruction.

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

Notes for Users: Required for QPI: 6

This is the date that the mastectomy and immediate reconstruction was performed.

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

If no mastectomy and immediate reconstruction is carried out, code as 10/10/1900 (Not applicable).
Type of Immediate Breast Reconstruction

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

Definition: This is the surgical procedure to reconstruct the breast, performed at the same time as a mastectomy.

Field Name: TYPERECON
Field Type: Integer
Field Length: 2


The three main types of reconstruction are categorised as follows:

Implant only reconstruction (with or without mesh)
A mesh or an acellular dermal matrix (ADM) may be used to cover the implant e.g. TiLOOP® is a mesh structure commonly used in pre-pectoral implant reconstructions

Flap reconstruction: where the patient’s own tissue is used to form the reconstructed breast
Common types of flap reconstruction:
LD (latissimus dorsi) flap
DIEP (deep inferior epigastric perforator) flap
TRAM (transverse rectus abdominis muscle) flap (free or pedicled)

A combination of the above

If the patient does not undergo breast reconstruction, code 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>Implant with mesh/ADM (prepectoral)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Implant with mesh/ADM (subpectoral)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Expander/Implant alone NOS</td>
<td>NOS: not otherwise specified</td>
</tr>
<tr>
<td>4</td>
<td>LD flap (no implant)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>LD flap (with implant)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Free abdominal flap</td>
<td>DIEP flap or TRAM flap</td>
</tr>
<tr>
<td>7</td>
<td>Other free flap</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Other combination: flap with implant NOS</td>
<td>NOS: not otherwise specified</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):
Date of First Definitive Breast Surgery {Breast Cancer}

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

Definition: This is the date of the first operative procedure to the breast.

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

Notes for Users: Required for national comparative analysis.

This is the first operative procedure with the intention of removing the whole tumour. It may be the same procedure as the final (or only) definitive surgery as described elsewhere. If the patient has axillary surgery alone this is the date which should be recorded

Procedures such as needle core biopsy which are undertaken to establish a diagnosis in preparation for later breast surgery are not classed as definitive surgery.

Excision or localising biopsies which both establish diagnosis, and with the intention of removing the whole tumour, are classed as definitive surgery.

This would still be the case where the margin is close or positive as the main bulk of the tumour has been removed.

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

If no surgical procedure is carried out, code as 10/10/1900 (Not applicable).

Related Data Item(s):
Type of Hormonal Therapy {Breast Cancer}
Type of Chemotherapy {Cancer} (1-2)

Notes by Users:
Date of Final Definitive (or Only) Surgery Performed to Breast or Axilla {Breast Cancer}

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

**Definition:** This is the date of the final definitive operative procedure to the breast or axilla.

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

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

This is the final (or only) operative procedure with the intention of removing all of the tumour. It may be the same procedure as the first (or only) definitive surgery as described elsewhere.

Some patients undergo axillary surgery at a later date than the surgery performed to the breast. In these cases the date of the axillary surgery should be recorded.

Procedures such as needle core biopsy which are undertaken to establish a diagnosis in preparation of later breast surgery is not classed as definitive surgery.

Excision or localising biopsies, which both establish diagnosis and with the intention of removing the whole tumour, are classed as definitive surgery if no further surgery is performed.

This would still be the case where the margin is close or positive as the main bulk of the tumour has been removed.

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

If no surgical procedure is carried out, code as 10/10/1900 (Not applicable).

**Related Data Items:**  
Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer}  
Final Axillary Surgery {Breast Cancer}

**Notes by Users:**
First Axillary Surgery {Breast Cancer}

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

**Definition:** This indicates the extent of the first surgery carried out in the axilla to remove a number of axillary lymph nodes to determine if the disease has spread outwith the breast.

**Field Name:** FIRSTAXIL  
**Field Type:** Characters  
**Field Length:** 2

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

Types of axillary surgery are:
- Sample – at least four individual nodes should be picked out from the lower axillary fat. This includes blue dye only guided sample.
- Clearance – a block dissection of the axillary contents.
- Sentinel node biopsy – a biopsy of first node of tumour spread along the chain from the breast to axilla. This combines the use of isotope colloid and blue dye to localise the sentinel node. There is not a specific limit to the number of nodes.

If no axillary surgery is undertaken code as 96 (Not applicable).

If the sentinel node or sample is found to be positive an axillary clearance may be performed. This may occur at the same operation and if so, should be recorded as: First axillary surgery = SNLB/Sample: Final axillary surgery = Axillary Clearance.

**NB:** Changes to codes and values between V3.0 and V3.1 to take effect for patients diagnosed from 01/01/2017. (Refer to Revision History)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Sub-values</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sample</td>
<td></td>
<td>This would include a blue dye only sample.</td>
</tr>
<tr>
<td>2</td>
<td>Clearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sentinel node biopsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A</td>
<td>Combined dye/isotope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3B</td>
<td>Blue dye alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3C</td>
<td>Isotope alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3D</td>
<td>Other</td>
<td></td>
<td>Without either blue die or isotope.</td>
</tr>
<tr>
<td>4</td>
<td>Failed SNLB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4A</td>
<td>Proceeding to Sample</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4B</td>
<td>Leading to clearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Sub-values</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Targeted Axillary Dissection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Final Axillary Surgery {Breast Cancer}

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

Definition: This indicates the extent of the final surgery carried out in the axilla to remove a number of axillary lymph nodes to determine if the disease has spread outwith the breast.

Field Name: FINALAXIL
Field Type: Integer
Field Length: 2

Notes for Users: Required for national comparative analysis.

Types of axillary surgery are:
- Sample – at least four individual nodes should be picked out from the lower axillary fat. This includes blue dye only guided sample.
- Clearance – a block dissection of the axillary contents.
- Sentinel node biopsy – a biopsy of first node of tumour spread along the chain from the breast to axilla. This combines the use of isotope colloid and blue dye to localise the sentinel node. There is not a specific limit to the number of nodes.

If no axillary surgery is undertaken code 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>Sample.</td>
<td>This would include a blue dye only sample.</td>
</tr>
<tr>
<td>2</td>
<td>Clearance</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sentinel Node Biopsy</td>
<td>Sentinel node biopsy can only be recorded when isotope colloid and blue dye have been used to localise the sentinel node</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Targeted Axillary Dissection</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused</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):
Date of Final (or Only) Surgery Performed to Breast or Axilla {Breast Cancer}

Notes by Users:
Section 5: Pathology Details
Type of Tumour {Breast Cancer}

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

Definition: This denotes the classification of tumour based on tissue or origin in the breast.

Field Name: TUMOUR
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 9, 10, 13, 18

This determines whether the tumour is invasive or in situ (these are lesions which show cytology of malignancy but are contained within the ductal and lobular structures). In tumours with both invasive and non-invasive components record the invasive part.

If the definitive diagnosis is made clinically or by imaging techniques only (i.e. no histology is available), code as 96 (Not applicable). On occasions a biopsy specimen and a specimen from definitive surgery may give differing tumour types. In this case code as the definitive type as stated by the pathologist in the final specimen report.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>DCIS (non-invasive)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>‘Ductal’/no specific type (NST)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Lobular carcinoma</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Medullary carcinoma</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Mucinous carcinoma</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Tubular carcinoma</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Mixed (invasive) carcinoma</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Other invasive carcinoma, specify</td>
<td>Includes Spindle Cell Carcinomas, Metaplastic, Microinvasive Tumours.</td>
</tr>
<tr>
<td>19</td>
<td>LCIS only (non-invasive)</td>
<td>This may be referred to as Lobular In-situ Neoplasia (LISN) but if this relates to Atypical Lobular Hyperplasia (ALH) this should not be included.</td>
</tr>
<tr>
<td>20</td>
<td>Paget’s (non-invasive)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Other non-invasive</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Pleomorphic carcinoma in-situ</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Malignant cells on cytology, not otherwise specified</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Occult invasive, with positive nodes on histology</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):
Tumour Grade {Breast Cancer}

Notes by Users:
Tumour Grade {Breast Cancer}

**Main Source of Data Item Standard:** Derived from Pathology Reporting for Breast Disease, NHSBSP Publication No 58, January 2005.

**Definition:** The pathological assessment of tumour differentiation used as a prognostic indicator.

**Field Name:** TGRADE  
**Field Type:** Integer  
**Field length:** 4

**Notes for Users:** Required for QPI: 10 and for national survival analysis / national comparative analysis.

For DCIS the pathology report should state grade as high, intermediate or low. If there are mixed statements (e.g. low to intermediate grade) record the worst situation (intermediate in this example).

In specimens with both invasive and non-invasive tumour record only the grade for the invasive component.

Record lobular carcinoma in-situ (LCIS) or Paget’s disease as 96 (Not applicable)

If the specimens from biopsy and definitive surgery differ, record the excision grade. However, if the tumour grade is downgraded by neo-adjuvant therapy then the biopsy grade should be recorded as this is the untreated status

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Grade I (invasive)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Grade II (invasive)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Grade III (invasive)</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Low grade Ductal Carcinoma In-Situ (DCIS)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Intermediate grade Ductal Carcinoma In-Situ (DCIS)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>High-grade Ductal Carcinoma In-Situ (DCIS)</td>
<td></td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
<td>Grade cannot be determined, e.g. specimen too poorly preserved or too small. Includes microinvasion/occult tumours</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery performed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Type of Tumour {Breast Cancer}

**Notes by Users:**
**Distance from Final Radial Excision Margin (Breast Cancer)**

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

**Definition:** This denotes the distance of the invasive or ductal carcinoma in situ (DCIS) component of the tumour from the nearest resection margin.

**Field Name:** DISTEX  
**Field Type:** Integer  
**Field length:** 4

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

Radial margins may also be known as Superior, Medial, Lateral or Inferior margins.

This will be confirmed by microscopic examination and the result can be found on the pathology report relating to the specimen from the final definitive (or only) surgery performed to breast as described elsewhere.

Record the distance to the closest margin regardless of whether this is invasive or in-situ and this is in relation to any radial margin.

Lobular carcinoma in situ (LCIS) is a multifocal disease which is not localised therefore cases of LCIS only should be excluded from the margin fields and recorded as not applicable. Ignore incidental foci of LCIS present in invasive/DCIS cases. This exclusion does not apply to **pleomorphic** lobular carcinoma in-situ which should be considered as similar to DCIS.

Where there is no residual disease after neo-adjuvant chemotherapy or endocrine therapy, record as ‘8888’ ‘Not Assessable’.

This is the final excision margin. If no distance is given or if a second procedure is carried out to achieve clear margins i.e. cavity shavings or completion mastectomy, record as code 4 if no residual disease. It is the FINAL excision margins and therefore this includes any cavity shaving whether done at same operation or later. Sometimes a measurement will be given which can be added to original margin of clearance but often it is only stated as “clear” in which case it should be recorded as code 4. Code 4 should only be used if there was no measurement and it was only stated as clear. Code 4 confirms the margins are clear and would be compliant with previous QIS standard.

If the patient is not treated by surgery, code as 96 (not applicable).
Codes and Values:
The distance is measured in millimetres.

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;1mm</td>
</tr>
<tr>
<td>2</td>
<td>1-5mm</td>
</tr>
<tr>
<td>3</td>
<td>&gt;5mm</td>
</tr>
<tr>
<td>4</td>
<td>Margins confirmed as clear, Cavity Shavings, Or Re-excision/completion mastectomy – no residual disease</td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Final Definitive (or Only) Surgery Performed to Breast {Breast Cancer}
Type of Tumour {Breast Cancer}

Notes by Users:
Maximum Invasive Pathological Diameter {Breast Cancer}

**Main Source of Data Item Standard:** Derived from Pathology Reporting for Breast Disease, NHSBSP Publication No 58, January 2005.

**Definition:** The size of the invasive tumour as measured in millimetres by the pathologist on microscopy.

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

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

In cases of multifocal disease, the size of the largest invasive component should be recorded.

If the patient does not undergo excision of breast lesion, code as ‘1010’ (not applicable).

Where there is only in-situ disease found at surgery, code as ‘1010’ (not applicable).

If the measurement is not recorded code as 9999.

If the patient has had neoadjuvant chemotherapy or endocrine therapy and there is no residual tumour found at time of definitive surgery, record as ‘8888’ (Not assessable).

If the tumour is excised in more than one operation, an amended pathology report may be issued. This may be reported at the MDT meeting. If the invasive tumour size remains unclear, advice should be sought from the pathologist.

In the case of occult tumours where the primary lesion is not found within the breast, record as ‘8888’, ‘Not Assessable’.

In cases of multifocal +ve disease, i.e. ≤1mm, record as ‘8888’ (Not assessable).

If this value is expressed with a decimal point in the pathology report then adopt the following rounding convention:

If the number after the decimal place is five or more, increase the value by one i.e. 27.5 becomes 28. Otherwise drop the number after the decimal point i.e. 27.4 becomes 27.

**Related Data Item(s):**  
Maximum Microscopic Whole Tumour Diameter {Cancer}
Maximum Microscopic Whole Tumour Diameter {Cancer}

**Common name:** Whole Tumour Size

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

**Definition:** The maximum microscopic size of the tumour as measured in millimetres (mm). This includes the invasive and DCIS component.

**Field Name:** WHOLEDIAM  
**Field Type:** Integer  
**Field length:** 4

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

- If the measurement is not recorded code as 9999.
- If the definitive diagnosis is made clinically or by imaging techniques only (i.e. no histology is available), code as 1010 (not applicable).
- If the patient has had neoadjuvant chemotherapy or endocrine therapy and there is no residual tumour found at time of definitive surgery, record as ‘8888’ ‘Not assessable’.
- If the tumour is excised in more than one operation, an amended pathology report may be issued. This may be reported at the MDT meeting. If the whole tumour size remains unclear, advice should be sought from the pathologist.

**IT systems should ensure that the unit of measurement for values is always clear to users, in whatever medium values are recorded.**

The diameter of the specimen will be described in the pathology report and should be recorded in millimetres (mm).

- If this value is expressed with a decimal point in the pathology report then adopt the following rounding convention:
  - If the number after the decimal place is five or more, increase the value by one i.e. 27.5 becomes 28. Otherwise drop the number after the decimal point i.e. 27.4 becomes 27.

**Related Data Item(s):**  
Maximum Invasive Pathological Diameter {Breast Cancer}

**Notes by Users:**
Final Total Number of Lymph Nodes Examined Microscopically {Cancer}

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 after final surgery.

Field Name: EXNODES
Field Type: Integer
Field length: 4

Notes for Users: Required to continue with NHS QIS standards.

Where there is more than one operation to the axilla on the same side, nodes from each should be added together.

If the total number examined is not known or not recorded, code as 9999.

If no surgery is performed code as not applicable, 1010.

Related Data Items: Laterality

Notes by Users:
Total Number of Lymph Nodes Involved {Cancer}

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

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

Field Name: INVNODES
Field Type: Integer
Field length: 4

Notes for Users: Required for QPI(s): 10, 17

Where there is more than one operation to the axilla on the same side, nodes from each should be added together.

Micrometastases (> 0.2 mm to ≤2 mm) count as positive nodes, isolated tumour cells (≤ 0.2 mm) are regarded as negative.

If nodes are positive but the number is unknown, code as 7777.
If the total number examined is not known or not recorded, code as 9999.
If no surgery is performed code as not applicable, 1010.

Related Data Item(s):
Laterality

Notes by Users:
**Tumour Extent {Breast Cancer}**

**Main Source of Data Item Standard:** The Royal College of Pathologists, Pathology Reporting for Breast Disease, January 2005.

**Definition:** An indicator of multiple separate foci of invasive tumour within the specimen.

**Field Name:** EXTENT  
**Field Type:** Integer  
**Field length:** 4

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

If the patient does not undergo excision of breast lesion, code as 96 (not applicable).

Classification of multiple foci should be based on the multidisciplinary team meeting (MDM) decision.

Cases of LCIS only should be recorded as not applicable, 96.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Localised</td>
<td>Includes DCIS</td>
</tr>
<tr>
<td>2</td>
<td>Multiple invasive foci</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Multiple DCIS foci*</td>
<td>Not yet covered by RCPath guidelines</td>
</tr>
<tr>
<td>4</td>
<td>Multiple foci includes Invasive and DCIS</td>
<td>Not yet covered by RCPath guidelines</td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

*NB: Definitions for multiple foci of DCIS have yet to be agreed nationally.

**Notes by Users:**
Oestrogen Receptor (ER) Status {Breast Cancer}

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

Definition: ER status denotes the results of an immunohistochemical staining technique used to determine the amount of oestrogen receptor sites in the tumour.

Field Name: ERSTATUS
Field Type: Integer
Field length: 4

Notes for Users: Required for QPI(s): 10, 11, 14, 17, 18

The greater the value the greater the response is likely to be to an anti-oestrogen e.g. Tamoxifen.

The standard scoring system across Scotland is the Allred system.

ER status of multifocal +ve disease may be not assessable.

Where there is a discrepancy between core and surgery, (if both specimens have been tested) the core ER status should be used. If in doubt, please record as agreed at the multidisciplinary meeting (MDT).

Cases of LCIS only should be recorded as not applicable, 96.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Negative (0-2)</td>
</tr>
<tr>
<td>3</td>
<td>Low Positive (3-5)</td>
</tr>
<tr>
<td>1</td>
<td>High Positive (6-8)</td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
**Progesterone Receptor (PR) Status (Breast Cancer)**

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

**Definition:** The results of immunohistochemical staining for Progestogen Receptor (PR) status for invasive tumours only.

**Field Name:** PRSTATUS  
**Field Type:** Integer  
**Field length:** 4

**Notes for Users:** Required for QPI(s): 11, 14, 18

The greater the value the greater the response is likely to be to an anti-oestrogen e.g. Tamoxifen.

PR positivity represents a degree of hormone sensitivity. This is most important in ER negative patients as it still suggests a possible response to hormone therapy.

PR status of microinvasive disease may be not assessable.

The standard scoring system across Scotland is the Allred system.

Where there is a discrepancy between core and surgery, (if both specimens have been tested) the core PR status should be used. If in doubt, please record as agreed at the multidisciplinary meeting (MDT).

Cases of DCIS and LCIS only should be recorded as not applicable, 96. If units are not testing PR where patients are ER positive, record as not known, 99.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Negative (0-2)</td>
</tr>
<tr>
<td>3</td>
<td>Low Positive (3-5)</td>
</tr>
<tr>
<td>1</td>
<td>High Positive (6-8)</td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Notes by Users:**
Date of HER2 Reporting

**Definition:** Date that HER2 test result (as detected by immunohistochemistry (IHC) and/or FISH analysis) was reported by pathology.

**Field Name:** HER2REPORT  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

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

The date which the HER2 test was reported should be recorded (as opposed to date of biopsy/surgical resection).

In instances where the pathologist provides a verbal report to the MDT, ahead of formal report issue, the date of verbal report (i.e. MDT date) should be recorded.

If the patient did not have HER2 status tested, record as Not applicable (10/10/1900).

If the date of reporting is unknown record as (09/09/1900).
Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Breast Cancer}

Common name: Her2 Status

Main Source of Data Item Standard: The Royal College of Pathologists, Pathology Reporting for Breast Disease, January 2005.

Definition: The measurement of human epidermal growth factor receptor-2 (HER2) as detected by immunohistochemistry (IHC) and/or FISH analysis i.e. the final conclusion for invasive tumours only.

Field Name: HER2STATUS
Field Type: Characters
Field length: 4

Notes for Users: Required for QPI(s): 10, 11, 14, 17, 18

If multifocal and the results differ between tumours, record the most positive score.

HER2 status should be recorded for invasive tumours only.

Cases of DCIS and LCIS only 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>2</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Inconclusive</td>
<td>Patients with an inconclusive FISH result.</td>
</tr>
<tr>
<td>1</td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. DCIS, Microinvasion</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>e.g. where a 2+ (IHC) result is obtained but no FISH test is carried out.</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Human Epidermal Growth Factor Receptor-2 (HER2) Status Available at Pre-treatment MDT {Breast Cancer}

Notes by Users:
**Lymphovascular Invasion (Breast Cancer)**

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

**Definition:** A record of whether lymphovascular invasion was present in the tumour specimen.

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

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

For cases of DCIS, lymphatic vascular invasion should be recorded as 96 (not applicable).

If the patient does not undergo excision of breast lesion, code 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>Yes</td>
<td></td>
</tr>
<tr>
<td>2</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 Item(s):**

**Notes by Users:**
Pathological Complete Response

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

Definition: A record of whether pathological complete response has been achieved in response to chemotherapy.

Field Name: PATHRESP
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 18

Pathological complete response can be defined as ypT0/is/ypN0 (absence of invasive cancer in breast and in axillary lymph nodes, irrespective of remaining DCIS in the primary tumour). Both tumour and nodal status should be documented.

If the patient has not undergone chemotherapy, code 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>Yes</td>
<td>ypT0 or ypTis and ypN0</td>
</tr>
<tr>
<td>2</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>
Section 6: Radiotherapy
Location Code {Radiotherapy Treatment}

**Common Name(s):** Location


**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:** HOSPRADIO
**Field Type:** Characters
**Field Length:** 5

**Notes for Users:** Required for regional/national analysis

This is the hospital in which the patient received the majority of their radiotherapy treatment.

Each location has a location code, which is maintained jointly by PHS and 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 PHSis 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/)

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 radiotherapy has not been performed or the patient has refused radiotherapy, record as Not applicable, X1010.

**Related Data Item(s):**
Radiotherapy Course Type (1-2)

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

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

Field Name: RADIO
RADIO2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI(s): 10, 19

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 ‘10’ and recorded additionally in Systemic Anti-Cancer Therapy under code ‘10’.

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>It is given after potentially curative surgery or chemotherapy.</td>
</tr>
<tr>
<td>2</td>
<td>Radical</td>
<td>It is primarily treatment and is given with curative intent.</td>
</tr>
<tr>
<td>3</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
<tr>
<td>7</td>
<td>Intraoperative Radiation Therapy (IORT)</td>
<td>Radiation therapy delivered immediately after surgical removal of cancer.</td>
</tr>
<tr>
<td>10</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient Refused Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. No external bean radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Treatment Started {Cancer} (Radiotherapy) 1-2
Site of External Beam Radiotherapy {Breast Cancer} (1-5)

Notes by Users:
Site of External Beam Radiotherapy {Breast Cancer} (1-5)

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

**Definition:** The part(s) of the body that receive radiotherapy for breast cancer and may include other sites out-with the breast.

**Field Name:** RADSITE1
  
  RADSITE2
  
  RADSITE3
  
  RADSITE4
  
  RADSITE5

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

**Notes for Users:** Required for national comparative analysis. Radiotherapy sites can include breast (after a wide local excision), chest wall (after mastectomy) and sometimes one or more of the ipsilateral lymphatic areas (supraclavicular fossa, axilla, internal mammary chain). Less commonly, one of the above lymphatic areas may be irradiated without irradiating the breast or chest wall. In some situations a ‘boost’ dose of radiotherapy is given to the tumour bed after conservation surgery.

IT systems should allow for the recording of multiple sites of external beam radiotherapy. Radiotherapy fields refer to the area of the body exposed to radiation. There may be more than one field if targeting the tumour from different angles.

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.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Breast</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Chest wall</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Axilla</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Supraclavicular fossa</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Boost</td>
<td>Dose of external beam radiotherapy given at the end of the primary external beam radiotherapy</td>
</tr>
<tr>
<td>3</td>
<td>Internal mammary chain</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No External beam radiotherapy given</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not recorded</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

Laterality {Cancer}
Radiotherapy Course Type (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 PHS.

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 national comparative analysis

This is the first fraction of a course of external beam radiotherapy or brachytherapy.

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

If the date radiotherapy started is unknown, record as 09/09/1900.

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.

Related Data Item(s):
Radiotherapy Course Type (1-2)

Notes by Users:
Deep Inspiratory Breath Hold (DIBH) Radiotherapy

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

Definition: A record of whether or not the patient received Deep Inspiratory Breath Hold (DIBH) Radiotherapy

Field Name: DIBH
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 19

Deep Inspiratory Breath Hold (DIBH) is a specialised technique of delivering radiotherapy while the patient holds their breath. This can move the heart away from the breast/chest wall therefore lowering the risk of damage to the heart.

This should also be recorded under Radiotherapy Course Type as code 1, Adjuvant.

For cases of bilateral breast cancer DIBH would be included on both sides.

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>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient Refused DIBH Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Partial Breast Irradiation (PBI)

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

Definition: A record of whether or not the patient received partial breast irradiation.

Field Name: PBI
Field Type: Integer
Field length:2

Notes for Users: Required for national comparative analysis.

Partial Breast Irradiation (PBI) is an alternative radiotherapy technique that involves treating a portion of the breast rather than the whole breast therefore reducing unnecessary exposure to the surrounding tissue.

This should also be recorded under Radiotherapy Course Type as code 1, Adjuvant.

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>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient Refused PBI</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Section 7: Systemic Therapy
Location Code {SACT Treatment}

Common Name(s): Location


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: HOSPSACT
Field Type: Characters
Field Length: 5

Notes for Users: Required for regional/national analysis

This is the hospital in which the patient received the majority of their SACT treatment.

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). 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 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.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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 SACT has not been performed or the patient has refused SACT, record as Not applicable, X1010.

Related Data Item(s):
Type of Hormonal Therapy (Breast Cancer)

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

Definition: Hormonal therapy is the use of hormones to treat breast cancer. Hormones are ‘chemical messengers’ released by the organs and dispersed by the blood to produce effects on target organs e.g. oestrogens.

Field Name: HORMON
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 10, 17

Some forms of breast cancer depend on oestrogens for continued growth. The use of hormonal therapy can reduce circulating concentrations of oestrogens, or antagonise the effects of oestrogen on the tumour. Hormonal therapy can be given in the form of drugs (anti oestrogens e.g. Tamoxifen, progestogens e.g. Methoxy progesterone or aromatase inhibitors e.g. Letrozole) or ovarian ablation/suppression (either by radiotherapy, surgery or drug therapy).

Type of hormonal therapy relates to the treatment intent as below.

Patients may have hormone therapy both before and after surgery. These patients should be recorded under neo-adjuvant Type.

Some patients may receive a short course of treatment for logistical or research reasons. These should be classified as peri-operative i.e.

If treatment is less than six weeks then record as peri-operative.
If treatment is six weeks or more then record as neo-adjuvant.

If hormonal therapy was not given as part of primary therapy, code as 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>Adjuvant</td>
<td>Additional therapy given after surgery.</td>
</tr>
<tr>
<td>2</td>
<td>Neo-adjuvant</td>
<td>Therapy given prior to definitive surgery to reduce tumour</td>
</tr>
<tr>
<td>3</td>
<td>Primary</td>
<td>Given as first line therapy where there is no intention of surgical intervention e.g. due to patient frailty. i.e. if the patient has not proceeded to surgery within one year of diagnosis.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Given as first line therapy in patients with metastatic disease at diagnosis.</td>
</tr>
<tr>
<td>11</td>
<td>Peri-operative</td>
<td>This would include patients in peri-operative treatment trials and those commenced on hormone therapy due to a need to delay surgery for patient related reasons e.g. further investigation or social.</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused hormone treatment</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):**
Date Hormonal Therapy Started {Breast Cancer}
Date of First Definitive Breast Surgery {Breast Cancer}

**Notes by Users:**
Date Hormonal Therapy Started {Breast Cancer}

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

**Definition:** This is the first date a patient has taken a hormonal drug or undergone ovarian ablation as part of breast cancer treatment.

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

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

It is not always clearly documented when hormone therapy starts. In the patient discharge or clinic letter the clinician may ask the GP to prescribe hormone therapy, in this case, record the date as two days from the day the discharge letter or clinic letter was typed.

If the date of clinic letter is not documented, record as 09/09/1900.

If hormonal therapy was not given as part of primary therapy, code as 10/10/1900 (Not applicable).

**Related Data Item(s):**  
Type of Hormonal Therapy {Breast Cancer}

**Notes by Users:**
% Predicted Survival Benefit

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

**Definition:** This is the % overall survival benefit of chemotherapy treatment at 10 years as generated by PREDICT*

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

**Notes for Users:** Required for QPI(s): 11, 17

* PREDICT is an online tool designed to help clinicians and patients make informed decisions about treatment following breast cancer surgery.

As a guide for clinicians it has been agreed that PREDICT version 2.1 should be used and third generation chemotherapy should be selected as default for the purpose of consistency, however this does not require to be evidenced for individual patients. Where a score has been documented this should be recorded as per table below.

Where PREDICT is not the tool that has been used to calculate benefit, code as 96 (Not applicable).

Patients who have had neo-adjuvant chemotherapy, Peri-operative hormone therapy, neo-adjuvant hormone therapy, patients who have in situ disease only and patients with M1 disease should all be recorded as “Not Applicable”

If the PREDICT score is not recorded, record as 99 (Not 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>&lt;3%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3 – 5%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>&gt;5%</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:**

**Notes by Users:**
Type of Chemotherapy \{Cancer\} \((1-2)\)

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

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

**Field Name:** CHEM1  
CHEM2  

**Field Type:** Character  

**Field Length:** 2

**Notes for Users:** Required for QPI(s): 6, 11, 17, 18

Patients may have ongoing chemotherapy 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.

Biological therapy (including Immunotherapy and biological response modifiers) is recorded in a separate standard.

Chemotherapy 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 ‘10’ and recorded additionally in Radiotherapy Course Type under code ‘10’.

If chemotherapy was not given as part of primary therapy, code as ‘8 (A/B/C/D)’, as applicable.
<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant</td>
<td>The start of adjuvant chemotherapy is after the date of the first surgery where there is no overt evidence of remaining disease within the breast.</td>
</tr>
<tr>
<td>2</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to first definitive surgery to reduce tumour size.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Chemotherapy given for symptom control without curative intent in patients with metastatic disease at time of diagnosis.</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>8A</td>
<td>None – Not clinically indicated</td>
<td>Best practice guidance and/or local protocols do not recommend.</td>
</tr>
<tr>
<td>8B</td>
<td>None – Clinical decision</td>
<td>Patient unfit or clinical assessment indicates other management.</td>
</tr>
<tr>
<td>8C</td>
<td>None – Patient died</td>
<td></td>
</tr>
<tr>
<td>8D</td>
<td>None – Patient refused treatment</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
- Date Treatment Started {Cancer} (Chemotherapy) (1-2)
- Date of First Definitive Breast Surgery {Breast Cancer}

**Notes by Users:**

---

*Data Definitions for the National Minimum Core Dataset for Breast Cancer.*
*Developed by ISD Scotland, 2013*
*Page 80*
Date Treatment Started {Cancer} (Chemotherapy) (1-2)

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

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE 2
Field Type: Date (DD/MM/CCYY).
Field length: 10

Notes for Users: Required for national comparative analysis.

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

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

If the date treatment started is unknown, record as 09/09/1900.

Related Data Items(s):
Type of Chemotherapy {Cancer} (1-2)
Date Treatment Completed {Cancer} (Chemotherapy) (1-2)

Notes by Users:
Date Treatment Completed {Cancer} (Chemotherapy) (1-2)

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

Definition:
The date cancer treatment course ended.

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

Notes for Users: Required for national comparative analysis.

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

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

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

If the date treatment started is unknown, record as 09/09/1900.

Related Data Item(s):
Type of Chemotherapy {Cancer} (1-2)
Date Treatment Started {Cancer} (Chemotherapy) 1-2

Notes by Users:
Biological Agent {Breast Cancer}

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

Definition: The type of biological agent administered for the treatment of the cancer.

Field Name: BIOAGENT
Field Type: Integer
Field Length: 2

Notes for Users: Required for national comparative analysis.

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

Biological therapy given directly after adjuvant therapy is still regarded as primary treatment.

If biological therapy was not given as part of primary therapy, code as 96 (Not applicable).

The biological agent can be given in or out-with the context of a clinical trial.

As new treatments are introduced, approval for inclusion of additional codes and values must be sought from PHS.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anti-HER2 Positive Therapy</td>
<td>e.g. Trastuzumab (Herceptin)</td>
</tr>
<tr>
<td>8</td>
<td>Other, specify</td>
<td>e.g. Non-anti-HER2 positive therapy</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused biological therapy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No Biological Agent</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Treatment Started {Cancer} (Biological Therapy)

Notes by Users:
Date Treatment Started {Cancer} (Biological Therapy)

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

Definition: The date cancer treatment course commenced.

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

Notes for Users: Required for national comparative analysis.

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

If the date treatment started is unknown, record as 09/09/1900.

Related Data Item(s): Biological Agent {Breast Cancer}

Notes by Users:
Genomic Test Performed

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

**Definition:** This is the name of the genomic, immunohistochemical or other multiparametric test performed on a tumour sample.

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

**Notes for Users:** Required for QPI: 17 and for national comparative analysis.

Currently the only test in routine use is oncotype DX but there are others available that may be used.

If no genomic test has been performed, code 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>Oncotype DX</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>IHC4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Endopredict</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MammaPrint</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Prosigna</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused genomic test</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):**  
Date of Genomic Test Result  
Recurrence Score (Oncotype DX)

**Notes by Users:**
**Date of Genomic Test Result**

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

**Definition:** Date that the genomic test result was reported.

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

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

The date which the genomic test was reported should be recorded (as opposed to date the test was carried out).

If the patient did not have a genomic test, record as Not applicable (10/10/1900).

If the date of reporting is not recorded record as (09/09/1900).

**Related Data Item(s):**  
Genomic Test Performed  
Recurrence Score (Oncotype DX)

**Notes by Users:**
Recurrence Score (Oncotype DX)

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

**Definition:** This denotes the score assigned as a result of the Oncotype DX test

**Field Name:** ONCSCORE  
**Field Type:** Integer  
**Field length:** 4

**Notes for Users:** Required for QPI: 11 and for national comparative analysis.

The Oncotype recurrence score will be a number between 0 and 100.

Occasionally the test is attempted and fails to give a result. This should be recorded as failed test, 8888. If the recurrence score is not recorded score as 9999.

Where patients have no Oncotype DX test performed this should be recorded as not applicable, 1010.

**Related Data Item(s):**  
Genomic Test Performed  
Date of Genomic Test Result

**Notes by Users:**
Section 8: Genetic Testing
Genetics Referral

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

**Definition:** This denotes whether the patient is referred to a specialist clinic for genetic testing following diagnosis.

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

**Notes for Users:** Required for QPI: 14

This should be documented in e.g. clinic letters (surgical or oncology) or reported at the MDT meeting.

Where genetic testing is arranged via the oncology clinic without referral to a specialist genetics service, e.g. for patients entering certain clinical trials, this should be recorded as Yes – via the oncology clinic.

**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 – referred to specialist clinic</td>
<td>Genetics Services</td>
</tr>
<tr>
<td>2</td>
<td>Yes – via the oncology clinic</td>
<td>As part of a clinical trial</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>No documented evidence that the patient was referred</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patient is already known to Genetics and referral is not required, or patient died before a referral was made</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Should only be used where there is no documented evidence of whether the patient was referred or not.</td>
</tr>
</tbody>
</table>

**Related data Item(s):**  
Date Referred for Genetic Testing
Date Referred for Genetic Testing

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

Definition: This denotes the date the patient is referred to a specialist clinic for genetic testing

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

Notes for Users: Required for national comparative analysis.

This is the date the patient is referred to a specialist clinic for genetic testing following diagnosis. This should be documented in e.g. clinic letters (surgical or oncology) or reported at the MDT meeting.

Where genetic testing is arranged via the oncology clinic without referral to a specialist genetics service, e.g. for patients entering certain clinical trials, this should be recorded as the clinic date.

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

If the patient was not referred for genetic testing, e.g. patient declined or where not applicable, record as 10/10/1900 (not applicable).

Related data Item(s):
Genetics Referral
Section 9: Clinical Trial Entry
Patient Entered into Clinical Trial (Breast Cancer)

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

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

Field Name: TRIAL  
Field Type: Characters  
Field Length: 2

Notes for Users: Required for QPI(s): 10, 11, 17

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>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Yes - Radiotherapy</td>
<td>Entered into a clinical trial involving radiotherapy</td>
</tr>
<tr>
<td>1B</td>
<td>Yes - Chemotherapy</td>
<td>Entered into a clinical trial involving chemotherapy</td>
</tr>
<tr>
<td>1C</td>
<td>Yes – Biological therapy</td>
<td>Entered into a clinical trial involving biological therapy</td>
</tr>
<tr>
<td>1D</td>
<td>Yes – More than one modality (including Radiotherapy)</td>
<td>Entered into a clinical trial involving more than one therapy including radiotherapy</td>
</tr>
<tr>
<td>1E</td>
<td>Yes – More than one modality (including Chemotherapy)</td>
<td>Entered into a clinical trial involving more than one therapy including chemotherapy</td>
</tr>
<tr>
<td>1F</td>
<td>Yes – More than one modality (including both Radiotherapy and Chemotherapy)</td>
<td>Entered into a clinical trial involving more than one therapy including radiotherapy and chemotherapy</td>
</tr>
<tr>
<td>1G</td>
<td>Yes – Not known</td>
<td>Entered into a clinical trial but type of therapy not known</td>
</tr>
<tr>
<td>1H</td>
<td>Yes – Hormone therapy</td>
<td>Entered into a clinical trial involving hormone therapy</td>
</tr>
<tr>
<td>1I</td>
<td>Yes – Other</td>
<td>Entered into a clinical trial involving a therapy or therapies which does not include radiotherapy, chemotherapy, biological therapy or hormone therapy</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>
Section 10: Follow-up and Death Details
Follow-up Date

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

**Definition:** The date on which the patient was last seen at follow-up.

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

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

This should be collected annually for a minimum of 10 years.

The follow-up period is calculated from the date of diagnosis to the date of follow-up.

If the exact date is not documented, or data are required for reporting within the year, record as 09/09/1900.

**Related Data Item(s):**  
Follow-up Status

**Notes by Users:**
Follow-up Status

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

**Definition:** An indicator of the patient’s vital status at follow-up.

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

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

IT systems should allow for follow-up status to be updated annually.

It is expected that this will be recorded up to 10 years after diagnosis.

It is essential that follow-status has a follow-up date recorded, without which time to relapse cannot be assessed.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alive and well</td>
<td>Never recurred.</td>
</tr>
<tr>
<td>3</td>
<td>Alive: relapse</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Moved away</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient deceased</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Follow-up Date.

**Notes by Users:**
Date of First Local Recurrence (Breast Cancer)

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

Definition: Date of first local recurrence is the date of diagnosis of local recurrence. The date recorded should be the date of the cytological or histological diagnosis, or if not performed, radiological or other diagnostic procedure. If no diagnostic procedure was performed then the first date the doctor records a recurrence is taken.

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

Notes for Users: Required for national comparative analysis.

Local disease refers to skin and soft tissue disease occurring in the anatomical area bounded by the ipsilateral clavicle, posterior axillary line, costal margin and mid sternal line, irrespective of the area which may have previously been subjected to local radiotherapy. This will be defined by the multidisciplinary team (MDT).

The date of diagnosis of recurrence is taken as the date the procedure was carried out, not the date the report was issued.

Local recurrences are usually biopsied and (as at first diagnosis) the date of the biopsy should be used.

Where patients had metastatic disease at diagnosis, or where no surgery was performed, record as not applicable, 10/10/1900.

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

Notes by Users:
**Date of First Regional Recurrence {Breast Cancer}**

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

**Definition:** Date of first axillary or supraclavicular recurrence is the date of diagnosis of axillary recurrence. The date recorded should be the date of cytological or histological diagnosis, or if not performed, radiological or other diagnostic procedure. If no diagnostic procedure was performed then the first date the doctor records a recurrence is taken.

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

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

This refers to the first detection of disease recurring in the nodes in the ipsilateral (same side as the breast surgery) axilla, ipsilateral supraclavicular fossa, or in the mammary chain. **This will be defined by the multidisciplinary team (MDT).**

Regional recurrences are **usually** biopsied and (as at first diagnosis) the date of the biopsy should be used.

Where patients had metastatic disease at diagnosis, or where no surgery was performed, record as not applicable, 10/10/1900.

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

**Notes by Users:**
**Date of First Distant Recurrence**

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

**Definition:** Date of distant recurrence is the date of diagnosis of distant recurrence. The date recorded should be the date histological diagnosis was confirmed, or if not performed, radiological or other diagnostic procedure. If no diagnostic procedure was performed then the first date the doctor records a recurrence is taken.

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

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

Sites of distant spread include contralateral axilla or contralateral supraclavicular fossa. If there is spread to the liver, bone and contralateral breast this is distant relapse. Conversely if a patient develops disease in the contralateral breast (histologically different to the first tumour) and there is no spread to bone, liver etc this is not distant relapse.

The date of diagnosis of recurrence is taken as the date the procedure was carried out, not the date the report was issued.

Some recurrences are never biopsied and therefore there is no histological date so the imaging date is taken. This is particularly the case with distant metastases.

Where patients had metastatic disease at diagnosis, or where no surgery was performed, record as not applicable, 10/10/1900.

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

**Notes by Users:**
Date of Death

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

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.

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

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

Related Data Item(s):
Primary (Underlying) Cause of Death

Notes by Users: