Cervical Cancer

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

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

Version 2.3: January 2019

To be used in conjunction with:

1. Cervical Clinical Quality Performance Indicators V2.0 (August 2016)
2. Cervical QPI Dataset Validations (Latest Published Version)
3. Cervical Measurability of Quality Performance Indicators (Latest Published Version)
**DOCUMENT CONTROL SHEET**

**Key Information**

<table>
<thead>
<tr>
<th>Title</th>
<th>Cervical – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs)</th>
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<tr>
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<tr>
<td>Author</td>
<td>Information Services Division of NHS National Services Scotland</td>
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**Revision History**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of Changes</th>
<th>Name</th>
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<td>April 2015</td>
<td>Changes agreed after QA of validation documents</td>
<td>Jane Garrett</td>
<td>See page iv</td>
</tr>
<tr>
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<td>July 2015</td>
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<td>Jane Garrett</td>
<td>See page iii</td>
</tr>
<tr>
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<td>Nov 2015</td>
<td>Typos amended</td>
<td>Jane Garrett</td>
<td>See page iii</td>
</tr>
<tr>
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<td>Sept 2016</td>
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<td>See page iii</td>
</tr>
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<td>Jan 2019</td>
<td>Changes agreed outwith Review</td>
<td>Jane Garrett</td>
<td>See page iii</td>
</tr>
</tbody>
</table>
CONTENTS
PREFACE ......................................................................................................................... i
NOTES FOR IMPLEMENTATION OF CHANGES .............................................................. ii
CONVENTIONS .............................................................................................................. ii
REVISIONS TO DATASET: ............................................................................................ iii
CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT .................................................. v
Section 1: Demographic Items ..................................................................................... 1
Person Family Name (at Diagnosis) .............................................................................. 2
Person Given Name ...................................................................................................... 3
Patient Postcode at Diagnosis ..................................................................................... 4
Date of Birth ................................................................................................................. 5
CHI Number ................................................................................................................ 6
Source of Cancer Referral ........................................................................................... 7
Section 2: Pre-treatment Imaging & Staging Investigations ........................................ 8
Location of Diagnosis (Cancer) .................................................................................... 9
Date of Diagnosis (Cancer) ........................................................................................ 10
MRI SCAN ..................................................................................................................... 11
Date of MRI Scan Completed ..................................................................................... 12
Date of PET CT Scan (Cervical Cancer) (Pre-treatment) .......................................... 13
WHO/ ECOG Performance Status ........................................................................... 14
Date Discussed by Care Team (MDT) ..................................................................... 15
Type of First Cancer Treatment ............................................................................. 16
Date of First Cancer Treatment ............................................................................... 17
Date of Definitive Treatment (Cervical Cancer) ....................................................... 18
Section 3: Surgery ........................................................................................................ 19
Location Code (Cancer Surgery) ................................................................................ 20
Date of Surgery .......................................................................................................... 22
Surgery Performed ..................................................................................................... 23
Section 4: Pathological Details .................................................................................. 24
Morphology of Tumour – Post-Operative ................................................................. 25
Final FIGO Stage (Cervical Cancer) ........................................................................ 26
Margin Status (Cervical Cancer) ............................................................................. 29
Section 5: Oncology ..................................................................................................... 30
Radiotherapy Course Type ....................................................................................... 31
Date Treatment Started (Radiotherapy) .................................................................. 32
Date Treatment Completed (Radiotherapy) ............................................................. 33
Brachytherapy (Cervical Cancer) ............................................................................. 34
Type of Systemic Anti-Cancer Therapy (SACT) 1-2 ............................................ 35
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (Cancer) 1-2 .... 36
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) 1-2 ... 37
Section 6: Clinical Trials ............................................................................................. 38
Patient Entered into Clinical Trial .......................................................................... 39
Section 7: Death Details .............................................................................................. 40
Date of Death ............................................................................................................. 41
PREFACE

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

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

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

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

Changes to definitions fall into the following categories:

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

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

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

NSS.ISDCANCERAUDIT@NHS.NET

CONVENTIONS

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

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

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

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

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/10/2015.

Revisions to Dataset Changes outwith Review (January 2019)

Person Family Name (at Diagnosis) – link updated

Person Given Name – link updated

Patient Postcode at Diagnosis {Cancer} – link updated

Date of Birth – link updated

Morphology of Tumour – Post-Operative – Codes and Values table add code ‘8933/3 – Adenosarcoma’

Revisions to Dataset following Baseline Review (September 2016)

Database Specification

Brachytherapy {Cervical Cancer} – Add Field Name – BRACHY; Field Type – Integer; Field Length - 2

Dataset

Date of Definitive Treatment {Cervical Cancer} – Notes for Users added the following text ‘Where a repeat LLETZ is undertaken this will only be considered definitive treatment where the cancer is stage la1 and it is performed to achieve clear margins, or for fertility conserving surgery.’

Date of Surgery – Notes for Users added the following text ‘Where a repeat LLETZ is undertaken this will only be considered definitive treatment where the cancer is stage la1 and it is performed to achieve clear margins, or for fertility conserving surgery.’

Brachytherapy {Cervical Cancer} – Added New Data Item

Revisions to Dataset Outwith Review (November 2015)

Database Specification - Format amended

Revisions to Dataset at 9 Month Review (July 2015)

Database Specification

Date of MRI SCAN (Pre-treatment) – Title Remove ‘Pre-treatment’
Date of MRI Scan Completed (Pre-treatment) – Title Remove ‘Pre-treatment’

Morphology – add new data item

Radiotherapy Course Type – Codes and Values table Typos Amended ’05 Chemoradiotherapy - in field 96 - Not applicable - e.g. Systemic therapy not given as primary part of therapy

Dataset

MRI SCAN (Pre-treatment) – Title Remove ‘Pre-treatment’ Definition ‘abdomen’ removed.

Date of MRI Scan Completed (Pre-treatment) – Title Remove ‘Pre-treatment’, Definition and notes for users removed ‘abdomen’.

Margin Status (Cervical Cancer) - Codes and Values table add Explanatory note for Not applicable ‘including LETZ performed’

Date Treatment Completed (Radiotherapy) – Notes for Users add ‘If patient has radiotherapy followed by brachytherapy it should be the final treatment date (i.e. brachytherapy) that is recorded.

Morphology – Add New Data Item

Revisions to Dataset after QA of validation documents (April 2015)

Dataset

Type of Systemic Anti-Cancer Therapy (SACT) 1-2 :
04 - Palliative - Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis
05 - Chemoradiotherapy - …in field ‘Radiotherapy Course Type’
96 - Not applicable - e.g. Systemic therapy not given as primary part of therapy.
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:
- Primary cervical cancer (including: squamous, adenocarcinoma and adenosquamous tumours) (ICD-10 C53)

Exclude:
- Pre-cancerous conditions including: cervical intra-epithelial neoplasia (CIN) and glandular intra-epithelial neoplasia (GIN)
- Patients with metastatic cervical cancer from another primary cancer site
- Patients where the origin of the primary is uncertain
- Patients with tumour type sarcoma or lymphoma
- Patients with recurrent disease (as opposed to a new primary)
- Patients with carcinoma in situ
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.

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

DATABASE SPECIFICATION

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<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
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<td>Section 1: Demographic Items</td>
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<td>Person Family Name (at Diagnosis)</td>
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**Section 6: Clinical Trials**

| Patient Entered into Clinical Trial | TRIAL | Characters | 3 | 38 |

**Section 7: Death Details**

| Date of Death | DOD | Date (DD/MM/CCYY) | 10 | 40 |
Section 1: Demographic Items
**Person Family Name (at Diagnosis)**

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

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

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

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

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

From SMR Definitions and Codes

**Notes by Users:**
**Person Given Name**

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

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

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

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

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

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

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

Main Source of Data Item Standard: [Government Data Standards Catalogue](#)

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

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

**Notes for Users:**  
Postcode is included in BS7666 Address (GDSC) but there is also a separate Post Code standard which will be populated from BS7666 Address Post Code.  
This item can be derived from the date of diagnosis and patient address at that time

**Related Data Item(s):**  
Date of Diagnosis

**Notes by Users:**
**Date of Birth**

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

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

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

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

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

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

**Notes by Users:**
**CHI Number**

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

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

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

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

From Designed to Care - Scottish Office

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

(ISD, Information Services, NHS National Services Scotland)

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

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

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

**Related Data Item(s):**  
Date of Birth

**Notes by Users:**
**Source of Cancer Referral**

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

**Definition:** This denotes the route by which the patient was referred for investigation of signs or symptoms that lead to a diagnosis of cancer.

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

**Notes for Users:** Required for analysis purposes.

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 (code 01). After attending for routine screening in a screening programme, a patient may be referred for further investigation, (code 02).

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 (code 03).

Patients presenting at A&E or acute admissions are often referred by their GP (code 07), or may already have an outstanding primary care referral for cancer (code 08).

Patients self-referring to A&E without any formal referral should be recorded as code 06.

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 (code 04) or because of a strong family history of cancer (code 05).

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

**Codes and Values:**

<table>
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<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Primary care clinician (GP, Nurse practitioner)</td>
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</tr>
<tr>
<td>02</td>
<td>Screening service</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Incidental finding</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Review clinic</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Cancer genetic clinic</td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Self-referral to A&amp;E</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>GP referral directly to hospital</td>
<td>A&amp;E or other</td>
</tr>
<tr>
<td>08</td>
<td>Previous GP referral but subsequently admitted to hospital</td>
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</tr>
<tr>
<td>12</td>
<td>Referral from private healthcare</td>
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<tr>
<td>13</td>
<td>Other</td>
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<td>99</td>
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**Related Data Items:**

Definitions for the National Core Data Set for Cervical Cancer.  
Developed by ISD Scotland  
1st October 2014
Section 2: Pre-treatment Imaging & Staging Investigations
Location of Diagnosis {Cancer}

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

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

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

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

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

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

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

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

Codes and Values:

Related Data Items:
Date of Diagnosis {Cancer}

Notes by Users:
Definitions for the National Core Data Set for Cervical Cancer.
Developed by ISD Scotland
1st October 2014

**Date of Diagnosis {Cancer}**

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

**Definition:** The date on which the cancer was first diagnosed whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods.

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

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

The date recorded is the date of the first investigative procedure that confirms a diagnosis of cervical cancer.

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

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

**Codes and Values:**

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

**Notes by Users:**
MRI SCAN

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

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

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

Notes for Users: Required for QPI: 1

Codes and values:

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

Related Data Items
Date of MRI Scan Completed
**Date of MRI Scan Completed**

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

**Definition:** The date pelvis imaging investigations were completed by MRI of the pelvis.

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

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

Several investigations may be undertaken prior to staging. As a minimum a MRI of the pelvis should be completed before definitive treatment commences.

If MRI pelvis was not completed then record as not applicable (10/10/1010).

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

**Related Data Items**  
MRI SCAN
**Date of PET CT Scan {Cervical Cancer} (Pre-treatment)**

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

**Definition:** A record of the date a Positive Emission Tomography Computed Tomography (PET CT) scan was performed prior to starting treatment.

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

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

If PET CT was not completed then record as not applicable (10/10/1010).

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

**Related Data Items:**
WHO/ECOG Performance Status

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


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

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

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

This item may occur more than once throughout a patient’s record.

This field relates to pre-treatment performance status i.e. at the time of the MDT closest to actual treatment. If the performance status falls between two scores, record the higher value i.e. the worst performance status.

Codes and values:

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

Related Data Items:
**Date Discussed by Care Team (MDT)**

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

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

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

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

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

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

The first MDT meeting date will be recorded.

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

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

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

Common name: Mode of first treatment

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

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

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

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

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Surgery</td>
<td>Includes - LEEP/LLETZ/Cone only</td>
</tr>
<tr>
<td>02</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Endoscopic</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>07</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all therapies</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

Notes for Users: Required for QPI: 1

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

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

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

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

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

Related Data Item(s):
Type of First Cancer Treatment
**Date of Definitive Treatment {Cervical Cancer}**

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

**Definition:** This denotes the date definitive cancer treatment was given to the patient.

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

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

For patients with cervical cancer definitive treatment may be:
- Surgical resection¹,
- Radiotherapy,
- Chemotherapy, or
- Chemoradiotherapy.

If a patient has more than one of those treatments listed the first should be recorded.

For patients who undergo LEEP/LLETZ or Cone Biopsy with no further treatment, date of this procedure should be recorded.

Where patients go onto have a hysterectomy or trachelectomy following LEEP/LLETZ or cone biopsy it is the date of hysterectomy or trachelectomy which should be recorded.

Where a repeat LLETZ is undertaken this will only be considered definitive treatment where the cancer is stage Ia1 and it is performed to achieve clear margins, or for fertility conserving surgery.

For patients undergoing no active treatment (e.g. supportive care only) the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. This will be therefore be the same date recorded as for First Treatment Date.

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

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

**Related Data Item(s):**

¹ This includes: Hysterectomy, Radical Hysterectomy, Trachelectomy, Radical Trachelectomy, LEEP/LLETZ or Cone Biopsy.

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*Definitions for the National Core Data Set for Cervical Cancer.  
Developed by ISD Scotland  
1st October 2014*
Section 3: Surgery
**Location Code (Cancer Surgery)**

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

**Main Source of Data Item Standard:** NHS National Reference Files

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

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

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

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

Each location has a location code, which is maintained jointly by ISD and General Register Office (Scotland). National Reference Files – datafiles.

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at ISD is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate. 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 surgery has not been performed or the patient has refused surgery, record as not applicable, X1010.

Examples of codes are given below:

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

**Related Data Item(s):**

Date of Surgery
**Date of Surgery**

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

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

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

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

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

For patients who undergo LEEP/LLETZ or Cone Biopsy with no further treatment, date of this procedure should be recorded.

Where patients go onto have a hysterectomy or trachelectomy following LEEP/LLETZ or cone biopsy it is the date of hysterectomy or trachelectomy which should be recorded.

Where a repeat LLETZ is undertaken, the date of this procedure should be recorded only where the cancer is stage 1a1 and it is performed to achieve clear margins, or for fertility conserving surgery.

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

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

All treatments given as part of the initial treatment plan.

**Related Data Items:**  
Location Code {Cancer Surgery}
Surgery Performed

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

Definition: This denotes the surgical procedure performed for treatment of Cervical Cancer.

Field Name: SURG  
Field Type: Integer  
Field Length: 2

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

For patients who undergo LEEP/LLETZ or Cone Biopsy with no further treatment, it is this procedure which should be recorded. Where patients go onto have a hysterectomy or trachelectomy following LEEP/LLETZ or cone biopsy it is the hysterectomy or trachelectomy which should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Hysterectomy</td>
<td>Surgical removal of the cervix and womb</td>
</tr>
<tr>
<td>02</td>
<td>Radical hysterectomy</td>
<td>Surgical removal of the cervix, womb and adjacent lymph glands</td>
</tr>
<tr>
<td>03</td>
<td>Trachelectomy</td>
<td>A method of removing an early cancer which leaves enough of the cervix behind to support a pregnancy thereby preserving fertility</td>
</tr>
</tbody>
</table>
| 04   | Radical trachelectomy | A method of removing an early cancer which leaves enough of the cervix behind to support a pregnancy thereby preserving fertility  
|      |                   | This should be recorded as 'radical' where stated as such by the surgeon |
| 05   | LEEP/LLETZ only   | A loop of wire, through which an electric current flows, is used to shave off abnormal cells. Also called Large Loop Excision of the Transformation Zone (LLETZ) |
| 06   | Cone biopsy only  | Surgeon cuts a cone shaped piece of tissue out of the neck of the womb at the top of the vagina |
| 94   | Patient died before treatment |                                                             |
| 95   | Patient refused treatment |                                                              |
| 96   | Not applicable    | E.G. non-surgical patient                                           |
| 99   | Not recorded      | Evidence in patient record that surgery was received but details of the type of surgery is not recorded |

Related Data Item(s):  
Date of Surgery
Section 4: Pathological Details
Morphology of Tumour – Post-Operative


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

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

Notes for Users:

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

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

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

If no invasive operative procedures were undertaken record as not applicable (1010/0).

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>8070/3</td>
<td>Squamous cell carcinoma</td>
</tr>
<tr>
<td>8140/3</td>
<td>Adenocarcinoma, usual type</td>
</tr>
<tr>
<td>8482/3</td>
<td>Gastric type including adenoma malignum / minimal deviation adenocarcinoma</td>
</tr>
<tr>
<td>8310/3</td>
<td>Clear cell adenocarcinoma</td>
</tr>
<tr>
<td>8441/3</td>
<td>Serous adenocarcinoma</td>
</tr>
<tr>
<td>9110/3</td>
<td>Mesonephric adenocarcinoma</td>
</tr>
<tr>
<td>8574/3</td>
<td>Adenocarcinoma admixed with neuroendocrine carcinoma</td>
</tr>
<tr>
<td>8560/3</td>
<td>Adenosquamous carcinoma</td>
</tr>
<tr>
<td>8041/3</td>
<td>Small cell neuroendocrine carcinoma (grade 3)</td>
</tr>
<tr>
<td>8013/3</td>
<td>Large cell neuroendocrine carcinoma (grade 3)</td>
</tr>
<tr>
<td>8933/3</td>
<td>Adenosarcoma'</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Final FIGO Stage {Cervical Cancer}

Main Source of Data Item Standard: International Federation of Obstetricians and Gynaecologists (FIGO) Staging System – revision 2009

Definition: This denotes the final stage of disease determined by surgical and pathological findings as classified by the International Federation of Obstetricians and Gynaecologists for cervical cancer.

Field Name: FIGO
Field Type: Characters
Field length: 4

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

If stage is not documented in the pathology report or MDT 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></td>
<td><strong>Stage I</strong> - The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded).</td>
</tr>
<tr>
<td>IA</td>
<td>Invasive carcinoma which can be diagnosed only by microscopy. All macroscopically visible lesions — even with superficial invasion — are allotted to Stage Ib carcinomas. Invasion is limited to a measured stromal invasion with a maximal depth of 5.0 mm and a horizontal extension of not &gt; 7.0 mm. Depth of invasion should not be &gt; 5.0 mm taken from the base of the epithelium of the original tissue — superficial or glandular. The involvement of vascular spaces — venous or lymphatic — should not change the stage allotment.</td>
</tr>
<tr>
<td>IA1</td>
<td>Measured stromal invasion of not &gt; 3.0 mm in depth and extension of not &gt; 7.0 mm.</td>
</tr>
<tr>
<td>IA2</td>
<td>Measured stromal invasion of &gt; 3.0 mm and not &gt; 5.0 mm with an extension of not &gt; 7.0 mm.</td>
</tr>
<tr>
<td>IB</td>
<td>Clinically visible lesions limited to the cervix uteri or preclinical cancers greater than Stage IA.</td>
</tr>
<tr>
<td>IB1</td>
<td>Clinically visible lesions not &gt; 4.0 cm.</td>
</tr>
<tr>
<td>IB2</td>
<td>Clinically visible lesions &gt; 4.0 cm.</td>
</tr>
<tr>
<td></td>
<td><strong>Stage II</strong> - Cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina.</td>
</tr>
<tr>
<td>IIA</td>
<td>No obvious parametrial involvement.</td>
</tr>
<tr>
<td>IIA1</td>
<td>Clinically visible lesion ≤4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>IIA2</td>
<td>Clinically visible lesion &gt;4.0 cm in greatest dimension</td>
</tr>
<tr>
<td>IIB</td>
<td>Obvious parametrial involvement.</td>
</tr>
</tbody>
</table>
Stage III - The carcinoma has extended to the pelvic wall. On rectal examination, there is no cancer-free space between the tumour and the pelvic wall. The tumour involves the lower-third of the vagina. All cases with hydronephrosis or non-functioning kidney are included, unless they are known to be due to other causes.

<table>
<thead>
<tr>
<th>IIIA</th>
<th>Tumour involves lower-third of the vagina, with no extension to the pelvic wall.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIIB</td>
<td>Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney.</td>
</tr>
</tbody>
</table>

Stage IV - The carcinoma has extended beyond the true pelvis, or has involved (biopsy-proven) the mucosa of the bladder or rectum. A bullous oedema, as such, does not permit a case to be allotted to Stage IV.

<table>
<thead>
<tr>
<th>IVA</th>
<th>Spread of the growth to adjacent organs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVB</td>
<td>Spread to distant organs.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Margin Status {Cervical Cancer}

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

Definition: The presence or absence of margin involvement following surgical resection.

Field Name: MARGIN
Field Type: Integer
Field length: 4

Notes for Users: Required for QPI: 5

Margin status should be defined by the pathologist and should be available on the pathology report. Do not deduce from surgical notes.

If reported in another format e.g. < 1 mm, clarify with local pathologist.

If the patient does not have surgery record ‘96 – not applicable’

If margin status is unknown record ‘99 – not recorded’

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Clear</td>
<td>Surgical margin is (microscopically) free of tumour</td>
</tr>
<tr>
<td>02</td>
<td>Involved</td>
<td>Surgical margin is (microscopically) involved by tumour</td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. surgery not performed, including LETZ performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Section 5: Oncology
**Radiotherapy Course Type**

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

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

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

**Notes for Users:** Required for QPI(s): 2, 6, 7

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 ‘06’ and recorded also in SACT under code ‘05’.

All treatments given as part of the initial treatment plan

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery.</td>
</tr>
<tr>
<td>02</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>03</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
<tr>
<td>04</td>
<td>Neo-adjuvant</td>
<td>It is given before potentially curative surgery.</td>
</tr>
<tr>
<td>06</td>
<td>Chemoradiotherapy</td>
<td>Radical radiotherapy given in combination with concurrent chemotherapy. Chemotherapy element of this combined treatment should be recorded separately in field ‘Type of Systemic Anti-Cancer Therapy (SACT) 1-2’</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date Treatment Started (Radiotherapy)  
Date Treatment Completed (Radiotherapy)
**Date Treatment Started (Radiotherapy)**

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

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

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

**Notes for Users:** Required for QPI(s): 2, 6

This is the first fraction of a course of radiotherapy.

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

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

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

**Related Data Items:**  
Radiotherapy Course Type  
Date Treatment Completed (Radiotherapy)
**Date Treatment Completed (Radiotherapy)**

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

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

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

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

This is the last fraction of a course of radiotherapy.

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

If patient has radiotherapy followed by brachytherapy it should be the final treatment date (i.e. brachytherapy) that is recorded.
If the date treatment completed is unknown, record as 09/09/0909 (Not recorded).

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

**Related Data Item(s):**
Radiotherapy Course Type
Date Treatment Started (Radiotherapy)
**Brachytherapy (Cervical Cancer)**

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

**Definition:** Denoted where the patient had Vaginal Vault Brachytherapy

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

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

For the purposes of national audit, only brachytherapy given as part of the primary treatment plan should be recorded.

If unknown, record as 99 (Not recorded).

**Code and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date Treatment Started (Radiotherapy)
Type of Systemic Anti-Cancer Therapy (SACT) 1-2

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

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

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

Notes for Users: Required for QPI(s): 4, 5, 7

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

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

For patients undergoing chemoradiotherapy the chemotherapy element should be recorded as code ‘05’ and recorded also in ‘Radiotherapy Course Type’ under code ‘06’.

Codes and Values:

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

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

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

Definition: The date cancer treatment course commenced.

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

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

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

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

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

Related data items:
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2
Type of Systemic Anti-Cancer Therapy (SACT) 1-2
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

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

Definition: The date cancer treatment course ended.

Field Name: CHEMENDATE1
CHEMENDATE2

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

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

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

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

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

Codes and values:

Related data items:
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2
Type of Systemic Anti-Cancer Therapy (SACT) 1-2
Section 6: Clinical Trials
**Patient Entered into Clinical Trial**

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

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

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

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

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

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>01A</td>
<td>Yes – surgical trial</td>
<td>E.g. SHAPE</td>
</tr>
<tr>
<td>01B</td>
<td>Yes – other trial</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Section 7: Death Details
**Date of Death**

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

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

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

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

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

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