Colorectal Cancer

Data Definitions for the National Minimum Core Dataset to support the Introduction of Colorectal Quality Performance Indicators

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

Version 4.3: May 2023

To be used in conjunction with:

1. Colorectal Cancer Clinical Quality Performance Indicators (Latest Published Version)
2. Colorectal Cancer QPI Dataset Validations (Latest Published Version)
3. Colorectal Cancer Measurability of Quality Performance Indicators (Latest Published Version)
## DOCUMENT CONTROL SHEET

### Key Information

<table>
<thead>
<tr>
<th>Title</th>
<th>Colorectal Cancer – Data Definitions for the National Minimum Core Dataset to support the Introduction of Colorectal QPIs</th>
</tr>
</thead>
<tbody>
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</table>
| Cross References | Colorectal Cancer Quality Performance Indicators  
Colorectal Cancer Measurability of Quality Performance Indicators |
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### 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>March 2014</td>
<td>Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; April 2014</td>
<td>David Early</td>
<td>See page xii</td>
</tr>
<tr>
<td>V2.1</td>
<td>June 2014</td>
<td>Changes agreed outwith review. Changes to be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; April 2014</td>
<td>Charlotte Anthony</td>
<td>See page xi</td>
</tr>
<tr>
<td>V2.2</td>
<td>September 2014</td>
<td>Changes agreed outwith review. Changes to be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; April 2014</td>
<td>Jane Garrett</td>
<td>See page x</td>
</tr>
<tr>
<td>V2.3</td>
<td>February 2015</td>
<td>Changes agreed outwith review. Changes to be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; April 2014</td>
<td>Charlotte Anthony</td>
<td>See page x</td>
</tr>
<tr>
<td>V2.4</td>
<td>May 2015</td>
<td>Changes agreed from Baseline Review</td>
<td>Charlotte Anthony</td>
<td>See page x</td>
</tr>
<tr>
<td>V2.5</td>
<td>November 2015</td>
<td>Changes agreed outwith review. Changes to be applied for patients diagnosed from 1&lt;sup&gt;st&lt;/sup&gt; April 2014</td>
<td>Jane Garrett</td>
<td>See page x</td>
</tr>
<tr>
<td>V2.6</td>
<td>October 2016</td>
<td>Changes agreed outwith review</td>
<td>Karen Heatlie</td>
<td>See page x</td>
</tr>
<tr>
<td>Version</td>
<td>Date</td>
<td>Description</td>
<td>Author</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
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<td>--------------------------------------------------</td>
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<td>------</td>
</tr>
<tr>
<td>V3.0</td>
<td>August 2017</td>
<td>Changes agreed at Formal Review</td>
<td>Charlotte Anthony</td>
<td>viii</td>
</tr>
<tr>
<td>V3.1</td>
<td>April 2018</td>
<td>Changes agreed outwith review</td>
<td>Jane Garrett</td>
<td>vii</td>
</tr>
<tr>
<td>V3.2</td>
<td>November 2018</td>
<td>Changes agreed outwith review</td>
<td>Ashleigh Morrissey</td>
<td>vii</td>
</tr>
<tr>
<td>V3.3</td>
<td>September 2019</td>
<td>Changes agreed outwith review</td>
<td>Caroline Dawson</td>
<td>vi</td>
</tr>
<tr>
<td>V3.4</td>
<td>May 2020</td>
<td>Addition to dataset during COVID 19 Pandemic</td>
<td>Jane Garrett</td>
<td>vi</td>
</tr>
<tr>
<td>V4.0</td>
<td>September 2021</td>
<td>Changes Agreed at Formal Review</td>
<td>Maiana Sanjuan</td>
<td>iii</td>
</tr>
<tr>
<td>V4.1</td>
<td>January 2022</td>
<td>Changes Agreed at Formal Review</td>
<td>Maiana Sanjuan</td>
<td>iii</td>
</tr>
<tr>
<td>V4.2</td>
<td>November 2022</td>
<td>Changes agreed outwith review</td>
<td>Caroline Dawson</td>
<td>iii</td>
</tr>
<tr>
<td>V4.3</td>
<td>May 2023</td>
<td>Changes agreed outwith review</td>
<td>Caroline Dawson</td>
<td>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** ............................. xvi

**Database Specification** ......................................................... xviii

### Section 1: Demographic Items ............................................. 1

Person Family Name (at Diagnosis) ........................................ 2
Person Given Name ................................................................. 3
Patient Postcode at Diagnosis (Cancer) ................................. 4
Date of Birth ........................................................................ 5
Person Sex at Birth ................................................................ 6
CHI Number ........................................................................ 7
Source of Cancer Referral ...................................................... 8

### Section 2: Pre-treatment Imaging & Staging Investigations ................................. 9

Date of Referral ...................................................................... 10
Staging Investigations Complete (Colorectal Cancer) ............. 12
Date Staging Investigations Completed .................................. 13
Distance from Anal Verge (Rectal Cancer) ............................ 14
CT Chest (Results) .................................................................. 15
Date of CT Chest (Results) .................................................... 16
Liver Imaging (Results) .......................................................... 17
Date of Liver Imaging (Results) ............................................. 18
Large Bowel Imaging .............................................................. 19
Date of Imaging Large Bowel .................................................. 21
Circumferential Resection Margin – Predicted (Rectal Cancer) 22
Location of Diagnosis (Cancer) .............................................. 23
Date of Diagnosis (Cancer) .................................................... 24
Date of Histological Diagnosis (Cancer) ............................... 25
Most Valid Basis of Diagnosis (Cancer) ............................... 26
Site of Origin of Primary Tumour (Cancer) ............................ 27
Date Discussed by Care Team (MDT) ..................................... 28
COVID 19 Impact ................................................................... 29
Seen by Stoma Nurse (Colorectal Cancer) ............................ 30
Date Seen by Stoma Nurse (Colorectal Cancer) .................... 31
Stoma Site Marked Pre-operatively ...................................... 32
Type of First Cancer Treatment ........................................... 33
Date of First Cancer Treatment .......................................... 34
Date of Definitive Treatment (Colorectal Cancer) ................... 35

### Section 3: Surgery ................................................................. 36

ASA Status ........................................................................... 37
Consultant in Charge of Surgery ........................................... 38
Location Code (Cancer Surgery) ............................................. 39
Final Definitive (or Only) Surgery Performed (Surgery) (Colorectal Cancer) .............................................. 41
Total Mesorectal Excision (TME) (Rectal Cancer) ................ 47
Surgical Approach (Colorectal Cancer) ................................. 48
Date of Final Definitive (or Only) Surgery (Colorectal Cancer) 49
Presentation Type ................................................................. 50
Anastomotic Leak (Colorectal Cancer) ................................ 51
Intent of Surgery ................................................................... 52
Re-operation ......................................................................... 53

### Section 4: Pathology Details ................................................. 54

Extramural Venous Invasion (Surgical Resection Specimen) (Colorectal Cancer) ........................................ 55

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Data Definitions for the National Minimum Core Dataset for Colorectal Cancer.
Developed by ISD Scotland, 2014
Section 5: Tumour Classification
TNM Tumour Classification (Final) (Colorectal Cancer)
TNM Nodal Classification (Final) (Colorectal Cancer)
TNM Metastasis Classification (Final) (Colorectal)

Section 6: Oncology
Location Code (SACT Treatment)
Location Code (Radiotherapy Treatment)
Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)
Date Neo-Adjuvant Oncology Treatment Started (Colorectal Cancer)
Date Neo-Adjuvant Oncology Treatment Completed (Colorectal Cancer)
Primary/Palliative/Adjuvant Oncology Treatment Type (Colorectal Cancer)
Date Primary/Palliative/Adjuvant Oncology Treatment Started (Colorectal Cancer)
Date Primary/Palliative/Adjuvant Oncology Treatment Completed (Colorectal Cancer)

Section 7: Colorectal Liver Metastases
Date of Diagnosis (Colorectal Liver Metastases)
Referral to HPB MDT (Colorectal Liver Metastases)

Section 8: Genetics
Microsatellite Instability (MSI) Status
Mismatch Repair (MMR) Immunohistochemical (IHC) Testing
BRAF Status
MLH1 Analysis
Genetics Referral

Section 9: Clinical Trial Entry
Patient Entered into Clinical Trial

Section 10: Death Details
Date of Death
PREFACE

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

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

To ensure that findings are comparable across Scotland, the national dataset and data definitions in conjunction with the final quality performance indicators were agreed through public engagement and are now ready for implementation for patients diagnosed from 1st April 2013.

Colorectal cancer is the third most common cancer in Scotland behind breast and lung in women and prostate and lung in men. In 2010 there were 1790 women and 2177 men diagnosed with colorectal cancer; and in 2011 there were 702 women and 824 men who died of colorectal cancer. Over the last 10 years mortality from colorectal cancer has decreased by almost 18% with five-year relative survival of around 55%. To improve survival further a truly multidisciplinary package of care has to be undertaken. The vast majority of patients will be treated by surgical resection. These patients need to be appropriately staged to ensure that patients who require neoadjuvant therapy get it. The agreed surgical QPIs will hopefully improve the quality of surgery performed hence increasing long term success with tumour eradication but also minimising post-operative surgical complications. For a smaller group of patients radiotherapy +/- chemotherapy used before surgery can increase the success in eradicating the cancer. However for these patients the whole package needs to be a success hence the relevant QPIs look at the outcome of that package of care.

The national colorectal cancer minimum dataset has been significantly decreased in size. The remaining data items will be used to allow standardised reporting of clinically and patient relevant outcomes. Regional and national reporting will be valuable in allowing the clinical teams looking after patients with colorectal cancer to compare their treatment outcomes with their peers in other parts of the country. Hopefully this will result in optimal care for all patients presenting with colorectal cancer in Scotland.

Jim Docherty Consultant Surgeon, SCAN
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with colorectal cancer on or after 1st April 2021, who are eligible for inclusion in the colorectal 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

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

CONVENTIONS

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

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

The following changes have been made to facilitate the recording of data.

Revisions to dataset following changes outwith review (May 2023)

Location Code {SACT Treatment} – Notes for Users amend 'If surgery has not been performed or the patient has refused surgery, record as inapplicable, X1010.' to 'If patients have not received SACT treatment, or the patient has declined SACT treatment record as inapplicable, X1010'

Revisions to Dataset following changes outwith review (November 2022) To be implemented from 1st April 2022

Database Specification

MLH1 Analysis - Add Data Item: MLH1 Analysis Field Name: MLH1, Field Type: Integer, Field Length: 2

Dataset

Microsatellite Instability (MSI) Status – Codes & Values table add code ‘5 - MSI low - i.e., slight instability, not suggestive of Lynch Syndrome’

MLH1 Analysis - Add new Data Item

Revisions to dataset following changes outwith review (January 2022)

Database Specification

CHI Number – amend Field type from ‘Integer’ to ‘Characters’

Revisions to dataset following formal review (September 2021)

Database specification

Dukes Classification (Colorectal Cancer) – remove Data Item: Field Name: DUKES, Field Type: Characters, Field Length: 2

Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer) – change Data Item: Field Name from NEOONC to NEOONC1, add new Data Item: Field Name: NEOONC2, Type: Integer, Field Length: 2

Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer} – change Data Item: Field name from NEOADJDATE to NEOADJDATE1, add new Field Name: NEOADJDATE2, Field Type: Date (DD/MM/CCYY), Field Length: 10
Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer} – change Data Item: Field name from NEOADJCOM to NEOADJCOM1, add new Field: Field Name: NEOADJCOM2, Field Type: Date (DD/MM/CCYY), Field Length: 10

Section 7 – change to Colorectal Liver Metastases

Date of Diagnosis {Colorectal Liver Metastases} – Add new Data Item: Field Name: LIVERDIAGDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Referral to HPB MDT {Colorectal Liver Metastases} – Field Name: HPBMDT, Field Type: Integer, Field Length: 2

Section 8 – change to Genetics

Microsatellite Instability (MSI) Status – add new Data Item: Field Name: MSISTATUS, Field Type: Integer, Field Length: 2

Mismatch Repair (MMR) Immunohistochemical (IHC) Testing – add new Data Item: Field Name: IHCSTATUS, Field Type: Integer, Field Length: 2

BRAF Status – Add new Data Item: Field Name: BRAF, Field Type: Integer, Field Length: 2

Genetics Referral - Add new Data Item: Field Name: GENETICS, Field Type: Integer, Field Length: 2

Section 9 – add section Clinical Trial Entry

Section 10 – add section Death Details

Dataset

Large Bowel Imaging – Notes for Users add “Code 3 ‘Incomplete due to obstructing tumour’ includes situations where it is deemed clinically unsafe to attempt colonoscopy due to impending obstruction.”

Date of Imaging Large Bowel – Notes for users, add “Required for QPI: 2”

Circumferential Resection Margin – Predicted {Rectal Cancer} – Notes for Users remove “Required for QPI: 6”

Date of Diagnosis {Cancer} – Notes for Users change “Required for QPI(s): 1-12” to “Required for QPI(s): 1, 2, 5, 7, 8, 9, 10, 11, 12, 16.”

Site of Origin of Primary Tumour {Cancer} – Notes for Users change “Required for QPI(s): 1, 7, Remove QPI 12.”

Date discussed by Care Team (MDT) – Notes for Users remove “Required for QPI: 3”

Seen by Stoma Nurse {Colorectal Cancer} – Notes for Users remove “Required for QPI: 4”

Date Seen by Stoma Nurse {Colorectal Cancer} – Notes for Users remove “Required for QPI: 4”
Stoma Site Marked Pre-operatively – Notes for Users remove “Required for QPI:4”

Type of First Cancer Treatment – Notes for Users change “Required for QPI(s): 3, 7” to “Required for QPI: 1”

Codes and Values table, remove code ‘3’ – Chemotherapy, remove code ‘5’ – Endoscopic - Includes endomucosal resection, and insertion of stents., add code ‘8’ - Radical Endoscopic – ‘e.g. endomucosal resection’, add code ‘9’ – Palliative Endoscopic – ‘e.g. insertion of stents’, add code ‘10’ – SACT – ‘Includes all types of SACT e.g. chemotherapy, biological therapy and immunotherapy’

Date of Definitive Treatment {Colorectal Cancer} - Notes for Users remove ‘Required for QPI: 3’

Location Code {Cancer Surgery} – Notes for Users change ‘Required for QPI’ to ‘Required for regional/national analysis’

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – Notes for Users change “Required for QPI(s): 1-12” to “Required for QPI(s): 1, 2, 5, 7, 8, 9, 10, 11”, change “If there are multiple tumours record the operation relating to the most advanced tumour (i.e. the one with the most advanced Dukes’ stage).” to “If there are multiple tumours record the operation relating to the most advanced tumour (i.e. the one with the most advanced stage).”

Total Mesorectal Excision (TME) {Rectal Cancer} – Notes for Users remove “Required for QPI: 9”, change “This is recorded for rectal tumours only. If there are multiple tumours record this for the operation related to the most advanced tumour (i.e., the one with the poorest Dukes’ stage).” to “This is recorded for rectal tumours only. If there are multiple tumours record this for the operation related to the most advanced tumour (i.e. the one with the poorest stage).”


Date of Final Definitive (or Only) Surgery {Colorectal Cancer} – Notes for Users change ‘Required for QPI(s): 4, 7, 10, 11’ to ‘Required for QPI(s): 2, 7, 10, 11’

Presentation Type – Notes for Users ‘Required for QPI(s): 1, 2, 3, 4, 6, 7, 10’ to ‘Required for QPI(s): 1, 2, 7, 10’

Anastomotic Leak (Colorectal Cancer) – Definition, change ‘An indication of whether or not there was anastomotic leak requiring radiological or surgical intervention in patients undergoing a surgical procedure involving anastomosis.’ to ‘An indication of whether or not there was anastomotic leak requiring medical, endoscopic, radiological or surgical intervention in patients undergoing a surgical procedure involving anastomosis.’

Extramural Venous Invasion (Surgical Resection Specimen) {Colorectal Cancer} – notes for users, remove ‘Required for QPI: 11’

Dukes Classification (Colorectal Cancer) – remove Data Item
Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer) – Field Name change NEOONC to NEOONC1, add NEOONC2

Notes for Users change ‘Required for QPI(s): 1, 5, 6, 7, 11, 12’ to ‘Required for QPI(s): 1, 5, 7, 11, 12’, SACT change from ‘Patients who have systemic therapy prior to surgery should be recorded under as neo-adjuvant Type.’ to ‘Patients who have systemic therapy prior to surgery should be recorded as neo-adjuvant.’

Date Neo-Adjuvant Oncology Treatment Started (Colorectal Cancer) – Field Name change NEOADJDATE to NEOADJDATE1, add NEOADJDATE2

Notes for Users remove ‘Required for QPI:

Date Neo-Adjuvant Oncology Treatment Started (Colorectal Cancer) – Field Name change NEOADJCOM to NEOADJCOM1, add NEOADJCOM2

Primary/Palliative/Adjuvant Oncology Treatment Type (Colorectal Cancer) – Codes and Values table add code ‘10’ – ‘Brachytherapy’

Section 7 – change from Clinical Trial Entry to Colorectal Liver Metastases

Date of Diagnosis (Colorectal Liver Metastases) – add new Data Item

Referral to HPB MDT (Colorectal Liver Metastases) – add new Data Item

Section 8 – change from Death Details to Genetics

Microsatellite Instability (MSI) Status – add new Data Item

Mismatch Repair (MMR) Immunohistochemical (IHC) Testing – add new Data Item

BRAF Status – Add new Data Item

Genetics Referral - Add new Data Item

Section 9 – add section Clinical Trial Entry

Section 10 – add section Death Details

Addition to dataset during COVID 19 Pandemic (May 2020)

Database Specification

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

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

Dataset

Date of Referral - add new data item - implement from 1 March 2020
COVID 19 Impact - add new Data item – implemented from 1 April 2019

Revisions to Dataset outwith review (May 2020)

Source of Cancer Referral - Codes and Values table remove leading ‘0’

Revisions to Dataset outwith review (September 2019)

Date Staging Investigations Completed - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date of Imaging Large Bowel - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date of Diagnosis – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’

Date of Histological Diagnosis {Cancer} – Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date Discussed by Care Team - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date Seen by Stoma Nurse {Colorectal Cancer} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date of First Cancer Treatment - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date of Definitive Treatment {Colorectal Cancer} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date of Final Definitive (or Only) Surgery {Colorectal Cancer} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer} - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date Neo-Adjuvant Oncology Treatment Completed {Colorectal Cancer} - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date Primary/Palliative/Adjuvant Oncology Treatment Started {Colorectal Cancer} - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

Date Primary/Palliative/Adjuvant Oncology Treatment Completed {Colorectal Cancer} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

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

Revisions to Dataset outwith review (November 2018)
Large Bowel Imaging – Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR’ to ‘Investigation must be performed before, or on, the date of surgical resection (or definitive treatment date where no resection is performed) unless patient has a polyp cancer treated only by polypectomy or EMR.’

Final Definitive (or Only) Surgery Performed (Surgery) (Colorectal Cancer) – Codes and Values table added operative procedure H15.3 re-fashioning of colostomy.

Revisions to Dataset outwith review (April 2018)

TNM Tumour Classification (Final) (Colorectal Cancer) - Definition changed from Fifth Edition, UICC, 1997 to Eighth Edition, 2017; Notes for Users delete ‘T4 has been subdivided into ‘A’ (Invades other organs or structures) and ‘B’ (Involves visceral peritoneum) to meet QPI requirements’. ‘Delete ‘T4 has been subdivided into ‘A’ (Invades other organs or structures) and ‘B’ (Involves visceral peritoneum) to meet QPI requirements’ T3 changed to ‘Tumour invades subserosa or into non peritonealized pericolic or perirectal tissues’; T4 change Explanatory Note to ‘Invades through to visceral peritoneum to involve the surface. Direct invasion in T4b includes invasion of other organs or segments of the colorectum by way of the serosa, as confirmed on microscopic examination, or for tumours in a retroperitoneal or subperitoneal location, direct invasion of other organs or structures by virtue of extension beyond the muscularis propria. Tumour that is adherent to other organs or structures, macroscopically, is classified cT4b. However, if no tumour is present in the adhesion, microscopically, the classification should be pT1-3 depending on the anatomical depth of wall invasion.

T4a changed to ‘Tumour perforates visceral peritoneum’ change Explanatory Note to ‘Tumour invades adjacent organs’; T4b changed to ‘Tumour directly invades other organs or structures’ change Explanatory Note to ‘Tumour invades adjacent organs’ Notes for Users Add ‘and for national survival analysis and national comparative analysis’.

Delete ‘Direct intramural spread of caecal carcinomas into the terminal ileum or rectal cancers into the anal canal does not affect the T stage. However, direct extramural spread (across the serosa) of a colorectal carcinoma into another part of the large or small intestine corresponds to T4. Extramural extension of a rectal cancer into the skeletal muscle of the external sphincter, levator ani and/or puborectalis is classified as T4a’.

TNM Nodal Classification (Final) (Colorectal Cancer) - Definition changed from Fifth Edition, UICC, 1997 to Eighth Edition, 2017

Add ‘N1a Metastasis in 1 regional lymph node’, ‘N1b Metastasis in 2 to 3 regional lymph nodes’, ‘N1c Tumour deposit(s), ie satellites,* in the subserosa, or in non peritonealized pericolic or perirectal soft tissue without regional lymph node metastasis’, ‘N2a Metastasis in 4–6 regional lymph nodes’, ‘N2b Metastasis in 7 or more regional lymph nodes’ Add *‘Tumour deposits (satellites) are discrete macroscopic or microscopic nodules of cancer in the pericolectal adipose tissue’s lymph drainage area of a primary carcinoma that are discontinuous from the primary and without histological evidence of residual lymph node or identifiable vascular or neural structures. If a vessel wall is identifiable on H&E, elastic or other stains, it should be classified as venous invasion (V1/2) or lymphatic invasion (L1). Similarly, if neural structures are identifiable, the lesion should be classified as perineural invasion (Pn1). The presence of tumour deposits does not change the primary tumour T category, but changes the node status (N) to pN1c if all regional lymph nodes are negative on pathological examination.’ Notes for Users delete ‘A tumour nodule measuring 3 mm or more in perirectal or pericolic adipose tissue without histological evidence of residual lymph
node is classified as regional lymph node metastasis. However, a tumour nodule of up to 3mm in diameter is classified in the T category as discontinuous extension i.e. T3.’

**TNM Metastasis Classification (Final) {Colorectal Cancer}** - Definition changed from Fifth Edition, UICC, 1997 to Eighth Edition, 2017
Delete code MX - Presence of distant metastasis cannot be assessed
Add ‘M1a Metastasis confined to one organ (liver, lung, ovary, non regional lymph node(s)) without peritoneal metastases’; ‘M1b Metastasis in more than one organ’; ‘M1c Metastasis to the peritoneum with or without other organ involvement’. Notes for Users add ‘and for national survival analysis and national comparative analysis’.

**Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}** - Operative Procedures – creation of artificial opening into ileum Add ‘G74.8 – Other specified’ and ‘G74.9 – Unspecified’; Add H23.5 - Endoscopic submucosal resection of lesion of lower bowel using fibreoptic sigmoidoscope
H26.6 - Endoscopic submucosal resection of lesion of sigmoid colon using rigid sigmoidoscope

**Grade of Differentiation (Colorectal Cancer)** - Notes for Users add ‘Where the grade is recorded as mucinous in the pathology report then this should be recorded as code 96, Not Applicable.’

**Revision to Dataset following Formal Review (August 2017)**

**Criteria for Inclusion of Patients in Audit** - inserted exclusion ‘Patients with appendiceal cancer’ and removed ‘(including appendix),’ from first bullet point.

**Person Family Name (at Diagnosis)** – link updated
**Person Given Name** – link updated
**Patient Postcode at Diagnosis {Cancer}** – link updated
**Date of Birth** – link updated

**Large Bowel Imaging** – Code and Value table add ‘code 4, Incomplete due to obstructing tumour, This includes patients with strictures which prevent passage of a scope’

**Location of Diagnosis {Cancer}** – Notes for Users add ‘This will be the hospital where the patient was diagnosed. If the diagnosis is made by screening colonoscopy; or if colonoscopy is carried out at a hospital for waiting list reasons i.e. Golden Jubilee, the hospital recorded should be the hospital where the patient was managed following their diagnosis of cancer’, delete ‘The hospital where the screening colonoscopy takes place should be recorded as the location of diagnosis.

**Date of Diagnosis** – Notes for Users ‘Required for QPIs’ from ’2, 7, 9, 12’ to ’1-12’

**Site of Origin of Primary Tumour** – Notes for Users Required for QPIs changed to 1-12 , removed code ‘C18.1 – Appendix’

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

**Final Definitive (or Only) Surgery Performed (Surgery) (Colorectal Cancer)** – Required for QPIs changed to 1-12. Notes for Users add ‘If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field ‘Re-operation’. Codes and Values tables add codes: H10.4 – Sigmoid Colectomy and ileostomy HFQ, H20.5 – Fibreoptic Endoscopic Submucosal Resection of Lesion of Colon H20.7 – Fibreoptic endoscopic mucosal resection of Lesion of Colon, H23.7 - Endoscopic Mucosal Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope, H37.1 Endoscopic mucosal resection of lesion of sigmoid colon using rigid Sigmoidoscope. Added following text to Endoscopic Operations: ‘If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field ‘Re-operation’.

**Surgical Approach (Colorectal Cancer)** – Notes for Users add ‘Required for QPI 1’

**Date of Final Definitive** – Notes for Users add ‘Required for QPI 11’

**Intent of Surgery** – Notes for Users add ‘Required QPIs 1, 2’

**Re-operation** – add new data item

**Final Total Number of Lymph Nodes Examined Microscopically (Cancer)** – Notes for Users add ‘Required QPI 5’

**TNM Nodal Classification (Final) (Colorectal Cancer)** – Notes for Users Required for QPI 11, also amended the text from ‘for survival analysis and comparative analysis’ to ‘and for national survival analysis and national comparative analysis’

**TNM Metastasis Classification (Final) (Colorectal)** – Notes for Users add Required for QPI 11

**Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)** – Notes for Users add Required for QPI 11: Inserted text ‘Short course radiotherapy also includes patients who undergo short course and delay to surgery’ in the Explanatory Notes for Short Course Radiotherapy.

**Primary/Palliative/Adjuvant Oncology Treatment Type (Colorectal Cancer)** – Notes for Users Required for QPI 1

**Date Primary/Palliative/Adjuvant Oncology Treatment Started (Colorectal Cancer)** – Notes for Users add Required for QPI 11.

**Revisions to Dataset outwith review (October 2016)**

**Presentation Type** - Had the text ‘If presentation is classed as ‘urgent’, code as ‘emergency’ only if surgery is performed within 72 hours of admission’ deleted as part of the Baseline Review changes (data set v2.4) but it has not been listed here in the revision history at that time.

**Revisions to Dataset outwith review (October 2015)**

*Data Definitions for the National Minimum Core Dataset for Colorectal Cancer.*

*Developed by ISD Scotland, 2014*
Dataset

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – Codes and Values table add H14.1 – Tube Caecostomy, H14.8 – Other specified Exteriorisation of caecum and H14.9 – Unspecified Exteriorisation of caecum (includes Caecostomy NEC)

Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer} - Notes for users add 'If there is no residual tumour at all in the specimen then it should be recorded as clear margin'

Revisions Following Baseline Review (May 2015)

Staging Investigations Complete (Pre-treatment) - Codes and Values table add code and value 4 – Incomplete – Contraindication, explanatory notes - Rectal Cancer only (should not be used for colon cancers)-- Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table

Revisions to Dataset outwith review (March 2015)

Dataset

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – Codes and Values table H13.0 does not exist therefore changed to H13.9 for Bypass of Colon, H07.2 Term Changed to Right Hemicolectomy and side to side anastomosis of ileum to transverse colon, H41.2 Term Changed to Peranal Excision of lesion of Rectum. Add H13.1 Bypass of colon by anastomosis of ileum to colon,H13.2 Bypass of colon by anastomosis of caecum to sigmoid colon,H13.3 Bypass of colon by anastomosis of transverse colon to sigmoid colon,H13.4 Bypass of colon by anastomosis of transverse colon to rectum,H13.5 Bypass of colon by anastomosis of colon to rectum NEC,H13.8 Other specified

Revisions to Dataset outwith review (September 2014)

Database Specification:

Dukes Classification (Colorectal Cancer) – Field Length change to 2 characters

Dataset

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}Final Definitive (or Only Surgery Performed (Surgery) {Colorectal Cancer} – Codes and Values table add Code ‘G74.2’ - Creation of temporary ileostomy, ‘H01.2’ - Emergency excision of abnormal appendix NEC, Code ‘J12.4’ - Percutaneous radiofrequency ablation of lesion of liver.

TNM Tumour Classification (Final) {Colorectal Cancer} - Notes for Users add "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."
TNM Metastasis Classification (Final) {Colorectal Cancer} - Notes for Users add "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."

TNM Nodal Classification (Final) {Colorectal Cancer} - Notes for Users add "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."

Revisions to Dataset outwith review (June 2014)

Database Specification

Date of Definitive Treatment {Colorectal Cancer} – add New Data Item: Field Name: DEFTREATDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Location Code (Radiological Treatment) - name change to Location Code (Radiotherapy Treatment)

Date Neo-Adjuvant/Oncology Treatment Started {Rectal Cancer} - Title changed to Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Rectal Cancer} – Title changed to Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Date of Diagnosis - Field Name changed from DDIAG to DIAGDATE

Dataset

Location Code (Radiological Treatment) - Title changed to Location Code (Radiotherapy Treatment), Text in ‘Notes for Users' radiological changed to radiotherapy

Date Neo-Adjuvant/Oncology Treatment Started {Rectal Cancer} - Title changed to Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Rectal Cancer} - Title changed to Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Revisions to Dataset outwith review (March 2014)

Criteria For Inclusion of Patients in Audit - Added the following note: ‘In the event of multiple, synchronous primary tumours, record that with the worst prognosis/poorest TNM stage. If there is any uncertainty, seek clinical advice.'

Source of Cancer Referral – add new data item

Location Code {SACT Treatment} – add new data item

Location Code {Radiological Treatment} – add new data item

Database Specification

Source of Cancer Referral - add Field Name: MREFER, Field Type: Integer, Field Length: 2.

Location Code {SACT Treatment} - add: Field Name: HOSPSACT, Field Type: Character, Field Length: 5.
Location Code {Radiological Treatment} - add: Field Name: HOSPRADIO, Field Type: Character, Field Length: 5.

Dataset

Staging Investigations Complete {Colorectal Cancer} - Notes for Users add ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’, Add to Notes for Users: ‘Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.’

Date Staging Investigations Completed {Colorectal Cancer} - Notes for Users add ‘Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.’

CT Chest (Results) – Notes for users add ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’

Date of CT Chest (Results) – Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’

Liver Imaging (Results) – Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’ Added to notes for users: ‘Results from CT colonography (with IV contrast) may be recorded, where it can be determined from the radiology report that the liver has been investigated.’

Date of Liver Imaging (Results) - Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’

Large Bowel Imaging - Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’

Date of Imaging Large Bowel - Notes for Users amend ‘Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.’

Date of Histological Diagnosis - Notes for Users add ‘If a primary colorectal cancer is confirmed by liver biopsy only, the date of the liver biopsy should be recorded here.’

Date Discussed by Care Team (MDT) – Notes for Users amend ‘This should be the date that the patient is discussed at the colorectal MDT for management of their cancer.’

Type of First Cancer Treatment – Codes and Values table removed code ’12 active surveillance’

Intent of Surgery – Notes for Users amend ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’
Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer} – Notes for Users add ‘Pathologist sometimes refer to the circumferential margin as the nonperitonealised margin.’

Grade of Differentiation {Colorectal Cancer} – Notes for Users add ‘If polypectomy or another endoscopic procedure is the only treatment administered, the grade of differentiation can be taken from this.’

TNM Tumour Classification (Final) {Colorectal Cancer} – Notes for Users add ‘For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT’.

TNM Nodal Classification (Final) {Colorectal Cancer} – Notes for Users add ‘For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT’.

TNM Metastasis Classification (Final) {Colorectal Cancer} – Notes for Users add ‘For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT’.

Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer} – Notes for Users add ‘It is the intended treatment, as defined by the initial treatment plan that should be recorded.’

Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer} – Amend Data Item name to remove forward slash (/) between ‘neo-adjuvant’ and ‘oncology’.

Date Neo-Adjuvant Oncology Treatment Completed {Colorectal Cancer} – Amended Data item name, to remove forward slash (/) between ‘neo-adjuvant’ and ‘oncology’.

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer} – Notes for Users add ‘If more than one course of primary/palliative/adjuvant oncology treatment is administered, record only the first course.’ Add to notes for users: ‘It is the intended treatment, as defined by the initial treatment plan that should be recorded.’ Added code ‘9: Palliative chemoradiotherapy’ to table of codes and values.

Revisions to Dataset outwith review (January 2014)

Dataset

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – Codes and Values Table add code ‘H06.3 Extended right hemicolecotomy and anastomosis NEC’, ‘H07.3 Right hemicolecotomy and anastomosis NEC’, ‘G74.1 Creation of continent ileostomy’

Revisions to Dataset outwith review (December 2013)

Dataset

ASA Status – Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’
**Consultant in Charge of Surgery** – Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 1010 (Not applicable).’

**Location Code** (Cancer Surgery) – Notes for Users amended ‘This is the hospital of first definitive surgery which removes the primary tumour. If an endoscopic procedure (e.g. polypectomy/stent insertion) is the only treatment, the location of this should be recorded. However, if an endoscopic procedure is performed and is followed by further excision of a segment of the colon or rectum, then the location code of the surgery to remove the segment of colon or rectum should be recorded.’

**Final Definitive (or Only) Surgery Performed (Surgery) (Colorectal Cancer)** – Codes and Values table Added codes ‘H06.5: Extended right hemicolectomy and end to side anastomosis’, ‘H07.5 Right hemicolectomy and end to side anastomosis’. ‘H08.6 Transverse colectomy and end to side anastomosis’. ‘H09.6 Left hemicolectomy and end to side anastomosis’. ‘H10.6 Sigmoid colectomy and end to side anastomosis’. ‘H11.6 Colectomy and end to side anastomosis NEC’.

**Total Mesorectal Excision (TME)** (Rectal Cancer) – Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’

**Surgical Approach** (Colorectal Cancer) – Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’

**Presentation Type** – Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’

**Anastomotic Leak** (Colorectal Cancer) – Notes for Users amended Anastomotic leaks occurring within 30 days of surgery should be recorded.’ Amended notes for users: ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).’

**Intent of Surgery** - Notes for Users amended ‘If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (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 patients with a confirmed new primary cancer of the colon or rectum (ICD-O(3) codes C18 & C20).
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
- All patients with tumour type adenocarcinoma (or undifferentiated/unspecified carcinoma, which is believed most likely to be adenocarcinoma).
- All patients with synchronous colorectal tumours (treatment recorded should relate to the tumour with the most advanced stage).

Exclude:
- Patients where the origin of the primary is uncertain.
- Patients with anal cancer.
- Patients with appendiceal cancer.
- Patients with carcinoid/endocrine tumours, lymphoma, melanoma, or sarcoma.
- Patients with recurrent disease (as opposed to a new primary).
- Patients with metastases in the colon or rectum originating from another primary site.
- Patients with carcinoma-in-situ, non-invasive tumours, or dysplasia.
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence out-with Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken out-with NHS Scotland.

N.B. In the event of multiple, synchronous primary tumours, record that with the worst prognosis/poorer TNM stage. If there is any uncertainly, seek clinical advice.
Data Definitions for the National Minimum Core Dataset for Colorectal Cancer.
Developed by ISD Scotland, 2014
xvii
DOWNLOAD FORMAT

To assist with downloading data to PHS for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

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<thead>
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<th>Data Item</th>
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<td>TNM Tumour Classification (Final) (Colorectal Cancer)</td>
<td>FINALT</td>
<td>Characters</td>
<td>3</td>
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<tr>
<td>TNM Nodal Classification (Final) (Colorectal Cancer)</td>
<td>FINALN</td>
<td>Characters</td>
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</tr>
<tr>
<td>TNM Metastasis Classification (Final) (Colorectal)</td>
<td>FINALM</td>
<td>Characters</td>
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</tr>
<tr>
<td><strong>Section 6: Oncology</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Data Item</td>
<td>Field Name</td>
<td>Field Type</td>
<td>Size</td>
<td>Page</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Location Code (SACT Treatment)</td>
<td>HOSPSACT</td>
<td>Characters</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td>Location Code (Radiotherapy Treatment)</td>
<td>HOSPRADIO</td>
<td>Characters</td>
<td>5</td>
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</tr>
<tr>
<td>Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)</td>
<td>NEOONC1</td>
<td>Integer</td>
<td>2</td>
<td>69</td>
</tr>
<tr>
<td>Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)</td>
<td>NEOONC2</td>
<td>Integer</td>
<td>2</td>
<td>69</td>
</tr>
<tr>
<td>Date Neo-Adjuvant Oncology Treatment Started (Colorectal Cancer)</td>
<td>NEOADJDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Date Neo-Adjuvant Oncology Treatment Started (Colorectal Cancer)</td>
<td>NEOADJDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Date Neo-Adjuvant Oncology Treatment Completed (Colorectal Cancer)</td>
<td>NEOADJCOM1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Date Neo-Adjuvant Oncology Treatment Completed (Colorectal Cancer)</td>
<td>NEOADJCOM2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Primary/Palliative/Adjuvant Oncology Treatment Type (Colorectal Cancer)</td>
<td>ADJONC</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Date Primary/Palliative/Adjuvant Oncology Treatment Started (Colorectal Cancer)</td>
<td>ADJONCDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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<tr>
<td>Date Primary/Palliative/Adjuvant Oncology Treatment Completed (Colorectal Cancer)</td>
<td>ADJONCOM</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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</tr>
<tr>
<td><strong>Section 7: Colorectal Liver Metastases</strong></td>
<td><strong>77</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Diagnosis (Colorectal Liver Metastases)</td>
<td>LIVERDIAGDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>78</td>
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<tr>
<td>Referral to HPB MDT (Colorectal Liver Metastases)</td>
<td>HPBMDT</td>
<td>Integer</td>
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</tr>
<tr>
<td><strong>Section 8: Genetics</strong></td>
<td><strong>80</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Microsatellite Instability (MSI) Status</td>
<td>MSISTATUS</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Mismatch Repair (MMR) Immunohistochemical (IHC) Testing</td>
<td>IHCSTATUS</td>
<td>Integer</td>
<td>2</td>
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<tr>
<td>BRAF Status</td>
<td>BRAF</td>
<td>Integer</td>
<td>2</td>
<td>83</td>
</tr>
<tr>
<td>MLH1 Analysis</td>
<td>MLH1</td>
<td>Integer</td>
<td>2</td>
<td>84</td>
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<tr>
<td>Genetics Referral</td>
<td>GENETICS</td>
<td>Integer</td>
<td>2</td>
<td>85</td>
</tr>
<tr>
<td><strong>Section 9: Clinical Trial Entry</strong></td>
<td><strong>86</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Entered into Clinical Trial</td>
<td>TRIAL</td>
<td>Integer</td>
<td>2</td>
<td>87</td>
</tr>
<tr>
<td><strong>Section 10: Death Details</strong></td>
<td><strong>88</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>89</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:
Main Source of Standard: Government Data Standards Catalogue
The surname of a person represents that part of the name of a person indicating the family group of which the person is part.

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

From SMR Definitions and Codes
Person Given Name

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

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

Definition: The forename or given name of a person.

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

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

Where the person's preferred forename is not the first forename, the related data item 'Preferred Forename' should be used to indicate this.
Patient Postcode at Diagnosis {Cancer}

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

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

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

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

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

Related Data Item(s):
Date of Histological Diagnosis
Date of Birth

Main source of Data Item Standard: Government Data Standards Catalogue

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

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

Notes for Users: Required for QPI; 11
If the patient's date of birth is recorded differently on different occasions, the most frequently used or latest date should be recorded.

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

Related Data Item(s):
CHI Number
Person Sex at Birth

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

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

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

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

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

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

**Codes and Values:**

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

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

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

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

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

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

*From Designed to Care - Scottish Office*

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

(PHS, 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.
Source of Cancer Referral

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

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 sub-analysis of data for DCE HEAT target

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>
<thead>
<tr>
<th>Code</th>
<th>Value</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>3</td>
<td>Incidental finding</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Review clinic</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cancer genetic clinic</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Self-referral to A&amp;E</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>GP referral directly to hospital</td>
<td>A&amp;E or other</td>
</tr>
<tr>
<td>8</td>
<td>Previous GP referral but subsequently admitted to hospital</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Primary care clinician (dental)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Referral from private healthcare</td>
<td></td>
</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:
Section 2: Pre-treatment Imaging & Staging Investigations
Date of Referral

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

Definition: The date on which the patient referral to secondary care for the investigation and/or treatment of colorectal 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><strong>Primary care clinician (Dentist, GP, Nurse practitioner)</strong></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><strong>Screening service</strong></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.</td>
</tr>
<tr>
<td><strong>Incidental finding / Secondary Care</strong></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><strong>Review clinic</strong></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><strong>Cancer genetic clinic</strong></td>
<td>Record the date the referral for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td><strong>Self-referral to A&amp;E</strong></td>
<td>Record the date the patient self presents to A&amp;E.</td>
</tr>
<tr>
<td><strong>GP referral directly to hospital</strong></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><strong>Previous GP referral but subsequently admitted to hospital</strong></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><strong>Primary care clinician (dental)</strong></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><strong>Referral from private healthcare</strong></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><strong>Other</strong></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><strong>Not recorded</strong></td>
<td>If the exact date is not documented, record as 09/09/1900.</td>
</tr>
</tbody>
</table>
Staging Investigations Complete {Colorectal 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 staging investigations were completed by CT (for colon cancer) and by CT and MRI (rectal cancer).

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

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

Complete staging for colon cancer is CT chest, abdomen and pelvis (and no other combination).

Complete staging for rectal cancer is CT chest, abdomen and pelvis with the addition of pelvic MRI.

Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.

These investigations may be done separately at different times but before definitive treatment.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete – CT Chest, Abdomen and Pelvis</td>
<td>Colon Cancer</td>
</tr>
<tr>
<td>2</td>
<td><strong>Complete – CT Chest, Abdomen and Pelvis and pelvic MRI</strong></td>
<td>Rectal Cancer</td>
</tr>
<tr>
<td>3</td>
<td>Incomplete</td>
<td>e.g. no imaging or part imaging</td>
</tr>
<tr>
<td>4</td>
<td>Incomplete - Contraindications</td>
<td>Rectal Cancer only (should not be used for colon cancers)- Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</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 Staging Investigations Complete  
Site of Origin of Primary Tumour {Cancer}
**Date Staging Investigations Completed**

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

**Definition:** The date that staging investigations were completed by CT of the chest, abdomen and pelvis for colon cancer plus a pelvic MRI for rectal cancer.

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

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

Complete staging for colon cancer is CT chest, abdomen and pelvis (and no other combination).

Complete staging for rectal cancer is CT chest, abdomen and pelvis with the addition of pelvic MRI.

Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis i.e. CT colonography (with contrast) and CT chest is complete staging.

These investigations may be done separately at different times but before definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Record the date that ALL items are complete, e.g. if done on separate days then record the final date.

If staging investigations were not completed, record as inapplicable (10/10/1900).

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

**Related Data Item(s):**  
Staging Investigations Complete
Distance from Anal Verge (Rectal 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 the distance from the anal verge to the lower margin of the tumour measured in centimetres (cm) by proctoscopy or sigmoidoscopy.

Field Name: ANALVERGE
Field Type: Integer
Field Length: 2

Notes for Users: Required for local analysis or submission to the UK National Bowel Cancer Audit.

This item should be recorded only for rectal tumours and is recorded in centimetres (cm).

Where there is a range e.g. 10-20cm, the lowest value should be recorded.

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

If not rectal cancer, record as ‘96’ (not applicable)

If the distance is not recorded, code as ‘99’ (Not recorded).
CT Chest (Results)

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

**Definition:** CT Chest (or CT Thorax) is a series of cross-sectional images of the thorax produced by a CT scanner.

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

**Notes for Users:** Required for Detect Cancer Early Initiative.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No metastases</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Metastases</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Equivocal</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Not performed</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

Date of CT Chest (Results)
Date of CT Chest (Results)

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

Definition: Date of CT Chest (or CT Thorax) investigation was carried out.

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

Notes for Users: Required for Detect Cancer Early Initiative

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Related Data Item(s):
CT Chest (Results)
Liver Imaging (Results)

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

**Definition:** Liver imaging is defined as, computed tomography (CT) for the identification of liver metastases.

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

**Notes for Users:** Required for Detect Cancer Early Initiative.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Results from CT colonography (with IV contrast) may be recorded, where it can be determined from the radiology report that the liver has been investigated.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No metastases</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Metastases</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Equivocal</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Not performed</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigaion</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 Liver Imaging (Results)
Date of Liver Imaging (Results)

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

**Definition:** Date of when liver imaging investigation was carried out.

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

**Notes for Users:** Required for Detect Cancer Early Initiative

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

**Related Data Item(s):**  
Liver Imaging (Results)
Large Bowel Imaging

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

Definition: A record to determine if the whole colon was visualised by colonoscopy or CT colonography pre-operatively.

Field Name: LBTYPE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 2

Colonoscopy examination is complete when the caecum/ileocaecal valve or small bowel colon anastomosis, if previous surgery has been performed, is reached. It is also complete when the non-visualised segment of colon is resected at the time of operation. e.g.: if hepatic flexure cancer has been reached but the colonoscope could not get through it to the caecum and the patient then went onto have a right hemicolectomy. The same would be true if there was a splenic flexure cancer which would not allow the colonoscope through and the patient underwent an extended right hemicolectomy with anastomosis of their terminal ileum to their sigmoid or descending colons. However it would be regarded as incomplete if the same patient with splenic flexure cancer underwent a local excision of their left colon and anastomosis of their proximal transverse colon to their descending colon i.e. caecum and ascending colon has not been visualised at the colonoscopy and has been left in the patient at the time of their operation.

Incomplete colonoscopy due to poor bowel prep would not be included here i.e. they would be regarded as incomplete examinations.

Code 3 ‘Incomplete due to obstructing tumour’ includes situations where it is deemed clinically unsafe to attempt colonoscopy due to impending obstruction.

Investigation must be performed before, or on, the date of surgical resection (or definitive treatment date where no resection is performed) unless patient has a polyp cancer treated only by polypectomy or EMR.

NB: Record only the most complete peri-operative colonoscopy.

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 – Colonoscopy or CT Colonography</td>
<td>Whole colon is visualised or non-visualised segment of colon has been removed.</td>
</tr>
<tr>
<td>2</td>
<td>Incomplete</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not performed</td>
<td>No colonoscopy or CT colonography performed</td>
</tr>
<tr>
<td>4</td>
<td>Incomplete due to obstructing tumour</td>
<td>This includes patients with strictures which prevent passage of a scope.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Related Data Items
Date of Large Bowel Imaging
Date of Imaging Large Bowel

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

Definition: The date on which imaging of the large bowel was carried out using colonoscopy of CT colonography.

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

Notes for Users: Required for QPI: 2

Colonoscopy examination is complete when the caecum/ileo-cesal valve or small bowel colon anastomosis, if previous surgery has been performed, is reached. It is also complete when the non-visualised bit of colon is resected at the time of operation.

NB: Record the date of the most complete peri-operative colonoscopy.

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

If no imaging was performed, record as 10/10/1900.

Related Data Items
Large Bowel Imaging
**Circumferential Resection Margin – Predicted (Rectal Cancer)**

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

**Definition:** A record of the predicted circumferential resection margin on imaging (MRI) prior to surgery, as documented on MRI report or following MDT discussion

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

**Notes for Users:**  
This should be obtained following discussion of MRI at the MDT meeting or from the MRI report.

For patients with rectal cancer MRI is utilised to assess the extent of disease prior to treatment.

This is recorded for rectal tumours only and for all patients who undergo MRI for staging of rectal cancer.

This is predicted circumferential resection margin on MRI/imaging and not the post-surgical result.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clear</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Threatened</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Involved</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Polyp cancer or locally resected</td>
</tr>
<tr>
<td>98</td>
<td>Not assessed</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Involvement of margin not noted on MRI report/MDT discussion</td>
</tr>
</tbody>
</table>
Location of Diagnosis {Cancer}


**Definition:** The patient's hospital of initial referral into secondary care which led to a diagnosis of cancer.

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

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

This will be the hospital where the patient was diagnosed. If the diagnosis is made by screening colonoscopy; or if colonoscopy is carried out at a hospital for waiting list reasons i.e. Golden Jubilee, the hospital recorded should be the hospital where the patient was managed following their diagnosis of cancer.

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

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

Location codes for hospitals are five character codes maintained by PHS 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

**Related Data Item(s):**  
Date of Diagnosis
Date of Diagnosis {Cancer}

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

Definition: The date on which the first confirmed cancer diagnosis 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 QPI(s): 1, 2, 5, 7, 8, 9, 10, 11, 12, 16.

Required for national survival analysis and clarifying responsibility for data collection.

The date recorded is the date of the first investigative procedure that confirms a diagnosis of colorectal cancer whether done radiologically or histologically.

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

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 date of the first provisional diagnosis should be recorded as the date of diagnosis.

For patients diagnosed with a cancer and not just a screening result, through a national screening programme, at a screening assessment/diagnostic clinic, this should be the date of diagnosis. This may be at the screening centre or hospital.

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

Related Data Item(s):
Location of Diagnosis {Cancer}
Date of Histological Diagnosis (Cancer)

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

Definition: The date on which the cancer was diagnosed microscopically.

Field Name: HDIAG
Format: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for national survival analysis.

If endoscopy and biopsy was not carried out or no histological diagnosis made, record as 10/10/1900.

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

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

If a primary colorectal cancer is confirmed by liver biopsy only, the date of the liver biopsy should be recorded here.

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

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

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

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

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 (without concurrent or previous histology)</td>
<td>The tumour has been visualised or palpated but there is no confirmatory microscopic evidence</td>
</tr>
<tr>
<td>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>99</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

Data Definitions for the National Minimum Core Dataset for Colorectal Cancer. Developed by ISD Scotland, 2014
Site of Origin of Primary Tumour {Cancer}

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

**Definition:** The anatomical site of origin of the primary tumour according to the International Classification of Diseases for Oncology (ICD-O(3)).

**Field Name:** SITE  
**Field Type:** Characters ICD-O (3)  
**Field length:** 4

**Notes for Users:** Required for QPI(s): 1, 7.

For ICD-O(3), tumours should be assigned to the subcategory that includes the point of origin of the tumour. A tumour that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified as subcategory ‘8’. It should be noted that this subcategory should only be used where it is impossible to identify the specific site of origin of the tumour.

**Codes and Values:**

<table>
<thead>
<tr>
<th>ICD-O(3) Code</th>
<th>Value</th>
<th>Notes on Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>C18.0</td>
<td>Caecum</td>
<td>Ileo caecal valve; Ileo caecal junction</td>
</tr>
<tr>
<td>C18.2</td>
<td>Ascending colon</td>
<td>Right colon</td>
</tr>
<tr>
<td>C18.3</td>
<td>Hepatic flexure</td>
<td></td>
</tr>
<tr>
<td>C18.4</td>
<td>Transverse colon</td>
<td></td>
</tr>
<tr>
<td>C18.5</td>
<td>Splenic flexure</td>
<td></td>
</tr>
<tr>
<td>C18.6</td>
<td>Descending colon</td>
<td>Left colon</td>
</tr>
<tr>
<td>C18.7</td>
<td>Sigmoid colon</td>
<td>Sigmoid NOS; Sigmoid flexure of colon; Pelvic colon</td>
</tr>
<tr>
<td>C18.8</td>
<td>Overlapping lesion of colon</td>
<td></td>
</tr>
<tr>
<td>C18.9</td>
<td>Colon, unspecified</td>
<td>Large intestine; Large Bowel NOS</td>
</tr>
<tr>
<td>C20.9</td>
<td>Rectum</td>
<td>Rectal ampulla</td>
</tr>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
**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:**

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.

This should be the date that the patient is discussed at the colorectal-specific MDT for the management of their cancer.

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

If the date of the MDT meeting is unknown, record as 09/09/1900 (Not recorded).
COVID 19 Impact

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

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

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

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

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

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

Codes and Values:

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

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

**Definition:** A record to determine if the patient has been referred to a nurse with expertise in stoma care.

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

**Notes for Users:**

All patients requiring stoma formation should be seen by a nurse with expertise in stoma care.

In cases where the patient will not require stoma formation (permanent or temporary) code as 96 (not applicable).

Can be the same day but prior to operation.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused</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):**

Date Seen by Stoma Nurse {Colorectal Cancer}  
Stoma Site Marked Pre-operatively
Date Seen by Stoma Nurse {Colorectal 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 patient was seen by a nurse with expertise in stoma care.

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

**Notes for Users:**

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

If the patient was not required to be seen by a nurse with expertise in stoma care, record as 10/10/1900 (not applicable).

**Related Data Item(s):**

- Seen by Stoma Nurse {Colorectal Cancer}
- Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
- Stoma Site Marked Pre-operatively
Stoma Site Marked Pre-operatively

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

Definition: A record to determine if the patient’s stoma site was marked pre-operatively by a nurse with expertise in stoma care.

Field Name: STOMAMARK
Field Type: Integer
Field Length: 2

Notes for Users:
All patients requiring stoma formation should be seen by a nurse with expertise in stoma care preoperatively and have their stoma site marked.

In cases where the patient will not require stoma formation (permanent or temporary) code as 96 (not applicable).

Can be the same day prior to operation even if it is on the same day

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused</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):
Date Seen by Stoma Nurse {Colorectal Cancer}
Seen by Stoma Nurse {Colorectal Cancer}
Type of First Cancer Treatment

Common name: Mode of first treatment

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

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

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

Notes for Users: Required for QPI: 1

Required for survival analysis and 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.

Dilations without other treatment are not considered as active treatment.

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

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>2</td>
<td>Radiotherapy</td>
<td>Includes Teletherapy (external beam radiotherapy)</td>
</tr>
<tr>
<td>4</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Supportive Care Only</td>
<td>Not for active treatment</td>
</tr>
<tr>
<td>8</td>
<td>Radical Endoscopic</td>
<td>e.g. endomucosal resection</td>
</tr>
<tr>
<td>9</td>
<td>Palliative Endoscopic</td>
<td>e.g. insertion of stents</td>
</tr>
<tr>
<td>10</td>
<td>SACT</td>
<td>Includes all types of SACT e.g. chemotherapy, biological therapy and immunotherapy</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 treatment</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 survival analysis and comparative analysis.

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

If type of first cancer treatment is ‘supportive care only’, the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. 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.

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

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

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

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

For patients with colorectal cancer definitive treatment will be either:

- Surgery;
- Neo-adjuvant Radiotherapy/ Chemotherapy/ Chemoradiotherapy;
- Primary/Radical Radiotherapy; or
- Primary Chemotherapy.

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

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

Malignant polyps may be removed at colonoscopy and if no further operation is carried out the date of polypectomy should be recorded in this field. However if an operation such as a bypass or formation of a stoma is carried out to relieve symptoms and a further operation which aims to remove the tumour is performed the date of the second operation is the one that should be recorded in this field.

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. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. This will therefore be the same date as the First Treatment Date for these patients.

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

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

**Related Data Item(s):**
Section 3: Surgery
ASA Status

**Common name:** Patient status

**Main source of Data Item Standard:** American Society of Anaesthesiologists.

**Definition:** The ASA PS classification globally assesses the degree of "sickness" or "physical state" prior to selecting the anaesthetic or prior to performing surgery.

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

**Notes for Users:** Required for local analysis or submission to the UK National Bowel Cancer Audit.

The American Society of Anaesthesiologists’ (ASA) physical status classification serves as a guide to better communication among anaesthesiologists about clinical conditions of patients. The ASA classification system by itself does not predict risk. However, one can estimate higher or lower medical risk when factoring anaesthetic technique and the extent of surgical trauma.

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded 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>A normal healthy patient.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>A patient with mild systemic disease.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>A patient with severe systemic disease</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A moribund patient who is not expected to survive without the operation.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Polypectomy only patients</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Consultant in Charge 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 name of the consultant who is in charge of the final definitive (or only) surgery.

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

**Notes for Users:** Required for survival analysis and comparative 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 no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 1010.

If the patient is managed by a team rather than with a consultant in overall charge, record as inapplicable, 1010.

If the patient is managed by a locum, record only that the clinician is a locum consultant, LOCUM.

**Related Data Item(s):**
- Location Code {Cancer Surgery}
- Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
- Surgical Approach {Colorectal Cancer}
- Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
- Presentation Type
- Intent of Surgery
**Location Code {Cancer Surgery}**

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


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

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

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

This is the hospital of first definitive surgery which removes the primary tumour. If an endoscopic procedure (e.g. polypectomy/stent insertion) is the only treatment, the location of this should be recorded. However, if an endoscopic procedure is performed and is followed by further excision of a segment of the colon or rectum, then the location code of the surgery to remove the segment of colon or rectum should be recorded.

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). [http://www.show.scot.nhs.uk/smrfiles/information.html](http://www.show.scot.nhs.uk/smrfiles/information.html) – 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 PHS is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate.  
[http://www.show.scot.nhs.uk/smrfiles](http://www.show.scot.nhs.uk/smrfiles)

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

If the location code is not documented, record as X9999.

If surgery has not been performed or the patient has refused surgery, record as inapplicable, X1010.

Examples of codes are given below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>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):** Consultant in Charge of Surgery
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Surgical Approach {Colorectal Cancer}
Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
Presentation Type
Intent of Surgery
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

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

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

Field Name: OPCODE2
OPCODE2B
Field Type: Characters
Field Length: 5

Notes for Users: Required for QPl(s): 1, 2, 5, 7, 8, 9, 10, 11

Malignant polyps may be removed at colonoscopy and if no further operation is carried out the appropriate code for the polypectomy should be recorded in this field.

If there are multiple tumours record the operation relating to the most advanced tumour (i.e. the one with the most advanced stage).

If a palliative operation such as a bypass or formation of a stoma is the only operation performed, the code for that operation should be entered in this field.

However if an operation such as a bypass or formation of a stoma is carried out to relieve symptoms and a further operation which aims to remove the tumour is performed the second operation is the one that should be coded in this field.

If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field ‘Re-operation’.

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

H06.1 = Extended right hemicolecctomy and end to end anastomosis
H06.2 = Extended right hemicolecctomy and anastomosis of ileum to colon

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

If the patient died before treatment, record as 94 (Patient died before treatment).

If the patient refused treatment, record as 95 (Patient refused treatment).
If only one code is required, record ‘OPCODE2B’ as 96 (Not applicable).

If operation code has not been recorded, record as 99 (Not recorded)
If the patient did not undergo surgery for other reasons, record as 96 (not applicable)

Examples of operative procedures are given below:
This list is not exhaustive and if a code is not on the list please contact phs.canceraudit@nhs.net.
<table>
<thead>
<tr>
<th>Emergency excision of appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>H01.2 Emergency excision of abnormal appendix NEC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other excision of appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>H02.1 Interval appendicectomy</td>
</tr>
<tr>
<td>H02.2 Planned delayed appendicectomy</td>
</tr>
<tr>
<td>H02.3 Prophylactic appendicectomy</td>
</tr>
<tr>
<td>H02.4 Incidental appendicectomy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLON - Total Excision of Colon and Rectum</th>
</tr>
</thead>
<tbody>
<tr>
<td>H04.1 Panproctocolectomy and Ileostomy</td>
</tr>
<tr>
<td>H04.2 Panproctocolectomy and Anastomosis of Ileum to Anus and Creation of Pouch</td>
</tr>
<tr>
<td>H04.3 Panproctocolectomy and Anastomosis of Ileum to Anus NEC</td>
</tr>
<tr>
<td>H04.8 Other Specified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excision of Sigmoid Colon</th>
</tr>
</thead>
<tbody>
<tr>
<td>H10.1 Sigmoid Colectomy and end to end Anastomosis of Ileum and Rectum</td>
</tr>
<tr>
<td>H10.2 Sigmoid Colectomy and Anastomosis of Colon to Rectum</td>
</tr>
<tr>
<td>H10.3 Sigmoid Colectomy and Anastomosis NEC</td>
</tr>
<tr>
<td>H10.4 Sigmoid Colectomy and ileostomy HFQ</td>
</tr>
<tr>
<td>H10.5 Sigmoid Colectomy and Exteriorisation of Bowel NEC</td>
</tr>
<tr>
<td>H10.6 Sigmoid colectomy and end to side anastomosis</td>
</tr>
<tr>
<td>H10.8 Other Specified</td>
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</table>

<table>
<thead>
<tr>
<th>Total Excision of Colon</th>
</tr>
</thead>
<tbody>
<tr>
<td>H05.1 Total Colectomy and Anastomosis</td>
</tr>
<tr>
<td>H05.2 Total Colectomy and Ileostomy with Creation of Rectal Fistula</td>
</tr>
<tr>
<td>H05.3 Total Colectomy and Ileostomy NEC</td>
</tr>
<tr>
<td>H05.8 Other Specified</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Extended Excision of Right Hemi Colon</th>
</tr>
</thead>
<tbody>
<tr>
<td>H06.1 Ext Right Hemicolectomy and end to end Anastomosis</td>
</tr>
<tr>
<td>H06.2 Ext Right Hemicolectomy and Anastomosis of Ileum to Colon</td>
</tr>
<tr>
<td>H06.3 Ext Right Hemicolectomy and Anastomosis NEC</td>
</tr>
<tr>
<td>H06.4 Ext Right Hemicolectomy and ileostomy HFQ</td>
</tr>
<tr>
<td>H06.5 Ext Right Hemicolectomy and end to side anastomosis</td>
</tr>
<tr>
<td>H06.8 Other Specified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Excision of Right Hemi Colon</th>
</tr>
</thead>
<tbody>
<tr>
<td>H07.1 Right Hemicolectomy and end to end anastomosis of Ileum to Colon</td>
</tr>
<tr>
<td>H07.2 Right Hemicolectomy and side to side anastomosis of ileum to transverse colon</td>
</tr>
<tr>
<td>H07.3 Right Hemicolectomy and Anastomosis NEC</td>
</tr>
<tr>
<td>H07.4 Hemicolectomy and ileostomy HFQ</td>
</tr>
<tr>
<td>H07.5 Right hemicolectomy and end to side anastomosis</td>
</tr>
<tr>
<td>H07.8 Other Specified</td>
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</table>
### Other Excision of Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H11.1</td>
<td>Colectomy and end to end Anastomosis of Colon to Colon NEC</td>
</tr>
<tr>
<td>H11.2</td>
<td>Colectomy and side to side Anastomosis of Ileum to Colon NEC</td>
</tr>
<tr>
<td>H11.3</td>
<td>Colectomy and Anastomosis of Ileum NEC</td>
</tr>
<tr>
<td>H11.4</td>
<td>Colectomy and Ileostomy NEC</td>
</tr>
<tr>
<td>H11.5</td>
<td>Colectomy and Exteriorisation of Bowel NEC</td>
</tr>
<tr>
<td>H11.6</td>
<td>Colectomy and end to side anastomosis</td>
</tr>
<tr>
<td>H11.7</td>
<td>Other Specified</td>
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</table>

### Extirpation of Lesion of Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H12.1</td>
<td>Excision of Diverticulum of Colon</td>
</tr>
<tr>
<td>H12.2</td>
<td>Excision of Lesion of Colon NEC</td>
</tr>
<tr>
<td>H12.3</td>
<td>Destruction of Lesion of Colon NEC</td>
</tr>
<tr>
<td>H12.4</td>
<td>Other Specified</td>
</tr>
</tbody>
</table>

### Bypass of Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H13.9</td>
<td>Bypass of Colon</td>
</tr>
<tr>
<td>H13.1</td>
<td>Bypass of colon by anastomosis of ileum to colon</td>
</tr>
<tr>
<td>H13.2</td>
<td>Bypass of colon by anastomosis of caecum to sigmoid colon</td>
</tr>
<tr>
<td>H13.3</td>
<td>Bypass of colon by anastomosis of transverse colon to sigmoid colon</td>
</tr>
<tr>
<td>H13.4</td>
<td>Bypass of colon by anastomosis of transverse colon to rectum</td>
</tr>
<tr>
<td>H13.5</td>
<td>Bypass of colon by anastomosis of colon to rectum NEC</td>
</tr>
<tr>
<td>H13.6</td>
<td>Other Specified</td>
</tr>
</tbody>
</table>

### Other Exteriorisation of Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H15.1</td>
<td>Loop Colostomy</td>
</tr>
<tr>
<td>H15.2</td>
<td>End Colostomy</td>
</tr>
<tr>
<td>H15.3</td>
<td>refashioning of colostomy</td>
</tr>
</tbody>
</table>

### Excision of Transverse Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H08.1</td>
<td>Transverse Colectomy and end to end Anastomosis</td>
</tr>
<tr>
<td>H08.2</td>
<td>Transverse Colectomy and Anastomosis of Ileum to Colon</td>
</tr>
<tr>
<td>H08.3</td>
<td>Transverse Colectomy and Anastomosis NEC</td>
</tr>
<tr>
<td>H08.4</td>
<td>Transverse Colectomy and Ileostomy HFQ</td>
</tr>
<tr>
<td>H08.5</td>
<td>Transverse Colectomy and Exteriorisation of Bowel NEC</td>
</tr>
<tr>
<td>H08.6</td>
<td>Transverse coectomy and end to side anastomosis</td>
</tr>
<tr>
<td>H08.7</td>
<td>Other Specified</td>
</tr>
</tbody>
</table>

### Excision of Left Hemi colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H09.1</td>
<td>Left Hemicolecctomy and End to End Anastomosis of Colon to Rectum</td>
</tr>
<tr>
<td>H09.2</td>
<td>Left Hemicolecctomy and End to End Anastomosis of Colon to Colon</td>
</tr>
<tr>
<td>H09.3</td>
<td>Left Hemicolecctomy and Anastomosis NEC</td>
</tr>
<tr>
<td>H09.4</td>
<td>Left Hemicolecctomy and Ileostomy HFQ</td>
</tr>
<tr>
<td>H09.5</td>
<td>Left Hemicolecctomy and Exteriorisation of Bowel NEC</td>
</tr>
<tr>
<td>H09.6</td>
<td>Left Hemicolecctomy and end to side anastomosis</td>
</tr>
<tr>
<td>H09.7</td>
<td>Other Specified</td>
</tr>
</tbody>
</table>

### Open Endoscopic Operations on Colon

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H18.1</td>
<td>Open Colonoscopy</td>
</tr>
<tr>
<td>H18.2</td>
<td>Other Specified</td>
</tr>
</tbody>
</table>

### Exteriorisation of caecum

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H14.1</td>
<td>Tube Caecostomy</td>
</tr>
<tr>
<td>H14.2</td>
<td>Other specified</td>
</tr>
<tr>
<td>H14.3</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

### Clearance of Pelvis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X14.1</td>
<td>Total exenteration of pelvis.</td>
</tr>
<tr>
<td>X14.2</td>
<td>Anterior exenteration</td>
</tr>
<tr>
<td>X14.3</td>
<td>Posterior exenteration of pelvis.</td>
</tr>
<tr>
<td>X14.4</td>
<td>Other specified clearance of pelvis</td>
</tr>
<tr>
<td>X14.9</td>
<td>Unspecified clearance of pelvis.</td>
</tr>
</tbody>
</table>
### Subtotal Excision of Colon

- **H29.1** Subtotal excision of colon and rectum and creation of colonic pouch and anastomosis of colon to anus
- **H29.2** Subtotal excision of colon and rectum and creation of colonic pouch NEC
- **H29.3** Subtotal excision of colon and creation of colonic pouch and anastomosis of colon to rectum
- **H29.4** Subtotal excision of colon and creation of colonic pouch NEC
- **H29.8** Other specified subtotal excision of colon
- **H29.9** Unspecified subtotal excision of colon

### Other Operations of Colon

- **H30.1** Radiological Reduction of Intussusception of Colon using Barium Enema
- **H30.2** Intubation of Colon for Pressure Manometry
- **H30.3** Passage of Flatus Tube to reduce Volvulus of Sigmoid Colon
- **H30.4** Intubation of Colon NEC
- **H30.8** Other Specified
- **H21.4** Fibreoptic endoscopic insertion of expanding metal stent into colon.
- **H24.4** Endoscopic insertion of expanding metal stent into lower bowel using fibreoptic sigmoidoscope
- **H27.4** Endoscopic insertion of expanding metal stent into sigmoid colon using rigid sigmoidoscope
- **H31.4** Image guided insertion of colorectal stent
- **H31.5** Image guided removal of colorectal stent

### OPERATIVE PROCEDURES - RECTUM

#### Excision of Rectum

- **H33.1** Abdominoperineal Excision of Rectum and End Colostomy
- **H33.2** Proctectomy and Anastomosis of Colon to Anus
- **H33.3** Anterior Resection of Rectum-Anastomosis of Colon to Rectum using Staples
- **H33.4** Anterior Resection of Rectum-Anastomosis NEC
- **H33.5** Rectosigmoidectomy and Closure of Rectal Stump and Exteriorisation of bowel
- **H33.6** Anterior Resection of Rectum and Exteriorisation of bowel
- **H33.8** Other Specified

#### Operations on Rectum through Anal Sphincter

- **H40.1** Transsphincteric Excision of Mucosa of Rectum
- **H40.2** Transsphincteric Excision of Lesion of Rectum
- **H40.3** Transsphincteric Destruction of Lesion of Rectum
- **H40.4** Transsphincteric Anastomosis of Colon to Anus
- **H40.8** Other Specified

#### Open Extirpation of Lesion of Rectum

- **H34.1** Open Excision of Lesion of Rectum
- **H34.2** Open Cauterisation of Lesion of Rectum
- **H34.3** Open Cryotherapy of Lesion of Rectum
- **H34.4** Open Laser Destruction of Lesion of Rectum
- **H34.5** Open Destruction of Lesion of Rectum
- **H34.8** Other Specified

#### Other Operations on Rectum through Anus

- **H41.1** Rectosigmoidectomy and Peranal Anastomosis
- **H41.2** Peranal Excision of lesion of Rectum
- **H41.3** Peranal Destruction of Lesion of Rectum
- **H41.4** Peranal Mucosal Proctectomy and Endoanal Anastomosis
- **H41.8** Other Specified
### OPERATIVE PROCEDURES - ENDOSCOPIC OPERATIONS

**Endoscopic Extirpation of Lesion of Colon**
- H20.1 Fibreoptic Endoscopic Snare Resection of Lesion of Colon
- H20.2 Fibreoptic Endoscopic Cauterisation of Lesion of Colon
- H20.3 Fibreoptic Endoscopic Laser Destruction of Lesion of Colon
- H20.4 Fibreoptic Endoscopic Destruction of Lesion of Colon NEC
- H20.5 Fibreoptic Endoscopic Submucosal Resection of Lesion of Colon
- H20.7 Fibreoptic endoscopic mucosal resection of Lesion of Colon
- H20.8 Other Specified

**Other Therapeutic Endoscopic Operations on Colon**
- H21.1 Fibreoptic Endoscopic Dilation of Colon
- H21.2 Fibreoptic Endoscopic Coagulation of Blood Vessel of Colon
- H21.8 Other Specified

**Endoscopic Extirpation of Lesion of Lower Bowel Using Fibreoptic Sigmoidoscope**
- H23.1 Endoscopic Snare Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.2 Endoscopic Cauterisation of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.3 Endoscopic Laser Destruction of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.4 Endoscopic Snare Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.5 Endoscopic submucosal resection of lesion of lower bowel using fibreoptic sigmoidoscope
- H23.7 Endoscopic Mucosal Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.8 Other Specified

**Other Endoscopic Operations – Lower Bowel using Fibreoptic Sigmoidoscope**
- H24.1 Endoscopic Dilation of Lower Bowel using Fibreoptic Sigmoidoscope
- H24.2 Endoscopic Coagulation of Blood Vessel of Lower Bowel using Fibreoptic Sigmoidoscope
- H24.8 Other Specified

**Endoscopic Extirpation of Lesion of Sigmoid Colon using Rigid Sigmoidoscope**
- H26.2 Endoscopic Cauterisation of Lesion of Sigmoid Colon using Rigid Sigmoidoscope
- H26.3 Endoscopic Laser Destruction of Lesion of Sigmoid Colon using Rigid Sigmoidoscope
- H26.4 Endoscopic Cryotherapy to Lesion of Sigmoid Colon using Rigid Sigmoidoscope NEC
- H26.6 Endoscopic submucosal resection of lesion of sigmoid colon using rigid sigmoidoscope
- H26.8 Other Specified

**Other Endoscopic Operations on Sigmoid Colon using Rigid Sigmoidoscope**
- H27.1 Endoscopic Dilation of Sigmoid Colon using Rigid Sigmoidoscope
- H27.8 Other Specified
### OPERATIVE PROCEDURES - SYNCHRONOUS LIVER RESECTION

- J02.1 Right hemihepatectomy
- J02.2 Left hemihepatectomy
- J02.3 Resection of segment of liver
- J02.4 Wedge excision of liver
- J02.6 Extended right hemihepatectomy
- J02.7 Extended left hemihepatectomy
- J03.2 Destruction of lesion of liver
- J03.3 Thermal ablation of single lesion of liver
- J03.4 Thermal ablation of multiple lesions of liver
- J03.5 Excision of multiple lesions of liver
- J12.4 Percutaneous radiofrequency ablation of lesion of liver

### OPERATIVE PROCEDURES – CREATION OF ARTIFICIAL OPENING INTO ILEUM

- G74.1 Creation of continent ileostomy
- G74.2 Creation of temporary ileostomy
- G74.3 Creation of defunctioning ileostomy
- G74.8 Other specified
- G74.9 Unspecified

**Related Data Item(s):**
- Consultant in Charge of Surgery
- Location Code {Cancer Surgery}
- Surgical Approach {Colorectal Cancer}
- Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
- Presentation Type
- Intent of Surgery
Total Mesorectal Excision (TME) {Rectal Cancer}

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

Definition: An indication of whether or not Total Mesorectal Excision (TME) has been performed.

Field Name: TEXCISION
Field Type: Integer
Field Length: 2

Notes for Users:

Total mesorectal excision (TME) is the en-bloc excision of the fatty tissue around the rectum along with its fascial envelope in the course of rectal excision.

Only excisions of the whole rectum (low anterior resection or AP excision) and where the intended plane of excision is mesorectal, count as TME.

This is recorded for rectal tumours only. If there are multiple tumours record this for the operation related to the most advanced tumour (i.e. the one with the poorest stage).

If the site of origin of the tumour is not the rectum (colon) code as inapplicable (96).

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Not rectal cancer/endoscopic treatment only.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
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</table>
Surgical Approach (Colorectal Cancer)

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

**Definition:** The type of surgical procedure(s) performed for treatment of cancer. This also includes nodal and reconstructive surgery performed on the patient for treatment of cancer.

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

**Notes for Users:** Required for QPI(s): 1, 5, 7

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

**Codes and Values:**

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<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
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<td>2A</td>
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<td>Includes laparoscopic assisted</td>
</tr>
<tr>
<td>2B</td>
<td>Laparoscopic - Converted</td>
<td>Includes laparoscopic assisted</td>
</tr>
<tr>
<td>3</td>
<td>Transanal Endoscopic Microsurgery/</td>
<td>TEM/TAMIS</td>
</tr>
<tr>
<td></td>
<td>Transanal Minimally Invasive Surgery</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Transanal Resection of Tumour</td>
<td>TART</td>
</tr>
<tr>
<td>5A</td>
<td>Robotic - Completed</td>
<td></td>
</tr>
<tr>
<td>5B</td>
<td>Robotic - Converted</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Surgery not performed/endoscopic treatment only</td>
</tr>
<tr>
<td>99</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Consultant in Charge of Surgery  
Location Code (Cancer Surgery)  
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}  
Date of Final Definitive (or Only) Surgery {Colorectal Cancer}  
Presentation Type  
Intent of Surgery
Date of Final Definitive (or Only) Surgery {Colorectal 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 operation described elsewhere as the final definitive (or only) operation for colorectal cancer was performed.

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

Notes for Users: Required for QPI(s): 2, 7, 10, 11

The date format should be DD/MM/CCYY.

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

If no surgical procedure is carried out, code as 10/10/1900 (inapplicable).

Related Data Item(s):
Consultant in Charge of Surgery
Location Code {Cancer Surgery}
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Surgical Approach {Colorectal Cancer}
Presentation Type
Intent of Surgery
**Presentation Type**

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

**Definition:** How the patient presented for surgery.

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

**Notes for Users:** Required for QPI(s): 1, 2, 7, 10

Both categories incorporate:

1. Transfer from another consultant and/or significant facility and/or specialty and/or hospital in the same or another trust where the patient was already undergoing hospital care for treatment.
2. A patient presenting for surgery while undergoing hospital care for an unrelated condition (incidental finding).

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded 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>Elective (routine)</td>
<td>A patient who presents for surgery as planned.</td>
</tr>
<tr>
<td>2</td>
<td>Emergency</td>
<td>A patient, who for clinical reasons, presents unplanned for surgery</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>If no operation was performed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
- Consultant in Charge of Surgery
- Location Code (Cancer Surgery)
- Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
- Surgical Approach {Colorectal Cancer}
- Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
- Intent of Surgery
Anastomotic Leak (Colorectal Cancer)

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

Definition: An indication of whether or not there was anastomotic leak requiring medical, endoscopic, radiological or surgical intervention in patients undergoing a surgical procedure involving anastomosis.

Field Name: ANASLEAK
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 9

Anastomotic leaks occurring within 30 days of surgery should be recorded.

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded 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 anastomotic leak</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Surgery not performed/endoscopic treatment only</td>
</tr>
<tr>
<td>99</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Total Mesorectal Excision (TME) (Rectal Cancer)
Intent of Surgery

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

**Definition:** Final assessment of intent of surgery as defined by the Multidisciplinary Team (MDT).

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

**Notes for Users:** Required QPI(s): 1, 2, 5 and survival analysis

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable)

**Codes and Values:**

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

**Related Data Items:**  
- Date Discussed by Care Team (MDT Pre-treatment)  
- Consultant in Charge of Surgery  
- Location Code {Cancer Surgery}  
- Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}  
- Surgical Approach {Colorectal Cancer}  
- Date of Final Definitive (or Only) Surgery {Colorectal Cancer}  
- Intent of Surgery  
- Presentation Type
Re-operation

**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 the patient underwent further surgery arising directly as a result of complications from their main (definitive) or only surgical procedure as detailed in the Final Definitive (or only) Surgery Performed (Surgery) {Colorectal Cancer}.

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

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

Post-operative complications that may require further surgery include intra-abdominal abscess, wound complications, anastomotic leak, organ injury, post-operative haemorrhage.

A condition is considered a post-operative complication if it occurs within 30 days of the date of operation. If further surgery is undertaken after 30 days this should be recorded as 2 (No).

If no main (definitive) surgery has been performed, or this was an endoscopic procedure (e.g. polypectomy/stent insertion) only, this should be recorded as 96 (Not applicable).

**Codes and Values:**

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

**Related Data Items:**
Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
Section 4: Pathology Details
Extramural Venous Invasion (Surgical Resection Specimen) {Colorectal Cancer}

Main Source of Data Item Standard: The Royal College of Pathologists, Dataset for Colorectal Cancer (2nd edition), September 2007.

Definition: A description of the presence of tumour within an extramural endothelium-lined space that is either surrounded by a rim of muscle or contains red blood cells.

Field Name: EXTRA
Field Type: Integer
Field Length: 2

Notes for Users:

The term “lymphovascular invasion” should not be used in this context as lymphatic vessel involvement is not classified as extramural venous invasion.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Present</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Not present</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. No resection carried out, surgery was polypectomy, other local excision, by endoscopy, or following neo-adjuvant treatment and no tumour present in biopsy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer}

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

Definition: A record of whether or not tumour is present at the circumferential margin.

Field Name: CIRCMARGIN
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 7

Applies to both rectal and colon cancer.

If there is no residual tumour at all in the specimen then it should be recorded as clear margin

Pathologist sometimes refer to the circumferential margin as the nonperitonealised margin.

The non-peritonealised circumferential margin requires particular attention in relation to rectal cancer but also with some colonic cancers, especially caecal and ascending colon cancers.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Involved</td>
<td>If the tumour is ≤ 1 mm from circumferential margin, regard as involved.</td>
</tr>
<tr>
<td>2</td>
<td>Not Involved</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery undertaken or following neo-adjuvant treatment and no tumour present in biopsy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Grade of Differentiation (Colorectal Cancer)

**Main Source of Data Item Standard:** The Royal College of Pathologists, Dataset for Colorectal Cancer (2nd edition), September 2007.

**Definition:** A description of how closely the tumour resembles normal morphology.

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

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

Poorly differentiated carcinomas should be separated from other types but only if this forms the predominant area of the tumour. The criteria for poorly differentiated tumours are either irregularly folded, distorted and often small tubules or the absence of any tubule formation.

If polypectomy or another endoscopic procedure is the only treatment administered, the grade of differentiation can be taken from this.

Where the grade is recorded as mucinous in the pathology report then this should be recorded as code 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>Well / Moderate</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery undertaken or following neo-adjuvant treatment and no tumour present in biopsy.</td>
</tr>
<tr>
<td>99</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>
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: LNEXAMINE
Field Type: Integer
Field Length: 4

Notes for Users: Required for QPI: 5

For procedures such as polypectomy only, bypasses or stents where surgery is performed but no lymph nodes examined, record as ‘1010’, not applicable.

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

If the total number examined is not known or not recorded, code as 9999.
Number of Lymph Nodes Involved {Cancer}

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

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

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

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

For procedures such as polypectomy only, bypasses or stents where surgery is performed but no lymph nodes examined, record as ‘1010’, not applicable.

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

If the total number examined is not known or not recorded, code as 9999.
Section 5: Tumour Classification
TNM Tumour Classification (Final) {Colorectal Cancer}

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

Definition: A record of the size and extent of the tumour of the colon or rectum according to TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

Field Name: FINALT
Field Type: Characters
Field Length: 3

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

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

Tumours that have perforated into the peritoneal cavity are regarded as pT4 irrespective of other factors.
<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Tumour invades submucosa.</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour invades muscularis propria.</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades subserosa or into non peritonealized pericolic or perirectal tissues</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour directly invades other organs or structures¹,²,³ and/or perforates visceral peritoneum.</td>
<td></td>
</tr>
<tr>
<td>T4a</td>
<td>Tumour perforates visceral peritoneum</td>
<td>Tumour cells breach serosa</td>
</tr>
<tr>
<td>T4b</td>
<td>Tumour directly invades other organs or structures</td>
<td>Tumour invades adjacent organs</td>
</tr>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed</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):**
- TNM Nodal Classification (Final) (Colorectal Cancer)
- TNM Metastasis Classification (Final) (Colorectal)
TNM Nodal Classification (Final) (Colorectal Cancer)

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

**Definition:** A record of the extent of regional lymph node metastases according to TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

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

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis.</td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis in 1 to 3 regional lymph nodes.</td>
</tr>
<tr>
<td>N1a</td>
<td>Metastasis in 1 regional lymph node</td>
</tr>
<tr>
<td>N1b</td>
<td>Metastasis in 2 to 3 regional lymph nodes</td>
</tr>
<tr>
<td>N1c</td>
<td>Tumour deposit(s), ie satellites,* in the subserosa, or in non peritonealized pericolic or perirectal soft tissue without regional lymph node metastasis</td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in 4 or more regional lymph nodes.</td>
</tr>
<tr>
<td>N2a</td>
<td>Metastasis in 4–6 regional lymph nodes</td>
</tr>
<tr>
<td>N2b</td>
<td>Metastasis in 7 or more regional lymph nodes</td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

*Tumour deposits (satellites) are discrete macroscopic or microscopic nodules of cancer in the pericolorectal adipose tissue’s lymph drainage area of a primary carcinoma that are discontinuous from the primary and without histological evidence of residual lymph node or identifiable vascular or neural structures. If a vessel wall is identifiable on H&E, elastic or other stains, it should be classified as venous invasion (V1/2) or lymphatic invasion (L1). Similarly, if neural structures are identifiable, the lesion should be classified as perineural invasion (Pn1). The presence of tumour deposits does not change the primary tumour T
category, but changes the node status (N) to pN1c if all regional lymph nodes are negative on pathological examination.

**Related Data Item(s):**
- TNM Tumour Classification (Final) (Colorectal Cancer)
- TNM Metastasis Classification (Final) (Colorectal)
TNM Metastasis Classification (Final) (Colorectal)

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

Definition: The extent of the spread of the disease outwith the colorectal system as agreed at the multidisciplinary team meeting according to TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

Field Name: FINALM
Field Type: Characters
Field Length: 2

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

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

Metastatic deposits in lymph nodes distant from those surrounding the main tumour or its main artery are regarded as distant metastases e.g. para aortic or iliac lymph nodes, which may be submitted separately by the surgeon. A serosal, mesenteric or omental deposit in the specimen which is distant from the primary mass and not in the region of adhesion over the tumour is classified as a distant metastasis.

If stage is not documented 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>M0</td>
<td>No distant metastasis.</td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis present.</td>
</tr>
<tr>
<td>M1a</td>
<td>Metastasis confined to one organ (liver, lung, ovary, non regional lymph node(s)) without peritoneal metastases</td>
</tr>
<tr>
<td>M1b</td>
<td>Metastasis in more than one organ</td>
</tr>
<tr>
<td>M1c</td>
<td>Metastasis to the peritoneum with or without other organ involvement</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):
TNM Tumour Classification (Final) (Colorectal Cancer)
TNM Nodal Classification (Final) (Colorectal)
Section 6: Oncology
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/](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.


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 patients have not received SACT treatment, or the patient has declined SACT treatment record as inapplicable, X1010

**Related Data Item(s):**  
Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}  
Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}
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 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.


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

If the location code is not documented, record as X9999.

If surgery has not been performed or the patient has refused surgery, record as inapplicable, X1010.

**Related Data Item(s):**
Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}
Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}
Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)

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

**Definition:** The type of course of neo-adjuvant oncological treatment administered for the treatment of the cancer.

**Field Name:** NEOONC1  
**Field Name:** NEOONC2  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 1, 5, 7, 11, 12

It is the intended treatment, as defined by the initial treatment plan that should be recorded.

**Radiotherapy**  
Only radiotherapy given to the primary site should be recorded.

**SACT**  
Patients who have systemic therapy prior to surgery should be recorded as neo-adjuvant. Some of these patients may have separate further completion systemic therapy post-operatively, which should be recorded as adjuvant. This may be recorded as two courses (1) neo-adjuvant and (2) adjuvant, which could be palliative.

Systemic therapy must be treatment received for initial management and not treatment for recurrence or relapse.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Short Course Radiotherapy</td>
<td>Radiotherapy given over 5 days (25Gy) prior to surgery. Short course radiotherapy also includes patients who undergo short course and delay to surgery.</td>
</tr>
<tr>
<td>2</td>
<td>Long Course Radiotherapy with Chemotherapy (Chemoradiotherapy)</td>
<td>Radiotherapy given over 5 weeks (25 fractions in 45Gy) in conjunction with chemotherapy (oral capecitabine) prior to surgery. Treatments will commence on the same day.</td>
</tr>
<tr>
<td>3</td>
<td>Long Course Radiotherapy only</td>
<td>Radiotherapy given over 5 weeks (25 fractions in 45Gy) with chemotherapy omitted e.g. due to patient fitness for chemotherapy.</td>
</tr>
<tr>
<td>4</td>
<td>Chemotherapy</td>
<td>Chemotherapy treatment given prior to surgery.</td>
</tr>
<tr>
<td>80</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Patient died before SACT treatment</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Patient died before chemoradiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Patient refused radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>85</td>
<td>Patient refused chemoradiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>86</td>
<td>Radiotherapy contraindicated for patient</td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Chemotherapy contraindicated for patient</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Chemoradiotherapy contraindicated for patient</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 Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}
- Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}
Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer}

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

Definition: The date cancer treatment course commenced.

Field Name: NEOADJDATE1
NEOADJDATE2
Field Type: Date (DD/MM/GCYY)
Field length: 10

Notes for Users:

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

If date treatment started is unknown, record as 09/09/1900 (Not recorded).

Radiotherapy

This is the first course of external beam radiotherapy.

Only radiotherapy given to the primary site should be recorded.

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

Systemic Anti Cancer Therapy (SACT)

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

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

Chemoradiotherapy

This is the first dose of treatment, whether it is radiotherapy or SACT.

Related Data Item(s):
Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)
Date Neo-Adjuvant/Oncology Treatment Completed (Colorectal Cancer)
Date Neo-Adjuvant Oncology Treatment Completed {Colorectal Cancer}

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

Definition: The date cancer treatment course ended.

Field Name: NEOADJCOM1  
NEOADJCOM2  
Field Type: Date (DD/MM/CCYY)  
Field length: 10

Notes for Users: Required for QPI(s): 7, 12
If treatment has not been given, record as 10/10/1900 (Not applicable).
If date treatment started is unknown, record as 09/09/1900 (Not recorded).

Radiotherapy

This is the last fraction of a course of external beam radiotherapy.
It should be noted this can be the same day as the day the therapy started.

Systemic Anti Cancer Therapy (SACT)

This is the first day of the last cycle of SACT the patients receives, i.e. last day treatment was administered.

Chemoradiotherapy

This is the last treatment date, whether it is radiotherapy or chemotherapy.

Related Data Item(s):
Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)
Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}
Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}

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

Definition: The type of Primary/ Palliative Adjuvant oncological treatment administered for the treatment of the cancer.

Field Name: ADJONC
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 1, 11, 12

It is the intended treatment, as defined by the initial treatment plan that should be recorded.

If more than one course of primary/palliative/adjuvant oncology treatment is administered, record only the first course.

Radiotherapy
Only radiotherapy given to the primary site should be recorded.

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

SACT
Patients who have SACT prior to surgery should be should be recorded under as neo-adjuvant Type. Some of these patients may have separate further completion systemic therapy post-operatively, which should be recorded as adjuvant. This may be recorded as two courses (1) neo-adjuvant and (2) adjuvant, which could be palliative.

Record patients who have SACT as their primary treatment.

SACT must be treatment received for initial management and not treatment for recurrence or relapse.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant Long Course Radiotherapy with Chemotherapy (rectal cancer)</td>
<td>Chemoradiotherapy. Treatment given to patients with rectal cancer following surgery if positive surgical margins (when no neo adjuvant radiotherapy given).</td>
</tr>
<tr>
<td>2</td>
<td>Adjuvant Chemotherapy</td>
<td>Chemotherapy treatment given following surgery where there is no overt evidence of remaining disease.</td>
</tr>
<tr>
<td>3</td>
<td>Adjuvant Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Primary Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Primary/Radical Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Palliative Radiotherapy</td>
<td>Radiotherapy given with the aim of relieving symptoms</td>
</tr>
<tr>
<td>7</td>
<td>Palliative Chemotherapy</td>
<td>Systemic therapy given for symptom control without curative intent e.g. in patients with metastatic disease at time of diagnosis</td>
</tr>
<tr>
<td>8</td>
<td>Biological therapy</td>
<td>For example, cetuximab for liver only metastases</td>
</tr>
<tr>
<td>9</td>
<td>Palliative Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Brachytherapy</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Patient died before SACT treatment</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Patient died before chemoradiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Patient refused radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>85</td>
<td>Patient refused chemoradiotherapy 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 Adjuvant/Primary Oncology Treatment Started {Colorectal Cancer}
- Date Adjuvant/Primary Oncology Treatment Completed {Colorectal Cancer}
Date Primary/Palliative/Adjuvant Oncology Treatment Started (Colorectal Cancer)

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

Definition: The date cancer treatment course commenced.

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

Notes for Users: Required for QPI: 11
If treatment has not been given, record as 10/10/1900 (Not applicable).
If date treatment started is unknown, record as 09/09/1900 (Not recorded).

Radiotherapy
This is the first course of external beam radiotherapy.
Only radiotherapy given to the primary site should be recorded.
For the purposes of national audit, only radiotherapy given as part of the primary treatment plan should be recorded. Palliative radiotherapy to other (metastatic) sites is only recorded if part of the initial treatment plan.

Systemic Anti Cancer Therapy (SACT)
This is the first dose of the first cycle of a course of SACT.
SACT must be treatment received for initial management and not treatment for recurrence or relapse.

Chemoradiotherapy
This is the first date of adjuvant chemoradiotherapy treatment, whether that be radiotherapy or SACT.

Related Data Item(s):
Primary/Adjuvant Oncology Treatment Type (Colorectal Cancer)
Date Adjuvant/Primary Oncology Treatment Completed (Colorectal Cancer)
Date Primary/Palliative/Adjuvant Oncology Treatment Completed {Colorectal Cancer}

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

Definition: The date cancer treatment course ended.

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

Notes for Users: Required for QPI: 12

If the date treatment completed is unknown, record as 09/09/1900 (Not recorded).

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

Radiotherapy Treatment
This is the last fraction of a course of external beam radiotherapy.

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

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

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

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

Chemoradiotherapy
This is the last treatment date, whether that be radiotherapy or chemotherapy.

Related Data Item(s):
Primary/Adjuvant Oncology Treatment Type {Colorectal Cancer}
Date Adjuvant/Primary Oncology Treatment Started (Colorectal Cancer)
Section 7: Colorectal Liver Metastases
Date of Diagnosis {Colorectal Liver Metastases}

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

Definition: Date of liver imaging investigation that confirms the presence of liver metastases.

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

Notes for Users: Required for QPI: 15

Computed tomography (CT) imaging is the main investigation for the identification of liver metastases. Results from CT colonography (with IV contrast) may be recorded, where it can be determined from the radiology report that the liver has been investigated. MRI investigation or PET CT may also be used to confirm.

Where liver metastases have been diagnosed by initial liver imaging at presentation, the ‘Date of Liver Imaging (Results)’ [LIVERDATE] should be recorded.

Where liver metastases have been diagnosed following the initial treatment pathway, the Date of Diagnosis {liver metastases} should only be recorded for those patients where the diagnosis of liver metastases has been identified through registration at a colorectal cancer MDT.

If the patient has not been diagnosed with colorectal liver metastases (after 1st April 2021), or has not been identified with liver metastases through registration at a colorectal cancer MDT, record as inapplicable (10/10/1900).

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

Related Data Item(s):
Referral to HPB MDT {Colorectal Liver Metastases}

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

**Definition:** A record of whether the patient has been referred to the HPB MDT.

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

**Notes for Users:** Required for QPI: 15

This field is applicable to patients with colorectal liver metastases only.

If the patient is not referred to the HPB MDT, the reason for this should be recorded as part of the MDT outcome and should not be deduced by audit staff.

**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 – primary colorectal cancer is unresectable</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No – extrahepatic disease</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>No – patient is clinically unfit for surgery</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>No – patient declined consideration of surgery</td>
<td>i.e. patients who decline any potential surgery following their liver met diagnosis.</td>
</tr>
<tr>
<td>6</td>
<td>No – no reason documented</td>
<td>No evidence of the reason the patient with liver metastases has not been referred to HPB MDT i.e. reason unknown.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>i.e. the patient does not have colorectal liver metastases.</td>
</tr>
</tbody>
</table>
Section 8: Genetics
Microsatellite Instability (MSI) Status

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

Definition: The result of analysis to assess for MSI status for patients with colorectal cancer.

Field Name: MSISTATUS
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 16

Analysis of MMR status/MSI status will be by either immunohistochemistry for MMR protein expression or analysis of MSI status in DNA. These are two different tests however only one of these requires to be carried out and either is acceptable.

Some Boards may use MMR IHC as the primary test whilst others use MSI testing- this will depend on local circumstances.

No MSI / MSS Non MSI
There is no evidence of microsatellite instability.

MSI Detected / MSI Positive
Tumour DNA from this patient is MSI high.

Can be determined from biopsy or surgical resection. If the result is not clear from the notes then pathology should be contacted to provide clarity.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MSI Positive</td>
<td>i.e. high amount of instability / MSI-high / MSI-H</td>
</tr>
<tr>
<td>2</td>
<td>MSS (non MSI)</td>
<td>i.e. microsatellite stable, no evidence of instability</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>e.g. sample insufficient, test failed</td>
</tr>
<tr>
<td>5</td>
<td>MSI low</td>
<td>i.e. slight instability, not suggestive of Lynch Syndrome</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:
Mismatch Repair (MMR) Immunohistochemical (IHC) Testing

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

Definition: The results of analysis by immunohistochemistry (IHC) to assess for MMR protein expression for patients with colorectal cancer.

Field Name: IHCSTATUS
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 16

Analysis of MMR status/MSI status will be by either IHC for MMR protein expression or analysis of MSI status in DNA. These are two different tests however only one of these requires to be carried out and either is acceptable.

Some Boards may use MMR IHC as the primary test whilst others use MSI testing- this will depend on local circumstances.

Local Boards / different pathologists may use different terminology to report abnormal IHC results. E.g. Abnormal IHC results may also be expressed as aberrant ICC/IHC/immunophenotype, loss of expression, reduced expression or absence.

No Loss / Normal
i.e. normal expression (no loss of expression) for MLH1, MSH2, MSH6 and PMS2 – all proteins are present. There is positive nuclear staining for MLH1, PMS2, MSH2 and MSH6 and this is, therefore, interpreted as showing no loss of mismatch repair protein expression.

Loss / Abnormal
i.e. aberrant, abnormal expression for MLH1, MSH2, MSH6 and PMS2 – one or more proteins are absent. The tumour cells show positive nuclear staining for XXX and XXX but loss of nuclear staining for XXX and XXX and this is, therefore, interpreted as showing loss of mismatch repair protein expression.

Can be determined from biopsy or surgical resection. If the result is not clear from the notes then pathology should be contacted to provide clarity.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abnormal IHC</td>
<td>Loss of expression, aberrant.</td>
</tr>
<tr>
<td>2</td>
<td>Normal IHC</td>
<td>No loss of expression.</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>Inconclusive</td>
<td>e.g. sample insufficient, test failed</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>
BRAF Status

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

Definition: A record of the outcome of BRAF testing carried out for patients with colorectal cancer.

Field Name: BRAF
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 16

BRAF testing will be undertaken in addition to either MMR (IHC) or MSI testing and is triggered to distinguish sporadic cancers from those possibly due to Lynch Syndrome.

Can be determined from biopsy or surgical resection. If the result is not clear from the notes then pathology should be contacted to provide clarity.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BRAF mutation</td>
<td>i.e. BRAF mutation detected</td>
</tr>
<tr>
<td>2</td>
<td>Wild type BRAF</td>
<td>i.e. no BRAF mutation detected</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>e.g. sample insufficient, test failed</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:
MLH1 Analysis

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

Definition: The result of analysis to assess for MLH1 promoter hypermethylation status for patients with colorectal cancer.

Field Name: MLH1
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 16

Can be determined from biopsy or surgical resection. If the result is not clear from the notes then pathology should be contacted to provide clarity.

This analysis may be carried out at the same time as initial testing or following BRAF testing on patients who demonstrate BRAF wildtype (no mutation). This is performed to distinguish sporadic cancers from those possibly due to Lynch Syndrome.

If MLH1 analysis failed and could not be repeated (and all other factors were met for possible Lynch Syndrome) then referral to genetics would be recommended.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Methylation detected</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Methylation not detected</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Analysis failed</td>
<td>e.g insufficient sample</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:
Genetics Referral

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

**Definition:** This denotes whether the patient is referred to genetics for consideration of genetics testing.

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

**Notes for Users:** Required for QPI: 16

This may be documented in e.g. genetic referral letters or clinic letters, reported at the MDT meeting, or recorded within clinical management systems.

**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>No evidence, includes unknown</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. results not suggestive of Lynch Syndrome</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Section 9: Clinical Trial Entry
Patient Entered into Clinical Trial

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

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

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

**Notes for Users:** Required for generic QPIs

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

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not known</td>
</tr>
</tbody>
</table>
Section 10: 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 QPIs: 10, 12

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

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