Lung Cancer

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

Definitions developed by PHS Scotland in collaboration with the Lung Quality Performance Indicator Development Group

Version 4.0: February 2021

To be used in conjunction with:

1. Lung Clinical Quality Performance Indicators v3.0 (November 2020)
2. Lung QPI Dataset Validations (latest published version)
3. Lung Measurability of Quality Performance Indicators (latest published version)
**DOCUMENT CONTROL SHEET**

**Key Information**

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**Revision History**

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

*Developed by PHS Scotland 2014*
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PREFACE

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

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

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

Lung Cancer remains one of the major causes of death in Scotland. Treatment challenges arise from both co morbidity and extent of disease at time of diagnosis, with the majority of patients presenting with too advanced disease for curative intent. The particular challenge for all is often the balance of survival benefits over quality of life especially when cure is not an option.

Multidisciplinary team working is important to enable that the best information is given to the patient and carers to help them make the correct decision for them. This involves being as accurate as possible about stage assessment, both to ensure that more aggressive radical treatment is offered to those that have most to gain and also to prevent interventions being performed where the patient with poor performance status is unlikely to benefit.

The use of combination chemoradiotherapy is increasing for specific subgroups, with challenges about increasing morbidity, often in patient groups with already significant comorbidity from heart and lung disease and reduced performance status.

Pathology is playing an increasing role in deciding on appropriate treatment option. This not only includes accurate staging of the mediastinum to determine appropriate radical treatment options but also in the subtyping of lung cancer, especially non-small cell lung cancer and for identifying specific gene mutations.

It is our intention that the QPIs that we have produced reflect the emerging evidence of care required to help deliver appropriate treatment to patients diagnosed with lung cancer in Scotland.

They have been developed as a collaborative approach involving multiple disciplines from all of the regions of Scotland to try and improve standards of care.

Carrie Featherstone
Consultant Clinical Oncologist
NOTES FOR IMPLEMENTATION OF CHANGES

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

Changes to definitions fall into the following categories:

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

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

General Enquiries on the collection of the National Minimum Core Dataset
If you have any comments on the attached data definitions PHS would welcome your feedback.

Please contact: phs.canceraudit@phs.scot

CONVENTIONS

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

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

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

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

Revisions to Dataset following Formal Review (January 2021)

Seen by Clinical Nurse Specialist {Lung Cancer/ Mesothelioma} - Remove Mesothelioma from title.

Definitive Surgery Performed – removed code 5 Pleurectomy from codes and values.

Date of Diagnosis {Cancer} notes for user added 'If imaging identifies metastatic disease which is later confirmed by CT chest to be a lung primary then the date of CT chest should be recorded.'

Site of Origin of Primary Tumour {Cancer} notes for user added 'Required for national comparative analysis'. Removed QPI 1-13, Codes and Values removed C45.0, C45.1, C45.2, C45.7, C45.9.

Origin of Tumour notes for user removed ‘and QPI(s): 1-16’. Codes and Values removed 2 Mesothelioma

Histological/Cytological Diagnosis {Lung Cancer} (Pre-Treatment) notes for user added ‘QPI 16’ added ‘or frozen section taking immediately prior to surgery.’ Added ‘Where more than one cancer site is reported in pathology reports, audit staff should clarify histology and cancer site from MDT documentation or confirm with a relevant clinician.’ Codes and Values removed ’42, 43, 44, 45’

Tumour profiling undertaken – data item added

Epidermal Growth Factor Receptor (EGFR) Status definition added ‘SACT’. Notes for user removed ‘QPI 2’. Codes and Values removed ‘99’. Added ‘Related Data Items:
Tumour Profiling Undertaken
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status
ROS1 Testing
PD-L1 Status’

Oncogenic Anaplastic Lymphoma Kinase (ALK) Status definition added ‘SACT’. Notes for user removed ‘QPI 2’. Codes and Values removed ‘99’. Related Data Items added ‘Related Data Items:
Epidermal Growth Factor Receptor (EGFR) Status
Tumour Profiling Undertaken
ROS1 Testing
PD-L1 Status’

ROS1 Testing – data item added

PD-L1 Status definition added ‘SACT’. Notes for user added ‘QPI 2’. Codes and Values removed ‘99’. Related Data Items added ‘Epidermal Growth Factor Receptor (EGFR) Status
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status
ROS1 Testing
Tumour Profiling Undertaken’

Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013
Date of Integrated FDG-PET/CT (PET/CT) Scan removed ‘Pre-treatment’ from title. Related Data Items added ‘Hilar’/ ‘Date of Radiology Request for FDG-PET/CT (PET/CT) Scan (Lung), Date of Integrated FDG-PET/CT (PET/CT) Scan Reported {Lung}’

Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lung} – data item added

Date Integrated FDG-PET/CT (PET/CT) Scan Reported {Lung} – data item added

Hilar/Mediastinal/SCF Sampling added ‘Hilar’ removed ‘Results (pre-treatment)’ to/from title. Definition added ‘hilar (N1/N3)/ (N2/N3)/’ ‘node evaluation (N3) is performed and’. Notes for user added ‘although if undertaken, this may be recorded for local audit purposes’. Removed ‘Where there is definitive evidence of distant metastases, or where there are no nodes to sample, record as ’96: Not applicable’.’ Added ‘Methods of sampling include: Neck US guided or direct biopsy (core or FNA), EBUS, EUS-B, EUS, Mediastinoscopy or VATS. Where there are no nodes to sample, record as ’96: Not applicable’. Removed ‘Methods of sampling for mediastinal nodes are - Endobronchial Ultrasound (EBUS), mediastinoscopy, mediastinotomy and video-assisted thoracoscopic surgery (VATS) sampling. Methods of sampling for SCF nodes are - ultrasound guidance or direct FNA (if palpable).’. Codes and Values table updated ‘e.g. if there are no nodes to sample’ Related Data Items added ‘Hilar/Mediastinal/Supraclavicular (SCF) node results at FDG-PET/CT (PET/CT) Scan’

TNM Tumour Classification (Clinical) {Lung Cancer} notes for user added ‘QPI 6, 8’. Added ‘If a patient is discussed at MDT after they have died, the TNM recorded at this time which relates to pre-treatment/pre-death staging can be recorded.’ ‘If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.’ Related Data Items added ‘TNM Tumour Classification (Clinical) {Lung Cancer} TNM Metastases Classification (Clinical) {Lung Cancer}’

TNM Nodal Classification (Clinical) {Lung Cancer} notes for user added ‘If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.’

TNM Metastases Classification (Clinical) {Lung Cancer} notes for user added ‘If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.’ Related Data Items added ‘TNM Metastases Classification (Clinical) {Lung Cancer} TNM Tumour Classification (Clinical) {Lung Cancer}’

TNM Tumour Classification (Clinical) {Pleural Mesothelioma} – removed data item

TNM Nodal Classification (Clinical) {Pleural Mesothelioma} – removed data item

TNM Metastases Classification (Clinical) {Pleural Mesothelioma} – removed data item

Brain Imaging definition removed ‘prior to commencing treatment’. Notes for user removed ‘and should be carried out prior to treatment.’ Added ‘If brain imaging has been undertaken in patients where N2 disease is not present, this can be recorded for local use’ removed ‘If brain imaging investigations are not documented, record as 99 (Not recorded).’ Added ‘Where there is no evidence that brain imaging has been
undertaken, record as 4 (Not performed).' Removed ‘or does not have N2 disease’ Code and Values ‘4’ added ‘includes not known’. Removed ‘99’. Related Data Items removed ‘(pre-treatment)’

**Date of Brain Imaging** removed ‘(Pre-treatment)’ from title

**Date Discussed by Care Team (MDT)** notes for user removed ‘May be used for analysis of generic QPI relating to MDT meetings.’

**Type of First Cancer Treatment** notes for user removed ‘QPI 1, 10, 12 &’. Codes and Values added:
- 16 - Targeted therapy
- 17 - Immunotherapy
- 18 - Chemoimmunotherapy

**Date of First Cancer Treatment** notes for user removed ‘QPI 15’ added ‘If the patient dies before MDT discussion, enter the date that supportive care was agreed on the ward / clinic.’

**Date of Definitive Treatment {Lung Cancer}** notes for user added ‘QPI 15,16’ ‘If the patient dies before MDT discussion, enter the date that supportive care was agreed on the ward / clinic’ ‘If a patient undergoes treatment for metastatic disease as their only active treatment, this should be recorded as their first and definitive treatment.’

**Histological/Cytological Diagnosis Following Surgery {Lung Cancer}** notes for user added ‘QPI 16’. Codes and Values removed ‘42, 43, 44 ,45’

**TNM Nodal Classification (Pathological) {Lung Cancer}** notes for user amend ‘QPI:’ to ‘DCE’

**TNM Tumour Classification (Pathological) {Pleural Mesothelioma} – removed data item**

**TNM Nodal Classification (Pathological) {Pleural Mesothelioma} – removed data item**

**TNM Metastases Classification (Pathological) {Pleural Mesothelioma} – removed data item**

**Location Code {Radiotherapy Treatment} – data item added**

**Location Code {SACT Treatment} – data item added**

**Type of Systemic Anti-Cancer Therapy (SACT) 1-3** notes for user removed ‘Actual treatment should be recorded. Where patients receive chemoradiotherapy and treatment is abandoned prior to receiving full dosage, this should be recorded as palliative.’ Added ‘Actual treatment should be recorded. If the radiotherapy element of chemoradiotherapy is abandoned prior to receiving full dosage, then the chemotherapy treatment should be recorded as palliative.’.

Codes and Values:
- Code 7 - ‘Biological therapy’ removed. Added Code 8 Targeted Therapy, Code 9 Immunotherapy, Code 10 Chemoimmunotherapy
Systemic Therapy Agent 1-3 {Lung Cancer} definition amended 'or biological therapy' to 'targeted therapy or immunotherapy'. Codes and Values removed '22' 'biological' added '25' 'other targeted therapy'. Added '26' 'Other immunotherapy agent'

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3 notes for user removed 'Required for QPI: 13'

Revisions to Dataset Outwith Review (July 2020)

COVID 19 Impact – remove leading ‘0’s

Date of CT Thorax amend ‘09/09/0909’ to ‘09/09/1900’

Date of Bronchoscopy amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Diagnosis {Cancer} amend ‘09/09/0909’ to ‘09/09/1900’

Date of Histological / Cytological Diagnosis {Cancer} amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Integrated FDG-PRT/CT (PET/CT (PET/CT) Scan amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Brain Imaging (Pre-treatment) amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date Discussed by Care Team (MDT) amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of First Cancer Treatment amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Definitive Treatment {Lung Cancer} amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Surgery amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Started {Cancer} Radiotherapy amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed {Cancer} Radiotherapy amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’

Date of Death amend ‘09/09/0909’ to ‘09/09/1900’, amend ‘10/10/1010’ to ‘10/10/1900’
Addition to Cancer Audit 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 - implement from 1 January 2019

Revisions to Dataset Outwith Review (March 2019)

Systemic Therapy Agent 1-3 {Lung Cancer} - Field Name amend ‘CHEMTYPE’ to ‘CHEMAGENT’

Histological/Cytological Diagnosis {Lung Cancer} {Pre-Treatment} - Notes for Users add ‘Pathologists often state ‘favouring’ a certain tumour sub-type and this should be documented as recorded rather than Not Otherwise Specified ‘NOS’.

Histological/Cytological Diagnosis Following Surgery {Lung Cancer} - Notes for Users add ‘Pathologists often state ‘favouring’ a certain tumour sub-type and this should be documented as recorded rather than Not Otherwise Specified ‘NOS’.

TNM Tumour Classification (Clinical) {Lung Cancer} - Implement this change from 1/1/2019 Notes for Users add ‘If the size of the tumour is not specified as pT2a or pT2b then it should be recorded as pT2a’; Codes and Values table remove T1, T2

TNM Tumour Classification (Pathological) {Lung Cancer} - Implement this change from 1/1/2019 Notes for Users add ‘If the size of the tumour is not specified as pT2a or pT2b then it should be recorded as pT2a’; Codes and Values table remove T1, T2

Revisions to Dataset Outwith Review (January 2018)

TNM Tumour Classification (Clinical) {Lung Cancer} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017
- Add code and value ‘T1mi’ - Minimally invasive adenocarcinoma
- Amend code description T1a to ‘Tumour ≤ 1cm in greatest dimension.’
- Amend code description T1b to ‘Tumour > 1cm – ≤ 2cm in greatest dimension.’
- Add code and value ‘T1c’ - Tumour >2cm - ≤3cm in greatest dimension.’
- Amend code description T2 to ‘Tumour > 3cm to ≤ 5cm, or tumour with any of the following features: Involves main bronchus regardless of distance to the carina, but without involvement of carina, or Invades visceral pleura or associated with atelectasis or obstructive pneumonitis that extends to the hilar region either involving part of or the entire lung.
- Amend code description T2a to ‘Tumour > 3cm – ≤ 4cm in greatest dimension.’
- Amend code description T2b to ‘Tumour > 4cm – ≤ 5cm in greatest dimension.’
- Amend code description T3 to ‘Tumour more than > 5cm - ≤ 7cm in greatest dimension or directly invades any of the following: parietal pleura, chest wall (including superior sulcus tumour), phrenic nerve, or parietal pericardium; or separate tumour nodule(s) in the same lobe as the primary.’
- Amend code description T4 to ‘Tumour > 7cm or of any size that invades any of the following: diaphragm, mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, oesophagus, vertebral body, carina; or separate tumour nodule(s) in a different ipsilateral lobe to that of the primary’.

TNM Nodal Classification (Clinical) {Lung Cancer} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

TNM Metastases Classification (Clinical) {Lung Cancer} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017
- Codes and Values table add code and value ‘M1 – Distant Metastasis’
- Amend code description M1a to include ‘or pericardial’, explanatory note changed from ‘the effusion should be excluded as a staging element and the patient should be classified as M0’ to ‘the effusion should be excluded as a staging descriptor.’
- Amend code description M1b to ‘Single extrathoracic metastasis in a single organ’
- Add code and value ‘M1c - Multiple extrathoracic metastasis in a single or multiple organs’

TNM Tumour Classification (Clinical) {Pleural Mesothelioma} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017, Codes and Values table amend code description T1 to include ‘mediastinal or diaphragmatic pleura’. Delete codes and values T1a and T1b
Amend code description T2 to ‘the ipsilateral pleural (parietal or visceral pleura), with at least one of the following:’
Amend code description T3 to ‘ipsilateral pleural (parietal or visceral pleura), with at least one of the following:’
Amend code description T4 to ‘(parietal or visceral pleura), with at least one of the following:
- chest wall, with or without associated rib destruction (diffuse or multifocal)
- peritoneum (via direct transdiaphragmatic extension)
- contralateral pleura
- mediastinal organs (oesophagus, trachea, heart, great vessels)
- vertebra, neuroforamen, spinal cord
- internal surface of the pericardium (transmural invasion with or without a pericardial effusion)

TNM Nodal Classification (Clinical) {Pleural Mesothelioma} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017
Codes and Values table amend code description N1 to ‘Metastasis to ipsilateral intrathoracic lymph nodes (includes ipsilateral bronchopulmonary, hilar, subcarinal, paratracheal, aortopulmonary, paraesophageal, peridiaphragmatic, pericardial fat pad, intercostal and internal mammary nodes).’
Amend code description N2 to ‘Metastasis to contralateral intrathoracic lymph nodes. Metastases to ipsilateral or contralateral supraclavicular lymph nodes’
Delete code and value N3

TNM Metastases Classification (Clinical) {Pleural Mesothelioma} - Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

Codes and Values table add code and value ‘pT1mi - Minimally invasive adenocarcinoma’
Amend code description pT1a to ‘Tumour ≤ 1cm in greatest dimension.’
Amend code description pT1b to ‘Tumour > 1cm - ≤ 2cm in greatest dimension.’
Add code and value ‘pT1c - Tumour >2cm - ≤3cm in greatest dimension.’
Amend code description pT2 to ‘Tumour > 3cm to ≤ 5cm, or tumour with any of the following features: Involves main bronchus regardless of distance to the carina, but without involvement of carina, or Invades visceral pleura or associated with atelectasis or obstructive pneumonitis that extends to the hilar region either involving part of or the entire lung.
Amend code description pT2a to ‘Tumour > 3cm – ≤ 4cm in greatest dimension.’
Amend code description pT2b to ‘Tumour > 4cm – ≤ 5cm in greatest dimension.’
Amend code description pT3 to ‘Tumour more than > 5cm - ≤ 7cm in greatest dimension or directly invades any of the following: parietal pleura, chest wall (including superior sulcus tumour), phrenic nerve, or parietal pericardium; or separate tumour nodule(s) in the same lobe as the primary.’
- Amend code description pT4 to ‘Tumour > 7cm or of any size that invades any of the following: diaphragm, mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, oesophagus, vertebral body, carina; or separate tumour nodule(s) in a different ipsilateral lobe to that of the primary’.


Amend code description pM1a to include ‘or pericardial’
Amend code description pM1b to ‘Single extrathoracic metastasis in a single organ’
Add code and value ‘pM1c - Multiple extrathoracic metastasis in a single or multiple organs’


Codes and Values table Amend code description pT1 to include ‘mediastinal or diaphragmatic pleura’ Delete codes and values pT1a and pT1b
Amend code description pT2 to ‘the ipsilateral pleural (parietal or visceral pleura), with at least one of the following’:
- Amend code description pT3 to ‘ipsilateral pleural (parietal or visceral pleura), with at least one of the following’:
- Amend code description pT4 to ‘(parietal or visceral pleura), with at least one of the following:
  - chest wall, with or without associated rib destruction (diffuse or multifocal)
  - peritoneum (via direct transdiaphragmatic extension)
  - contralateral pleura
  - mediastinal organs (oesophagus, trachea, heart, great vessels)
  - vertebra, neuroforamen, spinal cord
  - internal surface of the pericardium (transmural invasion with or without a pericardial effusion)

Codes and Values table amend code description pN1 to ‘Metastasis to ipsilateral intrathoracic lymph nodes (includes ipsilateral bronchopulmonary, hilar, subcarinal, paratracheal, aortopulmonary, paraesophageal, peridiaphragmatic, pericardial fat pad, intercostal and internal mammary nodes).’ Amend code description pN2 to ‘Metastasis to contralateral intrathoracic lymph nodes. Metastases to ipsilateral or contralateral supraclavicular lymph nodes’. Delete code and value ‘pN3’.

TNM Metastases Classification (Pathological) {Pleural Mesothelioma} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017 Codes and Values table delete code and value ‘pM0’. Amend code description pN1 to include ‘microscopically confirmed’

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

Systemic Therapy Agent 1-3 {Lung Cancer} – Codes and Values table add code 24 – Pembrolizumab

Revisions to Dataset Outwith Review (November 2017)

Criteria for Inclusion of Patients in Audit - Removed exclusion ‘Patients with lung neuroendocrine tumours’.

Person Family Name (at Diagnosis) - Link updated

Person Given Name - Link updated

Patient Postcode at Diagnosis - Link updated

Date of Birth - Link updated

Histological/Cytological Diagnosis {Lung Cancer} (Pre-Treatment) – Codes and Values Table Code 14 inserted the following explanatory text ‘Other neuroendocrine tumours and large cell neuroendocrine carcinomas,’ Inserted Code 22 - Carcinoid tumour - Includes typical and atypical carcinoid.

Epidermal Growth Factor Receptor (EGFR) Status – Notes for Users inserted ‘non-squamous’. Codes and Values table added Code 5 / EGFR undertaken as part of pathological assessment and a mutation of uncertain significance or one conferring resistance has been detected but not actionable.

PD-L1 Status (PDL1) - Notes for Users updated to say ‘the result recorded should be the percentage of cells where PD-L1 expression is present’. Delete the text ‘molecular profiling ‘from the definition (as PD-L1 testing is NOT considered a molecular profiling test by government definitions as it is not covered by the Molecular Pathology Consortium). Codes and Values table delete Code 1/ Positive/ PD-L1 testing undertaken as part of pathological assessment and result positive for PD-L1 expression and Code 2/Negative/ PD-L1 testing undertaken as part of pathological assessment and result negative for PD-L1 expression.

**Oncogenic Anaplastic Lymphoma Kinase (ALK) Status** – Notes for Users added the following ‘non-squamous’

**Histological/Cytological Diagnosis Following Surgery {Lung Cancer}** – Codes and Values table Code 14: inserted the following explanatory text ‘Other neuroendocrine tumours and large cell neuroendocrine carcinomas,’ Inserted Code 22 - Carcinoid tumour - Includes typical and atypical carcinoid. (Query 1467).

**Revisions to Dataset following Formal Review (March 2017)**
The following addition has been made to facilitate the recording of data. This change will take effect for patients diagnosed from 1st January 2017.

**Criteria for inclusion of Patients in Audit** – Exclude added bullet point ‘Patients with lung neuroendocrine tumours’.

**Origin of Tumour** - Notes for Users add Required for QPI(s) 1-16’.

**Histological/Cytological Diagnosis {Lung Cancer} (Pre-Treatment)** - Notes for Users Required for QPI(s)’14, 15’. Delete ‘13’. Codes and Values table delete Code 14 ‘Other neuroendocrine tumours and large cell neuroendocrine carcinomas,’ from the explanatory text. Code 22: delete code, description and explanatory note.

**Date of Histological / Cytological Diagnosis {Cancer}** – Add New Data Item.

**Epidermal Growth Factor Receptor (EGFR) Status** – Definition add text ‘molecular profiling’. Delete text ‘predictive marker’. Notes for Users: replace ‘, specific tests e.g. EGFR, and’ with ‘. Specific tests e.g. EGFR, are’. Delete text ‘adenocarcinoma’.

**Oncogenic Anaplastic Lymphoma Kinase (ALK) Status** – Add new Data Item

**PD-L1 Status (PDL1)** – Add New Data Item

**Date of Integrated FDG-PET/CT (PET/CT) Scan (Pre-treatment)** - Notes for Users remove QPI 5.

**Mediastinal/SCF Sampling Results (pre-treatment)** - Notes for Users add ‘is’ to first sentence.

**TNM Tumour Classification (Clinical) {Lung Cancer}** - Notes for Users Required for QPI(s) delete ‘4,8,12’ and add ‘9,10,11,14’.

**TNM Nodal Classification (Clinical) {Lung Cancer}** - Notes for Users: Required for QPI(s) delete ‘4,8,12’ and add ‘6,10,11,14,16’.
TNM Metastases Classification (Clinical) {Lung Cancer} - Notes for Users: Required for QPI(s) delete ‘4,12’ and add ‘5, 6,10,11,14’. Codes and Values Table delete ‘code M1’ and value ‘distant metastases’.

TNM Metastases Classification (Clinical) {Pleural Mesothelioma} - Definition delete ‘sixth’ edition and replace with ‘seventh’.

Brain Imaging – Add New Data Item.

Date of Brain Imaging (Pre-treatment) – Add New Data Item.

WHO/ ECOG Performance Status - Notes for Users Required for QPI ‘2’.

Type of First Cancer Treatment - Notes for Users Required for QPI(s) delete ‘2’ and add ‘1, 10, 11, 12 & 14’. Codes and Values Table code 2, explanatory note – add text ‘SABR’.

Date of First Cancer Treatment - Notes for Users add QPI(s) 4 & 15. Also used for the’.

Date of Definitive Treatment {Lung Cancer} - Notes for Users Delete QPI 3 and add 1.

Location Code {Cancer Surgery} - Notes for Users delete ‘QPI 10’ and add ‘analysis purposes’.

Definitive Surgery Performed {Lung Cancer} - Notes for Users Required for QPI(s) ‘2,14,15,16.

Date of Surgery - Notes for Users delete QPI ‘6’.

Histological/Cytological Diagnosis Following Surgery {Lung Cancer} - Notes for Users delete QPI(s) ‘8,9,10,11’. Codes and Values Table - Code 14, Explanatory note – delete text ‘Other neuroendocrine tumours and large cell neuroendocrine carcinomas’. Delete entry for code 22.

TNM Tumour Classification (Pathological) {Lung Cancer} - Notes for Users remove QPI ‘2’.

TNM Nodal Classification (Pathological) {Lung Cancer} - Notes for Users remove QPI ‘2’

TNM Metastases Classification (Pathological) {Lung Cancer} - Notes for Users remove QPI ‘2’

Radiotherapy Course Type (1-3) - Notes for Users add QPI ‘6,15,16’ and delete ‘11’. Notes for Users add ‘Actual treatment should be recorded. Where patients receive radiotherapy with radical intent (either radical radiotherapy or chemoradiotherapy) and treatment is abandoned prior to receiving full dosage, this should be recorded as palliative’. Delete ‘If patients receiving radiotherapy with radical intent (either radical radiotherapy or chemoradiotherapy) abandon treatment before full dosage is received, this should still be recorded as radical radiotherapy/chemoradiotherapy’ (unpublished change). Codes and Values Table code 2 Explanatory note, add text ‘Includes SABR.'
Stereotactic Ablative Radiotherapy (SABR) - Add New Data Item

Radiotherapy Dose: Total Administered {Cancer} 1-3 - Notes for Users remove QPI(s) ‘8,10’.

Date Treatment Started {Cancer} (Radiotherapy) 1-3 - Notes for Users Remove QPI(s) ‘4, 11, 12’.

Type of Systemic Anti-Cancer Therapy (SACT) 1-3 - Notes for Users remove QPI(s) ‘8,9’ and add ‘15, 16’. Notes for Users, add ‘Actual treatment should be recorded. Where patients receive chemoradiotherapy and treatment is abandoned prior to receiving full dosage, this should be recorded as palliative’.

Systemic Therapy Agent 1-3 {Lung Cancer} - Notes for Users remove QPI ‘11’. Codes and Values Table delete entry for codes ‘9, 13, 14, 98’ and add codes and values ‘20 Crizotinib, 21 Afatinib, 22 Other biological agent, 23 Other chemotherapy agent’.

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3 - Notes for Users remove QPI ‘5’

Revisions to Dataset Outwith Review (April 2016)
The following addition has been made to facilitate the recording of data. This change will take effect for patients diagnosed from 1st April 2015.

Date of Diagnosis – Notes for Users change CT scan to chest imaging

Revisions to Dataset Outwith Review (July 2015)

Date of Diagnosis – Notes for Users add ‘The date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat’ (effective from 1st April 2015)’ and remove ‘The date recorded is the date of the first investigative procedure that confirms a diagnosis of lung cancer whether done radiologically or histologically’.

Revisions to Dataset following Baseline Review (June 2015)

Dataset

Location of Diagnosis {Cancer} – Codes and Values Table removed X1010=Not applicable

Epidermal Growth Factor Receptor (EGFR) Status - Notes for Users amended to adenocarcinoma instead of non-squamous

Mediastinal/SCF Sampling Results (pre-treatment) – Notes for users add ‘video-assisted thoracoscopic surgery (VATs) sampling’ and for Methods of sampling for mediastinal nodes
Total Number of Hilar Lymph Nodes Examined Microscopically – Remove Data Item

Total Number of Mediastinal Lymph Nodes Examined Microscopically – Remove Data Item

N2 Lymph Node Stations – Add New Data Item

Histological/Cytological Diagnosis {Lung Cancer} (Pre-Treatment) – Codes and Values table move explanatory note ‘Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma’ from ‘code 13’ to code ‘14’

Histological/Cytological Diagnosis Following Surgery {Lung Cancer} – Codes and Values table move explanatory note ‘Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma’ from ‘code 13’ to code ‘14’

Database Specification

N2 Lymph Node Stations – Add new Data Item

Total Number of Hilar Lymph Nodes Examined Microscopically – Remove Data Item

Total Number of Mediastinal Lymph Nodes Examined Microscopically – Remove Data Item.

Revisions to Dataset Outwith Review (November 2014)

Date of Diagnosis {Cancer} - Notes for Users add ‘this may be the date of the CT scan where suspicion of lung cancer was raised and subsequently confirmed’

Therapy Agent 1-3 {Lung Cancer} - Codes and Values table remove terminology ‘palliative and neoadjuvant’

Revisions to Dataset Outwith Review (June 2014)

Database Specification

Origin of Tumour - Field Length corrected from 2 to 1

Date of Definitive Treatment {Lung Cancer} - Add new Data Item Field Name DEFTREATDATE, Field Type: Date, Field Length 10.

Dataset

Origin of Tumour - Field Length changed to 1

Date of Definitive Treatment {Lung Cancer} - Add New Data Item
Revisions to Dataset Following 9 Month Review (March 2014)

Database Specification - Corrected missing fields and page references updated.

Dataset

Seen by Clinical Nurse Specialist {Lung Cancer/Mesothelioma} - Notes for Users add: "In some settings, the clinical nurse specialist seen by the patient may be a palliative care nurse. This should be coded as ‘1: Yes’.”

Epidermal Growth Factor Receptor (EGFR) Status – Codes and Values Table added ‘4: Inconclusive’ to table of codes and values.

Mediastinal/SCF Sampling Results (Pre-treatment) - Notes for Users added "Where there is definitive evidence of distant metastases, or where there are no nodes to sample, record as ‘96: Not applicable. Codes and Values Table added ‘3: Inconclusive’.

TNM Tumour Classification (Clinical) {Lung Cancer} – Notes for Users amended “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes” and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.” Codes and Values Table removed ‘Tis: carcinoma in situ’ as these are excluded from the dataset.

TNM Nodal Classification (Clinical) {Lung Cancer} - Notes for users amended “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.”

TNM Metastases Classification (Clinical) {Lung Cancer} – Notes for Users amended: “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes” and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.”

TNM Tumour Classification (Clinical) {Pleural Mesothelioma} – Notes for Users amended “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes” and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.”

TNM Nodal Classification (Clinical) {Pleural Mesothelioma} – Notes for Users amended “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes” and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.”

TNM Metastases Classification (Clinical) {Pleural Mesothelioma} – Notes for Users “This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes” and “In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded.”

Location Code {Cancer Surgery} – Notes for Users amended ‘Each location has a location code, which is maintained jointly by PHS: http://www.PHSscotland.org/Products-and-Services/Data-Definitions-and-
References/National-Reference-Files/index.asp’ and ‘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.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/SMR-Reference-Files/

**Date of Surgery** – Notes for Users amended notes for users: removed ‘All treatments given as part of the initial treatment plan.’ Added: ‘Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.’

**TNM Tumour Classification (Pathological) {Lung Cancer}** - Codes and Values Table removed ‘Tis: carcinoma in situ’ as these are excluded from the dataset.

**Radiotherapy Course Type (1-3)** – Notes for Users amended “Patients treated within 6 months of initially refusing investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.”

**Date Treatment Completed {Cancer} (Radiotherapy) 1-3** – Filed Name amended from ‘RCOMPDATE11’ to ‘RCOMPDATE1’.

**Revisions to Dataset Outwith Review (December 2013)**

**Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3** - Notes for Users from ‘This is the last dose of the last cycle of course of chemotherapy, or biological therapy’ to ‘This is the first day of the last cycle of a course of SACT’.
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 bronchus, lung or trachea (see page 18 Site of Tumour, for ICD-10 codes that are included)

Including all patients who have:
  - Had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

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

**NB:**
- Only treatments as part of the initial treatment plan should be recorded.
- Patients treated within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.
### DATABASE SPECIFICATION

### 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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### Section 3: Surgery

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### Section 4: Pathological Details

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<tr>
<td>TNM Tumour Classification (Pathological) {Lung Cancer}</td>
<td>PTLUNG</td>
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<td>TNM Metastases Classification (Pathological) {Lung Cancer}</td>
<td>PMLUNG</td>
<td>Characters</td>
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<td>N2 Lymph Node Stations</td>
<td>N2NODES</td>
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### Section 5: Oncology
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<td>Radiotherapy Dose: Total Administered {Cancer}</td>
<td>TOTDOSE1</td>
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<td>70</td>
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<tr>
<td>Radiotherapy Dose: Total Administered {Cancer}</td>
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<td>Float</td>
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<td>Radiotherapy Fractions: Total Administered {Cancer}</td>
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<tr>
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<td>RSRTDATE2</td>
<td>Date</td>
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<tr>
<td>Date Treatment Started {Cancer} (Radiotherapy)</td>
<td>RSRTDATE3</td>
<td>Date</td>
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<tr>
<td>Date Treatment Completed {Cancer} (Radiotherapy)</td>
<td>RCOMPDATE1</td>
<td>Date</td>
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<tr>
<td>Date Treatment Completed {Cancer} (Radiotherapy)</td>
<td>RCOMPDATE2</td>
<td>Date</td>
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<tr>
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<td>RCOMPDATE3</td>
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<td>Location Code {SACT Treatment}</td>
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<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE1</td>
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<td>CHEMTYPE2</td>
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<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE3</td>
<td>Integer</td>
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<td>79</td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 (Lung Cancer)</td>
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<td>Integer</td>
<td>2</td>
<td>82</td>
</tr>
<tr>
<td>Data Item</td>
<td>Field Name</td>
<td>Field Type</td>
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<td>--------------</td>
<td>--------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 {Lung Cancer}</td>
<td>CHEMAGENT2</td>
<td>Integer</td>
<td>2</td>
<td>82</td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 {Lung Cancer}</td>
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<td>Integer</td>
<td>2</td>
<td>82</td>
</tr>
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<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
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<td>Date</td>
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<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMDATE2</td>
<td>Date</td>
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<td>84</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMDATE3</td>
<td>Date</td>
<td>10</td>
<td>84</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE1</td>
<td>Date</td>
<td>10</td>
<td>87</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE2</td>
<td>Date</td>
<td>10</td>
<td>87</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE3</td>
<td>Date</td>
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<td>87</td>
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<tr>
<td><strong>Section 6: Clinical Trials</strong></td>
<td></td>
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<td>90</td>
</tr>
<tr>
<td>Patient Entered into Clinical Trial</td>
<td>TRIAL</td>
<td>Integer</td>
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<td>91</td>
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<tr>
<td><strong>Section 7: Death Details</strong></td>
<td></td>
<td></td>
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<td>92</td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date</td>
<td>10</td>
<td>93</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:**
The surname of a person represents that part of the name of a person indicating the family group of which the person is part. It should be noted that in Western culture this is normally the latter part of the name of a person. However, this is not necessarily true of all cultures. This will, of course, give rise to some problems in the representation of the name. This is resolved by including the data item Name Element Position in the structured name indicating the order of the name elements.

From SMR Definitions and Codes

**Notes by Users:**
Person Given Name

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

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

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

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

**Notes for Users:**
The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

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

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

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

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

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

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

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

**Notes by Users:**
Date of Birth

Main source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Related Data Item(s):
CHI Number

Notes by Users:
Person Sex at Birth

Common Name(s): Sex at Birth

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

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

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

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

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

Codes and Values:

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

Related Data Item(s):
CHI Number

Notes by Users:
CHI Number

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

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

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

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

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

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

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

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

Related Data Item(s):
Date of Birth,
Person Sex at Birth.

Notes by Users:
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 Lung cancer was received.

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

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

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

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

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

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

**Notes by Users:**
Date of CT Thorax

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

**Definition:** The date the CT of the thorax was performed for staging and assessment.

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

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

If the patient has more than one CT of thorax to diagnose lung cancer the date of the first procedure is recorded.

Date CT Pulmonary angiogram (CTPA) can be recorded to diagnose lung cancer.

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

If CT thorax was not performed, record as 10/10/1900 (Not applicable).

**Codes and Values:**

**Related Data Items:**

**Notes by Users:**
Date of Bronchoscopy {Lung Cancer}

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

Definition: The date of bronchoscopy is the date the procedure was performed for the purposes of investigating a possible diagnosis of lung cancer.

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

Notes for Users: Required for QPI: 3

If the patient has more than one bronchoscopy to diagnose lung cancer, the date of the first procedure is recorded.

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

If bronchoscopy was not performed, record as 10/10/1900 (Not applicable).

Codes and Values:

Related Data Items:

Notes by Users:
See by Clinical Nurse Specialist (Lung Cancer)

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

**Definition:** A record to determine if the patient was seen by a clinical nurse specialist during their journey for the investigation and management of their cancer.

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

**Notes for Users:** Required for NLCA

In this context a clinical nurse specialist is a nurse who has specific expertise in the care and support of patients with cancer.

In some settings, the clinical nurse specialist seen by the patient may be a palliative care nurse. This should be coded as ‘1: Yes’.

**Codes and Values:**

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

**Related Data Items:**

**Notes by Users:**
Location of Diagnosis {Cancer}

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

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

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

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

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

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
X9999=Not recorded

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

Codes and Values:

Related Data Items:
Date of Diagnosis {Cancer}
Histological/Cytological Diagnosis {Lung Cancer}

Notes by Users:
Date of Diagnosis {Cancer}

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 cancer was first diagnosed whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods.

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

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

The date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat (effective from 1st April 2015).

This may be the date of the chest imaging where suspicion of lung cancer was raised and subsequently confirmed.

If imaging identifies metastatic disease which is later confirmed by CT chest to be a lung primary then the date of CT chest should be recorded.

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

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

Codes and Values:

Related Data Items: Location of Diagnosis (Cancer)

Notes by Users:
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 (ICD-10).

Field Name: SITE  
Field Type: Characters ICD-10 ()  
Field length: 5

Notes for Users: Required for national comparative analysis

For ICD-10, tumours should be assigned to the subcategory that includes the point of origin of the tumour. A tumour that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified as subcategory ‘C34.8’. 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.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Value</th>
<th>Notes on Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>C33.X</td>
<td>Malignant neoplasm of trachea</td>
<td></td>
</tr>
<tr>
<td>C34.0</td>
<td>Malignant neoplasm of bronchus and lung.</td>
<td>Includes: Carina, Hilus (of lung)</td>
</tr>
<tr>
<td>C34.1</td>
<td>Upper lobe, bronchus or lung</td>
<td></td>
</tr>
<tr>
<td>C34.2</td>
<td>Middle lobe, bronchus or lung</td>
<td></td>
</tr>
<tr>
<td>C34.3</td>
<td>Lower lobe, bronchus or lung</td>
<td></td>
</tr>
<tr>
<td>C34.8</td>
<td>Overlapping lesion of bronchus and lung</td>
<td></td>
</tr>
<tr>
<td>C34.9</td>
<td>Bronchus or lung, unspecified</td>
<td></td>
</tr>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Origin of Tumour

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

**Definition:** The origin of the primary tumour as detected clinically (including imaging).

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

**Notes for Users:** Required for DCE

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lung carcinoma</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

**Notes by Users:**
Histological/Cytological Diagnosis {Lung Cancer} (Pre-Treatment)

**Main Source of Data Item Standard:** The National Cancer Audit Datasets developed by the Scottish Pathology Network supported by PHS.

**Definition:** This is the histological/cytological microscopic examination of the specimen by a pathologist to determine the presence of malignancy and the classification of the malignant tumour prior to surgery.

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

**Notes for Users:** Required for QPI(s): 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16

A pathological diagnosis should be obtained from biopsy, or frozen section taken immediately prior to surgery.

If subtype is unknown use code 13 or 21 to record if tumour type is NSCLC or SCLC.


There may be more than one biopsy/histology report. If there is a discrepancy between reports of cytology and histology, the histology report should be recorded as the definitive report.

The WHO Classification is intended primarily for use with surgically resected cases (surgical resections pathology recorded elsewhere) and cannot be applied in full to small biopsy/cytology diagnosis. Consequently, a proportion of cases on biopsy/cytology specimens will be reported as “non-small cell carcinoma” (NSCLC), as this is as specific a diagnosis as may be possible on the material available Allocation to tumour subtype or variant category may not be achievable on diagnostic samples.

If a report is no more specific than “malignant cells” and does not further classify the tumour as carcinoma or other type of malignancy, the histology should be recorded as "other malignancies". Findings reported as “carcinoma, NOS” should also be recorded as "other malignancies."

Pathologists often state ‘favouring’ a certain tumour sub-type and this should be documented as recorded rather than Not Otherwise Specified ‘NOS’

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.

Where more than one cancer site is reported in pathology reports, audit staff should clarify histology and cancer site from MDT documentation or confirm with a relevant clinician.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Squamous</td>
<td>NSCLC Includes all variants</td>
</tr>
<tr>
<td>12</td>
<td>Adenocarcinoma</td>
<td>NSCLC Includes: acinar, papillary, bronchiolo-alveolar, solid, signet ring cell and mucus cell types or patterns</td>
</tr>
<tr>
<td>13</td>
<td>NSCLC, not otherwise specified (NOS)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Other specific non-small cell carcinomas</td>
<td>NSCLC Includes: Other neuroendocrine tumours and large cell neuroendocrine carcinomas, salivary-type carcinomas Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma</td>
</tr>
<tr>
<td>21</td>
<td>Small cell carcinoma (SCLC)</td>
<td>SCLC Includes:</td>
</tr>
<tr>
<td>22</td>
<td>Carcinoid tumour</td>
<td>Includes typical and atypical carcinoid</td>
</tr>
<tr>
<td>31</td>
<td>Combination of non-small cell components</td>
<td>NSCLC Includes: adenosquamous carcinoma and other mixed NSCLC-type cases</td>
</tr>
<tr>
<td>32</td>
<td>Small cell/non-small cell components</td>
<td>SCLC</td>
</tr>
<tr>
<td>41</td>
<td>Other malignancies (including malignancy NOS)</td>
<td>Includes cases reported as ‘carcinoma, NOS’ and metastatic tumours</td>
</tr>
<tr>
<td>8</td>
<td>Negative histology</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>e.g. no pathology carried out</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

- Location of Diagnosis (Cancer)
- Date of Diagnosis (Cancer)
Date of Histological / Cytological Diagnosis {Cancer}

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 lung cancer was first diagnosed whether by histology or cytology.

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

Notes for Users: Required for QPI 15.

There may be more than one biopsy/histology report. If there is a discrepancy between reports of cytology and histology, the histology report should be recorded as the definitive report.

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

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

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

Codes and Values:

Related Data Items: Location of Diagnosis {Cancer}

Notes by Users:
Tumour profiling undertaken

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

Definition: A record of whether tumour profiling tests have been undertaken as part of the pathological assessment, prior to treatment.

Field Name: PROFILE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 2

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers. Specific tests e.g. EGFR, ALK, ROS1, are therefore required to predict whether targeted treatments are likely to be effective.

If any tumour profiling test has been undertaken, record as 1 (Yes).

Patients with Small Cell Lung Cancer (SCLC) or Carcinoid Lung Cancer should be recorded as 96 (Not applicable).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>Includes failed attempt</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>Includes unknown</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Epidermal Growth Factor Receptor (EGFR) Status
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status
ROS1 Testing
Epidermal Growth Factor Receptor (EGFR) Status

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

**Definition:** A record of the outcome of an epidermal growth factor receptor (EGFR) molecular profiling test, as part of the pathological assessment, taken prior to SACT treatment.

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

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

There are structures on the surface of many types of cancer cells, known as epidermal growth factor receptors (EGFRs). The receptors allow epidermal growth factor (EGF), a particular protein present in the body, to attach to them. When EGF attaches to the receptor, it becomes activated and causes chemical processes to occur inside the cell that make it grow and divide more quickly. Erlotinib is an EGFR inhibitor, which has been accepted for use in Scotland by the SMC. This prevents the receptor from being activated and stops the cancer cells from growing so quickly.

Drugs known as EGFR antagonists attach themselves to the EGF receptor on the cell, and prevent the receptor from being activated. This can help to stop the cancer cells from growing so quickly.

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers. Specific tests e.g. EGFR, are therefore required to predict whether targeted treatments are likely to be effective.

EGFR should be undertaken on all patients with stage IIIB or IV non-squamous NSCLC.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>EGFR undertaken as part of pathological assessment and a sensitising mutation has been detected.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>EGFR undertaken as part of pathological assessment and no EGFR mutations are detected.</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>Biopsy sample insufficient, test failed.</td>
</tr>
<tr>
<td>5</td>
<td>Undertaken</td>
<td>EGFR undertaken as part of pathological assessment and a mutation of uncertain significance or one conferring resistance has been detected but not actionable.</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Tumour Profiling Undertaken
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status
ROS1 Testing
PD-L1 Status
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status

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

Definition: A record of the outcome of an oncogenic anaplastic lymphoma kinase (ALK) molecular profiling test, as part of the pathological assessment, taken prior to SACT treatment.

Field Name: ALK
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 11

The ALK gene rearrangement produces an abnormal ALK protein that causes the cells to grow and spread. Drugs known as tyrosine kinase inhibitors (TKI) target ALK protein and can stop the cells growing.

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers. Specific tests e.g. ALK, are therefore required to predict whether targeted treatments are likely to be effective.

ALK should be undertaken on all patients with stage IIIB or IV non-squamous NSCLC.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>ALK testing undertaken as part of pathological assessment and result positive for ALK fusion gene.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>ALK testing undertaken as part of pathological assessment and result negative for ALK fusion gene.</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>Biopsy sample insufficient, test failed.</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Epidermal Growth Factor Receptor (EGFR) Status
Tumour Profiling Undertaken
ROS1 Testing
PD-L1 Status
**ROS1 Testing**

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

**Definition:** A record of the outcome of ROS1 testing, undertaken as part of the pathological assessment, prior to SACT treatment.

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

**Notes for Users:**

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers. Specific tumour profiling tests e.g. ROS1, are therefore required to predict whether targeted treatments are likely to be effective.

ROS1 should be undertaken on patients with non-squamous NSCLC.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>ROS1 testing undertaken as part of pathological assessment and result positive for the ROS1 gene.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>ROS1 testing undertaken as part of pathological assessment and result negative for the ROS1 gene.</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>Biopsy sample insufficient, test failed.</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

- Epidermal Growth Factor Receptor (EGFR) Status
- Oncogenic Anaplastic Lymphoma Kinase (ALK) Status
- Tumour Profiling Undertaken
- PD-L1 Status
PD-L1 Status

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

**Definition:** A record of the outcome of an oncogenic PD-L1 test, as part of the pathological assessment, taken prior to SACT treatment.

**Field Name:** PDL1  
**Field Type:** Integer  
**Field Length:** 2

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

T-cells are part of the immune system and play a role in attacking cancer cells within the body. The PD-L1 expression attaches to a receptor on a T-cell which then prevents this process.

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers, specific tests e.g. PD-L1, and therefore are required to predict whether targeted treatments are likely to be effective.

The result recorded should be the percentage of cells where PD-L1 expression is present.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Inconclusive</td>
<td>Biopsy sample insufficient, test failed.</td>
</tr>
<tr>
<td>5</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1-10%</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>11-20%</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>21-30%</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>31-40%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>41-50%</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>51-60%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>61-70%</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>71-80%</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>81-90%</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>91-100%</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Epidermal Growth Factor Receptor (EGFR) Status  
Oncogenic Anaplastic Lymphoma Kinase (ALK) Status  
ROS1 Testing  
Tumour Profiling Undertaken
Date of Integrated FDG-PET/CT (PET/CT) Scan

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

Definition: This denotes the date of the integrated FDG-PET/CT (PET/CT) scan was performed for staging and assessment.

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

Notes for Users: Required for QPI: 4

A PET/CT scan should be completed and reported by the multi-disciplinary team (MDT) for patients with NSCLC who are being considered for treatment with curative intent.

If the patient has more than one PET/CT scan the date of the first procedure is recorded.

If the exact date of the PET/CT Scan is not documented, record as 09/09/1900.

If PET/CT scan was not performed, e.g. if patients has SCLC, record as 10/10/1900 (not applicable).

Related Data Item(s):
Hilar/Mediastinal/Supraclavicular (SCF) node results at FDG-PET/CT (PET/CT) Scan
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lung}
Date of Integrated FDG-PET/CT (PET/CT) Scan Reported {Lung}
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lung}

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

Definition: The date a PET/CT scan was requested for staging and assessment by a clinician and sent to radiology.

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

Notes for Users: Required for QPI: 4

If radiology request not required, record as 10/10/1900 (Not applicable).

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

Related Data Item(s):
Date of Integrated FDG-PET/CT (PET/CT) Scan {Lung}
Date Integrated FDG-PET/CT (PET/CT) Scan Reported {Lung}
Date Integrated FDG-PET/CT (PET/CT) Scan Reported {Lung}

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

Definition: The date integrated FDG-PET/CT (PET/CT) scan is reported for staging and assessment.

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

Notes for Users: Required for QPI: 4

If more than one PET/CT scan is undertaken the date of the report of the first procedure is recorded to align with date of investigation.

If the date of the PET/CT scan report is not documented record as 09/09/1900 (Not Recorded)

If PET/CT scan is not performed, record as 10/10/1900 (Not applicable).

Related Data Item(s):
Date Integrated FDG-PET/CT (PET/CT) Scan {Lung}
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lung}
Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013

Hilar/Mediastinal/Supraclavicular (SCF) Node Results at FDG-PET/CT (PET/CT) Scan

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

Definition: A record of the results of hilar (N1/N3)/mediastinal (N2/N3)/SCF node evaluation (N3) as determined by PET/CT imaging.

Field Name: MEDPET
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 5

Identification of the following is required: Enlarged or positive hilar (N1 if ipsilateral, N3 if contralateral), mediastinal (N2 if ipsilateral, N3 if contralateral) or SCF nodes (N3). If N staging is not detailed on the PET/CT, please refer to the descriptors detailed in the explanatory notes below:

- If the PET/CT report states that there are ‘no sizable nodes’, ‘no size significant LN’, or ‘sub centimetre nodes’ this would indicate N0 and would be recorded as code 2 ‘No positive nodes identified’.

- If the PET/CT report states that there are 'suspicious nodes', 'pathological nodes', 'abnormal nodes', 'bulky nodes', 'avid nodes' or 'high uptake' this would indicate there are positive nodes identified and should be recorded as code 1 ‘Enlarged or positive hilar/mediastinal/SCF nodes identified’.

- Where N staging is Nx, this should be recorded as code 2 ‘No positive nodes identified’. However, if any of the descriptors noted in the second point above (suspicious, pathological, abnormal etc) have been documented and staging has been recorded as Nx then the descriptors should take priority and this should be recorded as code 1.

Results recorded are based on PET/CT report as documented by radiologist/MDT, not on the sampling of hilar/mediastinal/SCF nodes.

MDT forms may also contain a record if nodes are present (and enlarged or avid) on PET/CT.

Additional key points:

- Station 1 nodes are always N3 regardless of whether they are ipsilateral or contralateral
- Anything in the neck above cricoid cartilage is M1b
- Station 10-14 hilar nodes on the same side are N1, but if on other side are N3
- Station 2-9 mediastinal nodes on the same side are N2, but if on other side are N3
- Station 3a, 3p, 5, 6, 7 have no laterality, ie no right or left
- Station 1, 2, 4, 8, 9, 10, 11, 12, 13, 14 have right and left nodes
**Supraclavicular Zone 1 (N3)**

**Station 1** Low cervical, supraclavicular and sternal notch nodes (right, left)

**Upper zone (Superior mediastinal nodes) 2-4**

(N2 if ipsilateral, N3 if contralateral)

**Station 2R** Right upper paratracheal nodes

**Station 2L** Left upper paratracheal nodes

**Station 3A** Pre-vascular

**Station 3P** Pre-vertebral

**Station 4R** Right lower paratracheal

**Station 4L** Left lower paratracheal

**Aortopulmonary zone 5-6**

**Station 5** Sub-aortic nodes

**Station 6** Para-aortic nodes

**Subcarinal zone (Inferior mediastinal nodes) 7**

**Station 7** Subcarinal nodes

**Lower Zone (Inferior mediastinal nodes) 8-9**

**Station 8** Paraesophageal nodes (right, left)

**Station 9** Pulmonary Ligament nodes (right, left)

**Hilar and Interlobar zone (pulmonary nodes) 10-11**

(N1 if ipsilateral, N3 if contralateral)

**Station 10** Hilar nodes (right, left)

**Station 11** Interlobar nodes (right, left)

**Peripheral zone (pulmonary nodes) 12-14**

**Station 12** Lobar nodes (right, left)

**Station 13** Segmental nodes (right, left)

**Station 14** Sub-segmental nodes (right, left)

---

**Codes and values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enlarged or positive hilar/mediastinal/SCF nodes identified</td>
<td>Enlarged or positive hilar (N1/N3)/mediastinal (N2/N3)/SCF (N3) nodes noted on PET/CT report (N1/N2/N3 disease recorded in radiology report)</td>
</tr>
<tr>
<td>2</td>
<td>No positive nodes identified</td>
<td>No enlarged or positive hilar (N1/N3) / mediastinal (N2/N3) / SCF (N3) nodes noted on PET/CT report (N0 disease recorded in radiology report).</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no PET/CT scan undertaken</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
<td></td>
</tr>
</tbody>
</table>
Related Data Item(s):
Hilar/Hilar/Mediastinal/SCF Sampling
Hilar/Mediastinal/SCF Sampling

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

Definition: A record to determine if hilar (N1/N3)/mediastinal (N2/N3)/supraclavicular fossa (SCF) node evaluation (N3) is performed and nodes were sampled.

Field Name: MEDSAMP
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 5

Sampling is not required if there is definitive distant metastatic disease although if undertaken, this may be recorded for local audit purposes.

Methods of sampling include: Neck US guided or direct biopsy (core or FNA), EBUS, EUS-B, EUS, Mediastinoscopy or VATS.

Where there are no nodes to sample, record as ‘96: Not applicable’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Inconclusive</td>
<td>e.g. failed attempt</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. if there are no nodes to sample</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
TNM Metastases Classification (Clinical) (Lung Cancer)
Hilar/Mediastinal/Supraclavicular (SCF) node results at FDG-PET/CT (PET/CT) Scan
Synchronous Primary Tumours

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

**Definition:** This denotes whether or not synchronous primary tumours are present.

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

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

This refers to the presence of synchronous primary tumours which may be in the same lung (ipsilateral) or involving both sides (Bilateral).

Record the presence or absence of synchronous tumours.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Ipsilateral</td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td>Bilateral</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Absent</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

**Notes by Users:**
TNM Tumour Classification (Clinical) {Lung Cancer}

Common name: Clinical TNM Tumour Classification (Lung Cancer)


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

Field Name: TLUNG
Field Type: Characters
Field length: 3

Notes for Users: Required for QPI(s): 2, 6, 8, 9, 10, 11 & 14

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes.

If a patient is discussed at MDT after they have died, the TNM recorded at this time which relates to pre-treatment/pre-death staging can be recorded.

In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded. If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table for T1 and T2 tumours is recommended. If the size of the tumour is not specified as pT2a or pT2b then it should be recorded as pT2a.
## Codes and Values:

<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>T1mi</td>
<td>Minimally invasive adenocarcinoma</td>
<td>Solitary adenocarcinoma (not more than 3cm in greatest dimension), with a predominantly lepidic pattern and not more than 5mm invasion in greatest dimension in any one focus)</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour ≤ 1cm in greatest dimension¹.</td>
<td></td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour &gt; 1cm – ≤ 2cm in greatest dimension¹.</td>
<td></td>
</tr>
<tr>
<td>T1c</td>
<td>Tumour &gt;2cm - ≤3cm in greatest dimension¹.</td>
<td></td>
</tr>
<tr>
<td>T2a</td>
<td>&gt; 3cm – ≤ 4cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>T2b</td>
<td>&gt; 4cm – ≤ 5cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour &gt; 5cm - ≤ 7cm in greatest dimension or one that directly invades any of the following: parietal pleura, chest wall (including superior sulcus tumours), phrenic nerve, or parietal pericardium; or separate tumour nodules(s) in the same lobe as the primary.</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour &gt; 7cm or of any size that invades any of the following: diaphragm, mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, oesophagus, vertebral body, carina; separate tumour nodule(s) in a different ipsilateral lobe to that of the primary.</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed, or tumour proven by presence of malignant cells in sputum or bronchial washings but not visualised by imaging or bronchoscopy.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>T Classification Not applicable</td>
<td>Not lung cancer</td>
</tr>
<tr>
<td>99</td>
<td>T Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

### Related Data items:
- TNM Tumour Classification (Clinical) {Lung Cancer}
- TNM Metastases Classification (Clinical) {Lung Cancer}
TNM Nodal Classification (Clinical) {Lung Cancer}

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


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

Field Name: NLUNG
Field Type: Characters
Field length: 2

Notes for Users: Required for QPI(s): 2, 6, 9, 10, 11, 14 & 16

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes.

If a patient is discussed at MDT after they have died, the TNM recorded at this time which relates to pre-treatment/pre-death staging can be recorded.

In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded. If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis.</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis in ipsilateral peribronchial and/or ipsilateral hilar lymph nodes and intrapulmonary nodes, including involvement by direct extension.</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed).</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data items:
TNM Tumour Classification (Clinical) {Lung Cancer}
TNM Metastases Classification (Clinical) {Lung Cancer}
TNM Metastases Classification (Clinical) {Lung Cancer}

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

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

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

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

**Notes for Users:** Required for QPI(s): 2, 5, 6, 8, 9, 10, 11 & 14

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes.

If a patient is discussed at MDT after they have died, the TNM recorded at this time which relates to pre-treatment/pre-death staging can be recorded

In cases where there are multiple or synchronous tumours, the tumour with the poorest prognosis should be recorded. If there is any doubt as to which tumour has the poorest prognosis, this should be clarified with the relevant clinician.

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table for M1 tumours is recommended.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1a</td>
<td>Separate tumour nodule(s) in a contralateral lobe; tumour with pleural or pericardial nodules or malignant pleural or pericardial effusion³.</td>
<td>³Most pleural (pericardial) effusions with lung cancer are due to tumour. In a few patients, multiple microscopical examinations of pleural (pericardial) fluid are negative for tumour, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgement dictate that the effusion is not related to the tumour, the effusion should be excluded as a staging descriptor.</td>
</tr>
<tr>
<td>M1b</td>
<td>Single extrathoracic metastasis in a single organ</td>
<td>This includes involvement of a single non-regional node.</td>
</tr>
<tr>
<td>M1c</td>
<td>Multiple extrathoracic metastasis in a single or multiple organs</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data items:**
TNM Tumour Classification (Clinical) {Lung Cancer}
TNM Metastases Classification (Clinical) {Lung Cancer}
Brain Imaging

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

**Definition:** An indicator of whether or not brain imaging investigations were completed by contrast enhanced CT or Magnetic Resonance Imaging (MRI).

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

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

Brain imaging is recommended for patients with N2 disease who are being considered for curative treatment. This could be either contrast enhanced CT or contrast enhanced MRI investigation.

If brain imaging has been undertaken in patients where N2 disease is not present, this can be recorded for local use.

Where there is no evidence that brain imaging has been undertaken, record as 4 (Not performed).

If the patient is not undergoing curative treatment record as 96 (Not applicable).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contrast enhanced CT</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Contrast enhanced MRI</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>CT/MRI – non contrast enhancing</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Not performed</td>
<td>Includes not known</td>
</tr>
<tr>
<td>5</td>
<td>Not performed - Contraindicated</td>
<td>Generally acknowledged clinical contraindication to performing both assessments exists. e.g. renal impairment, allergies to contrast media.</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Patient chose not to have brain imaging.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

Date of Brain Imaging
Date of Brain Imaging

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

Definition: This denotes the date the Contrast enhanced CT or MRI scan was performed for brain imaging.

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

Notes for Users: Required for QPI: 16

The date of procedure should be recorded.

If the patient has more than one brain imaging procedure the date of the first procedure is recorded.

If the exact date of the contrast enhanced CT / MRI scan is not documented, record as 09/09/1900.

If contrast enhanced CT / MRI scan was not performed, record as 10/10/1900 (not applicable).

Related Data Item(s):
Brain Imaging
WHO/ ECOG Performance Status

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


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

Notes for Users: Required for QPI(s): 2, 9, 10, 11

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

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

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

If the performance status falls between two scores, record the higher value i.e. the worst performance status.

Codes and values:

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

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

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

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

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

The first MDT meeting date will be recorded.

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

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

**Related data Item(s):**
COVID 19 Impact

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

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

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

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

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

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

**Codes and Values:**

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

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 PHS.

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

Field Name: MODE1
Field Type: Integer
Field length: 2

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

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

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

Dilatation without other treatment is not considered as active treatment. Steroids, drainage of pleural effusions etc should not be recorded as first treatment if more substantive treatment such as radiotherapy, chemotherapy or surgery is given. If no further treatment is given, then record as supportive care.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>Includes CHART, Stereotactic, Teletherapy (external beam radiotherapy), SABR and Brachytherapy.</td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Endoscopic</td>
<td>Includes Endobronchial, Photodynamic therapy (PDT), Electrocautery (Diathermy), Cryotherapy, Laser Therapy, Bronchoscopic debulking, Insertion of stents.</td>
</tr>
<tr>
<td>7</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td>Can be concurrent or sequential</td>
</tr>
<tr>
<td>16</td>
<td>Targeted therapy</td>
<td>Targeted therapies attack cancer cells to prevent them growing and dividing. Oral tablets (PO). All end in ‘-ib’ Includes drugs e.g. Crizotinib, Erlotinib, Afatinib, Dacomitinib, Ceritinib, Osimertinib</td>
</tr>
<tr>
<td>17</td>
<td>Immunotherapy</td>
<td>Uses the immune system to treat and control cancer. IV Intravenous treatments. All end in ‘-’</td>
</tr>
<tr>
<td>Code</td>
<td>Data Item(s)</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>18</td>
<td>Chemoimmunotherapy</td>
<td>A combination of immunotherapy and chemotherapy agents commenced concurrently. Also referred to as triplet therapy.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all therapies</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Date of First Cancer Treatment
Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013

46

Date of First Cancer Treatment

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

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

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

Notes for Users: Required for QPI: 4. Also used for the National lung cancer audit and detect cancer early

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. If the patient dies before MDT discussion, enter the date that supportive care was agreed on the ward / clinic.

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 {Lung Cancer}**

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

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

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

**Notes for Users:** Required for QPI(s): 15, 16

For patients with lung cancer definitive treatment will be either:

- Surgery;
- Radiotherapy;
- Chemoradiotherapy; or
- Systemic Anti Cancer Therapy (SACT).

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

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

For patients undergoing no active treatment (e.g. supportive care only) the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. If the patient dies before MDT discussion, enter the date that supportive care was agreed on the ward / clinic. This will therefore be the same date as the First Treatment Date for these patients.

If a patient undergoes treatment for metastatic disease as their only active treatment, this should be recorded as their first and definitive 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):**

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*Data Definitions for the National Minimum Core Dataset for Lung Cancer.  
Developed by PHS Scotland 2013  
47*
Section 3: Surgery
Location Code {Cancer Surgery}

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

**Main Source of Data Item Standard:** NHS National Reference Files, http://www.natref.scot.nhs.uk/.

**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 analysis purposes.

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

Each location has a location code, which is maintained jointly by PHS:

http://www.PHScotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/index.asp?

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.PHScotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/SMR-Reference-Files/

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

If the location code is not documented, record as X9999.
If surgery has not been performed or the patient has refused surgery, record as Not Applicable, X1010.

Examples of codes are given below:

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

Related Data Item(s):
Definitive Surgery Performed (Lung Cancer)
Date of Surgery
Surgical Approach
Definitive Surgery Performed (Lung Cancer)

Main Source of Data Item Standard:

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

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

**Notes for Users:** Required for QPI(s): 2, 4-16

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pneumonectomy</td>
<td>Removal of an entire lung (either left or right).</td>
</tr>
<tr>
<td>2</td>
<td>Lobectomy</td>
<td>Removal of an entire lobe of a lung (there are three lobes in the right lung and two in the left).</td>
</tr>
<tr>
<td>3</td>
<td>Wedge</td>
<td>Surgical technique which involves the removal of a piece of the lung.</td>
</tr>
<tr>
<td>4</td>
<td>Segmental</td>
<td>Removal of an anatomically defined segment of the lung and not the complete lobe</td>
</tr>
<tr>
<td>6</td>
<td>Inoperable</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before surgery</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused surgery</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other surgery performed</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- Location Code (Cancer Surgery)
- Date of Surgery
- Surgical Approach
Date of Surgery

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

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

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

Notes for Users: Required for QPI: 13

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

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

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

Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.

Related Data Items:
Location Code {Cancer Surgery}
Surgical Approach

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

Definition: The type of surgical procedure(s) performed for investigation and/or treatment of Cancer

Field Name: APPROACH
Field Type: Integer
Field length: 2

Notes for Users: Required for analysis purposes

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Thorascopic</td>
<td>Video assisted</td>
</tr>
<tr>
<td>3</td>
<td>Thorascopic - Converted</td>
<td>Video assisted converted to thoracotomy</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:
Location Code {Cancer Surgery}
Histological/Cytological Diagnosis Following Surgery {Lung Cancer}

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the Scottish Pathology Network supported by PHS.

Definition: This is the histological/cytological microscopic examination, following surgical resection, of the specimen by a pathologist to determine the presence of malignancy and the classification of the malignant tumour.

Field Name: HISTSURG
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 2, 4, 5, 6, 7, 12, 13, 16

If subtype is unknown use code 13 or 21 to record if tumour type is SCLC or NSCLC.


If a report is no more specific than "malignant cells" and does not further classify the tumour as carcinoma or other type of malignancy, the histology should be recorded as "other malignancies". Findings reported as “carcinoma, NOS” should also be recorded as "other malignancies.

Pathologists often state ‘favouring’ a certain tumour sub-type and this should be documented as recorded rather than Not Otherwise Specified 'NOS'.

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.
## Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Squamous</td>
<td>NSCLC Includes all variants</td>
</tr>
<tr>
<td>12</td>
<td>Adenocarcinoma</td>
<td>NSCLC Includes: acinar, papillary, bronchiolo-alveolar, solid, signet ring cell and mucus cell types or patterns</td>
</tr>
<tr>
<td>13</td>
<td>NSCLC, not otherwise specified (NOS)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Other specific non-small cell carcinomas</td>
<td>NSCLC Includes: Other neuroendocrine tumours and large cell neuroendocrine carcinomas, salivary-type carcinomas Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma</td>
</tr>
<tr>
<td>21</td>
<td>Small cell carcinoma (SCLC)</td>
<td>SCLC Includes:</td>
</tr>
<tr>
<td>22</td>
<td>Carcinoid tumour</td>
<td>Includes typical and atypical carcinoid</td>
</tr>
<tr>
<td>31</td>
<td>Combination of non-small cell components</td>
<td>NSCLC Includes adenosquamous carcinoma and other mixed NSCLC-type cases</td>
</tr>
<tr>
<td>32</td>
<td>Small cell/non-small cell components</td>
<td>SCLC</td>
</tr>
<tr>
<td>41</td>
<td>Other malignancies (including malignancy NOS)</td>
<td>Includes cases reported as ‘carcinoma, NOS’ and metastatic tumours</td>
</tr>
<tr>
<td>8</td>
<td>Negative histology</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>e.g. no pathology carried out</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>e.g. no pathology carried out</td>
</tr>
</tbody>
</table>

### Related Data Items:

**Definitive Surgery Performed (Lung Cancer)**
Section 4: Pathological Details
TNM Tumour Classification (Pathological) {Lung Cancer}

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

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

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

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

**Notes for Users:** Required for DCE

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

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

If the size of the tumour is not specified as pT2a or pT2b then it should be recorded as pT2a.

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>pT1mi</td>
<td>Minimally invasive adenocarcinoma</td>
<td>Solitary adenocarcinoma (not more than 3cm in greatest dimension), with a predominantly lepidic pattern and not more than 5mm invasion in greatest dimension in any one focus)</td>
</tr>
<tr>
<td>pT1a</td>
<td>Tumour ≤ 1cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT1b</td>
<td>Tumour &gt; 1cm – ≤ 2cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT1c</td>
<td>Tumour &gt; 2cm but ≤ 3cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT2a</td>
<td>&gt; 3cm – 4cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT2b</td>
<td>&gt; 4cm – 5cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour &gt; 5cm but not more than 7cm in greatest dimension or one that directly invades any of the following: parietal pleura, chest wall (including superior sulcus tumours), phrenic nerve, parietal pericardium; or separate tumour nodule(s) in the same lobe as the primary.</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour more than 7cm or of any size that invades any of the following: diaphragm, mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, oesophagus, vertebral body, carina; separate tumour nodule(s) in a different ipsilateral lobe to that of the primary.</td>
<td></td>
</tr>
<tr>
<td>pTX</td>
<td>Primary tumour cannot be assessed, or tumour proven by presence of malignant cells in sputum or bronchial washings but not visualised by imaging or bronchoscopy.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Not lung cancer</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

### Related Data Items:
- TNM Nodal Classification (Pathological) {Lung Cancer}
- TNM Metastases Classification (Pathological) {Lung Cancer}
Data Definitions for the National Minimum Core Dataset for Lung Cancer.

Developed by PHS Scotland 2013

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TNM Nodal Classification (Pathological) {Lung Cancer}

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


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

Field Name: PNLUNG
Field Type: Characters
Field length: 3

Notes for Users: Required for DCE

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pN0</td>
<td>No regional lymph nodes metastasis</td>
<td>Histological examination of hilar and mediastinal lymphadenectomy specimen(s) will ordinarily include 6 or more lymph nodes/stations. Three of these nodes/stations should be mediastinal, including the subcarinal nodes and 3 from N1 nodes/stations. Labeling according to the IASLC chart and table of definitions given in the TNM Supplement is desirable. If all the lymph nodes examined are negative, but the number ordinarily examined is not met, classify as pN0.</td>
</tr>
<tr>
<td>pN1</td>
<td>Metastasis in ipsilateral peribronchial and/or ipsilateral hilar lymph nodes and intrapulmonary nodes, including involvement by direct extension.</td>
<td></td>
</tr>
<tr>
<td>pN2</td>
<td>Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>pN3</td>
<td>Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>pNX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed).</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Not lung cancer</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:

Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013

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TNM Tumour Classification (Pathological) (Lung Cancer)
TNM Metastases Classification (Pathological) (Lung Cancer)
TNM Metastases Classification (Pathological) (Lung Cancer)

Common name: Pathological TNM Metastases Classification (Lung Cancer).


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

Field Name: PMLUNG
Field Type: Characters
Field length: 4

Notes for Users: Required for DCE

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

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

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pM0</td>
<td>No distant metastasis</td>
<td>(at autopsy only). i.e. pM0 does not exist and is not valid except at autopsy.</td>
</tr>
<tr>
<td>pM1</td>
<td>Distant metastasis</td>
<td></td>
</tr>
<tr>
<td>pM1a</td>
<td>Separate tumour nodule(s) in a contralateral lobe; tumour with pleural or pericardial nodules or malignant pleural or pericardial effusion³</td>
<td>Most pleural (pericardial) effusions with lung cancer are due to tumour. In a few patients, multiple microscopic examinations of pleural (pericardial) fluid are negative for tumour, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgement dictate that the effusion is not related to the tumour, the effusion should be excluded as a staging descriptor.</td>
</tr>
<tr>
<td>pM1b</td>
<td>Single extrathoracic metastasis in a single organ</td>
<td>This includes involvement of a single non-regional node.</td>
</tr>
<tr>
<td>pM1c</td>
<td>Multiple extrathoracic metastasis in a single or multiple organs</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Not lung cancer</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>e.g. M status not assessed.</td>
</tr>
</tbody>
</table>

Related Data Items:
TNM Tumour Classification (Pathological) (Lung Cancer)
TNM Nodal Classification (Pathological) (Lung Cancer)
N2 Lymph Node Stations

Main Source of Data Item Standard:

Definition: A record of the total number of mediastinal lymph node stations examined microscopically after surgical resection, or at previous mediastinoscopy.

Field Name: N2NODES
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 7

The number of nodal stations where at least 1 lymph node has been examined should be recorded.

The number of nodal stations examined will be recorded on pathology report of surgical resection and/or mediastinoscopy, with a corresponding number of lymph nodes examined from each station (as detailed below). Clarification should be sought from pathologist where this cannot be ascertained from the report.

Often nodes from paratracheal and subcarinal nodal stations are sampled at mediastinoscopy prior to surgical resection, these should also be recorded.

Mediastinal (N2) nodal stations are defined as:

- Superior Mediastinal Nodes:
  - Station 2R – Right upper paratracheal nodes
  - Station 2L – Upper left paratracheal nodes
  - Station 4R – Right lower paratracheal nodes
  - Station 4L – Left lower paratracheal nodes.

- Aortic Nodes
  - Station 5 – Aorto-pulmonary nodes
  - Station 6 – Anterior Mediastinal nodes

- Inferior Mediastinal nodes
  - Station 7 – Subcarinal nodes
  - Station 8 – Paraesophageal nodes
  - Station 9 – Pulmonary ligt. Nodes

Codes and values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>No N2 stations examined.</td>
</tr>
<tr>
<td>2</td>
<td>1-2</td>
<td>At least 1 lymph node from 1 or 2 N2 stations examined</td>
</tr>
<tr>
<td>3</td>
<td>3 or more</td>
<td>At least 1 lymph node from 3 or more N2 stations examined</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No surgical resection performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related data items:

Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013
Section 5: Oncology
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/

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.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

Related Data Item(s):
Radiotherapy Course Type (1-3)

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

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

**Field Name:**   
RADIOTYPE1  
RADIOTYPE2  
RADIOTYPE3

**Field Type:** Integer

**Field length:** 2

**Notes for Users:** Required for QPI(s): 4, 5, 6, 8, 9, 10, 12, 13, 15 and 16

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

Actual treatment should be recorded. Where patients receive radiotherapy with radical intent (either radical radiotherapy or chemoradiotherapy) and treatment is abandoned prior to receiving full dosage, this should be recorded as palliative.

For patients undergoing chemoradiotherapy the radiotherapy element should be recorded as code ‘6’ and recorded also in SACT under code ‘5’.

Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.

All treatments given as part of the initial treatment plan
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery.</td>
</tr>
</tbody>
</table>
| 2    | Radical       | Radical intent is defined as: NSCLC ≥ 54Gy  
SCLC ≥ 40Gy  
It is primary treatment and is given with curative intent.  
Includes SABR.                                |
| 3    | Palliative    | The aim is solely to relieve symptoms.                                                                                                           |
| 4    | Neo-adjuvant  | It is given before potentially curative surgery.                                                                                                  |
| 5    | Prophylactic  | The aim is to reduce the risk of development of disease e.g. prophylactic cranial irradiation.                                                    |
| 6    | Chemoradiotherapy | Radical radiotherapy given in combination with chemotherapy, either concurrently or sequentially. NSCLC ≥ 54Gy  
SCLC ≥ 40Gy  
Chemotherapy element of this combined treatment should be recorded separately in fields CHEMTYPE1-3. |
| 94   | Patient died before radiotherapy treatment |                                                                                                                                                |
| 95   | Patient refused radiotherapy treatment |                                                                                                                                                |
| 96   | Not applicable | e.g. no radiotherapy given.                                                                                                                      |
| 99   | Not recorded  |                                                                                                                                                |

### Related Data Items:
- Radiotherapy Dose: Total Administered (Cancer) 1-3
- Radiotherapy Fractions: Total Administered (Cancer) 1-3
- Date Treatment Started (Cancer) (Radiotherapy) 1-3
- Date Treatment Completed (Cancer) (Radiotherapy) 1-3
- Site of Radiotherapy (Courses 1-3)
Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by PHS Scotland 2013

### Stereotactic Ablative Radiotherapy (SABR)

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

**Definition:** An indication of whether or not the patient received stereotactic ablative radiotherapy (SABR).

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

**Notes for Users:** Required for QPI(s): 8, 14

Stereotactic ablative radiotherapy (SABR) is a specialised type of radiotherapy which precisely targets the tumour with radiation, whilst lowering the risk of damage to the healthy surrounding tissue.

This should also be recorded as code 2, Radical under Radiotherapy Course Type.

Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.

All treatments given as part of the initial treatment plan

**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 SABR</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Site of Radiotherapy (Courses 1-3)

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

Definition: This is the anatomical site(s) where the radiotherapy was given to the patient.

Field Name: RADIOSITE1
RADIOSITE2
RADIOSITE3
Field Type: Integer
Field length: 2

Notes for Users:

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chest</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Brain</td>
<td>If Prophylactic Cranial Irradiation (PCI) radiotherapy is given then record site as brain.</td>
</tr>
<tr>
<td>3</td>
<td>Bone</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other</td>
<td>Includes: pleural drain</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:

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

**Related Data Item(s):**

- Radiotherapy Course Type (1-3)
- Radiotherapy Dose: Total Administered {Cancer} 1-3
- Radiotherapy Fractions: Total Administered {Cancer} 1-3
- Date Treatment Started {Cancer} (Radiotherapy) 1-3
- Date Treatment Completed {Cancer} (Radiotherapy) 1-3
Radiotherapy Dose: Total Administered (Cancer) 1-3

**Common name:** Total External Beam Radiotherapy Dose Administered (Cancer)

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

**Definition:** The Tumour Applied Dose (TAD) actually given (recorded in Gy) between the start and completion dates recorded for the course.

**Field Name:** TOTDOSE1
TOTDOSE2
TOTDOSE3

**Field Type:** Float nnn.nnn

**Field length:** 7

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

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

Dose and fractions using CHART: 5400cGy (54 Gy) in 36 fractions.

Dose and fractions using Stereotactic Ablative Radiotherapy (SABR): >5000cGy (50 Gy) in 3-8 fractions.

Up to three courses may be recorded.

All treatments given as part of the initial treatment plan.

If radiotherapy was not given, record ‘888.888’ (Not applicable).

If radiotherapy dose is not recorded, record as ‘999.999’ (Not recorded).

**Codes and Values:**

**Related Data Items:**

Location Code {Radiotherapy Treatment}

**Common Name(s):** Location

**Main Source of Data Item Standard:** NHS National Reference Files, http://www.natref.scot.nhs.uk/.

**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/

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.

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

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

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

Related Data Item(s):

Radiotherapy Course Type (1-3)
Radiotherapy Fractions: Total Administered {Cancer} 1-3
Date Treatment Started {Cancer} (Radiotherapy) 1-3
Date Treatment Completed {Cancer} (Radiotherapy) 1-3
Site of Radiotherapy (Courses 1-3)
Radiotherapy Fractions: Total Administered (Cancer) 1-3

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

**Definition:** The number of radiation treatments actually given for any individual course of therapy (described by the start and completion dates of External Beam Radiotherapy).

**Field Name:** FRACTIONS1  
FRACTIONS2  
FRACTIONS3  

**Field Type:** Float nnnn  

**Field length:** 4  

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

Dose and fractions using CHART: 5400cGy (54 Gy) in 36 fractions.

Dose and fractions using Stereotactic Ablative Radiotherapy (SABR): > 5000cGy (50 Gy) in 3-8 fractions.

All treatments given as part of the initial treatment.

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

If radiotherapy fraction is unknown, record as 9999 (Not recorded).

**Related Data Items:**

Location Code {Radiotherapy Treatment}

**Common Name(s):** Location

**Main Source of Data Item Standard:** NHS National Reference Files, http://www.natref.scot.nhs.uk/.

**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/

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.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

Related Data Item(s):

Radiotherapy Course Type (1-3)
Radiotherapy Dose: Total Administered {Cancer} 1-3
Date Treatment Started {Cancer} (Radiotherapy) 1-3
Date Treatment Completed {Cancer} (Radiotherapy) 1-3
Site of Radiotherapy (Courses 1-3)
Date Treatment Started {Cancer} (Radiotherapy) 1-3

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

Definition: The date cancer treatment course commenced.

Field Name: RSRTDATE1
RSRTDATE2
RSRTDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:

This is the first fraction of a course of radiotherapy.

Up to three courses may 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.

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

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

Related Data Items:

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/
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.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

**Related Data Item(s):**

- Radiotherapy Course Type (1-3)
- Radiotherapy Dose: Total Administered {Cancer} 1-3
- Radiotherapy Fractions: Total Administered {Cancer} 1-3
- Date Treatment Completed {Cancer} (Radiotherapy) 1-3
- Site of Radiotherapy (Courses 1-3)
Date Treatment Completed \{Cancer\} (Radiotherapy) 1-3

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

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

**Field Name:** RCOMPDATE1  
RCOMPDATE2  
RCOMPDATE3

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

**Field Length:** 10

**Notes for Users:** Required for QPI: 13

This is the last fraction of a course of radiotherapy.

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

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

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

**Related Data Item(s):**

Location Code \{Radiotherapy Treatment\}

**Common Name(s): Location**

**Main Source of Data Item Standard:** NHS National Reference Files, http://www.natref.scot.nhs.uk/.

**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/

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

**Related Data Item(s):**

- Radiotherapy Course Type (1-3)
- Radiotherapy Dose: Total Administered {Cancer} 1-3
- Radiotherapy Fractions: Total Administered {Cancer} 1-3
- Date Treatment Started {Cancer} (Radiotherapy) 1-3
- Site of Radiotherapy (Courses 1-3)
Location Code (SACT Treatment)

Common Name(s): Location


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

Field Name: HOSPSACT
Field Type: Characters
Field Length: 5

Notes for Users: Required for regional/national analysis

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

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). http://www.natref.scot.nhs.uk/

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

http://www.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

Related Data Item(s):
Type of Systemic Anti-Cancer Therapy (SACT) 1-3

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

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

**Field Name:** CHEMTYPE1, CHEMTYPE2, CHEMTYPE3  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 4, 10, 11, 12, 13, 15 and 16

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

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

For patients undergoing chemoradiotherapy the chemotherapy element should be recorded as code ‘5’ and recorded also in ‘Radiotherapy Course Type) under code ‘6’. Actual treatment should be recorded. If the radiotherapy element of chemoradiotherapy is abandoned prior to receiving full dosage, then the chemotherapy treatment should be recorded as palliative.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to radiotherapy or first definitive surgery to reduce tumour size.</td>
</tr>
<tr>
<td>2</td>
<td>Adjuvant</td>
<td>Chemotherapy given after surgery within 3 months of surgery</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis.</td>
</tr>
</tbody>
</table>
| 5    | Chemoradiotherapy | For curative/radical treatment. Can be sequential or concurrent where radiotherapy = NSCLC ≥ 54Gy or SCLC ≥ 40Gy.  
<pre><code>                         | Radiotherapy element of this combined treatment should be recorded separately in fields RADIOTYPE1-3.                                             |
</code></pre>
<p>| 8    | Targeted Therapy | Targeted therapies attack cancer cells to prevent them growing and dividing. Oral tablets (PO). All end in ‘-ib’ Includes drugs e.g. Crizotinib, Erlotinib, Afatinib, Dacomitinib, Ceritinib, Osimertinib |
| 9    | Immunotherapy  | Uses the immune system to treat and control cancer. IV Intravenous treatments. All end in ‘-ab’.... Includes drugs e.g. Durvalumab, Pembrolizumab, Nivolumab, Atezolizumab |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Chemoimmunotherapy</td>
<td>A combination of immunotherapy and chemotherapy agents commenced concurrently. Also referred to as triplet therapy.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Systemic therapy not given as primary part of therapy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Systemic Therapy Agent 1-3 {Lung Cancer}
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Systemic Therapy Agent 1-3 [Lung Cancer]

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

Definition: The type of chemotherapy, targeted therapy or immunotherapy used either alone or in combination to treat lung cancer.

Field Name: CHEMAGENT1, CHEMAGENT2, CHEMAGENT3
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 10

Chemotherapy drugs can be given in or outwith the context of a clinical trial.

Up to three courses may be recorded.

If any systemic anti cancer therapy agent is not listed then please contact phs.canceraudit@phs.scot to allocate a code.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cisplatin/Vinorelbine</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Carboplatin/Vinorelbine</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Carboplatin/Gemcitabine</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Gemcitabine</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cisplatin/Etoposide</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Cisplatin/Docetaxel</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Cisplatin/Gemcitabine</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Vinorelbine</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Carboplatin/Etoposide</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Carboplatin single agent</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Cisplatin/Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Erlotinib</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Carboplatin/Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Carboplatin/Paclitaxel</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Crizotinib</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Afatinib</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Other chemotherapy agent</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Pembrolizumab</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Other targeted therapy agent</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Other immunotherapy agent</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Related Data Items:
Location Code {SACT Treatment}

Common Name(s): Location


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

Field Name: HOSPSACT
Field Type: Characters
Field Length: 5

Notes for Users: Required for regional/national analysis

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

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). http://www.natref.scot.nhs.uk/

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

http://www.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

Related Data Item(s):
Type of Systemic Anti-Cancer Therapy (SACT) 1-3

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by PHS.

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE2
CHEMDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:
This is the first dose of the first cycle of a course of chemotherapy or biological therapy.

Up to three courses may be recorded.

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

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

Related data items:
Location Code {SACT Treatment}

Common Name(s): Location


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

Field Name: HOSPSACT
Field Type: Characters
Field Length: 5

Notes for Users: Required for regional/national analysis

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

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). http://www.natref.scot.nhs.uk/

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at PHS is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate.
Information about location should be electronically stored, managed and transferred using the relevant location code. IT systems should allow the recording and display of locations on the user interface as the relevant location name and associated address, etc.

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

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

**Related Data Item(s):**

Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Systemic Therapy Agent 1-3 {Lung Cancer}
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) [Cancer] 1-3

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

Definition: The date cancer treatment course ended.

Field Name: CHEMENDATE1
CHEMENDATE2
CHEMENDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:

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.

Up to three courses may be recorded.

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

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

Codes and values:

Related data items:

Location Code {SACT Treatment}

Common Name(s): Location


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

Field Name: HOSPSACT
Field Type: Characters
Field Length: 5

Notes for Users: Required for regional/national analysis

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

Each location has a location code, which is maintained jointly by PHS and General Register Office (Scotland). http://www.natref.scot.nhs.uk/
Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at PHS is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate.

http://www.PHSscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/

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

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

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

**Related Data Item(s):**

Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Systemic Therapy Agent 1-3 {Lung Cancer}
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Section 6: Clinical Trials
Patient Entered into Clinical Trial

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

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

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

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

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

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Section 7: Death Details
Date of Death

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

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

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

**Notes for Users:** Required for QPI: 13

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).