Lung Cancer

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

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

Version 1.3: November 2014
(Update to 1st April 2013 publication)

To be used in conjunction with:

1. Lung Clinical Quality Performance Indicators V2.0
2. Lung QPI Dataset Validations (latest published version)
3. Lung Measurability of Quality Performance Indicators (latest published version)
# Key Information

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<td>Author</td>
<td>Information Services Division of NHS National Services Scotland</td>
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## Revision History

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Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by ISD Scotland 2013
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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 comorbidity 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 April 2013, 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 Minimum Core Data Set
If you have any comments on the attached data definitions ISD would welcome your feedback. Please contact:

NSS.ISDCANCERAUDIT@NHS.NET

CONVENTIONS

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

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

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/04/2013.

Revisions (11/2014):

Dataset:

Page 20 Date of Diagnosis add ‘this may be the date of the CT scan where suspicion of lung cancer was raised and subsequently confirmed’ to Notes for Users

Page 69 Systemic Therapy Agent 1-3 (Lung Cancer) remove terminology ‘palliative and neoadjuvant’ from the codes and values table.

Dataset:

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) 1-3:

i. Amended 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’.

Version 1.2: April 2014: Changes to dataset version and referencing only (as Lung Measurability of Quality Performance Indicators V1.2 updated)
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 or mesothelioma of the pleura, peritoneum, pericardium and other sites (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.
DOWNLOAD FORMAT
To assist with downloading data to ISD for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

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<td>Integer</td>
<td>2 63</td>
<td></td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE2</td>
<td>Integer</td>
<td>2 63</td>
<td></td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE3</td>
<td>Integer</td>
<td>2 63</td>
<td></td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 {Lung Cancer}</td>
<td>CHEMAGENT1</td>
<td>Integer</td>
<td>2 64</td>
<td></td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 {Lung Cancer}</td>
<td>CHEMAGENT2</td>
<td>Integer</td>
<td>2 64</td>
<td></td>
</tr>
<tr>
<td>Systemic Therapy Agent 1-3 {Lung Cancer}</td>
<td>CHEMAGENT3</td>
<td>Integer</td>
<td>2 64</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 65</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 65</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 65</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 66</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 66</td>
<td></td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3</td>
<td>CHEMENDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10 66</td>
<td></td>
</tr>
</tbody>
</table>

**Section 6: Clinical Trials**  
Patient Entered into Clinical Trial | TRIAL | Integer | 2 68

**Section 7: Death Details**
Date of Death | DOD | Date (DD/MM/CCYY) | 10 70

*Data Definitions for the National Minimum Core Dataset for Lung Cancer.*  
*Developed by ISD Scotland 2013*
Section 1: Demographic Items
**Person Family Name (at Diagnosis)**

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

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

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

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

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

From SMR Definitions and Codes

**Notes by Users:**
Person Given Name

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

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

Definition: The forename or given name of a person.

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

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

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

Notes by Users:
Patient Postcode at Diagnosis

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Related Data Item(s):
Date of Diagnosis

Notes by Users:
Date of Birth

Main source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Related Data Item(s):
CHI Number

Notes by Users:
### 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:**

---

Data Definitions for the National Minimum Core Dataset for Lung Cancer.  
Developed by ISD Scotland 2013
CHI Number

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

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

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

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

From Designed to Care - Scottish Office

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

(ISD, Information Services, NHS National Services Scotland)

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

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

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

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

Notes by Users:
Section 2: Pre-treatment Imaging & Staging Investigations
Date of CT Thorax

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

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(s), 2

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 09/09/0909 (Not recorded).

If CT thorax was not performed, record as 10/10/1010 (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 Information Services.

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(s), 2

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 09/09/0909 (Not recorded).

If bronchoscopy was not performed, record as 10/10/1010 (Not applicable).

Codes and Values:

Related Data Items:

Notes by Users:
Seen by Clinical Nurse Specialist {Lung Cancer/Mesothelioma}

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

**Definition:** A record to determine if the patient was seen by a 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.

**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 Information Services.

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

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

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

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

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

A111H=Crosshouse Hospital
G107H=Glasgow Royal Infirmary
X1010=Not applicable
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 Information Services.

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

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

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

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

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

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

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

Codes and Values:

Related Data Items:
Location of Diagnosis {Cancer}

Notes by Users:
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 QPI(s): 1 – 12.  
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.

**Codes and Values:**

<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. Main bronchus</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>C45.0</td>
<td>Mesothelioma of pleura</td>
<td></td>
</tr>
<tr>
<td>C45.1</td>
<td>Mesothelioma of peritoneum</td>
<td>Includes: Mesentery, Mesocolon, Omentum, Peritoneum (parietal)(pelvic) Excludes: other malignant neoplasms of peritoneum</td>
</tr>
<tr>
<td>C45.2</td>
<td>Mesothelioma of pericardium</td>
<td>Excludes: other malignant neoplasms of pericardium.</td>
</tr>
<tr>
<td>C45.7</td>
<td>Mesothelioma of other sites</td>
<td></td>
</tr>
<tr>
<td>C45.9</td>
<td>Mesothelioma, 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 Information Services.

**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>
<tr>
<td>2</td>
<td>Mesothelioma</td>
<td>Includes: Pleural, peritoneal, pericardial and other types</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 Information Services.

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

Required for QPI(s) 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

A pathological diagnosis should be obtained from biopsy.

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


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"

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>NSCLC Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma</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</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>42</td>
<td>Mesothelioma Unspecified</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>43</td>
<td>Epithelioid Mesothelioma</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>44</td>
<td>Sarcomatoid/Spindle Cell Mesothelioma</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>45</td>
<td>Biphasic Mesothelioma</td>
<td>Mesothelioma</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}
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 Information Services.

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

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

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

Epidermal growth factor receptors (EGFRs) are located on the surface of many types of cancer cells and they allow epidermal growth factor (a protein present in the body) to attach to them causing 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, that prevents the receptor from being activated and stops the cancer cells from growing so quickly.

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.

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, and 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 result positive for EGFR mutation.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>EGFR undertaken as part of pathological assessment and result negative for EGFR mutation.</td>
</tr>
<tr>
<td>3</td>
<td>Not done</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s): (pathological or clinical?)
TNM Tumour Classification (Clinical) {Lung Cancer}
TNM Nodal Classification (Clinical) {Lung Cancer}
TNM Metastases Classification (Clinical) {Lung Cancer}

Data Definitions for the National Minimum Core Dataset for Lung Cancer.
Developed by ISD Scotland 2013
Date of Integrated FDG-PET/CT (PET/CT) Scan (Pre-treatment)

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

Definition: This denotes the date 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(s): 3, 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 09/09/0909.

If PET/CT scan was not performed, e.g. if patients has SCLC, record as 10/10/1010 (not applicable).

Related Data Item(s):
Mediastinal/Supraclavicular (SCF) node results at FDG-PET/CT (PET/CT) Scan
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 Information Services.

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

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

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

Results recorded are based on PET CT scan results as reported by radiologist/MDT, not on the sampling of mediastinal/SCF 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>Positive mediastinal/SCF nodes identified</td>
<td>Positive mediastinal/SCF nodes noted on PET CT report (N2/N3 disease recorded in radiology report)</td>
</tr>
<tr>
<td>2</td>
<td>No positive nodes identified</td>
<td>No positive mediastinal/SCF nodes noted on PET CT report (N0/N1 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):
Mediastinal/SCF Sampling Results (pre-treatment)
Mediastinal/SCF Sampling Results (pre-treatment)

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

Definition: A record to determine if mediastinal/supraclavicular fossa (SCF) nodes were sampled.

Field Name: MEDSAMP
Field Type: Integer
Field Length: 2
Notes for Users: Required for QPI(s): 4

Sampling not required if there is definitive distant metastatic disease.

Methods of sampling for mediastinal nodes are - Endobronchial Ultrasound (EBUS), mediastinoscopy and mediastinotomy.

Methods of sampling for SCF nodes are - ultrasound guidance or direct FNA (if palpable).

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 investigation</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):

TNM Metastases Classification (Clinical) {Lung Cancer}
Synchronous Primary Tumours

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

Definition: This denotes whether 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)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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, Seventh Edition, 2009).

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

**Notes for Users:** Required for QPI(S): 1, 3, 7, 8 & 11

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. The TNM system is base 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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

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

**Developed by ISD Scotland 2013**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>T0</strong></td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td><strong>Tis</strong></td>
<td>Carcinoma in situ</td>
<td></td>
</tr>
<tr>
<td><strong>T1</strong></td>
<td>Tumour 3cm or less in greatest dimension, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e. not the main bronchus).&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>T1a</strong></td>
<td>Tumour ≤ 2cm in greatest dimension&lt;sup&gt;1&lt;/sup&gt;.</td>
<td></td>
</tr>
<tr>
<td><strong>T1b</strong></td>
<td>Tumour &gt; 2cm – ≤ 3cm in greatest dimension&lt;sup&gt;1&lt;/sup&gt;.</td>
<td></td>
</tr>
<tr>
<td><strong>T2</strong></td>
<td>Tumour &gt; 3cm to ≤ 7cm, or tumour with any of the following features: Involves main bronchus, 2cm or more distal to the carina, or invades visceral pleura, or associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung.&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>T2a</strong></td>
<td>&gt; 3cm – ≤ 5cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td><strong>T2b</strong></td>
<td>&gt; 5cm – ≤ 7cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td><strong>T3</strong></td>
<td>Tumour &gt; 7cm or one that directly invades any of the following: chest wall (including superior sulcus tumours), diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium; or tumour in the main bronchus less than 2cm distal to the carina&lt;sup&gt;1&lt;/sup&gt; but without involvement of the carina; or associated atelectasis or obstructive pneumonitis of the entire lung or separate tumour nodule(s) in the same lobe as the primary.</td>
<td></td>
</tr>
<tr>
<td><strong>T4</strong></td>
<td>Tumour of any size that invades any of the following: 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><strong>TX</strong></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><strong>96</strong></td>
<td>T Classification Not applicable</td>
<td>Not lung cancer</td>
</tr>
<tr>
<td><strong>99</strong></td>
<td>T Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
TNM Nodal Classification (Clinical) {Lung Cancer}

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

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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, Seventh Edition, 2009).

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

**Notes for Users:** Required for QPI(S): 1, 3, 7, 8 & 11

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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

**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 nodes 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, Seventh Edition, UICC, 2009).

**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, Seventh Edition, 2009).

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

**Notes for Users:** Required for QPI(s): 1, 3, 4, 7, 8 & 11

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. The TNM system is base 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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

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 node(s) in a contralateral lobe; tumour with pleural nodules or malignant pleural or pericardial effusion**.</td>
<td>*Most 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 element and the patient should be classified as M0.</td>
</tr>
<tr>
<td>M1b</td>
<td>Distant metastasis</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 Nodal Classification (Clinical) {Lung Cancer}
TNM Tumour Classification (Clinical) {Pleural Mesothelioma}

Common name: Clinical TNM Tumour Classification (Pleural Mesothelioma)


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, Seventh Edition, UICC, 2009).

Field Name: TMESO
Field Type: Characters
Field length: 3

Notes for Users:

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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

No TNM classification is available for other mesothelioma types.
**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>T1</td>
<td>Tumour involves ipsilateral parietal pleura, with or without focal involvement of visceral pleura.</td>
<td></td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour involves ipsilateral parietal mediastinal, diaphragmatic) pleura. No involvement of visceral pleura</td>
<td></td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour involves ipsilateral parietal (mediastinal, diaphragmatic) pleura, with focal involvement of visceral pleura</td>
<td></td>
</tr>
</tbody>
</table>
| T2   | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
- Confluent visceral pleural tumour (including fissure).  
- Invasion of diaphragmatic muscle.  
- Invasion of lung parenchyma. | |
| T3   | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
- Invasion of endothoracic fascia.  
- Invasion into mediastinal fat.  
- Solitary focus of tumour invading soft tissues of the chest wall.  
- Non-transmural involvement of the pericardium. | "T3 describes locally advanced, but potentially resectable tumour." |
| T4   | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
- Diffuse or multifocal invasion of soft tissues of chest wall.  
- Any involvement of rib.  
- Invasion through diaphragm to peritoneum.  
- Invasion of any mediastinal organ(s).  
- Direct extension to contralateral pleura.  
- Invasion in to the spine.  
- Extension to internal surface of pericardium.  
- Pericardial effusion with positive cytology.  
- Invasion of myocardium.  
- Invasion of brachial plexus. | "T4 describes locally advanced, technically unresectable tumour." |
| TX   | Primary tumour cannot be assessed. | |
| 96   | Not applicable | Diagnosis is not mesothelioma |
| 99   | Not recorded | |

**Related data items:**
TNM Nodal Classification (Clinical) {Pleural Mesothelioma}  
TNM Metastases Classification (Clinical) {Pleural Mesothelioma}

**Notes by Users:**
TNM Nodal Classification (Clinical) {Pleural Mesothelioma}

**Common name:** Clinical TNM Nodal Classification (Pleural Mesothelioma).

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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, Seventh Edition, UICC, 2009).

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

**Notes for Users:**

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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

No TNM classification is available for other mesothelioma types.

**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 nodes metastasis.</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis in ipsilateral bronchopulmonary and/or hilar lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in subcarinal lymph node(s) and/or internal mammary or mediastinal lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in contralateral mediastinal, internal mammary or hilar node(s) and/or contralateral supraclavicular or scalene lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed).</td>
<td>Diagnosis is not mesothelioma.</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) {Pleural Mesothelioma}  
TNM Metastases Classification (Clinical) {Pleural Mesothelioma}
TNM Metastases Classification (Clinical) {Pleural Mesothelioma}

**Common name:** Clinical TNM Metastases Classification (Pleural Mesothelioma).

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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, Sixth Edition, 2002).

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

**Notes for Users:**
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 by the Multidisciplinary Team Meeting (MDT) based on best knowledge. This may be at any MDT meeting up until first treatment.

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

No TNM classification is available for other mesothelioma types.

**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>96</td>
<td>Not applicable</td>
<td>Diagnosis is not mesothelioma.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related data items:**
TNM Tumour Classification (Clinical) {Pleural Mesothelioma}
TNM Nodal Classification (Clinical) {Pleural Mesothelioma}
WHO/ ECOG Performance Status

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

**Definition:** An overall assessment of the functional/physical performance of the patient.

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

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

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 Information Services.

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

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

**Notes for Users:** Required for generic QPIs. May be used for analysis of generic QPI relating to MDT meetings.

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

The first MDT meeting date will be recorded.

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

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

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

Common name: Mode of first treatment

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

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

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

Notes for Users: Required for QPI 1

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) and Brachytherapy.</td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td>Can be concurrent or sequential</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>13</td>
<td>Biological therapy</td>
<td>Includes Erlotinib, Gefitinib, Cetuximab, Bevacizumab, Interferon, Interleukin 2, BCG Vaccine etc.</td>
</tr>
<tr>
<td>7</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all therapies</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

Notes for Users: 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. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

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

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

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

Related Data Item(s):
Type of First Cancer Treatment
Section 3: Surgery
Location Code {Cancer Surgery}

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


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

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

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

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

Each location has a location code, which is maintained jointly by ISD and General Register Office (Scotland). [http://www.show.scot.nhs.uk/smrfiles/information.html](http://www.show.scot.nhs.uk/smrfiles/information.html) – datafiles.

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

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

If the location code is not documented, record as X9999.
If surgery has not been performed or the patient has refused surgery, record as 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): 3, 4, 5, 6, 7, 8, 9 10, 10, 11, 12

**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>5</td>
<td>Pleurectomy</td>
<td>Mesothelioma only, part of the pleura is removed.</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 Information Services.

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(s): 5 & 12

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 09/09/0909 (Not recorded).

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

All treatments given as part of the initial treatment plan.

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

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

Definition: The type of surgical procedure(s) performed for 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</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 Information Services.

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

Required for QPI(s) 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

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"

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>NSCLC Includes large cell carcinoma and undifferentiated, pleomorphic, sarcomatoid or anaplastic carcinoma</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</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>42</td>
<td>Mesothelioma Unspecified</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>43</td>
<td>Epithelioid Mesothelioma</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>44</td>
<td>Sarcomatoid/Spindle Cell Mesothelioma</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>45</td>
<td>Biphasic Mesothelioma</td>
<td>Mesothelioma</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:
Definitive Surgery Performed {Lung Cancer}
Section 4: Pathological Details
TNM Tumour Classification (Pathological) {Lung Cancer}

Common name: Pathological TNM Tumour Classification (Lung Cancer)


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 QPI(s) 1 and detect cancer early

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>pT0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>pTIS</td>
<td>Carcinoma in situ</td>
<td></td>
</tr>
<tr>
<td>pT1</td>
<td>Tumour up to ≤ 3cm in greatest dimension, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e. not the main bronchus)¹.</td>
<td>The uncommon superficial spreading tumour of any size with its invasive component limited to the bronchial wall, which may extend proximal to the main bronchus, is also classified as T1a.</td>
</tr>
<tr>
<td>pT1a</td>
<td>Tumour ≤ 2cm in greatest dimension¹.</td>
<td></td>
</tr>
<tr>
<td>pT1B</td>
<td>Tumour &gt; 2cm – ≤ 3cm in greatest dimension¹.</td>
<td></td>
</tr>
<tr>
<td>pT2</td>
<td>Tumour &gt; 3cm to ≤ 7cm, With any features: Involves main bronchus ≥ 2cm distal to the carina, or invades visceral pleura, or associated with atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung².</td>
<td>T2 tumours with above features are classified as T2a if 5cm of less, or if size cannot be determined.</td>
</tr>
<tr>
<td>pT2a</td>
<td>&gt; 3cm – 5cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT2b</td>
<td>&gt; 5cm – 7cm in greatest dimension.</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour &gt; 7cm or one that directly invades any of the following: chest wall (including superior sulcus tumours), diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium; or tumour in the main bronchus less than 2cm distal to the carina¹ but without involvement of the carina; or associated atelectasis or obstructive pneumonitis of the entire lung or separate tumour nodule(s) in the same lobe as the primary.</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour of any size that invades any of the following: 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}
## TNM Nodal Classification (Pathological) {Lung Cancer}

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

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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 QPI(s): 1 and detect cancer early

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. 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:**

- 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).

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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 QPI(s) 1 and detect cancer early

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 nodules or malignant pleural or pericardial effusion. Most 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 element and the patient should be classified as M0.</td>
<td></td>
</tr>
<tr>
<td>pM1b</td>
<td>Distant metastasis</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}
TNM Tumour Classification (Pathological) {Pleural Mesothelioma}

**Common name:** Pathological TNM Tumour stage (Pleural Mesothelioma)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

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

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

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

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.

No TNM classification is available for other mesothelioma types.
### 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>pT1</td>
<td>Tumour involves ipsilateral parietal pleura, with or without focal involvement of visceral pleura.</td>
<td></td>
</tr>
<tr>
<td>pT1a</td>
<td>Tumour involves ipsilateral parietal (mediastinal, diaphragmatic) pleura. No involvement of visceral pleura.</td>
<td></td>
</tr>
<tr>
<td>pT1b</td>
<td>Tumour involves ipsilateral parietal (mediastinal, diaphragmatic) pleura, with focal involvement of the visceral pleura</td>
<td></td>
</tr>
</tbody>
</table>
| pT2  | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
* Confluent visceral pleural tumour (including the fissure)  
* Invasion of diaphragmatic muscle  
* Invasion of lung parenchyma. | "T3 describes locally advanced, but potentially respectable tumour."
| pT3  | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
* Invasion of endothoracic fascia  
* Invasion into mediastinal fat  
* Solitary focus of tumour invading soft tissues of the chest wall  
* Non-transmural involvement of the pericardium | "T4 describes locally advanced, technically unresectable tumour."
| pT4  | Tumour involves any ipsilateral pleural surfaces, with at least one of the following:  
* Diffuse or multifocal invasion of the soft tissues of chest wall  
* Any involvement of rib  
* Invasion through diaphragm to peritoneum  
* Invasion of any mediastinal organ(s)  
* Direct extension to contralateral pleura  
* Invasion into the spine  
* Extension to internal surface of pericardium  
* Pericardial effusion with positive cytology  
* Invasion of myocardium  
* Invasion of brachial plexus. | "T4 describes locally advanced, technically unresectable tumour."
| pTX  | Primary tumour cannot be assessed | |
| 96   | Not applicable | Diagnosis is not mesothelioma |
| 99   | Not recorded | |

**Related data items:**
TNM Nodal Classification (Pathological) {Pleural Mesothelioma}
TNM Metastases Classification (Pathological) {Pleural Mesothelioma}
TNM Nodal Classification (Pathological) {Pleural Mesothelioma}

**Common name:** Pathological TNM Nodal stage (Pleural Mesothelioma)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009)

**Definition:** A record of the extent of regional lymph node metastases.

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

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

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.

No TNM classification is available for other mesothelioma types.

**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></td>
</tr>
<tr>
<td>pN1</td>
<td>Metastasis in ipsilateral bronchopulmonary and/or hilar lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>pN2</td>
<td>Metastasis in subcarinal lymph node(s) and/or ipsilateral internal mammary or mediastinal lymph node(s).</td>
<td></td>
</tr>
<tr>
<td>pN3</td>
<td>Metastasis in contralateral mediastinal, internal mammary or hilar node(s) and/or ipsilateral or contralateral supraclavicular or scalene 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>Diagnosis is not mesothelioma</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data items:**

TNM Tumour Classification (Pathological) {Pleural Mesothelioma}  
TNM Metastases Classification (Pathological) {Pleural Mesothelioma}
TNM Metastases Classification (Pathological) \{Pleural Mesothelioma\}

**Common name:** Pathological TNM Metastases Classification (Pleural Mesothelioma)

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009)

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

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

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

No TNM classification is available for other mesothelioma types.

**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></td>
</tr>
<tr>
<td>pM1</td>
<td>Distant metastases</td>
<td>Microscopically confirmed. Distant metastases present.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Diagnosis is not mesothelioma</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>M status is not assessed.</td>
</tr>
</tbody>
</table>

**Related data items:**

TNM Tumour Classification (Pathological) \{Pleural Mesothelioma\}

TNM Nodal Classification (Pathological) \{Pleural Mesothelioma\}
Total Number of Hilar Lymph Nodes Examined Microscopically

Main Source of Data Item Standard: Derived from the British thoracic Surgery and the Society of Cardiothoracic Surgery in Great Britain.

Definition: A record of the total number of hilar lymph nodes examined microscopically after definitive surgery.

Field Name: HILNOD
Field Type: Integer
Field Length: 2

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

Hilar nodes (N1) are:
- Station 10R – Right tracheo-bronchial angle nodes
- Station 10L – Left tracheo-bronchial angle nodes
- Station 11 – Interlobar
- Station 12 – Lobar
- Station 13 – Segmental nodes
- Station 14 – Subsegmental nodes

The number of nodes examined will be recorded on pathology report, against corresponding lymph node station numbers (as detailed above).

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 hilar/N1 nodes examined.</td>
</tr>
<tr>
<td>2</td>
<td>1-2</td>
<td>1-2 hilar/N1 nodes examined</td>
</tr>
<tr>
<td>3</td>
<td>3 or more</td>
<td>3 or more hilar/N1 nodes examined</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No surgery performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Total Number of Mediastinal Lymph Nodes Examined Microscopically
Total Number of Mediastinal Lymph Nodes Examined Microscopically

**Main Source of Data Item Standard:** Derived from the British thoracic Surgery and the Society of Cardiothoracic Surgery in Great Britain.

**Definition:** A record of the total number of mediastinal lymph nodes examined microscopically after definitive surgery.

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

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

Mediastinal (N2) nodes are:
- 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

The number of nodes examined will be recorded on pathology report, against corresponding lymph node station numbers (as detailed above).

**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 medistinal/N2 nodes examined.</td>
</tr>
<tr>
<td>2</td>
<td>1-2</td>
<td>1-2 medistinal/N2 nodes examined</td>
</tr>
<tr>
<td>3</td>
<td>3 or more</td>
<td>3 or more medistinal/N2 nodes examined</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>No surgery performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related data items:**
- Total Number of Hilar Lymph Nodes Examined Microscopically
Section 5: Oncology
Radiotherapy Course Type (1-3)

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

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

Field Name: RADIOTYPE1
            RADIOTYPE2
            RADIOTYPE3
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI(s): 3, 7, 8, 9 10, 11, 12

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

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

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

Related Data Items:
Site of Radiotherapy (Courses 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
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 Information Services

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:
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 Information Services

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:
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 (54Gy) in 36 fractions.

Dose and fractions using Stereotactic Ablative Radiotherapy (SABR) – >5000cGy (50GY) 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:
Radiotherapy Course Type (1-3)
Site of Radiotherapy (Courses 1-3)
Radiotherapy Fractions: Total Administered {Cancer} 1-3
Date Treatment Started {Cancer} (Radiotherapy) 1-3
Date Treatment Completed {Cancer} (Radiotherapy) 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 Information Services

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:

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

Dose and fractions using Stereotactic Ablative Radiotherapy (SABR) – >5000cGy (50Gy) 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:
Radiotherapy Course Type (1-3Site of Radiotherapy (Courses 1-3)
Radiotherapy Dose: Total Administered {Cancer} 1-3
Date Treatment Started {Cancer} (Radiotherapy) 1-3
Date Treatment Completed {Cancer} (Radiotherapy) 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 Information Services.

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

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

**Notes for Users:** Required for QPl(s): 3, 10, 11

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 09/09/0909 (Not recorded).

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

**Related Data Items:**  
Radiotherapy Course Type (1-3)  
Site of Radiotherapy (Courses 1-3)  
Radiotherapy Dose: Total Administered {Cancer} 1-3  
Radiotherapy Fractions: Total Administered {Cancer} 1-3  
Date Treatment Completed {Cancer} (Radiotherapy) 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 Information Services

Definition:
The date cancer treatment course ended.

Field Name: RCOMPDATE11
RCOMPDATE2
RCOMPDATE3
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users: Required for QPI(s): 12

This is the last fraction of a course of radiotherapy.

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

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

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

Related Data Item(s):
Radiotherapy Course Type (1-3)Site of Radiotherapy (Courses 1-3)
Site of Radiotherapy (Courses 1-3)
Radiotherapy Dose: Total Administered {Cancer} 1-3
Radiotherapy Fractions: Total Administered {Cancer} 1-3
Date Treatment Started {Cancer} (Radiotherapy) 1-3
**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 Information Services.

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

**Field Name:** CHEMTYPE1
CHEMTYPE2
CHEMTYPE3

**Field Type:** Integer

**Field Length:** 2

**Notes for Users:** Required for QPI(s): 3, 7, 8, 9, 10, 11, 12

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’.

**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>
<tr>
<td>5</td>
<td>Chemoradiotherapy</td>
<td>For curative/radical treatment. Can be sequential or concurrent where radiotherapy = NSCLC ≥ 54Gy or SCLC ≥ 40Gy. Radiotherapy element of this combined treatment should be recorded separately in fields RADIOTYPE1-3.</td>
</tr>
<tr>
<td>7</td>
<td>Biological Therapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Systemic therapy not given as primary part of therapy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

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 Information Services.

Definition: The type of chemotherapy or biological therapy 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 QPIs 9, 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 NSS.isdCANCERAUDIT@NHS.NET 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>9</td>
<td>Docetaxel</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>13</td>
<td>Cyclophosphamide, Doxorubicin and Vincristine (CAV)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Topotecan</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>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:

Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 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 Information Services.

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE2
CHEMDATE3

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

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

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 09/09/0909 (Not recorded).

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

Related data items:
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 Information Services.

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

**Field Name:**  CHEMENDATE1  
CHEMENDATE2  
CHEMENDATE3

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

**Field length:**  10

**Notes for Users:**  Required for QPI 12  
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 09/09/0909 (Not recorded).

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

**Codes and values:**

**Related data items:**
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 Information Services.

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

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

Notes for Users: Required for QPI(s): 10, 11
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 Information Services.

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

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

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

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

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