Lymphoma

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

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

Version 1.4: February 2015

To be used in conjunction with:

1. Lymphoma Clinical Quality Performance Indicators V1.0 (September 2013)
2. Lymphoma QPI Dataset Validations (latest published version).
3. Lymphoma Measurability of Quality Performance Indicators (latest published version)
## Key Information

<table>
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<td>Date Published/Issued</td>
<td>February 2015</td>
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<tr>
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<td>1 October 2013</td>
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<td>Document Status</td>
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<td>Standard Audience</td>
<td>NHS staff involved in implementing and recording Renal Cancer Quality Performance Indicators.</td>
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| Cross References | Lymphoma Quality Performance Indicators  
Lymphoma Measurability of Quality Performance Indicators |
| Author | Information Services Division of NHS National Services Scotland |

## Revision History

<table>
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<td>Changes agreed out with review to support data collection.</td>
<td>David Early ISD</td>
<td>See page iii.</td>
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<td>Jane Garrett ISD</td>
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<td>1.3</td>
<td>3/11/14</td>
<td>Changes agreed at 9 month review and subsequent request to update v1 documents</td>
<td>Jane Garrett ISD</td>
<td>See page iii.</td>
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<td>1.4</td>
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Developed by ISD Scotland, 2013
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Data Definitions for the National Minimum Core Dataset for Lymphoma.
Developed by ISD Scotland, 2013
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 1 October 2013.
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with Lymphoma cancer on or after 1 October 2013 who are eligible for inclusion in the Lymphoma 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 Improvement Indicators to be measured and reported against

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

CONVENTIONS

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

- {curly brackets} - definition relates to one specific named data set
- 'described elsewhere' - indicates there is a definition for the named item within this document
REVISIONS TO DATASET (January 2015)

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/10/2013.

Specification:

Virological Testing (1-3) incorrect field name change to HEPC
Haemoglobin incorrect field name change to HAEMOGLOB
Total Number of Systemic Anti-Cancer Therapy Cycles Planned (SACT) (1-3) Incorrect field length change to 4
Total Number of Systemic Anti-Cancer Therapy Cycles Given (SACT) (1-3) incorrect field name change to SACTCYC1

Dataset:

Virological Testing (1-3) – Not known changed to Not recorded
WHO/ ECOG Performance Status - Not known changed to Not recorded
WBC Total - field length 5
WBC Differential – Lymphocytes - field length 5
Rituximab {Lymphoma} - 99 - Not recorded
Rituximab + CHOP {Lymphoma} - 99 - Not recorded
Follow-up Status - Not known changed to Not recorded

REVISIONS TO DATASET (November 2014)

Dataset:

WBC Total
Delete code 1010 (not known)
Amend code 9999 (not recorded) to code 999.9

WBC Differential
Delete code 1010 (not known)
Amend code 9999 (not recorded) to code 99.99

REVISIONS TO DATASET OUT-WITH REVIEW (June 2014)

Dataset:

Date 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 a course of chemotherapy or immunotherapy e.g. day 1 of final cycle should be recorded, the date the final treatment was actually delivered to the patient, irrespective if this was planned completion or not.' to 'This is the first day of the last cycle of a course of SACT'.

REVISIONS TO DATASET OUT-WITH REVIEW (June 2014)

Dataset:

Systemic Therapy Agent {Lymphoma} (1-3)
  ii. Data item delete
Morphology of Tumour
   iii  Added codes ‘1111/1’ – Not assessable; 8888/8 – Negative Pathology; 9999/9
        Not recorded to table

Patient Entered into clinical Trial {Lymphoma}
   iv  Amended code ‘96’ - Not applicable and added code ’95’ – Patient refused
        clinical trial.

WBC Total
   v   Amended ‘Field Type’ to number. (nnn.n)

WBC Differential
   vi  Amended ‘Field Type’ to number (nn.nn)

Radiotherapy {Lymphoma}
   vii Removed explanatory notes against ‘Code 96 not applicable’ – No radiotherapy
        given

Type of Systemic Anti-Cancer Therapy (SACT) (1-3)
   viii Added code ‘06’ - Single Agent Immunotherapy.

Rituximab {Lymphoma}
   ix  Data item added

R-CHOP {Lymphoma}
   x   Data item added
CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT

To facilitate national comparisons the same patients must be audited throughout Scotland. It is therefore important to document the patient eligibility criteria for each national cancer audit data set.

Include:
- All patients with a confirmed new primary lymphoma (see page 32 for morphology inclusion codes)
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Exclude:
- Patients with recurrent disease (as opposed to a new primary) including patients with DLBCL transformed from low grade disorders.
- 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.
DATABASE SPECIFICATION

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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<tr>
<td>Developed by ISD Scotland, 2013</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapy (SACT) {Cancer} (1-3)</th>
<th>(DD/MM/CCYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)</td>
<td>SACTENDATE1 Date (DD/MM/CCYY) 10 55</td>
</tr>
<tr>
<td>Date Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)</td>
<td>SACTENDATE2 Date (DD/MM/CCYY) 10 55</td>
</tr>
<tr>
<td>Date Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)</td>
<td>SACTENDATE3 Date (DD/MM/CCYY) 10 55</td>
</tr>
</tbody>
</table>

| Bone Marrow Transplant | BONETR Integer 2 56 |
| Date of Radiological Imaging Post Treatment Completed (Lymphoma) | POSTIMAGDATE Date (DD/MM/CCYY) 10 57 |

**Section 6: Clinical Trial Entry**

| Patient Entered into Clinical Trial {Lymphoma} | TRIAL Integer 2 59 |

**Section 7: Follow-up**

| Response Post First Treatment | FTRESPONS Integer 2 61 |
| Post-Treatment Assessment Date | POSTTREATDATE Date (DD/MM/CCYY) 10 62 |
| Follow-up Status | FUSTATUS Integer 2 63 |
| Follow-up Date/Date of Relapse/Progression | FUDATE Date (DD/MM/CCYY) 10 64 |
| Transformation to High Grade | TRANS Integer 2 65 |

**Section 8: Death Details**

| Date of Death | DOD Date (DD/MM/CCYY) 10 67 |
Section 1: Demographic Items
Person Family Name

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

From SMR Definitions and Codes

Codes and Values:

Related Data Items:
Person Given Name

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

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

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

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

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

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

**Codes and Values:**

**Related Data Items:**
Patient Postcode at Diagnosis {Cancer}

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

**Codes and Values:** N/A

**Related Data Items:**
Date of Diagnosis {Cancer}
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.

Codes and Values: N/A

Related Data Items:
CHI Number
Person Sex at Birth

Common Name(s):  Sex at Birth

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

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

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

Notes for Users:
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>01</td>
<td>Male</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>09</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 Items:
CHI Number
**CHI Number**

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

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

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

**Notes for Users:**
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.

**Codes and values:** N/A

**Related Data Items:**
Date of Birth  
Person Sex at Birth
Section 2: Pre-treatment Imaging & Staging Investigations
Radiological Staging Investigations Complete {Lymphoma}

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 if radiological staging investigations were completed by Computed Tomography (CT) of the chest, abdomen and pelvis ± neck.

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

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

Staging investigations may be done separately but should be completed.

Complete staging is CT of the chest, abdomen and pelvis ± neck.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Complete – CT Chest, Abdomen and Pelvis</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Complete – CT Chest, Neck, Abdomen and Pelvis</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>Incomplete</td>
<td>e.g. no imaging or part imaging</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Radiological Staging Investigations Completed {Lymphoma}
**Date Radiological Staging Investigations Completed {Lymphoma}**

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

**Definition:** The date that radiological staging investigations were completed by CT of the chest, abdomen and pelvis ± neck.

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

**Notes for Users:** Required for QPI(s): 1

Complete staging is CT of chest, abdomen and pelvis ± neck (and no other combination).

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

If staging investigations were not completed, record as inapplicable (10/10/1010).

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

**Related Data Item(s):**  
Radiological Staging Investigations Complete {Lymphoma}  
Date of Radiology Request
Date of Radiology Request

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

**Definition:** The date a CT scan was requested by a Clinician and sent to radiology for CT of chest, abdomen and pelvis ± neck.

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

**Notes for Users:** Required for QPI(s): 1

If more than one CT scan undertaken the final CT scan date should be recorded to align with date of investigation.

If radiology request not required, record as 10/10/1010 (Not applicable).

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

**Related Data Item(s):**  
Radiological Staging Investigations Complete {Lymphoma}  
Date Radiological Staging Investigations Completed {Lymphoma}
FDG-PET/CT (PET/CT) Scan {Lymphoma} (Pre-treatment)

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

**Definition:** A record if a FDG-PET/CT (PET/CT) scan was performed for staging and assessment of Hodgkin’s Lymphoma.

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

**Notes for Users:** Required for QPI(s): 3

All newly diagnosed patients with Classical Hodgkin’s Lymphoma being considered for curative therapy should have a baseline PET CT scan

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Yes</td>
</tr>
<tr>
<td>02</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 known</td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lymphoma} (Pre-treatment)  
Date of Integrated FDG-PET/CT (PET/CT) Scan {Lymphoma} (Pre-treatment)
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan (Lymphoma) (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:** The date a PET/CT scan was requested by a Clinician and sent to radiology.

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

**Notes for Users:** Required for QPI(s): 3

Scan should be undertaken within 2 weeks of radiology request.

If radiology request not required, record as 10/10/1010 (Not applicable).

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

**Related Data Item(s):**  
Date of Integrated FDG-PET/CT (PET/CT) Scan (Lymphoma) (Pre-treatment)
Date of Integrated FDG-PET/CT (PET/CT) Scan {Lymphoma} (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 computed tomography 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

Scan should be undertaken within 2 weeks of radiology request

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 (Not recorded).

If PET/CT scan was not performed or patient has Non Hodgkins Lymphoma, record as 10/10/1010 (not applicable).

Related Data Items:
Date of Radiology Request for FDG-PET/CT (PET/CT) Scan {Lymphoma} (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 date MYC testing was reported using classical cytogenetics or Fluorescence in Situ Hybridization (FISH).

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

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

Classical cytogenetic or Fluorescence in Situ Hybridization (FISH) analysis is essential for the diagnosis of Burkitt lymphoma.

Rearrangements of MYC in DLBCL/Burkitts are a strong prognostic factor and will guide treatment options and provide important information to help inform patients and carers about the nature of the disease and prognosis.

If the date of the MYC report is unknown record as 09/09/0909 (Not Recorded)

If MYC testing is not required, record as 10/10/1010 (Not applicable).

**Related Data Items:**  
MYC Testing Result [DLBCL/Burkitts Lymphoma]
MYC Testing Result [DLBCL/Burkitts Lymphoma]

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

**Definition:** The result of the MYC testing as reported using classical cytogenetics or Fluorescence in Situ Hybridization (FISH).

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

**Notes for Users:**

Classical cytogenetic or Fluorescence in Situ Hybridization (FISH) analysis is essential for the diagnosis of Burkitt lymphoma.

Rearrangements of MYC in DLBCL/Burkitts are a strong prognostic factor and will guide treatment options and provide important information to help inform patients and carers about the nature of the disease and prognosis.

**Codes and Values:**

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<thead>
<tr>
<th>Code</th>
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<tr>
<td>02</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Test not done</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date MYC Testing Reported [DLBCL/Burkitts Lymphoma]
Location 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 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 clarifying responsibility for data collection and national comparative analysis.

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). [http://www.natref.scot.nhs.uk/](http://www.natref.scot.nhs.uk/)

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at 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.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/](http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/)

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

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

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

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

Definition: The date on which lymphoma was first diagnosed whether by histology, cytology, immunology or cytogenetics.

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

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

Diagnosis of lymphoma is usually determined by histology.

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.

Related Data Item(s):
Location of Diagnosis {Cancer}
Virological Testing (1-3)

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

**Definition:** A record of the result of virological testing for, hepatitis B, hepatitis C and HIV.

**Field Name:** HEPB
HEPC
HIV

**Field Type:** Integer

**Field Length:** 2

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

Hepatitis B includes core and surface.

Results for all 3 blood tests should be recorded separately.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Test not done</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigation</td>
<td>Patient not undergoing rituximab treatment</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patient not undergoing rituximab treatment</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Date of Virological Testing (1-3)
Date of Virological Testing (1-3)

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

Definition: A record of the date that virological testing, hepatitis B, hepatitis C and HIV was carried out.

Field Name: HEPBDATE
            HEPCDATE
            HIVDATE

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

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

Dates for each individual blood test should be recorded separately.

If the date of the test is unknown record as 09/09/0909. If test is not carried out record as Not Applicable 10/10/1010.

Related Data Items:
Virological Testing
Date Discussed by Haematology Care Team (MDT)

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

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

**Definition:** This denotes the date the Haematology care team meeting (also known as the multidisciplinary team) was held to discuss the management of the patient's care.

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

**Notes for Users:** Required for QPI: 5

A cancer multidisciplinary care team may include surgeons, oncologists, haemat-oncologists, radiologists, pathologists, nurses, 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 should be recorded.

If the date of the MDT meeting is unknown record as 09/09/0909 or if the patient has not been discussed by the MDT, record as Not applicable 10/10/1010.

**Related Data Item(s):**
Date Discussed by Specialist MDT [Primary Cutaneous Lymphoma]

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

Definition: This denotes the date the specialist MDT meeting which included representation from pathology, dermatology, oncology ± haemato-oncology was held to discuss the management of the patient's primary cutaneous lymphoma.

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

Notes for Users: Required for QPI 10

A specialist MDT for patients with primary cutaneous lymphoma facilitates clinico-pathological correlation, which is very important in this group of conditions where treatment is multi-faceted. Furthermore it allows for consolidation of expertise in this rare condition which will help develop robust diagnosis and management.

The first specialist MDT meeting should be recorded.

If the date of the MDT meeting is unknown record as 09/09/0909 or if the patient has not been discussed by the MDT, record as Not applicable 10/10/1010.

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

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


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

Notes for Users: Required for survival analysis

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

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>
## Treatment Intent

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

**Definition:** This is intent of treatment that was carried out.

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

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

This information should be recorded at MDT, clinical letter or within electronic prescribing systems, this should not be deduced.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Curative</td>
<td>Treatment given with the potential for cure (radical treatment). E.g. radical chemotherapy such as R-CHOP and ABVD.</td>
</tr>
<tr>
<td>02</td>
<td>Palliative</td>
<td>Any treatment given for the control of symptoms resulting from the cancer e.g. surgery, radiotherapy, or Systemic Anti-Cancer Therapy (SACT).</td>
</tr>
<tr>
<td>03</td>
<td>Supportive care only</td>
<td>Care aimed at symptom control and sustaining the patients and/or carers ability to cope with a medical condition.</td>
</tr>
<tr>
<td>04</td>
<td>Watch and Wait</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Pathology
Morphology of Tumour {Lymphoma}


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

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

Notes for Users: Required for QPI 1-11

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

If the pathology report is negative code to 8888/8.

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

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

ICD-O(3) code ‘96983’ has been subdivided into ‘A’ (Follicular Lymphoma Grade 3A) and ‘B’ (Follicular Lymphoma Grade 3B) to meet QPI requirements.

Lymphoma Morphology Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96893</td>
<td>Splenic B-cell Marginal Zone Lymphoma</td>
</tr>
<tr>
<td>95913A</td>
<td>Splenic B-cell Lymphoma/Leukaemia, Unclassifiable</td>
</tr>
<tr>
<td>95913B</td>
<td>Splenic Diffuse Red Pulp Small B-cell Lymphoma</td>
</tr>
<tr>
<td>96713C</td>
<td>Lymphoplasmacytic Lymphoma</td>
</tr>
<tr>
<td>97613D</td>
<td>WaldenstrÖm Macroglobulinaemia</td>
</tr>
<tr>
<td>96993A</td>
<td>Extranodal Marginal Zone Lymphoma of Mucosa-Associated Lymphoid Tissue (MALT-Lymphoma)</td>
</tr>
<tr>
<td>96993B</td>
<td>Nodal Marginal Zone Lymphoma</td>
</tr>
<tr>
<td>96903</td>
<td>Follicular Lymphoma</td>
</tr>
<tr>
<td>96913</td>
<td>Follicular Lymphoma Grade 2</td>
</tr>
<tr>
<td>96953</td>
<td>Follicular Lymphoma Grade 1</td>
</tr>
<tr>
<td>96983A</td>
<td>Follicular Lymphoma Grade 3A</td>
</tr>
<tr>
<td>96983B</td>
<td>Follicular Lymphoma Grade 3B</td>
</tr>
<tr>
<td>95973</td>
<td>Primary Cutaneous Follicle Centre Lymphoma</td>
</tr>
<tr>
<td>96733</td>
<td>Mantle Cell Lymphoma</td>
</tr>
<tr>
<td>96803A</td>
<td>Diffuse Large B-cell Lymphoma NOS</td>
</tr>
<tr>
<td>96883</td>
<td>T-cell Histiocyte-rich Large B-cell Lymphoma</td>
</tr>
<tr>
<td>96803B</td>
<td>Primary Diffuse Large B-cell Lymphoma of the CNS</td>
</tr>
<tr>
<td>96803C</td>
<td>Primary Cutaneous DLBCL, Leg Type</td>
</tr>
<tr>
<td>96803D</td>
<td>EBV Positive Diffuse Large B-cell Lymphoma of the Elderly</td>
</tr>
</tbody>
</table>
### B-cell Proliferations of Uncertain Malignant Potential

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99701</td>
<td>Post-transplant Lymphoproliferative Disorder, Polymorphic</td>
</tr>
</tbody>
</table>

### T-Cell and NK-Cell Neoplasms

#### Other Extranodal

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97193</td>
<td>Extranodal NK/T Cell Lymphoma, Nasal Type</td>
</tr>
<tr>
<td>97173</td>
<td>Enteropathy-associated T-cell Lymphoma</td>
</tr>
<tr>
<td>97163</td>
<td>Hepatosplenic T-cell Lymphoma</td>
</tr>
<tr>
<td>97083</td>
<td>Subcutaneous Panniculitis-like T-cell Lymphoma</td>
</tr>
</tbody>
</table>

#### Cutaneous

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97003</td>
<td>Mycosis Fungoides</td>
</tr>
<tr>
<td>97013</td>
<td>Sezary Syndrome</td>
</tr>
</tbody>
</table>

### Primary Cutaneous CD30-positive T-cell Lymphoproliferative Disorders

#### Code Description

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97183</td>
<td>Primary Cutaneous Anaplastic Large Cell Lymphoma (C-ALCL)</td>
</tr>
<tr>
<td>97263</td>
<td>Primary Cutaneous Gamma-delta T-cell Lymphoma</td>
</tr>
<tr>
<td>97093A</td>
<td>Primary Cutaneous CD8-positive Aggressive Epidermotropic Cytotoxic T-cell Lymphoma</td>
</tr>
<tr>
<td>97093B</td>
<td>Primary Cutaneous CD4-positive /small/Medium T-cell Lymphoma</td>
</tr>
</tbody>
</table>

### Nodal

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97023</td>
<td>Peripheral T-cell Lymphoma, Unspecified</td>
</tr>
<tr>
<td>97053</td>
<td>Angiimmunoblastic T-cell Lymphoma</td>
</tr>
<tr>
<td>97143</td>
<td>Anaplastic Large Cell Lymphoma, (ALCL) ALK Positive</td>
</tr>
<tr>
<td>97023</td>
<td>Anaplastic Large Cell Lymphoma, ALK Negative</td>
</tr>
</tbody>
</table>

### Uncertain if B or T cell

---

Data Definitions for the National Minimum Core Dataset for Lymphoma.  
Developed by ISD Scotland, 2013  
Page 27
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95903</td>
<td>Malignant Lymphoma, Not Otherwise Specified</td>
</tr>
<tr>
<td>95913</td>
<td>Malignant Lymphoma, Non-Hodgkin, Not Otherwise Specified</td>
</tr>
<tr>
<td>95963</td>
<td>Composite Hodgkin and Non-Hodgkin Lymphoma</td>
</tr>
</tbody>
</table>

**Hodgkin Lymphoma**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96593</td>
<td>Nodular Lymphocyte Predominant Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96503</td>
<td>Classical Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96633A</td>
<td>Nodular Sclerosis Classical Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96653</td>
<td>Nodular Sclerosis Classical Hodgkin Lymphoma, Grade 1</td>
</tr>
<tr>
<td>96673</td>
<td>Nodular Sclerosis Classical Hodgkin Lymphoma, Grade 2</td>
</tr>
<tr>
<td>96633B</td>
<td>Nodular Sclerosis Classical Hodgkin Lymphoma, Cellular Phase</td>
</tr>
<tr>
<td>96523</td>
<td>Mixed Cellularity Classical Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96513</td>
<td>Lymphocyte-rich Classical Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96533A</td>
<td>Lymphocyte-depleted Classical Hodgkin Lymphoma</td>
</tr>
<tr>
<td>96533B</td>
<td>Lymphocyte-depleted Classical Hodgkin Lymphoma, Diffuse Fibrosis</td>
</tr>
<tr>
<td>96533C</td>
<td>Lymphocyte-depleted Classical Hodgkin Lymphoma, Reticular</td>
</tr>
</tbody>
</table>
Number of Nodal Sites (Lymphoma)

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

Definition: The number of nodal sites involved with disease

Field Name: NONODAL
Field Type: Integer
Field Length: 2

Notes for Users: Required for survival analysis.

If number of nodal sites is not required, record as 96 (Not applicable).

If the number of nodal sites is unknown record as 99 (Not Recorded)

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>1-4</td>
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</tr>
<tr>
<td>03</td>
<td>≥ 5</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable/not assessed</td>
<td>not staged</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

List of Nodal Sites:

- CERVICAL
- COELIAC
- PRE-AURICULAR
- PARA-AORTIC
- POST-AURICULAR
- PORTA HEPATIS
- PAROTID
- MESENTERIC
- SUBMANDIBULAR
- RETROPERITONEAL
- SUBMAXILLARY
- ILIAC
- OCCIPITAL
- INGUINAL
- SUBMENTAL
- FEMORAL
- SUPRACLAVICULAR
- EPITROCHLEAR / BRACHIAL
- INFRACLAVICULAR
- OTHER NODAL
- AXILLARY
- THYMUS
- PECTORAL
- MEDIASTINUM
- INTERCOSTAL
- NASOPHARYNX
- LUNG HILAR
- WALDEYERS RING
- RETROCRURAL
- SPLEEN
- SPLENIC HILAR
Number of Extranodal Sites {Lymphoma}

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

**Definition:** The number of extranodal sites involved with disease

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

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

If number of extranodal sites is not required, record as 96 (Not applicable)

If the number of extranodal sites is unknown record as 99 (Not Recorded)

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>&gt;1</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable/not assessed</td>
<td>not staged</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**List of Extranodal Sites:**

<table>
<thead>
<tr>
<th>BONE</th>
<th>THYROID</th>
<th>PERITONEUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRAIN</td>
<td>SINUS</td>
<td>LIVER</td>
</tr>
<tr>
<td>SPINAL CORD</td>
<td>NOSE</td>
<td>PANCREAS</td>
</tr>
<tr>
<td>SKIN</td>
<td>TONGUE</td>
<td>GALLBLADDER</td>
</tr>
<tr>
<td>SUBCUTANEOUS</td>
<td>OROPHARYNX</td>
<td>ADRENAL</td>
</tr>
<tr>
<td>CERVIX</td>
<td>PALATE</td>
<td>PAROTID SALIVARY GLAND</td>
</tr>
<tr>
<td>OVARY</td>
<td>GUM</td>
<td>OMENTUM</td>
</tr>
<tr>
<td>VAGINA</td>
<td>BUCCAL</td>
<td>MUSCLE</td>
</tr>
<tr>
<td>LABIA</td>
<td>LARYNX</td>
<td>BLOOD BONE MARROW</td>
</tr>
<tr>
<td>TESTIS</td>
<td>TRACHEA</td>
<td>EXTRA NODAL</td>
</tr>
<tr>
<td>UTERUS</td>
<td>BRONCHUS</td>
<td>SUBMANDIBULAR SALIVARY GLAND</td>
</tr>
<tr>
<td>PROSTATE</td>
<td>LUNG</td>
<td>ORBIT</td>
</tr>
<tr>
<td>BLADDER</td>
<td>PLEURA</td>
<td>EYELID</td>
</tr>
<tr>
<td>KIDNEY</td>
<td>BREAST</td>
<td></td>
</tr>
<tr>
<td>OESOPHAGUS</td>
<td>CARDIAC</td>
<td></td>
</tr>
<tr>
<td>STOMACH</td>
<td>CHEST WALL</td>
<td></td>
</tr>
<tr>
<td>SMALL BOWEL</td>
<td>EAR</td>
<td></td>
</tr>
<tr>
<td>LARGE BOWEL</td>
<td>EXTRADURAL</td>
<td></td>
</tr>
<tr>
<td>RECTUM</td>
<td>LACRIMAL</td>
<td></td>
</tr>
</tbody>
</table>
Serum LDH

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

**Definition:** The level of lactate dehydrogenase (LDH) as measured at the time the patient was investigated for cancer.

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

**Notes for Users:** Required for survival analysis

The level recorded should normally be the first result after referral and before treatment. This information should be available in the MDT notes.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Normal or Below</td>
</tr>
<tr>
<td>02</td>
<td>Raised</td>
</tr>
<tr>
<td>03</td>
<td>Not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Haemoglobin

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

**Definition:** The level of haemoglobin (Hb) detected in the patient’s blood when they were investigated for cancer.

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

**Notes for Users:** Required for survival analysis

Hb should be recorded in g/l.

The level recorded should normally be the first result after referral and before treatment. This information should be available in the MDT notes.

If the test was not performed, record as 1010 (Not applicable)

If no level is recorded then record as 9999 (Not recorded).
Albumin at Diagnosis

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

**Definition:** The serum level of albumin at the time the patient was investigated for cancer.

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

**Notes for Users:** Required for survival analysis

Albumin should be recorded in g/l.

The level recorded should normally be the first result after referral and before treatment. This information should be available in the MDT notes.

If the test was not performed, record as 1010 (Not applicable)

If no level is recorded then record as 9999 (Not recorded).
WBC Total

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

**Definition:** The total white blood cell count in the patient’s blood when they were first investigated for cancer.

**Field Name:** WBCTOT  
**Field Type:** Number (nnn.n)  
**Field Length:** 5

**Notes for Users:** Required for survival analysis

The level recorded should normally be the first result after referral and before treatment. This information should be available in the MDT notes.

WBC total should be recorded in $10^9/l$.

If no blood count is recorded then record as 999.9 (Not recorded).
WBC Differential – Lymphocytes

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

Definition: The lymphocyte count in the patient’s blood when they were first investigated for cancer.

Field Name: WBCLYMPHO  
Field Type: Number (nn.nn)  
Field Length: 5

Notes for Users: Required for survival analysis

A WBC differential is a measure of an individual component (lymphocytes) of the total white blood cell count.

The level recorded should normally be the first result after referral and before treatment.

Lymphocytes should be recorded in $10^9/l$.

If no blood count is recorded then record as 99.99 (Not recorded).
Section 4: Classification
IPI (Lymphoma)

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

**Definition:** The International Prognostic Index (IPI) is for patients with high grade non-Hodgkin's lymphoma.

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

**Notes for Users:** Required for survival analysis


It is calculated as follows:

- Age >60 years
- WHO/ECOG >=2
- Cotswold III, IV (Ann Arbor)
- Extranodal Disease > 1 site
- LDH Raised

Score 1 for each of the above factors.

Cotswold staging will be utilised to determine IPI.

IPI is a calculated field. This should ensure no interpretation of clinical information by audit staff and provides background data for sub-analysis.

Record the calculated value.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>0-1</td>
<td>Low Risk</td>
</tr>
<tr>
<td>02</td>
<td>2</td>
<td>Intermediate/Low treatment Distant metastases</td>
</tr>
<tr>
<td>03</td>
<td>3</td>
<td>Intermediate/High</td>
</tr>
<tr>
<td>04</td>
<td>4-5</td>
<td>High Risk treatment Distant metastases</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable treatment Distant metastases</td>
<td>Patient does not have high grade follicular NHL</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded treatment Distant metastases</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items**  
Cotswold Clinical Stage (Lymphoma)
**FLIPI {Lymphoma}**

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

**Definition**: This is a 5 factor prognostic index for patients with low grade follicular non-Hodgkin's lymphoma.

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

**Notes for Users:**

FLIPI is calculated as follows:

- Age \(\geq60\) years
- Clinical Stage III, IV
- LDH Raised
- Hb \(<120\) g/l
- Number of Nodal Sites \(\geq5\)

Score 1 for each of the above factors.

FLIPI is a calculated field. This should ensure no interpretation of clinical information by audit staff and provides background data for sub-analysis.

Record the calculated value.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>0-1</td>
<td>Good</td>
</tr>
<tr>
<td>02</td>
<td>2</td>
<td>Intermediate</td>
</tr>
<tr>
<td>03</td>
<td>(\geq3)</td>
<td>Intermediate/High</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable treatment Distant metastases</td>
<td>Patient does not have low grade follicular NHL</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded treatment Distant metastases</td>
<td>Insufficient details</td>
</tr>
</tbody>
</table>
Hasenclever Index for Hodgkin's Disease (Lymphoma)

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

**Definition:** This is a prognostic index for patients with advanced Hodgkin’s disease.

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

**Notes for Users:**

This is a prognostic score for advanced Hodgkin’s Disease (The New England Journal of Medicine: 1998;339:1506-14).

**Factors required for calculation:**
- Serum albumin <40g/l (serum)
- Haemoglobin <105 g/l
- Male sex
- Stage IV disease
- Age ≥ 45 yrs
- White cell count ≥15,000/mm3 (≥15 x 10⁹/l)
- Lymphocyte count <600/mm3 (<0.6x10⁹/l)

Score 1 for each of the above factors.

Stage IV indicates diffuse or disseminated involvement of one or more extralymphatic organs, including any involvement of the liver, bone marrow, or nodular involvement of the lungs.

This is a calculated field. This should ensure no interpretation of clinical information and provides background data for sub-analysis.

Record the calculated value.  
If any of the elements of the score are missing the index cannot be calculated and should be recorded as 'Not recorded' (99).

If the patient does not have Hodgkin's Disease, record as 'Not applicable' (96).
Cotswold Clinical Stage {Lymphoma}

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

**Definition:** This denotes the clinical stage of the patient prior to the start of their treatment for lymphoma according to the Cotswold classification.

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

**Notes for Users:** Required for QPI 8, 9

The Cotswold Staging Classification is also known as the Ann Arbor Staging Classification, or the Revised Ann Arbor System.

Treatment depends both on the stage of the disease and whether or not symptoms are present. Stages are labelled with an A if no symptoms are present. If symptoms are present, drenching sweats, unexplained weight loss and fatigue, the stage is labelled with a B.

This information should be recorded at MDT.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>I</td>
<td>The disease is confined to one lymph node area (eg cervical, axillary, mediastinal) or lymphoid structure (eg spleen, Waldeyer’s ring).</td>
</tr>
<tr>
<td>02</td>
<td>IE</td>
<td>The disease extends from the one lymph node area to adjacent regions. Single extra lymphatic site as only site of disease.</td>
</tr>
<tr>
<td>03</td>
<td>II</td>
<td>The disease is in two or more lymph node areas on one side of the diaphragm (the muscle below the lungs) eg biphilar disease.</td>
</tr>
<tr>
<td>04</td>
<td>IIE</td>
<td>The disease extends to adjacent regions of at least one of these nodes. Extra nodal site which is contiguous or proximal to a known site.</td>
</tr>
<tr>
<td>05</td>
<td>III</td>
<td>The disease is in lymph node areas on both sides of the diaphragm.</td>
</tr>
<tr>
<td>06</td>
<td>IIIE</td>
<td>The disease extends into adjacent areas or organs.</td>
</tr>
<tr>
<td>07</td>
<td>IIISE</td>
<td>The disease extends into adjacent areas or organs and/or the spleen.</td>
</tr>
<tr>
<td>08</td>
<td>IV</td>
<td>The disease has spread from the lymphatic system to one or more other organs, such as the bone marrow or liver.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Not staged / Not applicable for Primary Cutaneous Lymphoma.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
IPI {Lymphoma}  
B Symptoms {Lymphoma}
B Symptoms \{Lymphoma\}

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

**Definition:** The presence of one or more B symptoms in the patient at presentation for investigation of the cancer.

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

**Notes for Users:** Required for QPI 8, 9

The following symptoms are classified as ‘B’ Symptoms:

- **Night sweats** - should be drenching  
- **Weight loss** - should exceed 10% body weight in the last 6 months  
- **Fever** - requires careful history and, ideally, confirmation by thermometry

Alcohol pain and itch are not ‘B’ symptoms.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Cotswold Clinical Stage \{Lymphoma\}
Manchester Stage {Lymphoma}

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

Definition: This denotes the clinical stage of the patients with gastrointestinal lymphoma prior to the start of their treatment.

Field Name: MANCHESTER
Field Type: Integer
Field Length: 2

Notes for Users: Required for survival analysis
Gastrointestinal lymphomas are defined as tumours originating in the stomach, small or large intestine.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Ia</td>
<td>Tumour confined to one area of the gastrointestinal tract without penetration of the serosa.</td>
</tr>
<tr>
<td>02</td>
<td>Ib</td>
<td>Multiple tumours confined to the gastrointestinal tract without penetration of the serosa.</td>
</tr>
<tr>
<td>03</td>
<td>IIa</td>
<td>Tumour with local nodes radiologically/histologically involved (gastric or mesenteric).</td>
</tr>
<tr>
<td>04</td>
<td>IIb</td>
<td>Tumour with perforation and/or adherence to adjacent structures.</td>
</tr>
<tr>
<td>05</td>
<td>IIc</td>
<td>Tumour with perforation and peritonitis.</td>
</tr>
<tr>
<td>06</td>
<td>III</td>
<td>Tumour with widespread nodal involvement (para-aortic or more distant nodes).</td>
</tr>
<tr>
<td>07</td>
<td>IV</td>
<td>Disseminated disease involving extra-lymphatic tissues not adjacent to the tumour (eg liver, bone marrow, bone, lung etc).</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Lymphoma not gastrointestinal</td>
</tr>
<tr>
<td>98</td>
<td>Not staged</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Bulk Disease

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

**Definition:** This indicates whether bulk disease was present at the time the patient was investigated for cancer.

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

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

This should have been assessed after referral and before treatment for cancer.

Bulk disease is defined as by Cotswold criteria (Lister et al, 1989).

The bulk of palpable lymph nodes will be defined by the largest dimension (cm) of a single node or conglomerate nodal mass in each region of involvement, using CT, MRI, lymphography, or ultrasonography. A node or nodal mass must be 10cm or greater to be recorded as ‘bulky’.

The overall amount of disease in the spleen will not be quantitatively assessed using imaging procedures. Lesions within the liver or spleen may be measured for assessment or response but the measurements will not be recorded for staging purposes.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes (≥10cm)</td>
</tr>
<tr>
<td>02</td>
<td>No Bulk Disease</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>98</td>
<td>Not assessed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Section 5: Oncology Treatment
Location Code {Oncology Treatment}

**Common Name(s):** Location

**Main Source of Data Item Standard:** Derived from SMR data standards.

**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:** HOSPNONSURG
**Field Type:** Characters
**Field Length:** 5

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

The hospital in which the patient received the majority of SACT Treatment.

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). [http://www.natref.scot.nhs.uk/](http://www.natref.scot.nhs.uk/)

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at 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.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/](http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/)

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

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 oncological treatment has not been performed or the patient has refused, record as Not applicable, X1010.
Radiotherapy {Lymphoma}

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

**Definition:** A record if external beam radiotherapy has been administered for the treatment of the cancer.

**Field Name:** RADIOTYPE1  
**Field Type:** Integer  
**Field length:** 2  

**Notes for Users:** Required for QPI(s): 5, 8 & 9

Combined treatments may be administered concurrently/synchronously e.g. chemotherapy and radiotherapy.

All treatments given as part of the initial treatment plan should be recorded, including consolidation radiotherapy.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>93</td>
<td>Patient contraindicated in treatment</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused treatment</td>
<td></td>
</tr>
<tr>
<td>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 {Oncology Treatment}
- Date Treatment Started {Cancer} (Radiotherapy)
- Date Treatment Completed {Cancer} (Radiotherapy)
Date Treatment Started (Cancer) (Radiotherapy)

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

Definition: The date cancer treatment course commenced.

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

Notes for Users:

This is the first fraction of a course of radiotherapy.

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

If the date radiotherapy started is unknown, record as 09/09/0909.

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

Related Data Items:
Location Code (Oncology Treatment)
Radiotherapy (Lymphoma)
Date Treatment Completed (Cancer) (Radiotherapy)
Date Treatment Completed {Cancer} (Radiotherapy)

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

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

**Field Name:** RCOMPDATE1
**Field Type:** Date (DD/MM/CCYY)
**Field Length:** 10

**Notes for Users:**
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.
If treatment has not been given, record as not applicable, 10/10/1010.

**Related Data Item(s):**
Location Code {Oncology Treatment}
Radiotherapy {Lymphoma}
Date Treatment Started {Cancer} (Radiotherapy)
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: SACT1, SACT2, SACT3
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 2, 5, 6, 7, 8 & 9

All treatment given as part of initial/first line treatment should be recorded, i.e. treatment for relapsed or recurrent disease should not be recorded.

If patient is receiving chemotherapy in combination with radiotherapy, record as option 1 and detail radiotherapy information in relevant radiotherapy field.

Up to 3 courses may be recorded, e.g. chemoimmunotherapy where any regimen where chemotherapy is given in combination with Rituximab, followed by maintenance immunotherapy.

Relevant SACT agents should be recorded (in Systemic Therapy Agent) for all courses of treatment.

Follicular Lymphoma only: rituximab for 2 years post chemotherapy. Maintenance immunotherapy occurs immediately after chemotherapy for a period of up to 2 years. At present Rituximab is the only immunotherapy agent which will be given in this indication.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Chemotherapy</td>
<td>Chemotherapy treatment may be given in combination with radiotherapy or alone.</td>
</tr>
<tr>
<td>02</td>
<td>Chemoimmunotherapy</td>
<td>Chemotherapy given in combination with immunotherapy, e.g. R-CHOP. Chemoimmunotherapy will include any combination of chemotherapy and Rituximab. (Systemic Therapy Agent codes 3,7,8,9,10,11,13,14,15,19,21,27,29)</td>
</tr>
<tr>
<td>03</td>
<td>Maintenance Immunotherapy</td>
<td>Follicular Lymphoma only</td>
</tr>
<tr>
<td>06</td>
<td>Single Agent Immunotherapy</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.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Location Code (Oncology Treatment)
Date Started Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)
Date Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)
Total Number of Systemic Anti-Cancer Therapy Cycles Planned (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 planned total number of cycles of SACT treatment to be given to the patient, regardless of the number of cycles the patient receives.

Field Name: PLSACTCYC1
PLSACTCYC2
PLSACTCYC3

Field Type: Integer
Field Length: 4

Notes for Users: Required for survival analysis

This is for all chemotherapy regimens.

There is no requirement to complete this field for maintenance immunotherapy.

If systemic therapy not given record as ‘1010’ (Not applicable).

If number of cycles has not been recorded or unknown, record as ‘9999’ (Not recorded).

Related Data Item(s):
Location Code (Oncology Treatment)
Type of Systemic Anti-Cancer Therapy (SACT) (1-3)
Total Number of Systemic Anti-Cancer Therapy Cycles Given (SACT) (1-3)
Date Started Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Date Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Total Number of Systemic Anti-Cancer Therapy Cycles Given (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: A record of the total number of cycles of SACT treatment given to the patient.

Field Name: SACTCYC1
SACTCYC2
SACTCYC3

Field Type: Integer
Field Length: 4

Notes for Users: Required for QPI(s): 2, 8 & 9

There is no requirement to complete this field for maintenance immunotherapy.

If systemic therapy not given record as ‘1010’ (Not applicable).

If number of cycles has not been recorded or unknown, record as ‘9999’ (Not recorded).

Related Data Item(s):
Location Code {Oncology Treatment}
Type of Systemic Anti-Cancer Therapy (SACT) (1-3)
Total Number of Systemic Anti-Cancer Therapy Cycles Planned (SACT) (1-3)
Date Started Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Date Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Rituximab {Lymphoma}

**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 lymphoma containing rituximab.

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

**Notes for Users:** Required for QPIs 6 & 11

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**List of drugs containing Rituximab** (includes but is not limited to):

- Rituximab
- Bendamustine, rituximab
- R-CODOX-M (Rituximab + CODOX-M)
- R-CODOX-M/IVAC (Rituximab + CODOX-M/IVAC)
- Fludarabine, rituximab
- Fludarabine, Cyclophosphamide and Rituximab (FCR)
- Rituximab/CVP
- Rituximab/EPOCH
- Rituximab/hyper CVAD
- R-CEOP
- R-GCVP
- R-ESHAP (Rituximab + ESHAP)
- Rituximab maintenance
- R-DHAP (Rituximab + DHAP)
- R-IVE (Rituximab + IVE)
- R-CHOP (Rituximab + CHOP)

**Related Data Items:**
- Type of Systemic Anti-Cancer Therapy (SACT) (1-3)
- Date Started Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)
- Date Completed Systemic Anti-Cancer Therapy (SACT) (Cancer) (1-3)
Rituximab + CHOP {Lymphoma}

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

Definition: Rituximab and CHOP (R-CHOP) used in combination to treat lymphoma.

Field Name: RCHOP
Field Type: Integer
Field length: 2

Notes for Users: Required for QPIs 6, 7 & 11

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Type of Systemic Anti-Cancer Therapy (SACT) (1-3)
Date Started Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Date Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
**Date 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 systemic anti cancer therapy course commenced.

**Field Name:** SACTDATE1  
SACTDATE2  
SACTDATE3

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

**Field length:** 10

**Notes for Users:** Required for QPI(s), 4, 5, 11  
This is the first dose of the first cycle of a course of chemotherapy or immunotherapy.

Up to three courses may be recorded.

If the date SACT started is unknown, record as 09/09/0909.

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

**Codes and values:**

**Related Data Items:**
Location Code {Oncology Treatment}  
Type of Systemic Anti-Cancer Therapy (SACT) (1-3)  
Date Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} (1-3)
Date 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:** SACTENDATE1  
SACTENDATE2  
SACTENDATE3  

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

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

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.

There is no requirement to complete this field for maintenance immunotherapy.

If the date treatment started is unknown, record as 09/09/0909.

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

**Codes and values:**

**Related Data Items:**
Location Code \{Oncology Treatment\}  
Type of Systemic Anti-Cancer Therapy (SACT) \{Cancer\} (1-3)  
Date Started Systemic Anti-Cancer Therapy (SACT) \{Cancer\} (1-3)
Bone Marrow Transplant

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

Definition: A record if the patient received a bone marrow transplant as first line of treatment.

Field Name: BONETR
Field Type: Integer
Field Length: 2

Notes for Users:

Bone marrow transplant for first line treatment is rare.

Only record if treatment was first line.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td>e.g. Bone marrow transplant not given</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Date of Radiological Imaging Post Treatment Completed {Lymphoma}

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

**Definition:** The date that radiological imaging was completed by CT of the chest, abdomen and pelvis ± neck at the end of treatment.

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

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

Completed at the end of induction treatment.

CT scans within 6 weeks of the last day of the final cycle of chemotherapy or within 3 months of radiotherapy will be classified as an end of treatment scan. Date should be recorded.

Complete imaging is of the CT of chest, abdomen and pelvis ± neck (and no other combination).

If imaging was not completed or not done, record as 10/10/1010 (Not applicable).

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

**Related Data Item(s):**
Section 6: Clinical Trial Entry
Patient Entered into Clinical Trial {Lymphoma}

**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 6, 7, 8, 9

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

The majority of non-commercial multi-centred trials available in Scotland are National Cancer Research Network (NCRN) badged or equivalent.

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No trial available</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>No trial offered</td>
<td>Trial available but not offered to patient</td>
</tr>
<tr>
<td>04</td>
<td>Not eligible for trial</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused clinical trial</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patient died before treatment</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Section 7: Follow-up
Response Post First Treatment

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

Definition: A record of what the patient’s best response was as determined by the clinician at the post treatment assessment.

Field Name: FTRESPONS
Field Type: Integer
Field length: 2

Notes for Users: Required for survival analysis

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Complete remission (CR)/Complete Remission Unconfirmed (CRU)</td>
<td>No signs or symptoms of disease</td>
</tr>
<tr>
<td>02</td>
<td>Partial Remission (PR)</td>
<td>50% decrease in tumour size</td>
</tr>
<tr>
<td>03</td>
<td>Stable Disease</td>
<td>Neither partial response nor progressive disease</td>
</tr>
<tr>
<td>04</td>
<td>Progressive Disease/Refractory Disease</td>
<td>50% increase in disease</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Watch &amp; wait / Patient died before treatment</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Post-Treatment Assessment Date

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

**Definition:** The date on which the patient had their post-treatment assessment.

**Field Name:** POSTTREATDATE

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

**Field Length:** 10

**Notes for Users:** Required for survival analysis

If patient did not have a post-treatment assessment, record as 10/10/1010 (not applicable).

Post treatment assessment date should be the date of radiological evidence i.e. date of CT post primary therapy whether chemo/radiotherapy etc., if no radiology undertaken/available the date of the clinic appointment should be recorded.

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

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

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

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

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

**Notes for Users:** Required for survival analysis

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Continued first remission</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Stable Disease</td>
<td>e.g. Watch &amp; wait</td>
</tr>
<tr>
<td>03</td>
<td>Relapsed Disease</td>
<td>Includes watch &amp; wait with progressive disease</td>
</tr>
<tr>
<td>04</td>
<td>Moved away</td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>Patient deceased</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Follow-up Date/Date of Relapse/Progression
Follow-up Date/Date of Relapse/Progression

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

**Definition:** The date on which the patient was last seen at follow-up for patients with continued first remission or stable disease, or date of relapse/progression, for patients with relapsed/progressive disease.

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

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

This should be collected annually for a minimum of 5 years.

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

If patient has relapsed/progressive disease the date of relapse/progression should be recorded rather than follow up date.

If the exact date is not documented, or data are required for reporting within the year, record as 09/09/0909 (Not recorded).

If the patient was not seem for follow up, record as 10/10/1010

**Related Data Item(s):**  
Follow-up Status  
Date of Diagnosis {Cancer}
Transformation to High Grade

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

**Definition:** An indicator as to whether a patient’s lymphoma, if relapsed, has transformed from low to high grade lymphoma.

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

**Notes for Users:**

In low grade lymphomas the cancerous lymphocytes multiply slowly. This kind of lymphoma therefore accumulates at a slow rate over time. This is in contrast to high-grade lymphomas, in which the cells are multiplying very quickly and the lymphoma accumulates rapidly over a matter of weeks.

Transformation can happen with any low grade lymphoma.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not Applicable</td>
<td>Already high grade disease e.g. DLBCL</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Section 8: Death Details
Date of Death

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

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

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

**Notes for Users:** Required for QPIs: 4, 7, 10

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

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

**Codes and Values:** N/A

**Related Data Items:**