Melanoma

Data Definitions for the National Minimum Core Dataset to support the introduction of Melanoma Quality Performance Indicators

Definitions developed by Public Health Scotland (PHS) in Collaboration with the Melanoma Quality Performance Indicator Development Group

Version 4.0: February 2022

To be used in conjunction with:

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

### Key Information

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Melanoma Measurability of Quality Performance Indicators |
| **Author** | Public Health Scotland (PHS) |

### Revision History

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<td>Jane Garrett</td>
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*Data Definitions for the National Minimum Core Data Set for Melanoma.*
*Developed by ISD Scotland*  
*1st July 2014*
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PREFACE

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

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

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

The following changes should be implemented for all patients who are diagnosed with Melanoma on or after 1\textsuperscript{st} July 2021, who are eligible for inclusion in the Melanoma 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

General Enquiries on the Collection of the Minimum Core Data Set

If you have any difficulties in using individual definitions within this document, or any comments on the data definitions, Public Health Scotland would welcome your feedback. Please contact: phs.canceraudit@phs.scot

CONVENTIONS

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

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

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.

Revisions to Dataset following formal review (February 2022)

CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT - Exclude: Add “Patients diagnosed with metastatic disease only i.e. the origin of the primary is uncertain”

Database Specification

Date of Radiology Request for CT Scan – add new Data item, Field Name: RADREQDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Staging Investigations Complete - add new Data item, Field Name: SINVEST, Field Type: Integer, Field Length: 2

Date Staging Investigations Complete - add new Data item, Field Name: SINVESTDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Date of CT – Archive Data Item

Wide Local Excision (WLE) Performed {Melanoma} – add new Data item, Field Name: WLE, Field Type: Integer, Field Length: 2

Date Staged IIC or above – add new Data item, Field Name: DSTAGE, Field Type: Date (DD/MM/CCYY), Field Length: 10

Lymphovascular Invasion {Melanoma} – add new Data item, Field Name: LYMPINV, Field Type: Integer, Field Length: 2

Dataset

Date of Referral - Main Source of Data Item Standard: Amend “PHS” to “Public Health Scotland” & Notes for users updates to include table for guidance

Date of Radiology Request for CT Scan – add new data item

Staging Investigations Complete – add new data item

Date Staging Investigations Complete – add new data item

Date of CT Scan – Archive Data Item

Tumour Resectable – Note for Users: Remove QPI “8”.

Data Definitions for the National Minimum Core Data Set for Melanoma. Developed by ISD Scotland 1st July 2014
Surgery Performed 1-4 {Melanoma} – Note for Users: Remove QPI “12”, Codes and Values table amend code 95 from ‘refused’ to ‘declined’

Operating Surgeon {Melanoma} – Note for Users: Remove “QPI(S): Required for”

Clinical Margin 1-4 {Melanoma} – Note for Users: Remove “Required for QPI:12”

Wide Local Excision (WLE) Performed {Melanoma} – Add new Data Item

Sentinel Node Biopsy Performed {Melanoma} – Note for Users: Amend “QPI: 5” to “QPI: 5, 10, 14”

Date Specimen Received in the Lab – Note for Users: Add “This should relate to the first diagnostic biopsy that confirms a diagnosis of melanoma”

Date of Issue of Pathology Report – Note for Users. Amend “Required for national comparative analysis in relation to QPI 7” to “Required for QPI: 7” & Add “This should relate to the first diagnostic biopsy that confirms a diagnosis of melanoma”

Date Staged IIC or above – Add Data Item

Mitotic Rate – Note for Users. Add “QPI: 14 and for” Remove “If this value is expressed with a decimal point in the pathology report then adopt the following rounding convention: If mitotic rate is > 0 and < 1 increase the value to 1. E.g. 2.4 should be recorded as 3.!”

Lymphovascular Invasion {Melanoma} – Add Data item

AJCC Staging {Melanoma} – Note for Users: add QPI “3”

TNM Tumour Classification (Pathological) (Melanoma) – Note for Users: Amend “Required to allow adjustments for stage when undertaking survival analysis” to “Required for QPI: 14 and to allow adjustments for stage when undertaking survival analysis”

Histopathology Report Complete {Melanoma} – Note for Users: Add “**Peripheral margin - in-situ component - this will only be documented on the pathology report if this is present. If this is noted as N/A or is not documented this should not deem the report incomplete providing all other information is recorded.

**Peripheral and deep margins – invasive component - if the invasive component has all been removed in the initial partial biopsy, this should be referred to within the excision biopsy report (diagnostic excision or wide local
excision) in order to be recorded as complete. All other items should be documented in either the partial biopsy or excision biopsy report.

Full Information Required: Amend “Pathology Cutaneous Malignant Melanoma” to “Pathologists”.

Add “for histopathological reporting of primary cutaneous malignant melanoma and regional lymph nodes, 2019)”

Amend “Microsatellite/in-transit metastasis” to “ Microsatellite/in-transit metastasis – and if present whether the margin is involved or not involved”

Amend “margin – in-situ component” to “*Peripheral margin – in-situ component (if present)”

Amend “margins – invasive component” to “***Peripheral and deep margins – invasive component (both peripheral and deep need to be stated)”

**Regional Lymph Node Histopathology Report Complete (Melanoma)** – Full Information Required: Amend “(As defined by the Royal College of Pathology Regional Lymph Nodes associated with Cutaneous Malignant Melanoma Dataset)” to “(As defined by the Royal College of Pathologists Dataset for histopathological reporting of primary cutaneous malignant melanoma and regional lymph nodes, 2019)”

Remove “For each positive node”, “Location of deposits”, “Subcapsular”, “Parenchymal”

Add “For each positive node:

• Location and pattern of deposit(s): Subcapsular only, or parenchymal

• For parenchymal deposits, whether localised (and/or ≤3) or multifocal (and/or >3) i.e. either the terms localised or multifocal, OR the number of deposits should be stated.

• Tumour burden (maximum dimension of largest tumour deposit)

• Extranodal/capsular extension – presence or absence”

**Non-Surgical treatment Type 1-3 (Melanoma)** – Codes and Values table:

Remove “ 1 Chemotherapy”

Remove “2 Radiotherapy”

Remove “4 Immunotherapy”
Remove “5 Targeted therapy – e.g. Vemurafenib, Dabrafenib, Trametinib”

Add “6 Chemotherapy – neoadjuvant”

Add “7 Chemotherapy – adjuvant”

Add “8 Chemotherapy – palliative”

Add “9 Targeted therapy – primary/palliative e.g. Vemurafenib, Dabrafenib, Trametinib”

Add “10 Targeted therapy – adjuvant”

Add “11 Immunotherapy – primary/palliative”

Add “12 Immunotherapy – adjuvant”

Add “13 Radiotherapy – primary/palliative”

Add “14 Radiotherapy – adjuvant”

Amend code 95 from ‘refused’ to ‘declined’

**Date B-RAF Status Checked {Melanoma}** – Notes for Users amend ‘If B-RAF status was not checked or the patient refused’ to ‘If B-RAF status was not checked or the patient declined’.

**Type of First Cancer Treatment** - Codes and Values table amend Code 95 from refused to declined.

**Date of First Cancer Treatment** – Notes for users amend ‘If the patient died before treatment or the patient refused’ to ‘If the patient died before treatment or the patient declined’.

**Date of Definitive Treatment {Melanoma}** – Notes for users amend ‘If the patient died before treatment or the patient refused’ to ‘If the patient died before treatment or the patient declined’.

**Location Code 1 – 4 {Cancer Surgery}** – Notes for users amend ‘If surgery has not been performed or the patient has refused surgery’ to ‘If surgery has not been performed or the patient has declined surgery’

**B-RAF Status {Melanoma}** – Codes and Values table amend code 95 from ‘refused’ to ‘declined’.

**Date Non-Surgical Treatment Started 1-3 {Melanoma}** – Notes for users amend ‘If non-surgical therapy has not been given or the patient has refused’ to ‘If non-surgical therapy has not been given or the patient has declined’
Rebranding Update (February 2021)

Key Information – Author amended from Information Services Division (ISD) to Public Health Scotland (PHS)

Addition to Dataset during COVID 19 Pandemic (June 2020)

Database Specification

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

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

Dataset

Date of Referral - add new data item - implement from 1 March 2020

COVID 19 Impact - add new Data item - implement from 1 July 2019

Revisions to Dataset Outwith Review (June 2020)

Histology (TUMOUR) – Codes and Values table add 8772/3 Spindle cell melanoma

Person Sex at Birth – Codes and Values table remove leading ‘0’

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

Site of Origin of Primary Tumour {Cancer} – Codes and Values table remove leading ‘0’

Type of First Cancer Treatment – Codes and Values table remove leading ‘0’

Tumour Resectable – Codes and Values table remove leading ‘0’

Surgery Performed 1-4 {Melanoma} – Codes and Values table remove leading ‘0’

Excision Biopsy Clinician {Melanoma} – Codes and Values table remove leading ‘0’

Partial Biopsy Clinician {Melanoma} – Codes and Values table remove leading ‘0’
Depth of Excision – Codes and Values table remove leading ‘0’

Smallest Clinical Margin of Excision – Codes and Values table remove leading ‘0’

Clinical Margin 1-4 – Codes and Values table remove leading ‘0’

Sentinel Node Biopsy Performed {Melanoma} – Codes and Values table remove leading ‘0’

Ulceration – Codes and Values table remove leading ‘0’

Histopathology Report Complete {Melanoma} – Codes and Values table remove leading ‘0’

Regional Lymph Node Histopathology Report Complete {Melanoma} – Codes and Values table remove leading ‘0’

B-Raf Status {Melanoma} – Codes and Values table remove leading ‘0’

Non-Surgical Treatment Type 1-3 {Melanoma} – Codes and Values table remove leading ‘0’

Patient Entered into Clinical Trial {Cancer} – Codes and Values table remove leading ‘0’

Site of Metastases at Presentation {Melanoma} – Codes and Values table remove leading ‘0’

Local Nodes at Presentation {Melanoma} – Codes and Values table remove leading ‘0’

Disseminated Disease at Presentation 1-5 {Melanoma} – Codes and Values table remove leading ‘0’

Revisions to Dataset Outwith Review (July 2019)

Date of Diagnosis {Melanoma} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’

Date of CT Scan Notes for Users - amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Draining Lymph Node Basins Examined - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Discussed by Care Team (MDT) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’
Date of First Cancer Treatment - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

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

Date of Surgery 1 - 4 {Melanoma} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Specimen Received in the Lab – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date of Issue of Pathology Report - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date B-RAF Status Checked {Melanoma} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Non-Surgical Treatment Started 1-3 {Melanoma} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

Date Non-Surgical Treatment Completed 1-3 {Melanoma} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’; amend ‘10/10/1010’ to ‘10/10/1900’

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

Revisions to Dataset Outwith Review (November 2018)

Database Specification

Mitotic Rate – Field size amend from ‘2’ to ‘3’

Dataset

Mitotic Rate - Field size amend from ‘2’ to ‘3’; Notes for users amend ‘88’ to ‘888’, and ‘99’ to ‘999’

Revisions following Formal Review (September 2018)

Database Specification

Side of Origin of Primary Tumour {Cancer} – Archive Data Item
Partial Biopsy Clinician {Melanoma} – Field Name add PARTSURG, Field Type Integer, Field Length 2

Date of Lymphadenectomy – Archive Data Item

Clinical Margin 1-4 {Melanoma} – Field Name add CLMARGIN1, CLMARGIN2, CLMARGIN3, CLMARGIN4, Field Type Integer, Field Length 2

Groin Block Dissection Performed {Melanoma} – Archive Data Item

Date Specimen Received in the Lab – Field Name Add DSPECREC, Field Type Date (DD/MM/CCYY), Field Length 10

Date of issue of pathology Report - Field Name add DPATHREP, Field Type Date (DD/MM/CCYY), Field Length 10

Access to Lymphoedema Service – Archive Data Item

Dataset

Person Family Name (at Diagnosis) – Link updated

Person Given Name – Link updated

Patient Postcode at Diagnosis {Cancer} – Link updated

Date of Birth – Link updated

Date of CT Scan – Definition Remove ‘prior to surgery’

Side of Origin of Primary Tumour {Cancer} – Archive data item

Date Draining Lymph Node Basins Examined – Notes for Users delete ‘after diagnosis, which means it would be after biopsy (which is diagnosis) but ‘; add ‘Where it has been documented that the patient has no regional disease, no lymphadenopathy, or no palpable lymph nodes then this is confirmation that relevant draining lymph node basins have been examined’

Date of First Cancer Treatment – Notes for Users add ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded’

Date of Definitive Treatment {Melanoma} - Notes for Users add ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded’

Surgery Performed 1-4 {Melanoma} – Notes for Users add required for QPI ‘12’
Excision Biopsy Clinician {Melanoma} – Notes for Users add ‘Oral and Maxillofacial Surgeon’

Partial Biopsy Clinician {Melanoma} – add new data item

Date of Lymphadenectomy – Archive data item

Clinical Margin 1-4 {Melanoma} – add new data item

Groin Block Dissection Performed {Melanoma} – Archive data item

Date Specimen Received in the Lab – add new data item

Date of issue of pathology Report – add new data item


TNM Tumour Classification (Pathological) (Melanoma) – Standard and Notes for Users changed from 7th edition American Joint Committee on Cancer (AJCC) to 8th edition American Joint Committee on Cancer (AJCC); Value updated for pT1a, pT1b, pT2, pT3

Histopathology Report Complete (Melanoma) – Remove AJCC, Curettings, Clinical Site, Specimen Type, Size of Specimen, Maximum diameter of lesion, Maximum height of lesion, Atypical features, Invasion If invasion identified from bullet points.

Regional Lymph Node Histopathology Report Complete {Melanoma} – Bullet points remove ‘Three dimensional size, Macroscopic abnormality present, Dye seen in tissue’.

Access to Lymphoedema Service – Archive data item

Revisions to Dataset Outwith Review (July 2017)

Access to Lymphoedema Service – Notes for Users add ‘Patients who did not develop lymphoedema would be classed as N/A.’

Revisions to Dataset Outwith Review (May 2016)

Removed any reference to ‘TNM Nodal Classification: (Pathological) (Melanoma) and TNM Metastasis Classification (Pathological) (Melanoma)’ as they are not present within the dataset or validations.
**Disseminated Disease at Presentation** – Title amend to ‘Disseminated Disease at Presentation 1-5 {Melanoma}

**Revisions to Dataset following Baseline Review (March 2016)**

**Criteria for Inclusion of Patients in Audit** – under Include add ‘Multiple independent primary tumours should be recorded separately’.

**Tumour Resectable** – Notes for Users add ‘Where the origin of the primary lesion is not identifiable this would be classed as unresectable.’

**Excision Biopsy Clinician {Melanoma}** – Notes for Users amend ‘A locally designated clinician with a specialist interest in skin cancer, and who is also a member of the melanoma MDT’ to ‘A locally designated clinician with a specialist interest in skin cancer who is also a member (or under the supervision of a member) of the Melanoma MDT’.

**Histopathology Report Complete {Melanoma}** – Notes for Users remove ‘SNOMED’.

**Regional Lymph Node Histopathology Report Complete {Melanoma}** – Remove TNM Pathological (p) Stage, Localisation, SNOMED code and Localising marker from Notes for Users.

**Revisions to Dataset Outwith Review (June 2015)**

**Database Specification**

**Breslow Thickness** - Change to 2 decimal points, change field length to 5

**Clark’s Level** – Archive Data Item

**Disseminated Disease at Presentation {Melanoma}** – Field Length Change to Change to 5

**Dataset**

**Location of Diagnosis** – Remove X1010=Not applicable

**Location Code 1 – 4** – Update [National Reference Files](#) hyperlink

**Excision Biopsy Clinician {Melanoma}** - Notes for users add ‘For nominated Clinician the responsible Clinician can be assumed to be named person on pathology form’.

**Smallest Clinical Margin of Excision** – Notes for Users add 'excision scar' / tumour from the resection margin’ and ‘and documented’
**Breslow Thickness** - Amend to 2 decimal points, field length amend to 5, amend 'not applicable' to 96.99 and 'not recorded' to 99.99

**Clark’s Level** – Archive data item

**TNM Tumour Classification (Pathological) {Melanoma}** – add new data item

**Number of Sentinel Nodes Involved** – Notes for Users amend to ‘no sentinel nodes involved’ from ‘examined’

**Number of Non-Sentinel Nodes Examined** – Definition amend from 'surgery' to 'completion Lymphadenectomy'

**Number of Non-Sentinel Nodes Involved** – Notes for Users amend to 'no sentinel nodes involved' from 'examined'

**Distance of Peripheral Margin (Invasive Component)** – Notes for Users remove 2nd paragraph’ add 'This should be recorded from the first excisional biopsy'

**Date B-RAF Status Checked {Melanoma}** - Definition amend 'checked' to 'reported'. Notes for Users remove 'usually'.

**Disseminated Disease at Presentation {Melanoma}** – Field Length amend to 5 fields

**Revisions to Dataset Outwith Review (changes March 2015)**

**Patient Postcode at Diagnosis** - Field Length amend to 8

**Date Draining Lymph Node Basins Examined** - Field Type amend to Date (DD/MM/CCYY)

**Revisions to Dataset Outwith Review (changes November 2014)**

**Smallest Clinical Margin of Excision** – Codes and Values table amend to <1cm, 1-<2cm, 2-<3cm, ≥3cm

**Site of Origin of Primary Tumour {Cancer}** – Explanatory notes remove gallbladder

**Revisions to Dataset Outwith Review (changes October 2014)**
Date Draining Lymph Node Basins Examined – Notes for Users add ‘which means it would be after biopsy (which is diagnosis) but before Wide Local Excision.’

Site of Origin of Primary Tumour {Cancer} – Codes and Values table remove ‘52 Genital Mucosal’ and ‘53 Anal Mucosal’

Date of First Cancer Treatment – Notes for Users remove ‘Required for QPI(s)’.

Histology – Notes for Users add ‘This list is not exhaustive and if a code is not on the list please contact – phs.canceraudit@phs.scot for advice’.
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 cutaneous invasive melanoma (i.e. Breslow > 0). Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Multiple independent primary tumours should be recorded separately.

Exclude:
- Patients diagnosed with metastatic disease only i.e. the origin of the primary is uncertain
- Patients with recurrent disease (as opposed to a new primary)
- Patients with cutaneous squamous cell carcinoma, basal cell carcinoma, primary cutaneous lymphoma and non-cutaneous melanoma (including ocular).
- 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 PHS for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Demographic Items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person Family Name (at Diagnosis)</td>
<td>PATSNAME</td>
<td>Characters</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Person Given Name</td>
<td>PATFNAME</td>
<td>Characters</td>
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<td>3</td>
</tr>
<tr>
<td>Patient Postcode at Diagnosis</td>
<td>PATPCODE</td>
<td>Characters</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>DOB</td>
<td>Date</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Person Sex at Birth</td>
<td>SEX</td>
<td>Integer</td>
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<td>6</td>
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<tr>
<td>CHI Number</td>
<td>CHINUM</td>
<td>Characters</td>
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<tr>
<td>Source of Cancer Referral</td>
<td>MREFER</td>
<td>Integer</td>
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<tr>
<td><strong>Section 2: Pre-treatment Imaging and Staging Investigations</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Date of Referral</td>
<td>REFERDATE</td>
<td>Date</td>
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<td>Location of Diagnosis (Cancer)</td>
<td>HOSP</td>
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<td>Date of Diagnosis (Melanoma)</td>
<td>DIAGDATE</td>
<td>Date</td>
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<tr>
<td>Date of Radiology Request for CT Scan</td>
<td>RADREQDATE</td>
<td>Date</td>
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<tr>
<td>Staging Investigations Complete</td>
<td>SINVEST</td>
<td>Integer</td>
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<tr>
<td>Date Staging Investigations Complete</td>
<td>SINVESTDATE</td>
<td>Date</td>
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<tr>
<td>Site of Origin of Primary Tumour (Cancer)</td>
<td>SITE</td>
<td>Integer</td>
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<tr>
<td>Clinical Largest Diameter (Melanoma)</td>
<td>CLINDIA</td>
<td>Number</td>
<td>5</td>
<td>18</td>
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<tr>
<td>Date Draining Lymph Node Basins Examined</td>
<td>DBASINS</td>
<td>Date</td>
<td>10</td>
<td>19</td>
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<tr>
<td>Date Discussed by Care Team (MDT)</td>
<td>MDTDATE</td>
<td>Date</td>
<td>10</td>
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<td>COVID 19 Impact</td>
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<td>Type of First Cancer Treatment</td>
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<td>Date (DD/MM/CCYY)</td>
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<td>Date of Definitive Treatment {Melanoma}</td>
<td>DEFTREATDATE</td>
<td>Date (DD/MM/CCYY)</td>
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<td>Tumour Resectable</td>
<td>TUMRESECT</td>
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</table>

**Section 3: Surgery**

<p>| Location Code 1 – 4 {Cancer Surgery}          | HOSPSURG1    | Characters    | 5    | 27   |
| Location Code 1 – 4 {Cancer Surgery}          | HOSPSURG2    | Characters    | 5    | 27   |
| Location Code 1 – 4 {Cancer Surgery}          | HOSPSURG3    | Characters    | 5    | 27   |
| Location Code 1 – 4 {Cancer Surgery}          | HOSPSURG4    | Characters    | 5    | 27   |
| Surgery Performed 1 - 4 {Melanoma}            | SURG1        | Characters    | 2    | 29   |
| Surgery Performed 1 - 4 {Melanoma}            | SURG2        | Characters    | 2    | 29   |
| Surgery Performed 1 - 4 {Melanoma}            | SURG3        | Characters    | 2    | 29   |
| Surgery Performed 1 - 4 {Melanoma}            | SURG4        | Characters    | 2    | 29   |
| Date of Surgery 1- 4 {Melanoma}               | DSURG1       | Date (DD/MM/CCYY) | 10   | 30   |
| Date of Surgery 1- 4 {Melanoma}               | DSURG2       | Date (DD/MM/CCYY) | 10   | 30   |
| Date of Surgery 1- 4 {Melanoma}               | DSURG3       | Date (DD/MM/CCYY) | 10   | 30   |
| Date of Surgery 1- 4 {Melanoma}               | DSURG4       | Date (DD/MM/CCYY) | 10   | 30   |
| Operating Surgeon {Melanoma}                  | OPSURG       | Characters    | 20   | 31   |
| Excision Biopsy Clinician {Melanoma}          | BIOSURG      | Integer       | 2    | 32   |
| Partial Biopsy Clinician {Melanoma}           | PARTSURG     | Integer       | 2    | 33   |
| Depth of Excision                             | EXDEPTH      | Integer       | 2    | 34   |
| Smallest Clinical Margin of Excision          | EXMARGIN     | Integer       | 2    | 35   |
| Clinical Margin 1-4 {Melanoma}                | CLMARGIN1    | Integer       | 2    | 36   |
| Clinical Margin 1-4 {Melanoma}                | CLMARGIN2    | Integer       | 2    | 36   |
| Clinical Margin 1-4 {Melanoma}                | CLMARGIN3    | Integer       | 2    | 36   |</p>
<table>
<thead>
<tr>
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<th>Field Type</th>
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<tbody>
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<td>CLMARGIN4</td>
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<td>Wide Local Excision (WLE) Performed (Melanoma)</td>
<td>WLE</td>
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<td>Sentinel Node Biopsy Performed (Melanoma)</td>
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**Section 4: Pathological Details**

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<td>Date Specimen Received in the Lab</td>
<td>DSPECREC</td>
<td>Date (DD/MM/CCYY)</td>
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<td>Date of Issue of Pathology Report</td>
<td>DPATHREP</td>
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<td>Date Staged IIC or above</td>
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<td>Date (DD/MM/CCYY)</td>
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<td>Histology</td>
<td>TUMOUR</td>
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<tr>
<td>Breslow Thickness</td>
<td>BRESLOW</td>
<td>Number(nn.nn)</td>
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<td>Ulceration</td>
<td>ULCER</td>
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<td>Mitotic Rate</td>
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<td>Lymphovascular Invasion (Melanoma)</td>
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<td>AJCC Staging (Melanoma)</td>
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<tr>
<td>TNM Tumour Classification (Pathological) (Melanoma)</td>
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<td>Characters</td>
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<td>Histopathology Report Complete (Melanoma)</td>
<td>PATHCOMPL</td>
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<td>55</td>
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<tr>
<td>Number of Non-Sentinel Nodes Involved</td>
<td>NSINVNODES</td>
<td>Integer</td>
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<td>56</td>
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<tr>
<td>Distance to Peripheral Margin (Invasive Component)</td>
<td>PINVMARGIN</td>
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<td>Regional Lymph Node Histopathology Report Complete (Melanoma)</td>
<td>NODEPATHCOMPL</td>
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<td>B-RAF Status (Melanoma)</td>
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<td>Integer</td>
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<td>Date B-RAF Status Checked (Melanoma)</td>
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**Section 5: Non-Surgical Treatment**

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<td>Non-Surgical Treatment Type 1-3 (Melanoma)</td>
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<td>Data Item</td>
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<td>Field Type</td>
<td>Size</td>
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<td>Non-Surgical Treatment Type 1-3 {Melanoma}</td>
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<td>Non-Surgical Treatment Type 1-3 {Melanoma}</td>
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<td>Date Non-Surgical Treatment Started 1-3 (Melanoma)</td>
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<tr>
<td>Date Non-Surgical Treatment Started 1-3 (Melanoma)</td>
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<td>Date (DD/MM/CCYY)</td>
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<td>63</td>
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<td>Date Non-Surgical Treatment Started 1-3 (Melanoma)</td>
<td>NSSTARTDATE3</td>
<td>Date (DD/MM/CCYY)</td>
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<tr>
<td>Date Non-Surgical Treatment Completed 1-3 (Melanoma)</td>
<td>NSCOMPDATE1</td>
<td>Date (DD/MM/CCYY)</td>
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<td>64</td>
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<tr>
<td>Date Non-Surgical Treatment Completed 1-3 (Melanoma)</td>
<td>NSCOMPDATE2</td>
<td>Date (DD/MM/CCYY)</td>
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<td>64</td>
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<tr>
<td>Date Non-Surgical Treatment Completed 1-3 (Melanoma)</td>
<td>NSCOMPDATE3</td>
<td>Date (DD/MM/CCYY)</td>
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<td>64</td>
</tr>
</tbody>
</table>

**Section 6: Clinical Trial Entry** 65

| Patient Entered into Clinical Trial {Cancer} | TRIAL | Integer | 2 | 66 |

**Section 7: Metastases and Death Details** 67

<p>| Site of Metastases at Presentation {Melanoma} | LOCDIS | Integer | 2 | 68 |
| Local Nodes at Presentation {Melanoma}        | LOCNODE | Integer | 2 | 69 |
| Disseminated Disease at Presentation 1-5 {Melanoma} | ISSEM1 | Integer | 2 | 70 |
| Disseminated Disease at Presentation 1-5 {Melanoma} | ISSEM2 | Integer | 2 | 70 |
| Disseminated Disease at Presentation 1-5 {Melanoma} | ISSEM3 | Integer | 2 | 70 |
| Disseminated Disease at Presentation 1-5 {Melanoma} | ISSEM4 | Integer | 2 | 70 |
| Disseminated Disease at Presentation 1-5 {Melanoma} | ISSEM5 | Integer | 2 | 70 |</p>
<table>
<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
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</tr>
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<tbody>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>71</td>
</tr>
</tbody>
</table>
Section 1: Demographic Items
Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

From SMR Definitions and Codes
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:
Main Source of Standard:
The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

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

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: 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 {Melanoma}
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
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>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>
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</tbody>
</table>

**Related Data Item(s):**
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.

**Related Data Item(s):**
Date of Birth,  
Person Sex at Birth
Source of Cancer Referral

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

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

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

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

A primary care clinician will usually be a general practitioner (GP) but may be any member of the primary care team, e.g. practice nurse (code 01). After attending for routine screening in a screening programme, a patient may be referred for further investigation, (code 02).

Some patients may be attending or referred to hospital for investigation or treatment of a condition unrelated to their cancer and a tumour is diagnosed (code 03).

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

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

Patients may attend an outpatient cancer clinic as they are being followed up for benign disease or a previous cancer of the same site as diagnosed (code 04) or because of a strong family history of cancer (code 05).

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Primary care clinician (GP, Nurse practitioner)</td>
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</tr>
<tr>
<td>2</td>
<td>Screening service</td>
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</tr>
<tr>
<td>3</td>
<td>Incidental finding</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Review clinic</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cancer genetic clinic</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Self-referral to A&amp;E</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>GP referral directly to hospital</td>
<td>A&amp;E or other</td>
</tr>
<tr>
<td>8</td>
<td>Previous GP referral but subsequently admitted to hospital</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Primary care clinician (dental)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Referral from private healthcare</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Section 2: Pre-treatment Imaging and Staging Investigations
Date of Referral

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

Definition: The date on which the patient referral to secondary care for the investigation and / or treatment of Melanoma cancer was received.

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

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

See table Overleaf.
<table>
<thead>
<tr>
<th>Referral Mode</th>
<th>Guidance on date of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care clinician (Dentist, GP, Nurse practitioner)</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Screening service</td>
<td>Record the date on which the referral from screening was received by the hospital. If a Screening referrals has not been stamped with the date the referral was received and the exact date cannot be found, the earliest available date should be used.</td>
</tr>
<tr>
<td>Incidental finding / Secondary Care</td>
<td>For patients who are incidentally found or suspected of having a cancer (and a new cancer is subsequently confirmed), the date the patient was referred to a specialist for further investigation and treatment should be used. If no referral is required, the date of the investigation that led to the suspicion of cancer should be used. For example, if a patient was having a mammogram for follow up of a previously diagnosed breast cancer, and a new breast cancer is picked up, an onward referral may not be necessary and the date of the mammogram should be used.</td>
</tr>
<tr>
<td>Review clinic</td>
<td>For patients who attend for routine review either for follow up of a previous cancer (and a new cancer is found) or, patients who attend for follow up for benign disease (and a new cancer is found), the date the patient was referred to a specialist for further investigation and treatment should be used. If no referral is required, the date of the investigation that led to the suspicion of cancer should be used. For example, if a patient was having a mammogram for follow up of a previously diagnosed breast cancer, and a new breast cancer is picked up, an onward referral may not be necessary and the date of the mammogram should be used.</td>
</tr>
<tr>
<td>Cancer genetic clinic</td>
<td>Record the date the referral for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Self-referral to A&amp;E</td>
<td>Record the date the patient self presents to A&amp;E.</td>
</tr>
<tr>
<td>GP referral directly to hospital</td>
<td>Record the date the patient presents to hospital (A&amp;E or other) following referral by their GP (usually the same date as referral).</td>
</tr>
<tr>
<td>Previous GP referral but subsequently admitted to hospital</td>
<td>If the previous GP referral was made due to the same or similar symptoms that led to the patient presenting at A&amp;E, record the date the initial GP referral was received. If the previous referral made by the GP was due to different symptoms, record the patient as self-referral to A&amp;E or GP referral directly to hospital, whichever is appropriate.</td>
</tr>
<tr>
<td>Primary care clinician (dental)</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Referral from private healthcare</td>
<td>Record the date on which the patient referral from a private healthcare provider for the investigation and / or treatment of cancer was received by the NHS hospital.</td>
</tr>
<tr>
<td>Other</td>
<td>Record the date on which the patient referral to secondary care for the investigation and / or treatment of cancer was received.</td>
</tr>
<tr>
<td>Not recorded</td>
<td>If the exact date is not documented, record as 09/09/1900.</td>
</tr>
</tbody>
</table>

Notes by Users:

_Data Definitions for the National Minimum Core Data Set for Melanoma._
_Developed by ISD Scotland_
_1st July 2014_
Location of Diagnosis {Cancer}

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

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

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

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

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

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

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

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

Codes and Values:

Related Data Items:
Date of Diagnosis {Melanoma}
Date of Diagnosis {Melanoma}

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

Definition: The date of diagnosis is the date on which there was confirmation of the diagnosis of cutaneous invasive melanoma by histology.

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

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

If multiple histological findings have been carried out, the date of the first procedure that confirmed a positive diagnosis of melanoma is taken.

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

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

Codes and Values:

Related Data Items:
Date of Radiology Request for CT Scan

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

Definition: The date a CT or PET/CT scan was requested by a Clinician and sent to radiology for staging investigations.

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

Notes for Users: Required for national comparative analysis in relation to QPI 9

If more than one CT scan is undertaken, the request date for the final procedure should be recorded.

If no radiology request, record as 10/10/1900 (Not applicable).

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

Related Data Item:
Date Staging Investigations Complete
Staging Investigations Complete

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

**Definition:** A record to determine if radiological staging investigations were completed.

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

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

Staging investigations may be done separately but should be completed.

Complete staging of melanoma is CT or PET/CT of the chest, abdomen, pelvis and head.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete – CT chest, abdomen, pelvis &amp; head</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Incomplete</td>
<td>i.e. part imaging or no imaging.</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined investigations</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

Date Staging Investigations Complete
Date Staging Investigations Complete

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

Definition: The date that radiological staging investigations were completed for melanoma.

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

Notes for Users: Required for QPI: 9

Record the date that staging investigations are complete e.g. if done on separate days record the final date.

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

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

Related Data Items:
Date of Radiology Request for CT Scan
Site of Origin of Primary Tumour {Cancer}

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

Definition: This denotes the anatomical site of origin of the primary tumour.

Field Name: SITE
Field Type: Integer
Field length: 2

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

Codes used were as supplied by the Scottish Melanoma Group (SMG).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Face</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Vermilion border of lip</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Scalp</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Ears</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Trunk anterior</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Trunk anterior above waist</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Trunk anterior below waist</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Trunk posterior</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Trunk posterior above waist</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Trunk posterior below waist</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Arm</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Arm above elbow</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Arm below elbow</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Leg</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Leg above knee</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Leg below knee</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Dorsum of foot</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Dorsum of hand</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Palm</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Sole</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Subungual hand</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Subungual toe</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>Other</td>
<td>Includes non-mucosal sites.</td>
</tr>
<tr>
<td>98</td>
<td>Metastatic Disease only</td>
<td>No primary found</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Largest Diameter (Melanoma)

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

Definition: This is the size of the tumour as determined by a physical examination

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

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

This is the size of the tumour as determined by the Clinician after a physical examination.

The size should be measured in centimetres.

If no measurement has been recorded code as 99.99

If the patient presents with disease where no identifiable primary lesion can be found, code as not applicable 96.99.

Related data items:
Date Draining Lymph Node Basins Examined

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

Definition: This the date that relevant draining lymph node basins were clinically examined.

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

Notes for Users: Required for QPI: 4

Before any surgical endeavour is undertaken for a malignancy, palpation of regional lymph nodes and basins should be performed as it is an important predictor of outcome and prognosis. This will be the first date the relevant draining lymph node basins were clinically examined (palpated in clinic) before Wide Local Excision.

The date should be recorded in clinic notes, letters, or MDM summary. Where it has been documented that the patient has no regional disease, no lymphadenopathy, or no palpable lymph nodes then this is confirmation that relevant draining lymph node basins have been examined.

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

If the relevant draining lymph node basins have not been clinically examined then record as 10/10/1900 (Not applicable).

Related data items:
Date Discussed by Care Team (MDT)

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

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

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

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

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

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, dermatologists, nurses, 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, which may be after first treatment, e.g. excision biopsy.

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

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

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

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

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

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

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

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

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

Codes and Values:

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

Data Definitions for the National Minimum Core Data Set for Melanoma.
Developed by ISD Scotland
1st July 2014
21
Type of First Cancer Treatment

Common name: Mode of first treatment

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

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

Field Name: FIRSTTREATTYPE
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 3

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td></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 declined 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 Definitive Treatment (Melanoma)
Date of First Cancer Treatment

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

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

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

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

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

If type of first cancer treatment is ‘supportive care only’, the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

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

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

If the patient died before treatment or the patient declined treatment, record as 10/10/1900 (Not applicable).
Date of Definitive Treatment {Melanoma}

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

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

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

Notes for Users: Required for QPI: 3

For patients with Cutaneous Melanoma definitive treatment will be either:

- Wide local excision
- Chemotherapy/SACT or
- Radiotherapy

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

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

For patients who undergo diagnostic excision biopsy with no further treatment, date of excision biopsy should be recorded.

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

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

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

Related Data Item(s):
Date of first Cancer Treatment
Type of First Cancer Treatment
Tumour Resectable

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

Definition: This denotes whether or not the tumour is resectable or not.

Field Name: TUMRESECT
Field Type: Integer
Field length: 2

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

Unresectable melanoma is such that all sites of melanoma tumours cannot be completely removed surgically.

It should be documented on the MDM summary whether or not the tumour is resectable and should not be deduced.

Where the origin of the primary lesion is not identifiable this would be classed as unresectable.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes - resectable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No - unresectable</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):
Section 3: Surgery
Location Code 1 – 4 {Cancer Surgery}

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

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

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

Field Name: HOSPSURG1, HOSPSURG2, HOSPSURG3, HOSPSURG4
Field Type: Characters
Field Length: 5

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

A location should be recorded for each surgical procedure performed and should be recorded in the same chronological order as SURG 1-4 (Surgery Performed 1 - 4 {Melanoma}) All biopsies should be included.

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

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

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

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

If surgery has not been performed or the patient has declined surgery, record as X1010 not applicable.
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>
</tbody>
</table>

**Related Data Item(s):**
Surgery Performed 1 - 4 {Melanoma}

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

Definition: This denotes surgery performed on the patient for primary diagnosis or treatment of melanoma.

Field Name: SURG1
SURG2
SURG3
SURG4
Field Type: Characters
Field Length: 2

Notes for Users: Required for QPI(s): 1, 2, 6, 7

A patient may have up to four operations recorded covering diagnosis and treatment.

This field is linked to ‘Date of Surgery 1-4’ and should be recorded in the same chronological order.

If no surgery was undertaken record as ‘96’ (Not applicable).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FNA</td>
<td>Fine needle aspiration (FNA) involves cytological examination of cells obtained by FNA</td>
</tr>
<tr>
<td>2</td>
<td>Diagnostic Excision Biopsy</td>
<td>Complete removal of the tumour at biopsy. This is usually followed by wide local excision to gain appropriate clearance.</td>
</tr>
<tr>
<td>3</td>
<td>Partial Biopsy</td>
<td>Incision/partial biopsy is where tissue is surgically removed for pathological examination. Both punch and shave biopsies should be recorded as ‘partial biopsy’.</td>
</tr>
<tr>
<td>3A</td>
<td>Punch</td>
<td></td>
</tr>
<tr>
<td>3B</td>
<td>Incision</td>
<td></td>
</tr>
<tr>
<td>3C</td>
<td>Curette</td>
<td></td>
</tr>
<tr>
<td>3D</td>
<td>Shave</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Wide Local Excision</td>
<td>Complete removal of tumour with appropriate clearance (see SIGN guideline for levels by pathological tumour stage).</td>
</tr>
<tr>
<td>5</td>
<td>Amputation</td>
<td>Usually the removal of fingers or toes, or unusually a larger part of a limb</td>
</tr>
<tr>
<td>6</td>
<td>Metastectomy</td>
<td>Removal of distant skin, node and visceral metastases, or where the site of the primary is unknown, disseminated metastases</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Re-excision</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</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>
**Date of Surgery 1-4 {Melanoma}**

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

**Definition:** This is the date of surgery performed.

**Field Name:** DSURG1  
DSURG2  
DSURG3  
DSURG4  

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

**Notes for Users:** Required for QPI: 7

A patient may have up to four operations recorded covering diagnosis and treatment, this includes biopsies.

This field is linked to ‘Surgery Performed 1-4’ and should be recorded in the same chronological order.

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

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

**Related Data Items:**  
Location Code 1 – 4 {Cancer Surgery}  
Surgery Performed 1-4 {Melanoma}
Operating Surgeon (Melanoma)

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

**Definition:** The name of the clinician performing the diagnostic excision biopsy.

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

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

The GMC number of the clinician in charge at the operation should be recorded.

If the patient is operated on by a clinician who is working as a locum, record only that the clinician is a locum, “LOCUM”,

If the clinician’s name is not recorded code as 9999.

If no surgery was performed record as not applicable (1010).

Related Data Item(s):
Excision Biopsy Clinician {Melanoma}

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

Definition: This denotes whether the patient’s diagnostic excision biopsy was carried out by a skin cancer clinician.

Field Name: BIOSURG
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 1

Patients with cutaneous melanoma should have their diagnostic excision biopsy carried out by a skin cancer clinician.

For nominated clinician the responsible clinician can be assumed to be the named person on the pathology form.

A skin cancer clinician can be defined as:
• Dermatologist
• Plastic Surgeon
• Oral and Maxillofacial Surgeon
• A locally designated clinician with a specialist interest in skin cancer, who is also a member (or under the supervision of a member) of the melanoma MDT

If the clinician’s designation is not recorded code as 99 (Not recorded).

If no surgery was performed record as 96 (Not applicable).

Codes and Values:

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

Related Data Item(s):
Partial Biopsy Clinician {Melanoma}

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

**Definition:** This denotes whether the patient’s partial biopsy was carried out by a skin cancer clinician.

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

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

Patients with cutaneous melanoma should have their partial biopsy carried out by a skin cancer clinician.

For nominated clinician the responsible clinician can be assumed to be the named person on the pathology form.

A skin cancer clinician can be defined as:

- Dermatologist
- Plastic Surgeon
- Oral and Maxillofacial Surgeon
- A locally designated clinician with a specialist interest in skin cancer, who is also a member (or under the supervision of a member) of the melanoma MDT

If the clinician’s designation is not recorded code as 99 (Not recorded).

If no surgery was performed record as 96 (Not applicable).

**Codes and Values:**

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

**Related Data Item(s):**
Depth of Excision

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

**Definition:** This indicates at the time of definitive surgery the extent of the deep excision margin in terms of tissue layers (e.g. adipose tissue, deep fascia).

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

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

This should be recorded by the operating surgeon on the operation notes or in the clinical notes relating to the specimen from the final definitive surgery.

This will be confirmed later by microscopic examination and the result can be found on the pathology report.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Less than Deep Fascia</td>
</tr>
<tr>
<td>2</td>
<td>Down to Deep Fascia</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Smallest Clinical Margin of Excision

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

Definition: This denotes the distance to the edge of the visible component of the excision scar / tumour from the resection margin.

Field Name: EXMARGIN
Field Type: Integer
Field Length: 2

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

This will be clinically measured and documented at the time of final definitive surgery i.e. not at the time of diagnostic excision biopsy.

The distance is measured in centimetres.

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;1cm</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1 - &lt;2cm</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2 - &lt;3cm</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>≥3cm</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>i.e. Patients that do not have further surgery following their diagnostic excision biopsy</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Clinical Margin 1-4 {Melanoma}

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

Definition: This denotes the clinical margin at the time of excisional biopsy prior to wide local excision.

Field Name: CLMARGIN1
CLMARGIN2
CLMARGIN3
CLMARGIN4

Field Type: Integer
Field Length: 2

Notes for Users:

This field relates to ‘Date of Surgery 1-4’ and should be recorded in the same chronological order for all surgeries prior to wide local excision.

This will be clinically measured and documented at the time of each surgical procedure and can be found on either the pathology report or surgical operation note.

The distance is usually measured in millimetres.

If no surgery was performed, record as 96 (Not applicable).

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;2mm</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2mm</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>&gt;2mm</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>i.e. patient did not have surgery or full excision not performed (sample biopsy)</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Wide Local Excision (WLE) Performed {Melanoma}

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

**Definition:** This denotes whether or not a WLE/amputation is performed for the treatment of melanoma

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

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No - agreed by MDT</td>
<td>MDT agree that no further excision is required</td>
</tr>
<tr>
<td>3</td>
<td>No – other</td>
<td>i.e. WLE not performed for any other reason including reason unknown</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Sentinel Node Biopsy Performed {Melanoma}

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

Definition: This denotes whether or not a biopsy was performed on the sentinel node.

Field Name: SNODE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 5, 10, 14

The sentinel lymph node(s) is/are the first node(s) to receive drainage from a primary tumour. Identification of the node(s) is by injection of blue dye +/- injection of radioactive colloid and lymphoscintigraphy.

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not performed</td>
<td>E.g. Due to technical failure, patient declined</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Patient not eligible</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Section 4: Pathological Details
Date Specimen Received in the Lab

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

Definition: This is the date that the specimen was received in the laboratory.

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

Notes for Users: Required for national comparative analysis in relation to QPI 7.

This should relate to the first diagnostic biopsy that confirms a diagnosis of melanoma.

If the exact date when the specimen was received is not known, record as 09/09/1900 (Not recorded).

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

Related Data Items:
**Date of Issue of Pathology Report**

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

**Definition:** This is the date that the pathology report was issued.

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

**Notes for Users:** Required for QPI: 7.

This should relate to the first diagnostic biopsy that confirms a diagnosis of melanoma.

This is the date of the actual report date (as documented on the pathology form) and not the date approved by the laboratory.

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

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

**Related Data Items:**
Date Staged IIC or above

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

Definition: This is the date that confirms pathological evidence of stage IIC or above.

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

Notes for Users: Required for QPI: 9.

This should relate to the first pathology report that confirms pathological evidence of stage IIC or above. This may be the same date as ‘Date of Issue of Pathology Report’ if patients are initially staged as IIC or above. If the patient has been upstaged to stage IIC or above, record the date of the pathology report which provides confirmation of this.

This is the date of the actual report date (as documented on the pathology form) and not the date approved by the laboratory.

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

If the tumour is not staged as IIC or above, record as 10/10/1900 (Not applicable).

Related Data Items:
Histology

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

**Definition:** This denotes the classification of tumour based on histological sub-type.

**Field Name:** TUMOUR  
**Field Type:** Characters  
**Field Length:** 7

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

This list is not exhaustive and if a code is not on the list please contact – phs.canceraudit@phs.scot for advice.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8743/3</td>
<td>Superficial Spreading Melanoma</td>
<td></td>
</tr>
<tr>
<td>8721/3</td>
<td>Nodular Melanoma</td>
<td></td>
</tr>
<tr>
<td>8742/3</td>
<td>Lentigo Maligna Melanoma</td>
<td></td>
</tr>
<tr>
<td>8744/3</td>
<td>Acral Lentiginous Melanoma</td>
<td></td>
</tr>
<tr>
<td>8745/3</td>
<td>Desmoplastic Melanoma</td>
<td>Desmoplastic melanoma (DM) is a rare subtype of melanoma characterized by malignant spindle cells separated by prominent fibrocollagenous stroma. Primary melanomas may be entirely or almost entirely desmoplastic (“pure” DM) or exhibit a desmoplastic component admixed with a non-desmoplastic component (“mixed” DM).</td>
</tr>
<tr>
<td>8745/3A</td>
<td>Pure</td>
<td>&gt; 90% Desmoplastic Melanoma</td>
</tr>
<tr>
<td>8745/3B</td>
<td>Mixed</td>
<td>Mixed Desmoplastic/Non-desmoplastic Melanoma</td>
</tr>
<tr>
<td>8746/3</td>
<td>Mucosal Lentiginous Melanoma</td>
<td></td>
</tr>
<tr>
<td>8720/3</td>
<td>Malignant Melanoma NOS</td>
<td></td>
</tr>
<tr>
<td>8772/3</td>
<td>Spindle cell melanoma</td>
<td></td>
</tr>
<tr>
<td>9898/8</td>
<td>Other</td>
<td>e.g. Melanoma Arising from Blue Naevus, Melanoma arising in a giant congenital naevus, Naevoid Melanoma, Spitzoid Melanoma</td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

Data Definitions for the National Minimum Core Data Set for Melanoma.  
Developed by ISD Scotland  
1st July 2014

43
Breslow Thickness


Definition: A record of the thickness of the melanoma measured by the pathologist in millimetres (mm).

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

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

Breslow thickness is the single most important prognostic factor for clinically localised primary melanoma.

The greatest thickness of a cutaneous melanoma, measured in tissue sections from the top of the epidermal granular layer, or from the ulcer base if the tumour is ulcerated, to the deeps invasive cell across the broad base of the tumour, and used to estimate the rate of metastasis.

The Breslow thickness cannot be determined if a superficial biopsy transects a melanoma and includes only its superficial portion. In such instances, the pathologist can only report the melanoma to be ‘at least’ a certain thickness. Correlation with the re-excision specimen is necessary i.e. if there are two samples, record the thickest e.g. if punch biopsy is 2mm and excision is 3 mm the record the latter.

If Breslow thickness is not measured record as not applicable, 96.99
If the measurement is not recorded code as 99.99

Related Data Items:
Ulceration


**Definition:** An indication of whether or not ulceration is present.

**Field Name:** ULCER

**Field Type:** Integer

**Field Length:** 2

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

Ulceration is an integral component of the AJCC/UICC staging system and an independent predictor of outcome in patients with clinically localised cutaneous melanoma.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not identified</td>
<td>includes insipient ulceration</td>
</tr>
<tr>
<td>2</td>
<td>Present</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Mitotic Rate


**Definition:** A record of the mitotic rate measured in millimetres\(^2\) (mm\(^2\)).

**Field Name:** MITOSIS  
**Field Type:** Integer  
**Field Length:** 3

**Notes for Users:** Required for QPI:14 and for national survival analysis and national comparative analysis.

A measure of how fast cancer cells are dividing and growing. To find the mitotic rate, the number of cells dividing in a certain amount of cancer tissue is counted. Mitotic rate is used to help find the stage of melanoma. Higher mitotic rates are linked with lower survival rates. Also called MR.

Multiple studies indicate that mitotic rate is an important prognostic factor for localised primary melanomas (including in very large studies utilizing the methodology for mitotic rate determination)

If no mitoses are identified, the mitotic rate may be recorded as 0/mm\(^2\).

If mitotic rate is recorded as indeterminate record as 888
If mitotic rate is not recorded or not known, record as 999

**Related Data Items:**
Lymphovascular Invasion {Melanoma}

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

Definition: A record of whether lymphovascular invasion is present.

Field Name: LYMPINV
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 14

Should be recorded in the histopathology report.

Codes and Values:

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

Related Data Items:
AJCC Staging {Melanoma}


**Definition:** This describes the extent of cancer in a patient’s body. The American Joint Committee on Cancer (AJCC) system groups according to individual elements of the TNM clinical classification.

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

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

This is the final clinical stage as defined by the MDT.

Clinical staging includes microstaging of the primary melanoma and clinical/radiological evaluation for metastases. By convention, it should be used after complete excision of the primary melanoma with clinical assessment for regional and distant metastases.

**Codes and Values:**

<table>
<thead>
<tr>
<th>AJCC Stage</th>
<th>T</th>
<th>N</th>
<th>M</th>
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<tbody>
<tr>
<td>0</td>
<td>pTis</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IA</td>
<td>pT1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IB</td>
<td>pT1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIA</td>
<td>pT2b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>pT3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIB</td>
<td>pT3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>pT4a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIC</td>
<td>pT4b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>III</td>
<td>Any pT</td>
<td>N1, N2, N3</td>
<td>M0</td>
</tr>
<tr>
<td>IV</td>
<td>Any pT</td>
<td>Any N</td>
<td>M1</td>
</tr>
<tr>
<td>99</td>
<td>TX or not recorded</td>
<td>Not assessed or not recorded</td>
<td>Not assessed or not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**

*Data Definitions for the National Minimum Core Data Set for Melanoma.  
Developed by ISD Scotland  
1st July 2014*
TNM Tumour Classification (Pathological) (Melanoma)

**Common Name:** Pathological TNM Tumour stage (Melanoma)

**Main Source of Data Item Standard:** 8th edition American Joint Committee on Cancer (AJCC)

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

**Field Name:** pT
**Field Type:** Characters
**Field Length:** 4

**Notes for Users:** Required for QPI: 14 and to allow adjustments for stage when undertaking survival analysis.

pT status should be recorded according to the 8th edition AJCC TNM stage grouping should be deferred until all current staging information is available and if appropriate, until after skin cancer MDT discussion.

In the case of multiple tumours, the tumour with the worst prognosis should be used for classification. If in doubt, check with pathology.

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

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as ‘not recorded’.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
</tr>
<tr>
<td>pT1</td>
<td>Melanomas 1.0 mm or less in thickness</td>
</tr>
<tr>
<td>pT1a</td>
<td>Breslow &lt;0.8 mm without ulceration</td>
</tr>
<tr>
<td>pT1b</td>
<td>Breslow 0.8-1.0 without ulceration or ≤ 1.0 mm with ulceration</td>
</tr>
<tr>
<td>pT2</td>
<td>Melanomas 1.1 – 2.0 mm</td>
</tr>
<tr>
<td>pT2a</td>
<td>Without ulceration</td>
</tr>
<tr>
<td>pT2b</td>
<td>With ulceration</td>
</tr>
<tr>
<td>pT3</td>
<td>Melanomas 2.1 – 4.0 mm</td>
</tr>
<tr>
<td>pT3a</td>
<td>Without ulceration</td>
</tr>
<tr>
<td>pT3b</td>
<td>With ulceration</td>
</tr>
<tr>
<td>pT4</td>
<td>Melanomas &gt; 4.0 mm</td>
</tr>
<tr>
<td>pT4a</td>
<td>Without ulceration</td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>pT4b</td>
<td>With ulceration</td>
</tr>
<tr>
<td>Tis</td>
<td>Melanoma in situ</td>
</tr>
<tr>
<td>pTX</td>
<td>Primary tumour cannot be assessed e.g. Curettaged or severely regressed melanoma</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related data items:**

**Notes by Users:**
Histopathology Report Complete (Melanoma)

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

**Definition:** A record to determine if all information required in the pathology report is complete.

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

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

Should be recorded in histopathology report from the diagnostic excision biopsy.

**Full Information Required:**  
(As defined by the Royal College of Pathologists Dataset for histopathological reporting of primary cutaneous malignant melanoma and regional lymph nodes, 2019)

- Histopathological subtype  
- Breslow thickness  
- Ulceration  
- Mitotic index  
- Lymphovascular invasion  
- Microsatellite/in-transit metastasis — and if present whether the margin is involved or not involved  
- Neurotropic/perineural invasion  
- Growth phase  
- Tumour infiltrating lymphocytes  
- Regression  
- *Peripheral margin – in-situ component (if present)*  
- **Peripheral and deep margins – invasive component (both peripheral and deep need to be stated)**  
- TNM Pathological stage

*Peripheral margin - in-situ component - this will only be documented on the pathology report if this is present. If this is noted as N/A or is not documented this should not deem the report incomplete providing all other information is recorded.

**Peripheral and deep margins – invasive component - if the invasive component has all been removed in the initial partial biopsy, this should be referred to within the excision biopsy report (diagnostic excision or wide local excision) in order to be recorded as complete. All other items should be documented in either the partial biopsy or excision biopsy report.
Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Not complete</td>
<td>Not all data items recorded.</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:
Number of Sentinel Nodes Examined

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

Definition: This is the number of sentinel lymph nodes found in the specimen removed from the patient at the time of surgery and sent to pathology for analysis.

Field Name: NSEXNODE
Field Type: Integer
Field Length: 4

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

The examination of the nodes is associated with invasive cancer only.

If no histology is available or no sentinel nodes examined, code as 1010 (not applicable).

If sentinel nodes are examined and the number is not available, code as 9999 (not recorded)

Related Data Items:
Number of Sentinel Nodes Involved

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

Definition: This is the number of sentinel lymph nodes found in the specimen removed from the patient at the time of surgery and sent to pathology for analysis that are infiltrated with tumour cells.

Field Name: NSINVNODE
Field Type: Integer
Field Length: 4

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

Examination of the sentinel nodes is associated with invasive cancer only.

If no histology is available or no sentinel nodes involved, code as 1010 (Not applicable).

If the number of sentinel nodes involved is not available, code as 9999 (Not recorded)

NB: Nodes involved and nodes with metastases are the same.

Related Data Items:
Number of Non-Sentinel Nodes Examined

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

**Definition:** This is the number of non-sentinel lymph nodes found in the specimen removed from the patient at the time of completion Lymphadenectomy and sent to pathology for analysis.

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

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

The examination of the nodes is associated with invasive cancer only. If sentinel node biopsy has been performed these are recorded separately.

If no histology is available or no non-sentinel nodes examined, code as 1010 (Not applicable).

If non-sentinel nodes are examined and the number is not available, code as 9999 (Not recorded)

**Related Data Items:**
Number of Non-Sentinel Nodes Involved

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

**Definition:** This is the number of non-sentinel lymph nodes found in the specimen removed from the patient at the time of surgery and sent to pathology for analysis that are infiltrated with tumour cells.

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

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

Examination of the nodes is associated with invasive cancer only. If sentinel node biopsy has been performed these are recorded separately.

If no histology is available or no non-sentinel nodes involved, code as 1010 (Not applicable).

If the number of non-sentinel nodes involved is not available, code as 9999 (Not recorded)

**NB:** Nodes involved and nodes with metastases are the same.

**Related Data Items:**
Distance to Peripheral Margin (Invasive Component)

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

**Definition:** The distance of the invasive melanoma component from the closest peripheral margin in millimetres (mm).

**Field Name:** PINVMARGIN  
**Field Type:** Number (nn.n)  
**Field Length:** 4

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

This will be confirmed by microscopic examination and the final result can be found on the pathology report relating to the specimen from the surgery performed.

This should be recorded from the first excisional biopsy.

If the distance is not assessable, record as 88.8.  
If the distance is not measured record as not applicable, 96.6.  
If the distance is not recorded, code as 99.9.

**Related Data Items:**
Regional Lymph Node Histopathology Report Complete {Melanoma}

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

Definition: A record to determine if all information required in the regional lymph nodes associated with cutaneous melanoma pathology report is complete following sentinel node biopsy (SNB).

Field Name: NODEPATHCOMPL
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 5

Full Information Required:
(As defined by the Royal College of Pathologists Dataset for histopathological reporting of primary cutaneous malignant melanoma and regional lymph nodes, 2019)

- Clinical site

Sentinel Lymph Node Biopsy:
- Number of sentinel nodes identified
- Number of nodes involved

For each positive node:
- Location and pattern of deposit(s): Subcapsular only, or parenchymal
- For parenchymal deposits, whether localised (and/or ≤3) or multifocal (and/or >3) i.e. either the terms localised or multifocal, OR the number of deposits should be stated.
- Tumour burden (maximum dimension of largest tumour deposit)
- Extranodal/capsular extension – presence or absence

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Not complete</td>
<td>Not all data items recorded.</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:
B-RAF Status {Melanoma}

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

**Definition:** This denotes the result of the B-RAF status from the patient’s biopsy.

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

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

The B-RAF status result can be found on the pathology report and/or recorded in the clinical notes

**Codes and Values:**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>V600 BRAF mutation present</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>V600 BRAF mutation NOT present</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not Done</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined investigations</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Insufficient tissue, patient with stage I or II disease</td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td>Patient not suitable e.g. significant co-morbidities, unfit for investigation</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date B-RAF Status Checked {Melanoma}
**Date B-RAF Status Checked {Melanoma}**

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

**Definition:** This is the date that the patient’s biopsy had the B-RAF status reported.

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

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

The date recorded is the date the B-RAF status was confirmed, this will be the date the report was issued.

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

If B-RAF status was not checked or the patient declined, record as 10/10/1900 (Not applicable).

**Related Data Items:**  
B-RAF Status {Melanoma}
Section 5: Non-Surgical Treatment
Non-Surgical Treatment Type 1-3 {Melanoma}

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

**Definition:** The type of non-surgical course administered for the treatment of the cancer.

**Field Name:** NSTYPE1
   NSTYPE2
   NSTYPE3

**Field Type:** Integer

**Field length:** 2

**Notes for Users:** Required for QPI: 10

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>6</td>
<td>Chemotherapy - neoadjuvant</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chemotherapy - adjuvant</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Chemotherapy - palliative</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Targeted therapy – primary/palliative</td>
<td>E.g. Vemurafenib, Dabrafenib, Trametinib</td>
</tr>
<tr>
<td>10</td>
<td>Targeted therapy - adjuvant</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Immunotherapy - primary/palliative</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Immunotherapy - adjuvant</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Radiotherapy - primary/palliative</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Radiotherapy - adjuvant</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. patient received curative surgery or patient did not have active treatment such as best supportive care</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
Date Non-Surgical Treatment Started 1-3 {Melanoma}

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

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

**Field Name:** NSSTARTDATE1
   NSSTARTDATE2
   NSSTARTDATE3

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

**Field length:** 10

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

Up to three courses may be recorded.

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

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

If non-surgical therapy has not been given or the patient has declined record as 10/10/1900 (Not applicable).

**Related Data Items:**
Non-Surgical Treatment Type 1-3 {Melanoma}
Date Non-Surgical Treatment Completed 1-3 {Melanoma}
Date Non-Surgical Treatment Completed 1-3 {Melanoma}

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

Definition: The date cancer treatment course ended.

Field Name: NSCOMPDAT1
  NSCOMPDAT2
  NSCOMPDAT3
Field Type: Date (DD/MM/CCYY)
Field Length: 10

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

Radiotherapy Treatment
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.

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

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

Immunotherapy and Targeted therapy
This is the last fraction of a course of treatment.

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

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

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

Related Data Item(s):
Non-Surgical Treatment Type 1-3 {Melanoma}
Date Non-Surgical Treatment Started 1-3 {Melanoma}
Section 6: Clinical Trial Entry
Patient Entered into Clinical Trial {Cancer}

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

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

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

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

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

The majority of non-commercial multi-centred trials available in Scotland are 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>
</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:**
Section 7: Metastases and Death Details
Site of Metastases at Presentation {Melanoma}

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

Definition: This denotes the extent of spread of disease at the time of initial presentation with cancer.

Field Name: LOCDIS
Field Type: Integer
Field Length: 2

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

The site recorded should be as detected by the diagnosing clinician. This will normally be the hospital clinician but in situations where the GP has removed the tumour findings by the GP should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Local – within 2cm of the primary tumour</td>
</tr>
<tr>
<td>2</td>
<td>Local - &gt; 2cm from the primary tumour</td>
</tr>
<tr>
<td>3</td>
<td>Not possible to assess</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Local Nodes at Presentation {Melanoma}

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

Definition: This denotes whether the local nodes were affected at the time of initial presentation with cancer.

Field Name: LOCNODE
Field Type: Integer
Field Length: 2

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

The site recorded should be as detected by the diagnosing clinician. This will normally be the hospital clinician but in situations where the GP has removed the tumour findings by the GP should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Local – Clinically positive no histology</td>
</tr>
<tr>
<td>2</td>
<td>Local – Histologically positive</td>
</tr>
<tr>
<td>3</td>
<td>Not possible to assess</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Disseminated Disease at Presentation 1-5 {Melanoma}

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

**Definition:** This denotes whether disseminated disease was first identified in sites other than those detailed for site of metastases described elsewhere at the time of initial presentation with cancer.

**Field Name:** ISSEM1
- ISSEM2
- ISSEM3
- ISSEM4
- ISSEM5

**Field Type:** Integer

**Field Length:** 2

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

Disseminated disease is where the tumour is widely distributed in an organ or in the whole body separate from its site of origin.

The site recorded should be as detected by the diagnosing clinician. This will normally be the hospital clinician but in situations where the GP has removed the tumour findings by the GP should be recorded.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nodal – other than local</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Skin</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Visceral</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Brain</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Not possible to assess</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td>E.g. Bone</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 Death

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

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

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

Notes for Users: Required for QPI(s): Required for national survival analysis and national comparative analysis.

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

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