Mesothelioma

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

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

Version 3.0: April 2023

To be used in conjunction with:

1. Mesothelioma Clinical Quality Performance Indicators (latest published version)
2. Mesothelioma QPI Dataset Validations (latest published version)
3. Mesothelioma Measurability of Quality Performance Indicators (latest published version)
## DOCUMENT CONTROL SHEET

### Key Information

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<td><strong>Author</strong></td>
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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 June 2019.
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with Mesothelioma on or after 1st January 2023*, who are eligible for inclusion in the Mesothelioma audit.

*NB: This may include some data for patients diagnosed from 1st January 2022 where required for QPIs reported a year in arrears. This applies to the following data items:

Radiotherapy {Mesothelioma} – RADIO (new option added)
Cordotomy – CORDOT (new field)

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 National Minimum Core Dataset:

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):**
**Notes by Users:**

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

- {curly brackets} - definition relates to one specific named data set
- ‘described elsewhere’ - indicates there is a definition for the named item within this document
CRITERIA FOR INCLUSION OF PATIENTS IN AUDIT

To facilitate national comparisons, the same patients must be audited throughout Scotland. The following eligibility criteria have been documented for this purpose.

Include:
- All patients with a confirmed new primary mesothelioma of the pleura, peritoneum, pericardium and other sites (see page 15 Site of Tumour, for ICD-10 codes that are included).

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

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

NB:
- Only treatments as part of the initial treatment plan should be recorded unless otherwise stated.
REVISIONS TO DATASET
The following changes have been made to facilitate the recording of data.

Changes agreed at Formal Review April 2023

Database Spec

COVID 19 Impact – Remove Data Item, Field Name: COVID, Field Type: Integer, Field Length: 2

Cordotomy – add data item, Field Name: CORDOT, Field Type: Integer, Field Length: 2

Location Code {Radiotherapy Treatment} – add data item Field Name: HOSPRADIO, Field Type: Characters, Field Length: 5

Location Code {SACT Treatment} – add new Data item Field Name: HOSPSACT, Field Type: Characters, Field Length: 5

Patient Consented for Clinical Trial – remove Data item Field Name: CONSENT, Field Type: Integer, Field Length: 2

Database

Amend ‘**NB: This may include some data for patients diagnosed from 1st January 2020’ to ‘**NB: This may include some data for patients diagnosed from 1st January 2022’.
Remove ‘Systemic Therapy Agent 1-2 {Mesothelioma} – CHEMAGENT1-2, In addition, the following data item is applicable to patients diagnosed from 1st January 2022: Pain Referral – PAIN’
add ‘Radiotherapy {Mesothelioma} – RADIO (new option added) Cordotomy – CORDOT (new field)’

Person Family Name (at Diagnosis) – Notes for Users add ‘Required for survival analysis and national comparative analysis’

Person Given Name - Notes for Users add ‘Required for survival analysis and national comparative analysis’

Patient Postcode at Diagnosis - Notes for Users add ‘Required for survival analysis and national comparative analysis’

Date of Birth - Notes for Users add ‘Required for survival analysis and national comparative analysis’

Person Sex at Birth - Notes for Users add ‘Required for survival analysis and national comparative analysis’
**CHI Number** - Notes for Users add ‘Required for survival analysis and national comparative analysis’

**Date of Diagnosis {Cancer}** – Notes for Users add ‘Note – any suspicious imaging or pathology requires to be confirmed by a relevant clinician and/or MDT’

**Histological/Cytological Diagnosis {Mesothelioma}** – Codes & Values Table amend ‘refused’ to ‘declined’

**Date of Histological/Cytological Diagnosis {Cancer}** – Notes for users remove ‘Required for QPI(s):’

**Immunohistochemical Panel** – Notes for Users add’ D240 or Podoplanin’ remove ‘D240’, add ‘MOC31/ERA or’ & ‘Claudin 4’ remove ‘MOC31, ERA’. Codes & Values table amend ‘refused’ to ‘declined’

**COVID 19 Impact** – Remove Data Item

**Type of First Cancer Treatment** – Codes & Values Table add ‘Code 14 Immunotherapy’. & arrange Codes to Numerical order, amend ‘refused’ to ‘declined’

**Date of First Cancer Treatment** – Notes for Users amend ‘refused to ‘declined’

**Section 3** - Rename form ‘Oncology’ to ‘Pain Management and Oncology’

**Pain Referral** – Notes for Users remove ‘despite analgesia’

**Cordotomy** – Add new Data Item

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

**Radiotherapy {Mesothelioma}** – Notes for Users amend ‘refused’ to ‘declined’ add ‘Patients with uncontrolled pain should be re-checked at the time of reporting to ensure that pain has not subsequently became controlled following optimisation of analgesia. If there is any doubt, this should be clarified with the relevant clinician.’ Codes & Values Table add ‘Code 3 No – pain now controlled/ i.e. pain was initially uncontrolled and has subsequently became controlled after optimisation of analgesia’, amend ‘refused’ to ‘declined’.

**Date Treatment Started {Cancer} (Radiotherapy)** – Notes for Users amend ‘refused’ to ‘declined’

**Date Treatment Completed {Cancer} (Radiotherapy)** – Notes for Users remove ‘Required for QPI(s):

**Location Code {SACT Treatment}** – add new Data item
Systemic Therapy Agent 1-2 {Mesothelioma} – Notes for Users amend ‘refuse’ to ‘decline’, Codes & Values table – amend ‘refused’ to ‘declined’

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2 – Notes for Users add ‘Required for survival analysis’ & amend ‘refused’ to ‘declined’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2 - Notes for Users remove ‘Required for QPI(s): & amend ‘refused’ to ‘declined’

Fluid Management Procedure – Notes for Users add ‘If it is documented that the patient does not require definitive pleural fluid management e.g. patients who do not re-accumulate fluid following initial aspiration or removal of fluid during thoracoscopy, this should be recorded as code 6. This should be documented on patient notes or recorded at MDT.’ Amend ‘Only patients who receive no drainage should be recorded as code 4 (No fluid management procedure undertaken).’ To ‘Patients who receive no drainage (and no documentation to state that it is not required) should be recorded as code 4 (No fluid management procedure undertaken).’ Codes & Values Table Explanatory notes for Code 2 add ‘Including insertion at thoracoscopy’; Code 4 explanatory notes add ‘No documentation to state that this is not required.’ Add Code 6 - No fluid management procedure undertaken – not required / It must be documented that this is not required. Add code 7 - Fluid drainage at thoracoscopy without talc poudrage or IPC insertion”; Amend ‘refused to ‘declined’

Patient Consented for Clinical Trial – Remove Data item

Changes agreed outwith Review June 2022

Systemic Therapy Agent 1-2 {Mesothelioma} – Codes and Values table add ‘code 24 - Nivolumab and Ipilimumab (NIVO-IPILIM)’

Baseline Review (January 2022)

Notes for Implementation of Changes – implementation date amended from 1st June 2019 to 1st January 2021

Notes for Implementation of Changes – added additional information – ‘**NB: This may include some data for patients diagnosed from 1st January 2020 where required for QPIs reported a year in arrears. This applies to the following data item:

Systemic Therapy Agent 1-2 {Mesothelioma} – CHEMAGENT1-2
In addition, the following data item is applicable to patients diagnosed from 1\textsuperscript{st} January 2022:

**Pain Referral – PAIN**

**Criteria for inclusion of Patients in Audit** – removed ‘Patients treated within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded’

**Database Specification**

**CHI Number** – field type amended to ‘Characters’

**Dataset**

**Date of Referral** – add new table ‘Guidance on Date of Referral’ to Notes for users.

**Pain Referral** – notes for users – added information ‘Only those patients where it is documented that pain is uncontrolled despite analgesia should be recorded as ‘Yes’.’

**Radiotherapy \{Mesothelioma\}** – notes for users – added information ‘This includes where patients may initially refuse treatment or whose initial treatment is ‘Watch and Wait’ or ‘Supportive Care’.’

**Systemic Therapy Agent 1-2 \{Mesothelioma\}** – notes for users – added information ‘Systemic Therapy given within 12 months of diagnosis should be recorded. This includes where patients may initially refuse treatment or whose initial treatment is ‘Watch and Wait’ or ‘Supportive Care’.’

**Systemic Therapy Agent 1-2 \{Mesothelioma\}** – codes and values – explanatory note ‘This includes patients who defer treatment within audit period’ for Code 95 removed.

**Fluid Management Procedure** – notes for users – added information ‘If more than one procedure is undertaken, and any one of these is Talc Pleurodesis or IPC insertion then the first of these (i.e. Talc Pleurodesis or IPC insertion) should be recorded.’

**Rebranding Updates (February 2021)**

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

**Revisions to Dataset Changes Outwith Review (February 2021)**

**Dataset**
COVID19 Impact – remove leading ‘0’ from COVID19 Impact Data Item and any other Data Item integer codes with an under 10.

Changes agreed at 7-month dataset review (November 2020)

Dataset

Histological/Cytological Diagnosis {Mesothelioma} – added morphology code 9000/9 Other Specific Mesothelioma subtype

Symptomatic Pleural Effusion – notes for users - removed text ‘Symptoms may include shortness of breath, cough, chest pain, weight loss or fever’

Fluid Management Procedure – Notes for users amended to ‘If the patient is treated with an intercostal (chest) drain alone this should be recorded as code 5. Only patients who receive no drainage should be recorded as code 4 (No fluid management procedure undertaken)’

Fluid Management Procedure – codes 5 ‘Intercostal (chest) drain without Talc’ and 94 ‘Patient died before undergoing fluid management procedure’

Addition to dataset during COVID 19 Pandemic (May 2020)

Database Specification

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

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

Dataset

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

COVID 19 Impact - add new Data item – implemented from 1 June 2019
DATABASE SPECIFICATION

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

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*Data Definitions for the National Minimum Core Dataset for Mesothelioma*
*Developed by ISD Scotland 2019*
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<td>Date (DD/MM/CCYY)</td>
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<td>43</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2</td>
<td>CHEMENDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>43</td>
</tr>
<tr>
<td><strong>Section 4: Fluid Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic Pleural Effusion</td>
<td>PLEURAL</td>
<td>Integer</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>Fluid Management Procedure</td>
<td>FLUIDMGMT</td>
<td>Integer</td>
<td>2</td>
<td>46</td>
</tr>
<tr>
<td><strong>Section 5: Clinical Trials</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Entered into Clinical Trial</td>
<td>TRIAL</td>
<td>Characters</td>
<td>2</td>
<td>49</td>
</tr>
<tr>
<td><strong>Section 6: Death Details</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>51</td>
</tr>
<tr>
<td>Post Mortem Examination</td>
<td>POSTMORT</td>
<td>Integer</td>
<td>2</td>
<td>52</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: Required for survival analysis and national comparative analysis.

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

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

From SMR Definitions and Codes

Notes by Users:
Person Given Name

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

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition: The forename or given name of a person.

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

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

The first forename of a person represents that part of the name of a person which after the surname is the principal identifier of a person.

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

Notes by Users:
Patient Postcode at Diagnosis

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

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

Related Data Item(s):
Date of Diagnosis

Notes by Users:
Date of Birth

Main source of Data Item Standard: Government Data Standards Catalogue

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

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

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

If the patient’s date of birth is recorded differently on different occasions, the most frequently used or latest date should be recorded.

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

Related Data Item(s):
CHI Number

Notes by Users:
**Person Sex at Birth**

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

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

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

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

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

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

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

**Codes and Values:**

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

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

**Notes by Users:**
**CHI Number**

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

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

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

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

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

From Designed to Care – Scottish Office

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

(PhS, Public Health Scotland, 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.
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 Mesothelioma 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:

**Notes by Users:**
<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>
</tbody>
</table>
| Screening service                  | 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.  

Note: the following will only be added to the applicable datasets:  
Bowel Screening Programme patients (colorectal cancer)  
The referral date is the date a request for a further diagnostic intervention is received via SCI gateway.  
The template of Bowel Screening SCI Gateway Referral letter now includes 'Date referral submitted', which should be used for recording the 'Date of Receipt of Referral' for bowel screening patients with an urgent suspicion of cancer.  
Breast Screening Programme patients (breast cancer)  
The referral date is the date that the letter for the assessment center is generated to request recall to an assessment center for further diagnostic intervention.  
Cervical Screening Programme patients (cervical cancer)  
The referral date is the date a request for a further diagnostic intervention is received via SCI gateway. |
<p>| Incidental finding / Secondary Care | 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. |
| Review clinic                      | 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. |</p>
<table>
<thead>
<tr>
<th>Referral Mode</th>
<th>Guidance on Date of Referral</th>
</tr>
</thead>
<tbody>
<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>
Date of CT Thorax

**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 the CT of the thorax was performed for staging and assessment.

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

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

If the patient has more than one CT of thorax to complete staging and assessment of mesothelioma which includes a non-CTPA or ‘venous phase’ CT, the date of the venous phase procedure should be recorded.

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

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

**Related Data Items:**  
CT Contrast Timing
CT Contrast Timing

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

**Definition:** A record to determine the contrast timing in the CT of thorax that is performed.

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

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

Timing of contrast is important in order to view the optimal image on CT.

If the CT scan has been described as non-CTPA or 'venous phase' or 'pleural', this defines that it is optimised for pleural assessment between 60 and 90 seconds.

If the patient has more than one CT of thorax for staging and assessment of mesothelioma which includes a non-CTPA or 'venous phase' CT, this one should be recorded in line with the Date of CT Thorax described.

If the contrast timing of the CT of thorax is not documented, record as 99 (Not recorded).

If CT of thorax was not performed, record as 96 (Not applicable).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-CTPA</td>
<td>Venous phase / Pleural</td>
</tr>
<tr>
<td>2</td>
<td>CTPA</td>
<td>Pulmonary arterial phase</td>
</tr>
<tr>
<td>3</td>
<td>No contrast given</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Patient chose to not undergo CT of thorax investigation</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. where no CT of thorax has been performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date of CT Thorax

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

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

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

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

**Notes for Users:**

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

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

**Codes and Values:**

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

**Related Data Items:**

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

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

**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 Public Health Scotland.

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.

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

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

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

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

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

Notes for Users: Required for QPI(s): 1-8 and for national survival analysis / national comparative analysis.

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

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

Note – any suspicious imaging or pathology requires to be confirmed by a relevant clinician and/or MDT.

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

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

Related Data Items:
Location of Diagnosis (Cancer)

Notes by Users:
Site of Origin of Primary Tumour {Cancer}

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

**Definition:** The anatomical site of origin of the primary tumour according to the International Classification of Diseases (ICD-10).

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

**Notes for Users:** Required for QPI(s): 1 – 8

For ICD-10, tumours should be assigned to the subcategory that includes the point of origin of the tumour. Where a tumour overlaps the boundaries of two or more subcategories, the site of origin should be clarified by the relevant clinician.

**Codes and Values:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Value</th>
<th>Notes on Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>C45.0</td>
<td>Mesothelioma of pleura</td>
<td></td>
</tr>
<tr>
<td>C45.1</td>
<td>Mesothelioma of peritoneum</td>
<td><strong>Includes:</strong> Mesentery, Mesocolon, Omentum, Peritoneum (parietal)(pelvic) <strong>Excludes:</strong> other malignant neoplasms of peritoneum</td>
</tr>
<tr>
<td>C45.2</td>
<td>Mesothelioma of pericardium</td>
<td><strong>Excludes:</strong> other malignant neoplasms of pericardium.</td>
</tr>
<tr>
<td>C45.7</td>
<td>Mesothelioma of other sites</td>
<td></td>
</tr>
<tr>
<td>C45.9</td>
<td>Mesothelioma, unspecified</td>
<td></td>
</tr>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Histological/Cytological Diagnosis {Mesothelioma}

**Main Source of Data Item Standard:** This is the morphology of the tumour according to the International Classification of Diseases for Oncology (ICD-O(3)).

**Definition:** This is the histological/cytological microscopic examination of the specimen by a pathologist to determine the presence of malignancy and the morphology of the tumour according to the International Classification of Diseases for Oncology (ICD-O(3)).

**Field Name:** HIST  
**Field Type:** Integer  
**Field Length:** 6  

**Notes for users:** Required for QPI(s): 2, 8

A pathological diagnosis should be obtained from biopsy.

If subtype is unknown use code 9050/3 to record Mesothelioma, unspecified.

Adequate tissue sampling should be undertaken, ensuring appropriate balance of risk to patients, to allow for pathological diagnosis including tumour subtyping.

The morphology terms have five-digit code numbers; the first four digits indicate the specific histologic terms and the fifth digit, after the slash, is a behaviour code.

There may be more than one biopsy/histology report. If there is a discrepancy between reports of cytology and histology, the histology report should be recorded as the definitive report. If the report is negative, code to 8888/8.

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

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

Morphology codes are shown below. This list is not exhaustive and if a code is not on the list please contact by email to: phs.canceraudit@phs.scot for advice.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>9050/3</td>
<td>Mesothelioma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td>9051/3</td>
<td>Sarcomatoid/Spindle Cell Mesothelioma</td>
<td>Includes desmoplastic mesothelioma</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanatory Note</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>9052/3</td>
<td>Epithelioid Mesothelioma</td>
<td></td>
</tr>
<tr>
<td>9053/3</td>
<td>Biphasic Mesothelioma</td>
<td></td>
</tr>
<tr>
<td>9000/9</td>
<td>Other Specific Mesothelioma subtype</td>
<td>Includes any other subtypes not described above</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>5555/5</td>
<td>Patient declined investigation</td>
<td></td>
</tr>
<tr>
<td>8888/8</td>
<td>Negative histology</td>
<td></td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
<td></td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
<td>e.g. no pathology carried out</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Location of Diagnosis (Cancer)
Date of Diagnosis (Cancer)
Date of Histological/Cytological Diagnosis {Cancer}

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

Definition: The date on which the mesothelioma was first diagnosed whether by histology or cytology.

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

Notes for Users:

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

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

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

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

Related Data Items:
Location of Diagnosis {Cancer}

Notes by Users:
**Immunohistochemical Panel**

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

**Definition:** This denotes whether or not an appropriate immuno-histochemical (IHC) panel has been undertaken.

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

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

Immuno-histochemical markers are used to increase diagnostic accuracy when differentiating between malignant epithelial mesothelioma and adenocarcinoma.

A minimum of 2 mesothelioma and 2 adenocarcinoma specific markers should be undertaken for an appropriate IHC panel.

The mesothelioma specific markers should include at least 2 of the following: Calretinin, D240 or Podoplanin, CK5, CK5/6, WT1.

The adenocarcinoma specific markers should include at least 2 of the following: CEA, MOC31/ERA or BerEP4, TTF1, Claudin 4.

If 2 or more from each category has been carried out this should be recorded as 1, Yes.

**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</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Inconclusive</td>
<td>Biopsy sample insufficient, test failed.</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>

**Related Data Items:**

**Notes by Users:**
**Synchronous Primary Tumours**

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

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

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

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

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

Record the presence or absence of synchronous tumours.

**Codes and Values:**

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

**Related Data Items:**

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

**Common name:** Clinical TNM Tumour Classification (Pleural Mesothelioma)

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

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

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

**Notes for Users:** Required for QPI(s): 1 and for national survival analysis.

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

Accurate staging is required to report good quality survival analysis. This is a pre/non-operative classification as defined prior to first treatment and may be documented within clinical systems / patient notes / MDT.

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

No TNM classification is available for other mesothelioma types.

**Codes and values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Tumour involves ipsilateral parietal pleura, with or without involvement of visceral, mediastinal or diaphragmatic pleura.</td>
<td></td>
</tr>
</tbody>
</table>
| T2   | Tumour involves the ipsilateral pleura (parietal or visceral pleura), with at least one of the following:  
       • Invasion of diaphragmatic muscle.  
       • Invasion of lung parenchyma. |                   |
<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
</table>
| T3   | Tumour involves ipsilateral pleura (parietal or visceral pleura), with at least one of the following:  
- Invasion of endotheorical fascia.  
- Invasion into mediastinal fat.  
- Solitary focus of tumour invading soft tissues of the chest wall.  
- Non-transmural involvement of the pericardium. |
| T4   | Tumour involves any ipsilateral pleura (parietal or visceral pleura), with at least one of the following:  
- Chest wall, with or without associated rib destruction (diffuse or multifocal)  
- Peritoneum (via direct transdiaphragmatic extension)  
- Contralateral pleura  
- Mediastinal organs s (oesophagus, trachea, heart, great vessels)  
- vertebra, neuroforamen, spinal cord  
- internal surface of the pericardium (transmural invasion with or without a pericardial effusion) |
| TX   | Primary tumour cannot be assessed. |
| 96   | Not applicable | Diagnosis is not pleural mesothelioma |
| 99   | Not recorded |

**Related data items:**

**TNM Nodal Classification (Clinical) {Pleural Mesothelioma}**

**TNM Metastases Classification (Clinical) {Pleural Mesothelioma}**

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

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


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

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

Notes for Users: Required for QPI: 1 and for national survival analysis.

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

Accurate staging is required to report good quality survival analysis. This is a pre/non-operative classification as defined prior to first treatment and may be documented within clinical systems / patient notes / MDT.

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

No TNM classification is available for other mesothelioma types.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node 25ntercosta.</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastases to ipsilateral intrathoracic lymph nodes (includes ipsilateral bronchopulmonary, hilar, subcarinal, paratracheal, aortopulmonary, paraesophageal, peridiaphragmatic, pericardial fat pad, 25ntercostals and internal mammary nodes)</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastases to contralateral intrathoracic lymph nodes. Metastases to ipsilateral or contralateral supraclavicular lymph nodes</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed).</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>----------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Diagnosis is not pleural mesothelioma.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data items:**
- TNM Tumour Classification (Clinical) {Pleural Mesothelioma}
- TNM Metastases Classification (Clinical) {Pleural Mesothelioma}
TNM Metastases Classification (Clinical) {Pleural Mesothelioma}

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


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

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

**Notes for Users**: Required for QPI: 1 and for national survival analysis.

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

Accurate staging is required to report good quality survival analysis. This is a pre/non-operative classification as defined prior to first treatment and may be documented within clinical systems / patient notes / MDT.

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

No TNM classification is available for other mesothelioma types.

**Codes and values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis.</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Diagnosis is not pleural mesothelioma.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

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


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

Notes for Users: Required for QPI: 4

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

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

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

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

Codes and values:

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

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

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

**Definition:** This denotes the date the national MDT 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, nurses, speech language therapists, physiotherapists and others relevant to the treatment of a specific cancer.

The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first **national** MDT meeting date will be recorded.

The date of any local MDT discussion should not be recorded. If the patient has not been discussed at the national MDT meeting, record as 10/10/1900 (Not applicable).

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

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

Common name: Mode of first treatment

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

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

Field Name: MODE1
Field Type: Integer
Field Length: 2

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

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

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

Steroids, drainage of pleural effusions etc. should not be recorded as first treatment if more substantive treatment such as radiotherapy, chemotherapy or surgery is given. If no further treatment is given, then record as supportive care.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td>This would only be given in the context of a clinical trial.</td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>Radiotherapy for mesothelioma would be palliative only.</td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Endoscopic</td>
<td>E.g. Endobronchial stenting.</td>
</tr>
<tr>
<td>7</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Immunotherapy</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died</td>
<td></td>
</tr>
<tr>
<td></td>
<td>before treatment</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanatory notes</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------</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 First Cancer Treatment

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

**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).

**Related Data Item(s):**  
Type of First Cancer Treatment
Section 3: Pain Management and Oncology
Pain Referral

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

Definition: A record of whether or not the patient has been referred to the national MDT for management of pain.

Field Name: PAIN  
Field Type: Integer  
Field Length: 2

Notes for Users: Required for QPI: 5

This may be documented on patient notes or recorded at MDT.

Only those patients where it is documented that pain is uncontrolled should be recorded as ‘Yes’.

Referral within 18 months of a patient being diagnosed can be recorded.

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:
Cordotomy

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

**Definition:** A record of whether or not the patient has undergone a cordotomy procedure for the management of pain.

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

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

A cordotomy is a surgical procedure whereby nerves of the spinal cord are cut or destroyed to achieve loss of pain.

This may be documented on patient notes or recorded at MDT.

A cordotomy within 18 months of a patient being diagnosed can be recorded.

**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:**
Location Code {Radiotherapy Treatment}

**Common Name(s):** Location


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

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

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

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

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

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


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

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

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

**Related Data Item(s):**
Radiotherapy {Mesothelioma}

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

**Definition:** A record of whether external beam radiotherapy has been administered for the treatment of symptoms of mesothelioma.

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

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

The use of radiotherapy treatment in patients with mesothelioma should be for symptom control and the management of pain. This can therefore be given at a later stage within the patient pathway rather than planned as initial treatment.

Radiotherapy given within 18 months of diagnosis should be recorded. This includes where patients may initially decline treatment or whose initial treatment is ‘Watch and Wait’ or ‘Supportive Care’.

Patients with uncontrolled pain should be re-checked at the time of reporting to ensure that pain has not subsequently become controlled following optimisation of analgesia. If there is any doubt, this should be clarified with the relevant clinician.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No – pain now controlled</td>
<td>i.e. pain was initially uncontrolled and has subsequently became controlled after optimisation of analgesia.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Date Treatment Started {Cancer} (Radiotherapy)  
Date Treatment Completed {Cancer} (Radiotherapy)
Date Treatment Started {Cancer} (Radiotherapy)

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

Definition: The date cancer treatment course commenced.

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

Notes for Users:

This is the first fraction of a course of radiotherapy.

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

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

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

Related Data Items:
Radiotherapy {Mesothelioma}

Date Treatment Completed {Cancer} (Radiotherapy)
Date Treatment Completed {Cancer} (Radiotherapy)

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

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

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

**Notes for Users:**

This is the last fraction of a course of radiotherapy.

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

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

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

**Related Data Item(s):**  
Radiotherapy {Mesothelioma}  
Date Treatment Started {Cancer} (Radiotherapy)
Location Code {SACT Treatment}

Common Name(s): Location


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

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

Notes for Users: Required for regional/national comparative analysis

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

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

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

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

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

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

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

Related Data Item(s):
Systemic Therapy Agent 1-2 {Mesothelioma}

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

Definition: The type of chemotherapy or biological therapy used either alone or in combination to treat mesothelioma.

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

Notes for Users: Required for QPI: 4

Chemotherapy drugs can be given in or out with the context of a clinical trial. Up to two courses may be recorded.

Systemic Therapy given within 12 months of diagnosis should be recorded. This includes where patients may initially decline treatment or whose initial treatment is ‘Watch and Wait’ or ‘Supportive Care’.

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Carboplatin single agent</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Cisplatin/Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Carboplatin/Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Pemetrexed</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Other biological agent</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Other chemotherapy agent</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Nivolumab and Ipilimumab</td>
<td>(NIVO-IPILIM)</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

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 cancer treatment course commenced.

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

Notes for Users: Required for survival analysis

This is the first dose of the first cycle of a course of chemotherapy or biological therapy.

Up to two courses may be recorded.

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

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

Related data items:
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) [Cancer]

1-2

**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 cancer treatment course ended.

**Field Name:** CHEMENDATE1

**CHEMENDATE2**

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

**Field length:** 10

**Notes for Users:**

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

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

Up to two courses may be recorded.

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

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

**Related data items:**
Section 4: Fluid Management
Symptomatic Pleural Effusion

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

Definition: A record of whether or not the patient has pleural effusion which is symptomatic.

Field Name: PLEURAL
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 6

Pleural effusion is a build-up of fluid within the chest cavity.

The majority of patients will present with symptomatic effusion, particularly shortness of breath. If shortness of breath has been documented as a symptom of pleural effusion this should be recorded as code 1, Symptomatic Pleural Effusion.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Symptomatic pleural effusion</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Asymptomatic pleural effusion</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No pleural effusion</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related data items:
Fluid Management Procedure
**Fluid Management Procedure**

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

**Definition:** A record of the type of fluid management procedure undertaken.

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

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

Fluid management procedures can be undertaken to treat pleural effusion (build-up of fluid in the chest). If more than one procedure is undertaken, and any one of these is Talc Pleurodesis or IPC insertion then the first of these (i.e. Talc Pleurodesis or IPC insertion) should be recorded.

If the patient is treated with an intercostal (chest) drain alone this should be recorded as code 5.

If it is documented that the patient does not require definitive pleural fluid management e.g. patients who do not re-accumulate fluid following initial aspiration or removal of fluid during thoracoscopy, this should be recorded as code 6. This should be documented on patient notes or recorded at MDT.

Patients who receive no drainage (and no documentation to state that it is not required) should be recorded as code 4 (No fluid management procedure undertaken).

This should be recorded if undertaken within the initial treatment pathway.

If the patient did not have symptomatic pleural effusion this should be recorded as 96 (Not applicable).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Talc pleurodesis (via slurry or poudrage)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Indwelling pleural catheter (IPC) insertion</td>
<td>Including insertion at thoracoscopy</td>
</tr>
<tr>
<td>3</td>
<td>Large volume pleural aspiration</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>No fluid management procedure undertaken</td>
<td>No documentation to state that this is not required.</td>
</tr>
<tr>
<td>5</td>
<td>Intercostal (chest) drain without Talc</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>No fluid management procedure undertaken – not required</td>
<td>It must be documented that this is not required.</td>
</tr>
<tr>
<td></td>
<td>Related data items:</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptomatic Pleural Effusion</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Fluid drainage at thoracoscopy without talc poudrage or IPC insertion</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Patient died before undergoing fluid management procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>94</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Patient declined fluid management procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>96</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>
Section 5: Clinical Trials
Patient Entered into Clinical Trial

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

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

Field Name: TRIAL
Field Type: Characters
Field Length: 2

Notes for Users: Required for QPI: 4

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

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Yes – Surgical</td>
</tr>
<tr>
<td>1B</td>
<td>Yes – Radiotherapy</td>
</tr>
<tr>
<td>1C</td>
<td>Yes – Chemotherapy</td>
</tr>
<tr>
<td>1D</td>
<td>Yes – More than one modality (including surgical)</td>
</tr>
<tr>
<td>1E</td>
<td>Yes – More than one modality (including radiotherapy)</td>
</tr>
<tr>
<td>1F</td>
<td>Yes – More than one modality (including chemotherapy)</td>
</tr>
<tr>
<td>1G</td>
<td>Yes – More than one modality (including both radiotherapy and chemotherapy)</td>
</tr>
<tr>
<td>1H</td>
<td>Yes – type of therapy unknown</td>
</tr>
<tr>
<td>1I</td>
<td>Yes – other type of therapy</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Section 6: Death Details
Date of Death

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

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

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

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

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

If the patient is alive, use the code 10/10/1900 (Not applicable).
Post Mortem Examination

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

Definition: A record of whether a post mortem has been carried out.

Field Name: POSTMORT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 8

Details of whether a post mortem has been carried out may be found, for example in General Register Office (Scotland) (GRO(S)) data recorded on the ACaDMe (Acute Cancer Deaths and Mental Health) system, or within clinical systems/MDT records.

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

Codes and Values:

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