Epithelial Ovarian Cancer

Data Definitions for the

National Minimum Core Dataset to Support the

Introduction of Epithelial Ovarian Quality Performance Indicators

Definitions developed by ISD Scotland in collaboration with the Ovarian Quality Performance Indicators Development Group

Version 3.2: May 2020

To be used in conjunction with:

1. Ovarian Quality Performance Indicators (latest published version)
2. Epithelial Ovarian QPI Dataset Validations (latest Published Version)
3. Epithelial Ovarian Measurability of Quality Performance Indicators (latest Published Version)
# DOCUMENT CONTROL SHEET

## Key Information

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

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Data Definitions for the National Minimum Core Dataset for Ovarian Cancer.
Developed by ISD Scotland, 2013
PREFACE

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

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

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

The following changes should be implemented for all patients who are diagnosed with epithelial ovarian cancer on or after 1 October 2014, who are eligible for inclusion in the OVARIAN cancer audit.

Changes to definitions fall into the following categories:

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

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

CONVENTIONS

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

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

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 - implement from 1 October 2018

Revisions to Dataset Out with Review (January 2020)

Date Abdomen and pelvis Imaging Investigations Completed - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

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

Date of Histological/Cytological Confirmation Prior to Treatment - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

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

Morphology of Tumour – Pre-Operative Biopsy - Codes and Values table add 8472/1 Mucinous cystic tumour of borderline malignancy

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

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

Date of Staging Primary Surgery {Cancer} - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Morphology of Tumour - Post-Operative - Codes and Values table add 8990/3 Carcinosarcoma, NOS

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’
Revisions to Dataset agreed at Formal Review (May 2018)

Database Specification

Section 6 – Change to Genetics

Genetic Testing – Add New Data Item

Section 7 – Change to Clinical Trial Entry

Section 8 – Change to Death Details

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

Risk of Malignancy Index (RMI I) (Pre-Treatment) – Notes for Users delete ‘Required for QPI 1, 4

Date of Diagnosis {Cancer} - Notes for Users change ‘Required for QPI(s) 1-9 to 2-12’

Site of Origin of Primary Tumour {Epithelial Ovarian Cancer} - Notes for Users change ‘Required for QPI(s) 1-9 to 2-12’

Type of First Cancer Treatment - Notes for Users add ‘Required for QPI(s) 7’

Date of First Cancer Treatment - Notes for Users add ‘e.g. supportive care only’ and ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.’

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

Date of Staging Primary Surgery {Cancer} - Notes for Users change ‘Required for QPI: 8’ to ‘Required for QPI: 12’

Presentation Type - Notes for Users delete ‘Required for QPI: 1’

Type of Staging Primary Operation - Notes for Users change ‘Required for QPI(s) 1, 4, 5, 8 to 4, 6, 10, 12’

Measurement of Macroscopic Residual Disease - Notes for Users change ‘Required for QPI(s) 5, 8 to 10’
Histopathology Report Complete {Epithelial Ovarian Cancer} - Notes for Users add ‘FIGO stage and Peritoneal washings are not required for patients that have undergone delayed primary surgery.’

Morphology of Tumour - Post-Operative - Notes for Users add ‘Required for QPI: 11

Tumour Grade - Notes for Users add ‘Required for QPI: 11

Final FIGO Stage - Notes for Users change ‘Required for QPI(s) 1, 4, 5, 8, 9 to 4, 9, 10’; add ‘Sub-staging should be possible for most specimens. Some staging is done by clinical / radiological assessment and therefore it may be appropriate to apply a more generic stage. Where sub-staging has not been applied, e.g. stage 4, this should be clarified with the relevant clinical team to ensure accurate recording of the sub-stage where possible.’ Remove Original Codes and Values 1st October 2013 – 31st December 2013 table.

Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} - Notes for Users change ‘Required for QPI(s) 7, 8, 9 to 7, 9, 12’

Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2) - Notes for Users add ‘Where chemotherapy is given within the context of a clinical trial, please check with oncology colleagues to ensure the regimen is recorded accurately.’

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) - Notes for Users delete ‘Required for QPI(s) 7, 8’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) - Notes for Users add ‘Required for QPI: 12’

Section 6 – Change to Genetics

Genetic Testing – Add New Data Item

Section 7 – Change to Clinical Trial Entry

Section 8 – Change to Death Details

Date of Death - Notes for Users add ‘Required for QPI(s) 12’

Revisions to Dataset Outwith Review (July 2016)

Risk of Malignancy Index (RMI I) (Pre-Treatment) – Notes for Users amended the following text – from ‘If the patient has had no ultrasound performed record as 101010 (Not applicable) to ‘If the patient has had no ultrasound or Menopausal status or Serum CA125 performed record RMISCORE as 101010 (Not applicable)’

Histocytological/Cytological Confirmation of Epithelial Ovarian Cancer –
Explanatory Notes for Code 96 – not applicable inserted ‘e.g. if no surgery has been performed’
Revisions to Dataset following Baseline Review (March 2016)

Risk of Malignancy Index (RMI I) (Pre-Treatment) – Notes for Users inserted the following text – ‘If the patient has had no ultrasound performed record as 101010 (Not applicable)

Date of Diagnosis – Notes for Users removed ‘The date recorded is the date of the first investigative procedure that confirms a diagnosis of ovarian cancer whether done radiologically or histologically’ and inserted ‘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.’


Revisions to Dataset out with Review (June 2015)

Location of Diagnosis {Cancer} – Codes and Values table inserted X9999=Not Recorded

Revisions to Dataset out with Review (April 2015)

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/10/2014.

Dataset

CHI Number - Field Type changed from Characters to Integer

Site of Origin of Primary Tumour {Epithelial Ovarian Cancer} - Field Type changed from Characters ICD-0(3) to Characters

Histopathology Report Complete {Epithelial Ovarian Cancer} - remove “Microinvasion” from Full Information required list within notes for users.

Final FIGO Stage - Field Length changed from 2 to 3

Database Specification

CHI Number - Field Type changed from Characters to Integer

Measurement of Macroscopic Residual Disease - Field Length changed from 4 to 2

Final FIGO Stage - Field Length changed from 2 to 3

Patient Entered into Clinical Trial {Cancer} - Field Type changed from Characters to Integer

Revisions to Dataset from 9 Month Review (September 2014)
**Dataset**

*Morphology of Tumour Pre-Operative Biopsy* – Add New Data Item

*Date of Histological/Cytological Diagnosis {Cancer} - Archive Data Item*

*Microinvasion {Epithelial Ovarian Cancer} – Archive Data Item*

*Cause of Death – Archive Data Item*

**Database Specification**

*Date of Histological/Cytological Diagnosis {Cancer} – Archive Data Item*

*Microinvasion {Epithelial Ovarian Cancer} – Archive Data Item*

*Cause of Death – Archive Data Item*

*Morphology of Tumour –Pre-Operative* - Add New Data Item Biopsy Field Name: BIOMORPHOL, Field type: Characters, Field Length: 6

**Dataset**

*Abdomen and Pelvis Imaging Investigations Completed* - Code and Values Table removed Code 96 Not Applicable, ‘complete’ added to Yes and ‘Not complete’ added to No.

*Risk of Malignancy Index (RMI I) (Pre-Treatment) – Notes for Users remove “stage 1” and “If not applicable, record as 101010(Not applicable)*

*Type of Staging Primary Operation {Epithelial Ovarian Cancer} - Codes and Values Table Omental biopsy added into explanatory notes of 01 – Complete staging operation.

*Morphology of Tumour* – Title added Post Operative; Notes for Users added “If material supplied cannot be assessed code to ‘not assessable’ (1111/1). If not recorded, record as 9999/9 (Not recorded). If the pathology report is negative code to 8888/8. E.g. if a polyp is removed showing no residual disease. If no invasive operative procedures were undertaken record as not applicable (1010/0).” codes added “mixed mesodermal” to 8950/3; added “8010/3 – Carcinoma, not otherwise specified”

*Tumour Grade – Notes for Users add “low or high grade” and “take back to MDT for clarification”.

*Patient entered into Clinical Trial {Cancer} - Field Type changes from Characters to Integer.*

**Revisions to Dataset Outwith Review (July 2014)**

**Dataset**

*Type of First Cancer Treatment – Add New Data Item*

*Date of First Cancer Treatment – Add New Data Item*
Data Definitions for the National Minimum Core Dataset for Ovarian Cancer
Developed by ISD Scotland, 2013

Date of Definitive Treatment {Renal Cancer} – Add New Data Item

Database Specification

**Type of First Cancer Treatment** - New data item added: Field Name: FIRSTTREATMODE, Field type: Integer, Field Length: 2

**Date of First Cancer Treatment** – New Data Item added Field Name: FIRSTTREATDATE, Field Type: Date, Field Length: 10

**Date of Definitive Treatment {Renal Cancer}** - New Data Item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.

Dataset

Final FIGO Stage add New Codes and Values 1st January 2014 – to date
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 epithelial ovarian (ICD-O(3) C56), primary peritoneal (ICD-O(3) C48) and fallopian tube (ICD-O(3) C57) malignancies See page 35 for morphology codes to be included. Including those 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 with borderline ovarian cancers
- Patients with Pseudomyxoma peritonei
- Patients with sarcoma
- Patients with Benign tumours.
- Patients with Neuroendocrine tumours.
- Patients with Germ cell tumours
- Patients where the origin of the primary is uncertain.
- Patients with recurrent disease (as opposed to a new primary).
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.
### DATABASE SPECIFICATION

#### DOWNLOAD FORMAT

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

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**Section 4: Pathology Details**

- Histopathology Report Complete (Epithelial Ovarian Cancer) | PATHCOMPL | Integer | 2 | 34 |
- Morphology of Tumour - Post-Operative                      | MORPHOL  | Characters | 6 | 35 |
- Tumour Grade                                              | GRADE    | Integer | 2 | 37 |
- Peritoneal Biopsy Involvement (Epithelial Ovarian Cancer)  | PERIBIOP  | Integer | 2 | 38 |
- Omentum Involvement (Epithelial Ovarian Cancer)            | OMENTINV  | Integer | 2 | 39 |
- Fallopian Tube Involvement (Epithelial Ovarian Cancer)     | FALLOP   | Integer | 2 | 40 |
- Malignant Presence in Peritoneal/Ascitic Fluid (Epithelial Ovarian Cancer) | PAWASH | Integer | 2 | 41 |
- Number of Lymph Nodes Involved (Cancer)                    | LNININVOLVE | Integer | 4 | 42 |
- Final Total Number of Lymph Nodes Examined Microscopically (Cancer) | LNEXAMINE | Integer | 4 | 43 |
- Final FIGO Stage                                          | FIGO2    | Characters | 3 | 44 |

**Section 5: Oncological Treatment**

- Systemic Anti-Cancer Therapy (SACT) (Epithelial Ovarian Cancer) (1-2) | SACT1 | Integer | 2 | 47 |
- Systemic Anti-Cancer Therapy (SACT) (Epithelial Ovarian Cancer) (1-2) | SACT2 | Integer | 2 | 47 |
- Systemic Therapy Agent (Epithelial Ovarian Cancer) (1-2) | SACTAGENT1 | Integer | 2 | 48 |
- Systemic Therapy Agent (Epithelial Ovarian Cancer) (1-2) | SACTAGENT2 | Integer | 2 | 48 |
- Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) | SACTDATE1 | Date (DD/MM/CCYY) | 10 | 49 |
- Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) | SACTDATE2 | Date (DD/MM/CCYY) | 10 | 49 |
- Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) | SACTENDATE1 | Date (DD/MM/CCYY) | 10 | 50 |
- Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) | SACTENDATE2 | Date (DD/MM/CCYY) | 10 | 50 |

**Section 6: Genetics**

- Genetic Testing | GENTEST | Integer | 2 | 52 |

**Section 7: Clinical Trial Entry**

- Patient Entered into Clinical Trial (Cancer) | TRIAL | Integer | 2 | 54 |

**Section 8: Death Details**

- Date of Death | DOD | Date (DD/MM/CCYY) | 10 | 56 |
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

**Codes and Values:**

**Related Data Items:**

**Notes by Users:**
Person Given Name

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

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition:
The forename or given name of a person.

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

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

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

Codes and Values:

Related Data Items:

Notes by Users:
**Patient Postcode at Diagnosis (Cancer)**

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

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

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

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

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

**Codes and Values:** N/A

**Related Data Items:**
Date of Diagnosis

**Notes by Users:**
**Date of Birth**

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

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

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

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

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

**Codes and Values:** N/A

**Related Data Items:**
CHI Number

**Notes by Users:**
**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:** Integer  
**Field Length:** 10

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

From Designed to Care – Scottish Office

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

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

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

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

**Codes and values:** N/A

**Related Data Items:**
Date of Birth

**Notes by Users:**
Section 2: Pre-treatment Imaging & Staging Investigations
Date of Referral

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

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

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

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

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

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

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

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

Notes by Users:
**Abdomen and Pelvis Imaging Investigations Completed**

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

**Definition:** A record to show that scanning of the abdomen and pelvis was assessed using computed tomography (CT) or magnetic resonance imaging (MRI). From the superior aspect of the diaphragm as far as the inferior border of the pubic symphysis.

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

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

A MRI or CT scan should be carried out prior to treatment.

Imaging of the pelvis and abdomen should be carried out to establish the extent of disease.

Chest CT is not routinely part of this assessment.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes - Complete</td>
<td>Both abdomen and pelvis assessed.</td>
</tr>
<tr>
<td>02</td>
<td>No – Not Complete</td>
<td>Abdomen and/or pelvis not assessed.</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Abdomen and/or pelvis not assessed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data items:**
Date Abdomen and Pelvis Imaging Investigations Completed

**Notes by Users:**
Date Abdomen and Pelvis Imaging Investigations Completed

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

Definition: The date abdomen and pelvis imaging investigations were completed by computed tomography (CT) or magnetic resonance imaging (MRI) of the abdomen and pelvis.

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

Notes for Users:
Date of Procedure to be recorded.
Complete staging is where both abdomen and pelvis is assessed.
These investigations may be done separately at different times but before first treatment.
Record the date that ALL items are complete, e.g. if done on separate days then record the final date.
If staging investigations were not completed, record as not applicable (10/10/1900).
If the exact date is not documented, record as (09/09/1900).

Related Data Item(s):
Abdomen and Pelvis Imaging Investigations Completed
Date of Staging Primary Surgery {Cancer}

Notes by Users:
Risk of Malignancy Index (RMI I) (Pre-Treatment)

Main Source of Data Item Standard:

**Definition:** A record of the Risk of Malignancy Index (RMI I) as recorded in the patient’s notes or at MDT prior to treatment.

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

**Notes for Users:**

The Risk of Malignancy Index (RMI I) score should be recorded by a clinician for all patients at MDT pre-treatment. This should not be deduced.

For information the ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites, and bilateral lesions. U = 0 for an ultrasound score of 0 points, U = 1 for an ultrasound score of 1 point, U = 3 for an ultrasound score of 2–5 points.

Menopausal status is scored as 1 = pre-menopausal and 3 = post-menopausal. The classification of ‘post-menopausal’ is a woman who has had no period for more than 1 year or a woman over 50 who has had a hysterectomy.

Serum CA125 is measured in IU/ml.

If it is not documented in notes do not deduce from other information and record as ‘999999’ ‘(Not recorded).

If the patient has had no ultrasound or Menopausal status or Serum CA125 performed record RMISCORE as 101010 (Not applicable)

**Related Data Items:**

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

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

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

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

**Notes for Users:** Required for clarifying responsibility for data collection and national comparative analysis.

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

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

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

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

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

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

Definition: The date on which 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): 2 - 12

Required for national survival analysis and national comparative analysis.

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

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

Histological and cytological confirmation refers specifically to pre-treatment.

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

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

Notes by Users:
Date of Histological/Cytological Confirmation Prior to Treatment

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

Definition: This is the date that the histological/cytological microscopic examination of the specimen to determine the presence of malignancy and the classification of the malignant tumour was confirmed prior to the start of treatment.

Field Name: HCONF
Format: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI: 7

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 prior to treatment.

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

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)
Histocytological/Cytological Confirmation Prior to Treatment
**Histocytological/Cytological Confirmation Prior to Treatment**

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

**Definition:** Confirmation if a histological or cytological examination was carried out to diagnose a cancer prior to treatment.

**Field Name:** HCCONF  
**Format:** Integer  
**Field length:** 2

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Histological</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Cytological</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Diagnosis based on other clinical investigations only, e.g. imaging</td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td>e.g. not suitable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**  
Location of Diagnosis (Cancer)  
Date of Histological/Cytological Confirmation Prior to Treatment
Site of Origin of Primary Tumour {Epithelial Ovarian 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 for Oncology (ICD-O(3)).

**Field Name:** SITE  
**Field Type:** Characters  
**Field length:** 5

**Notes for Users:** Required for QPI(s): 2 - 12

All ovarian cancers should be collected through the audit process. Only epithelial type cancers (assumed for all cases by default) should be included, other tumour type will be excluded based on explicit histological confirmation.

Tumours should be assigned to the subcategory that includes the point of origin of the tumour. A tumour that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified as ‘C48.8’. It should be noted that this subcategory should only be used where it is impossible to identify the specific site of origin of the tumour.

**Codes and Values:**

<table>
<thead>
<tr>
<th>ICD-O(3) Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C56.9</td>
<td>Ovary</td>
<td>Periadrenal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perinephric tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peripancreatic tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perirenal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retrocaecal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retroperitoneal tissue</td>
</tr>
<tr>
<td>C57.0</td>
<td>Fallopian Tube</td>
<td></td>
</tr>
<tr>
<td>C48.0</td>
<td>Retroperitoneum</td>
<td>Periadrenal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perinephric tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peripancreatic tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perirenal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retrocaecal tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retroperitoneal tissue</td>
</tr>
<tr>
<td>C48.1</td>
<td>Specified parts of peritoneum</td>
<td>Pelvic peritoneum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pouch of Douglas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cul de sac</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rectouterine pouch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mesocolon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mesoappendix</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mesentery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Omentum</td>
</tr>
<tr>
<td>C48.2</td>
<td>Peritoneum, NOS</td>
<td>Peritoneal cavity</td>
</tr>
<tr>
<td>C48.8</td>
<td>Overlapping lesion of retroperitoneum and peritoneum</td>
<td>Peritoneal cavity</td>
</tr>
<tr>
<td>C99.X</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
**Date Discussed by Care Team (MDT)**

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

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

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

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

**Notes for Users:** Required for QPI: 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 MDT meeting should be recorded.

If the date of the MDT meeting is unknown record as 09/09/1900 or if the patient has not been discussed by the MDT, record as Not applicable 10/10/1900.

**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 Information Services.

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>01</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>02</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>03</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>04</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>
Morphology of Tumour – Pre-Operative Biopsy

Main Source of Data Item Standard: Pathology and Genetics of Tumours of the Digestive System, WHO Histological Classification of Tumours 2007.

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

Field Name: BIOMORPHOL
Field Type: Characters
Field Length: 6

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

The morphology terms have five-digit code numbers which run from 8000/0 to 9989/1; the first four digits indicate the specific histologic terms and the fifth digit, after the slash, is a behaviour code.

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

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

If no biopsy diagnostic procedures were undertaken prior to definitive operation record as not applicable (1010/0).

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

Morphology codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8441/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>8461/3</td>
<td>Surface papillary adenocarcinoma</td>
</tr>
<tr>
<td>9014/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>8472/1</td>
<td>Mucinous cystic tumour of borderline malignancy</td>
</tr>
<tr>
<td>8480/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>9015/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>8380/3</td>
<td>Adenocarcinoma, not otherwise specified</td>
</tr>
<tr>
<td>8381/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>8950/3</td>
<td>Malignant Mullerian mixed tumour (carcinosarcoma), mixed mesodermal</td>
</tr>
<tr>
<td>8933/3</td>
<td>Adenosarcoma</td>
</tr>
<tr>
<td>8310/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>8313/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>8120/3</td>
<td>Transitional cell carcinoma (non-Brenner type)</td>
</tr>
<tr>
<td>9000/3</td>
<td>Malignant Brenner tumour</td>
</tr>
<tr>
<td>8070/3</td>
<td>Squamous cell carcinoma</td>
</tr>
<tr>
<td>8323/3</td>
<td>Malignant</td>
</tr>
</tbody>
</table>
### Undifferentiated and unclassified tumours - malignant

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8010/3</td>
<td>Carcinoma, not otherwise specified</td>
</tr>
<tr>
<td>8020/3</td>
<td>Undifferentiated carcinoma</td>
</tr>
<tr>
<td>8140/3</td>
<td>Adenocarcinoma, not otherwise specified</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
</tr>
<tr>
<td>8888/8</td>
<td>Negative Pathology</td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Related Data Items:**
Type of First Cancer Treatment

**Common name:** Mode of first treatment

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

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

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

**Notes for Users:** Required for QPI(s): 3, 7

This field is included in the data standards to enable the accurate recording of waiting times. 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. Some biopsies, such as excisional biopsies and cone biopsies may be included as these may have some therapeutic benefits i.e. the removal of the tumour.

Record patients as having ‘no active treatment’ if a decision was taken not to give the patient treatment as part of their primary therapy (some patients that have ‘no active treatment’ may subsequently have treatment when symptoms develop but this is not primary therapy). No active treatment includes watchful waiting and supportive care but not palliative chemotherapy and/or radiotherapy.

Radiotherapy includes teletherapy (external beam radiotherapy) and brachytherapy. Endoscopic treatment includes photodynamic therapy, transurethral resection (TUR), laparoscopic treatment, endomucosal resection (EMR) and insertion of stents. Dilatations without other treatment is not considered as active treatment.

Biological therapies such as Interferon, Interleukin 2, BCG vaccine etc. should be recorded under other therapy.

**Codes and values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Surgery</td>
</tr>
<tr>
<td>02</td>
<td>Radiotherapy</td>
</tr>
<tr>
<td>03</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>04</td>
<td>Synchronous Chemoradiotherapy</td>
</tr>
<tr>
<td>05</td>
<td>Endoscopic</td>
</tr>
<tr>
<td>06</td>
<td>Hormone therapy</td>
</tr>
<tr>
<td>07</td>
<td>Supportive care</td>
</tr>
<tr>
<td>11</td>
<td>Other therapy</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all therapies</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related data item:** Date of first cancer treatment
Date of First Cancer Treatment

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

Definition: This denotes the date the 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:

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

If type of first cancer treatment is ‘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. 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.

If the patient died before treatment or the patient refused treatment, record as 10/10/1900.

Related data item: Type of first cancer treatment.
**Date of Definitive Treatment {Ovarian Cancer}**

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

**Definition:** This denotes the date 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 ovarian cancer definitive treatment will be either:

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

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

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

For patients undergoing no active treatment (e.g. supportive care only) the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. Where this has subsequently been confirmed at MDT, the date of MDT should be recorded. 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 refused treatment, record as 10/10/1900 (Not applicable).

**Related Data Item(s):**
Section 3: Surgery
**Location Code** {Cancer Surgery}

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

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

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

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

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

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

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

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

The first character denotes the health board, the next three are assigned and the fifth denotes the type of location (H=hospital) e.g.

A111H=Crosshouse Hospital  
G107H=Glasgow Royal Infirmary

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

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

If surgery has not been performed or the patient has refused surgery, record as Not applicable, X1010.

**Related Data Item(s):**  
Date of Staging Primary Surgery {Cancer}  
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

**Notes by Users:**

---

*Data Definitions for the National Minimum Core Dataset for Ovarian Cancer.  
Developed by ISD Scotland, 2013*  
*Page 25*
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

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

Definition: The GMC number of the consultant in charge at operation performing the definitive surgery as described elsewhere.

Field Name: OPSURG1  
Field Type: Characters  
Field Length: 14

Notes for Users:

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

If the patient is operated on by a clinician who is working as a locum consultant, record only that the clinician is a locum consultant ‘LOCUM’.

If the operating surgeon is not a consultant record as non-consultant grade ‘8889’ regardless of whether the surgeon was a locum or not.

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):
Location Code {Cancer Surgery}  
Date of Staging Primary Surgery {Cancer}

Notes by Users:
**Date of Staging Primary Surgery {Cancer}**

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

**Definition:** This is the date of the primary operative procedure described elsewhere;

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

**Notes for Users:** Required for QPI: 12

Surgery may be staging, primary and delayed primary surgery or following neo-adjuvant chemotherapy.

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

If no surgical procedure is carried out, code as 10/10/1900 (Not applicable).

**Codes and values:** N/A

**Related data items:**  
Location Code {Cancer Surgery}  
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

**Notes by Users:**
Histocytological/Cytological Confirmation of Epithelial Ovarian Cancer

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

Definition: Confirmation if a histological or cytological examination was carried out to diagnose a cancer.

Field Name: HCDIAG
Format: Integer
Field length: 2

Notes for Users:
Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Histological</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Cytological</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. if no surgery has been performed</td>
</tr>
<tr>
<td>98</td>
<td>Clinically inappropriate</td>
<td>e.g. not suitable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
Location Code {Cancer Surgery}
Presentation Type

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

Definition: How the patient presented for surgery.

Field Name: PRESENT
Field Type: Integer
Field Length: 2

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

Both categories incorporate:
1. Transfer from another consultant and/or significant facility and/or specialty and/or hospital in the same or another trust where the patient was already undergoing hospital care for treatment.
2. A patient presenting for surgery while undergoing hospital care for an unrelated condition (incidental finding).

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Elective (routine)</td>
<td>A patient who presents for surgery as planned.</td>
</tr>
<tr>
<td>02</td>
<td>Emergency</td>
<td>A patient, who for clinical reasons, presents unplanned for surgery. If presentation is classed as ‘urgent’, code as ‘emergency’ only if surgery is performed within 72 hours of admission</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>If no operation was performed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Type of Staging Primary Operation {Epithelial Ovarian Cancer}

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

Definition: This is the main operation performed on the patient for treatment of ovarian cancer.

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

Notes for Users: Required for QPI(s) 4, 6, 10, 12

Complete staging patients may have organs absent due to previous surgeries for benign conditions.

If code 02 or 03 is being recorded please verify with the clinician if the patient had undergone a previous operation to remove an ovary or had a sub total Hysterectomy.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Complete staging operation</td>
<td>Complete staging patients may have organs absent due to previous surgeries.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete staging = Total abdominal hysterectomy (TAH),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bilateral salpingo-oophorectomy (BSO), Omentectomy + peritoneal or ascites washings.</td>
</tr>
<tr>
<td>02</td>
<td>Incomplete staging</td>
<td>Unilateral oophorectomy, no omentectomy, hysterectomy</td>
</tr>
<tr>
<td>03</td>
<td>Incomplete staging – fertility sparing</td>
<td>Unilateral oophorectomy. Fertility conserving surgery is where only the ovary containing the tumour and connecting fallopian tube is removed. The remaining healthy ovary and fallopian tube is retained.</td>
</tr>
<tr>
<td>04</td>
<td>Delayed Primary Operation - complete</td>
<td>Surgery following Neoadjuvant therapy</td>
</tr>
<tr>
<td>05</td>
<td>Delayed Primary Operation - incomplete</td>
<td>Surgery following Neoadjuvant therapy</td>
</tr>
<tr>
<td>93</td>
<td>Patient unfit for surgery</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before surgery</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined surgery</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. patient with advanced disease</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related data items:
Location Code (Cancer Surgery)
Date of Staging Primary Surgery (Cancer)
Operating Consultant Gynaecologist (Epithelial Ovarian Cancer)
**Second Operation to Complete**

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

**Definition:** A record to show if there was a second operation to complete the staging.

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

**Notes for Users:**

Some patients may have had a previous operation where incomplete staging is identified and then gone on to have a second operation in an attempt to complete staging.

A second operation should be recorded in this section if there has been no chemotherapy given following the initial procedure and the time interval has not exceeded 3 months.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes :- Staging complete</td>
<td>Second operation undertaken to complete staging</td>
</tr>
<tr>
<td>02</td>
<td>Yes :- Staging Incomplete</td>
<td>Second operation undertaken in an attempt to complete staging</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:-**  
Type of Staging Primary Operation

**Notes by Users:**

[Data Definitions for the National Minimum Core Dataset for Ovarian Cancer.  
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Page 31]
Measurement of Macroscopic Residual Disease

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

Definition: The measurement of macroscopic residual disease for patients undergoing surgery as defined by the main type of definitive operation.

Field Name: TUMSIZE
Field Type: Integer
Field length: 2

Notes for Users: Required QPI: 10

This is the total residual disease – as defined in the surgical notes. The measurements for the largest deposit(s) should be recorded (cm in diameter).

Although the objective of surgery is to resect all visible disease this is not always possible in patients with advanced disease because of widespread involvement of peritoneal surfaces, bowel mesentery and serosa of bowel. In these instance or if no surgery was carried out 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>01</td>
<td>No residual disease</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>&lt;1cm</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>1-5cm</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>&gt;5cm</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Residual disease present, not documented.</td>
</tr>
</tbody>
</table>

Related Data Items:

Notes by Users:
Section 4: Pathology Details
Histopathology Report Complete (Epithelial Ovarian Cancer)

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

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

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

Notes for Users: Required for QPI: 6

Full Information Required:
- Tumour type
- Tumour grade
- Lymph node status
- Peritoneal biopsies
- Omentum
- Peritoneal washings or ascitic fluid*
- Fallopian tubes
- Staging – FIGO stage*

Pathology report should include complete information for all relevant tissue samples received by pathology, for example if no lymph node or omental tissue is received by pathology it is not expected that this would be reported by the pathologist; therefore, if all other information noted, this report should be recorded as complete.

*FIGO stage and Peritoneal washings are not required for patients that have undergone delayed primary surgery.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Not complete</td>
<td>e.g. not all data items completed.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. patient did not have surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Morphology of Tumour - Post-Operative

Main Source of Data Item Standard: Pathology and Genetics of Tumours of the Digestive System, WHO Histological Classification of Tumours.

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

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

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

The morphology terms have five-digit code numbers which run from 8000/0 to 9989/1; the first four digits indicate the specific histologic terms and the fifth digit, after the slash, is a behaviour code.

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

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

If the pathology report is negative code to 8888/8. E.g. if a polyp is removed showing no residual disease.

If no invasive operative procedures were undertaken record as not applicable (1010/0).

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

Morphology codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serous tumours- malignant</td>
<td></td>
</tr>
<tr>
<td>8441/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>8461/3</td>
<td>Surface papillary adenocarcinoma</td>
</tr>
<tr>
<td>9014/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>Mucinous tumours- malignant</td>
<td></td>
</tr>
<tr>
<td>8480/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>9015/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>Endometrioid tumours including variants with squamous differentiation- malignant</td>
<td></td>
</tr>
<tr>
<td>8380/3</td>
<td>Adenocarcinoma, not otherwise specified</td>
</tr>
<tr>
<td>8381/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>8950/3</td>
<td>Malignant Mullerian mixed tumour (carcinosarcoma), mixed mesodermal</td>
</tr>
<tr>
<td>8933/3</td>
<td>Adenosarcoma</td>
</tr>
<tr>
<td>Clear cell tumours- malignant</td>
<td></td>
</tr>
<tr>
<td>8310/3</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>8313/3</td>
<td>Adenocarcinofibroma (malignant adenofibroma)</td>
</tr>
<tr>
<td>Transitional cell tumours - malignant</td>
<td></td>
</tr>
<tr>
<td>8120/3</td>
<td>Transitional cell carcinoma (non-Brenner type)</td>
</tr>
<tr>
<td>9000/3</td>
<td>Malignant Brenner tumour</td>
</tr>
<tr>
<td>Squamous cell tumours- malignant</td>
<td></td>
</tr>
<tr>
<td>8070/3</td>
<td>Squamous cell carcinoma</td>
</tr>
<tr>
<td>Mixed epithelial tumours (specify components)</td>
<td>8323/3</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Complex mixed and stromal neoplasms</td>
<td>8990/3</td>
</tr>
<tr>
<td>Undifferentiated and unclassified tumours - malignant</td>
<td>8010/3</td>
</tr>
<tr>
<td></td>
<td>8020/3</td>
</tr>
<tr>
<td></td>
<td>8140/3</td>
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<tr>
<td></td>
<td>1111/1</td>
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<tr>
<td></td>
<td>8888/8</td>
</tr>
<tr>
<td></td>
<td>9999/9</td>
</tr>
<tr>
<td></td>
<td>1010/0</td>
</tr>
</tbody>
</table>
**Tumour Grade**

**Main Source of Data Item Standard:**

**Definition:** A record of the grade of tumour as recorded in the pathological report.

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

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

If the tumour is described as having mixed differentiation (e.g. moderate to well) the option with the poorer prognosis is recorded (moderate).

If low or high grade is not documented do not deduce from other information, take back to MDT for clarification or record as ‘not recorded’.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Non Serous</td>
<td>Well Differentiated</td>
</tr>
<tr>
<td>02</td>
<td>Non Serous</td>
<td>Moderately Differentiated</td>
</tr>
<tr>
<td>03</td>
<td>Non Serous</td>
<td>Poorly Differentiated</td>
</tr>
<tr>
<td>04</td>
<td>Serous</td>
<td>Low Grade</td>
</tr>
<tr>
<td>05</td>
<td>Serous</td>
<td>High Grade</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>
Peritoneal Biopsy Involvement {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

Definition: A record to determine presence or absence of malignant cells in the peritoneum.

Field Name: PERIBIOP
Field Type: Integer
Field Length: 2

Notes for Users:

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Involved</td>
</tr>
<tr>
<td>02</td>
<td>Not involved</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Omentum Involvement {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

**Definition:** A record to determine if there is omental involvement.

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

**Notes for Users:**

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Involved</td>
</tr>
<tr>
<td>02</td>
<td>Not involved</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Fallopian Tube Involvement (Epithelial Ovarian Cancer)

Main Source of Data Item Standard:

Definition: A record to determine if there is Fallopian Tube involvement.

Field Name: FALLOP
Field Type: Integer
Field Length: 2

Notes for Users:

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Involved</td>
</tr>
<tr>
<td>02</td>
<td>Not involved</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
Malignant Presence in Peritoneal/Ascitic Fluid (Epithelial Ovarian Cancer)

Main Source of Data Item Standard:

**Definition:** The presence or absence of malignant cells in peritoneal and/or ascitic fluid.

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

Notes for Users:

Cytological assessment of peritoneal fluid forms part of the staging system for ovarian carcinoma and in stage I tumours the presence or absence of tumour cells in peritoneal washings may be critical in determining the need for adjuvant therapy.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Present</td>
</tr>
<tr>
<td>02</td>
<td>Not present</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>
**Number of Lymph Nodes Involved [Cancer]**

**Main Source of Data Item Standard:**

**Main source of standard:** Derived from the Royal College of Pathologists standards and minimum datasets for reporting cancers.

**Definition:** The number of lymph nodes reported as positive for the presence of tumour metastases by microscopy.

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

**Notes for Users:**

If no surgery is performed or no attempt to sample/dissect nodes code as ‘1010’, not applicable.  
If the total number examined is not known or not recorded, code as 9999.
Final Total Number of Lymph Nodes Examined Microscopically {Cancer}

Main Source of Data Item Standard: Derived from the Royal College of Pathologists standards and datasets for reporting cancers.

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

Field Name: LNEXAMINE
Field Type: Integer
Field Length: 4

Notes for Users:

If no surgery is performed or no attempt to sample/dissect nodes code as ‘1010’, not applicable.

If the total number examined is not known or not recorded, code as 9999.

Notes by Users:
Final FIGO Stage

**Main Source of Data Item Standard:** International Federation of Obstetricians and Gynaecologists (FIGO)

**Definition:** The stage of the disease of the ovary as recorded in the patient's notes at the time of the MDT meeting.

**Field Name:** FIGO2  
**Field Type:** Characters  
**Field Length:** 3

**Notes for Users:** Required for QPI(s): 4, 9, 10

Final stage is clinical/pathological correlation as agreed by the MDT.

Primary peritoneal carcinomas are staged in a similar manner to ovarian carcinomas.

If there are two conflicting stages record the worst case scenario.

Sub-staging should be possible for most specimens. Some staging is done by clinical / radiological assessment and therefore it may be appropriate to apply a more generic stage. Where sub-staging has not been applied, e.g. stage 4, this should be clarified with the relevant clinical team to ensure accurate recording of the sub-stage where possible.

**New Codes and Values 1st January 2014 – to date**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Ovarian Primary</td>
</tr>
<tr>
<td>1a</td>
<td>Tumour in one ovary, capsule intact, no tumour on surface, negative washings.</td>
</tr>
<tr>
<td>1b</td>
<td>Tumour involves both ovaries, capsule intact, no tumour on surface, negative washings.</td>
</tr>
<tr>
<td>1c</td>
<td>Tumour limited to one or both ovaries</td>
</tr>
<tr>
<td>1c1</td>
<td>Surgical spill</td>
</tr>
<tr>
<td>1c2</td>
<td>Capsule rupture before surgery or tumour on ovarian surface</td>
</tr>
<tr>
<td>1c3</td>
<td>Malignant cells in the ascites or peritoneal washings.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Tumour involves one or both ovaries with pelvic extension (below the pelvic brim) or primary peritoneal cancer</td>
</tr>
<tr>
<td>2a</td>
<td>Extension and/or implant on uterus and/or Fallopian tubes</td>
</tr>
<tr>
<td>2b</td>
<td>Extension to other pelvic intraperitoneal tissues</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Tumour involves one or both ovaries with cytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis to the retroperitoneal lymph nodes</td>
</tr>
<tr>
<td>3a</td>
<td>Positive retroperitoneal lymph nodes and/or microscopic metastasis beyond the pelvis.</td>
</tr>
<tr>
<td>3a1</td>
<td>Positive retroperitoneal lymph nodes only</td>
</tr>
</tbody>
</table>
### Stage 3

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a2</td>
<td>Microscopic, extrapelvic (above the brim) peritoneal involvement ± positive retroperitoneal lymph nodes</td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>Macroscopic, extrapelvic, peritoneal metastasis ≤ 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.</td>
<td>Tumour deposits &lt; 2 cm on organ surfaces</td>
</tr>
<tr>
<td>3c</td>
<td>Macroscopic, extrapelvic, peritoneal metastasis &gt; 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.</td>
<td>Tumour deposits &gt; 2 cm and/or spread to local lymph nodes.</td>
</tr>
</tbody>
</table>

### Stage 4

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a</td>
<td>Pleural effusion with positive cytology</td>
<td>Distant solid organ metastases (e.g. intra-hepatic).</td>
</tr>
<tr>
<td>4b</td>
<td>Hepatic and/or splenic parenchymal metastasis, metastasis to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity)</td>
<td></td>
</tr>
</tbody>
</table>

### Related Data Items:

- Not applicable
- Not recorded

### Notes by Users:

- Data Definitions for the National Minimum Core Dataset for Ovarian Cancer.
  - Developed by ISD Scotland, 2013
  - Page 45
Section 5: Oncological Treatment
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)

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

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

Field Name: SACT1
           SACT2
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 7, 9, 12

Patients may have ongoing SACT both before and after surgery. These patients should be recorded under neo-adjuvant Type. If a patient is prescribed 6 cycles and then after 3 cycles is deemed appropriate for surgery and recommences the last 3 cycles following their surgery this would be considered one treatment package.

Some patients may have separate completion SACT post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

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

If the patient’s type of first treatment was ‘supportive care only’, then subsequently proceeds to active treatment at a later date, only record if systemic therapy occurs within 6-months of diagnosis.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to definitive surgery to reduce tumour size, even when there is intent for surgery but no surgery is done.</td>
</tr>
<tr>
<td>02</td>
<td>Adjuvant</td>
<td>The start of adjuvant SACT is after the date of the first surgery where there is no overt evidence of remaining disease.</td>
</tr>
<tr>
<td>04</td>
<td>Palliative/Primary</td>
<td>Primary systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis</td>
</tr>
<tr>
<td>05</td>
<td>Hormone Therapy</td>
<td>Letrozole would be used on relapsed and low grade tumours</td>
</tr>
<tr>
<td>93</td>
<td>SACT contraindicated in patient</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. not given as part of primary therapy</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)
Systemic Therapy Agent (Epithelial Ovarian Cancer) (1-2)

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

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

Field Name: SACTAGENT1
Field Name: SACTAGENT2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 9

Chemotherapy drugs can be given in or outwith the context of a clinical trial. Where chemotherapy is given within the context of a clinical trial, please check with oncology colleagues to ensure the regimen is recorded accurately.

Up to two courses may be recorded, i.e. neo-adjuvant and adjuvant therapies.

All treatments given as part of the initial treatment plan plus second-line treatment received within six months of diagnosis should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Paclitaxel in combination with platinum based compound</td>
</tr>
<tr>
<td>02</td>
<td>Carboplatin single agent</td>
</tr>
<tr>
<td>03</td>
<td>Other SACT agent</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined SACT treatment</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>98</td>
<td>Other</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Item(s):
**Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)**

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

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

**Field Name:** SACTDATE1  
SACTDATE2

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

**Field length:** 10

**Notes for Users:**

This is the first dose of the first cycle of a course of SACT.

If the patient’s type of first treatment was ‘supportive care only’, then subsequently proceeds to active treatment at a later date, only record if systemic therapy occurs within 6-months of diagnosis.

If the date of SACT treatment started is not known or not documented, record as 09/09/1900 (Not recorded).

If SACT treatment is not carried out, record (10/10/1900) (Not applicable).

**Related Data Items(s):**

- Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)
- Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
- Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)

**Notes by Users:**
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)

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

Definition: The date cancer treatment course ended.

Field Name: SACTENDATE1  
            SACTENDATE2
Field Type: Date (DD/MM/CCYY).
Field length: 10

Notes for Users: Required for QPI: 12

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

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

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

If the date treatment started is unknown, or patient is receiving maintenance end date should be recorded as 09/09/1900 (not recorded).

Related Data Item(s):
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)

Notes by Users:
Section 6: Genetics
Genetic Testing

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

Definition: This denotes whether the patient undergoes genetic testing following diagnosis.

Field Name: GENTEST
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 11

This should be documented in genetic referral letters or clinic letters (surgical or oncology), reported at the MDT meeting, or recorded within clinical management systems.

Genetic testing can be undertaking within the oncology clinic or arranged via referral to a specialist genetics service.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>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>
Section 7: 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 Information Services.

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

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

**Notes for Users:**
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>01</td>
<td>Yes</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**

**Notes by Users:**
Section 8: Death Details
Date of Death

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

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

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

Notes for Users: Required for QPI: 12

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

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

Codes and Values: N/A

Related Data Items:

Notes by Users: