Prostate Cancer

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

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

Version 4.5: February 2022

To be used in conjunction with:

1. Prostate Cancer Clinical Quality Performance Indicators V4.0
2. Prostate Cancer QPI Dataset Validations (latest published version)
3. Prostate Cancer Measurability of Quality Performance Indicators (latest published version)
## DOCUMENT CONTROL SHEET

### Key Information

<table>
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<td>February 2022</td>
</tr>
<tr>
<td>Date Effective From</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; July 2019 (Please see Notes for Implementation of Changes)</td>
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<td>V4.5</td>
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<td>NHS staff involved in implementing and recording Prostate Cancer Quality Performance Indicators.</td>
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| Cross References                                                    | Prostate Cancer Quality Performance Indicators  
Prostate Cancer Measurability of Quality Performance Indicators   |
| Author                                                              | Public Health Scotland (PHS)                                                                          |

### Revision History

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PREFACE

Following the completion of the Scottish Urological Cancer Audit (SUCA) in 2004 and as a requirement of the Cancer in Scotland: Action for Change, a national urological cancer data set was developed by ISD in collaboration with the three cancer networks.

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 and the accompanying measurability document were agreed in public engagement and are now ready for implementation for patients diagnosed from 1st July 2012.

Prostate Cancer QPI Development Group Subgroup Lead Clinicians
Mr Sudhir Borganokar, Consultant Urologist, NHS Highland
Mr Prasad Bollina, Consultant Urologist, NHS Lothian
Dr Phyllis Windsor, Consultant Clinical Oncologist, NHS Tayside
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with prostate cancer on or after 1st July 2019, who are eligible for inclusion in the prostate cancer audit.

NB: Dataset applies for data reported within the 2019-2020 reporting cohort. This may include some data for patients diagnosed from 1st July 2018, where required for QPIs reported a year in arrears. This applies to the following data items:

MRI Scan (Surveillance) – MPMRISURV
Date of MRI Scan (Surveillance – MPDATESURV
TRUS Re-biopsy - REBIOPSY
PROMs Tool Provided (Post-operative) - POSTOPSENT
PROMs Tool Returned (Post-operative) - POSTOPRETURN
Urinary Incontinence Domain Summary Score (Post-operative) - URINEPOST

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
REVISIONS TO DATASET

Revisions to Dataset Changes Outwith Review (February 2022)

Database Specification

CHI Number – ‘Field Type’ changed from ‘Integer’ to ‘Characters’.

Dataset

CHI Number – ‘Field Type’ changed from ‘Integer’ to ‘Characters’.

Revisions to Dataset Changes Outwith Review (June 2021)

Dataset

Type of Specimen for Histological Diagnosis {Prostate Cancer} – Codes & Values add code ‘5 Transperineal biopsy’. (Changes apply from 1/7/2020)

Type of Surgery – remove “e.g. Nerve Sparing” from the note for Value 2 – Conservative.

MRI Scan (Surveillance) – add “Includes patients who have had radical treatment and are no longer under active surveillance” to explanatory notes for Value 96 – Not applicable.

Date of Referral Notes for users updates to include table for guidance.

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

Burden of Metastatic Disease – change ‘<4 metastases or ≥4 metastases with none outside the vertebral bodies or pelvis, or visceral metastases’ to ‘<4 metastases or ≥4 metastases with none outside the vertebral bodies or pelvis, and no visceral metastases’; add ‘e.g. no metastases’ against 96, not applicable in the Codes and Values table.

Definitive Operative Procedure {Prostate Cancer} – add ‘Where OPCS codes have been recorded in the patient notes by the surgeon, this code should be used. Where no OPCS code has been recorded, the table below should be used. For queries or issues regarding recording OPCS please contact phs.terminologyhelp@phs.scot’
Revisions to Dataset Changes Following NCQSG meeting (October 2020)

Dataset

Operating Consultant Surgeon (1-2) Notes for Users - Replace text ‘If two consultant surgeons share an operation each operating surgeon code should be recorded.’ with 'If two consultant surgeons share an operation the lead surgeon should be recorded as Operating Consultant Surgeon (1) and the other as Operating Consultant Surgeon (2).'

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 July 2019

Revisions to Dataset Changes Following Formal Review (February 2020)

Notes for Implementation of Changes – data items updated

Database Specification

Date Prostate Biopsy - add new Data item, Field Name: BIOPDATE, Field Type Date (DD/MM/CCYY), Field Length 10

Likert Grading - add new Data item, Field Name: LIKERT, Field Type: Characters, Field Length 2

Burden of Metastatic Disease - add new Data item, Field Name: BURDEN, Field Type: Characters, Field Length 2

Location Code (Radiotherapy Treatment) - add new data item, Field Name: HOSPRADIO, Field Type: Characters, Field Length 5

Radiotherapy for Low Metastatic Burden - add new data item, Field Name: RADIOMETS, Field Type: Integer, Field length 2
**Location Code (SACT Treatment)** - add new data item, Field Name HOSPSACT, Field Type Characters, Field Length 5

**Androgen Receptor Targeted Agent (ARTA)** - add new data item, Field Name ARTA, Field Type Integer, Field length 2

**PROMs Tool Provided (pre-operative)** - add new data item, Field Name PREOPSENT, Field Type Characters, Field Length 2

**PROMs Tool Returned (pre-operative)** add new data item, Field Name PREOPRETURN, Field Type Characters, Field Length 2

**PROMs Tool Provided (post-operative)** - add new data item, Field Name POSTOPSENT, Field Type Characters, Field Length 2

**PROMs Tool Returned (post-operative)** - add new data item, Field Name POSTOPRETURN, Field Type Characters, Field Length 2

**Urinary Incontinence Domain Summary Score (Pre-operative)** - add new data item Field Name URINEPRE, Field Type Integer (nnn), Field Length 3

**Urinary Incontinence Domain Summary Score (Post-operative)** - add new data item, Field Name URINEPOST, Field Type Integer (nnn), Field Length 3

**Post-Surgical Continence at One Year** - remove data item

**Dataset**

**Type of Specimen for Histological Diagnosis (Prostate Cancer)** - Notes for Users Required for QPI(s) remove ‘1, 3’; Codes and values table add code ‘4’ - Laser enucleation of the Prostate.

**Date Prostate Biopsy** - add new Data item.

**TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)** - Notes for Users Required for QPI(s) remove ‘1’, add ‘14, 15’.

**TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)** - Notes for Users Required for QPI(s) remove ‘1’, add ‘14, 15’.

**TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)** - Notes for Users Required for QPI(s) remove ‘1’, add ‘14, 15’.

**Date First Discussed by Care Team** - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

**Date of Diagnosis** - Notes for Users amend 09/09/0909 to 09/09/1900

**Date of First Cancer Treatment** - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.
Date of Definitive Treatment {Prostate Cancer} - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Multiparametric MRI Scan (Diagnostic) - Heading remove ‘Multiparametric’, Definition remove ‘Multiparametric’, (mpMRI), add (multiparametric or biparametric), Notes for Users remove ‘additional information’, amend ‘1’ to ‘14’, add ‘This can be either a multiparametric MRI (mpMRI) or biparametric MRI (bpMRI)’, remove ‘Multiparametric’, add ‘Where there is no evidence that a MRI (biparametric or multiparametric) has been undertaken, record as ‘2’ (No)’. Codes and Values table remove code ‘1 Yes’, ‘99 Not recorded’ add code ‘4 Yes – multiparametric’ and ‘5 Yes – biparametric’, amend code 95 ‘multiparametric MRI’ to ‘mpMRI or bpMRI’, add explanatory note to code 2 ‘Includes Not known’

Date of Multiparametric MRI Scan (Diagnosis) - Heading remove ‘Multiparametric’, Definition add ‘or biparametric MRI (bpMRI)’, Notes for Users remove ‘as additional information’, amend ‘1’ to ‘14’, amend ‘Multiparametric MRI’ to ‘mpMRI or bpMRI’, amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900, add ‘or bpMRI’. Related Data Item(s) remove ‘Multiparametric’

Likert Grading add new Data item.

Burden of Metastatic Disease add new Data item.

Location Code {Cancer Surgery} - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded.’

Definitive Operative Procedure {Prostate Cancer} - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’

Type of Surgery - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’

Surgical Procedure Approach - Notes for Users remove ‘active treatment’, ‘record if surgery occurs within six months of diagnosis’, add ‘radical prostatectomy’, ‘this should be recorded’.

Date of Definitive Surgery - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’, amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Operating Consultant Surgeon (1-2) Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Number of Needle Cores Received (Right-Left) - Notes for Users remove ‘Required for QPI(s): 1, 3’
Number of Needle Cores Received (Targeted) - Notes for Users remove ‘Required for QPI: 3’

Transurethral Resection of Prostate (TURP) Weight - Notes for Users remove ‘Required for QPI: 3’

Prostate Specimen Tumour Type Notes for Users remove ‘Required for QPI: 3’

Number of Needle Cores Involved (Right-Left) Notes for Users remove ‘Required for QPI: 3’

Total Percentage of Tumour Involvement in Needle Core Notes for Users remove ‘Required for QPI: 3’

Greatest Percentage of Tumour Involvement in Needle Core - Notes for Users remove ‘Required for QPI: 3’

Adipose Tissue Invasion Seen - Notes for Users remove ‘Required for QPI: 3’

Perineural Invasion Seen - Notes for Users remove ‘Required for QPI: 3’

Primary Gleason Grade (Needle Biopsy) Notes for Users remove ‘Required for QPI: 3’

Secondary Gleason Grade (Needle Biopsy) Notes for Users remove ‘Required for QPI: 3’

Gleason Total Score (Needle Biopsy) Notes for Users remove Required for QPI: ‘3’

Primary Gleason Grade (Pathology) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Secondary Gleason Grade (Pathology) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Tertiary Gleason Grade (Pathology) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Gleason Total Score (Pathology) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

TNM Tumour Classification (Pathology) (Prostate) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.
TNM Nodal Classification (Pathology) (Prostate) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

TNM Metastasis Classification (Pathological) (Prostate) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Margin Status (Prostatectomy) - Notes for Users add ‘If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded’.

Location Code {Radiotherapy Treatment} - add new data item

Date Treatment Started (External Beam Radiotherapy) - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Date Treatment Completed (External Beam Radiotherapy) - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Radiotherapy for Low Metastatic Burden add new data item

Date Treatment Started (Brachytherapy) Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Date Treatment Started (Hormone Therapy) - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Location Code {SACT Treatment} - add new data item

Date Treatment Started (Chemotherapy) - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Date Treatment Completed (Chemotherapy) - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

Androgen Receptor Targeted Agent (ARTA) - add new data item

PROMs Tool Provided (pre-operative) - add new data item

PROMs Tool Returned (pre-operative) - add new data item

PROMs Tool Provided (post-operative) - add new data item

PROMs Tool Returned (post-operative) - add new data item

Urinary Incontinence Domain Summary Score (Pre-operative) - add new data item

Urinary Incontinence Domain Summary Score (Post-operative) - add new data item
**Multiparametric MRI Scan (Surveillance)** - Heading remove ‘Multiparametric’, definition remove ‘multiparametric’, ‘(mpMRI)’, add ‘(multiparametric or biparametric)’, Notes for Users add ‘This can be either a multiparametric MRI (mpMRI) or biparametric MRI (bpMRI) and’, ‘This should be undertaken between 12-18 months following diagnosis’, remove “multiparametric”, ‘(mpMRI)’, ‘Note this may be the same as Multiparametric MRI Scan (Diagnostic)’; add Where there is no evidence that a MRI (biparametric or multiparametric) has been undertaken, record as ’2’ (No), remove ‘If MRI investigation is not documented record as 99 (Not recorded). ‘Codes and Values table remove code ‘1 Yes’, add code ‘4 Yes – multiparametric’, code ‘5 Yes – biparametric’, amend code 95 ‘multiparametric MRI’ to ‘mpMRI or bpMRI’, remove code 99 Not known, add explanatory note to code 2 ‘Includes not known’. footer add ‘NB: See note pii – Notes of Implementation of Changes’.

**Date of Multiparametric MRI Scan (Surveillance)** - Heading remove ‘Multiparametric’, definition add ‘or biparametric MRI (bpMRI)’, Notes for Users remove ‘Multiparametric MRI’, add ‘mpMRI or bpMRI’, remove ‘Note this may be the same as the Date of Multiparametric MRI Scan (Diagnostic)’, add ‘This should be undertaken between 12-18 months following diagnosis’, amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900, add ‘or bpMRI’. footer add ‘NB: See note pii – Notes of Implementation of Changes’

**Post-Surgical Continence at One Year** - remove data item

**TRUS Re-biopsy** - Notes for Users remove ‘Required for QPI:11’, footer add ‘NB: See note pii – Notes of Implementation of Changes’

**Date of TRUS Re-biopsy** - Notes for Users remove ‘Required for QPI:11’, footer add ‘NB: See note pii – Notes of Implementation of Changes.’

**Date of Death** - Notes for Users amend 09/09/0909 to 09/09/1900, 10/10/1010 to 10/10/1900.

**Revisions to Dataset Changes Outwith Review (November 2019)**

Changes apply from 1/7/2018

**Date of First Cancer Treatment** – Notes for Users amend to ‘If type of first cancer treatment is ‘no active treatment including supportive care, watchful waiting or active surveillance’, 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.

**Date of Definitive Treatment [Prostate Cancer]** – Notes for Users add ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.’

**Revisions to Dataset Changes Outwith Review (July 2018)**

**Database Specification**

*Data Definitions for the National Minimum Core Dataset for Prostate Cancer. Developed by ISD Scotland, 2013 Page xi*
Transurethral Resection of Prostate (TURP) Weight - Field name changed from TURPW to TURPWT

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

TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment) - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017;
Explanatory notes T1 change ‘Clinically inapparent tumour not palpable or visible by imaging’ to ‘Clinically inapparent tumour that is not palpable’;
T2 change ‘Tumour confined within prostate’ to ‘Tumour that is palpable and confined within prostate’
T3 change ‘Extra capsular extension to Extraprostatic extension; Tumour that is palpable and confined within prostate’
T4 change or pelvic wall to and/or pelvic wall; Add ‘Invasion into the prostatic apex or into (but not beyond) the prostatic capsule is not classified as T3, but as T2’

TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment) - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017;

TNM Metastases Classification (Clinical) (Prostate) (Pre-treatment) - Standard and Definition changed from Seventh Edition, 2009 to Eighth Edition 2017;

Notes for Users add ‘or subcategories of pT2
Explanatory Notes pT2 add ‘that is palpable and’ delete ‘* Tumour found in one or both lobes by needle biopsy but not palpable or visible by imaging, is classified as T1c’; delete ‘subcategories of pT2; pT3a change ‘Extracapsular’ to ‘Extraprostatic’; pT4 change ‘or pelvic wall’ to ‘and/or pelvic wall’

TNM Nodal Classification (Pathological) (Prostate) - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017

TNM Metastases Classification (Pathological) (Prostate) - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017

Revisions to Dataset Outwith Review (February 2017)

Document Control Sheet – inserted ‘(see note)’ within Date effective from, linking to the added note in Notes for Implementation of Changes
Notes for Implementation of Changes - inserted the following note with links to data items:

NB: Dataset applies for data reported within the 2016-2017 reporting cohort. This may include some data for patients diagnosed from 1st July 2015, where Required for QPIs reported a year in arrears. This applies to the following data items:

Multiparametric MRI Scan (Surveillance) – MPMRISURV
Date of Multiparametric MRI Scan (Surveillance) – MPDATESURV
TRUS Re-biopsy – REBIOPSY
Date of TRUS Re-biopsy - REBIODATE
Post-Surgical Continence at One Year – CONTINENT

Each data item listed above has the following text added with a link to the added note in Notes for Implementation of Changes:

NB: See note pii – Notes of Implementation of Changes

Total Percentage of Tumour Involvement in Needle Core – Notes for Users add ‘Percentage involvement may be expressed as a total for all cores received or as separate totals for left and right-sided cores’

Revisions to Dataset Following Formal Review (November 2016)

Imaging Investigations Complete - Notes for Users Required for QPI replace ‘3’ with ‘2’.

Prostate Specific Antigen at Diagnosis {Prostate Cancer} – Codes and Values table Intermediate Risk Explanatory Note delete ‘or T2c’
High Risk Explanatory Note add ‘≥T2c’ and delete ‘T3-T4’.

Type of Specimen for Histological Diagnosis (Prostate Cancer) - Codes and Value table add ‘3/ Transrectal Ultrasound Guided Biopsy (mpMRI fusion biopsy)/Targeted TRUS biopsy using images from mpMRI scan’

Codes and Values Tables add T3a ‘including microscopic bladder neck involvement’ to explanatory notes. T4 remove text ‘bladder neck’.
Intermediate Risk Explanatory Note: delete ‘or T2c’.
High Risk Explanatory Note: add ‘≥T2c’ and delete ‘T3-T4’.


Date First Discussed by care Team (MDT) - Notes for Users Required for QPIs add ‘(s)’.
Type of First Cancer Treatment - Notes for Users Required for QPI replace ‘7’ with ‘4’ and ‘11’.

Date of First Cancer Treatment - Notes for Users remove Required for QPI ‘7’

Date of Definitive Treatment [Prostate Cancer] - Notes for Users Required for QPI replace ‘3’ with ‘4’.

Multiparametric MRI Scan (Diagnostic) – add new data item

Date of Multiparametric MRI Scan (Diagnostic) – add new data item

Type of Surgery - Notes for Users Required for QPIs replace ‘5’ and ‘6’ with ‘2’.

Surgical Procedure Approach - Notes for Users add ‘Required for national comparative analysis’.

Date of Definitive Surgery - Notes for Users Required for QPIs add ‘8’ and delete ‘1’ and ‘3’

Number of Needle Cores Received (Right-Left) – Definition add the word ‘standard’.

Number of Needle Cores Received (Targeted) – add new data item

Transurethral Resection of Prostate - Notes for Users Required for QPI add ‘(s)’

Number of Needle Cores Involved (Right-Left) – Definition replace ‘received by the pathologist’ with ‘involved’

Primary Gleason Grade (Needle Biopsy) - Notes for Users Required for QPI replace ‘2’ with ‘3’

Secondary Gleason Grade (Needle Biopsy) - Notes for Users Required for QPI replace ‘2’ with ‘3’

Gleason Total Score (Needle Biopsy) - Intermediate Risk Explanatory Note delete ‘or T2c’. High Risk Explanatory Note add ‘≥T2c’ and delete ‘T3-T4’.

  pT3a: add ')' including microscopic bladder neck involvement'.
  pT4: remove ‘bladder neck’


TNM Metastasis Classification (Pathological) (Prostate) - Replace sixth edition 2002 with seventh edition 2009. Notes for Users: add ‘If no distant metastasis are
present record as ‘not applicable’. Codes and Values table delete pM0, pM1a, pM1b, pM1c and pMx. pM1 and replace ‘present’ with ‘microscopically confirmed’.

**External Beam Radiotherapy Course** - Notes for Users add Required for QPI ‘2,’

**Date Treatment Started (External Beam Radiotherapy)** - Notes for Users delete Required for QPI ‘8’

**Date Treatment Completed (External Beam Radiotherapy)** - Notes for Users add Required for QPI ‘8’ and delete ‘Data to support reporting of QPIs 8 and 9 will not be required to be collected in all Boards in year 1 of implementation as these QPIs will be piloted in some Boards and subsequently reviewed’.

**Date Treatment Started (Brachytherapy)** - Notes for Users add Required for QPI ‘2’ & Delete ‘Data to support reporting of QPI 8 and 9 will not be required to be collected in all Boards in year 1 of implementation as these QPIs will be piloted in some Boards and subsequently reviewed’

**Section 7: Chemotherapy** - New section inserted

**Chemotherapy Agent (Prostate Cancer)** - add new data item

**Date Treatment Started (Chemotherapy)** – add new data item

**Date Treatment Completed (Chemotherapy)** – add new data item

**Section 8: Clinical Trials** – was section 7

**Section 9: Follow-up and Death Details** – was section 8

**Multiparametric MRI Scan (Surveillance)** – add new data item

**Date of Multiparametric MRI Scan (Surveillance)** – add new data item

**Post-Surgical Continence at One Year** - Definition add ‘using a validated tool’*. Notes for Users add ‘**Validated tools appropriate for this measurement would be: The Expanded Prostate Cancer Index Composite (EPIC) Urinary Assessment Incontinence Questionnaire (ICIQ)**’ Codes and values table: code 3 value replace with ‘≥2 pads per day’ & Delete code 4.

**TRUS Re-biopsy** – add new data item

**Date of TRUS Re-biopsy** – add new data item

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

**Prostate Specimen Tumour Type** – Codes and Values table remove the following tumour types from explanatory notes under ‘code 98’: Adenosquamous, Basaloid, Adenoid Cystic, Neuroendocrine, Transitional cell update Location of Diagnosis – add ‘X9999=Not recorded’
Revisions to Dataset Following Baseline Review (March 2015)

Date Treatment Started (Hormone Therapy) – Notes for Users add 'Immediate therapy would be within 31 days of the patient being discussed at MDT meeting'

Definitive Operative Procedure {Prostate Cancer} – Codes and Values table remove the word ‘Bilateral’

Revisions to Dataset Following Baseline Review (November 2014)

Database Specification

Definitive Operative Procedure {Prostate Cancer} - Change 'OPCODE' to 'OPCODE1' and Add 'OPCODE2'

Dataset

Definitive Operative Procedure {Prostate Cancer} – Field Name - change 'OPCODE' to 'OPCODE1 and Add 'OPCODE2'

Definitive Operative Procedure {Prostate Cancer} - Note for Users remove 'If an operation to relieve symptoms and a further operation which aims to remove the tumour is performed the second operation is the one that should be coded in this field.'

'If any operation is not listed then please contact Public Health Scotland as described elsewhere so that standard codes can be allocated throughout Scotland.'

'If any operation is not listed then please contact PHS to obtain coding details before entering details to the local database.

e.g.
M02.1 = Nephrectomy and excision of perirenal tissue
M61.1 = Total excision of prostate and capsule of prostate
N06.3 = Orchidectomy nec
T87.7 = Excision or biopsy of inguinal lymph node.'
add 'OPCODE 2 for lymphadenectomy. For example - a patient undergoing a laparoscopic radical prostatectomy with lymphadenectomy would be coded as follows: OPCODE1 = M61.1, OPCODE2 = T87.8 and SURGAPPR = 2A'
Explanatory notes add ‘Radical prostatectomy’ to code M61.1 Total excision of prostate and capsule of prostate

Revisions to Dataset Following Change Outwith Review (July 2014)

Database Specification

Date of Definitive Treatment – add new data item

Dataset

Adipose Tissue Invasion Seen - Notes for Users add ‘extraprostatic extension’ made at the request of the Scottish Urology Pathology Group.

Date of Definitive Treatment – add new data Item

Gleason Total Score (Needle Biopsy) - Notes for Users add ‘The purpose of the guidance to record this data item as 'Not recorded' is to measure when it has been omitted on the Scottish Prostate Needle Biopsy Dataset (as required by QPI 3)’

TNM Nodal Classification (Pathological) (Prostate) - Notes for Users remove ‘Metastasis no larger than 0.2 cm can be designated pN1mi’

Revisions to Dataset Following 9-Month Review (December 2013 & January 2014)

The following changes have been made following the review of Prostate Cancer Data Definitions for the National Minimum Core Data Set. Changes to take effect for patients diagnosed from 01/07/2014.

Criteria For Inclusion of Patients in Audit -

Inclusion criteria removed:

• ‘All patients who have received any part of their diagnosis / treatment within the NHS even if part of their treatment was carried out privately or outwith Scotland.’
• ‘All patients aged 16 years and over’

Exclusion criteria added:

• ‘Patients with metastatic prostatic disease from another primary cancer site’
• ‘Patients with tumour type sarcoma or lymphoma’
• ‘Patients with carcinoma in situ or prostatic intraepithelial neoplasia’
• ‘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’
• ‘Patients with normal residence outwith Scotland’
• ‘Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland’

Exclusion criteria removed:

• ‘Patients with prostate sarcomas’
• ‘Death Certificate Only (DCO) cases’
• ‘All patients under 16 years of age’
• ‘Carcinoma in-situ’
• ‘Prostatic Intraepithelial Neoplasia (PIN)’

Database Specification

Primary Gleason Grade (Pathology) – add new data item

Secondary Gleason Grade (Pathology) - add new data item

Tertiary Gleason Grade (Pathology) – add new data item

Gleason Total Score (Pathology) – add new data item

Primary Gleason Grade – renamed to Primary Gleason Grade (Needle Biopsy)

Secondary Gleason Grade - renamed to Secondary Gleason Grade (Needle Biopsy)

Gleason Total Score - renamed to Gleason Total Score (Needle Biopsy)

Dataset

Primary Gleason Grade (Pathology) – add new data item Field Name: MAJGGRADEPATH, Field Type: Integer, Field Length: 2.

Secondary Gleason Grade (Pathology) – add new data item Field Name: MINGGRADEPATH, Field Type: Integer, Field Length: 2.

Tertiary Gleason Grade (Pathology) - add new data item: Field Name: TERTGGRADEPATH, Field Type: Integer, Field Length: 2.

Gleason Total Score (Pathology) – add new data item: Field Name: GTOTALPATH, Field Type: Integer, Field Length: 2.

Imaging Investigations Complete – Notes for Users updated to reflect changes to QPI numbering and add note to state that ‘pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting’

Imaging Investigations Complete – Codes and Values tables amend ‘99 Not known’ to ‘99: Not recorded’

Prostate Specific Antigen at Diagnosis – Notes for Users update QPI references to reflect new QPI number specification & Amended note to state that ‘1010101.0’ is ‘not applicable’.

Type of Specimen for Histological Diagnosis – Codes and Values table amend ‘99 Not known’ to ‘99 Not recorded’.

TNM Tumour Classification (Clinical) (Prostate) – Notes for Users update QPI references to reflect new QPI number specification
Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.’

Notes for users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

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

Notes for Users add ‘to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.

**TNM Tumour Classification (Clinical) (Prostate)** - Codes and Values table add ‘96: Not applicable’ and amend ‘99 Not known’ to ‘99 Not recorded’

**TNM Nodal Classification (Clinical) (Prostate)** – Notes for Users update QPI references to reflect new QPI number specification

Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.’

Notes for Users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

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

Notes for users add ‘to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.

**TNM Nodal Classification (Clinical) (Prostate)** – Codes and Values table add ‘96 Not applicable’ and amended code ‘99 Not known’ to ‘99 Not recorded’

**TNM Metastasis Classification (Clinical) (Prostate)** - Notes for Users update QPI references to reflect new QPI number specification

Notes for Users add ‘Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.’
Notes for Users add ‘In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.’

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

Notes for users updated to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.

**TNM Metastasis Classification (Clinical) (Prostate)** – Codes and Values table add ‘96: Not applicable’ and amend ‘99 Not known’ to ‘99 Not recorded’

**Date First Discussed by care Team (MDT)** – Notes for Users update QPI references to reflect new QPI number specification and amend ‘inapplicable 10/10/1010’ is now ‘Not applicable 10/10/1010’.

**Most Valid Basis of Diagnosis** – Codes and Values table amend ’99 Not known’ to ‘99 Not recorded’

**Type of First Cancer Treatment** - Notes for Users update QPI references to reflect new QPI number specification

**Type of First Cancer Treatment** - Codes and Values table amend ‘99 Not known’ to ‘99 Not recorded’

**Date of First Cancer Treatment** - Notes for Users update QPI references to reflect new QPI number specification

**Location Code {Cancer Surgery}** – Notes for Users amend ‘Inapplicable X1010’ to ‘Not applicable X1010’ and remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’

**Definitive Operative Procedure {Prostate Cancer}** - Notes for Users update QPI references to reflect new QPI number specification and update ‘Inapplicable 96’ to ‘Not applicable 96’ and remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’.

**Definitive Operative Procedure {Prostate Cancer}** – Codes and Values table add M34.1: Cystoprostatectomy’ M61.1: Total excision of prostate and capsule of prostate’ M61.4: Perineal prostatectomy’ and remove code ‘M61.3: Transvesical prostatectomy’ as this is not a radical treatment for cancer. Correct code ‘M61.8: Other specified open excision of prostate’ Amend code ‘99: Not known’ to ‘99: Not recorded’ and amend code ‘96: Inapplicable’ to ’96: Not applicable’

**Type of Surgery** – Notes for Users update QPI references to reflect new QPI number specification and remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’
Type of Surgery – Codes and Values table amend ‘99 Not known’ to ‘99 Not recorded’.

Surgical Procedure Approach – Main Source of Data Item remove reference to ‘National Clinical Dataset Development Programme (NCDDP)’

Surgical Procedure Approach - Notes for Users remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’

Surgical Procedure Approach – Codes and Values table amend ‘99 Not known’ to ‘99 Not recorded’

Date of Definitive Surgery – Notes for Users amend ‘10/10/1010 (Inapplicable) to ‘10/10/1010 (Not applicable)’ and remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’

Operating Consultant Surgeon (1-2) – Notes for Users update QPI references to reflect new QPI number specification, amend ‘Inapplicable (1010)’ to ‘Not applicable (1010)’ and remove ‘Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI’

Prostate Specimen Tumour Type – Codes and Values table remove ‘3 High Grade Prostatic Intraepithelial Neoplasia’ and amended ‘99 Not known’ to ‘99 Not recorded’

Total Percentage of Tumour Involvement in Needle Core – Notes for Users amend ‘999 Not known’ to ‘999 Not recorded’.

Greatest Percentage of Tumour Involvement in Needle Core – Notes for Users amend ‘999 Not known’ to ‘999 Not recorded’.

Adipose Tissue Invasion Seen – Codes and Values table amended ‘99 Not known’ to ’99 Not recorded’

Perineural Invasion Seen – Codes and Values table amend ’99 Not known’ to ’99 Not recorded’

Primary Gleason Grade (Biopsy) - Data item renamed from ‘Primary Gleason Grade’ to ‘Primary Gleason Grade (Biopsy)’.

Primary Gleason Grade (Biopsy) – Amend Definition to clarify that this data item is for needle biopsy specimens.

Primary Gleason Grade (Biopsy) - Notes for Users remove ‘For all radical prostatectomy specimens, record the most prevalent pattern for each tumour.’ and update related Data Items to reflect changes made elsewhere in dataset.

Secondary Gleason Grade – Rename Data Item from ‘Secondary Gleason Grade’ to ‘Secondary Gleason Grade (Needle Biopsy)’.
Secondary Gleason Grade – Amend definition to clarify that this data item is for needle biopsy specimens.

Secondary Gleason Grade – Notes for Users Remove ‘There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded’ and update related Data Items to reflect changes made elsewhere in dataset.

Gleason Total Score – Rename Data item from ‘Gleason Total Score’ to ‘Gleason Total Score (Needle Biopsy)’.

Gleason Total Score - Amend definition to clarify that this data item is for needle biopsy specimens.

Gleason Total Score – Amend Notes for Users ‘Not known (99)’ to Not recorded (99).
Amend ‘If there is a tertiary grade (of higher Gleason score than the primary or secondary grade), the total Gleason score is derived from the sum of the primary (major) and tertiary Gleason grades, remove ‘Exceptions for Radical Prostatectomies: Gleason score by prevalence and the presence of a tertiary grade’ and update Related Data Items to reflect changes made elsewhere in dataset.

Primary Gleason Grade (Pathology) – add new data item

Secondary Gleason Grade (Pathology) – add new data item

Tertiary Gleason Grade (Pathology) – add new data item

Gleason Total Score (Pathology) – add new data item

TNM Tumour Classification (Pathological) (Prostate) – Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amend code ‘99 Not known’ to ‘99 Not recorded’.

TNM Nodal Classification (Pathological) (Prostate) – Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amend code ‘99 Not known’ to ‘99 Not recorded’.

TNM Metastasis Classification (Pathological) (Prostate) – Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amend code ‘99 Not known’ to ‘99 Not recorded’.

Margin Status (Prostatectomy) - Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amended code ‘99 Not known’ to ‘99 Not recorded’.

External Beam Radiotherapy Course Type - Notes for Users update QPI references to reflect new QPI number specification. Amend ‘Main Source of Data Item Standard’ to remove reference to ‘National Clinical Dataset Development
Date Treatment Started (External Beam Radiotherapy) – Notes for Users Update QPI references to reflect new QPI number specification and amend ‘Inapplicable (10/10/1010)’ to ‘Not applicable (10/10/1010)’. Main Source of Data Item Standard remove reference to ‘National Clinical Dataset Development Programme (NCDDP).

Date Treatment Completed (External Beam Radiotherapy) – Notes for Users Update QPI references to reflect new QPI number specification and amend ‘Inapplicable (10/10/1010)’ to ‘Not applicable (10/10/1010)’. Main Source of Data Item Standard remove reference to ‘National Clinical Dataset Development Programme (NCDDP).

Date Treatment Started (Brachytherapy) – Notes for Users Update QPI references to reflect new QPI number specification and amend ‘Inapplicable (10/10/1010)’ to ‘Not applicable (10/10/1010)’. Main Source of Data Item Standard remove reference to ‘National Clinical Dataset Development Programme (NCDDP).

Type of Hormone Therapy – Notes for Users Update QPI references to reflect new QPI number specification and amend ‘Inapplicable (96)’ to ‘Not applicable (96)’. Main Source of Data Item Standard remove reference to ‘National Clinical Dataset Development Programme (NCDDP). Codes and Values table amend code ‘96: Inapplicable to ‘99: Not applicable’.

Date Treatment Started (Hormone Therapy) – Notes for Users Update QPI references to reflect new QPI number specification and amend ‘Inapplicable (10/10/1010)’ to ‘Not applicable (10/10/1010)’. Main Source of Data Item Standard remove reference to ‘National Clinical Dataset Development Programme (NCDDP).

Hormonal Therapy Agent {Prostate Cancer} – Notes for Users update QPI references to reflect new QPI number specification, add: ‘If more than one hormone therapy agent is administered, record the main agent’. Codes and Values table amend ‘99 Not known’ to ‘99 Not recorded’.

Patient Entered into Clinical Trial {Prostate Cancer} – Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amended code ‘99 Not known’ to ‘99 Not recorded’.

Post-Surgical Continence at One Year – Notes for Users update QPI references to reflect new QPI number specification. Codes and Values table amended code ‘99 Not known’ to ‘99 Not recorded’.

Radiotherapy Post-Treatment Related Morbidity (Urinary) – Notes for Users update QPI references to reflect new QPI number specification and amend ‘Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death) also amend ‘Details on the criteria for each grade can be found at the RTOG website:’
Radiotherapy Post-Treatment Related Morbidity (Urinary) - Main Source of Data Item Standard updated to correct reference for RTOG scoring schema and amend definition to clarify that this data item relates only to urinary morbidity directly attributable to radiation therapy. Codes and Values table amend references to RTOG website and amend ‘99 Not known’ to ‘99 Not recorded’.

Radiotherapy Post-Treatment Related Morbidity (Bowel) - Notes for Users update QPI references to reflect new QPI number specification. Amend ‘Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death) also amend ‘Details on the criteria for each grade can be found at the RTOG website: [http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx](http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx)’.

Radiotherapy Post-Treatment Related Morbidity (Bowel) - Main Source of Data Item Standard’ updated to correct reference to RTOG scoring schema and amend definition to clarify that this data item relates only to bowel morbidity directly attributable to radiation therapy. Codes and Values table. Amended references to RTOG website and amend ‘99 Not known’ to ‘99 Not recorded’.

Date of Death – Notes for Users amend ‘Inapplicable (10/10/1010)’ to ‘Not applicable (10/10/1010)’.
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 invasive adenocarcinoma of the prostate (International Classification of Diseases, Tenth Revision [ICD 10] code C61).
  - This includes patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Exclude

- Patients with metastatic prostatic disease from another primary cancer site.
- Patients where the origin of the primary is uncertain.
- Patients with tumour type sarcoma or lymphoma.
- Patients with recurrent disease (as opposed to a new primary).
- Patients with carcinoma in situ or prostatic intraepithelial neoplasia.
- 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.
DOWNLOAD FORMAT
To assist with downloading data to PHS for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

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**Section 3: Surgery**

| Location Code {Cancer Surgery}                      | HOSPSURG               | Characters | 5    | 32   |
| Definitive Operative Procedure {Prostate Cancer}    | OPCODE1 OPCODE2        | Characters | 5    | 33   |
| Type of Surgery                                     | TYPESURG               | Integer    | 2    | 35   |
| Surgical Procedure Approach                         | SURGAPPR               | Characters | 2    | 36   |
| Date of Definitive Surgery                          | SURGDATE               | Date       | 10   | 37   |
| Operating Consultant Surgeon (1-2)                  | OPSURG1 OPSURG2        | Characters | 20   | 38   |

**Section 4: Pathology Details**

<p>| Number of Needle Cores Received (Right-Left)         | NUMCORESRECR NUMCORESRECL | Integer | 2    | 40   |
| Number of Needle Cores Received (Targeted)          | NUMCORESRECT            | Integer  | 2    | 41   |
| Transurethral Resection of Prostate (TURP) Weight    | TURPWT                  | Numeric   | 7    | 42   |
| Prostate Specimen Tumour Type                        | TUMTYPE                 | Integer   | 2    | 43   |
| Prostate Specimen Tumour Type                        | TUMTYPE98               | Characters| 150  | 43   |
| Number of Needle Cores Involved (Right-Left)         | NUMCORESINVR NUMCORESINVL | Integer | 2    | 44   |
| Total Percentage of Tumour Involvement in Needle Core| TOTPERCINV              | Integer   | 3    | 45   |
| Greatest Percentage of Tumour Involvement in Needle Core| GRTPERCINV         | Integer   | 3    | 46   |
| Adipose Tissue Invasion Seen                         | ADIPOSE                 | Integer   | 2    | 47   |
| Perineural Invasion Seen                             | PERINEURAL              | Integer   | 2    | 48   |
| Primary Gleason Grade (Needle Biopsy)                | MAJGGRADE               | Integer   | 2    | 49   |
| Secondary Gleason Grade (Needle Biopsy)              | MINGGRADE               | Integer   | 2    | 50   |
| Gleason Total Score (Needle Biopsy)                  | GTOTAL                  | Integer   | 2    | 51   |</p>
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<th>Size</th>
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</thead>
<tbody>
<tr>
<td>Primary Gleason Grade (Pathology)</td>
<td>MAJGGRADEPATH</td>
<td>Integer</td>
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<tr>
<td>Secondary Gleason Grade (Pathology)</td>
<td>MINGGRADEPATH</td>
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<tr>
<td>Tertiary Gleason Grade (Pathology)</td>
<td>TERTGGRADEPATH</td>
<td>Integer</td>
<td>2</td>
<td>54</td>
</tr>
<tr>
<td>Gleason Total Score (Pathology)</td>
<td>GTOTALPATH</td>
<td>Integer</td>
<td>2</td>
<td>55</td>
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<tr>
<td>TNM Tumour Classification (Pathological) (Prostate)</td>
<td>pT</td>
<td>Characters</td>
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</tr>
<tr>
<td>TNM Nodal Classification (Pathological) (Prostate)</td>
<td>pN</td>
<td>Characters</td>
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<tr>
<td>TNM Metastasis Classification (Pathological) (Prostate)</td>
<td>pM</td>
<td>Characters</td>
<td>4</td>
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</tr>
<tr>
<td>Margin Status (Prostatectomy)</td>
<td>MARGIN</td>
<td>Integer</td>
<td>2</td>
<td>59</td>
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<tr>
<td><strong>Section 5: Radiotherapy</strong></td>
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<td></td>
<td>60</td>
</tr>
<tr>
<td>Location Code {Radiotherapy Treatment}</td>
<td>HOSPRADIO</td>
<td>Characters</td>
<td>5</td>
<td>61</td>
</tr>
<tr>
<td>External Beam Radiotherapy Course Type</td>
<td>RADIO</td>
<td>Integer</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Date Treatment Started (External Beam Radiotherapy)</td>
<td>RADDATE</td>
<td>Date</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Date Treatment Completed (External Beam Radiotherapy)</td>
<td>RCOMPDATE</td>
<td>Date</td>
<td>10</td>
<td>64</td>
</tr>
<tr>
<td>Radiotherapy for Low Metastatic Burden</td>
<td>RADIOMETS</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Date Treatment Started (Brachytherapy)</td>
<td>BRACHYDATE</td>
<td>Date</td>
<td>10</td>
<td>66</td>
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<tr>
<td><strong>Section 6: Hormone Therapy</strong></td>
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<td>Type of Hormone Therapy</td>
<td>HORMTYPE</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Type of Hormone Therapy</td>
<td>HORMTYPE98</td>
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<td>150</td>
<td>68</td>
</tr>
<tr>
<td>Date Treatment Started (Hormone Therapy)</td>
<td>HORMDATE</td>
<td>Date</td>
<td>10</td>
<td>69</td>
</tr>
<tr>
<td>Hormonal Therapy Agent {Prostate Cancer}</td>
<td>HORMAGENT</td>
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</tr>
<tr>
<td>Hormonal Therapy Agent {Prostate Cancer}</td>
<td>HORMAGENT98</td>
<td>Characters</td>
<td>150</td>
<td>70</td>
</tr>
<tr>
<td><strong>Section 7: Chemotherapy</strong></td>
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<td>71</td>
</tr>
<tr>
<td>Location Code {SACT Treatment}</td>
<td>HOSPSACT</td>
<td>Characters</td>
<td>5</td>
<td>72</td>
</tr>
<tr>
<td>Chemotherapy Agent {Prostate Cancer}</td>
<td>CHEMAGENT</td>
<td>Integer</td>
<td>2</td>
<td>73</td>
</tr>
<tr>
<td>Date Treatment Started (Chemotherapy)</td>
<td>CHEMDATE</td>
<td>Date</td>
<td>10</td>
<td>74</td>
</tr>
<tr>
<td>Date Treatment Completed (Chemotherapy)</td>
<td>CHEMENDATE</td>
<td>Date</td>
<td>10</td>
<td>75</td>
</tr>
<tr>
<td>Data item</td>
<td>Field name</td>
<td>Field type</td>
<td>Size</td>
<td>Page</td>
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<tr>
<td>------------------------------------------------------------</td>
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<td>------------</td>
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<td>------</td>
</tr>
<tr>
<td>Androgen Receptor Targeted Agent (ARTA)</td>
<td>ARTA</td>
<td>Integer</td>
<td>2</td>
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<tr>
<td><strong>Section 8: Clinical Trials</strong></td>
<td></td>
<td></td>
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<td>77</td>
</tr>
<tr>
<td>Patient Entered into Clinical Trial (Prostate Cancer)</td>
<td>TRIAL</td>
<td>Characters</td>
<td>2</td>
<td>78</td>
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<tr>
<td><strong>Section 9: Urinary Incontinence</strong></td>
<td></td>
<td></td>
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<td>79</td>
</tr>
<tr>
<td>PROMs Tool Provided (pre-operative)</td>
<td>PREOPSENT</td>
<td>Integer</td>
<td>2</td>
<td>80</td>
</tr>
<tr>
<td>PROMs Tool Returned (pre-operative)</td>
<td>PREOPRETURN</td>
<td>Integer</td>
<td>2</td>
<td>81</td>
</tr>
<tr>
<td>PROMs Tool Provided (post-operative)</td>
<td>POSTOPSENT</td>
<td>Integer</td>
<td>2</td>
<td>82</td>
</tr>
<tr>
<td>PROMs Tool Returned (post-operative)</td>
<td>POSTOPRETURN</td>
<td>Integer</td>
<td>2</td>
<td>83</td>
</tr>
<tr>
<td>Urinary Incontinence Domain Summary Score (Pre-operative)</td>
<td>URINEPRE</td>
<td>Integer</td>
<td>3</td>
<td>84</td>
</tr>
<tr>
<td>Urinary Incontinence Domain Summary Score (Post-operative)</td>
<td>URINEPOST</td>
<td>Integer</td>
<td>3</td>
<td>85</td>
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<tr>
<td><strong>Section 10: Follow-up and Death Details</strong></td>
<td></td>
<td></td>
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<td>86</td>
</tr>
<tr>
<td>MRI Scan (Surveillance)</td>
<td>MPMRISURV</td>
<td>Characters</td>
<td>2</td>
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</tr>
<tr>
<td>Date of MRI Scan (Surveillance)</td>
<td>MPDATESURV</td>
<td>Date</td>
<td>10</td>
<td>88</td>
</tr>
<tr>
<td>TRUS Re-biopsy</td>
<td>REBIOPSY</td>
<td>Integer</td>
<td>2</td>
<td>89</td>
</tr>
<tr>
<td>Date of TRUS Re-biopsy</td>
<td>REBIODATE</td>
<td>Date</td>
<td>10</td>
<td>90</td>
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<tr>
<td>Radiotherapy Post-Treatment Related Morbidity (Urinary)</td>
<td>URIMORBID</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Radiotherapy Post-Treatment Related Morbidity (Urinary)</td>
<td>URIMORBID98</td>
<td>Characters</td>
<td>150</td>
<td>91</td>
</tr>
<tr>
<td>Radiotherapy Post-Treatment Related Morbidity (Bowel)</td>
<td>BOWMORBID</td>
<td>Integer</td>
<td>2</td>
<td>93</td>
</tr>
<tr>
<td>Radiotherapy Post-Treatment Related Morbidity (Bowel)</td>
<td>BOWMORBID98</td>
<td>Characters</td>
<td>150</td>
<td>93</td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date</td>
<td>10</td>
<td>94</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, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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 {Cancer}

Main Source of Data Item Standard: Government Data Standards

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, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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:
CHI Number

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

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

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

Notes for Users:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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.

(Public Health 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

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 PHS.

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

**Field Name:** REFERDATE

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

**Field Length:** 10

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

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

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

Definition: An indicator of whether or not imaging investigations were completed by Magnetic Resonance Imaging (MRI) and isotope bone scan, or whole body MRI.

Field Name: IMAGE
Field Type: Characters
Field Length: 2

Notes for Users: Required for QPI: 2

Pre-treatment imaging and staging investigations are considered complete if carried out within 6 weeks of hormone therapy being started.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete MRI and Isotope Bone Scan or Whole Body MRI</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Incomplete – Reason not Documented</td>
<td></td>
</tr>
<tr>
<td>2A</td>
<td>Incomplete - Contraindicated</td>
<td>Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table.</td>
</tr>
<tr>
<td>2B</td>
<td>Incomplete - Bone Scan Only</td>
<td></td>
</tr>
<tr>
<td>2C</td>
<td>Incomplete – MRI of Prostate only</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Patient chose not to have assessment</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Low risk patients</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

Notes by Users:
Prostate Specific Antigen at Diagnosis {Prostate Cancer}

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

Definition: This denotes the levels of Prostate Specific Antigen (PSA) as detected by a biochemical test.

Field Name: PSA
Field Type: Float (nnnnnnn.n)
Field Length: 9

Notes for Users: Required for QPI(s) 2, 10

The level of PSA as measured on the date of diagnosis or at the time diagnostic procedures were undertaken. If there are multiple PSA results available at the time of diagnosis, record the result closest prior to the date of diagnosis.

PSA is a protein produced by the prostate and a small amount is normally found in the blood. Men with cancer of the prostate tend to have more PSA in the blood. This test is not always reliable as PSA levels also increase as men get older and due to other conditions of the prostate such as infection or Benign Prostatic Hyperplasia (BPH). Recent prostate biopsies, prostate or bladder surgery and prostatic massage can also raise the level of PSA.

Normal levels of PSA are less than 3-4 nanogrammes per millilitre of blood depending on age. Levels between 4-10 suggest a possibility of prostate cancer and a biopsy may be recommended. Levels of 10 and above should be investigated.

Once the cancer has been treated the level of PSA will fall. For this reason, measuring PSA levels can be a helpful way of assessing the progress of the disease and the effectiveness of treatment.

PSA levels should be recorded in μg/l. If the actual level is ‘not recorded’ state as 9999999.9 (not recorded) or no measurement is made record as 1010101.0 (Not applicable).

This field is also required to determine the risk level i.e.

<table>
<thead>
<tr>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Clinical Stage T1-T2a and Gleason Score ≤ 6 and PSA at diagnosis &lt;10ng/ml</td>
</tr>
<tr>
<td>Intermediate Risk</td>
<td>Clinical Stage T2b or Gleason Score 7 or PSA at diagnosis 10-20 ng/ml</td>
</tr>
<tr>
<td>High Risk</td>
<td>Clinical Stage ≥T2c or Gleason Score 8-10 or PSA at diagnosis &gt;20ng/ml</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date of Diagnosis

Notes by Users:
Data Definitions for the National Minimum Core Dataset for Prostate Cancer.
Developed by ISD Scotland, 2013
Page 11
Type of Specimen for Histological Diagnosis (Prostate 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 type of specimen submitted for histological diagnosis.

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

**Notes for Users:** Required for QPI: 14

In the case of multiple specimens, it is the specimen where cancer is first diagnosed that should be recorded.

Users should augment code ‘98 – Other (specify)’ with a free text field for recording other values of this item.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Transrectal Ultrasound Guided Biopsy</td>
<td>TRUS</td>
</tr>
<tr>
<td>2</td>
<td>Transurethral Resection of Prostate.</td>
<td>TURP</td>
</tr>
<tr>
<td>3</td>
<td>Transrectal Ultrasound Guided Biopsy (mpMRI fusion biopsy)</td>
<td>Targeted TRUS biopsy using images from mpMRI scan</td>
</tr>
<tr>
<td>4</td>
<td>Laser enucleation of the Prostate</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Transperineal biopsy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other, specify</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Number of Needle Cores Received (Right-Left)

**Notes by Users:**
Date Prostate Biopsy

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 biopsy was undertaken for the diagnosis of prostate cancer.

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

Notes for Users: Required for QPI: 14

In the case of multiple biopsies, it is the date of the first biopsy that should be recorded.

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

If the patient has not had a biopsy performed, record as 10/10/1900 (Not applicable).

Notes by Users:
TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)

Common name: Clinical TNM Tumour Classification (Cancer of the Prostate).


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

Field Name: cT
Field Type: Characters
Field length: 3

Notes for Users: Required for QPI(s): 2, 4, 7, 10, 14, 15

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

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

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 ‘Not recorded’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour.</td>
</tr>
<tr>
<td>T1</td>
<td>Clinically inapparent tumour that is not palpable</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour incidental histological finding in 5% or less of tissue resected.</td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour incidental histological finding in more than 5% of tissue resected.</td>
</tr>
<tr>
<td>T1c</td>
<td>Tumour identified by needle biopsy (e.g. because of elevated PSA).</td>
</tr>
<tr>
<td>T2</td>
<td>Tumour that is palpable and confined within prostate.</td>
</tr>
<tr>
<td>T2a</td>
<td>Tumour involves one half of one lobe or less.</td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>T2b</td>
<td>Tumour involves more than half of one lobe, but not both lobes.</td>
</tr>
<tr>
<td>T2c</td>
<td>Tumour involves both lobes.</td>
</tr>
<tr>
<td>T3</td>
<td>Tumour extends through the prostatic capsule*</td>
</tr>
<tr>
<td>T3a</td>
<td>Extraprostatic extension (unilateral or bilateral)</td>
</tr>
<tr>
<td></td>
<td>including microscopic bladder neck involvement.</td>
</tr>
<tr>
<td>T3b</td>
<td>Tumour invades seminal vesicle(s).</td>
</tr>
<tr>
<td>T4</td>
<td>Tumour is fixed or invades adjacent structures other than seminal</td>
</tr>
<tr>
<td></td>
<td>vesicles: external sphincter, rectum, levator muscles, and/or pelvic</td>
</tr>
<tr>
<td></td>
<td>wall.</td>
</tr>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded.</td>
</tr>
</tbody>
</table>

*Invasion into the prostatic apex or into (but not beyond) the prostatic capsule is not classified as T3, but as T2.

This field is also required to determine the risk level i.e.

<table>
<thead>
<tr>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Clinical Stage T1-T2a and Gleason Score ≤ 6 and PSA at diagnosis &lt;10ng/ml</td>
</tr>
<tr>
<td>Intermediate Risk</td>
<td>Clinical Stage T2b or Gleason Score 7 or PSA at diagnosis 10-20 ng/ml</td>
</tr>
<tr>
<td>High Risk</td>
<td>Clinical Stage ≥T2c or Gleason Score 8-10 or PSA at diagnosis &gt;20ng/ml</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
- TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)
- TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)
TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)

Common name: Clinical TNM Nodal Classification (Cancer of the Prostate).


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

Field Name: cN
Field Type: Characters
Field length: 2

Notes for Users: Required for QPI(s): 2, 4, 7, 10, 14, 15.

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

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

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 ‘Not recorded’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis.</td>
</tr>
<tr>
<td>N1</td>
<td>Regional lymph node metastasis.</td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed (e.g. previously removed).</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded.</td>
</tr>
</tbody>
</table>

Related Data Item(s):
TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)
TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)

Notes by Users:
TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)

**Common name:** Clinical TNM Metastases Classification (Cancer of the Prostate).

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

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

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

**Notes for Users:** Required for QPI(s): 2, 4, 7, 10, 14, 15.

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

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

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 ‘Not recorded’.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis.</td>
</tr>
<tr>
<td>M1*</td>
<td>Distant metastasis.</td>
</tr>
<tr>
<td>M1a</td>
<td>Non-regional lymph node(s).</td>
</tr>
<tr>
<td>M1b</td>
<td>Bone(s).</td>
</tr>
<tr>
<td>M1c</td>
<td>Other site(s).</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

*When more than one site of metastasis is present, the most advanced category is used. M1c is the most advanced category.*
Date First 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 first date the care team meeting was held to discuss the management of the patient’s care.

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

**Notes for Users:** Required for QPI(s): 4, 7

The first MDT meeting date will be recorded.

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.

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.

**Notes by Users:**
COVID 19 Impact

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

Codes and Values:

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

This may also be a GP surgery code if a biopsy was taken by a GP. This will be the hospital/GP surgery where the sample was taken or the hospital at which the patient was managed when the diagnosis was made.

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 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

**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 of diagnosis is the date on which there was first confirmation of
the diagnosis of prostate cancer whether by histology, cytology or clinical (including
radiological) methods.

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

**Notes for Users:** Required to define patient cohorts for local QPI, and national
survival, analysis.

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

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

If no histological or cytological procedures were undertaken, the date of diagnosis
will be the date of any imaging procedure performed that confirmed a diagnosis of
prostate cancer; otherwise the date will be based on clinical findings and will be the
first date upon which the clinician concludes a diagnosis of prostate cancer.

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

**Notes by Users:**
**Most Valid Basis of Diagnosis (Cancer)**


**Definition:** The best evidence in support of the diagnosis of cancer.

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

**Notes for Users:**
The conclusion of a diagnosis of cancer may be based on one or several procedures; clinical findings or as a report on the death certificate. Histological confirmation is considered as the most valid basis of diagnosis.

The methods of diagnosis are listed in essentially ascending order of validity, microscopic methods having greater validity than non-microscopic methods.

NB: With the emergence of molecular markers etc., there are plans to review the definition of this variable in the context of updating the IARC monograph, Cancer Registration Principles and Methods.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinical only</td>
<td>The diagnosis is based solely on clinical findings (history and/or physical examination). This is made before death but without the benefit of the following:</td>
</tr>
<tr>
<td>2</td>
<td>Clinical investigation</td>
<td>The diagnosis is supported by investigations such as x-ray, CT scan, ultrasound etc.</td>
</tr>
<tr>
<td>3</td>
<td>Exploratory surgery/endooscopy/autopsy</td>
<td>The tumour has been visualised or palpated but there is no confirmatory microscopic evidence</td>
</tr>
<tr>
<td></td>
<td>(without concurrent or previous histology)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Tumour specific markers</td>
<td>The diagnosis is supported by specific tests</td>
</tr>
<tr>
<td></td>
<td>(biochemical/immunological tests)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cytology</td>
<td>The diagnosis is supported by cytology (the examination of cells whether from a primary or secondary site).</td>
</tr>
<tr>
<td>6</td>
<td>Histology of metastasis</td>
<td>The diagnosis is based on the histology of a metastasis (secondary deposit), e.g. resulting from a lymph node biopsy</td>
</tr>
<tr>
<td>7</td>
<td>Histology of primary</td>
<td>The diagnosis is based on the histology of the primary either resulting from a biopsy or from complete resection of the tumour.</td>
</tr>
<tr>
<td>8</td>
<td>Autopsy (with histology)</td>
<td>The diagnosis is based on the findings at autopsy supported by concurrent or previous histology.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Notes by Users:**
**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:** FIRSTTREATMODE  
**Field Type:** Integer  
**Field length:** 2

**Notes for Users:** Required for QPI(s): 4, 11

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.

**NB:** Transurethral Resection of Prostate (TURP) is not a legitimate first treatment for cancer of the prostate. If no further treatment is given following TURP, then record as supportive care only.

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.

Radiotherapy includes Teletherapy (external beam radiotherapy) and brachytherapy.

**Steroids etc should not be recorded as first treatment if more substantive treatment such as chemotherapy or surgery is given. If no further treatment is given, then record as supportive care only.**

### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Hormone Therapy</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Supportive Care Only</td>
<td>Not for active treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused all therapies</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Active Surveillance</td>
<td>Intense follow-up including repeat clinic visits, tests and biopsies after an interval until the disease progresses or the grade of the tumour changes.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanatory notes</td>
</tr>
<tr>
<td>------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>Watchful Waiting</td>
<td>When patients with advanced or metastatic prostate cancer (not suitable for radical therapy) are not started on immediate androgen deprivation therapy, then the treatment is reserved until the time when the patient develops symptomatic progression. This is the traditional “watch and wait” situation.</td>
</tr>
<tr>
<td>14</td>
<td>Patient died before treatment</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

**Notes by Users:**
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:** 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', including supportive care, watchful waiting or active surveillance' 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(s):**  
Type of First Cancer Treatment

**Notes by Users:**
Date of Definitive Treatment {Prostate 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 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: 4

For patients with prostate cancer definitive treatment will be either:

- Surgery;
- Radiotherapy;
- Primary Hormone Therapy; or
- Brachytherapy.

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.

If an operation to relieve symptoms and a further operation which aims to remove the tumour is performed the date of the second operation is the one that should be coded in this field.

For patients undergoing no active treatment (e.g. active surveillance, watchful waiting or 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):
MRI Scan (Diagnostic)

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

**Definition:** A record to determine if a MRI (multiparametric or biparametric) investigation has been undertaken for diagnostic purposes.

**Field Name:** MPMRIDIAG  
**Field Type:** Characters  
**Field Length:** 2

**Notes for Users:** Required for QPI: 14

This can be either a multiparametric MRI (mpMRI) or biparametric MRI (bpMRI). This field relates to pre-treatment MRI for diagnostic purposes e.g. for MRI guided biopsy procedures.

Where there is no evidence that a MRI (biparametric or multiparametric) has been undertaken, record as ‘2’ (No).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>No</td>
<td>Includes not known</td>
</tr>
<tr>
<td>3</td>
<td>No – contraindicated</td>
<td>Generally acknowledged clinical contraindication to performing assessment exists – Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table.</td>
</tr>
<tr>
<td>4</td>
<td>Yes - multiparametric</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Yes - biparametric</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Patient refused mpMRI or bpMRI</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date of MRI Scan (Diagnostic)
Date of MRI Scan (Diagnostic)

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 multiparametric MRI (mpMRI) or biparametric MRI (bpMRI) investigation has been undertaken for diagnostic purposes.

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

Notes for Users: Required for QPI: 14

This is the date the mpMRI or bpMRI has been undertaken for diagnostic purposes. The date recorded is the date the procedure was performed, not the date the report was issued.

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

If the patient has not had a mpMRI or bpMRI, record as 10/10/1900 (Not applicable).

Related data item(s):
MRI Scan (Diagnostic)
Likert Grading

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

Definition: A record of whether the patient has a PI-RADS/Likert score (1-5) reported following diagnostic MRI investigation.

Field Name: LIKERT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 14.

This field relates to MRI for diagnostic purposes.

The PI-RADS / Likert score is a measure of the likelihood that a clinically significant cancer is present based on MRI imaging. For completeness the scores of 1-5 are noted below, however it is unlikely that a score of 1 or 2 will be used in patients diagnosed with prostate cancer.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 – Very Low</td>
<td>Clinically significant cancer is highly unlikely to be present</td>
</tr>
<tr>
<td>2</td>
<td>2 – Low</td>
<td>Clinically significant cancer is unlikely to be present</td>
</tr>
<tr>
<td>3</td>
<td>3 – Intermediate</td>
<td>Presence of clinically significant cancer is equivocal</td>
</tr>
<tr>
<td>4</td>
<td>4 – High</td>
<td>Clinically significant cancer is likely to be present</td>
</tr>
<tr>
<td>5</td>
<td>5 – Very High</td>
<td>Clinically significant cancer is highly likely to be present</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. MRI has not been undertaken for diagnostic purposes</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

Related Data Item(s):
MRI Scan (Diagnostic)
Burden of Metastatic Disease

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

Definition: A record of the burden of metastatic disease as assessed by imaging in order to guide treatment decisions.

Field Name: BURDEN
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 15.

Methods routinely used at the current time within NHS Scotland to assess the burden of metastatic disease are MRI, Bone Scan or CT.

A record of whether the patient has low or high burden of metastatic disease may be found on imaging reports, clinical records or recorded as part of the MDT outcome.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low metastatic burden</td>
<td>&lt;4 metastases or ≥4 metastases with none outside the vertebral bodies or pelvis, and no visceral metastases.</td>
</tr>
<tr>
<td>2</td>
<td>High metastatic burden</td>
<td>≥4 metastases with one or more outside the vertebral bodies or pelvis, or visceral metastases, or both.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no metastasis</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

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

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

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

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

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

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded.

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

Examples of codes are given below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>A111H</td>
<td>CROSSHOUSE HOSPITAL</td>
</tr>
<tr>
<td>C418H</td>
<td>ROYAL ALEXANDRA HOSPITAL</td>
</tr>
<tr>
<td>F704H</td>
<td>VICTORIA HOSPITAL, KIRKCALDY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>G107H</td>
<td>GLASGOW ROYAL INFIRMARY</td>
</tr>
<tr>
<td>G405H</td>
<td>SOUTHERN GENERAL HOSPITAL, GLASGOW</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date of Definitive Surgery
Definitive Operative Procedure {Prostate 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 surgical procedure(s) performed for treatment of cancer.

Field Name: OPCODE1  
           OPCODE2  
Field Type: Characters  
Field Length: 5

Notes for Users: OPCODE1 Required for QPI(s): 5, 8.

The field OPCODE2 has been added to allow the recording of concurrent lymphadenectomy. For example, a patient undergoing a laparoscopic radical prostatectomy with lymphadenectomy would be coded as follows:

OPCODE1 = M61.1  
OPCODE2 = T87.8  
SURGAPPR = 2A

Operation is coded to the 4-digit code according to the Fourth Revision of the OPCS Classification of Surgical Operations (OPCS4). Centres using READ codes may continue provided the codes can be mapped to OPCS.

Where OPCS codes have been recorded in the patient notes by the surgeon, this code should be used. Where no OPCS code has been recorded, the table below should be used. For queries or issues regarding recording OPCS please contact phs.terminologyhelp@phs.scot

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

If the patient refused treatment code as ‘95’ or did not undergo surgery for other reasons code as Not applicable ‘96’.

Codes and Values:

<table>
<thead>
<tr>
<th>OPCS4 Code</th>
<th>Description</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>M34.1</td>
<td>Cystoprostatectomy</td>
<td></td>
</tr>
<tr>
<td>M61.1</td>
<td>Total excision of prostate and capsule of prostate.</td>
<td>Radical prostatectomy</td>
</tr>
<tr>
<td>T87.8</td>
<td>Other specified lymphadenectomy</td>
<td>Pelvic lymphadenectomy</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused surgery</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>OPCS4</td>
<td>Description</td>
<td>Explanatory Note</td>
</tr>
<tr>
<td>Code</td>
<td>Not recorded</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-------------</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Date of Definitive Surgery
Surgical Procedure Approach

**Notes by Users:**
Type of Surgery

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

Definition: The type of operative procedure performed.

Field Name: TYPESURG  
Field Type: Integer  
Field Length: 2

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

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Radical Surgery</td>
<td>Surgery to remove entire prostate.</td>
</tr>
<tr>
<td>2</td>
<td>Conservative Surgery</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Salvage Surgery</td>
<td>Surgery performed if the cancer has not responded to other treatments.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. surgery not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):  
Definitive Operative Procedure {Prostate Cancer}  
Date of Definitive Surgery  
Surgical Procedure Approach

Notes by Users:
Surgical Procedure Approach

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

Definition: The approach of surgical procedure(s) performed for treatment of cancer.

Field Name: SURGAPPR
Field Type: Characters
Field Length: 2

Notes for Users: Required for national comparative analysis

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>2A</td>
<td>Laparoscopic - Completed</td>
<td></td>
</tr>
<tr>
<td>2B</td>
<td>Laparoscopic - Converted</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Perineal</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Robotic</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Surgery not performed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Definitive Operative Procedure {Prostate Cancer}
Date of Definitive Surgery

Notes by Users:
Date of Definitive Surgery

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 date of the operative procedure described elsewhere.

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

Notes for Users: Required for QPI: 8

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded.

The date format should be DDMMCCYY.

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

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

Related Data Item(s):
Definitive Operative Procedure (Prostate Cancer)

Notes by Users:
Operating Consultant Surgeon (1-2)

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

Definition: The surgeon performing the definitive surgery as described elsewhere.

Field Name: OPSURG1
   OPSURG2
Field Type: Characters
Field Length: 20

Notes for Users: Required for QPI: 6

The surname and forename of each consultant should be recorded to distinguish between surgeons with common surnames. Consultants’ names should be stored in databases as General Medical Council (GMC) number.

If two consultant surgeons share an operation the lead surgeon should be recorded as Operating Consultant Surgeon (1) and the other as Operating Consultant Surgeon (2).

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 the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

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

Related Data Item(s):
Location Code {Cancer Surgery}
Definitive Operative Procedure
Date of Definitive Surgery

Notes by Users:
Section 4: Pathology Details
Number of Needle Cores Received (Right-Left)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The number of standard needle cores received by the pathologist.

Field Name: NUMCORESRECR
            NUMCORESRECL
Field Type: Integer (nn)
Field Length: 2

Notes for Users:

If the number of needle cores received is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Related Data Items:
Type of Specimen for Histological Diagnosis {Prostate Cancer}

Notes by Users:
Number of Needle Cores Received (Targeted)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The number of targeted needle cores received by the pathologist.

Field Name: NUMCORESRECT
Field Type: Integer (nn)
Field Length: 2

Notes for Users:

Total number of targeted cores from suspicious MRI lesions (where mpMRI fusion biopsy has been undertaken) should be recorded.

If the number of targeted needle cores received is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or targeted needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Related Data Items:
Type of Specimen for Histological Diagnosis {Prostate Cancer}

Notes by Users:
Transurethral Resection of Prostate (TURP) Weight

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

**Common Name:** Weight of Specimen

**Definition:** A record of the weight of the TURP specimen in grams.

**Field Name:** TURPWT
**Field Type:** Numeric float (nnnn.dd)
**Field Length:** 7

**Notes for Users:**

The weight of the specimen will be described in the pathology report and should be recorded in grams.

If the TURP weight is not recorded on the pathology report, record as 9999.99.

If there is no histological diagnosis, or TURP has not been performed prior to surgery, record as 1010.10, not applicable.

**Notes by Users:**
Prostate Specimen Tumour Type

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The type of tumour present in the specimen

Field Name: TUMTYPE
Field Type: Integer
Field Length: 2

Notes for Users:

Users may wish to augment code '98 – Other, specify' with a free text field for recording this item.

If the tumour type is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Codes and Values:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Microacinar</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other (specify)</td>
<td>Users should augment this code with a free text field, e.g. Prostatic duct, Mucinous, Signet Ring etc.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Number of Needle Cores Involved (Right-Left)

**Main Source of Data Item Standard:** The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

**Definition:** The number of needle cores involved.

**Field Name:** NUMCORESINVR  
NUMCORESINVL  
**Field Type:** Integer (nn)  
**Field Length:** 2

**Notes for Users:**

If the number of needle cores involved is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

**Related Data Items:**
Type of Specimen for Histological Diagnosis {Prostate Cancer}  
Number of Needle Cores Received (Right-Left)

**Notes by Users:**
Total Percentage of Tumour Involvement in Needle Core

**Main Source of Data Item Standard:** The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

**Definition:** A record of the overall percentage of needle cores involved with tumour. (total cancer length/total core lengths)

**Field Name:** TOTPERCINV  
**Field Type:** Integer (nnn)  
**Field Length:** 3

**Notes for Users:**

The total cancer length expressed as a percentage of the total lengths of the needle cores. Percentage involvement may be expressed as a total for all cores received or as separate totals for left and right-sided cores.

If the total percentage of tumour involvement is not recorded on the pathology report, record as 999.

**If the pathologist has recorded only the greatest percentage of tumour involvement, record this field as ‘999’ Not recorded.**

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 966, not applicable.

**Notes by Users:**
Greatest Percentage of Tumour Involvement in Needle Core

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: A record of the percentage of tumour in the core most involved by cancer.

Field Name: GRTPERCINV  
Field Type: Integer (nnn)  
Field Length: 3

Notes for Users:

The core with the highest percentage involvement by cancer as determined by the total length of cancer relative to the total length of that core.

If the greatest percentage of tumour involvement is not recorded on the pathology report, record as 999.

If the pathologist has recorded only the total percentage of tumour involvement, record this field as ‘999’ Not recorded.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 966, not applicable.

Notes by Users:
Adipose Tissue Invasion Seen

**Definition:** An indication of whether or not adipose tissue invasion was seen in the specimen.

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

**Notes for Users:**

If invasion of adipose tissue (or extraprostatic extension) is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record 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>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>e.g. No Invasion</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Not Sampled</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Notes by Users:**

---

*Data Definitions for the National Minimum Core Dataset for Prostate Cancer.*  
*Developed by ISD Scotland, 2013*  
*Page 47*
Perineural Invasion Seen

**Definition:** An indication of whether or not perineural invasion was seen in the specimen.

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

**Notes for Users:**

If perineural invasion is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record 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>Yes</td>
<td>e.g. No Invasion</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>e.g. Not Sampled</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>

**Notes by Users:**
Primary Gleason Grade (Needle Biopsy)

Common Name: Major Gleason


Definition: The predominant histological pattern of disease in a needle biopsy specimen, based on low power visualisation of prostatic tissue.

Field Name: MAJGGRADE
Field Type: Integer (nn)
Field length: 2

Notes for Users:

For needle biopsies Gleason scores of 1 or 2 should not be recorded.

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If the major Gleason grade is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, record as 96, not applicable.

Related Data Item(s):
Secondary Gleason Grade (Needle Biopsy)
Gleason Total Score (Needle Biopsy)

Notes by Users:
Secondary Gleason Grade (Needle Biopsy)

**Common Name:** Minor Gleason


**Definition:** The next most common histological pattern of disease in a needle biopsy specimen after the Major Gleason Grade, based on low power visualisation of prostatic tissue.

**Field Name:** MINGGRADE  
**Field Type:** Integer (nn)  
**Field Length:** 2

**Notes for Users:**

For needle biopsies Gleason scores of 1 or 2 should not be recorded.

1) The highest Gleason score in a core biopsy should always be reported.  
2) A second tumour grade, no matter its extent should always be reported.

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If the minor Gleason grade is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, record as 96, not applicable

**Related Data Item(s):**  
Primary Gleason Grade (Needle Biopsy)  
Gleason Total Score (Needle Biopsy)

**Notes by Users:**
Gleason Total Score (Needle Biopsy)

**Main Source of Data Item Standard:** The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

**Definition:** The sum of the “Major” and “Minor” Gleason grades in a needle biopsy specimen. See Notes for Users.

**Field Name:** GTOTAL
**Field Type:** Integer (nn)
**Field length:** 2

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

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If there is no histological diagnosis, record as ‘Not applicable’ (96).

If the Gleason score is not recorded on the pathology report, record as ‘Not recorded’ (99). The purpose of the guidance to record this data item as 'Not recorded' is to measure when it has been omitted on the Scottish Prostate Needle Biopsy Dataset (as required by QPI 3).

**Exceptions:**
If there is a tertiary grade (of higher Gleason score than the primary or secondary grade), the total Gleason score is derived from the sum of primary (major) and tertiary Gleason grades.

This field is also required to determine the risk level i.e.

<table>
<thead>
<tr>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Clinical Stage T1 – T2a and Gleason score ≤ 6 and PSA at diagnosis &lt;10 ng/ml</td>
</tr>
<tr>
<td>Intermediate Risk</td>
<td>Clinical Stage T2b or Gleason score 7 or PSA at diagnosis 10-20 ng/ml</td>
</tr>
<tr>
<td>High Risk</td>
<td>Clinical Stage ≥T2c or Gleason score 8-10 or PSA at diagnosis &gt;20 ng/ml</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Primary Gleason Grade (Needle Biopsy)
Secondary Gleason Grade (Needle Biopsy)

**Notes by Users:**
Primary Gleason Grade (Pathology)

**Common Name:** Major Gleason


**Definition:** The predominant histological pattern of disease in a surgical specimen, based on low power visualisation of prostatic tissue.

**Field Name:** MAJGGRADEPATH

**Field Type:** Integer (nn)

**Field length:** 2

**Notes for Users:**

For all radical prostatectomy specimens record the most prevalent pattern for each tumour.

There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded.

If the primary (major) Gleason grade is not recorded on the pathology report, record as 99.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded.

If the patient has not undergone a radical prostatectomy, record as 96, not applicable.

**Related Data Item(s):**

- Secondary Gleason Grade (Pathology)
- Tertiary Gleason Grade (Pathology)
- Gleason Total Score (Pathology)

**Notes by Users:**
Secondary Gleason Grade (Pathology)

Common Name: Minor Gleason


Definition: The next most common histological pattern of disease in a surgical specimen after the Major Gleason Grade, based on low power visualisation of prostatic tissue.

Field Name: MINGGRADEPATH
Field Type: Integer (nn)
Field Length: 2

Notes for Users:

For all radical prostatectomy specimens record the most prevalent pattern for each tumour.

There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded.

If the secondary (minor) Gleason grade from a radical prostatectomy is not recorded on the pathology report, record as 99.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

If the patient has not undergone a radical prostatectomy, record as 96, not applicable.

Related Data Item(s):
Primary Gleason Grade (Pathology)
Tertiary Gleason Grade (Pathology)
Gleason Total Score (Pathology)

Notes by Users:
Tertiary Gleason Grade (Pathology)


**Definition:** The score of any area of a radical prostatectomy specimen with a higher Gleason grade than either the primary or secondary grade, based on low power visualisation of prostatic tissue.

**Field Name:** TERTGGRADEPATH  
**Field Type:** Integer (nn)  
**Field Length:** 2

**Notes for Users:**

The tertiary Gleason score as recorded from a radical prostatectomy on the pathology report, where any area of the specimen contains a third, higher Gleason grade histological pattern of disease than either the primary or secondary grade.

If the tertiary Gleason grade is not recorded on the pathology report, record as 99, not recorded.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

If there was no surgical specimen, record as 96, not applicable

**Related Data Item(s):**  
Primary Gleason Grade (Pathology)  
Secondary Gleason Grade (Pathology)  
Gleason Total Score (Pathology)

**Notes by Users:**
Gleason Total Score (Pathology)

**Main Source of Data Item Standard:** The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

**Definition:** The sum of the “Major” and “Minor” Gleason grades in a radical prostatectomy specimen. See Notes for Users.

**Field Name:** GTOTALPATH
**Field Type:** Integer (nn)
**Field length:** 2

**Notes for Users:**

Gleason Total Score in radical prostatectomy specimens should be based on the primary and secondary patterns, with a note on any tertiary (higher grade) pattern present.

If the Gleason grade from a radical prostatectomy specimen is not recorded on the pathology report, record as 99.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

If there was no surgical specimen, record as 96, not applicable

**Related Data Item(s):**
Primary Gleason Grade (Pathology)
Secondary Gleason Grade (Pathology)
Tertiary Gleason Grade (Pathology)

**Notes by Users:**
TNM Tumour Classification (Pathological) (Prostate)

**Common name:** Pathological TNM Tumour stage (Prostate)

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

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

**Field Name:** pT

**Field Type:** Characters

**Field length:** 4

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

This classification applies only to adenocarcinoma of prostate. There is no pT1 category as there is insufficient tissue to access the highest pT category or subcategories of pT2.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

**Codes and values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>pT2</td>
<td>Tumour that is palpable and confined within the prostate.</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour extends through the prostatic capsule *</td>
<td>* Invasion into the prostatic apex or into (but not beyond) the prostatic capsule is not classified as T3 but as T2.</td>
</tr>
<tr>
<td>pT3a</td>
<td>Extraprostatic extension (unilateral or bilateral) including microscopic bladder neck involvement.</td>
<td></td>
</tr>
<tr>
<td>pT3b</td>
<td>Tumour invades seminal vesicle(s)</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour is fixed or invades adjacent structures other than seminal vesicles: external sphincter, rectum, levator muscles, and/or pelvic wall.</td>
<td></td>
</tr>
<tr>
<td>pTX</td>
<td>Primary tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

TNM Nodal Classification: (Pathological) (Prostate),
TNM Metastases Classification (Pathological) (Prostate),
Date of Staging (Cancer).

**Notes by Users:**

Data Definitions for the National Minimum Core Dataset for Prostate Cancer.
Developed by ISD Scotland, 2013
Page 56
TNM Nodal Classification (Pathological) (Prostate)

**Common name:** Pathological TNM Nodal stage (Prostate)

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

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

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

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

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pN0</td>
<td>No regional lymph node metastasis.</td>
<td></td>
</tr>
<tr>
<td>pN1</td>
<td>Regional lymph node metastasis.</td>
<td></td>
</tr>
<tr>
<td>pNX</td>
<td>Regional lymph nodes cannot be assessed.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. No surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
TNM Tumour Classification (Pathological) (Prostate)  
TNM Metastases Classification (Pathological) (Prostate)

**Notes by Users:**
TNM Metastasis Classification (Pathological) (Prostate)

**Common name:** Pathological TNM Metastases Classification (Prostate)

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

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

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

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

If no distant metastasis is present record as ‘not applicable’.

If the patient’s first treatment was ‘active surveillance’, then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pM1</td>
<td>Distant metastasis microscopically confirmed.</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. No Surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

- TNM Nodal Classification (Pathological) (Prostate)
- TNM Tumour Classification (Pathological) (Prostate)

**Notes by Users:**
Margin Status (Prostatectomy)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The presence or absence of margin involvement following prostatectomy.

Field Name: MARGIN
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 5

If reported in another format e.g. < 1 mm, clarify with local pathologist.

If the patient's first treatment was 'active surveillance', then subsequently proceeds to radical prostatectomy at a later date, this should be recorded

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive</td>
<td>Tumour present at the surgical margin.</td>
</tr>
<tr>
<td>2</td>
<td>Negative</td>
<td>Tumour not present at the surgical margin.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. prostatectomy not performed</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Section 5: Radiotherapy
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 PHS 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 PHS is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate. [http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/](http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/)

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 refused radiotherapy, record as inapplicable, X1010.

**Related Data Item(s):**
External Beam Radiotherapy Course Type

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 course of external beam radiotherapy administered for the treatment of the cancer.

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

Notes for Users: Required for QPI(s): 2, 8, 9, 10

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery.</td>
</tr>
<tr>
<td>3</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms e.g. bone metastases.</td>
</tr>
<tr>
<td>95</td>
<td>Patient</td>
<td>Patient declined</td>
</tr>
<tr>
<td>96</td>
<td>declined</td>
<td>e.g. no external beam radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Treatment Started (External Beam Radiotherapy)
Date Treatment Completed (External Beam Radiotherapy)

Notes by Users:
**Date Treatment Started (External Beam 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 commenced.

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

**Notes for Users:**

This is the first fraction of a course of external beam radiotherapy.

If the date radiotherapy started is unknown, record as 09/09/1900.

If radiotherapy has not been given or the patient has refused radiotherapy, record as Not applicable, 10/10/1900.

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.

**This may be up to one year from date of diagnosis.**

**Related Data Item(s):**  
External Beam Radiotherapy Course Type  
Date Treatment Completed (External Beam Radiotherapy)

**Notes by Users:**
Date Treatment Completed (External Beam 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 a cancer treatment course ended.

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

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

This is the last fraction of a course of external beam radiotherapy.

If the date radiotherapy ended is unknown, record as 09/09/1900.

If radiotherapy has not been given or the patient has refused radiotherapy, record as Not applicable, 10/10/1900.

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.

Related Data Item(s):  
External Beam Radiotherapy Course Type  
Date Treatment Started (External Beam Radiotherapy)

Notes by Users:
Radiotherapy for Low Metastatic Burden

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 an appropriate radiotherapy regime has been administered for the treatment of metastatic prostate cancer.

Field Name: RADIOMETS
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 15

The radiotherapy regimes that are appropriate for measurement of QPI 15 are 36Gy (6 fractions) or a minimum of 50Gy (20 fractions). This allows for any higher dose which is deemed appropriate e.g. 55Gy or 60Gy.

If any lower dose than those outlined above are administered, this should be recorded as 2 (No). If there is any doubt, please clarify with an appropriate clinician.

If radiotherapy has not been given record as 96 (Not applicable).

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.

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>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 Item(s):
Date Treatment Started (Brachytherapy)

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. This date will also be utilised as completion date.

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

Notes for Users: Required for QPI(s): 2, 10

This is the date an implant was inserted for brachytherapy.

If the date brachytherapy started is unknown, record as 09/09/1900.

If brachytherapy has not been given or the patient has refused brachytherapy, record as Not applicable, 10/10/1900.

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

Related Data Item(s):
Brachytherapy Type {Cancer}

Notes by Users:
Section 6: Hormone Therapy
**Type of Hormone Therapy**

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

**Definition:** Hormonal therapy is the use of agents, which manipulate hormone levels, by using drugs, surgery or radiotherapy. Hormones are 'chemical messengers' released by the organs and dispersed by the blood to produce effects on target organs e.g. oestrogens.

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

**Notes for Users:** Required for QPI(s): 7, 10

This is also known as Androgen Deprivation Therapy (ADT).

Patients may have hormone therapy both before and after definitive treatment. Where it is radiotherapy, it is given beforehand to reduce the size of the tumour (neo-adjuvant) and may be continued afterwards (adjuvant).

- **Neo-adjuvant:** Hormone therapy is given for a defined period before curative treatment (approximately three months).
- **Adjuvant:** Hormone therapy is given for a defined period after primary treatment.
- **Neo-adjuvant & Adjuvant:** Hormone therapy given in combination before and after primary treatment.
- **Primary:** Hormone therapy is used as initial treatment usually for locally advanced or metastatic disease. Orchidectomy may be used as primary treatment.

If hormonal therapy was not given as part of primary therapy, code as 96 (Not applicable).

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neo-adjuvant</td>
</tr>
<tr>
<td>2</td>
<td>Adjuvant</td>
</tr>
<tr>
<td>3</td>
<td>Neo-adjuvant &amp; Adjuvant</td>
</tr>
<tr>
<td>4</td>
<td>Primary</td>
</tr>
<tr>
<td>95</td>
<td>Patient Refused</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>98</td>
<td>Other (Specify)</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Date Treatment Started (Hormone Therapy)  
Hormonal therapy Agent (Prostate Cancer)

**Notes by Users:**

*Data Definitions for the National Minimum Core Dataset for Prostate Cancer.*  
*Developed by ISD Scotland, 2013*  
*Page 68*
**Date Treatment Started (Hormone Therapy)**

**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 hormone treatment course commenced.

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

**Field Length:** 10

**Notes for Users:** Required for QPI(s): 7, 10

This is the first dose of hormonal therapy or the date an implant was inserted for hormonal therapy.

It is not always clearly documented when hormone therapy starts.  
If the patient is given the prescription directly at the clinic then that date should be used as the date treatment started.

If the GP is asked to prescribe hormone therapy, record the date as two days from the day of the discharge letter being typed or from the date the patient is given a handwritten note to take to the GP, whichever is the earlier.

Immediate therapy would be within 31 days of the patient being discussed at MDT meeting.

If the date hormone therapy started is unknown, record as 09/09/1900.

If hormone therapy has not been given or the patient has refused hormone therapy, record as Not applicable, 10/10/1900.

**Related Data Item(s):**  
Type of Hormone Therapy  
Hormonal Therapy Agent {Prostate Cancer}  
Date First Discussed by Care Team (MDT)

**Notes by Users:**
Hormonal Therapy Agent {Prostate 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 type of hormonal therapy delivered.

Field Name: HORMAGENT
Field Type: Integer
Field length: 2

Notes for Users: Required for QP(s): 7

If any hormonal therapy agent is not listed then please contact PHS as described elsewhere so that standard codes can be allocated throughout Scotland.

Users may wish to augment code ’98 – Other (specify)’ and sub-codes ’Z - Other (specify)’ with a free text field for recording other values of this item.

If more than one hormone therapy agent is administered, record the main agent.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gonadorelin Agonist (GnRH)</td>
<td>Includes drugs: Buserelin; Goserelin Histrelin; Leuprolelin; Triptorelin;</td>
</tr>
<tr>
<td>2</td>
<td>Gonadorelin Antagonist</td>
<td>Includes drugs: Degarelix</td>
</tr>
<tr>
<td>3</td>
<td>Anti-androgen</td>
<td>Includes drugs: Cyproterone; Flutamide; Bicalutamide;</td>
</tr>
<tr>
<td>7</td>
<td>Orchidectomy</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Maximum Androgen Blockade (MAB)</td>
<td>Combination of anti-androgen and GnRH regulators</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Type of Hormone Therapy
Date Treatment Started (Hormone Therapy)

Notes by Users:
Section 7: Chemotherapy
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 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 PHS 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 PHS is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate. 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 refused SACT, record as inapplicable, X1010.

Related Data Item(s):
Chemotherapy Agent {Prostate 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 type of chemotherapy agent used either alone or in combination to treat prostate cancer.

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

**Notes for Users:** Required for QP(s): 7, 12

Please note that only chemotherapy received within twelve months of diagnosis should be included in the analysis against the relevant QPI.

If any chemotherapy agent is not listed then please contact PHS as described elsewhere so that standard codes can be allocated throughout Scotland.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Docetaxel</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Other</td>
<td>Including clinical trials</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before chemotherapy</td>
<td>i.e. Patient who died before receiving planned chemotherapy</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused chemotherapy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Chemotherapy not given as primary part of therapy</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date Treatment Started (Chemotherapy)  
Date Treatment Completed (Chemotherapy)

**Notes by Users:**
Date Treatment Started (Chemotherapy)

**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 chemotherapy course commenced.

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

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

Please note that only chemotherapy received within twelve months of diagnosis should be included in the analysis against the relevant QPI.

This is the first dose of the first cycle of chemotherapy.

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

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

**Related Data Item(s):**  
Chemotherapy Agent {Prostate Cancer}  
Date Treatment Completed (Chemotherapy)
Date Treatment Completed (Chemotherapy)

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 chemotherapy treatment course ended.

Field Name: CHEMENDATE
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 chemotherapy. It should be noted that this can be the same day as the day the therapy started.

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

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

Related Data Item(s):
Chemotherapy Agent {Prostate Cancer}
Date Treatment Started (Chemotherapy)
Androgen Receptor Targeted Agent (ARTA)

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

Definition: A record of whether or not the patient received an Androgen Receptor Targeted Agent (ARTA) to treat prostate cancer.

Field Name: ARTA  
Field Type: Integer  
Field length: 2

Notes for Users: Required for QP(s): 7

Please note that only therapy received within twelve months of diagnosis should be included in the analysis against the relevant QPI.

Androgen receptor-targeted agents (ARTA) include abiraterone, enzalutamide and apalutamide.

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

Related Data Item(s):
Section 8: Clinical Trials
Patient Entered into Clinical Trial {Prostate Cancer}

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: 7

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

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

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

Codes and Values:

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

Notes by Users:
Section 9: Urinary Incontinence
PROMs Tool Provided (pre-operative)

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

Definition: A record to determine whether an EPIC 26 (The Expanded Prostate Cancer Index Composite) form has been given to the patient pre-operatively.

Field Name: PREOPSENT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 8

This information should be obtained by linking with the relevant surgical centre.

If there is evidence that the questionnaire has not be given to the patient, record as 2 (No).

If it has not been documented as to whether an EPIC 26 form has been given to the patient pre-operatively, record as 99 (Not recorded).

If the patient does not undergo surgery, record 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>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

Related Data Item(s):

- PROMs tool returned (pre-operative)
- PROMs tool provided (post-operative)
- PROMs tool returned (post-operative)
PROMs Tool Returned (pre-operative)

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

**Definition:** A record to determine whether the pre-operative EPIC 26 (The Expanded Prostate Cancer Index Composite) form has been returned by the patient.

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

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

This information should be obtained by linking with the relevant surgical centre.

If there is evidence that the questionnaire has not been returned by the patient, record as 2, (No).

If it has not been documented as to whether the pre-operative EPIC 26 form has been returned by the patient, record as 99 (Not recorded).

If the patient does not undergo surgery, record 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>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

- PROMs tool provided (pre-operative)
- PROMs tool provided (post-operative)
- PROMs tool returned (post-operative)
PROMs Tool Provided (post-operative)

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

Definition: A record to determine whether an EPIC 26 (The Expanded Prostate Cancer Index Composite) form has been given to the patient 12-18 months post-operatively.

Field Name: POSTOPSENT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 8

This information should be obtained by linking with the relevant surgical centre.

If there is evidence that the questionnaire has not been given to the patient, record as 2 (No).

If it has not been documented as to whether an EPIC 26 form has been given to the patient 12-18 months post-operatively, record as 99 (Not recorded).

If the patient does not undergo surgery, record 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>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

Related Data Item(s):
PROMs tool returned (pre-operative)
PROMs tool provided (pre-operative)
PROMs tool returned (post-operative)
PROMs Tool Returned (post-operative)

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

**Definition**: A record to determine whether the post-operative EPIC 26 (The Expanded Prostate Cancer Index Composite) form has been returned by the patient.

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

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

This information should be obtained by linking with the relevant surgical centre.

If there is evidence that the questionnaire has not been returned by the patient, record as 2 (No).

If it has not been documented as to whether the post-operative EPIC 26 form has been returned by the patient, record as 99 (Not recorded).

If the patient does not undergo surgery, record as 96 (Not applicable).

**Codes and Values:**

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<td>Yes</td>
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<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Includes not known</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**

- PROMs tool returned (pre-operative)
- PROMs tool provided (pre-operative)
- PROMs tool provided (post-operative)
Urinary Incontinence Domain Summary Score (Pre-operative)

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

Definition: A record of the pre-operative urinary incontinence domain summary score as calculated by the EPIC26 questionnaire.

Field Name: URINEPRE
Field Type: Integer (nnn)
Field Length: 3

Notes for Users: Required for national comparative analysis

The urinary incontinence domain summary score is a calculated average score which is determined by the values applied for each of the urinary incontinence questions within the EPIC26 tool (pre-operative).

This information should be obtained by linking with the relevant surgical centre. The score should be documented and not calculated by audit staff.

If the urinary incontinence domain summary score for the pre-operative EPIC26 questionnaire is not documented, record as 999 (Not recorded).

If there is no pre-operative EPIC26 questionnaire returned or the patient does not undergo surgery record as 966 (Not applicable).

Related Data Item(s): Urinary Incontinence Domain Summary Score (post-operative)
Urinary Incontinence Domain Summary Score (Post-operative)

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

**Definition:** A record of the post-operative urinary incontinence domain summary score as calculated by the EPIC26 questionnaire.

**Field Name:** URINEPOST  
**Field Type:** Integer (nnn)  
**Field Length:** 3

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

The urinary incontinence domain summary score is a calculated average score which is determined by the values applied for each of the urinary incontinence questions within the EPIC26 tool (post-operative).

This information should be obtained by linking with the relevant surgical centre. The score should be documented and not calculated by audit staff.

If the urinary incontinence domain summary score for the post-operative EPIC26 questionnaire is not documented, record as 999 (Not recorded).

If there is no post-operative EPIC26 questionnaire returned or the patient does not undergo surgery record as 966 (Not applicable).

**Related Data Item(s):**  
Urinary Incontinence Domain Summary Score (Pre-operative)
Section 10: Follow-up and Death Details
MRI Scan (Surveillance)

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

Definition: A record to determine if a MRI (multiparametric or biparametric) investigation has been undertaken for surveillance purposes.

Field Name: MPMRISURV
Field Type: Characters
Field Length: 2

Notes for Users: Required for QPI: 11

This can be either a multiparametric MRI (mpMRI) or biparametric MRI (bpMRI) and relates to MRI for patients undergoing active surveillance as their primary treatment. This should be undertaken between 12-18 months following diagnosis.

Where there is no evidence that a MRI (biparametric or multiparametric) has been undertaken, record as ‘2’ (No).

If the patient is not under active surveillance, record 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>2</td>
<td>No</td>
<td>Includes not known</td>
</tr>
<tr>
<td>3</td>
<td>No – contraindicated</td>
<td>Generally acknowledged clinical contraindication to performing assessment exists – Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table.</td>
</tr>
<tr>
<td>4</td>
<td>Yes – multiparametric</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Yes – biparametric</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined</td>
<td>Patient refused mpMRI or bpMRI</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Including patients who have had radical treatment and are no longer under active surveillance.</td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date of MRI Scan (Surveillance)

NB: See note pii – Notes of Implementation of Changes
Date of MRI Scan (Surveillance)

**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 multiparametric MRI (mpMRI) or biparametric MRI (bpMRI) investigation has been undertaken for surveillance purposes.

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

**Notes for Users:** Required for QPI: 11

This is the date the mpMRI or bpMRI has been undertaken for patients undergoing active surveillance as their primary treatment. This should be undertaken between 12-18 months following diagnosis.

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

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

If the patient has not had a mpMRI or bpMRI, record as 10/10/1900 (Not applicable).

**Related Data Item(s):**  
MRI Scan (Surveillance)

**NB:** See note pii – Notes of Implementation of Changes
TRUS Re-biopsy

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

Definition: This denotes whether a Trans-Rectal Ultrasound guided (TRUS) prostate re-biopsy has been carried out for patients undergoing active surveillance

Field Name: REBIOPSY
Field Type: Integer
Field Length: 2

Notes for Users:

A TRUS prostate re-biopsy should be carried out for patients under active surveillance. This would generally be undertaken approximately 12 months after diagnosis.

If the patient was under active surveillance as their primary therapy and has since received radical treatment within 14 months of diagnosis this should be recorded as 3, Patient has undergone radical treatment.

Codes and Values:

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<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>Patient has undergone radical treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused biopsy</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. patient not under active surveillance</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
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</tbody>
</table>

NB: See note pii – Notes of Implementation of Changes
Date of TRUS Re-biopsy

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 trans-rectal ultrasound guided (TRUS) prostate re-biopsy has been carried out for patients undergoing active surveillance

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

Notes for Users:

A TRUS prostate re-biopsy should be carried out for patients under active surveillance. This would generally be undertaken approximately 12 months after diagnosis.

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

If the patient is not under active surveillance or refused biopsy, record as 10/10/1900 (Not applicable).

Related data item(s):
TRUS Re-biopsy

NB: See note pii – Notes of Implementation of Changes
Radiotherapy Post-Treatment Related Morbidity (Urinary)

Main Source of Data Standard: Late Radiation Morbidity Scoring Schema. URL: http://www.rtog.org

Definition: An indication of the extent of urinary morbidity that is directly attributable to radiation therapy.

Field Name: URIMORBID
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 9

This relates to urinary toxicity occurring within six to 12 months after completion of the radiotherapy (as toxicity following the radiotherapy would be expected to have been resolved by six months after treatment completion).

Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).

Details on the criteria for each grade can be found at the RTOG website: http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx

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<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Grade 0 – None</td>
<td>None is a positively recorded response e.g. patient has no treatment related morbidity.</td>
</tr>
<tr>
<td>1</td>
<td>Grade 1</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>2</td>
<td>Grade 2</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>3</td>
<td>Grade 3</td>
<td>See RTOG website for detail on grades.</td>
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<td>4</td>
<td>Grade 4</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>5</td>
<td>Grade 5 - Death</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Radiotherapy not given.</td>
</tr>
<tr>
<td>98</td>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
Date Treatment Completed (External Beam Radiotherapy)
Date Treatment Started (Brachytherapy)
External Beam Radiotherapy Course Type
Brachytherapy Type

Notes by Users:
Radiotherapy Post-Treatment Related Morbidity (Bowel)

**Main Source of Data Standard:** Late Radiation Morbidity Scoring Schema. URL: [http://www.rtog.org](http://www.rtog.org)

**Definition:** An indication of the extent of urinary morbidity that is directly attributable to radiation therapy.

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

**Notes for Users:**  
Required for QPI: 9  
This relates to bowel toxicity occurring within six to 12 months after completion of the radiotherapy (as toxicity following the radiotherapy would be expected to have been resolved by six months after treatment completion).

Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).

Details on the criteria for each grade can be found at the RTOG website: [http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx](http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx)

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<td>6</td>
<td>Grade 0 – None</td>
<td>None is a positively recorded response e.g. patient has no treatment related morbidity.</td>
</tr>
<tr>
<td>1</td>
<td>Grade 1</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>2</td>
<td>Grade 2</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>3</td>
<td>Grade 3</td>
<td>See RTOG website for detail on grades.</td>
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<tr>
<td>4</td>
<td>Grade 4</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>5</td>
<td>Grade 5 - Death</td>
<td>See RTOG website for detail on grades.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Radiotherapy not given.</td>
</tr>
<tr>
<td>98</td>
<td>Other (specify)</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date Treatment Completed (External Beam Radiotherapy)  
Date Treatment Started (Brachytherapy)  
External Beam Radiotherapy Course Type  
Brachytherapy Type

**Notes by Users:**
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:** The certified date of death as recorded by the National Records of Scotland (NRS) (previously General Register Office Scotland (GRO(S))

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

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

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

If the patient is still alive, record as 10/10/1900 (Not applicable)

**Related Data Item(s):**
Underlying Cause of Death

**Notes by Users:**