Testicular Cancer

Data Definitions for the National Minimum Core Data Set to support the introduction of Testicular Cancer Quality Performance Indicators

Definitions developed by ISD Scotland in Collaboration with the Testicular Quality Performance Indicator Development Group

Version 4.1: May 2023

To be used in conjunction with:

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

**Key Information**

<table>
<thead>
<tr>
<th>Title</th>
<th>Testicular – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs)</th>
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<td>Date Published/Issued</td>
<td>May 2023</td>
</tr>
<tr>
<td>Date Effective From</td>
<td>1st October 2022</td>
</tr>
<tr>
<td>Version/Issue Number</td>
<td>V4.1</td>
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<td>Document Type</td>
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<td>Document Status</td>
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| Cross References | Testicular Quality Performance Indicators  
Testicular Measurability of Quality Performance Indicators |
| Author | Public Health Scotland (PHS) |

**Revision History**

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<tr>
<th>Version</th>
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<th>Name</th>
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<td>Jane Garrett</td>
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<td>V3.2</td>
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<td>Jane Garrett</td>
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<td>Caroline Dawson</td>
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<td>Grant Callahan, PHS</td>
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PREFACE

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

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

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

The following changes should be implemented for all patients who are diagnosed with testicular cancer on or after 1\textsuperscript{st} October 2022, who are eligible for inclusion in the testicular cancer audit.

Changes to definitions fall into the following categories:

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

If you have difficulties in using individual definitions within this document please contact

**General Enquiries on the Collection of the Minimum Core Data Set**
If you have any comments on the attached data definitions PHS would welcome your feedback. Please contact: phs.canceraudit@phs.scot

CONVENTIONS

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

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

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

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

Revisions to Dataset Out with Review (May 2023)

**Type of Systemic Anti-Cancer Therapy (SACT) 1-3** – Codes & Values
Table Explanatory Notes: Code 4 remove ‘e.g. for patients with metastatic disease at time of diagnosis’

**Calculation of Renal Function** – Codes & Values Table Explanatory notes
Code 1 Add ‘This may also be described as Nuclear Medicine GFR estimation’

Revisions to Dataset Following Formal Review (March 2023)

**NOTES FOR IMPLEMENTATION OF CHANGES** – Amend 1st October 2015 to 1st October 2022

Database Specification

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

**Date Surveillance CT/MRI Scan 1-2** - Remove Data Item, Field Name: SURVCTMRIDATE 1, Field Type: Date (DD/MM/CCYY), Field Length: 10

**MRI Scan (Surveillance)** – Add Data Item Field Name: MRISURV, Field Characters, Field Length: 2

**Date Surveillance MRI Scan** Add Data Item Field Name: SURVMRIDATE, Field Date (DD/MM/CCYY), Field Length: 10

Database

**Date of Referral** – Definition remove ‘Brain and CNS’ replace with ‘testicular’

**Date of Diagnosis {Testicular Cancer}** – Notes for Users Remove QPI 10 add QPI 12

**Date CT Scan Completed** – Notes for Users Add QPI 12

**Pre-Operative Assessment** - Notes for Users remove ‘Lactate Dehydrogenase (LDH)’ Codes & Values table amend ‘refused’ to ‘declined’

**COVID 19 Impact** – Remove Data Item

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

Definitions for the National Minimum Core Data Set for Testicular Cancer. Developed by ISD Scotland, 2014
Date of First Cancer Treatment - Notes for Users amend ‘refused’ to ‘declined’

Location Code {Cancer Surgery} - Notes for Users amend ‘refused’ to ‘declined’

Date of Surgery – Notes for Users Remove QPI 10

Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer} - Notes for Users remove QPI 10, Codes & Values Table amend ‘refused’ to ‘declined’

Vascular Invasion {Testicular Cancer} – Notes for users amend ‘If vascular invasion is not recorded record as ‘99’ or if there is no surgery has been undertaken record as ‘96’ not applicable’ to ‘If vascular invasion is not recorded record as ‘99’ or if no surgery has been undertaken record as ‘96’ not applicable.’

Rete Stromal Invasion {Testicular Cancer} – Notes for users amend ‘If rete stromal invasion is not recorded record as ‘99’ or if there is no surgery has been undertaken record as ‘96’ not applicable’ to ‘If rete stromal invasion is not recorded record as ‘99’ or if no surgery has been undertaken record as ‘96’ not applicable’

S Category {Testicular Cancer} - Notes for Users add ‘Testicular cancer staging is based on T, N, M and S, where S represents the value of the serum level of tumour markers in germ cell cancer (these are AFP, HCG and LDH). Patients may have normal markers with or without metastatic disease, but they are usually raised in metastatic cases. Tumour markers should fall to normal levels with the removal of the primary tumour at orchidectomy in stage 1 disease. However, these markers fall with the following half-lives: AFP 5-7 days, HCG 24-48 hours and LDH 24-48 hours. The time to normalisation will depend on the initial pre-operative level and thus should be subject to serial measurements.

The interpretation of borderline levels should be taken with caution as they can be affected by other conditions such as post-operative complications or alcohol etc. hence clinicians look at a series of readings before designation of the S stage.

Generally after surgery, the S value will normalise (S0) however some stage 1 disease with persistently elevated or more accurately rising tumour markers means they have stage 1M or stage 1S i.e. biochemical evidence of disease without changes on CT of metastatic disease. If patients have a significantly raised or more accurately rising post-operative tumour marker level, they have metastatic disease, irrespective of CT staging.
A patient’s S value will change over time, for example following treatment, therefore a patient may have multiple S values recorded at different stages in their treatment pathway. For QPI audit purposes it is important to record the nadir result (post-surgical S value), at the appropriate time period after surgery (4-6 weeks after surgery).

For patients undergoing chemotherapy as their primary treatment, the S marker level should be assigned on the basis of the most recent marker on or before chemotherapy commences. S markers may be reported as Sx while marker results are awaited and therefore it is important to check for further results at a later date rather than record Sx within eCASE.

Remove ‘If elevated after orchidectomy, markers should be performed serially according to the normal decay of AFP (half-life 7 days) and hCG (half-life 3 days) to assess for serum tumour marker elevation. The S classification is based on the nadir value of hCG and AFP after orchidectomy. The serum level of LDH (but not its half-life levels) has prognostic value in patients with metastatic disease and is included for staging. N indicates the upper limit of normal for the LDH assay.’

**Stage Grouping {Testicular Cancer}** – Notes for Users remove QPI 9 & add QPI 12

**Morphology of Tumour {Testicular Cancer}** – Notes for Users remove QPI 9 & add QPI 12

**Radiotherapy Course Type {Testicular Cancer}** – Codes & Values Table amend ‘refused’ to ‘declined’

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

**Date Treatment Completed {Testicular Cancer} (Radiotherapy)** – Notes for Users remove Required for QPI: 10

**Date of Serum Tumour Markers Test (Pre-SACT)** – Notes for Users remove ‘Lactate Dehydrogenase (LDH)’

**Calculation of Renal Function** – Codes & Values Table Code 1 Remove EDTA add ‘Isotopic estimation of creatinine clearance’: Explanatory notes add E.g. & (EDTA) or diethylenetriaminepentaacetic acid (DTPA)

**Type of Systemic Anti-Cancer Therapy (SACT) 1-3** – Notes for Users remove QPI 9 & 10 and add ‘Only those patients with stage 1 disease are eligible for ‘adjuvant’ chemotherapy. If the ‘adjuvant’ label is used in clinical letters or on CEPAS and stage is anything higher than stage 1b, including stage 1S/M, please seek clarification from a clinician to ensure that the correct SACT intention is recorded.

*Definitions for the National Minimum Core Data Set for Testicular Cancer. Developed by ISD Scotland, 2014*
Primary chemotherapy is defined as chemotherapy given with curative intent, regardless of whether the patient has undergone surgery or not.

Codes & Values table Code 2 Explanatory notes add ‘Only applicable for patients with stage 1 disease. Code 3 Explanatory notes amend ‘Chemotherapy given with curative intent with no surgery performed’ to ‘Chemotherapy given with curative intent whether surgery is performed or not.’ Amend refused to declined

**Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3 – Notes for users amend ‘refused’ to ‘declined’**

**Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3 - Notes for users remove Required for QPI: 10 & amend ‘refused’ to ‘declined’**

**Location Code {Radiotherapy Treatment} – Notes for Users amend ‘refused’ to ‘declined’**

**Location Code {SACT Treatment} - Notes for Users amend ‘refused’ to ‘declined’**

**Patient Entered into Clinical Trial - Notes for Users remove QPI 9**

**Date Surveillance CT/MRI Scan 1-2 – Remove Data Item**

**MRI Scan (Surveillance) – Add new Data item**

**Date Surveillance MRI Scan - Add new Data item**

**Date of Death – Notes for Users add national survival analysis & remove QPI 10**

**Outwith review changes (March 2022)**

**Date of Referral** Added data items, Location Code {Radiotherapy Treatment} HOSPRADIO and Location Code {SACT Treatment} HOSPSACT - implement from October 2021

**Rebranding Updates (February 2021)**

**Key Information** – Author amended from Information Services Division (ISD) to Public Health Scotland (PHS)
Addition to dataset during COVID 19 Pandemic (May 2020)

Database Specification

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

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

Dataset

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

**COVID 19 Impact** - add new Data item – implemented from 1 October 2019

Revisions to Dataset Outwith Review (May 2020)

**Pre-Operative Assessment** – Codes and Values table remove leading ‘0’

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

**Contralateral Biopsy of Testis** - Codes and Values table remove leading ‘0’

**Vascular Invasion {Testicular Cancer}** - Codes and Values table remove leading ‘0’

**Rete Stromal Invasion {Testicular Cancer}** - Codes and Values table remove leading ‘0’

**Radiotherapy Course Type {Testicular Cancer}** - Codes and Values table remove leading ‘0’

**Calculation of Renal Function** - Codes and Values table remove leading ‘0’

**Type of Systemic Anti-Cancer Therapy (SACT) 1-3** - Codes and Values table remove leading ‘0’

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

Revisions to Dataset Outwith Review (September 2019)

**Date of Diagnosis {Testicular Cancer}** – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’
Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014

Date of Ultrasound Diagnosis {Testicular Cancer} - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date CT Scan Completed – Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

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

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

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

Date of Surgery – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Started {Testicular Cancer} (Radiotherapy) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed {Testicular Cancer} (Radiotherapy) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date of Serum Tumour Markers Test (Pre-SACT) - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3 - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3 - Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’ and ‘10/10/1010’ to ‘10/10/1900’

Date Surveillance CT/MRI Scan 1-2 – Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’ and ‘09/09/0909’ to ‘09/09/1900’

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

Revisions to Dataset Following Formal Review (October 2018)

Database Specification
Date Surveillance CT Scan 1-2 – Heading amend to ‘Date Surveillance CT/MRI Scan 1-2’; Field Name amend to ‘SURVCTMRIDATE1 and SURVCTMRIDATE2’

Dataset

Criteria for Inclusion Exclude - add Patients with non-germ cell tumours

Person Family Name (at Diagnosis) – link updated

Person Given Name – link updated

Patient Postcode at Diagnosis {Cancer} – link updated

Date of Birth – link updated

Date of Diagnosis {Testicular Cancer} – Notes for Users amend ‘QPI 9’ to ‘QPI 1 -10’

Date CT Scan Completed - Notes for Users amend ‘QPI 9’ to ‘QPI 1’

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

Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer} - Notes for Users remove ‘QPI 5’

Tumour Size {Testicular Cancer} – Notes for Users remove ‘required for QPI(s): 5’

Vascular Invasion {Testicular Cancer} - Notes for Users remove ‘required for QPI(s): 5’

Rete Stromal Invasion {Testicular Cancer} - Notes for Users remove ‘required for QPI(s): 5’

TNM Tumour Classification (Final) {Testicular Cancer} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017; Footnote add * AJCC subdivides T1 by T1a and T1b depending on size no greater than 3cm or greater than 3 cm in greatest dimension

TNM Nodal Classification (Final) {Testicular Cancer} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017; Codes and Values table amend ‘or 5’ to ‘and 5’

TNM Metastasis Classification (Final) {Testicular Cancer} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017
Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014

S Category {Testicular Cancer} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017; Codes and Values table add ‘or not performed’

Stage Grouping {Testicular Cancer} - Standard changed from Seventh Edition, 2009 to Eighth Edition 2017; Notes for Users: Requires for QPI(s) remove ‘7’

Morphology of Tumour {Testicular Cancer} – Notes for Users: Required for QPI(s): remove ‘5’; Codes and Values table remove ‘8650/3 Leydig cell tumour/malignant’ amend value for 9101/3 to ‘Choriocarcinoma combined with other germ cell elements; Choriocarcinoma combined with Teratoma; Choriocarcinoma combined with embryonal carcinoma’

Date of Serum Tumour Makers Test (Pre-SACT) - Notes for Users remove ‘required for QPI(s): 7’

Type of Systemic Anti-Cancer Therapy (SACT) 1-3 - Notes for Users: Requires for QPI(s) remove ‘1, 2, 3, 7’, add ‘10’; Codes and Values table add ’03 Primary Chemotherapy given with curative intent with no surgery performed.

Date Surveillance CT Scan 1-2 – Heading amend to ‘Date Surveillance CT/MRI Scan 1-2’; Definition add ‘or magnetic resonance imaging (MRI)’; Field Name amend to ‘SURVCTMRIDATE1 and SURVCTMRIDATE2’; Notes for Users add ‘or MRI’, ‘/MRI’, ‘This should be recorded for patients on a pure surveillance regimen i.e. on surveillance post orchidectomy with no chemotherapy. For those patients who are not on a pure surveillance regimen, record as not applicable (10/10/1010)’, ‘/MRI’.

Revisions to Dataset Outwith Review (July 2017)

Morphology of Tumour {Testicular Cancer} – Codes and Values table add code ‘9101/3’ Choriocarcinoma within the Morphology code list.

TNM Tumour Classification (Final) {Testicular Cancer} (FINALT) - Field Length amend field length from ‘3’ to ‘2’

TNM Nodal Classification (Final) {Testicular Cancer} - Field Length amend field length from ‘3’ to ‘2’

Revisions to Dataset following Formal Review (August 2016)

Tumour Size {Testicular Cancer} - Notes for User add ‘Where patients have had systemic therapy prior to orchidectomy and the pathology report states
that there is no evidence of viable malignancy, record as ‘1010’ not applicable’.

**Vascular Invasion (Testicular Cancer)** - Notes for User add ‘Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, record as ‘96’ not applicable’.

**Rete Stromal Invasion (Testicular Cancer)** - Notes for User add ‘Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, record as ‘96’ not applicable’.

**Morphology of Tumour (Testicular Cancer)** - Notes for User add ‘Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, record as ‘1010’ not applicable’.

The following code has been added 8650/3 - Leydig cell tumour/ malignant.

**Revisions to Dataset Following 9 Month Review (July 2015)**

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

**Location of Diagnosis (Testicular Cancer)** – removed X1010=Not applicable.

**Date of Diagnosis** – Notes for Users and Definition replaced “of the first investigative procedure that confirms a diagnosis of testicular cancer” with "of the earliest relevant investigation that raised the suspicion of cancer (which was subsequently confirmed)"

**Date of Ultrasound Diagnosis (Testicular Cancer)** – Notes for Users remove ‘first’

**Date SACT Discussed by Care Team (MDT)** – replace ‘treat’ with ‘recommend’ and inserted ‘be treated’

**Tumour Size (Testicular Cancer)** – Definition inserted (mm) in definition and ‘The unit of measurement for tumours is mm.’ Notes for Users remove ‘there is’

**Vascular Invasion (Testicular Cancer)** - Notes for Users add Where “lymphovascular invasion” is noted within a pathology report record as 01 yes as terms are used interchangeably.
TNM Tumour Classification (Final) {Testicular Cancer} – Codes and Values Table removed ‘p’. Notes for users removed “T – primary tumour: Except for pT4, where radical orchidectomy is not always necessary for classification purposes, the extent of the primary tumour is classified after radical orchidectomy. In other circumstances, pTX is used if no radical orchidectomy has been performed.”

TNM Nodal Classification (Final) {Testicular Cancer} – Codes and Values Table removed ‘p’. Notes for Users removed ‘in the pathology report’ and ‘Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.’

TNM Metastasis Classification (Final) {Testicular Cancer} – Codes and Values table removed ‘p’. Notes for Users removed the following text ‘in the pathology report’ and ‘Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.’

Stage Grouping {Testicular Cancer} – Notes for Users add “Where RMH staging is used this can be recorded where this system corresponds to UICC staging (Stage I and II), otherwise clarify with the relevant clinician.”

Revisions to Dataset Outwith Review (January 2015)

Dataset

Morphology of Tumour {Testicular Cancer} – Codes and Values table spelling mistake corrected 9080/3: teratoblastoma

Patient Entered into Clinical Trial {Cancer} - Field type changed to characters from character

Database Specification

CHI Number field type changed to characters from character
Date of Serum Tumour Markers Test (Pre-SACT) field name corrected to STMDATE

Patient Entered into Clinical Trial {Cancer} field type changed to characters from character
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 cancer of the testis (ICD-10 C62)
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
- Multiple independent primary tumours should be recorded separately.

Exclude:
- Patients where the origin of the primary is uncertain
- Patients with non-germ cell tumours
- Patients with tumour type sarcoma or lymphoma
- Patients with recurrent disease (as opposed to a new primary)
- Patients with metastases in the testis originating from another primary site.
- Patients with malignant mesothelioma of the tunica vaginalis, non-invasive tumours or dysplasia
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.

NB:
- Only treatments as part of the initial treatment plan should be recorded.
- Patients treated within 6 months of a patient initially refusing further investigation or whose initial treatment is ‘Watch and Wait’ can also be recorded.
DOWNLOAD FORMAT
To assist with downloading data to PHS for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

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<td>Date of Ultrasound Diagnosis {Testicular Cancer}</td>
<td>DUSS</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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<tr>
<td>Date CT Scan Completed</td>
<td>CTDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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</tr>
<tr>
<td>Pre-Operative Assessment</td>
<td>PREOP</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>WHO/ ECOG Performance Status</td>
<td>PSTATUS</td>
<td>Integer</td>
<td>1</td>
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</tr>
<tr>
<td>Date Discussed by Care Team (MDT)</td>
<td>MDTDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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<tr>
<td>Date SACT Discussed by Care Team (MDT)</td>
<td>SMDTDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
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</tr>
<tr>
<td>Type of First Cancer Treatment</td>
<td>FIRSTTREATMODE</td>
<td>Integer</td>
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</tr>
<tr>
<td>Date of First Cancer Treatment</td>
<td>FIRSTTREATDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td><strong>Section 3: Surgery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location Code {Cancer Surgery}</td>
<td>HOSPSURG</td>
<td>Characters</td>
<td>5</td>
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<tr>
<td>Contralateral Biopsy of Testis {Testicular Cancer}</td>
<td>CONTRABIOP</td>
<td>Integer</td>
<td>2</td>
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</tr>
<tr>
<td>Date of Surgery</td>
<td>DSURG</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer}</td>
<td>OPCODE1</td>
<td>Characters</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer}</td>
<td>OPCODE2</td>
<td>Characters</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td><strong>Section 4: Pathological Details</strong></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014
<table>
<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour Size {Testicular Cancer}</td>
<td>TSIZE</td>
<td>Integer</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Vascular Invasion {Testicular Cancer}</td>
<td>VASCINV</td>
<td>Integer</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Rete Stromal Invasion {Testicular Cancer}</td>
<td>RSINV</td>
<td>Integer</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>TNM Tumour Classification (Final) {Testicular Cancer}</td>
<td>FINALT</td>
<td>Characters</td>
<td>2</td>
<td>32</td>
</tr>
<tr>
<td>TNM Nodal Classification (Final) {Testicular Cancer}</td>
<td>FINALN</td>
<td>Characters</td>
<td>2</td>
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</tr>
<tr>
<td>TNM Metastasis Classification (Final) {Testicular Cancer}</td>
<td>FINALM</td>
<td>Characters</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>S Category {Testicular Cancer}</td>
<td>SERUM</td>
<td>Characters</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>Stage Grouping {Testicular Cancer}</td>
<td>STAGE</td>
<td>Characters</td>
<td>4</td>
<td>38</td>
</tr>
<tr>
<td>Morphology of Tumour {Testicular Cancer}</td>
<td>MORPHOL</td>
<td>Characters</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td><strong>Section 5: Oncology</strong></td>
<td></td>
<td></td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>Location Code {Radiotherapy Treatment}</td>
<td>HOSPRADIO</td>
<td>Characters</td>
<td>5</td>
<td>43</td>
</tr>
<tr>
<td>Radiotherapy Course Type {Testicular Cancer}</td>
<td>RADIO</td>
<td>Integer</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Date Treatment Started {Testicular Cancer}</td>
<td>RADDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Date Treatment Completed {Testicular Cancer}</td>
<td>RCOMPDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>46</td>
</tr>
<tr>
<td>Date of Serum Tumour Markers Test (Pre-SACT)</td>
<td>STMDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>47</td>
</tr>
<tr>
<td>Calculation of Renal Function</td>
<td>CALC</td>
<td>Integer</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Location Code (SACT Treatment)</td>
<td>HOSPSACT</td>
<td>Characters</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE1</td>
<td>Integer</td>
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<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE2</td>
<td>Integer</td>
<td>2</td>
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<tr>
<td>Type of Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMTYPE3</td>
<td>Integer</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>52</td>
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<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>52</td>
</tr>
<tr>
<td>Date Treatment Started Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>52</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMENDATE1</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>53</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMENDATE2</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>53</td>
</tr>
<tr>
<td>Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) 1-3</td>
<td>CHEMENDATE3</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>53</td>
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</tbody>
</table>

*Definitions for the National Minimum Core Data Set for Testicular Cancer.*
*Developed by ISD Scotland, 2014*
<table>
<thead>
<tr>
<th>Data Item</th>
<th>Field Name</th>
<th>Field Type</th>
<th>Size</th>
<th>Page</th>
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</thead>
<tbody>
<tr>
<td><strong>Section 6: Clinical Trials</strong></td>
<td></td>
<td></td>
<td></td>
<td>54</td>
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<tr>
<td>Patient Entered into Clinical Trial</td>
<td>TRIAL</td>
<td>Characters</td>
<td>3</td>
<td>55</td>
</tr>
<tr>
<td><strong>Section 7: Follow Up and Death Details</strong></td>
<td></td>
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<td>56</td>
</tr>
<tr>
<td>MRI Scan (Surveillance)</td>
<td>MRISURV</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>57</td>
</tr>
<tr>
<td>Date Surveillance MRI Scan</td>
<td>SURVMRIDATE</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>58</td>
</tr>
<tr>
<td>Date of Death</td>
<td>DOD</td>
<td>Date (DD/MM/CCYY)</td>
<td>10</td>
<td>59</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:
Main Source of Standard: Government Data Standards Catalogue

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 of Standard: Government Data Standards Catalogue

Definition: The forename or given name of a person.

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

Notes for Users:
Main Source of Standard: Government Data Standards Catalogue

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.

Related Data Item(s):

Notes by Users:
Patient Postcode at Diagnosis

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

Notes for Users:
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:
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 of Standard: Scottish Executive Health Department.

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

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

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

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

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:

Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014
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 testicular 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>

**Notes by Users:**

Definitions for the National Minimum Core Data Set for Testicular Cancer.
Developed by ISD Scotland, 2014

9
Location of Diagnosis {Testicular Cancer}

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

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

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

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

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

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

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

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

**Codes and Values:**

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

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

**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 suspicion of cancer was first raised by the earliest relevant investigation whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods (which was subsequently confirmed).

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

**Notes for Users:** Required for QPI(s): 1-8, 12

The date recorded is the date of the earliest relevant investigative procedure that raises a suspicion of testicular cancer whether done clinically, radiologically or histologically (which is subsequently confirmed).

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

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

**Related Data Items:**

Location of Diagnosis {Testicular Cancer}

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

**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 testicular cancer was diagnosed by ultrasound.

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

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

The date recorded is the date of the ultrasound that lead to a diagnosis of testicular cancer. If the date is unclear then clarify with the relevant clinician.

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

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

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

This may be the same date as recorded in ‘Date of Diagnosis’.

**Related Data Items:**

Location of Diagnosis {Testicular Cancer}

**Notes by Users:**
**Date CT Scan Completed**

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

**Definition:** The date chest, abdomen and pelvis imaging investigations were completed by computed tomography (CT) of the chest, abdomen and pelvis.

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

**Notes for Users:** Required for QPI(s): 1, 12

As a minimum a CT of the chest, abdomen AND pelvis should be completed. Several investigations may be undertaken prior to staging. It is the date of the FIRST COMPLETE SET of CT scans carried out which should be recorded for this item.

These investigations may be done separately and at different times. Record the date that ALL items are complete, e.g. if CT chest and CT abdomen and pelvis were done on separate days then record the final date.

If CT chest, abdomen and pelvis was not completed or if only some components were completed then record as not applicable (10/10/1900).

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

**Related data item(s):**

**Error! Reference source not found.**

**Notes by Users:**
Pre-Operative Assessment

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

Definition: Denotes whether a pre-operative assessment was completed prior to surgery.

Field Name: PREOP
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 2

Several investigations may be undertaken prior to surgery. As a minimum a testicular ultrasound and a check of serum tumour markers (STMs) must be completed before surgery.

These investigations (ultrasound and STMs) may be done separately and at different times.

Serum tumour markers (STMs) are:
Alpha Feta Protein (AFP)
Human Chorionic Gonadotropin (HCG)

If only one component (i.e. testicular ultrasound) or not all parts of STMs done then record as 02 (No).

If pre-operative assessment is not documented, record as 99 (Not recorded).

If the patient is a non-surgical patient then 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>Testicular ultrasound completed and STMs</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>E.g. Only one component completed</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined pre-operative assessment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Non-surgical patient</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related data item(s):
WHO/ ECOG Performance Status

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


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

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

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

This item may occur more than once throughout a patient's record however, it is the initial WHO/ECOG performance status which should be recorded.

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

Codes and values:

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

Related Data Item(s):
Date Discussed by Care Team (MDT)

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

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

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

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

**Notes for Users:** Required for QPI: 4

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, physiotherapists and others relevant to the treatment of a specific cancer. The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first MDT meeting date **post-orchidectomy** should be recorded. If the patient has not had an orchidectomy then record the first MDT.

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

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

**Related data Item(s):**
Date SACT Discussed by Care Team (MDT)

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

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

Definition: This denotes the date the care team meeting was held to discuss whether the patient should be treated with systemic anti-cancer therapy (SACT).

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

Notes for Users: Required for QPI: 8

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, physiotherapists and others relevant to the treatment of a specific cancer. The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first MDT meeting date where the decision to recommend the patient be treated with SACT should be recorded. This could be pre or post orchidectomy.

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

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

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

Common name: Mode of first treatment

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

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

Field Name: FIRSTTREATMODE  
Field Type: Integer  
Field length: 2

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

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

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chemoradiotherapy</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Biological therapy</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Supportive care</td>
<td>No active treatment</td>
</tr>
<tr>
<td>10</td>
<td>Active Surveillance</td>
<td>Scheduled 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>12</td>
<td>Watchful waiting</td>
<td>No active treatment</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined all therapies</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Item(s):**
Date of First Cancer Treatment
**Date of First Cancer Treatment**

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

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

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

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

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

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

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

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

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

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

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

**Main Source of Data Item Standard:** NHS National Reference Files, http://www.natref.scot.nhs.uk/.

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

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

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

This is the hospital of the **main 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 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.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 surgery has not been performed or the patient has declined surgery, record as inapplicable, 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>
<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):
Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer}
Contralateral Biopsy of Testis {Testicular Cancer}

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

Definition: A record to determine whether the patient had a contralateral biopsy of the testis.

Field Name: CONTRABIOP
Field Type: Integer
Field Length: 2

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

If contralateral biopsy of testis is not recorded record as ‘99’ or if there is no surgery has been undertaken 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>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
**Date of Surgery**

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

**Definition:** This is the date the main (definitive) surgery was performed.

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

**Notes for Users:** Required for QPI(s): 1, 2, 3, 4, 6

This is the date of tumour resection and not the date of any diagnostic surgical procedures.

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

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

All treatments given as part of the initial treatment plan.

**Related Data Items:**  
Location Code {Cancer Surgery}
Final Definitive (or Only) Surgery Performed (Surgery) {Testicular Cancer}

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

Definition: This is the main (definitive) or only operation performed for treatment of testicular cancer.

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

Notes for Users: Required for QPI(s): 1, 2, 3, 4, 6

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.

Operation is coded to the 4-digit code according to the Fourth Revision of the OPCS Classification of Surgical Operations (OPCS4).

Coding instructions and a full list of codes are included in the OPCS4 manual. It should be noted that it may be necessary to record two codes in order to fully specify the operation.

Key = NEC – Not elsewhere classified

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N05.2</td>
<td>Bilateral orchidectomy</td>
<td></td>
</tr>
<tr>
<td>N05.3</td>
<td>Bilateral inguinal orchidectomy</td>
<td></td>
</tr>
<tr>
<td>N06.2</td>
<td>Excision of aberrant testis</td>
<td></td>
</tr>
<tr>
<td>N06.3</td>
<td>Orchidectomy NEC</td>
<td></td>
</tr>
<tr>
<td>N06.6</td>
<td>Inguinal orchidectomy NEC</td>
<td></td>
</tr>
<tr>
<td>N07.1</td>
<td>Excision of lesion of testis</td>
<td></td>
</tr>
<tr>
<td>N07.2</td>
<td>Destruction of lesion of testis</td>
<td></td>
</tr>
<tr>
<td>N10.1</td>
<td>Insertion of prosthetic replacement for testis</td>
<td></td>
</tr>
<tr>
<td>T85.8</td>
<td>Other specified block dissection of lymph nodes</td>
<td>Includes - retroperitoneal</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.G. non-surgical patient</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>Evidence in patient record that surgery was received but details of the type of surgery is not recorded</td>
</tr>
</tbody>
</table>
Related Data Items:
Location Code {Cancer Surgery}
Section 4: Pathological Details
Tumour Size {Testicular Cancer}

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

Definition: This is the maximum diameter (mm) of the tumour.

Field Name: TSIZE
Field Type: Integer
Field Length: 4

Notes for Users:

If there is more than one lesion the size of the largest tumour should be recorded. The unit of measurement for tumours is mm.

If size of the tumour is not recorded record as ‘9999’ or if no surgery has been undertaken record as ‘1010’ not applicable.

Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, record as ‘1010’ not applicable.

Related Data Items:
Vascular Invasion {Testicular Cancer}
Rete Stromal Invasion {Testicular Cancer}
Vascular Invasion {Testicular Cancer}

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

**Definition:** A record to determine whether there has been vascular invasion.

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

**Notes for Users:**

Where “lymphovascular invasion” is noted within a pathology report record as 01 yes as terms are used interchangeably.

If vascular invasion is not recorded record as ‘99’ or if no surgery has been undertaken record as ‘96’ not applicable.

Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, 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>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>98</td>
<td>Cannot be assessed</td>
<td>E.g. technical failure</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
- Tumour Size {Testicular Cancer}
- Rete Stromal Invasion {Testicular Cancer}
Rete Stromal Invasion {Testicular Cancer}

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

Definition: A record to determine whether there has been rete stromal invasion.

Field Name: RSINV
Field Type: Integer
Field Length: 2

Notes for Users:

If rete stromal invasion is not recorded record as ‘99’ or if no surgery has been undertaken record as ‘96’ not applicable.

Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, 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>E.g. patient did not have surgery</td>
</tr>
<tr>
<td>98</td>
<td>Cannot be assessed</td>
<td>E.g. technical failure</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>E.g. patient had surgery but no information recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
- Tumour Size {Testicular Cancer}
- Vascular Invasion {Testicular Cancer}
TNM Tumour Classification (Final) {Testicular Cancer}


Definition: A record of the size and extent of the tumour of the testis.

Field Name: FINALT
Field Type: Characters
Field length: 2

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

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as ‘not recorded’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Primary tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td>E.g. histological scar in testis</td>
</tr>
<tr>
<td>T1</td>
<td>Tumour limited to testis and epididymis without vascular/lymphatic invasion; tumour may invade tunica albuginea but not tunica vaginalis*</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour limited to testis and epididymis with vascular/lymphatic invasion, or tumour extending through tunica albuginea with involvement of tunica vaginalis</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades spermatic cord with or without vascular/lymphatic invasion</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour invades scrotum with or without vascular/lymphatic invasion</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>

* AJCC subdivides T1 by T1a and T1b depending on size no greater than 3cm or greater than 3 cm in greatest dimension.
Related Data Items:
TNM Nodal Classification (Final) {Testicular Cancer}
TNM Metastasis Classification (Final) {Testicular Cancer}
S Category {Testicular Cancer}
TNM Nodal Classification (Final) {Testicular Cancer}

**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 involvement of the testis following resection of the primary cancer.

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

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

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as 'not recorded'.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis with a lymph node mass 2cm or less in greatest dimension and 5 or fewer positive nodes, none more than 2cm in greatest dimension</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis with a lymph node mass more than 2cm but not more than 5cm in greatest dimension; or more than 5 nodes positive, none more than 5cm; or evidence of extranodal extension of tumour</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis with a lymph node mass more than 5cm in greatest dimension</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- TNM Tumour Classification (Final) {Testicular Cancer}
- TNM Metastasis Classification (Final) {Testicular Cancer}
- S Category {Testicular Cancer}
TNM Metastasis Classification (Final) {Testicular Cancer}


Definition: A record of the extent of metastatic spread of the tumour of the testis following resection of the primary cancer.

Field Name: FINALM
Field Type: Characters
Field length: 2

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

Final TNM staging is a clinical/radiological/pathological classification of the size and extent of the (patient's cancer/disease). This represents the poorest (most advanced) stage of disease evident, as agreed by the MDT and informed by all available clinical, radiological and histopathological information.

If stage is not documented do not deduce from other information and record as 'not recorded'.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis</td>
<td></td>
</tr>
<tr>
<td>M1a</td>
<td>Non-regional lymph node(s) or lung metastasis</td>
<td></td>
</tr>
<tr>
<td>M1b</td>
<td>Distant metastasis other than non-regional lymph nodes and lung</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
TNM Tumour Classification (Final) {Testicular Cancer}
TNM Nodal Classification (Final) {Testicular Cancer}
S Category {Testicular Cancer}
S Category {Testicular Cancer}


Definition: This denotes the nadir levels as obtained after orchidectomy.

Field Name: SERUM
Field Type: Characters
Field length: 2

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

Testicular cancer staging is based on T, N, M and S, where S represents the value of the serum level of tumour markers in germ cell cancer (these are AFP, HCG and LDH). Patients may have normal markers with or without metastatic disease, but they are usually raised in metastatic cases.

Tumour markers should fall to normal levels with the removal of the primary tumour at orchidectomy in stage 1 disease. However, these markers fall with the following half-lives: AFP 5-7 days, HCG 24-48 hours and LDH 24-48 hours. The time to normalisation will depend on the initial pre-operative level and thus should be subject to serial measurements.

The interpretation of borderline levels should be taken with caution as they can be affected by other conditions such as post-operative complications or alcohol etc. hence clinicians look at a series of readings before designation of the S stage.

Generally after surgery, the S value will normalise (S0) however some stage 1 disease with persistently elevated or more accurately rising tumour markers means they have stage 1M or stage 1S i.e. biochemical evidence of disease without changes on CT of metastatic disease. If patients have a significantly raised or more accurately rising post-operative tumour marker level, they have metastatic disease, irrespective of CT staging.

A patient’s S value will change over time, for example following treatment, therefore a patient may have multiple S values recorded at different stages in their treatment pathway. For QPI audit purposes it is important to record the nadir result (post-surgical S value), at the appropriate time period after surgery (4-6 weeks after surgery).

For patients undergoing chemotherapy as their primary treatment, the S marker level should be assigned on the basis of the most recent marker on or before chemotherapy commences. S markers may be reported as Sx while marker results are awaited and therefore it is important to check for further results at a later date rather than record Sx within eCASE.
This must not be calculated and should only be recorded if actually documented in the case notes.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sx</td>
<td>Serum markers not available or not performed</td>
<td></td>
</tr>
<tr>
<td>S0</td>
<td>Serum marker study levels within reference range</td>
<td>E.g. Negative, normal limits</td>
</tr>
<tr>
<td>S1</td>
<td>LDH &lt;1.5 * N and hCG &lt;5,000(mIU/ml) and AFP &lt; 1000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>LDH 1.5-10* N or hCG 5,000 – 50,000 (mIU/ml) or AFP 1,000 -10,000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>LDH &gt;10 * N or hCG &gt;50,000(mIU/ml) or AFP &gt;10,000 (ng/ml)</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. S category not assessed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- TNM Tumour Classification (Final) {Testicular Cancer}
- TNM Nodal Classification (Final) {Testicular Cancer}
- TNM Metastasis Classification (Final) {Testicular Cancer}
Stage Grouping {Testicular Cancer}

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

**Definition:** This describes the extent of cancer in a patient’s body according to the TNM pathological classification.

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

**Notes for Users:** Required for QPI(s): 6, 8

If TNMS is not documented in the pathology report or MDT then clarify with relevant clinician, do not deduce from other information.

Where RMH staging is used this can be recorded where this system corresponds to UICC staging (Stage I and II), otherwise clarify with the relevant clinician.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Stage</th>
<th>T</th>
<th>N</th>
<th>M</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>T1-T4</td>
<td>N0</td>
<td>M0</td>
<td>SX</td>
</tr>
<tr>
<td>IA</td>
<td>T1</td>
<td>N0</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IB</td>
<td>T2-T4</td>
<td>N0</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IS</td>
<td>Any pT/TX</td>
<td>N0</td>
<td>M0</td>
<td>S1-S3</td>
</tr>
<tr>
<td>II</td>
<td>Any pT/TX</td>
<td>N1-N3</td>
<td>M0</td>
<td>SX</td>
</tr>
<tr>
<td>IIA</td>
<td>Any pT/TX</td>
<td>N1</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IIB</td>
<td>Any pT/TX</td>
<td>N2</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>IIC</td>
<td>Any pT/TX</td>
<td>N3</td>
<td>M0</td>
<td>S0</td>
</tr>
<tr>
<td>III</td>
<td>Any pT/TX</td>
<td>Any N</td>
<td>M1a</td>
<td>SX</td>
</tr>
<tr>
<td>Stage</td>
<td>T</td>
<td>N</td>
<td>M</td>
<td>S</td>
</tr>
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<td>-------</td>
<td>------------------</td>
<td>--------------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>IIIA</td>
<td>Any pT/TX, Any pT/TX</td>
<td>Any N, Any N</td>
<td>M1a</td>
<td>S0/S1</td>
</tr>
<tr>
<td>IIIB</td>
<td>Any pT/TX, Any pT/TX</td>
<td>N1-N3, Any N</td>
<td>M0</td>
<td>S2/S2</td>
</tr>
<tr>
<td>IIIC</td>
<td>Any pT/TX, Any pT/TX</td>
<td>N1-N3, Any N</td>
<td>M0</td>
<td>S3/S3</td>
</tr>
<tr>
<td></td>
<td>Any pT/TX, Any pT/TX</td>
<td>Any N, Any N</td>
<td>M1a/M1b</td>
<td>Any S</td>
</tr>
<tr>
<td>99</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
</tr>
</tbody>
</table>

**Related Data Items:**
**Morphology of Tumour {Testicular Cancer}**

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

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

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

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

If surgical resection has not been performed morphology of the tumour can be determined from biopsy.

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

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

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

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

If no invasive diagnostic procedures were undertaken record as inapplicable (1010/0).

Where patients have had systemic therapy prior to orchidectomy and the pathology report states that there is no evidence of viable malignancy, record as ‘1010’ not applicable.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>9061/3</td>
<td>Seminoma, classical</td>
</tr>
<tr>
<td>9063/3</td>
<td>Spermatocytic seminoma; spermatocytoma</td>
</tr>
<tr>
<td>9065/3</td>
<td>Germ cell tumour, nonseminomatous</td>
</tr>
<tr>
<td>9070/3</td>
<td>Embryonal carcinoma; embryonal adenocarcinoma</td>
</tr>
<tr>
<td>9080/3</td>
<td>Teratoma malignant, NOS; embryonal teratoma; teratoblastoma, malignant; immature teratoma, malignant; immature teratoma, NOS</td>
</tr>
<tr>
<td>9071/3</td>
<td>Yolk sac tumour; endostructural sinus tumour; polyvesicular vitelline tumour; orchioblastoma; embryonal carcinoma, infantile; hepatoid yolk sac tumour</td>
</tr>
<tr>
<td>9081/3</td>
<td>Teratocarcinoma; mixed embryonal carcinoma and teratoma</td>
</tr>
<tr>
<td>9085/3</td>
<td>Mixed germ cell tumour; mixed teratoma and seminoma</td>
</tr>
<tr>
<td>9100/3</td>
<td>Choriocarcinoma; chorionepithelioma; chorioepithelioma</td>
</tr>
<tr>
<td>9101/3</td>
<td>Choriocarcinoma combined with other germ cell elements; Choriocarcinoma combined with Teratoma; Choriocarcinoma combined with embryonal carcinoma.</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
</tr>
<tr>
<td>8888/8</td>
<td>Negative Pathology</td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
</tr>
<tr>
<td>1010/0</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Related Data Items:
Section 5: Oncology
Location Code {Radiotherapy Treatment}

Common Name(s): Location


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

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

Notes for Users: Required for regional/national analysis

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

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

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

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

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

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

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

Related Data Item(s):
Radiotherapy Course Type \{Testicular Cancer\}

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

**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 national survival analysis and national comparative analysis.

Combined treatments may be administered concurrently/synchronously e.g. chemotherapy and radiotherapy, intra-operative radiotherapy.

For patients undergoing chemoradiotherapy the radiotherapy element should be recorded as code ‘6’ and recorded also in SACT under code ‘5’.

All treatments given as part of the initial treatment plan

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</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.</td>
</tr>
<tr>
<td>5</td>
<td>Neo-adjuvant</td>
<td>It is given before potentially curative surgery.</td>
</tr>
<tr>
<td>6</td>
<td>Chemoradiotherapy</td>
<td>Radical radiotherapy given in combination with chemotherapy, either concurrently or sequentially. Chemotherapy element of this combined treatment should be recorded separately in field Type of Systemic Anti-Cancer Therapy (SACT) 1-3.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined radiotherapy treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**

**Date Treatment Started \{Testicular Cancer\} (Radiotherapy)**

**Date Treatment Completed \{Testicular Cancer\} (Radiotherapy)**
Date Treatment Started {Testicular Cancer} (Radiotherapy)

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

Definition: The date cancer treatment course commenced.

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

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

This is the first fraction of a course of radiotherapy.

Up to three courses may be recorded

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

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

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

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

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

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

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

**Notes for Users:**

This is the last fraction of a course of radiotherapy.

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

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

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

**Related Data Item(s):**
**Date of Serum Tumour Markers Test (Pre-SACT)**

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

**Definition:** This is the date the Serum Tumour Markers (STMs) test was performed prior to commencing SACT.

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

**Notes for Users:**

It is beneficial to measure STMs to allow for appropriate treatment planning.

Serum tumour markers (STMs) are:  
Alpha Feta Protein (AFP)  
Human Chorionic Gonadotropin (HCG)

If the STMs test was done on more than one occasion prior to the commencement of SACT then record the most recent one pre-SACT.

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

If no STMs test was performed record as 10/10/1900 (Not applicable).

**Related Data Items:**

*Definitions for the National Minimum Core Data Set for Testicular Cancer.*  
*Developed by ISD Scotland, 2014*
Calculation of Renal Function

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

Definition: This denotes the method used in the calculation of renal function.

Field Name: CALC
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 6

This should only be recorded for patients receiving Carboplatin otherwise 96 (not applicable) should be recorded.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
</table>
| 1    | Isotopic estimation of creatinine clearance | E.g. ethylenediaminetetraacetic acid (EDTA) or diethylenetriaminepentaacetic acid (DTPA)
      |                                             | This may also be described as Nuclear Medicine GFR estimation'                      |
| 2    | Other                                      | E.g. Blood, urine                                                                  |
| 96   | Not applicable                             | E.g. not assessed.                                                                |
| 99   | Not recorded                               |                                                                                  |

Related Data Items:
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 ISD and General Register Office (Scotland). http://www.natref.scot.nhs.uk/

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

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

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

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

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

Related Data Item(s):
Type of Systemic Anti-Cancer Therapy (SACT) 1-3

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

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

Field Name: CHEMTYPE1
CHEMTYPE2
CHEMTYPE3
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 6, 8,

Patients may have ongoing systemic therapy both before and after surgery. These patients should be recorded under neo-adjuvant Type. Some patients may have separate completion chemotherapy post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

Only those patients with stage 1 disease are eligible for ‘adjuvant’ chemotherapy. If the ‘adjuvant’ label is used in clinical letters or on CEPAS and stage is anything higher than stage 1b, including stage 1S/M, please seek clarification from a clinician to ensure that the correct SACT intention is recorded.

Primary chemotherapy is defined as chemotherapy given with curative intent, regardless of whether the patient has undergone surgery or not.

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

For patients undergoing chemoradiotherapy the chemotherapy element should be recorded as code ‘5’ and recorded also in ‘Radiotherapy Course Type) under code ‘6’.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neoadjuvant</td>
<td>Therapy given prior to radiotherapy or first definitive surgery to reduce tumour size.</td>
</tr>
<tr>
<td>2</td>
<td>Adjuvant</td>
<td>Only applicable for patients with stage 1 disease.</td>
</tr>
<tr>
<td>3</td>
<td>Primary</td>
<td>Chemotherapy given with curative intent whether surgery is performed or not.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent</td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Chemoradiotherapy</td>
<td>Can be sequential or concurrent. Radiotherapy element of this combined treatment should be recorded separately in field Radiotherapy Course Type (1-3)</td>
</tr>
<tr>
<td>7</td>
<td>Biological Therapy</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Adjuvant Single Agent Therapy - Carboplatin UC 7</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>E.g. Systemic therapy not given as primary part of therapy.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3

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

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE2
CHEMDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI(s): 1, 2, 3, 6, 8

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

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

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

Related data items:
Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3

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

Definition: The date cancer treatment course ended.

Field Name: CHEMENDATE1
           CHEMENDATE2
           CHEMENDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:

This is the first day of the last cycle of a course of chemotherapy, or biological therapy.

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

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

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

Related data items:
Type of Systemic Anti-Cancer Therapy (SACT) 1-3
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Testicular Cancer} 1-3
Section 6: Clinical Trials
Patient Entered into Clinical Trial

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

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: 3

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

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

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

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Yes – Chemotherapy</td>
</tr>
<tr>
<td>011B</td>
<td>Yes – Other trial</td>
</tr>
<tr>
<td>02</td>
<td>No</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Section 7: 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 PHS.

**Definition:** A record to determine if a MRI of the abdomen (+/- pelvis) has been undertaken for surveillance purposes.

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

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

This relates to MRI for patients on a pure surveillance regimen following orchidectomy.

This should be undertaken up to 8 months after initial staging CT scan (if surveillance MRI has been undertaken outwith this time the date should still be recorded).

Where there is no evidence that a MRI of the abdomen (+/- pelvis) has been undertaken, record as ‘2’ (No).

If the patient is not on a pure surveillance regimen, 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>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>95</td>
<td>Patient declined MRI</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>Patient is not under surveillance</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Definitions for the National Minimum Core Data Set for Testicular Cancer.  
Developed by ISD Scotland, 2014
Date Surveillance MRI Scan

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

Definition: The date MRI scanning of the abdomen (+/- pelvis) has been undertaken for surveillance purposes.

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

Notes for Users: Required for QPI: 12

This is the date the MRI of the abdomen (+/- pelvis) has been undertaken for surveillance purposes.

This should be recorded for patients on a pure surveillance regimen i.e. on surveillance post orchidectomy with no adjuvant chemotherapy or radiotherapy.

For those patients who are not on a pure surveillance regimen, record as not applicable (10/10/1900).

If the patient has not had a MRI of the abdomen (+/- pelvis) then record as not applicable (10/10/1900).

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).

Related data item(s):
Date of Death

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

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

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

Notes for Users: Required for national survival analysis.

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

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

Related Data Items: