Oesophago-Gastric (OG) Cancer

Data Definitions for the
National Minimum Core Dataset to Support the Introduction of Oesophago-Gastric (OG) Cancer Quality Performance Indicators

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

Version 5.0: April 2023

To be used in conjunction with:

1. Oesophago-Gastric (OG) Cancer Clinical Quality Performance Indicators V4.0 (September 2020)
2. Oesophago-Gastric (OG) Cancer QPI Dataset Validations (Latest published version)
3. Oesophago-Gastric (OG) Cancer Measurability of Quality Performance Indicators (Latest published version)
# DOCUMENT CONTROL SHEET

## Key Information

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OG Cancer Measurability of Quality Performance Indicators |
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## Revision History

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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 2012.

Scotland has one of the highest incidences of Oesophago-gastric(OG) cancer in the world. It is a cancer that is usually advanced at the time of presentation and tends to occur in an elderly population with significant co-morbidity. 75% of patients receive palliative treatment as curative treatment is either impossible or inappropriate. This symptom palliation involves oncology and palliative care support, but dysphagia (difficulty in swallowing) and difficulty in eating requires the support of dietetics and endoscopic intervention.

Curative treatment carries a significant morbidity and mortality as it involves combination treatments of neo-adjuvant chemotherapy followed by surgical resection or chemoradiotherapy. The nature of the disease and the risk associated with treatment mean that curative treatment is only performed after a staging process has demonstrated localised disease, but this can involve a variety of investigations including CT scan, CT-PET, Endoscopic ultrasound and laparoscopy.

The particular challenge for clinicians in the management of OG cancer is, therefore, that the majority of patients need effective local symptom palliation in primary and secondary care while patients suitable for curative treatment may have to travel for tertiary investigations or treatment. It is imperative that the cancer networks work together in ensuring that the journey of care provides for the individual patient’s needs regardless of their point of presentation or nature of disease.

It is our intention that the QPIs that we have produced reflect the various components of the patient pathway. They have been developed as a collaborative approach involving multiple disciplines from all of the regions in Scotland. We would hope that their utilisation will lead to an improvement of cancer care for this unfortunate group of patients.

Colin K MacKay
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with Oesophago-Gastric (OG) cancer on or after 1st January 2023, who are eligible for inclusion in the OG cancer audit.

Changes to definitions fall into the following categories:

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

General enquiries on the collection of the National Minimum Core Dataset

If you have any difficulties in using individual definitions within this document, or any comments on the data definitions, PHS would welcome your feedback.

Please contact phs.canercaudit@phs.scot

CONVENTIONS

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

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

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

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

Revisions to Dataset Following Formal Review (May 2023)

Database Specification

**COVID 19 Impact** – Remove data item Field Name: COVID, Field Type: Integer, Field Length: 2

**Date of PDL1 Reporting** – add new Data item Field Name: PDL1REPORT, Field Type: Date (DD/MM/CCYY), Field Length: 10

**PDL1 Score {OG Cancer}** – add new data item Field Name: PDL1STATUS, Field Type: Characters, Field Length: 4

**Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)** – Remove data item Field Name: CHEMENDATE, Field Type: Date (DD/MM/CCYY), Field: Integer, Field Length: 10

**Dataset**

**QPI Title** – Rename ‘Upper GI Cancer’ to ‘Oesophago-Gastric (OG) Cancer’

**NOTES FOR IMPLEMENTATION OF CHANGES** – Amend ‘upper GI’ to ‘Oesophago-Gastric (OG)’ & amend ‘January 2021’ to ‘January 2023.’

**Date of Referral** – Definition remove ‘renal’ replace with ‘OG’

**CT Imaging Investigations** – Codes & Values Table remove ‘Code 3 – Incomplete’ & amend ‘refused’ to ‘declined’, Explanatory notes remove ‘not dponeno’ replace with ‘CT abdomen’

**Date of Diagnosis (Cancer)** – Notes for Users add ‘QPI 15’, remove ‘Upper-GI’ & replace with ‘OG’

**Site of Origin of Primary Tumour (Cancer)** – Notes for Users Add ‘QPI 15’

**TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** – Amend title to ‘TNM Tumour Classification (Clinical) {OG Cancer} (Pre-treatment). Notes for Users add ‘If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.’

**TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** – Amend Title to ‘TNM Nodal Classification (Clinical) {OG GI Cancer} (Pre-treatment)’. Notes for users add ‘If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM
documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.'

**TNM Metastases Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** – Title amend to ‘TNM Metastases Classification (Clinical) {OG Cancer} (Pre-treatment)’. Notes for users add ‘If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.’

**TNM Recorded at MDT** – Notes for users add ‘If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable. This should be documented at an MDT within 4 weeks of EMR.’

**Date Discussed by Care Team** – Notes for users remove ‘Upper GI’ replace with ‘OG’

**COVID 19 Impact** – Remove Data Item.

**Treatment Intent Recorded at MDT** – Notes for Users ‘add Treatment intent may be amended at subsequent MDT following discussion with the patient. The final treatment intent prior to treatment should be recorded.’ Codes & Values table amend ‘refused’ to ‘declined’.

**Type of First Cancer Treatment** – Notes for users add QPI 15. Codes & Values table Code 3 – Explanatory notes add ‘chemoimmunotherapy and immunotherapy.’ & amend ‘refused’ to ‘declined’

**Date of First Cancer Treatment** – Notes for users amend ‘Required for’ to ‘Required for QPI: 5 and for’. Amend ‘refused’ to ‘declined’.

**Title Date of Definitive Treatment {Upper GI Cancer}** – amend to ‘Date of Definitive Treatment {OG Cancer}. Notes for users remove ‘upper GI’ & replace with ‘OG’ & amend ‘refused’ to ‘declined’

**First Endoscopic Treatment** – Codes & Values table amend ‘refused’ to ‘declined’.

**Location Code (Cancer Surgery)** – Notes for users amend ‘refused’ to ‘declined’

**Main Type of Definitive Operation {Upper GI Cancer}** – Title amend to ‘Main Type of Definitive Operation {OG Cancer}’, Definition remove ‘Upper GI’ replace with ‘OG’, Codes & Values table amend ‘refused’ to ‘declined’
**Surgical Approach {Upper GI Cancer}** – Title amend to ‘Surgical Approach {OG Cancer}’.

**Date of Definitive Surgery** – Notes for users add ‘QPI 9’

**Operating Consultant Surgeon (1-2) {Upper GI Cancer}** – Title amend to ‘Operating Consultant Surgeon (1-2) {OG Cancer}’.

**Morphology of Tumour** – Notes for users add ‘QPI 15’

**Involvement of Longitudinal Margin {Upper GI Cancer}** – Title amend to ‘Involvement of Longitudinal Margin {OG Cancer}’

**TNM Tumour Classification (Pathological) {Upper GI}** – Title amend to ‘TNM Tumour Classification (Pathological) {OG Cancer}’. Definition remove ‘upper GI’ replace with ‘OG’

**TNM Nodal Classification (Pathological) {Upper GI}** – title amend to ‘TNM Nodal Classification (Pathological) {OG Cancer}’

**TNM Metastasis Classification (Pathological) {Upper GI}** – Title amend to ‘TNM Metastasis Classification (Pathological) {OG Cancer}’

**Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Upper GI Cancer}** – Title amend to ‘Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {OG Cancer}’

**Date of PDL1 Reporting** – Add new data item

**PDL1 Score {OG Cancer}** – Add new data item

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

**Date Treatment Started (Radiotherapy) {Upper GI Cancer} (1-2)** – Title amend to ‘Date Treatment Started (Radiotherapy) {OG Cancer} (1-2)’. Notes for users amend ‘refused’ to ‘declined’.

**Date Treatment Completed (Radiotherapy) {Upper GI Cancer} (1-2)** – Title amend to ‘Date Treatment Completed (Radiotherapy) {OG Cancer} (1-2)’

**Radiotherapy Course Type (1-2) {Upper GI Cancer}** – Title amed to ‘Radiotherapy Course Type (1-2) {OG Cancer}’. Notes for users amend ‘refused’ to ‘declined’

**Location Code {SACT Treatment}** – Notes for users amend ‘refused’ to ‘declined’
Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer} –
Title amend to ‘Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {OG Cancer}’. Notes for users add ‘OPI 15’ & ‘Chemotherapy, immunotherapy and chemoimmunotherapy should be recorded under the setting in which they are given i.e. Adjuvant, Neoadjuvant or Palliative.’ remove ‘Trastuzumab is currently the only AntiHer2 therapy indicated and is for gastro-oesophageal junction cancers.’; Codes & Values table Code 1 Explanatory notes remove ‘The start of adjuvant SACT is’ & add ‘Systemic therapy given’. Code 2 add ‘Systemic’. Code 4 Palliative Explanatory notes add ‘This includes chemotherapy given in combination with Anti-HER2 therapy.’ Remove Code 15 - Chemotherapy in combination with AntiHer2 Therapy’. Code 95 amend ‘refused’ to ‘declined’

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) –
Notes for users add ‘QPI 15’

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) –
Remove data item

Date of Death – Notes for users remove ‘QPI 12’

Revisions to Dataset outwith review (July 2022)

CHI Number CHINUM – Field type changed from integer to character

Date of Referral REFERDATE – item updated table of guidance added

Revisions to Dataset Outwith Review (February 2021)

Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Upper GI Cancer} – Notes for user amend ‘HER2 testing would normally be carried out for patients with metastatic gastric and gastro-oesophageal junction cancers only.’ to ‘HER2 testing would normally be carried out for patients with metastatic gastric and oesophageal cancers.’

Covid 19 Impact – Leading zero dropped from data item integers with a value below 10.

Rebranding Updates (February 2021)

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

Revisions to Dataset Following Formal Review (November 2020)

Database Specification
Referral to Dietitian & Date of Referral for Nutritional Assessment – removed Data Items

Dietetic Assessment, Date of Dietetic Assessment, Date of Discharge, TNM Recorded at MDT, Location Code {SACT Treatment} and Location Code {Radiotherapy Treatment} – added new Data Items

Dataset

TNM Tumour Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Metastases Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
– text in user notes updated and explanatory note “e.g. If not discussed at MDT” removed from code 96.

Date Discussed by Care Team – Notes for users text updated to remove ‘May be used for analysis of generic QPI relating to MDT meetings’

Referral to Dietitian & Date of Referral for Nutritional Assessment – removed Data Items

Dietetic Assessment, Date of Dietetic Assessment, Date of Discharge, TNM Recorded at MDT, Location Code {SACT Treatment} and Location Code {Radiotherapy Treatment} – added new Data Items

Main Type of Definitive Operation {Upper GI Cancer} – notes for users: Required for QPI(s): 9 has been inserted.

Date Treatment Completed (Radiotherapy) {Upper GI Cancer} (1-2) - notes for users: Required for QPI(s): 12 has been removed

Radiotherapy Course Type (1-2) {Upper GI Cancer} - notes for users: Required for QPI(s): 12 has been removed

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) - notes for users: Required for QPI(s): 12 has been removed

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 - 1 January 2019

Revisions to Dataset outwith review (February 2020)

**Date of Initial Investigative Endoscopy** – Notes for Users add ‘a patient under routine surveillance for Barrett’s, with no clinical reason to suspect cancer, the endoscopy at which cancer was diagnosed should be used as the index endoscopy’. Amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

**Date of Diagnosis (Cancer)** – Notes for Users amend ‘09/09/0909’ to ‘09/09/1900’

**Date of Histological Diagnosis (Cancer)** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

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

**Date of Nutritional Screening** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

**Date of Referral for Nutritional Assessment** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

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

**Date of Definitive Treatment** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

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

**Date of Definitive Surgery** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

**Date of HER2 reporting** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

**Date Treatment Started (Radiotherapy) {Upper GO} (1-2)** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

**Date Treatment Completed (Radiotherapy) {Upper GO} (1-2)** - Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) -
Notes for Users amend ‘10/10/1010’ to ‘10/10/1900’, ‘09/09/0909’ to ‘09/09/1900’.

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

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

Revisions to Dataset Outwith Review (January 2018)
TNM Tumour Classification (Clinical) {Upper GI Cancer} (Pre-treatment) -
Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017; Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9),Insert ‘azygos vein, or peritoneum’ to values for T4a; Stomach (ICD-O(3) C16.1-C16.9) Change ‘Tumour penetrates subserosa’ to ‘Tumour invades subserosa’ to values for T3, remove ‘curvature’ from explanatory notes for pT4b

TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment) -

TNM Metastases Classification (Clinical) (Upper GI Cancer) (Pre-treatment) - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

TNM Tumour Classification (Pathological) {Upper GI} - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017; ; Insert ‘azygos vein, or peritoneum’ to values for T4a; Change ‘Tumour penetrates subserosa’ to ‘Tumour invades subserosa’ to values for T3, remove ‘curvature’ from explanatory notes for pT4b

TNM Nodal Classification (Pathological) {Upper GI} - Main Source of Data Item Standard and definition changed from Seventh Edition, 2009 to Eighth Edition 2017

TNM Metastasis Classification (Pathological) {Upper GI} - Main Source of Data Item Standard changed from Seventh Edition, 2009 to Eighth Edition 2017

Date of First Cancer Treatment - Insert into Notes for Users ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.

Date of Definitive Treatment - Insert into Notes for Users ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.’

Person Family Name (at Diagnosis) – link updated
Person Given Name – link updated

Patient Postcode at Diagnosis {Cancer} – link updated

Date of Birth – link updated

Revisions to Dataset Following Formal Review (April 2017)

Dataset Specification - Removed space from CHEMDATE 1 and CHEMDATE 2

CT imaging investigations – Notes for Users removed ‘required for QPI(s) 2’

Date of Diagnosis (Cancer) – Notes for Users required for QPI(s) removed 2, 12 and inserted 13

Site of Origin of Primary Tumour (Cancer) – Notes for Users required for QPI(s) removed 2, 12 and inserted 13

TNM Metastases Classification (Clinical) {Upper GI} (Pre-treatment) – Notes for Users required for QPI(s) inserted 13

Date of Nutritional Screening – add New Data Item

Malnutrition Universal Screening Tool (MUST) Score – add New Data Item

Referral to Dietitian – add New Data Item

Date of Referral for Nutritional Assessment – removed ‘Required for QPI(s) –5’

Type of First Cancer Treatment – Notes for Users required for QPI(s) inserted 13

Main Type of Definitive Operation {Upper GI Cancer} – Notes for Users inserted text ‘Required for QPI(s)”; inserted the following text within explanatory notes for Code 1 ‘Gastrectomy can be treatment for types III tumours of the GO junction (classed as oesophageal cancer) as well as gastric cancer’

Morphology of Tumour – Notes for Users inserted the following text ‘QPI(s): 13, Also for’

Date of HER2 Reporting – add new Data Item.

Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {Upper GI Cancer} – add New Data Item
Radiotherapy Course Type (1-2) {Upper GI Cancer} – removed code 7 – Chemoradiotherapy, inserted the following codes, value and explanatory notes;

Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer} – required for QPI(s) inserted 13; inserted the text ‘Maintenance therapy will occur immediately after the chemotherapy combination regime and there is no requirement to record this separately. Trastuzumab is currently the only AntiHer2 therapy indicated and is for gastro-oesophageal junction cancers’. Removed code 7 – chemoradiotherapy; inserted the following codes, values and explanatory notes;

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) – inserted ‘required for QPI(s): 13’. Inserted text ‘There is no requirement to record maintenance therapy separately’.

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) (CHEMENDATE1-2) – inserted text ‘Where maintenance therapy has been given there is no requirement to complete the date this treatment ended. The date of the chemotherapy in combination with AntiHer2 therapy should be recorded’.

Revisions to Dataset Outwith Review (June 2015)

Date of Referral for Nutritional Assessment - amended notes for users “prior to treatment” removed.

Revisions to Dataset Following Baseline Review (May 2015)

CT Imaging Investigations - Remove ‘contrast enhanced’ from definition. Add code and value for CT abdomen only. Change note to users to ‘and/or chest and/or pelvis’.

Location of Diagnosis (Cancer) - add code for not recorded as per query 608 on query log.

Location Code {Cancer Surgery} – Update link to reference files.

Revisions to Dataset Outwith Review (December 2014)

Morphology of Tumour – Table of Codes and Values add ‘medullary carcinoma 8510/3’.

Revisions to Dataset Outwith Review (June 2014)

Dataset

Date of Definitive Treatment {Upper GI} – add New Data Item
Database Specification

**Date of Definitive Treatment {Upper GI}** - add New data item added: Field Name: DEFTREATDATE, Field Type: Date (DD/MM/CCYY), Field Length: 10

**Dataset**

**Type of Systemic Anti-Cancer Therapy {Upper GI Cancer}** – Explanatory Notes Curative Treatment removed from code 7 Chemoradiotherapy.

**TNM Metastasis Classification (Pathological) {Upper GI}** – Codes and Values Table Code pM0 – No distant metastasis removed

**Revisions to Dataset Outwith Review February 2014**

**Criteria for Inclusion of Patients in Audit** - Added ‘neuroendocrine tumours’ to list of exclusions.

**Revisions to Dataset Outwith Review (December 2013)**

**Dataset** - Location of Diagnosis (Cancer)

**TNM Tumour Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** – Explanatory Notes amended code 96 – added “If not discussed at MDT”

**TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** - Explanatory Notes amended code 96 – added “If not discussed at MDT”.

**TNM Metastases Classification (Clinical) {Upper GI Cancer} (Pre-treatment)** – Explanatory Notes amended code 96 – added “If not discussed at MDT” into the explanatory notes.

**Date Discussed by Care Team** - Notes for Users add “relevant to the treatment of Upper GI cancer”

**Treatment Intent Recorded at MDT {Pre-treatment}** – Title remove {Pre-treatment}. Codes and Values Table added the following examples in the explanatory notes ‘Code 2 – Radical – Down staging with curative intent’ and ‘Code 3 – Palliative – stent’

**Type of First Cancer Treatment** - Notes for Users add “Treatment to metastatic disease counts as first treatment e.g. radiotherapy to metastatic disease.”
Surgical Approach - Codes and Values Table explanatory notes for code 1 – Open “Open includes midline, rooftop, horizontal skin incision and thoracoabdominal opening muscle with ultrascion.”

Morphology of Tumour - Codes and Values Table Removed code “8246/3 – Neuroendocrine carcinoma; synonymous with carcinoid – Oesophageal tumours”

Involvement of Circumferential Margin – Notes for Users add ‘For resection and Endoscopic mucosal resection patients only’. Codes and Values Table added the following codes ‘C150 Cervical oesophagus’, ‘C151 Thoracic oesophagus’, ‘C152 Abdominal part of oesophagus’, ‘C153 Upper third of oesophagus’, ‘C154 Middle third of oesophagus’, ‘C155 Lower third of oesophagus’, ‘C158 Overlapping lesion of oesophagus’, ‘C159 Oesophagus, NOS’, ‘C160 Cardia, NOS’. Explanatory notes added for ‘code 1 – Yes EMR refers to circumferential peripheral and deep margin assessment’

Involvement of Longitudinal Margin – Codes and Values Table Explanatory Notes added ‘code 96 – Not Applicable’ Endoscopic Mucosal Resection (EMR). Add to Notes by Users ‘EMR has no involvement of longitudinal margin therefore record as not applicable’.

TNM Tumour Classification (Pathological) {Upper GI} - Notes for Users remove “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation.

TNM Nodal Classification (Pathological) {Upper GI} - Notes for Users remove “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation.

TNM Metastasis Classification (Pathological) {Upper GI} – Notes for Users removed “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation”

Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer} - Notes for Users added a) or ‘active surveillance’. Explanatory notes for Neoadjuvant removed “to reduce tumour size”. Codes and Values Table added 11 – Downstaging Chemotherapy - New code - Chemotherapy given to initially inoperable tumours to make surgically operable added;
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 cancer of the Upper GI tract (ICD-O(3) codes C15 and C16)
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
  - In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

Multiple independent primary tumours should be recorded separately.

Exclude:
- Patients where the origin of the primary is uncertain
- Patients with tumour type sarcoma or lymphoma
- Neuroendocrine tumours
- Patients with recurrent disease (as opposed to a new primary)
- Patients with metastases in the Upper GI tract originating from another primary site.
- Patients with carcinoma in situ, non-invasive tumours, GIST 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.
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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<tr>
<th>DATA ITEM</th>
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<th>FIELD TYPE</th>
<th>SIZE</th>
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<td>Section 1: Demographic Items</td>
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<td>Section 2: Pre-treatment Imaging &amp; Staging Investigations</td>
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<td><strong>Section 3: Endoscopic Treatment/Surgery</strong></td>
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<td><strong>Section 4: Pathology Details</strong></td>
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<td><strong>Section 5: Oncology</strong></td>
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<td><strong>Section 6: Clinical Trial Entry</strong></td>
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<td><strong>Section 7: Death Details</strong></td>
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<td>Date of Death</td>
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</table>
Section 1: Demographic Items
Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

From SMR Definitions and Codes

Codes and Values: N/A

Notes by Users:
Person Given Name

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

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition: The forename or given name of a person.

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

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

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

Codes and Values: N/A

Notes by Users:
Patient Postcode at Diagnosis (Cancer)

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Codes and Values: N/A

Related Data Items: Date of Histological Diagnosis
Date of Birth

Main source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Codes and Values: N/A

Related Data Items: CHI Number

Notes by Users:
Person Sex at Birth

Common Name(s): Sex at Birth

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

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

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

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

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

Codes and Values:

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<th>Value</th>
<th>Explanatory Notes</th>
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</tr>
<tr>
<td>2</td>
<td>Female</td>
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</tr>
<tr>
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Related Data Items: CHI Number

Notes by Users:
CHI Number

**Main Source 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.

**Codes and values:** N/A

**Related Data Items:** Date of Birth, Person Sex at Birth.

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

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

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

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

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

See table overleaf

**Notes by Users:**
<table>
<thead>
<tr>
<th>Referral Mode</th>
<th>Guidance on date of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><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>
CT Imaging Investigations

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

Definition: An indication of whether or not staging investigations were completed by CT at the same time.

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

Notes for Users:

CT of the abdomen +/- chest +/- pelvis.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CT Chest and Abdomen</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CT Chest, Abdomen and Pelvis</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>CT Abdomen</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined investigations</td>
<td>e.g. no CT abdomen</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no CT abdomen</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Date of Initial Investigative Endoscopy

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

Definition: This denotes the date that the initial investigative endoscopy was performed.

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

Notes for Users: Required for QPI: 1

The first investigative endoscopy should be recorded and may not relate to the date of histological diagnosis, or a cancer investigation.

A patient under routine surveillance for Barrett’s, with no clinical reason to suspect cancer, the endoscopy at which cancer was diagnosed should be used as the index endoscopy.

Where multiple endoscopies are undertaken in the 12 month period prior to the date of histological diagnosis, record the earliest date.

If no part of the date is recorded, use 09/09/1900.

If an endoscopy was not performed, record as 10/10/1900 (Not applicable).
Location of Diagnosis (Cancer)


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

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

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

This will be the hospital where the sample was taken or the hospital at which the patient was managed when the diagnosis was made.

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

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

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

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

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

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

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

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

**Notes for Users:** Required for QPI(s): 1, 3 – 11, 13, 15  
Required for national survival analysis and national comparative analysis.

The date recorded is the date of the first investigative procedure that confirms a diagnosis of OG cancer whether done radiologically or histologically.

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

The date of diagnosis may not relate to ‘Most Valid Basis of Diagnosis’.

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

**Related Data Item(s):**  
Location of Diagnosis (Cancer)

**Notes by Users:**
Date of Histological Diagnosis (Cancer)

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

Definition: The date on which the cancer was diagnosed microscopically following endoscopy and biopsy.

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

Notes for Users: Required for QPI: 1

If endoscopy and biopsy was not carried out or no histological diagnosis made, record as 10/10/1900.

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

The date of diagnosis may not relate to ‘Most Valid Basis of Diagnosis’.

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

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


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

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

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

The methods of diagnosis from 1-8 are listed in essentially ascending order of validity, microscopic methods having greater validity than non-microscopic methods.

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

Codes and Values:

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

Notes by Users:
Site of Origin of Primary Tumour (Cancer)

**Main Source of Data Item Standard:** The World Health Organisation (WHO) International Classification of Disease (ICD-O(3)).

**Definition:** The anatomical site of origin of the primary tumour according to the International Classification of Diseases for Oncology (ICD-O(3)).

**Field Name:** SITE  
**Format:** Characters ICD-O(3)  
**Field length:** 4

**Notes for Users:** Required for QPI(s): 1, 3 – 11, 13, 15.

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

**Codes and Values:**

<table>
<thead>
<tr>
<th>ICD-O(3)</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C150</td>
<td>Cervical oesophagus</td>
<td></td>
</tr>
<tr>
<td>C151</td>
<td>Thoracic oesophagus</td>
<td></td>
</tr>
<tr>
<td>C152</td>
<td>Abdominal part of oesophagus</td>
<td></td>
</tr>
<tr>
<td>C153</td>
<td>Upper third of oesophagus</td>
<td>Proximal third of oesophagus Up to 20cm from back of teeth</td>
</tr>
<tr>
<td>C154</td>
<td>Middle third of oesophagus</td>
<td>20-30cm from back of teeth</td>
</tr>
<tr>
<td>C155</td>
<td>Lower third of oesophagus</td>
<td>Distal third of oesophagus 30-40cm from back of teeth</td>
</tr>
<tr>
<td>C158</td>
<td>Overlapping lesion of</td>
<td></td>
</tr>
<tr>
<td>C159</td>
<td>Oesophagus, NOS.</td>
<td></td>
</tr>
</tbody>
</table>
| C160     | Cardia, NOS.                   | Gastric cardia  
Cardio-oesophageal junction  
Oesophagogastric Junction  
Gastro- oesophageal junction |
| C161     | Fundus of stomach              | Gastric fundus                                                                   |
| C162     | Body of stomach                | Corpus of stomach  
Gastric corpus                                                                      |
| C163     | Gastric antrum                 | Antrum of stomach  
Pyloric antrum                                                                  |
| C164     | Pylorus                        | Prepylorus  
Pyloric canal                                                                |
<p>| C165     | Lesser curvature of stomach,   | Lesser curvature of stomach, not classifiable to C16.0 – C16.4                  |
|          | unspecified                    |                                                                                  |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C166</td>
<td>Greater curvature of stomach, unspecified</td>
<td>Greater curvature of stomach, not classifiable to C16.0 – C16.4</td>
</tr>
<tr>
<td>C168</td>
<td>Overlapping lesion of the stomach</td>
<td>Anterior wall of stomach, NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not classifiable to C16.0 to C16.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Posterior wall of stomach, NOS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not classifiable to C16.0 to C16.4</td>
</tr>
<tr>
<td>C169</td>
<td>Stomach, (NOS)</td>
<td>Gastric, NOS</td>
</tr>
</tbody>
</table>

**Notes by Users:**
TNM Tumour Classification (Clinical) (OG Cancer) (Pre-treatment)

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

**Definition:** This is the size of the tumour as determined by physical examination and imaging techniques (not pathological), and is coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

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

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes or at the multidisciplinary team meeting (MDT) based on best knowledge. For the majority of cases, this will be recorded at the MDT meeting where decision to treat was discussed. If pre-treatment stage is not documented at MDT and is available in the clinical record, then this should be recorded.

If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.

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

For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation.

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table is recommended.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>-------------------</td>
</tr>
<tr>
<td>T1</td>
<td>Tumour invades lamina propria, muscularis mucosae, or submucosa</td>
<td></td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour invades lamina propria or muscularis mucosae</td>
<td></td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour invades submucosa</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades adventitia</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour invades adjacent structures</td>
<td></td>
</tr>
<tr>
<td>T4a</td>
<td>Tumour invades pleura, pericardium, azygos vein, diaphragm or peritoneum</td>
<td></td>
</tr>
<tr>
<td>T4b</td>
<td>Tumour invades other adjacent structures such as aorta, vertebral body, or trachea</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>Tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>T Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>T Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Stomach (ICD-O(3) C16.1-C16.9)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>T1</td>
<td>Tumour invades lamina propria, muscularis mucosae, or submucosa</td>
<td></td>
</tr>
<tr>
<td>T1a</td>
<td>Tumour invades lamina propria or muscularis mucosae</td>
<td></td>
</tr>
<tr>
<td>T1b</td>
<td>Tumour invades submucosa</td>
<td></td>
</tr>
<tr>
<td>T2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>T3</td>
<td>Tumour invades subserosa</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour perforates serosa (visceral peritoneum) or invades adjacent structures</td>
<td></td>
</tr>
<tr>
<td>T4a</td>
<td>Tumour perforates serosa</td>
<td></td>
</tr>
<tr>
<td>T4b</td>
<td>Tumour invades adjacent structures</td>
<td>The adjacent structures of the stomach are the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine and retroperitoneum. Intramural extension to the duodenum or oesophagus is classified by the depth of greatest invasion in any of these sites, including stomach. Tumour that extends into gastrocolic or gastrohepatic ligaments or into greater or lesser omentum, without perforation of visceral peritoneum, is T3.</td>
</tr>
<tr>
<td>TX</td>
<td>Tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>T Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>T Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related data items:**
TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Metastases Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Nodal Classification (Clinical) {OG Cancer} (Pre-treatment)

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

**Definition:** This is the size and position of nodes detected by physical examination and imaging techniques (not pathological), and is coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

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

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment.

This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes or at MDT based on best knowledge. For the majority of cases, this will be at the MDT meeting where decision to treat was discussed. If pre-treatment stage is not documented at MDT and is available in the clinical record, then this should be recorded.

If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.

For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation.

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

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table is recommended.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis in 1-2 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in 3-6 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in 7 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>N Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>N Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Stomach (ICD-O(3) C16)

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>N1</td>
<td>Metastasis in 1-2 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N2</td>
<td>Metastasis in 3-6 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N3</td>
<td>Metastasis in 7 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N3a</td>
<td>Metastasis in 7-15 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>N3b</td>
<td>Metastasis in 16 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>N Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>N Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
TNM Tumour Classification (Clinical) {Upper GI Cancer}{Upper GI Cancer} (Pre-treatment)
TNM Metastases Classification (Clinical) {Upper GI Cancer}{Upper GI Cancer} (Pre-treatment)

**Notes by Users:**
TNM Metastases Classification (Clinical) {OG Cancer} (Pre-treatment)

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

**Definition:** This indicates the extent of the spread of the disease outwith the upper GI determined by clinical, imaging and biochemical methods (not pathological), and is coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Eighth Edition, 2017).

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

**Notes for Users:** Required for QPI: 4  
In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

The TNM system is based on the assessment of three components (T tumour, N node and M metastases) and the addition of numbers after the letter components to indicate the extent of the malignant disease.

Clinical TNM is derived from all the clinical, radiological and biochemical results prior to treatment. This is a pre/non-operative classification as defined prior to first treatment and documented in patient notes or at MDT based on best knowledge. For the majority of cases, this will be recorded at the MDT meeting where decision to treat was discussed. If pre-treatment stage is not documented at MDT and is available in the clinical record, then this should be recorded.

If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.

For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TxNxM1 is therefore accepted as complete staging in this situation.

If stage is not documented in the clinical record, 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>96</td>
<td>M Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>M Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9, C16.0). Stomach (ICD-O(3) C16)**
Related Data Items:
TNM Tumour Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
TNM Recorded at MDT

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

**Definition:** A record of whether the TNM is recorded at the MDT meeting.

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

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

This is a record of whether a pre/non-operative TNM classification has been recorded at MDT. For the majority of cases, this will be recorded at the MDT meeting where decision to treat was discussed.

If the cancer is an incidental finding, and EMR has been used for staging purposes & treatment then a TNM documented at MDT post EMR (with CT prior or subsequent to EMR and EMR information available) is acceptable.

This should be documented at an MDT within 4 weeks of EMR.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>Patient is discussed at MDT but cT,cN and cM not all recorded.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

**Notes by Users:**
Date Discussed by Care Team

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 of the first care team meeting that was held to discuss the management of the patient's care.

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

Notes for Users: Required for QPI: 3

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, speech language therapists, physiotherapists and others relevant to the treatment of OG cancer e.g. a patient with high oesophageal cancer may be discussed first/only by Head & Neck MDT. The team meets on a regular basis to discuss optimal patient management. Documentation of the discussion should be included in the case-note or other formal documentation.

The first MDT meeting date will be recorded.

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

Notes by Users:
Treatment Intent Recorded at MDT

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

**Definition:** This is intent of treatment plan, which should be agreed, for the majority of cases, at the MDT meeting where decision to treat was discussed.

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

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

It is highly unlikely that any treatment plan would be drawn up, where the intention of the treatment is recorded as ‘Not recorded'. The use of this code should be carefully monitored.

Treatment intent may be amended at subsequent MDT following discussion with the patient. The final treatment intent prior to treatment should be recorded.

### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Radical</td>
<td>Treatment given with the potential for cure (radical treatment). E.g. downstaging with curative intent.</td>
</tr>
<tr>
<td>3</td>
<td>Palliative</td>
<td>Any treatment given for the control of symptoms resulting from the cancer e.g. surgery, radiotherapy, Systemic Anti-Cancer Therapy (SACT) or stent.</td>
</tr>
<tr>
<td>4</td>
<td>Supportive care only</td>
<td>Care aimed at symptom control and sustaining the patients and/ or carers ability to cope with a medical condition.</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before MDT</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined treatment</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Other</td>
<td>Treatment plans which do not align with codes noted above (i.e. radical, palliative, supportive care)</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>e.g. No plan, plan not discussed at MDT meeting</td>
</tr>
</tbody>
</table>

**Notes by Users:**
Date of Nutritional Screening

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

Definition: This denotes the date the patient underwent nutritional screening using the Malnutrition Universal Screening Tool (MUST).

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

Notes for Users: Required for QPI: 5

This is the date the patient underwent nutritional screening using MUST.

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

If the patient did not receive nutritional screening, e.g. patient declined or where not applicable, record as 10/10/1900 (not applicable).
Malnutrition Universal Screening Tool (MUST) Score

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

Definition: The overall score derived from screening using the validated Malnutrition Universal Screening Tool (MUST) to assess nutritional risk.

Field Name: MUST
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 5

The score should be documented within the patient record and / or at MDT.

If the overall score is not documented do not deduce from other information and record as 99 'Not recorded'.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Low Risk</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Medium Risk</td>
</tr>
<tr>
<td>2</td>
<td>2 or more</td>
<td>High Risk</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>MUST Screening not undertaken</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Dietetic Assessment

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

Definition: This denotes whether the patient was assessed by a dietitian.

Field Name: ASSES Diablo
Field Type: Integer
Field length: 2

Notes for Users: Required for QPI: 5.

Dietetic assessment must include interaction with the patient rather than review of case notes / standard letter. This may be a telephone assessment or face to face with the patient and documentation of this will usually be kept within dietetic records.

Dietetic assessments within 3 months of MUST screening should be recorded.

Where patients are deemed not at risk (MUST score 0 or 1), 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>95</td>
<td>Patient declined</td>
<td>e.g. patient not at risk (score 0 or 1 using</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Date of Dietetic Assessment

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

Definition: The date the patient was first assessed by a dietitian.

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

Notes for Users: Required for comparative analysis in relation to QPI 5.
Dietetic assessments within 3 months of screening should be recorded.
If the patient was not assessed by a dietitian, record as 10/10/1900.
If the exact date is not recorded, record as 09/09/1900.

Notes by Users:
Type of First Cancer Treatment

Common name: Mode of first treatment

Main Source of Data Item Standard: The National Cancer Audit Datasets developed by the regional Cancer Networks supported by 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 QPI(s): 3, 13, 15

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. Some biopsies, such as excisional biopsies and cone biopsies may be included as these may have some therapeutic benefits i.e. the removal of the tumour. Treatment to metastatic disease counts as first treatment e.g. radiotherapy to metastatic disease.

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.

Dilations without other treatment are not considered as active treatment.

Steroids etc. should not be recorded as first treatment if more substantive treatment such as surgery is given. If no further treatment is given, then record as supportive care only.
### Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Radiotherapy</td>
<td>Includes Teletherapy (external beam radiotherapy, proton beam therapy) and Brachytherapy.</td>
</tr>
<tr>
<td>3</td>
<td>Systemic Anti-Cancer Therapy (SACT)</td>
<td>Includes chemotherapy, chemoimmunotherapy and immunotherapy.</td>
</tr>
<tr>
<td>4</td>
<td>Chemoradiotherapy</td>
<td>Chemoradiotherapy may be administered concurrently or synchronously. For example, chemotherapy and radiotherapy elements of treatment may commence on the same day/in the same week or 2 cycles of chemotherapy may be given prior to the start of radiotherapy treatment.</td>
</tr>
<tr>
<td>5</td>
<td>Endoscopic</td>
<td>Includes photodynamic therapy, endoscopic e.g. endomucosal resection, and insertion of stents.</td>
</tr>
<tr>
<td>7</td>
<td>Supportive Care Only</td>
<td>Not for active treatment</td>
</tr>
<tr>
<td>12</td>
<td>Active Surveillance</td>
<td>Intense follow-up including repeat clinic visits, tests and biopsies after an interval until the disease progresses or the grade of the tumour changes.</td>
</tr>
<tr>
<td>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>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related data item:**
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 QPI: 5 and for national survival analysis/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.

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

**Related data item:**  
Type of First Cancer Treatment

**Notes by Users:**
Date of Definitive Treatment {OG 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 definitive cancer treatment was given to the patient.

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

Notes for Users: Required for QPI: 3

For patients with OG cancer definitive treatment will be either:

- Surgery;
- Endoscopic treatment;
- Radiotherapy;
- Chemoradiotherapy; or
- Systemic Anti-Cancer Therapy (SACT).

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

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

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

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

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

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.

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

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

Codes and values:

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

Related Data Items:

Notes by Users:
Section 3: Endoscopic Treatment/Surgery
First Endoscopic 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 endoscopic treatment that was given to the patient.

Field Name: FENDO
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 11

Endoscopies for investigation should not be recorded.

An endoscope is a fibre optic tubular device which transmits light to the end to aid diagnosis or therapy. Specialised endoscopes may be threaded down the oesophagus to the stomach or beyond, or through an incision in the abdomen. Treatments in this category are generally palliative but endoscopic mucosal resection (EMR) is given with curative intent. Other treatments include stenting, laser or argon beam treatment, photodynamic therapy.

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stent</td>
</tr>
<tr>
<td>12</td>
<td>Laser</td>
</tr>
<tr>
<td>14</td>
<td>Argon</td>
</tr>
<tr>
<td>5</td>
<td>Dilation alone</td>
</tr>
<tr>
<td>6</td>
<td>Endo-mucosal resection (EMR)</td>
</tr>
<tr>
<td>7</td>
<td>Photodynamic therapy</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient declined treatment</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Related Data Items:
Date of first Endoscopic Treatment

Notes by Users:
Date of First Endoscopic 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 that the first endoscopic treatment as described elsewhere, was administered.

**Field Name:** DENDO2  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

**Notes for Users:**

Endoscopies for investigation should not be recorded.

If no part of the date is recorded, use 09/09/1900 (Not recorded).

If no endoscopic treatment, record as 10/10/1900 (Not applicable).

**Related Data Items:**  
First Endoscopic Treatment

**Notes by Users:**
Location Code (Cancer Surgery)

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

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

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

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

**Notes for Users:** This is the hospital where main type of definitive operation is undertaken.

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

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 Not Applicable, X1010.

Examples of codes are given below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>A111H</td>
<td>CROSSHOUSE HOSPITAL</td>
</tr>
<tr>
<td>C418H</td>
<td>ROYAL ALEXANDRA HOSPITAL</td>
</tr>
<tr>
<td>F704H</td>
<td>VICTORIA HOSPITAL, KIRKCALDY</td>
</tr>
<tr>
<td>G107H</td>
<td>GLASGOW ROYAL INFIRMARY</td>
</tr>
<tr>
<td>G405H</td>
<td>SOUTHERN GENERAL HOSPITAL, GLASGOW</td>
</tr>
</tbody>
</table>

**Related Data Item(s):**  
Date of Definitive Surgery  
Main Type of Definitive Operation {Upper GI Cancer}  
Operating Consultant Surgeon  
Surgical Approach {Upper GI Cancer}
Main Type of Definitive Operation {OG 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) operation performed on the patient for treatment of OG cancer.

Field Name: OPCODE1
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 6, 7, 8, 9, 10, 11

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total gastrectomy</td>
<td>Gastrectomy can be treatment for types III tumours of the GO junction (classed as oesophageal cancer) as well as gastric cancer</td>
</tr>
<tr>
<td>2</td>
<td>Subtotal gastrectomy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Completion gastrectomy</td>
<td>Stump gastrectomy Previous gastric resection carried out</td>
</tr>
<tr>
<td>5</td>
<td>Partial gastrectomy</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Right 2 phase subtotal oesophagectomy</td>
<td>Ivor Lewis oesophagectomy</td>
</tr>
<tr>
<td>7</td>
<td>L thoraco-abdominal oesophagectomy</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>McKeown 3 stage subtotal oesophagectomy</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Trans-hiatal oesophagectomy</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Laparotomy</td>
<td>Open and shut</td>
</tr>
<tr>
<td>13</td>
<td>Thoracotomy</td>
<td>Open and shut</td>
</tr>
<tr>
<td>15</td>
<td>Wedge/localised gastric resection</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Pharynolaryngeal oesophagectomy</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Bypass procedure/Jejunostomy</td>
<td>Palliative treatment</td>
</tr>
<tr>
<td>18</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before treatment</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient declined treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Non-surgical patient</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:

Date of Definitive Surgery
Location Code (Cancer Surgery)
Operating Consultant Surgeon (1-2) {Upper GI Cancer}
Surgical Approach {Upper GI Cancer}

Notes by Users:
Surgical Approach {OG 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 surgical procedure(s) performed for treatment of cancer.

Field Name: SURGAPPR
Field Type: Integer
Field length: 2

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Open</td>
<td>Open includes midline, rooftop, horizontal skin incision and thoracoabdominal opening</td>
</tr>
<tr>
<td>2</td>
<td>Hybrid procedure</td>
<td>Planned combination of surgical approaches e.g. open, laparoscopic and/or thoracoscopic.</td>
</tr>
<tr>
<td>3</td>
<td>Minimally invasive</td>
<td>Includes laparoscopic or thoracoscopic</td>
</tr>
<tr>
<td>4</td>
<td>Converted</td>
<td>Unplanned change in surgical approach</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Surgery not performed.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:

Related Data Items:
Date of Definitive Surgery
Location Code (Cancer Surgery)
Operating Consultant Surgeon (1-2) {Upper GI Cancer}
Main Type of Definitive Operation {Upper GI Cancer}
Date of Definitive 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 of the operative procedure described elsewhere.

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

Notes for Users: Required for QPI: 7, 9

The date format should be DD/MM/CCYY.

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

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

Related Data Items
Main Type of Definitive Operation {Upper GI Cancer]
Operating Consultant Surgeon (1-2) {Upper GI Cancer}
Location Code (Cancer Surgery)
Surgical Approach {Upper GI Cancer}

Notes by Users:
Date of Discharge

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

Definition: This denotes the date that the patient is discharged following the main (definitive) operation performed for the treatment of cancer.

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

Notes for Users: Required for QPI: 9

The date format should be DD/MM/CCYY.

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

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

Related Data Item(s):
Main Type of Definitive Operation [Upper GI Cancer]
Date of Definitive Surgery
Operating Consultant Surgeon (1-2) {OG Cancer}

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

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

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

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

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

If two consultant surgeons share an operation each operating surgeon code should be recorded.

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

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

If only one surgeon performed the operation OPSURG2 should be recorded as Not applicable (1010).

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

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

Related Data Item(s):
Location Code (Cancer Surgery)
Main Type of Definitive Operation {Upper GI Cancer}
Date of Definitive Surgery {Upper GI Cancer}

Notes by Users:
Section 4: Pathology Details
Morphology of Tumour

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

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): 13, 15. Also for sub-analysis and inclusion criteria.

The morphology terms have five-digit code numbers which run from 8000/0 to 9989/1; the first four digits indicate the specific histological 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 the pathology report is negative, code to 8888/8.

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.

Examples of Morphology codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8070/3</td>
<td>Squamous Cell Carcinoma; epidermoid carcinoma; nos; squamous carcinoma; squamous cell epithelioma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8051/3</td>
<td>Verrucous (Squamous) Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8083/3</td>
<td>Basaloid Squamous Cell Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8074/3</td>
<td>Spindle Cell (Squamous) Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8140/3</td>
<td>Adenocarcinoma</td>
<td>Oesophageal &amp; Gastric tumours</td>
</tr>
<tr>
<td>8144/3</td>
<td>Adenocarcinoma, Intestinal type</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8145/3</td>
<td>Adenocarcinoma, Diffuse type</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8260/3</td>
<td>Papillary Adenocarcinoma</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8211/3</td>
<td>Tubular Adenocarcinoma</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8480/3</td>
<td>Mucinous Adenocarcinoma</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8490/3</td>
<td>Signet-ring Cell Carcinoma</td>
<td>Gastric tumours</td>
</tr>
<tr>
<td>8560/3</td>
<td>Adenosquamous carcinoma</td>
<td>Oesophageal &amp; Gastric tumours</td>
</tr>
<tr>
<td>8240/3</td>
<td>Carcinoid tumour</td>
<td>Oesophageal &amp; Gastric tumours</td>
</tr>
<tr>
<td>8244/3</td>
<td>Mixed Endocrine /Exocrine Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8470/3</td>
<td>Cystadenocarcinoma mucinous, nos</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8430/3</td>
<td>Mucoepidermoid Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8200/3</td>
<td>Adenoid Cystic Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8041/3</td>
<td>Small Cell Carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8510/3</td>
<td>Medullary carcinoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>8543/3</td>
<td>Intraductal papillary-mucinous tumour</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8980/3</td>
<td>Carcinosarcoma</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8010/3</td>
<td>Carcinoma nos; epithelial tumour</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8020/3</td>
<td>Carcinoma; undifferentiated, nos</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8000/3</td>
<td>Neoplasm; malignant; tumour; malignant;</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>1111/1</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>8888/8</td>
<td>Negative Pathology</td>
<td></td>
</tr>
<tr>
<td>9999/9</td>
<td>Not recorded</td>
<td></td>
</tr>
<tr>
<td>1010/0</td>
<td>Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
Tumour Grade

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

**Definition:** Differentiation denotes the extent to which different characteristics of cells have developed.

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

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

This should be recorded following surgical resection. However, if no surgery performed use biopsy reports, where available.

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

If report states between two grades e.g. poor to moderate, record poorest grade.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Well</td>
</tr>
<tr>
<td>2</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Poor</td>
</tr>
<tr>
<td>4</td>
<td>Undifferentiated</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

**Notes by Users:**
Total Number of Lymph Nodes Examined Microscopically

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

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

Field Name: EXNODES
Field Type: Integer
Field length: 4

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

If surgery is performed but no lymph nodes are taken/examined record as 0
If the total number examined is not recorded, code as 9999.
If no surgery is performed record as not applicable, 1010.

Related Data Items:

Notes by Users:
Involvement of Circumferential Margin {Oesophageal Cancer only}

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

**Definition:** An indication of whether or not the circumferential margin is involved with tumour.

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

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

For oesophageal cancers only (as listed below) as circumferential resection margin is not clinically relevant for gastric cancers.

C150 Cervical oesophagus  
C151 Thoracic oesophagus  
C152 Abdominal part of oesophagus  
C153 Upper third of oesophagus  
C154 Middle third of oesophagus  
C155 Lower third of oesophagus  
C158 Overlapping lesion of oesophagus  
C159 Oesophagus, NOS  
C160 Cardia, NOS

For resection and endoscopic mucosal resection patients only. If pathology report states ‘margins’ are clear then discuss with pathologist as to which margin this relates. If there is no further information then record all margins as being clear.

If no definitive surgery is carried out record as Not applicable (96).

**Coding Details:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>The circumferential margin is classified as involved if the clearance is less than 1mm. EMR refers to circumferential peripheral and deep margin assessment.</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>The circumferential margin is ≥ 1mm or reported as ‘clear’ or reported as R0.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Gastric cancer or non-resection patients</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Notes by Users:**
Involvement of Longitudinal Margin {OG Cancer}

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

Definition: An indication of whether or not the longitudinal margin is involved with tumour.

Field Name: LMARGIN
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI: 10

For resection patients only.

If pathology report states ‘margins’ are clear then discuss with pathologist as to which margin this relates. If there is no further information then record all margins as being clear.

EMR has no involvement of longitudinal margin therefore record as not applicable. If no definitive surgery is carried out, record as Not applicable (96).

Coding Details:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>The longitudinal margin is classified as involved if the clearance is less than 1mm.</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>The longitudinal margin is ≥ 1mm or reported as ‘clear’ or reported as R0.</td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. Non-resection patients, Endoscopic Mucosal Resection (EMR)</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
<td></td>
</tr>
</tbody>
</table>

Notes by Users:
TNM Tumour Classification (Pathological) \{OG Cancer\}

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

**Definition:** The size of the tumour following resection of the primary OG cancer.

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

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

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table is recommended.

**Codes and Values:**

**Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9, C16.0)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>pT1</td>
<td>Tumour invades lamina propria, muscularis mucosae, or submucosa</td>
<td></td>
</tr>
<tr>
<td>pT1a</td>
<td>Tumour invades lamina propia or muscularis mucosae</td>
<td></td>
</tr>
<tr>
<td>pT1b</td>
<td>Tumour invades submucosa</td>
<td></td>
</tr>
<tr>
<td>pT2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour invades adventitia</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour invades adjacent structures</td>
<td></td>
</tr>
<tr>
<td>pT4a</td>
<td>Tumour invades pleura, pericardium, azygos vein, diaphragm or peritoneum</td>
<td></td>
</tr>
<tr>
<td>pT4b</td>
<td>Tumour invades other adjacent structures such as aorta, vertebral body, or trachea</td>
<td></td>
</tr>
<tr>
<td>pTX</td>
<td>Tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>pT Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>pT Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
### Stomach (ICD-O(3) C16.1-C16.9)

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT0</td>
<td>No evidence of primary tumour</td>
<td></td>
</tr>
<tr>
<td>pT1</td>
<td>Tumour invades lamina propria, muscularis mucosae, or submucosa</td>
<td></td>
</tr>
<tr>
<td>pT1a</td>
<td>Tumour invades lamina propria or muscularis mucosae</td>
<td></td>
</tr>
<tr>
<td>pT1b</td>
<td>Tumour invades submucosa</td>
<td></td>
</tr>
<tr>
<td>pT2</td>
<td>Tumour invades muscularis propria</td>
<td></td>
</tr>
<tr>
<td>pT3</td>
<td>Tumour invades subserosa</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour perforates serosa (visceral peritoneum) or invades adjacent structures</td>
<td>The adjacent structures of the stomach are the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine and retroperitoneum. Intramural extension to the duodenum or oesophagus is classified by the depth of greatest invasion in any of these sites, including stomach. Tumour that extends into gastrocolic or gastrohepatic ligaments or into greater or lesser omentum, without perforation of visceral peritoneum, is T3.</td>
</tr>
<tr>
<td>pT4a</td>
<td>Tumour perforates serosa</td>
<td></td>
</tr>
<tr>
<td>pT4b</td>
<td>Tumour invades adjacent structures</td>
<td></td>
</tr>
<tr>
<td>pTX</td>
<td>Tumour cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>pT Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>pT Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- TNM Nodal Classification (Pathological) {Upper GI}
- TNM Metastasis Classification (Pathological) {Upper GI}
TNM Nodal Classification (Pathological) {OG Cancer}


Definition: A record of the extent of regional lymph node metastases.
Field Name: pN
Field Type: Characters
Field Length: 4

Notes for Users: Required to allow adjustments for stage when undertaking survival analysis.

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

To adhere to the stage grouping in the TNM classification, recording the subdivision codes ‘a’ and ‘b’ in the codes and values table is recommended.

Codes and Values:
Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9, C16.0)

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pN0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>pN1</td>
<td>Metastasis in 1-2 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN2</td>
<td>Metastasis in 3-6 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN3</td>
<td>Metastasis in 7 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pNX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>pN Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>pN Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Stomach (ICD-O(3) C16.1-C16.9)

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>pN0</td>
<td>No regional lymph node metastasis</td>
<td></td>
</tr>
<tr>
<td>pN1</td>
<td>Metastasis in 1-2 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN2</td>
<td>Metastasis in 3-6 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN3</td>
<td>Metastasis in 7 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN3a</td>
<td>Metastasis in 7-15 regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pN3b</td>
<td>Metastasis in 16 or more regional lymph nodes</td>
<td></td>
</tr>
<tr>
<td>pNX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>pN Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>pN Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

**Related Data Items:**
- TNM Tumour Classification (Pathological) {Upper GI}
- TNM Metastasis Classification (Pathological) {Upper GI}

**Notes by Users:**
TNM Metastasis Classification (Pathological) {OG Cancer}


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

Field Name: pM
Field Type: Characters
Field length: 3

Notes for Users: Required to allow adjustments for stage when undertaking survival analysis.

In cases where there are multiple tumours, the tumour with the worst TNM stage should be recorded.

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

If stage is not documented in case notes 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 Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>pM1</td>
<td>Distant metastasis</td>
<td>If no distant metastasis are present, record as ‘not applicable’.</td>
</tr>
<tr>
<td>96</td>
<td>M Classification Not applicable</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>M Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Items:
- TNM Tumour Classification (Pathological) {Upper GI}
- TNM Nodal Classification (Pathological) {Upper GI}

Notes by Users:
**Date of HER2 Reporting**

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

**Definition:** Date that the final HER2 test result (as detected by immunohistochemistry (IHC) and/or FISH analysis) was reported by pathology.

**Field Name:** HER2REPORT  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

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

The date which the final HER2 test was reported should be recorded (as opposed to date of biopsy/surgical resection).

In instances where the pathologist provides a verbal report to the MDT, ahead of formal report issue, the date of verbal report (i.e. MDT date) should be recorded.

If the patient did not have HER2 status tested, record as Not applicable (10/10/1900).

If the date of reporting is unknown, record as (09/09/1900).
Final Human Epidermal Growth Factor Receptor-2 (HER2) Status {OG Cancer}

**Common name:** Her2 Status

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

**Definition:** The measurement of human epidermal growth factor receptor-2 (HER2) as detected by immunohistochemistry (IHC) and/or FISH analysis.

**Field Name:** HER2STATUS  
**Field Type:** Characters  
**Field length:** 4

**Notes for Users:**

HER2 testing would normally be carried out for patients with metastatic gastric and oesophageal cancers.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Inconclusive</td>
<td>Patients with an inconclusive FISH result.</td>
</tr>
<tr>
<td>1</td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>8888</td>
<td>Not assessable</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. where HER2 testing has not been done</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td>e.g. where a 2+ (IHC) result is obtained but no FISH test is carried out.</td>
</tr>
</tbody>
</table>
Date of PDL1 Reporting

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

**Definition:** The date that the final PD-L1 test result was reported by pathology.

**Field Name:** PDL1REPORT  
**Field Type:** Date (DD/MM/CCYY)  
**Field Length:** 10

**Notes for Users:** Required for QPI: 15

The date which the final PD-L1 test was reported should be recorded (as opposed to date of biopsy/surgical resection).

In instances where the pathologist provides a verbal report to the MDT, ahead of formal report issue, the date of verbal report (i.e. MDT date) should be recorded.

If the patient did not have PD-L1 testing, record as Not applicable (10/10/1900).

If the date of reporting is unknown, record as (09/09/1900).
PDL1 Score {OG Cancer}

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

Definition: A record of the combined positive score (CPS) for PD-L1 protein expression.

Field Name: PDL1STATUS
Field Type: Characters
Field length: 4

Notes for Users:

T-cells are part of the immune system and play a role in attacking cancer cells within the body. The PD-L1 expression attaches to a receptor on a T-cell which then prevents this process.

Some drug treatments work best if they are targeted on the basis of histological subtype/predictive markers, e.g. PD-L1, and therefore are required to predict whether targeted treatments are likely to be effective.

The PD-L1 CPS will be a whole number between 1 and 100. If the result is inconclusive, record as 111.

If PD-L1 testing has been undertaken and the CPS is not documented, record as 999, Not recorded.

If PD-L1 testing has not been performed, record as 966, Not applicable.
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 PHS and the General Register Office (Scotland). http://www.natref.scot.nhs.uk/

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

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

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

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

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

Related Data Item(s):
Date Treatment Started (Radiotherapy) {OG Cancer} (1-2)

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: RADDATE1
              RADDATE2
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:

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

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

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

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

Related Data Items:
Date Treatment Completed (Radiotherapy) {Upper GI Cancer} (1-2)
Radiotherapy Course Type 1-2 {Upper GI Cancer}

Notes by Users:
Date Treatment Completed (Radiotherapy) {OG Cancer} (1-2)

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: RCOMPDATE1  
RCOMPDATE2
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users:

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

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.

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

Related Data Items:
Date Treatment Started (Radiotherapy) {Upper GI Cancer} (1-2)
Radiotherapy Course Type (1-2) {Upper GI Cancer}

Notes by Users:
Radiotherapy Course Type (1-2) {OG 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: RADIOTYPE1
   RADIOTYPE2
Field Type: Integer
Field length: 2

Notes for Users:

Combined treatments may be administered concurrently/synchronously e.g. Systemic Anti-Cancer Therapy (SACT) and radiotherapy, or intra-operative radiotherapy.

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

Codes and Values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
<th>Explanatory Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant</td>
<td>It is given after potentially curative surgery or SACT.</td>
</tr>
<tr>
<td>2</td>
<td>Radical</td>
<td>It is primary treatment and is given with curative intent.</td>
</tr>
<tr>
<td>3</td>
<td>Palliative</td>
<td>The aim is solely to relieve symptoms.</td>
</tr>
<tr>
<td>4</td>
<td>Neo-adjuvant</td>
<td>It is given before potentially curative surgery.</td>
</tr>
<tr>
<td>8</td>
<td>Neoadjuvant Chemoradiotherapy</td>
<td>Chemoradiotherapy may be administered concurrently or synchronously. For example, chemotherapy and radiotherapy elements of treatment may commence on the same day/in the same week or 2 cycles of chemotherapy may be given prior to the start of radiotherapy treatment. This would be given prior to definitive surgery.</td>
</tr>
<tr>
<td>9</td>
<td>Radical Chemoradiotherapy</td>
<td>Chemoradiotherapy may be administered concurrently or synchronously. For example, chemotherapy and radiotherapy elements of treatment may commence on the same day/in the same week or 2 cycles of chemotherapy may be given prior to the start of radiotherapy treatment.</td>
</tr>
<tr>
<td></td>
<td>Related Data Items:</td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Date Treatment Started (Radiotherapy) {Upper GI Cancer} (1-2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date Treatment Completed (Radiotherapy) {Upper GI Cancer} (1-2)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Other Chemoradiotherapy</th>
<th>This includes high dose palliative and adjuvant chemoradiotherapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94</td>
<td>Patient died before radiotherapy treatment</td>
<td>i.e. Patient who died before receiving planned radiotherapy treatment</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. no radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>
Location Code {SACT Treatment}

Common Name(s): Location


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

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

Notes for Users: Required for regional/national analysis

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

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

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

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

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

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

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

Related Data Item(s):
**Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {OG 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 cytotoxic drugs administered for the treatment of the cancer. Cytotoxic drugs are drugs which destroy cells.

**Field Name:** CHEM1  
CHEM2  
**Field Type:** Integer  
**Field Length:** 2

**Notes for Users:** Required for QPI(s): 6, 11, 13, 15

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

Chemotherapy, immunotherapy and chemoimmunotherapy should be recorded under the setting in which they are given i.e. Adjuvant, Neoadjuvant or Palliative.

SACT must be treatment received for initial management and not treatment for recurrence or relapse. If the patient’s type of first treatment was ‘supportive care only’ or ‘active surveillance’ then subsequently proceeds to active treatment at a later date, only record if systemic therapy occurs within 6-months of diagnosis.

Maintenance therapy will occur immediately after the chemotherapy combination regime and there is no requirement to record this separately.

**Codes and Values:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Value</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adjuvant</td>
<td>Systemic therapy given after the date of the first surgery where there is no overt evidence of remaining disease.</td>
</tr>
<tr>
<td>2</td>
<td>Neoadjuvant</td>
<td>Systemic therapy given prior to definitive surgery.</td>
</tr>
<tr>
<td>4</td>
<td>Palliative</td>
<td>Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis. This includes chemotherapy given in combination with Anti-HER2 therapy.</td>
</tr>
<tr>
<td>11</td>
<td>Downstaging</td>
<td>Chemotherapy given to initially inoperable tumours to make surgically operable</td>
</tr>
<tr>
<td></td>
<td>Chemotherapy</td>
<td></td>
</tr>
</tbody>
</table>
12  Neoadjuvant Chemoradiotherapy  Chemoradiotherapy may be administered concurrently or synchronously. For example, chemotherapy and radiotherapy elements of treatment may commence on the same day/in the same week or 2 cycles of chemotherapy may be given prior to the start of radiotherapy treatment. This would be given prior to definitive surgery.

13  Radical Chemoradiotherapy  Chemoradiotherapy may be administered concurrently or synchronously. For example, chemotherapy and radiotherapy elements of treatment may commence on the same day/in the same week or 2 cycles of chemotherapy may be given prior to the start of radiotherapy treatment.

14  Other Chemoradiotherapy  This includes high dose palliative and adjuvant chemoradiotherapy.

94  Patient died before SACT treatment  i.e. Patient who died before receiving planned SACT treatment

95  Patient declined SACT treatment

96  Not applicable  e.g. not given as part of primary therapy

99  Not recorded

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

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

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

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1

CHEMDATE2

Field Type: Date (DD/MM/CCYY)

Field length: 10

Notes for Users: Required for QPI: 13, 15

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

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

There is no requirement to record maintenance therapy separately.

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

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

Related Data Items:
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)
Type of Systemic Anti-Cancer Therapy (SACT) (1-2)

Notes by Users:
Section 6: Clinical Trial Entry
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: Integer
Field Length: 2

Notes for Users: Required for generic QPIs

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

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

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

Codes and Values:

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

Notes by Users:
Section 7: Death Details
Date of Death

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

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

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

Notes for Users: Required for QPI: 7

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:

Notes by Users: