Upper GI Cancer

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

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

Version 2.5: June 2015

To be used in conjunction with:

1. Upper GI Clinical Quality Performance Indicators V2.1 (January 2015)
2. Upper GI QPI Dataset Validations (Latest published version)
3. Upper GI Measurability of Quality Performance Indicators (Latest published version)
Data Definitions for the National Minimum Core Dataset to support the introduction of Upper GI Quality Performance Indicators (QPIs)

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Document Status: Final
Standard Audience: NHS staff involved in implementing and recording Upper GI Quality Performance Indicators.

Cross References:
- Upper GI Quality Performance Indicators
- Upper GI Measurability of Quality Performance Indicators

Author: Information Services Division of NHS National Services Scotland

Revision History

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<th>Summary of Changes</th>
<th>Name</th>
<th>Changes Marked</th>
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<td>1.0</td>
<td>20/12/2012</td>
<td>Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1st January 2014.</td>
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<td>2.1</td>
<td>21/02/2014</td>
<td>Updated 'Criteria for Inclusion' to reflect changes made at 9 month review.</td>
<td>David Early, ISD</td>
<td>See page vii.</td>
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<td>2.4</td>
<td>12/01/2015</td>
<td>Baseline Review Updates</td>
<td>Karen Heatlie ISD</td>
<td>See page vii</td>
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<td>22/06/2015</td>
<td>Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st January 2014.</td>
<td>Charlotte Anthony</td>
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PREFACE

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

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

To ensure that findings are comparable across Scotland, the national dataset and data definitions in conjunction with the final quality performance indicators were agreed through public engagement and are now ready for implementation for patients diagnosed from 1st October 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
Lead Clinician West of Scotland Upper GI Cancer Managed Clinical Network
Consultant Surgeon, Glasgow Royal Infirmary
NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with upper GI cancer on or after 1st January 2014, who are eligible for inclusion in the upper GI 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, ISD would welcome your feedback.

Please contact NSS.ISDCANCERAUDIT@nhs.net

CONVENTIONS

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

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

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

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

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

Include:

- All patients with a confirmed new primary 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.
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 (field name SINVEST) 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 add medullary carcinoma 8510/3.

REVISIONS TO DATASET OUTWITH REVIEW (June 2014)

New Data Items Added:

Page 28: ‘Date of Definitive Treatment {Upper GI}’

Database Specification

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

Dataset

Type of Systemic Anti-Cancer Therapy (SACT) (!-2) {Upper GI Cancer}

i. Curative Treatment removed from explanatory notes of code 7 Chemoradiotherapy.

TNM Metastasis Classification (Pathological) {Upper GI}

i. Code pM0 – No distant metastasis removed

Revisions To Dataset Following 9-Month Review (December 2013)

The following changes have been made following the 9-month review of Upper GI Cancer Data Definitions for the National Minimum Core Data Set. Changes to take effect for patients diagnosed from 01/01/2014.

Data Definitions for the National Minimum Core Dataset for Upper GI Cancer. Developed by ISD Scotland, 2014
Page vii
Revisions (02/2014):

Criteria for Inclusion of Patients in Audit:

Added ‘neuroendocrine tumours’ to list of exclusions.

Revisions (12/2013):

Dataset
Location of Diagnosis (Cancer)

TNM Tumour Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
   i. Amended code 96 – added “If not discussed at MDT” into the explanatory notes.

TNM Nodal Classification (Clinical) {Upper GI Cancer} (Pre-treatment)
   i. Amended code 96 – added “If not discussed at MDT” into the explanatory notes.

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

Date Discussed by Care Team
   i. Added text in Notes for Users – “relevant to the treatment of Upper GI cancer”

Treatment Intent Recorded at MDT {Pre-treatment}
   i. Amended title by removing {Pre-treatment}
   ii. Added the following examples in the explanatory notes
      a. Code 2 – Radical – Downstaging with curative intent
      b. Code 3 – Palliative – stent

Type of First Cancer Treatment
   i. The following text added to notes for users “Treatment to metastatic disease counts as first treatment e.g. radiotherapy to metastatic disease.”

Surgical Approach
   i. Added examples to explanatory notes for code 1 – Open “Open includes midline, rooftop, horizontal skin incision and thoracoabdominal opening muscle with ultrasicion.”

Morphology of Tumour
   i. Removed code “8246/3 – Neuroendocrine carcinoma; synonymous with carcinoid – Oesophageal tumours”

Involvement of Circumferential Margin
   i. Added codes the following codes
      a. C150 Cervical oesophagus
      b. C151 Thoracic oesophagus
      c. C152 Abdominal part of oesophagus
      d. C153 Upper third of oesophagus
e. C154 Middle third of oesophagus  
   f. C155 Lower third of oesophagus  
   g. C158 Overlapping lesion of oesophagus  
   h. C159 Oesophagus, NOS  
   i. C160 Cardia, NOS  

ii. And text to Notes for Users  
   a. For resection and Endoscopic mucosal resection patients only  

iii. Text added to explanatory notes for code 1 – Yes  
   a. EMR refers to circumferential peripheral and deep margin assessment  

Involvement of Longitudinal Margin  
   i. Text added to the explanatory notes for code 96 – Not Applicable  
   a. Endoscopic Mucosal Resection (EMR)  

   i. And to Notes by Users  
   a. EMR has no involvement of longitudinal margin therefore record as not applicable.  

TNM Tumour Classification (Pathological) {Upper GI}  
   i. The following text was removed in Notes for Users  
   a. “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TNxNxM1 is therefore accepted as complete staging in this situation.  

TNM Nodal Classification (Pathological) {Upper GI}  
   i. The following text was removed in Notes for Users  
   a. “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TNxNxM1 is therefore accepted as complete staging in this situation.  

TNM Metastasis Classification (Pathological) {Upper GI}  
   i. The following text was removed in Notes for Users  
   a. “For patients presenting with metastatic disease it is not always possible or appropriate to determine T and N stage. In respect to the QPI, TNxNxM1 is therefore accepted as complete staging in this situation.  

Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer}  
   i. Text added in Notes for Users  
   a. or ‘active surveillance’  
   ii. Removed “to reduce tumour size” from the explanatory notes for Neoadjuvant.  
   iii. New code added;  

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<tr>
<td>11</td>
<td>Downstaging Chemotherapy</td>
<td>Chemotherapy given to initially inoperable tumours to make surgically operable</td>
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DOWNLOAD FORMAT
To assist with downloading data to ISD for the National Quality Assurance Programme and other agreed activities, all sites should be able export data according to the following specification.

DATABASE SPECIFICATION

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Developed by ISD Scotland, 2014
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| **Surgical Approach (Upper GI Cancer)** | **SURGAPPR** | **Integer** | 2 | 35 |
| Date of Definitive Surgery | DSURG | **Date** | 10 | 36 |
| Operating Consultant Surgeon (1-2) (Upper GI Cancer) | OPSURG1 | **Characters** | 20 | 37 |
| **Section 4: Pathology Details** | **38** |
| **Morphology of Tumour** | MORPHOL | **Characters** | 6 | 39 |
| **Tumour Grade** | TGRADE | **Integer** | 2 | 41 |
| Total Number of Lymph Nodes Examined Microscopically | EXNODES | **Integer** | 4 | 42 |
| Involvement of Circumferential Margin (Oesophageal Cancer only) | CMARGIN | **Integer** | 2 | 43 |
| Involvement of Longitudinal Margin (Upper GI Cancer) | LMARGIN | **Integer** | 2 | 44 |
| **TNM Tumour Classification (Pathological) (Upper GI)** | **pT** | **Characters** | 4 | 45 |
| **TNM Nodal Classification (Pathological) (Upper GI)** | **pN** | **Characters** | 4 | 47 |
| **TNM Metastasis Classification (Pathological) (Upper GI)** | **pM** | **Characters** | 3 | 48 |
| **Section 5: Oncology** | **49** |
| Date Treatment Started (Radiotherapy) (Upper GI Cancer) (1-2) | RADDATE1 | **Date** | 10 | 50 |
| Date Treatment Completed (Radiotherapy) (Upper GI Cancer) (1-2) | RCOMPDATE1 | **Date** | 10 | 51 |
| Radiotherapy Course Type (1-2) (Upper GI Cancer) | RADIOTYPE1 | **Integer** | 2 | 52 |
| Type of Systemic Anti-Cancer Therapy (SACT) (1-2) (Upper GI Cancer) | CHEM1 | **Integer** | 2 | 53 |
| Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2) | CHEMDATE 1 | **Date** | 10 | 54 |
| Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2) | CHEMENDATE1 | **Date** | 10 | 55 |
| **Section 6: Clinical Trial Entry** | **56** |
| Patient Entered into Clinical Trial | TRIAL | **Integer** | 2 | 57 |
| **Section 7: Death Details** | **58** |
| Date of Death | DOD | **Date** | 10 | 59 |
Section 1: Demographic Items
**Person Family Name (at Diagnosis)**

**Common Name(s):** Surname, Family name

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

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

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

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

From SMR Definitions and Codes

**Codes and Values:** N/A

**Notes by Users:**
**Person Given Name**

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

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

**Definition:** The forename or given name of a person.

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

**Notes for Users:**
Main Source of Standard: [Government Data Standards Catalogue](#)

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

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

**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:

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

Related Data 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.

(ISD, Information Services, NHS National Services Scotland)

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

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

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

**Codes and values:** N/A

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

**Notes by Users:**
Section 2: Pre-treatment Imaging & Staging Investigations
CT Imaging Investigations

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

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: Required for QPI(s): 2.

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>3</td>
<td>Incomplete</td>
<td>Inadequate investigations or further investigations required e.g. single site scan.</td>
</tr>
<tr>
<td>4</td>
<td>CT Abdomen</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Patient refused investigations</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. not done</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 Information Services.

**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(s): 1

- The first investigative endoscopy should be recorded and may not relate to the date of histological diagnosis, or a cancer investigation.
- 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 09/09/0909.
- If an endoscopy was not performed, record as 10/10/1010 (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 ISD Scotland.

Location codes for hospitals are five character codes maintained by ISD 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 Information Services.

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

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

**Notes for Users:** Required for QPI(s): 1 – 8, 10 - 12  
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 upper GI cancer whether done radiologically or histologically.

If the exact date is not documented, record as 09/09/0909.

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 Information Services.

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(s): 1

If endoscopy and biopsy was not carried out or no histological diagnosis made, record as 10/10/1010

If the exact date is not documented, record as 09/09/0909.

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)


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 – 8, 10 - 12.

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) Code</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 oesophagus</td>
<td></td>
</tr>
<tr>
<td>C159</td>
<td>Oesophagus, NOS.</td>
<td></td>
</tr>
<tr>
<td>C160</td>
<td>Cardia, NOS</td>
<td>Gastric cardia Cardio-oesophageal junction Oesophagogastric Junction Gastro- oesophageal junction</td>
</tr>
<tr>
<td>C161</td>
<td>Fundus of stomach</td>
<td>Gastric fundus</td>
</tr>
<tr>
<td>C162</td>
<td>Body of stomach</td>
<td>Corpus of stomach Gastric corpus</td>
</tr>
<tr>
<td>C163</td>
<td>Gastric antrum</td>
<td>Antrum of stomach Pyloric antrum</td>
</tr>
<tr>
<td>C164</td>
<td>Pylorus</td>
<td>Prepylorus Pyloric canal</td>
</tr>
<tr>
<td>C165</td>
<td>Lesser curvature of stomach, unspecified</td>
<td>Lesser curvature of stomach, not classifiable to C16.0 – C16.4</td>
</tr>
<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>
</tbody>
</table>
C168 | Overlapping lesion of the stomach | Anterior wall of stomach, NOS  
    |                               | Not classifiable to C16.0 to C16.4  
    |                               | Posterior wall of stomach, NOS  
    |                               | Not classifiable to C16.0 to C16.4

C169 | Stomach, (NOS) | Gastric, NOS

Notes by Users:
TNM Tumour Classification (Clinical) (Upper GI Cancer) (Pre-treatment)


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, Seventh Edition, 2009).

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

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

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

This is a pre/non-operative classification as defined by and recorded at the MDT based on best knowledge. For the majority of cases, this will be at the MDT meeting where decision to treat was discussed.

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:

| Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9, C16.0) |
|---|---|---|
| Code | Value | Explanatory Notes |
| T0 | No evidence of primary tumour |  |
| T1 | Tumour invades lamina propria, muscularis mucosae, or submucosa |  |
| T1a | Tumour invades lamina propria or muscularis mucosae |  |
| T1b | Tumour invades submucosa |  |
| T2 | Tumour invades muscularis propria |  |
| T3 | Tumour invades adventitia |  |
| T4 | Tumour invades adjacent structures |  |
| T4a | Tumour invades pleura, pericardium, or diaphragm |  |
| T4b | Tumour invades other adjacent structures such as aorta, vertebral body, or trachea |  |
| TX | Tumour cannot be assessed |  |
| 96 | T Classification Not applicable | e.g. If not discussed at MDT |
| 99 | T Classification Not recorded |  |
## 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 penetrates subserosa</td>
<td></td>
</tr>
<tr>
<td>T4</td>
<td>Tumour perforates serosa 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 curvature 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>e.g. If not discussed at MDT</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)

**Notes by Users:**

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*Data Definitions for the National Minimum Core Dataset for Upper GI Cancer.*
*Developed by ISD Scotland, 2014*
**TNM Nodal Classification (Clinical) (Upper GI Cancer) (Pre-treatment)**

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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, Seventh Edition, 2009).

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

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

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

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

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT) based on best knowledge. For the majority of cases, this will be at the MDT meeting where decision to treat was discussed.

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:**

**Oesophagus and Oesophagogastric Junction (ICD-O(3) C15.0-C15.9, 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>NX</td>
<td>Regional lymph nodes cannot be assessed</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>N Classification Not applicable</td>
<td>e.g. If not discussed at MDT</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>e.g. If not discussed at MDT</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) {Upper GI Cancer} (Pre-treatment)


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, Seventh Edition, 2009).

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

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

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

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT) based on best knowledge. For the majority of cases, this will be at the MDT meeting where decision to treat was discussed.

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>e.g. If not discussed at MDT</td>
</tr>
<tr>
<td>99</td>
<td>M Classification Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

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 Information Services.

**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(s): 3.

May be used for analysis of generic QPI relating to MDT meetings.

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, speech language therapists, physiotherapists and others relevant to the treatment of Upper GI 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 09/09/0909 or if the patient has not been discussed by the MDT, record as Not applicable 10/10/1010.

**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 Information Services

**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(s): 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.

**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 refused 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 Referral for Nutritional Assessment

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

Definition: The date the patient was first referred to a dietician for nutritional assessment.

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

Notes for Users: Required for QPI(s): 5

If the patient was not referred to a dietician, record as 10/10/1010.

If the exact date is not recorded, record as 09/09/0909.

Notes by Users:
Type of First Cancer Treatment

Common name: Mode of first treatment

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

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

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

Notes for Users: Required for QPI 3
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.
Data Definitions for the National Minimum Core Data Set for Upper GI Cancer.
Developed by ISD Scotland, 2014

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<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</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 refused 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 Information Services.

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

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

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

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

If type of first cancer treatment is ‘supportive care only’, the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. 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 09/09/0909.

If the patient died before treatment or the patient refused treatment, record as 10/10/1010.

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

**Notes by Users:**
Date of Definitive Treatment (Upper GI Cancer)

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

Definition: This denotes the date definitive cancer treatment was given to the patient.

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

Notes for Users: Required for QPI: 3

For patients with upper GI 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. This will therefore be the same date as the First Treatment Date for these patients.

If the exact date is not documented, record as 09/09/0909 (Not recorded).

If the patient died before treatment or the patient refused treatment, record as 10/10/1010 (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 Information Services.

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(s): 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 refused 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 Information Services.

**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:** Required for QPI(s):

Endoscopies for investigation should not be recorded.

If no part of the date is recorded, use 09/09/0909 (Not recorded).

If no endoscopic treatment, record as 10/10/1010 (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 ISD and General Register Office (Scotland). http://www.isd-n3.scot.nhs.uk/National-Reference-Files/Nat-Ref-Files/location?84577144— datafiles.

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

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

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

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

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 {Upper GI Cancer}

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

Definition: This is the main (definitive) operation performed on the patient for treatment of Upper GI cancer.

Field Name: OPCODE1
Field Type: Integer
Field Length: 2
Notes for Users: 6, 7, 8, 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></td>
</tr>
<tr>
<td>2</td>
<td>Sub total 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 sub total oesophagectomy</td>
<td>Ivor Lewis oesophagectomy</td>
</tr>
<tr>
<td>7</td>
<td>L thoraco-abdominal oesophagectomy (oesophago-gastrectomy)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>McKeown 3 stage sub total 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 refused 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 {Upper GI Cancer}**

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

**Definition:** The type of 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 muscle with ultrasonic.</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 during surgery</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 Information Services.

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

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

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

The date format should be DD/MM/CCYY.

If the exact date is not documented, record as 09/09/0909.

If no surgical procedure is carried out, code as 10/10/1010 (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:**
Operating Consultant Surgeon (1-2) {Upper GI Cancer}

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

**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 Information Services.

**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 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 NSS.isdCANCERAUDIT@nhs.net 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>8543/3</td>
<td>Intraductal papillary-mucinous tumour (invasive)</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 malignant</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>8020/3</td>
<td>Carcinoma; undifferentiated, nos unclassified</td>
<td>Oesophageal tumours</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>8000/3</td>
<td>Neoplasm; malignant; tumour; malignant; nos;</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 Information Services.

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 Information Services.

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(s): 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 {Upper GI Cancer}**

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

**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(s): 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) {Upper GI}


Definition: The size of the tumour following resection of the primary upper GI 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:

<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</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, or diaphragm</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>
<tr>
<td>Code</td>
<td>Value</td>
<td>Explanatory Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------------------</td>
</tr>
<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 penetrates subserosa</td>
<td></td>
</tr>
<tr>
<td>pT4</td>
<td>Tumour perforates serosa or invades adjacent structures</td>
<td></td>
</tr>
<tr>
<td>pT4a</td>
<td>Tumour perforates serosa</td>
<td></td>
</tr>
<tr>
<td>pT4b</td>
<td>Tumour invades adjacent structures 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 lessor curvature omentum, without perforation of visceral peritoneum, is T3.</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) {Upper GI}


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>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) {Upper GI}**

**Main Source of Data Item Standard:** TNM Classification (TNM Classification of Malignant Tumours, Seventh Edition, UICC, 2009).

**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>
</tr>
</thead>
<tbody>
<tr>
<td>pM1</td>
<td>Distant metastasis</td>
</tr>
<tr>
<td>96</td>
<td>M Classification Not applicable</td>
</tr>
<tr>
<td>99</td>
<td>M Classification Not recorded</td>
</tr>
</tbody>
</table>

**Related Data Items:**
TNM Tumour Classification (Pathological) {Upper GI}  
TNM Nodal Classification (Pathological) {Upper GI}
Section 5: Oncology
Date Treatment Started (Radiotherapy) {Upper GI Cancer} (1-2)

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

Definition: The date cancer treatment course commenced.

Field Name: RADDATE1
RADDATE2

Field Type: Date (DD/MM/CCYY)

Field length: 10

Notes for Users: Required for QPI(s):

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

If the date radiotherapy started is unknown, record as 09/09/0909.

If radiotherapy has not been given or the patient has refused radiotherapy, record as Not Applicable, 10/10/1010.

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) {Upper GI Cancer} (1-2)

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

Definition: The date cancer treatment course ended.

Field Name: RCOMPDATE1

RCOMPDATE2

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s): 12

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 09/09/0909.

If treatment has not been given, record as Not Applicable, 10/10/1010.

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) {Upper GI Cancer}

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

Definition: The type of course of external beam radiotherapy administered for the treatment of the cancer.

Field Name: RADIOTYPE1  
RADIOTYPE2  
Field Type: Integer  
Field length: 2

Notes for Users: Required for QPI(s): 12  
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>7</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>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 Refused Treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. no radiotherapy given.</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

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

Notes by Users:
Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer}

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

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

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

Notes for Users: Required for QPI(s):6, 11, 12

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.

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.

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>The start of adjuvant SACT is after the date of the first surgery where there is no overt evidence of remaining disease.</td>
</tr>
<tr>
<td>2</td>
<td>Neoadjuvant</td>
<td>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</td>
</tr>
<tr>
<td>7</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>11</td>
<td>Downstaging Chemotherapy</td>
<td>Chemotherapy given to initially inoperable tumours to make surgically operable</td>
</tr>
<tr>
<td>94</td>
<td>Patient died before SACT treatment</td>
<td>i.e. Patient who died before receiving planned SACT treatment</td>
</tr>
<tr>
<td>95</td>
<td>Patient refused SACT treatment</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Not applicable</td>
<td>e.g. not given as part of primary therapy</td>
</tr>
<tr>
<td>99</td>
<td>Not recorded</td>
<td></td>
</tr>
</tbody>
</table>

Related Data Item(s):
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 Information Services.

Definition: The date cancer treatment course commenced.

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

Notes for Users:

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

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

If the date treatment started is unknown, record as 09/09/0909.

If treatment has not been given, record as Not Applicable, 10/10/1010.

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

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

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

**Field Name:** CHEMENDATE1  
CHEMENDATE2  

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

**Field length:** 10

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

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

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

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

If the date treatment started is unknown, record as 09/09/0909.

If treatment has not been given, record as Not Applicable, 10/10/1010.

**Related Data Items:**  
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)  
Type of Systemic Anti-Cancer Therapy (SACT) (1-2) {Upper GI Cancer}  

**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 Information Services.

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

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

**Notes for Users:** 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 Information Services.

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

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

Notes for Users: Required for QPIs: 7, 12

If the exact date is not documented, record as 09/09/0909 (Not recorded).

If the patient is alive use the code 10/10/1010 (Not applicable).

Related Data Items:

Notes by Users: