



Colorectal Cancer

Data Definitions for the National Minimum Core Dataset to support the Introduction of Colorectal Quality Performance Indicators

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

Version 3.0: August 2017

To be used in conjunction with:

1. Colorectal Cancer Clinical Quality Performance Indicators (Latest Published Version)
2. Colorectal Cancer QPI Dataset Validations (Latest Published Version)
3. Colorectal Cancer Measurability of Quality Performance Indicators (Latest Published Version)

DOCUMENT CONTROL SHEET

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Author	Information Services Division of NHS National Services Scotland

Revision History

Version	Date	Summary of Changes	Name	Changes Marked
3.0	August 2017	Changes agreed at Formal Review	Charlotte Anthony	See page iii
2.6	Oct 2016	Correction	Karen Heatlie	See page iii
2.5	Nov 2015	Changes agreed out with review. Changes to be applied for patients diagnosed from 1 st April 2014	Jane Garrett ISD	See page iii.
2.4	05/15	Changes agreed from Baseline Review	Charlotte Anthony ISD	See page iii.
2.3	02/15	Changes agreed out with review. Changes to be applied for patients diagnosed from 1 st April 2014	Charlotte Anthony ISD	See page iii.
2.2	03/09/14	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1 st April 2014	Jane Garrett ISD	See page iii.
2.1	20/06/14	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1 st April 2014	Charlotte Anthony ISD	See page iv.
2.0	21/03/14	Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1 st April 2014	David Early ISD	See page v.

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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 April 2013.

Colorectal cancer is the third most common cancer in Scotland behind breast and lung in women and prostate and lung in men. In 2010 there were 1790 women and 2177 men diagnosed with colorectal cancer; and in 2011 there were 702 women and 824 men who died of colorectal cancer. Over the last 10 years mortality from colorectal cancer has decreased by almost 18% with five-year relative survival of around 55%. To improve survival further a truly multidisciplinary package of care has to be undertaken. The vast majority of patients will be treated by surgical resection. These patients need to be appropriately staged to ensure that patients who require neoadjuvant therapy get it. The agreed surgical QPIs will hopefully improve the quality of surgery performed hence increasing long term success with tumour eradication but also minimising post-operative surgical complications. For a smaller group of patients radiotherapy +/- chemotherapy used before surgery can increase the success in eradicating the cancer. However for these patients the whole package needs to be a success hence the relevant QPIs look at the outcome of that package of care.

The national colorectal cancer minimum dataset has been significantly decreased in size. The remaining data items will be used to allow standardised reporting of clinically and patient relevant outcomes. Regional and national reporting will be valuable in allowing the clinical teams looking after patients with colorectal cancer to compare their treatment outcomes with their peers in other parts of the country. Hopefully this will result in optimal care for all patients presenting with colorectal cancer in Scotland.

Jim Docherty Consultant Surgeon, SCAN

NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with colorectal cancer on or after 1st April 2017, who are eligible for inclusion in the colorectal 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

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

CONVENTIONS

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

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

REVISIONS TO DATASET

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/04/2017.

Revision to Dataset following Formal Review (August 2017)

Criteria For Inclusion of Patients in Audit – inserted exclusion – ‘Patients with appendiceal cancer’ and removed ‘(including appendix),’ from first bullet point.

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

Person Given Name (PATFNAME) – link updated

Patient Postcode at Diagnosis {Cancer} (PATPCODE) – link updated

Date of Birth (DOB) – link updated

Large Bowel Imaging – inserted new code and value as follows;

4	Incomplete due to obstructing tumour	This includes patients with strictures which prevent passage of a scope.
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Location of Diagnosis {Cancer} – the following text has been inserted within Notes for Users - This will be the hospital where the patient was diagnosed. If the diagnosis is made by screening colonoscopy; or if colonoscopy is carried out at a hospital for waiting list reasons i.e. Golden Jubilee, the hospital recorded should be the hospital where the patient was managed following their diagnosis of cancer.

The text below has been removed from Notes for Users;
‘The hospital where the screening colonoscopy takes place should be recorded as the location of diagnosis.’

Date of Diagnosis – Change ‘Required for QPIs’ from ‘2, 7, 9, 12’ to ‘1-12’

Site of Origin of Primary Tumour – Changed to 1-12 under ‘Required for QPIs’; removed code ‘C18.1 – Appendix’

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

Date of Definitive Treatment - – inserted the following text within Notes for Users ‘Where this has subsequently been confirmed at MDT, the date of MDT should be recorded.’

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – Changed to 1-12 under ‘Required for QPIs’. Inserted the following text within Notes for Users; ‘If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field ‘Re-operation’. Inserted the following codes:

H10.4 – Sigmoid Colectomy and ileostomy HFQ

H20.5 – Fibreoptic Endoscopic Submucosal Resection of Lesion of Colon

H20.7 – Fibreoptic endoscopic mucosal resection of Lesion of Colon

H23.7 - Endoscopic Mucosal Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope

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Developed by ISD Scotland, 2014

H37.1 Endoscopic mucosal resection of lesion of sigmoid colon using rigid Sigmoidoscope. Added following text to Endoscopic Operations: 'If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field 'Re-operation'.

Surgical Approach (Colorectal Cancer) – inserted reference to QPI 1 under 'Required for QPIs'

Date of Final Definitive – inserted reference to QPI 11 under 'Required for QPIs'

Intent of Surgery – inserted reference to QPI 1, 2 under 'Required for QPIs'

New data item: Re-operation – see entry for full detail

Final Total Number of Lymph Nodes Examined Microscopically {Cancer} – inserted reference to QPI 5 under 'Required for QPIs'

TNM Nodal Classification (Final) (Colorectal Cancer) – inserted reference to QPI 11, also amended the text from 'for survival analysis and comparative analysis' to 'and for national survival analysis and national comparative analysis'

TNM Metastasis Classification (Final) (Colorectal) – inserted reference to QPI 11 under 'Required for QPIs'

Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer) – inserted reference to QPI 11 under 'Required for QPIs'. Inserted text 'Short course radiotherapy also includes patients who undergo short course and delay to surgery' in the Explanatory Notes for Short Course Radiotherapy.

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer} – inserted reference to QPI 1 under 'Required for QPIs'

Date Primary/Palliative/Adjuvant Oncology Treatment Started {Colorectal Cancer} – inserted reference to QPI 11 under 'Required for QPIs'

Correction (10/16)

The data item **Presentation Type** (PRESENT) had the text 'If presentation is classed as 'urgent', code as 'emergency' only if surgery is performed within 72 hours of admission' deleted as part of the Baseline Review changes (data set v2.4) but it has not been listed here in the revision history at that time.

Revisions (11/2015)

Dataset:

(Query 1080) - Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} – add H14.1 – Tube Caecostomy, H14.8 – Other specified Exteriorisation of caecum and H14.9 – Unspecified Exteriorisation of caecum (includes Caecostomy NEC)

(Query 1071) - Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer} – add to notes for users 'If there is no residual tumour at all in the specimen then it should be recorded as clear margin'

REVISIONS FOLLOWING BASELINE REVIEW;

Staging Investigations Complete (Pre-treatment) – inserted new code and value 4 – Incomplete – Contraindication, explanatory notes - Rectal Cancer only (should not be used for colon cancers)-- Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table

Revisions (03/2015) – V2.3

Dataset:

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} amendment to operation codes –

H13.0 does not exist therefore changed to H13.9 for Bypass of Colon.
H07.2 Term Changed to Right Hemicolectomy and side to side anastomosis of ileum to transverse colon
H41.2 Term Changed to Peranal Excision of lesion of Rectum

All the following bypass of colon codes have been added to the operative procedures code list;

H13.1 Bypass of colon by anastomosis of ileum to colon
H13.2 Bypass of colon by anastomosis of caecum to sigmoid colon
H13.3 Bypass of colon by anastomosis of transverse colon to sigmoid colon
H13.4 Bypass of colon by anastomosis of transverse colon to rectum
H13.5 Bypass of colon by anastomosis of colon to rectum NEC
H13.8 Other specified

Revisions (09/2014) – V2.2

Database Specification:

Dukes Classification (Colorectal Cancer) change to 2_characters

Dataset

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer} Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Code 'G74.2' - Creation of temporary ileostomy added
Code 'H01.2' - Emergency excision of abnormal appendix NEC added
Code 'J12.4' - Percutaneous radiofrequency ablation of lesion of liver added

TNM Tumour Classification (Final) {Colorectal Cancer}
Notes for Users - "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."

TNM Metastasis Classification (Final) {Colorectal Cancer}
Notes for Users - "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."

TNM Nodal Classification (Final) {Colorectal Cancer}

Notes for Users - "The original clinical/radiological staging would have precedence in patients who have a highly positive response to neo-adjuvant therapy and are effectively downstaged" replaced with "The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy."

Revisions (06/2014) – V2.1

New Data Items Added:

Page 31: 'Date of Definitive Treatment {Colorectal Cancer}'

Database Specification:

Date of Definitive Treatment {Colorectal Cancer} data item added: Field Name:

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

Location Code (Radiological Treatment) name change to Location Code (Radiotherapy Treatment)

Date Neo-Adjuvant/Oncology Treatment Started {Rectal Cancer} name change to Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Rectal Cancer} name change to Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Date of Diagnosis changed Field Name from DDIAG to DIAGDATE

Dataset

Location Code (Radiological Treatment)

- i. Title changed to Location Code (Radiotherapy Treatment)
- ii. Text in 'Notes for Users' radiological changed to radiotherapy

Date Neo-Adjuvant/Oncology Treatment Started {Rectal Cancer}

- i. Title changed to Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Rectal Cancer}

- i. Title changed to Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Revisions (03/2014) - V2.0:

Criteria For Inclusion of Patients in Audit:

Added the following note:

- 'In the event of multiple, synchronous primary tumours, record that with the worst prognosis/poorest TNM stage. If there is any uncertainty, seek clinical advice.'

New Data Items Added:

Page 8: 'Source of Cancer Referral'

Page 59: 'Location Code {SACT Treatment}'

Page 60: 'Location Code {Radiological Treatment}'

Data Items Removed:

None

Other minor changes include:

Database Specification:

Source of Cancer Referral data item added: Field Name: MREFER, Field Type: Integer, Field Length: 2.

Location Code {SACT Treatment} data item added: Field Name: HOSPSACT, Field Type: Character, Field Length: 5.

Location Code {Radiological Treatment} data item added: Field Name: HOSPRADIO, Field Type: Character, Field Length: 5.

Dataset:

Staging Investigations Complete {Colorectal Cancer}:

- i. Add to notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'
- ii. Add to notes for users: 'Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.'

Date Staging Investigations Completed {Colorectal Cancer}:

- i. Add to notes for users: 'Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.'

CT Chest (Results):

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'

Date of CT Chest (Results):

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'

Liver Imaging (Results):

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'
- ii. Added to notes for users: 'Results from CT colonography (with IV contrast) may be recorded, where it can be determined from the radiology report that the liver has been investigated.'

Date of Liver Imaging (Results):

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'

Large Bowel Imaging:

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'

Date of Imaging Large Bowel:

- i. Amended notes for users: 'Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.'

Date of Histological Diagnosis:

- i. Add to notes for users: 'If a primary colorectal cancer is confirmed by liver biopsy only, the date of the liver biopsy should be recorded here.'

Date Discussed by Care Team (MDT):

- i. Amended notes for users: 'This should be the date that the patient is discussed at the colorectal MDT for management of their cancer.'

Type of First Cancer Treatment:

- i. Removed code: '12: active surveillance' from table of codes and values.

Intent of Surgery:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer}:

- i. Add to notes for users: 'Pathologist sometimes refer to the circumferential margin as the nonperitonealised margin.'

Grade of Differentiation {Colorectal Cancer}:

- i. Add notes for users: 'If polypectomy or another endoscopic procedure is the only treatment administered, the grade of differentiation can be taken from this.'

TNM Tumour Classification (Final) {Colorectal Cancer}:

- i. Add to notes for users: 'For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT'.

TNM Nodal Classification (Final) {Colorectal Cancer}:

- i. Add to notes for users: 'For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT'.

TNM Metastasis Classification (Final) {Colorectal Cancer}:

- i. Add to notes for users: 'For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT'.

Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}:

- i. Add to notes for users: 'It is the intended treatment, as defined by the initial treatment plan that should be recorded.'

Date Neo-Adjuvant Oncology Treatment Started {Colorectal Cancer}:

- i. Corrected data item name, to remove forward slash (/) between 'neo-adjuvant' and 'oncology'.

Date Neo-Adjuvant Oncology Treatment Completed {Colorectal Cancer}:

- i. Corrected data item name, to remove forward slash (/) between 'neo-adjuvant' and 'oncology'.

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}

- i. Add to notes for users: 'If more than one course of primary/palliative/adjuvant oncology treatment is administered, record only the first course.'

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- ii. Add to notes for users: 'It is the intended treatment, as defined by the initial treatment plan that should be recorded.'
- iii. Added code '9: Palliative chemoradiotherapy' to table of codes and values.

Previous Revisions (01/2014) – V1.2:

Dataset:

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}:

- i. Added code 'H06.3: Extended right hemicolectomy and anastomosis NEC'
- ii. Added code 'H07.3: Right hemicolectomy and anastomosis NEC'
- iii. Added code 'G74.1: Creation of continent ileostomy'

Previous Revisions (12/2013) – V1.1:

Dataset:

ASA Status:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Consultant in Charge of Surgery:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 1010 (Not applicable).'

Location Code {Cancer Surgery}:

- i. Amended notes for users: 'This is the hospital of first definitive surgery which removes the primary tumour. If an endoscopic procedure (e.g. polypectomy/stent insertion) is the only treatment, the location of this should be recorded. However, if an endoscopic procedure is performed and is followed by further excision of a segment of the colon or rectum, then the location code of the surgery to remove the segment of colon or rectum should be recorded.'

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}:

- i. Added code 'H06.5: Extended right hemicolectomy and end to side anastomosis'.
- ii. Added code 'H07.5: Right hemicolectomy and end to side anastomosis'.
- iii. Added code 'H08.6: Transverse colectomy and end to side anastomosis'.
- iv. Added code 'H09.6: Left hemicolectomy and end to side anastomosis'.
- v. Added code 'H10.6: Sigmoid colectomy and end to side anastomosis'.
- vi. Added code 'H11.6: Colectomy and end to side anastomosis NEC'.

Total Mesorectal Excision (TME) {Rectal Cancer}:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Surgical Approach {Colorectal Cancer}:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Presentation Type:

- i. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Anastomotic Leak {Colorectal Cancer}:

- i. Amended notes for users: 'Anastomotic leaks occurring within 30 days of surgery should be recorded.'
- ii. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

Intent of Surgery:

- ii. Amended notes for users: 'If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).'

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.

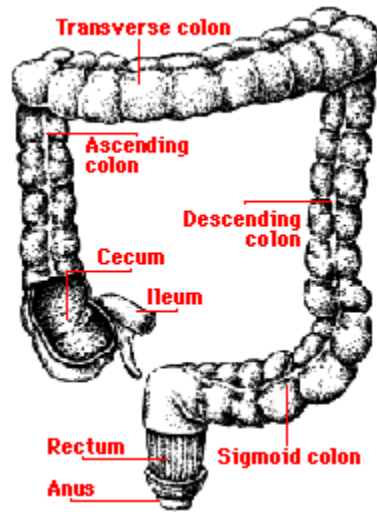
Include:

- All patients with a confirmed new primary cancer of the colon or rectum (ICD-O(3) codes C18 & C20).
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.
- All patients with tumour type adenocarcinoma (or undifferentiated/unspecified carcinoma, which is believed most likely to be adenocarcinoma).
- All patients with synchronous colorectal tumours (treatment recorded should relate to the tumour with the most advanced stage).

Exclude:

- Patients where the origin of the primary is uncertain.
- Patients with anal cancer.
- Patients with appendiceal cancer.
- Patients with carcinoid/endocrine tumours, lymphoma, melanoma, or sarcoma.
- Patients with recurrent disease (as opposed to a new primary).
- Patients with metastases in the colon or rectum originating from another primary site.
- Patients with carcinoma-in-situ, non-invasive tumours, or dysplasia.
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence out-with Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken out-with NHS Scotland.

N.B. In the event of multiple, synchronous primary tumours, record that with the worst prognosis/poorest TNM stage. If there is any uncertainty, seek clinical advice.



DATABASE SPECIFICATION

DOWNLOAD FORMAT

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

Data Item	Field Name	Field Type	Size	Page
Section 1: Demographic Items				1
Person Family Name (at Diagnosis)	PATSNAM	Characters	35	2
Person Given Name	PATFNAM	Characters	35	3
Patient Postcode at Diagnosis {Cancer}	PATPCODE	Characters	8	4
Date of Birth	DOB	Date	10	5
Person Sex at Birth	SEX	Integer	2	6
CHI Number	CHINUM	Integer	10	7
Source of Cancer Referral	MREFER	Integer	2	8
Section 2: Pre-treatment Imaging & Staging Investigations				9
Staging Investigations Complete {Colorectal Cancer}	SINVEST	Integer	2	10
Date Staging Investigations Completed	SINVESTDATE	Date (DD/MM/CCYY)	10	12
Distance from Anal Verge (Rectal Cancer)	ANALVERGE	Integer	2	13
CT Chest (Results)	CXR	Integer	2	14
Date of CT Chest (Results)	XDATE	Date (DD/MM/CCYY)	10	15
Liver Imaging (Results)	LIVER	Integer	2	16
Date of Liver Imaging (Results)	LIVERDATE	Date (DD/MM/CCYY)	10	17
Large Bowel Imaging	LBTYPE	Integer	2	18
Date of Imaging Large Bowel	LBDATE	Date (DD/MM/CCYY)	10	19
Circumferential Resection Margin – Predicted (Rectal Cancer)	CMARGINPREDICT	Integer	2	20
Location of Diagnosis {Cancer}	HOSP	Characters	5	21
Date of Diagnosis {Cancer}	DIAGDATE	Date (DD/MM/CCYY)	10	22
Date of Histological Diagnosis {Cancer}	HDIAG	Date (DD/MM/CCYY)	10	23
Most Valid Basis of Diagnosis {Cancer}	VALID	Integer	2	24
Site of Origin of Primary Tumour {Cancer}	SITE	Characters ICD-O (3)	4	25
Date Discussed by Care Team (MDT)	MDTDATE	Date (DD/MM/CCYY)	10	26
Seen by Stoma Nurse {Colorectal	STOMANURSE	Integer	2	27

Cancer}				
Date Seen by Stoma Nurse {Colorectal Cancer}	STOMANDATE	Date (DD/MM/CCYY)	10	28
Stoma Site Marked Pre-operatively	STOMAMARK	Integer	2	29
Type of First Cancer Treatment	FIRSTTREATM ODE	Integer	2	30
Date of First Cancer Treatment	FIRSTTREATD ATE	Date (DD/MM/CCYY)	10	31
Date of Definitive Treatment {Colorectal Cancer}	DEFTREATDAT E	Date (DD/MM/CCYY)	10	32
Section 3: Surgery				33
ASA Status	ASA	Integer	2	34
Consultant in Charge of Surgery	SURGCON	Characters	20	35
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Section 1: Demographic Items

Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

Field Name: PATSNAME

Field Type: Characters

Field Length: 35

Notes for Users:

Main Source of Standard: [Government Data Standards Catalogue](#)

The surname of a person represents that part of the name of a person indicating the family group of which the person is part.

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

From SMR Definitions and Codes

Person Given Name

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

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

Definition: The forename or given name of a person.

Field Name: PATFNAME

Field Type: Characters

Field Length: 35

Notes for Users:

Main Source of Standard: [Government Data Standards Catalogue](#)

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

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

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

Related Data Item(s):

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: Required for QPI(s); 11

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

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

Related Data Item(s):

CHI Number

Person Sex at Birth

Common Name(s): Sex at Birth

Main Source of Data Item Standard 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:

Code	Value	Explanatory Notes
1	Male	
2	Female	
9	Not specified/Indeterminate	Where it has not been possible to determine if the person is male or female at birth, e.g. intersex / hermaphrodite.
99	Not known	

Related Data Item(s):

CHI Number

CHI Number

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

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

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

Notes for Users:

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

From Designed to Care - Scottish Office

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

Related Data Item(s):

Date of Birth,
Person Sex at Birth.

Source of Cancer Referral

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

Definition: This denotes the route by which the patient was referred for investigation of signs or symptoms that lead to a diagnosis of cancer.

Field Name: MREFER

Field Type: Integer

Field Length: 2

Notes for Users: Required for sub-analysis of data for DCE HEAT target

A primary care clinician will usually be a general practitioner (GP) but may be any member of the primary care team, e.g. practice nurse (code 01). After attending for routine screening in a screening programme, a patient may be referred for further investigation, (code 02).

Some patients may be attending or referred to hospital for investigation or treatment of a condition unrelated to their cancer and a tumour is diagnosed (code 03).

Patients presenting at A&E or acute admissions are often referred by their GP (code 07), or may already have an outstanding primary care referral for cancer (code 08)

Patients self-referring to A&E without any formal referral should be recorded as code 06.

Patients may attend an outpatient cancer clinic as they are being followed up for benign disease or a previous cancer of the same site as diagnosed (code 04) or because of a strong family history of cancer (code 05).

13 (Other) includes following a domiciliary visit by a hospital clinician.

Codes and Values:

Code	Value	Explanatory Notes
01	Primary care clinician (GP, Nurse practitioner)	
02	Screening service	
03	Incidental finding	
04	Review clinic	
05	Cancer genetic clinic	
06	Self-referral to A&E	
07	GP referral directly to hospital	A&E or other
08	Previous GP referral but subsequently admitted to hospital	
11	Primary care clinician (dental)	
12	Referral from private healthcare	
13	Other	
99	Not recorded	

Notes by Users:

Section 2: Pre-treatment Imaging & Staging Investigations

Staging Investigations Complete {Colorectal Cancer}

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 (for colon cancer) and by CT and MRI (rectal cancer).

Field Name: SINVEST

Field Type: Integer

Field Length: 2

Notes for Users: Required for QPI(s): 1

Complete staging for colon cancer is CT chest, abdomen and pelvis (and no other combination).

Complete staging for rectal cancer is CT chest, abdomen and pelvis with the addition of pelvic MRI.

Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis. i.e. CT colonography (with contrast) and CT chest is complete staging.

These investigations may be done separately at different times but before definitive treatment.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Codes and Values:

Code	Value	Explanatory Notes
1	Complete – CT Chest, Abdomen and Pelvis	Colon Cancer
2	Complete – CT Chest, Abdomen and Pelvis and pelvic MRI	Rectal Cancer
3	Incomplete	e.g. no imaging or part imaging
4	Incomplete - Contraindications	Rectal Cancer only (should not be used for colon cancers)- Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table
95	Patient refused investigations	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date Staging Investigations Complete

Site of Origin of Primary Tumour {Cancer}

Date Staging Investigations Completed

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

Definition: The date that staging investigations were completed by CT of the chest, abdomen and pelvis for colon cancer plus a pelvic MRI for rectal cancer.

Field Name: SINVESTDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s):

Complete staging for colon cancer is CT chest, abdomen and pelvis (and no other combination).

Complete staging for rectal cancer is CT chest, abdomen and pelvis with the addition of pelvic MRI.

Where CT colonography has been performed with IV contrast, this is equivalent to CT abdomen and CT pelvis i.e. CT colonography (with contrast) and CT chest is complete staging.

These investigations may be done separately at different times but before definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Record the date that ALL items are complete, e.g. if done on separate days then record the final date.

If staging investigations were not completed, record as inapplicable (10/10/1010).

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

Related Data Item(s):

Staging Investigations Complete

Distance from Anal Verge (Rectal Cancer)

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

Definition: A record of the distance from the anal verge to the lower margin of the tumour measured in centimetres (cm) by proctoscopy or sigmoidoscopy.

Field Name: ANALVERGE

Field Type: Integer

Field Length: 2

Notes for Users: Required for local analysis or submission to the UK National Bowel Cancer Audit.

This item should be recorded only for rectal tumours and is recorded in centimetres (cm).

Where there is a range e.g. 10-20cm, the lowest value should be recorded.

IT systems should ensure that the unit of measurement for values is always clear to users, in whatever medium values are recorded.

If not rectal cancer, record as '96' (not applicable)

If the distance is not recorded, code as '99' (Not recorded).

CT Chest (Results)

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

Definition: CT Chest (or CT Thorax) is a series of cross-sectional images of the thorax produced by a CT scanner.

Field Name: CXR

Field Type: Integer

Field Length: 2

Notes for Users: Required for Detect Cancer Early Initiative.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Codes and Values:

Code	Value	Explanatory Notes
1	No metastases	
2	Metastases	
3	Equivocal	
4	Not performed	
95	Patient refused investigation	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date of CT Chest (Results)

Date of CT Chest (Results)

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

Definition: Date of CT Chest (or CT Thorax) investigation was carried out.

Field Name: XDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for Detect Cancer Early Initiative

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Related Data Item(s):

CT Chest (Results)

Liver Imaging (Results)

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

Definition: Liver imaging is defined as, computed tomography (CT) for the identification of liver metastases.

Field Name: LIVER

Field Type: Integer

Field Length: 2

Notes for Users: Required for Detect Cancer Early Initiative.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Results from CT colonography (with IV contrast) may be recorded, where it can be determined from the radiology report that the liver has been investigated.

Codes and Values:

Code	Value	Explanatory Notes
1	No metastases	
2	Metastases	
3	Equivocal	
4	Not performed	
95	Patient refused investigation	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date of Liver Imaging (Results)

Date of Liver Imaging (Results)

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

Definition: Date of when liver imaging investigation was carried out.

Field Name: LIVERDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for Detect Cancer Early Initiative

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

Related Data Item(s):

Liver Imaging (Results)

Large Bowel Imaging

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

Definition: A record to determine if the whole colon was visualised by colonoscopy or CT colonography pre-operatively.

Field Name: LBTYPE

Field Type: Integer

Field Length: 2

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

Colonoscopy examination is complete when the caecum/ileocaecal valve or small bowel colon anastomosis, if previous surgery has been performed, is reached. It is also complete when the non visualised segment of colon is resected at the time of operation. e.g.: if hepatic flexure cancer has been reached but the colonoscope could not get through it to the caecum and the patient then went onto have a right hemicolectomy. The same would be true if there was a splenic flexure cancer which would not allow the colonoscope through and the patient underwent an extended right hemicolectomy with anastomosis of their terminal ileum to their sigmoid or descending colons. However it would be regarded as incomplete if the same patient with splenic flexure cancer underwent a local excision of their left colon and anastomosis of their proximal transverse colon to their descending colon i.e. caecum and ascending colon has not been visualised at the colonoscopy and has been left in the patient at the time of their operation.

Incomplete colonoscopy due to poor bowel prep would not be included here i.e. they would be regarded as incomplete examinations.

Investigation must be performed prior to definitive treatment, unless patient has a polyp cancer treated only by polypectomy or EMR.

NB: Record only the most complete peri-operative colonoscopy.

Codes and values:

Code	Value	Explanatory Notes
1	Yes – Colonoscopy or CT Colonography	Whole colon is visualised or non-visualised segment of colon has been removed.
2	Incomplete	
3	Not performed	No colonoscopy or CT colonography performed
4	Incomplete due to obstructing tumour	This includes patients with strictures which prevent passage of a scope.
94	Patient died before treatment	
95	Patient refused treatment	
96	Not applicable	
99	Not recorded	

Related Data Items

Date of Large Bowel Imaging

Date of Imaging Large Bowel

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 on which imaging of the large bowel was carried out using colonoscopy of CT colonography.

Field Name: LBDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s):

Colonoscopy examination is complete when the caecum/ileocaecal valve or small bowel colon anastomosis, if previous surgery has been performed, is reached. It is also complete when the non visualised bit of colon is resected at the time of operation.

NB: Record the date of the most complete peri-operative colonoscopy.

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

If no imaging was performed, record as 10/10/1010.

Related Data Items

Large Bowel Imaging

Circumferential Resection Margin – Predicted (Rectal Cancer)

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

Definition: A record of the predicted circumferential resection margin on imaging (MRI) prior to surgery, as documented on MRI report or following MDT discussion

Field Name: CMARGINPREDICT

Field Type: Integer

Field Length: 2

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

This should be obtained following discussion of MRI at the MDT meeting or from the MRI report.

For patients with rectal cancer MRI is utilised to assess the extent of disease prior to treatment.

This is recorded for rectal tumours only and for all patients who undergo MRI for staging of rectal cancer.

This is predicted circumferential resection margin on MRI/imaging and not the post surgical result.

Codes and Values:

Code	Value	Explanatory Notes
1	Clear	
2	Threatened	
3	Involved	
96	Not applicable	Polyp cancer or locally resected
98	Not assessed	
99	Not recorded	Involvement of margin not noted on MRI report/MDT discussion

Location of Diagnosis {Cancer}

Main Source of Data Item Standard: NHS National reference files
<http://www.natref.scot.nhs.uk/>.

Definition: The patient's hospital of initial referral into secondary care which led to a diagnosis of cancer.

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

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

This will be the hospital where the patient was diagnosed. If the diagnosis is made by screening colonoscopy; or if colonoscopy is carried out at a hospital for waiting list reasons i.e. Golden Jubilee, the hospital recorded should be the hospital where the patient was managed following their diagnosis of cancer.

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 and would retain responsibility for collection of the patient record.

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

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 first confirmed cancer diagnosis whether by histology, cytology, immunology, cytogenetics or clinical (including radiological) methods.

Field Name: DIAGDATE

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

Required for national survival analysis and clarifying responsibility for data collection.

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

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

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

For patients diagnosed with a cancer and not just a screening result, through a national screening programme at a screening assessment/diagnostic clinic, this should be the date of diagnosis. This may be at the screening centre or hospital.

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

Related Data Item(s):

Location of Diagnosis {Cancer}

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.

Field Name: HDIAG

Format: Date (DD/MM/CCYY)

Field length: 10

Notes for Users: Required for national survival analysis.

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 histological/cytological diagnosis' may not relate to 'Most Valid Basis of Diagnosis'.

If a primary colorectal cancer is confirmed by liver biopsy only, the date of the liver biopsy should be recorded here.

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

Most Valid Basis of Diagnosis {Cancer}

Main Source of Data Item Standard of Standard: International Agency for Research on Cancer (IARC) and Scottish Cancer Registry Guidelines, Fourth Edition, 2001.

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

Field Name: VALID

Field Type: Integer

Field Length: 2

Notes for Users: Required for Cancer Registration.

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:

Code	Value	Explanatory Notes
1	Clinical only	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:
2	Clinical investigation	The diagnosis is supported by investigations such as x-ray, CT scan, ultrasound etc.
3	Exploratory surgery/endoscopy/autopsy (without concurrent or previous histology)	The tumour has been visualised or palpated but there is no confirmatory microscopic evidence
4	Tumour specific markers (biochemical/immunological tests)	The diagnosis is supported by specific tests
5	Cytology	The diagnosis is supported by cytology (the examination of cells whether from a primary or secondary site).
6	Histology of metastasis	The diagnosis is based on the histology of a metastasis (secondary deposit), e.g. resulting from a lymph node biopsy
7	Histology of primary	The diagnosis is based on the histology of the primary either resulting from a biopsy or from complete resection of the tumour.
99	Not known	

Site of Origin of Primary Tumour {Cancer}

Main Source of Data Item Standard: The World Health Organisation (WHO) and the Cancer Registration New Data definitions for Socrates (August 1999 Version 8.0).

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

Field Name: SITE

Field Type: Characters ICD-O (3)

Field length: 4

Notes for Users: Required for QPI(s): 1-12.

For ICD-O(3), 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:

ICD-O(3) Code	Value	Notes on Inclusion
C18.0	Caecum	Ileocaecal valve; Ileocaecal junction
C18.2	Ascending colon	Right colon
C18.3	Hepatic flexure	
C18.4	Transverse colon	
C18.5	Splenic flexure	
C18.6	Descending colon	Left colon
C18.7	Sigmoid colon	Sigmoid NOS; Sigmoid flexure of colon; Pelvic colon
C18.8	Overlapping lesion of colon	
C18.9	Colon, unspecified	Large intestine; Large Bowel NOS
C20.9	Rectum	Rectal ampulla
C99.X	Not recorded	

Date Discussed by Care Team (MDT)

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

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

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

Field Name: MDTDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s): 3

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

The first MDT meeting date will be recorded.

This should be the date that the patient is discussed at the colorectal-specific MDT for the management of their cancer.

If the patient has not been discussed by the MDT record as 10/10/1010 (Not applicable).

If the date of the MDT meeting is unknown, record as 09/09/0909 (Not recorded).

Seen by Stoma Nurse {Colorectal Cancer}

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

Definition: A record to determine if the patient has been referred to a nurse with expertise in stoma care.

Field Name: STOMANURSE

Field Type: Integer

Field Length: 2

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

All patients requiring stoma formation should be seen by a nurse with expertise in stoma care.

In cases where the patient will not require stoma formation (permanent or temporary) code as 96 (not applicable).

Can be the same day but prior to operation.

Codes and Values:

Code	Value
1	Yes
2	No
95	Patient refused
96	Not applicable
99	Not recorded

Related Data Item(s):

Date Seen by Stoma Nurse {Colorectal Cancer}

Stoma Site Marked Pre-operatively

Date Seen by Stoma Nurse {Colorectal Cancer}

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

Definition: The date on which the patient was seen by a nurse with expertise in stoma care.

Field Name: STOMANDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

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

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

If the patient was not required to be seen by a nurse with expertise in stoma care, record as 10/10/1010 (not applicable).

Related Data Item(s):

Seen by Stoma Nurse {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Stoma Site Marked Pre-operatively

Stoma Site Marked Pre-operatively

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

Definition: A record to determine if the patient's stoma site was marked pre-operatively by a nurse with expertise in stoma care.

Field Name: STOMAMARK

Field Type: Integer

Field Length: 2

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

All patients requiring stoma formation should be seen by a nurse with expertise in stoma care preoperatively and have their stoma site marked.

In cases where the patient will not require stoma formation (permanent or temporary) code as 96 (not applicable).

Can be the same day prior to operation even if it is on the same day

Codes and Values:

Code	Value
1	Yes
2	No
95	Patient refused
96	Not applicable
99	Not recorded

Related Data Item(s):

Date Seen by Stoma Nurse {Colorectal Cancer}

Seen by Stoma Nurse {Colorectal Cancer}

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 Information Services.

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

Field Name: FIRS TTREATMODE

Field Type: Integer

Field length: 2

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

Required for survival analysis and comparative analysis.

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

Record patients as having 'supportive care only' if a decision was taken not to give the patient any active treatment as part of their primary therapy.

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:

Code	Value	Explanatory notes
1	Surgery	
2	Radiotherapy	Includes Teletherapy (external beam radiotherapy)
3	Chemotherapy	
4	Chemoradiotherapy	
5	Endoscopic	Includes endomucosal resection, and insertion of stents.
7	Supportive Care Only	Not for active treatment
11	Other therapy	
94	Patient died before treatment	
95	Patient refused treatment	
99	Not recorded	

Related Data Item(s):

Date of First Cancer Treatment

Date of First Cancer Treatment

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

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

Field Name: FIRS TTREATDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for survival analysis and 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 09/09/0909 (Not recorded).

If the patient died before treatment or the patient refused treatment, record as 10/10/1010 (Not applicable).

Related Data Item(s):

Type of First Cancer Treatment

Date of Definitive Treatment {Colorectal 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(s): 3

For patients with colorectal cancer definitive treatment will be either:

- Surgery;
- Neo-adjuvant Radiotherapy/ Chemotherapy/ Chemoradiotherapy;
- Primary/Radical Radiotherapy; or
- Primary Chemotherapy.

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.

Malignant polyps may be removed at colonoscopy and if no further operation is carried out the date of polypectomy should be recorded in this field. However if an operation such as a bypass or formation of a stoma is carried out to relieve symptoms and a further operation which aims to remove the tumour is performed the date of the second operation is the one that should be recorded in this field.

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 09/09/0909 (Not recorded).

If the patient died before treatment or the patient refused treatment, record as 10/10/1010 (Not applicable).

Related Data Item(s):

Section 3: Surgery

ASA Status

Common name: Patient status

Main source of Data Item Standard: American Society of Anaesthesiologists.

Definition: The ASA PS classification globally assesses the degree of "sickness" or "physical state" prior to selecting the anaesthetic or prior to performing surgery.

Field Name: ASA

Field Type: Integer

Field Length: 2

Notes for Users: Required for local analysis or submission to the UK National Bowel Cancer Audit.

The American Society of Anaesthesiologists' (ASA) physical status classification serves as a guide to better communication among anaesthesiologists about clinical conditions of patients. The ASA classification system by itself does not predict risk. However, one can estimate higher or lower medical risk when factoring anaesthetic technique and the extent of surgical trauma.

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Value	Explanatory Notes
1	A normal healthy patient.	
2	A patient with mild systemic disease.	
3	A patient with severe systemic disease	
4	A patient with severe systemic disease that is a constant threat to life	
5	A moribund patient who is not expected to survive without the operation.	
6	A declared brain-dead patient whose organs are being removed for donor purposes.	
96	Not applicable	e.g. Polypectomy only patients
99	Not recorded	

Consultant in Charge of 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 name of the consultant who is in charge of the final definitive (or only) surgery.

Field Name: SURGCON

Field Type: Characters

Field Length: 20

Notes for Users: Required for survival analysis and comparative analysis

The surname and forename of the consultant should be recorded to distinguish between consultants with common surnames.

NB: On the database, the consultant's name will be stored as a GMC number

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

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 1010.

If the patient is managed by a team rather than with a consultant in overall charge, record as inapplicable, 1010.

If the patient is managed by a locum, record only that the clinician is a locum consultant, LOCUM.

Related Data Item(s):

Location Code {Cancer Surgery}

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Surgical Approach {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Presentation Type

Intent of Surgery

Location Code {Cancer Surgery}

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

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

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

Field Name: HOSPSURG

Field Type: Characters

Field Length: 5

Notes for Users: Required for QPI(s):

This is the hospital of first definitive surgery which removes the primary tumour. If an endoscopic procedure (e.g. polypectomy/stent insertion) is the only treatment, the location of this should be recorded. However, if an endoscopic procedure is performed and is followed by further excision of a segment of the colon or rectum, then the location code of the surgery to remove the segment of colon or rectum should be recorded.

Each location has a location code, which is maintained jointly by ISD and General Register Office (Scotland). <http://www.show.scot.nhs.uk/smrfiles/information.html> – datafiles.

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

<http://www.show.scot.nhs.uk/smrfiles>

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 inapplicable, X1010.

Examples of codes are given below:

Code	Institution
A111H	CROSSHOUSE HOSPITAL
C418H	ROYAL ALEXANDRA HOSPITAL
F704H	VICTORIA HOSPITAL, KIRKCALDY
G107H	GLASGOW ROYAL INFIRMARY
G405H	SOUTHERN GENERAL HOSPITAL, GLASGOW

Related Data Item(s):

Consultant in Charge of Surgery

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Surgical Approach {Colorectal Cancer}
Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
Presentation Type
Intent of Surgery

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal 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) or only operation performed for treatment of colorectal cancer.

Field Name: OPCODE2
OPCODE2B

Field Type: Characters

Field Length: 5

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

Malignant polyps may be removed at colonoscopy and if no further operation is carried out the appropriate code for the polypectomy should be recorded in this field.

If there are multiple tumours record the operation relating to the most advanced tumour (i.e. the one with the most advanced Dukes' stage).

If a palliative operation such as a bypass or formation of a stoma is the only operation performed, the code for that operation should be entered in this field.

However if an operation such as a bypass or formation of a stoma is carried out to relieve symptoms and a further operation which aims to remove the tumour is performed the second operation is the one that should be coded in this field.

If a second operation is carried out as a direct result of complications arising from the main (definitive) operation this should not be recorded in this field but should be coded as Yes in the field 'Re-operation'.

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

H06.1 = Extended right hemicolectomy and end to end anastomosis

H06.2 = Extended right hemicolectomy and anastomosis of ileum to colon

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

If the patient died before treatment, record as 94 (Patient died before treatment).

If the patient refused treatment, record as 95 (Patient refused treatment).

If only one code is required, record 'OPCODE2B' as 96 (Not applicable).

If operation code has not been recorded, record as 99 (Not recorded)

If the patient did not undergo surgery for other reasons, record as 96 (not applicable)

Examples of operative procedures are given below:

This list is not exhaustive and if a code is not on the list please contact

NSS.terminologyhelp@nhs.net.

<p>Emergency excision of appendix H01.2 Emergency excision of abnormal appendix NEC</p> <p>Other excision of appendix H02.1 Interval appendicectomy H02.2 Planned delayed appendicectomy H02.3 Prophylactic appendicectomy H02.4 Incidental appendicectomy</p>	<p>COLON - Total Excision of Colon and Rectum H04.1 Panproctocolectomy and Ileostomy H04.2 Panproctocolectomy and Anastomosis of Ileum to Anus and Creation of Pouch H04.3 Panproctocolectomy and Anastomosis of Ileum to Anus NEC H04.8 Other Specified</p>
<p>Excision of Sigmoid colon H10.1 Sigmoid Colectomy and end to end Anastomosis of Ileum and Rectum H10.2 Sigmoid Colectomy and Anastomosis of Colon to Rectum H10.3 Sigmoid Colectomy and Anastomosis NEC H10.4 Sigmoid Colectomy and ileostomy HFQ H10.5 Sigmoid Colectomy and Exteriorisation of Bowel NEC H10.6 Sigmoid colectomy and end to side anastomosis H10.8 Other Specified</p> <p>Total Excision of Colon H05.1 Total Colectomy and Anastomosis H05.2 Total Colectomy and Ileostomy with Creation of Rectal Fistula H05.3 Total Colectomy and Ileostomy NEC H05.8 Other Specified</p>	<p>Extended Excision of Right Hemi colon H06.1 Ext Right Hemicolectomy and end to end Anastomosis H06.2 Ext Right Hemicolectomy and Anastomosis of Ileum to Colon H06.3 Ext Right Hemicolectomy and anastomosis NEC H06.4 Ext Right Hemicolectomy and Ileostomy HFQ H06.5 Ext Right Hemicolectomy and end to side anastomosis H06.8 Other Specified</p> <p>Other Excision of Right Hemi colon H07.1 Right Hemicolectomy and end to end anastomosis of Ileum to Colon H07.2 Right Hemicolectomy and side to side anastomosis of ileum to transverse colon H07.3 Right Hemicolectomy and anastomosis NEC H07.4 Hemicolectomy and Ileostomy HFQ H07.5 Right hemicolectomy and end to side anastomosis H07.8 Other Specified</p>

Other Excision of Colon

- H11.1 Colectomy and end to end Anastomosis of Colon to Colon NEC
- H11.2 Colectomy and side to side Anastomosis of Ileum to Colon NEC
- H11.3 Colectomy and Anastomosis of Ileum NEC
- H11.4 Colectomy and Ileostomy NEC
- H11.5 Colectomy and Exteriorisation of Bowel NEC
- H11.6 Colectomy and end to side anastomosis
- H11.8 Other Specified

Extirpation of Lesion of Colon

- H12.1 Excision of Diverticulum of Colon
- H12.2 Excision of Lesion of Colon NEC
- H12.3 Destruction of Lesion of Colon NEC
- H12.8 Other Specified

Bypass of Colon

- H13.9 Bypass of Colon
- H13.1 Bypass of colon by anastomosis of ileum to colon
- H13.2 Bypass of colon by anastomosis of caecum to sigmoid colon
- H13.3 Bypass of colon by anastomosis of transverse colon to sigmoid colon
- H13.4 Bypass of colon by anastomosis of transverse colon to rectum
- H13.5 Bypass of colon by anastomosis of colon to rectum NEC
- H13.8 Other specified

Other Exteriorisation of Colon

- H15.1 Loop Colostomy
- H15.2 End Colostomy

Excision of Transverse Colon

- H08.1 Transverse Colectomy and end to end Anastomosis
- H08.2 Transverse Colectomy and Anastomosis of Ileum to Colon
- H08.3 Transverse Colectomy and Anastomosis NEC
- H08.4 Transverse Colectomy and Ileostomy HFQ
- H08.5 Transverse Colectomy and Exteriorisation of Bowel NEC
- H08.6 Transverse colectomy and end to side anastomosis
- H08.8 Other Specified

Excision of Left Hemi colon

- H09.1 Left Hemicolectomy and End to End Anastomosis of Colon to Rectum
- H09.2 Left Hemicolectomy and End to End Anastomosis of Colon to Colon
- H09.3 Left Hemicolectomy and Anastomosis NEC
- H09.4 Left Hemicolectomy and Ileostomy HFQ
- H09.5 Left Hemicolectomy and Exteriorisation of Bowel NEC
- H09.6 Left Hemicolectomy and end to side anastomosis
- H09.8 Other Specified

Open Endoscopic Operations on Colon

- H18.1 Open Colonoscopy
- H18.8 Other Specified

Exteriorisation of caecum

- H14.1 Tube Caecostomy
- H14.8 Other specified
- H14.9 Unspecified

Clearance of Pelvis

- X14.1 - Total exenteration of pelvis.
- X14.2 - Anterior extenteration
- X14.3 Posterior exenteration of pelvis.
- X14.8 - Other specified clearance of pelvis
- X14.9 is Unspecified clearance of pelvis

<p>Subtotal Excision of Colon</p> <p>H29.1 Subtotal excision of colon and rectum and creation of colonic pouch and anastomosis of colon to anus</p> <p>H29.2 Subtotal excision of colon and rectum and creation of colonic pouch NEC</p> <p>H29.3 Subtotal excision of colon and creation of colonic pouch and anastomosis of colon to rectum</p> <p>H29.4 Subtotal excision of colon and creation of colonic pouch NEC</p> <p>H29.8 Other specified subtotal excision of colon</p> <p>H29.9 Unspecified subtotal excision of colon</p> <p>Other Operations of Colon</p> <p>H30.1 Radiological Reduction of Intussusception of Colon using Barium Enema</p> <p>H30.2 Intubation of Colon for Pressure Manometry</p> <p>H30.3 Passage of Flatus Tube to reduce Volvulus of Sigmoid Colon</p> <p>H30.4 Intubation of Colon NEC</p> <p>H30.8 Other Specified</p> <p>H21.4 Fiberoptic endoscopic insertion of expanding metal stent into colon.</p> <p>H24.4 Endoscopic insertion of expanding metal stent into lower bowel using fiberoptic sigmoidoscope</p> <p>H27.4 Endoscopic insertion of expanding metal stent into sigmoid colon using rigid sigmoidoscope</p> <p>H31.4 Image guided insertion of colorectal stent</p> <p>H31.5 Image guided removal of colorectal stent</p>	<p>OPERATIVE PROCEDURES - RECTUM</p> <p>Excision of Rectum</p> <p>H33.1 Abdominoperineal Excision of Rectum and End Colostomy</p> <p>H33.2 Proctectomy and Anastomosis of Colon to Anus</p> <p>H33.3 Anterior Resection of Rectum-Anastomosis of Colon to Rectum using Staples</p> <p>H33.4 Anterior Resection of Rectum-Anastomosis NEC</p> <p>H33.5 Rectosigmoidectomy and Closure of Rectal Stump and Exteriorisation of bowel</p> <p>H33.6 Anterior Resection of Rectum and Exteriorisation of bowel</p> <p>H33.8 Other Specified</p> <p>Operations on Rectum through Anal Sphincter</p> <p>H40.1 Transsphincteric Excision of Mucosa of Rectum</p> <p>H40.2 Transsphincteric Excision of Lesion of Rectum</p> <p>H40.3 Transsphincteric Destruction of Lesion of Rectum</p> <p>H40.4 Transsphincteric Anastomosis of Colon to Anus</p> <p>H40.8 Other Specified</p> <p>Open Extirpation of Lesion of Rectum</p> <p>H34.1 Open Excision of Lesion of Rectum</p> <p>H34.2 Open Cauterisation of Lesion of Rectum</p> <p>H34.3 Open Cryotherapy of Lesion of Rectum</p> <p>H34.4 Open Laser Destruction of Lesion of Rectum</p> <p>H34.5 Open Destruction of Lesion of Rectum</p> <p>H34.8 Other Specified</p> <p>Other Operations on Rectum through Anus</p> <p>H41.1 Rectosigmoidectomy and Peranal Anastomosis</p> <p>H41.2 Peranal Excision of lesion of Rectum</p> <p>H41.3 Peranal Destruction of Lesion of Rectum</p> <p>H41.4 Peranal Mucosal Proctectomy and Endoanal Anastomosis</p> <p>H41.8 Other Specified</p>
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OPERATIVE PROCEDURES - ENDOSCOPIC OPERATIONS

Endoscopic Extirpation of Lesion of Colon

- H20.1 Fibreoptic Endoscopic Snare Resection of Lesion of Colon
- H20.2 Fibreoptic Endoscopic Cauterisation of Lesion of Colon
- H20.3 Fibreoptic Endoscopic Laser Destruction of Lesion of Colon
- H20.4 Fibreoptic Endoscopic Destruction of Lesion of Colon NEC
- H20.5 Fibreoptic Endoscopic Submucosal Resection of Lesion of Colon
- H20.7 Fibreoptic endoscopic mucosal resection of Lesion of Colon
- H20.8 Other Specified

Other Therapeutic Endoscopic Operations on Colon

- H21.1 Fibreoptic Endoscopic Dilation of Colon
- H21.2 Fibreoptic Endoscopic Coagulation of Blood Vessel of Colon
- H21.8 Other Specified

Endoscopic Extirpation of Lesion of Lower Bowel Using Fibreoptic Sigmoidoscope

- H23.1 Endoscopic Snare Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.2 Endoscopic Cauterisation of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.3 Endoscopic Laser Destruction of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.4 Endoscopic Snare Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.7 Endoscopic Mucosal Resection of Lesion of Lower Bowel using Fibreoptic Sigmoidoscope
- H23.8 Other Specified

Other Endoscopic Operations – Lower Bowel using Fibreoptic Sigmoidoscope

- H24.1 Endoscopic Dilation of Lower Bowel using Fibreoptic Sigmoidoscope
- H24.2 Endoscopic Coagulation of Blood Vessel of Lower Bowel using Fibreoptic Sigmoidoscope
- H24.8 Other Specified

Endoscopic Extirpation of Lesion of Sigmoid Colon using Rigid Sigmoidoscope

- H26.2 Endoscopic Cauterisation of Lesion of Sigmoid Colon using Rigid Sigmoidoscope
- H26.3 Endoscopic Laser Destruction of Lesion of Sigmoid Colon using Rigid Sigmoidoscope
- H26.4 Endoscopic Cryotherapy to Lesion of Sigmoid Colon using Rigid Sigmoidoscope NEC
- H26.8 Other Specified
- H37.1 Endoscopic mucosal resection of lesion of sigmoid colon using rigid sigmoidoscope

Other Endoscopic Operations on Sigmoid Colon using Rigid Sigmoidoscope

- H27.1 Endoscopic Dilation of Sigmoid Colon using Rigid Sigmoidoscope
- H27.8 Other Specified

OPERATIVE PROCEDURES - SYNCHRONOUS LIVER RESECTION

J02.1 Right hemihepatectomy
J02.2 Left hemihepatectomy
J02.3 Resection of segment of liver
J02.4 Wedge excision of liver
J02.6 Extended right hemihepatectomy
J02.7 Extended left hemihepatectomy
J03.2 Destruction of lesion of liver
J03.3 Thermal ablation of single lesion of liver
J03.4 Thermal ablation of multiple lesions of liver
J03.5 Excision of multiple lesions of liver
J12.4 Percutaneous radiofrequency ablation of lesion of liver

OPERATIVE PROCEDURES – CREATION OF ARTIFICIAL OPENING INTO ILEUM

G74.1 Creation of continent ileostomy
G74.2 Creation of temporary ileostomy
G74.3 Creation of defunctioning ileostomy

Related Data Item(s):

Consultant in Charge of Surgery
Location Code {Cancer Surgery}
Surgical Approach {Colorectal Cancer}
Date of Final Definitive (or Only) Surgery {Colorectal Cancer}
Presentation Type
Intent of Surgery

Total Mesorectal Excision (TME) {Rectal Cancer}

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

Definition: An indication of whether or not Total Mesorectal Excision (TME) has been performed.

Field Name: TEXCISION

Field Type: Integer

Field Length: 2

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

Total mesorectal excision (TME) is the en-bloc excision of the fatty tissue around the rectum along with its fascial envelope in the course of rectal excision.

Only excisions of the whole rectum (low anterior resection or AP excision) and where the intended plane of excision is mesorectal, count as TME.

This is recorded for rectal tumours only. If there are multiple tumours record this for the operation related to the most advanced tumour (i.e. the one with the poorest Dukes' stage).

If the site of origin of the tumour is not the rectum (colon) code as inapplicable (96).

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Description	
1	Yes	
2	No	
96	Not applicable	e.g. Not rectal cancer/endoscopic treatment only.
99	Not recorded	

Surgical Approach (Colorectal 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. This also includes nodal and reconstructive surgery performed on the patient for treatment of cancer.

Field Name: SURGAPPR

Field Type: Characters

Field length: 2

Notes for Users: Required for QPI(s): 1, 5, 7

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Value	Explanatory Notes
1	Open	
2A	Laparoscopic - Completed	
2B	Laparoscopic - Converted	
3	Transanal Endoscopic Microsurgery	TEM
4	Transanal Resection of Tumour	TART
96	Not applicable	e.g. Surgery not performed/endoscopic treatment only
99	Not known	

Related Data Item(s):

Consultant in Charge of Surgery

Location Code {Cancer Surgery}

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Presentation Type

Intent of Surgery

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

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

Definition: The date on which the operation described elsewhere as the final definitive (or only) operation for colorectal cancer was performed.

Field Name: FINSURGDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s): 4, 7, 10, 11

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 (inapplicable).

Related Data Item(s):

Consultant in Charge of Surgery

Location Code {Cancer Surgery}

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Surgical Approach {Colorectal Cancer}

Presentation Type

Intent of Surgery

Presentation Type

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

Definition: How the patient presented for surgery.

Field Name: PRESENT

Field Type: Integer

Field Length: 2

Notes for Users: Required for QPI(s): 1, 2, 3, 4, 6, 7, 10

Both categories incorporate:

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

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Value	Explanatory Notes
1	Elective (routine)	A patient who presents for surgery as planned.
2	Emergency	A patient, who for clinical reasons, presents unplanned for surgery
96	Not applicable	If no operation was performed.
99	Not recorded	

Related Data Item(s):

Consultant in Charge of Surgery

Location Code {Cancer Surgery}

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Surgical Approach {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Intent of Surgery

Anastomotic Leak (Colorectal Cancer)

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

Definition: An indication of whether or not there was anastomotic leak requiring radiological or surgical intervention in patients undergoing a surgical procedure involving anastomosis.

Field Name: ANASLEAK

Field Type: Integer

Field Length: 2

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

Anastomotic leaks occurring within 30 days of surgery should be recorded.

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Value	Explanatory Notes
1	Yes	
2	No anastomotic leak	
96	Not applicable	e.g. Surgery not performed/endoscopic treatment only
99	Not known	

Related Data Item(s):

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}
Total Mesorectal Excision (TME) (Rectal Cancer)

Intent of Surgery

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

Definition: Final assessment of intent of surgery as defined by the Multidisciplinary Team (MDT).

Field Name: OPINTENT

Field Type: Integer

Field Length: 2

Notes for Users: Required QPI(s): 1, 2, 5 and survival analysis

If no surgery was performed, or an endoscopic procedure (e.g. polypectomy/stent insertion) was the only treatment administered to the patient, this should be recorded as 96 (Not applicable)

Codes and Values:

Code	Value
1	Curative
2	Palliative
96	Not applicable
99	Not recorded

Related Data Items:

Date Discussed by Care Team (MDT Pre-treatment)

Consultant in Charge of Surgery

Location Code {Cancer Surgery}

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Surgical Approach {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Intent of Surgery

Presentation Type

Re-operation

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 the patient underwent further surgery arising directly as a result of complications from their main (definitive) or only surgical procedure as detailed in the Final Definitive (or only) Surgery Performed (Surgery) {Colorectal Cancer} .

Field Name: REOPER

Field Type: Integer

Field Length: 2

Notes for Users: Required QPI(s) 8

Post operative complications that may require further surgery include intra-abdominal abscess, wound complications, anastomotic leak, organ injury, post operative haemorrhage.

A condition is considered a post operative complication if it occurs within 30 days of the date of operation. If further surgery is undertaken after 30 days this should be recorded as 2 (No).

If no main (definitive) surgery has been performed, or this was an endoscopic procedure (e.g. polypectomy/stent insertion) only, this should be recorded as 96 (Not applicable).

Codes and Values:

Code	Value
1	Yes
2	No
96	Not applicable
99	Not recorded

Related Data Items:

Final Definitive (or Only) Surgery Performed (Surgery) {Colorectal Cancer}

Date of Final Definitive (or Only) Surgery {Colorectal Cancer}

Section 4: Pathology Details

Extramural Venous Invasion (Surgical Resection Specimen) {Colorectal Cancer}

Main Source of Data Item Standard: The Royal College of Pathologists, Dataset for Colorectal Cancer (2nd edition), September 2007.

Definition: A description of the presence of tumour within an extramural endothelium-lined space that is either surrounded by a rim of muscle or contains red blood cells.

Field Name: EXTRA

Field Type: Integer

Field Length: 2

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

The term “lymphovascular invasion” should not be used in this context as *lymphatic* vessel involvement is not classified as extramural venous invasion.

Codes and Values:

Code	Value	Explanatory Notes
1	Present	
2	Not present	
96	Not applicable	e.g. No resection carried out, surgery was polypectomy, other local excision ,by endoscopy, or following neo-adjuvant treatment and no tumour present in biopsy.
99	Not recorded	

Circumferential Margin Involved (Surgical Resection Specimen) {Colorectal Cancer}

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

Definition: A record of whether or not tumour is present at the circumferential margin.

Field Name: CIRCMARGIN

Field Type: Integer

Field Length: 2

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

Applies to both rectal and colon cancer.

If there is no residual tumour at all in the specimen then it should be recorded as clear margin

Pathologist sometimes refer to the circumferential margin as the nonperitonealised margin.

The non-peritonealised circumferential margin requires particular attention in relation to rectal cancer but also with some colonic cancers, especially caecal and ascending colon cancers.

Codes and Values:

Code	Value	Explanatory Notes
1	Involved	If the tumour is \leq 1 mm from circumferential margin, regard as involved.
2	Not Involved	
96	Not applicable	e.g. no surgery undertaken or following neo-adjuvant treatment and no tumour present in biopsy.
99	Not recorded	

Grade of Differentiation (Colorectal Cancer)

Main Source of Data Item Standard: The Royal College of Pathologists, Dataset for Colorectal Cancer (2nd edition), September 2007.

Definition: A description of how closely the tumour resembles normal morphology.

Field Name: DIFFERENT

Field Type: Integer

Field Length: 2

Notes for Users: Required for Survival analysis.

Poorly differentiated carcinomas should be separated from other types but only if this forms the predominant area of the tumour. The criteria for poorly differentiated tumours are either irregularly folded, distorted and often small tubules or the absence of any tubule formation.

If polypectomy or another endoscopic procedure is the only treatment administered, the grade of differentiation can be taken from this.

Codes and Values:

Code	Value	Explanatory Notes
1	Well / Moderate	
2	Poor	
3	Not assessable	
96	Not applicable	e.g. no surgery undertaken or following neo-adjuvant treatment and no tumour present in biopsy.
99	Not known	

Final Total Number of Lymph Nodes Examined Microscopically {Cancer}

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

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

Field Name: LNEXAMINE

Field Type: Integer

Field Length: 4

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

For procedures such as polypectomy only, bypasses or stents where surgery is performed but no lymph nodes examined, record as '1010', not applicable

If no surgery is performed code as '1010', not applicable.

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

Number of Lymph Nodes Involved {Cancer}

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

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

Field Name: LNINVOLVE

Field Type: Integer

Field Length: 4

Notes for Users: Required for analytical purposes.

For procedures such as polypectomy only, bypasses or stents where surgery is performed but no lymph nodes examined, record as '1010', not applicable

If no surgery is performed code as '1010', not applicable.

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

Section 5: Tumour Classification

TNM Tumour Classification (Final) {Colorectal Cancer}

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

Definition: A record of the size and extent of the tumour of the colon or rectum according to TNM Classification (TNM Classification of Malignant Tumours, Fifth Edition, UICC, 1997).

Field Name: FINALT

Field Type: Characters

Field Length: 3

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

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

Tumours that have perforated into the peritoneal cavity are regarded as pT4 irrespective of other factors.

Direct intramural spread of caecal carcinomas into the terminal ileum or rectal cancers into the anal canal does not affect the T stage. However, direct extramural spread (across the serosa) of a colorectal carcinoma into another part of the large or small intestine corresponds to T4. Extramural extension of a rectal cancer into the skeletal muscle of the external sphincter, levator ani and/or puborectalis is classified as T4a.

T4 has been subdivided into 'A' (Invades other organs or structures) and 'B' (Involves visceral peritoneum) to meet QPI requirements.

Codes and Values:

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour invades submucosa.	
T2	Tumour invades muscularis propria.	
T3	Tumour invades through muscularis propria into subserosa or into non-peritonealised pericolic or perirectal tissue.	
T4	Tumour directly invades other organs or structures ² and/or perforates visceral peritoneum.	² Direct invasion in T4 includes invasion of other segments of the colorectum by way of the serosa, e.g. invasion of sigmoid colon by a carcinoma of the caecum.
T4A	Invades other organs or structures	Tumour invades adjacent organs
T4B	Involves visceral peritoneum	Tumour cells breach serosa
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

TNM Nodal Classification (Final) (Colorectal Cancer)

TNM Metastasis Classification (Final) (Colorectal)

TNM Nodal Classification (Final) (Colorectal Cancer)

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

Definition: A record of the extent of regional lymph node metastases according to TNM Classification (TNM Classification of Malignant Tumours, Fifth Edition, UICC, 1997).

Field Name: FINALN

Field Type: Characters

Field Length: 2

Notes for Users: Required for QPI(s): 11, and for national survival analysis and national comparative analysis.

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

A tumour nodule measuring 3 mm or more in perirectal or pericolic adipose tissue without histological evidence of residual lymph node is classified as regional lymph node metastasis. However, a tumour nodule of up to 3mm in diameter is classified in the T category as discontinuous extension i.e. T3.

Codes and Values:

Code	Value
N0	No regional lymph node metastasis.
N1	Metastasis in 1 to 3 regional lymph nodes.
N2	Metastasis in 4 or more regional lymph nodes.
NX	Regional lymph nodes cannot be assessed.
96	Not applicable
99	Not recorded

Related Data Item(s):

TNM Tumour Classification (Final) (Colorectal Cancer)

TNM Metastasis Classification (Final) (Colorectal)

TNM Metastasis Classification (Final) (Colorectal)

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

Definition: The extent of the spread of the disease outwith the colorectal system as agreed at the multidisciplinary team meeting according to TNM Classification (TNM Classification of Malignant Tumours, Fifth Edition, UICC, 1997).

Field Name: FINALM
Field Type: Characters
Field Length: 2

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

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

For patients undergoing surgery, the final TNM stage can be recorded from that agreed at the post-operative surgical MDT.

The original clinical/radiological staging would have precedence in patients who have neo-adjuvant therapy.

Metastatic deposits in lymph nodes distant from those surrounding the main tumour or its main artery are regarded as distant metastases e.g. para aortic or iliac lymph nodes, which may be submitted separately by the surgeon. A serosal, mesenteric or omental deposit in the specimen which is distant from the primary mass and not in the region of adhesion over the tumour is classified as a distant metastasis.

If stage is not documented in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.

Codes and Values:

Code	Value
M0	No distant metastasis.
M1	Distant metastasis present.
MX	Presence of distant metastasis cannot be assessed.
96	Not applicable
99	Not recorded

Related Data Item(s):

TNM Tumour Classification (Final) (Colorectal Cancer)
TNM Nodal Classification (Final) (Colorectal)

Dukes Classification (Colorectal Cancer)

Common name: Dukes Stage.

Main Source of Data Item Standard: The Royal College of Pathologists, Dataset for Colorectal Cancer (2nd edition), September 2007.

Definition: The final clinical/pathological stage as defined by the MDT.

Field Name: DUKES

Field Type: Characters

Field Length: 2

Notes for Users: Required for QPI(s): 11 and for national survival analysis and national comparative analysis.

All invasive polyp cancers that are not followed by a colectomy are staged as Dukes' A, unless there is evidence to the contrary (e.g. from imaging).

Codes and Values:

Code	Value	Explanatory Notes
1	Dukes A	Tumour limited to the bowel wall, lymph nodes negative.
2	Dukes B	Tumour spread beyond muscularis propria, lymph nodes negative.
3A	Dukes C1	Lymph nodes positive but apical node negative or not identified.
3B	Dukes C2	Apical lymph node involved.
4	Dukes D	Distant metastasis. This information may not always be recorded by pathologists.
96	Not applicable	
99	Not recorded	

Section 6: Oncology

Location Code {SACT Treatment}

Common Name(s): Location

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

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

Field Name: HOSPSACT

Field Type: Characters

Field Length: 5

Notes for Users: Required for regional/national analysis

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

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

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

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

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

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

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

Related Data Item(s):

Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}

Location Code {Radiotherapy Treatment}

Common Name(s): Location

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

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

Field Name: HOSPRADIO

Field Type: Characters

Field Length: 5

Notes for Users: Required for regional/national analysis

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

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

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

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

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

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

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

Related Data Item(s):

Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}

Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)

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

Definition: The type of course of neo-adjuvant oncological treatment administered for the treatment of the cancer.

Field Name: NEOONC

Field Type: Integer

Field Length: 2

Notes for Users: Required for QPI(s): 1, 5, 6, 7, 11, 12

It is the intended treatment, as defined by the initial treatment plan that should be recorded.

Radiotherapy

Only radiotherapy given to the primary site should be recorded.

SACT

Patients who have systemic therapy prior to surgery should be recorded under as neo-adjuvant Type. Some of these patients may have separate further completion systemic therapy post-operatively, which should be recorded as adjuvant. This may be recorded as two courses (1) neo-adjuvant and (2) adjuvant, which could be palliative.

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

Codes and Values:

Code	Value	Explanatory Notes
1	Short Course Radiotherapy	Radiotherapy given over 5 days (25Gy) prior to surgery. Short course radiotherapy also includes patients who undergo short course and delay to surgery.
2	Long Course Radiotherapy with Chemotherapy (Chemoradiotherapy)	Radiotherapy given over 5 weeks (25 fractions in 45Gy) in conjunction with chemotherapy (oral capecitabine) prior to surgery. Treatments will commence on the same day.
3	Long Course Radiotherapy only	Radiotherapy given over 5 weeks (25 fractions in 45Gy) with chemotherapy omitted e.g. due to patient fitness for chemotherapy.
4	Chemotherapy	Chemotherapy treatment given prior to surgery.
80	Patient died before radiotherapy treatment	
81	Patient died before SACT treatment	
82	Patient died before chemoradiotherapy treatment	
83	Patient refused radiotherapy treatment	
84	Patient refused SACT treatment	
85	Patient refused chemoradiotherapy treatment	
86	Radiotherapy contraindicated for patient	
87	Chemotherapy contraindicated for patient	
88	Chemoradiotherapy contraindicated for patient	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Date Neo-Adjuvant Oncology Treatment Started {Colorectal 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 cancer treatment course commenced.

Field Name: NEOADJDATE

Field Type: Date (DD/MM/CCYY)

Field length: 10

Notes for Users: Required for QPI(s):

If treatment has not been given, record as 10/10/1010 (Not applicable).

If date treatment started is unknown, record as 09/09/0909 (Not recorded).

Radiotherapy

This is the first course of external beam radiotherapy.

Only radiotherapy given to the primary site should be recorded.

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

Systemic Anti Cancer Therapy (SACT)

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

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

Chemoradiotherapy

This is the first dose of treatment, whether it is radiotherapy or SACT.

Related Data Item(s):

Neo-Adjuvant Oncology Treatment Type {Colorectal Cancer}

Date Neo-Adjuvant/Oncology Treatment Completed {Colorectal Cancer}

Date Neo-Adjuvant Oncology Treatment Completed {Colorectal 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 cancer treatment course ended.

Field Name: NEOADJCOM

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

If treatment has not been given, record as 10/10/1010 (Not applicable).

If date treatment started is unknown, record as 09/09/0909 (Not recorded).

Radiotherapy

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

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

Systemic Anti Cancer Therapy (SACT)

This is the first day of the last cycle of SACT the patients receives, i.e. last day treatment was administered.

Chemoradiotherapy

This is the last treatment date, whether it is radiotherapy or chemotherapy.

Related Data Item(s):

Neo-Adjuvant Oncology Treatment Type (Colorectal Cancer)

Date Neo-Adjuvant/Oncology Treatment Started {Colorectal Cancer}

Primary/Palliative/Adjuvant Oncology Treatment Type {Colorectal Cancer}

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

Definition: The type of Primary/ Palliative Adjuvant oncological treatment administered for the treatment of the cancer.

Field Name: ADJONC

Field Type: Integer

Field Length: 2

Notes for Users: Required for QPI(s): 1, 11, 12

It is the intended treatment, as defined by the initial treatment plan that should be recorded.

If more than one course of primary/palliative/adjuvant oncology treatment is administered, record only the first course.

Radiotherapy

Only radiotherapy given to the primary site should be recorded.

For the purposes of national audit, only radiotherapy given as part of the primary treatment plan should be recorded.

SACT

Patients who have SACT prior to surgery should be recorded under as neo-adjuvant Type. Some of these patients may have separate further completion systemic therapy post-operatively, which should be recorded as adjuvant. This may be recorded as two courses (1) neo-adjuvant and (2) adjuvant, which could be palliative.

Record patients who have SACT as their primary treatment.

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

Codes and Values:

Code	Value	Explanatory Notes
1	Adjuvant Long Course Radiotherapy with Chemotherapy (rectal cancer)	Chemoradiotherapy. Treatment given to patients with rectal cancer following surgery if positive surgical margins (when no neo adjuvant radiotherapy given).
2	Adjuvant Chemotherapy	Chemotherapy treatment given following surgery where there is no overt evidence of remaining disease.
3	Adjuvant Radiotherapy	
4	Primary Chemotherapy	
5	Primary/Radical Radiotherapy	
6	Palliative Radiotherapy	Radiotherapy given with the aim of relieving symptoms
7	Palliative Chemotherapy	Systemic therapy given for symptom control without curative intent e.g. in patients with metastatic disease at time of diagnosis
8	Biological therapy	For example, cetuximab for liver only metastases
9	Palliative Chemoradiotherapy	
80	Patient died before radiotherapy treatment	
81	Patient died before SACT treatment	
82	Patient died before chemoradiotherapy treatment	
83	Patient refused radiotherapy treatment	
84	Patient refused SACT treatment	
85	Patient refused chemoradiotherapy treatment	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date Adjuvant/Primary Oncology Treatment Started {Colorectal Cancer}

Date Adjuvant/Primary Oncology Treatment Completed {Colorectal Cancer}

Date Primary/Palliative/Adjuvant Oncology Treatment Started {Colorectal 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 cancer treatment course commenced.

Field Name: ADJONCDATE

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

If treatment has not been given, record as 10/10/1010 (Not applicable).

If date treatment started is unknown, record as 09/09/0909 (Not recorded).

Radiotherapy

This is the first course of external beam radiotherapy.

Only radiotherapy given to the primary site should be recorded.

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

Systemic Anti Cancer Therapy (SACT)

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

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

Chemoradiotherapy

This is the first date of adjuvant chemoradiotherapy treatment, whether that be radiotherapy or SACT.

Related Data Item(s):

Primary/Adjuvant Oncology Treatment Type {Colorectal Cancer}

Date Adjuvant/Primary Oncology Treatment Completed (Colorectal Cancer)

Date Primary/Palliative/Adjuvant Oncology Treatment Completed {Colorectal 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 cancer treatment course ended.

Field Name: ADJONCOM

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

If the date treatment completed is unknown, record as 09/09/0909 (Not recorded).

If treatment has not been given, record as, 10/10/1010 (Not applicable).

Radiotherapy Treatment

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

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

SACT

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.

Chemoradiotherapy

This is the last treatment date, whether that be radiotherapy or chemotherapy.

Related Data Item(s):

Primary/Adjuvant Oncology Treatment Type {Colorectal Cancer}

Date Adjuvant/Primary Oncology Treatment Started (Colorectal Cancer)

Section 7: 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:

Code	Value
1	Yes
2	No
99	Not known

Section 8: Death Details

Date of Death

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

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

Field Name: DOD

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

Field Length: 10

Notes for Users: Required for QPIs: 10, 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).