



Endometrial Cancer

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

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

Version 1.2: July 2015

To be used in conjunction with:

1. Endometrial Clinical Quality Performance Indicators V1.0 (October 2014)
2. Endometrial QPI Dataset Validations (Latest Published Version (v1)).
3. Endometrial Measurability of Quality Performance Indicators (Latest Published Version (v1))

DOCUMENT CONTROL SHEET

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Revision History

Version	Date	Summary of Changes	Name	Changes Marked
V1.1	Mar 2015	Changes agreed out with review during validation QA to support data collection.	Jane Garrett	See page iii
V1.2	July 2015	Changes agreed at 9mth Review and backdated	Jane Garrett	See page iii

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PREFACE

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

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

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

NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with endometrial cancer on or after 1st October 2014, who are eligible for inclusion in the Endometrial cancer audit.

Changes to definitions fall into the following categories:

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

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

General Enquiries on the Collection of the Minimum Core Data Set

If you have any comments on the attached data definitions ISD would welcome your feedback. Please contact:

NSS.ISDCANCERAUDIT@NHS.NET

CONVENTIONS

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

Common Name(s):

Main Source of Data Item Standard:

Definition:

Field Name:

Field Type:

Field Length:

Notes for Users:

Codes and Values:

Related Data Item(s):

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

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

REVISIONS TO DATASET:

The following changes have been made to facilitate the recording of data. Changes to take effect for patients diagnosed from 01/10/2014.

Dataset (July 2015):

Date Imaging Completed (Pre-treatment)_ - Remove 'Pre-treatment' from title

Morphology of Tumour – Pre-Operative Biopsy_ - Add new code '6666/6 for 'Suspicious of cancer', Change adenoma to adenosarcoma

Morphology of Tumour – Post-Operative - Change adenoma to adenosarcoma

Dataset Specification:

Date Imaging Completed (Pre-treatment)_ - Remove 'Pre-treatment' from title

Dataset (March 2015):

Date of Definitive Treatment {Endometrial Cancer} - footnote referenced

Dataset Specification:

Surgery Performed – Amend field length 2

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:

- Primary endometrial cancer (including: endometrioid, carcinosarcoma, papillary serous and clear cell carcinomas) (ICD-10 C54)

Exclude:

- Pre-cancerous conditions including: cervical intra-epithelial neoplasia (CIN) and glandular intra-epithelial neoplasia (GIN)
- Patients with metastatic endometrial cancer from another primary cancer site
- Patients where the origin of the primary is uncertain
- Patients with neuroendocrine carcinomas or uterine leiomyosarcoma
- Patients with tumour type sarcoma or lymphoma
- Patients with recurrent disease (as opposed to a new primary)
- Patients with carcinoma in situ
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.

NB:

- Only treatments as part of the initial treatment plan should be recorded.
- Patients treated within 6 months of a patient initially refusing further investigation can also be recorded.

DOWNLOAD FORMAT

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

DATABASE SPECIFICATION

Data Item	Field Name	Field Type	Size	Page
Section 1: Demographic Items				1
Person Family Name (at Diagnosis)	PATSNAME	Characters	35	2
Person Given Name	PATFNAME	Characters	35	3
Patient Postcode at Diagnosis	PATPCODE	Characters	8	4
Date of Birth	DOB	Date (DD/MM/CCYY)	10	5
CHI Number	CHINUM	Characters	10	6
Section 2: Pre-treatment Imaging & Staging Investigations				7
Location of Diagnosis {Cancer}	HOSP	Characters	5	8
Date of Diagnosis {Cancer}	DIAGDATE	Date (DD/MM/CCYY)	10	9
Date Imaging Completed	SINVESTDATE	Date (DD/MM/CCYY)	10	10
WHO/ ECOG Performance Status	PSTATUS	Integer	1	11
Date Discussed by Care Team (MDT)	MDTDATE	Date (DD/MM/CCYY)	10	12
Morphology of Tumour – Pre-Operative Biopsy	BIOMORPHOL	Characters	6	13
Tumour Grade – Pre-Operative Biopsy {Endometrial Cancer}	BIOTGRADE	Characters	4	15
Type of First Cancer Treatment	FIRSTTREATMODE	Integer	2	16
Date of First Cancer Treatment	FIRSTTREATDATE	Date (DD/MM/CCYY)	10	17
Date of Definitive Treatment {Endometrial Cancer}	DEFTREATDATE	Date (DD/MM/CCYY)	10	18
Section 3: Surgery				19
Location Code {Cancer Surgery}	HOSPSURG	Characters	5	20
Date of Surgery	SURGDATE	Date (DD/MM/CCYY)	10	22
Surgery Performed	SURG	Integer	2	23
Surgical Approach	SURGAPPR	Characters	3	24
Section 4: Pathological Details				25
Morphology of Tumour – Post-Operative	MORPHOL	Characters	6	26
Final FIGO Stage {Endometrial Cancer}	FIGO	Characters	5	28
Tumour Grade – Post Operative {Endometrial Cancer}	TGRADE	Characters	4	29
Section 5: Oncology				30
Radiotherapy Course Type	RADIOTYPE	Integer	2	31
Date Treatment Started	RSTARTDATE	Date	10	32

(Radiotherapy)		(DD/MM/CCYY)		
Date Treatment Completed (Radiotherapy)	RCOMPDATE	Date (DD/MM/CCYY)	10	33
Vaginal Vault Brachytherapy {Endometrial Cancer}	BRACHY	Integer	2	34
Type of Systemic Anti-Cancer Therapy (SACT) 1-2	CHEMTYPE1	Integer	2	35
Type of Systemic Anti-Cancer Therapy (SACT) 1-2	CHEMTYPE2	Integer	2	35
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2	CHEMDATE1	Date (DD/MM/CCYY)	10	36
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2	CHEMDATE2	Date (DD/MM/CCYY)	10	36
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2	CHEMENDATE1	Date (DD/MM/CCYY)	10	37
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2	CHEMENDATE2	Date (DD/MM/CCYY)	10	37
Section 6: Clinical Trials				38
Patient Entered into Clinical Trial	TRIAL	Integer	2	39
Section 7: Death Details				40
Date of Death	DOD	Date (DD/MM/CCYY)	10	41

Section 1: Demographic Items

Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition:

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

Field Name: PATSNAME

Field Type: Characters

Field Length: 35

Notes for Users:

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

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

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

From SMR Definitions and Codes

Notes by Users:

Person Given Name

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

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

Definition: The forename or given name of a person.

Field Name: PATFNAME

Field Type: Characters

Field Length: 35

Notes for Users:

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

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

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

Notes by Users:

Patient Postcode at Diagnosis

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

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

Field Name: PATPCODE

Field Type: Characters

Field Length: Maximum 8

Notes for Users:

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

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

Related Data Item(s):

Date of Diagnosis

Notes by Users:

Date of Birth

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

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

Field Name: DOB

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users:

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

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

Related Data Item(s):

CHI Number

Notes by Users:

CHI Number

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

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

Field Name: CHINUM

Field Type: Characters

Field Length: 10

Notes for Users:

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

From Designed to Care - Scottish Office

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

Notes by Users:

Section 2: Pre-treatment Imaging & Staging Investigations

Location 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 patient's hospital of investigation in which the diagnosis of cancer was first made.

Field Name: HOSP

Field Type: Characters

Field Length: 5

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

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

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

A111H=Crosshouse Hospital

G107H=Glasgow Royal Infirmary

X9999=Not recorded

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

Codes and Values:

Related Data Items:

Date of Diagnosis {Cancer}

Notes by Users:

Date of Diagnosis {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 cancer was first diagnosed 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 national survival analysis and national comparative analysis.

The date recorded is the date of the first investigative procedure that confirms a diagnosis of endometrial cancer.

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

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

Codes and Values:

Related Data Items:

Location of Diagnosis {Cancer}

Notes by Users:

Date Imaging Completed

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

Definition: The date abdomen and pelvis imaging investigations were completed by computed tomography (CT) or magnetic resonance imaging (MRI).

Field Name: SINVESTDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

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

Several investigations may be undertaken prior to staging. As a minimum a CT or MRI of the abdomen **AND** pelvis should be completed before definitive treatment commences.

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

If CT or MRI of abdomen and pelvis was not completed or if only one component was completed then record as not applicable (10/10/1010).

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

Related data item(s):

Notes by Users:

WHO/ ECOG Performance Status

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

Definition: An overall assessment of the functional/physical performance of the patient.

Field Name: PSTATUS

Field Type: Integer

Field length: 1

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

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

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

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

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

Codes and values:

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

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

The first MDT meeting date will be recorded.

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)

Related data Item(s):

Morphology of Tumour – Pre-Operative Biopsy

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

Definition: This is the morphology of the tumour according to the International Classification of Diseases for Oncology (ICD-O(3)) based on the pre-operative biopsy.

Field Name: BIOMORPHOL

Field Type: Characters

Field Length: 6

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

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

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

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

If no biopsy diagnostic procedures were undertaken prior to definitive operation record as not applicable (1010/0).

Morphology codes are shown below. This list is not exhaustive and if a code is not on the list please contact - NSS.isdCANCERAUDIT@nhs.net for advice.

Morphology codes

Code	Value
8010/3	Carcinoma, NOS, epithelial tumour, malignant
8020/3	Carcinoma, undifferentiated, NOS
8050/3	Papillary carcinoma, NOS
8070/3	Squamous cell carcinoma
8120/3	Transitional cell carcinoma
8140/3	Adenocarcinoma, NOS
8262/3	Villous adenocarcinoma
8310/3	Clear cell adenocarcinoma, clear cell carcinoma
8323/3	Mixed cell adenosarcoma
8380/3	Endometrioid adenocarcinoma, endometrioid carcinoma, endometrioid cystadenocarcinoma
8382/3	Endometrioid adenocarcinoma, secretory variant
8383/3	Endometrioid adenocarcinoma, ciliated cell variant
8441/3	Serous cystadenocarcinoma, serous adenocarcinoma, serous carcinoma
8480/3	Mucinous adenocarcinoma
8481/3	Mucin-producing (or secreting) adenocarcinoma, mucin-producing (or secreting) carcinoma
8570/3	Endometrioid adenocarcinoma with squamous differentiation
8041/3	Small cell carcinoma
8560/3	Adenosquamous carcinoma
8980/3	Carcinosarcoma, NOS
7777/7	Atypical Hyperplasia
6666/6	Suspicious of cancer
1111/1	Not assessable
1010/0	Not applicable
9999/9	Not recorded

Related Data Items:

Tumour Grade – Pre-Operative Biopsy {Endometrial Cancer}

Definition: The pathological assessment of tumour differentiation used as a prognostic indicator. This is the tumour grade based on the pre-operative biopsy.

Field Name: BIOTGRADE

Field Type: Characters

Field length: 4

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

The pathology report should state grade as high, moderate or low. If there are mixed statements (e.g. low to moderate grade) record the worst situation (moderate in this example).

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

If no biopsy diagnostic procedures were undertaken prior to definitive operation record as not applicable (96).

Codes and Values:

Code	Value	Explanatory Notes
G1	Low Grade	Well differentiated
G2	Moderate Grade	Moderately differentiated
G3	High Grade	Poorly differentiated, undifferentiated
8888	Not assessable	Grade cannot be determined, e.g. specimen too poorly preserved or too small. Includes microinvasion.
96	Not applicable	e.g. no biopsy performed, negative pathology
99	Not recorded	

Related Data Item(s):

Type of First Cancer Treatment

Common name: Mode of first treatment

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

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

Field Name: FIRSTTREATMODE

Field Type: Integer

Field length: 2

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

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

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

Codes and Values:

Code	Description	Explanatory notes
01	Surgery	
02	Radiotherapy	
03	Chemotherapy	
13	Biological therapy	
05	Endoscopic	
15	Chemoradiotherapy	
07	Supportive care	No active treatment
12	Watchful waiting	No active treatment
11	Other therapy	
94	Patient died before treatment	
95	Patient refused all therapies	
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 QPI(s): 1

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' or 'Watchful waiting', the date recorded should be the first date the decision was taken not to give the patient treatment as part of their primary therapy. The aim of this date is to distinguish between patients who have initially had no treatment but receive some therapy when symptoms develop.

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

If the exact date is not documented, record as 09/09/0909 (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 {Endometrial 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: 2

For patients with Endometrial cancer definitive treatment may be:

- Surgical resection¹
- Radiotherapy,
- Chemotherapy or
- Hormonal therapy.

If a patient has more than one of those treatments listed the first should be recorded.

For patients who receive hormonal therapy with no further treatment, it is the start date of hormone therapy which should be recorded. For patients who receive hormone therapy prior to surgical resection / start of oncological therapy the date of surgery / radiotherapy / chemotherapy should be recorded.

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

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):

¹ Total Hysterectomy/BSO, Total Hysterectomy/BSO and Lymphadectomy (pelvic, aortic, pelvic and para-aortic, inguinal) or Subtotal Hysterectomy/BSO

Section 3: Surgery

Location Code {Cancer Surgery}

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

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

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

Field Name: HOSPSURG

Field Type: Characters

Field Length: 5

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

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

Each location has a location code, which is maintained jointly by 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 not applicable, 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):

Date of Surgery

Date 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 date the main (definitive) surgery was performed.

Field Name: SURGDATE

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

Field Length: 10

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

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

Note that if a lymphadenectomy is done at a later stage than the total hysterectomy (TAH) and bilateral salpingo-oophorectomy (BSO) then record the date the TAH/BSO was performed.

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

If no surgery was performed, record as 10/10/1010 (Not applicable).

All treatments given as part of the initial treatment plan.

Related Data Items:

Location Code {Cancer Surgery}

Surgery Performed

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 surgical procedure performed for treatment of Endometrial Cancer.

Field Name: SURG

Field Type: Integer

Field Length: 2

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

Note that if a lymphadenectomy is done at a later stage than the total hysterectomy and bilateral salpingo-oophorectomy then code "02" should be recorded to capture the complete operation.

Codes and Values:

Code	Value	Explanatory Notes
01	Total hysterectomy and bilateral salpingo-oophorectomy	Removal of the uterus, cervix, both fallopian tubes, and both ovaries.
02	Total hysterectomy, bilateral salpingo-oophorectomy and lymphadenectomy	Removal of pelvic nodes in addition to removal of the uterus, cervix, both fallopian tubes, and both ovaries.
03	Sub total hysterectomy and bilateral salpingo-oophorectomy	Removal of the uterus, both fallopian tubes, and both ovaries (cervix left in place).
04	Total hysterectomy	Removal of uterus and cervix
05	Total hysterectomy and lymphadenectomy	Removal of pelvic nodes in addition to removal of uterus and cervix.
06	Sub total hysterectomy	Removal of the uterus but the cervix is left in place.
94	Patient died before treatment	
95	Patient refused treatment	
96	Not applicable	E.G. non-surgical patient.
99	Not recorded	Evidence in patient record that surgery was received but details of the type of surgery is not recorded.

Related Data Item(s):

Date of Surgery

Surgical Approach

Surgical Approach

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 method of surgical approach for the main (definitive) or only operation performed.

Field Name: SURGAPPR

Field Type: Characters

Field Length: 3

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

Codes and Values:

Code	Value	Explanatory Notes
01	Open	
02A	Laparoscopic	
02B	Laparoscopic converted to open	
96	Not applicable	E.g. non-surgical patient
99	Not recorded	Evidence in patient record that surgery was undertaken but details of the type of surgery is not recorded

Related Data Item(s):

Surgery Performed

Section 4: Pathological Details

Morphology of Tumour – Post-Operative

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

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

Field Name: MORPHOL

Field Type: Characters

Field Length: 6

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

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

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

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

If the pathology report is negative code to 8888/8. E.g. if a polyp is removed showing no residual disease.

If no invasive operative procedures were undertaken record as not applicable (1010/0).

Morphology codes are shown below. This list is not exhaustive and if a code is not on the list please contact - NSS.isdCANCERAUDIT@nhs.net for advice.

Morphology codes

Code	Value
8010/3	Carcinoma, NOS, epithelial tumour, malignant
8020/3	Carcinoma, undifferentiated, NOS
8050/3	Papillary carcinoma, NOS
8070/3	Squamous cell carcinoma
8120/3	Transitional cell carcinoma
8140/3	Adenocarcinoma, NOS
8262/3	Villous adenocarcinoma
8310/3	Clear cell adenocarcinoma, clear cell carcinoma
8323/3	Mixed cell adenosarcoma
8380/3	Endometrioid adenocarcinoma, endometrioid carcinoma, endometrioid cystadenocarcinoma
8382/3	Endometrioid adenocarcinoma, secretory variant
8383/3	Endometrioid adenocarcinoma, ciliated cell variant
8441/3	Serous cystadenocarcinoma, serous adenocarcinoma, serous carcinoma
8480/3	Mucinous adenocarcinoma
8481/3	Mucin-producing (or secreting) adenocarcinoma, mucin-producing (or secreting) carcinoma
8570/3	Endometrioid adenocarcinoma with squamous differentiation
8041/3	Small cell carcinoma
8560/3	Adenosquamous carcinoma
8980/3	Carcinosarcoma, NOS
1111/1	Not assessable
1010/0	Not applicable
8888/8	Negative Pathology
9999/9	Not recorded

Related Data Items:

Final FIGO Stage {Endometrial Cancer}

Main Source of Data Item Standard: International Federation of Obstetricians and Gynaecologists (FIGO) Staging System – revision 2009

Definition: This denotes the final stage of disease as classified by the International Federation of Obstetricians and Gynaecologists for endometrial cancer.

Field Name: FIGO

Field Type: Characters

Field length: 5

Notes for Users: Required for QPI(s): 3, 5, 6

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

Codes and Values:

Code	Value
	I - Tumour contained to corpus uteri
IA	No or less than half myometrial invasion
IB	Invasion equal to or more than half of the myometrium
II	Tumour invades the cervical stroma but does not extend beyond the uterus
	III - Local and/or regional spread of tumour
IIIA	Tumour invades the serosa of the corpus uteri and/or adnexas
IIIB	Vaginal and/or parametrial involvement
IIIC	Metastases to pelvis and/or para-aortic lymph nodes
IIIC1	- Positive pelvic nodes
IIIC2	- Positive para-aortic lymph nodes with or without positive pelvic lymph nodes
	IV - Tumour invades into bladder and/or bowel mucosa and/or distant
IVA	Tumour invasion bladder and/or bowel
IVB	Distant metastases including intra-abdominal and/or inguinal lymph nodes
96	Not applicable
99	Not recorded

Related Data Items:

Tumour Grade – Post Operative {Endometrial Cancer}

Main Source of Data Item Standard:

Definition: The pathological assessment of tumour differentiation used as a prognostic indicator. This is the tumour grade based on the operative procedure.

Field Name: TGRADE
Field Type: Characters
Field length: 4

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

The pathology report should state grade as high, moderate or low. If there are mixed statements (e.g. low to moderate grade) record the worst situation (moderate in this example).

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

If no operative procedures were undertaken record as not applicable (96).

Codes and Values:

Code	Value	Explanatory Notes
G1	Grade 1 - Low Grade	Well differentiated
G2	Grade 2 - Moderate Grade	Moderately differentiated
G3	Grade 3 - High Grade	Poorly differentiated, undifferentiated
8888	Not assessable	Grade cannot be determined, e.g. specimen too poorly preserved or too small. Includes microinvasion.
96	Not applicable	e.g. no surgery performed
99	Not recorded	

Related Data Item(s):

Section 5: Oncology

Radiotherapy Course Type

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

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

Field Name: RADIOTYPE

Field Type: Integer

Field length: 2

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

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

For patients undergoing chemoradiotherapy the radiotherapy element should be recorded as code '06' and recorded also in SACT under code '05'.

All treatments given as part of the initial treatment plan

Codes and Values:

Code	Value	Explanatory Notes
01	Adjuvant	It is given after potentially curative surgery. .
02	Radical	It is primary treatment and is given with curative intent.
03	Palliative	The aim is solely to relieve symptoms.
04	Neo-adjuvant	It is given before potentially curative surgery.
06	Chemoradiotherapy	Radical radiotherapy given in combination with concurrent chemotherapy. Chemotherapy element of this combined treatment should be recorded separately in field ' <i>Type of Systemic Anti-Cancer Therapy (SACT) 1-2</i> '
94	Patient died before radiotherapy treatment	
95	Patient refused radiotherapy treatment	
96	Not applicable	e.g. no radiotherapy given.
99	Not recorded	

Related Data Items:

Date Treatment Started (Radiotherapy)

Date Treatment Completed (Radiotherapy)

Date Treatment Started (Radiotherapy)

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

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

This is the first fraction of a course of radiotherapy.

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

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

If radiotherapy has not been given or the patient has refused radiotherapy, record as 10/10/1010 (not applicable).

Related Data Items:

Radiotherapy Course Type
Date Treatment Completed (Radiotherapy)

Date Treatment Completed (Radiotherapy)

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

Definition:

The date cancer treatment course ended.

Field Name: RCOMPDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

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

This is the last fraction of a course of radiotherapy.

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

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

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

Related Data Item(s):

Radiotherapy Course Type

Date Treatment Started (Radiotherapy)

Vaginal Vault Brachytherapy {Endometrial Cancer}

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

Definition: Denoted where the patient had Vaginal Vault Brachytherapy

Field Name: BRACHY

Field Type: Integer

Field Length: 2

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

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

If unknown, record as 99 (Not recorded).

Code and Values:

Code	Value
01	Yes
02	No
95	Patient refused treatment
99	Not recorded

Related Data Item(s):

Radiotherapy Course Type

Date Treatment Started (Radiotherapy)

Type of Systemic Anti-Cancer Therapy (SACT) 1-2

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

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

Field Name: CHEMTYPE1
CHEMTYPE2

Field Type: Integer

Field Length: 2

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

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

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

For patients undergoing chemoradiotherapy the chemotherapy element should be recorded as code '05' and recorded also in 'Radiotherapy Course Type' under code '06'.

Codes and Values:

Code	Value	Explanatory Notes
01	Neoadjuvant	Therapy given prior to radiotherapy or first definitive surgery to reduce tumour size.
02	Adjuvant	
04	Palliative	Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic
05	Chemoradiotherapy	Concurrent radiotherapy element of this combined treatment should be recorded separately in field 'Radiotherapy Course Type'
07	Biological Therapy	
08	Hormone Therapy	E.g. oral progestin, letrozole, mirena coil
94	Patient died before SACT treatment	i.e. Patient who died before receiving planned SACT treatment
95	Patient refused SACT treatment	
96	Not applicable	e.g. Systemic therapy not given as primary part of
99	Not recorded	

Related Data Items:

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

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

Definition: The date cancer treatment course commenced.

Field Name: CHEMDATE1
CHEMDATE2

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

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

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

If SACT has not been given or the patient has refused SACT, record as 10/10/1010 (not applicable).

Related data items:

Type of Systemic Anti-Cancer Therapy (SACT) 1-2

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

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

Definition: The date cancer treatment course ended.

Field Name: CHEMENDATE1
CHEMENDATE2

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

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

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

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

If SACT has not been given or the patient has refused SACT, record as 10/10/1010 (Not applicable).

Codes and values:

Related data items:

Type of Systemic Anti-Cancer Therapy (SACT) 1-2

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) {Cancer} 1-2

Section 6: Clinical Trials

Patient Entered into Clinical Trial

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

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
01	Yes
02	No
99	Not recorded

Section 7: Death Details

Date of Death

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

Definition:

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

Field Name: DOD

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

Field Length: 10

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

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).