Hepatopancreaticobiliary (HPB) Cancer

Data Definitions for the

National Minimum Core Dataset to support the

Introduction of HPB Quality Performance Indicators

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

Version 2.6: June 2016

To be used in conjunction with:

1. HPB Cancer Clinical Quality Performance Indicators V2.1 (March 2015)
2. HPB Cancer QPI Dataset Validations (latest published version).
3. HPB Cancer Measurability of Quality Performance Indicators (latest published version)

DOCUMENT CONTROL SHEET

Key Information

Title	**HPB Cancer – Data Definitions for the National Minimum Core Dataset to support the Introduction of HPB QPIs**
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Cross References	**HPB Cancer Quality Performance Indicators HPB Cancer Measurability of Quality Performance Indicators**
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Revision History

Version	Date	Summary of Changes	Name	Changes Marked
1.1	**20/11/12**		**ISD NHS National Services Scotland**	**N/A**
2.0	**20/12/13**	**Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1st January 2014.**	**David Early, ISD**	**See page iii.**
2.1	**21/02/14**	**Addition of new code to 'Type of First Cancer Treatment'.**	**David Early, ISD**	**See page iii.**
2.2	**20/06/14**	**Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st January 2014**	**Charlotte Anthony ISD**	**See page iii.**
2.3	**25/11/14**	**Change to version number due to changes in measurabilty document**	**Jane Garrett**	**See page iii.**
2.4	**05/15**	**Changes following baseline review**	**Jane Garrett**	**See page iii.**
2.5	**22/06/15**	**Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st January 2014**	**Charlotte Anthony ISD**	**See page iii.**
2.6	**06/16**	**Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st January 2014**	**Charlotte Anthony ISD**	**See page iii.**

CONTENTS

PREFACE

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

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

To ensure that findings are comparable across Scotland, the national dataset and data definitions in conjunction with the final quality performance indicators were agreed through public engagement and are now ready for implementation for patients diagnosed from 1st October 2012.

HepatoPancreaticoBiliary (HPB) cancers include primary liver cancer (primarily hepatocellular carcinoma), pancreatic cancer, cancer of the biliary tract and duodenal and ampullary cancers. Many HPB cancers are associated with a poor prognosis, and surgical treatment carries high morbidity. In order to drive improvements in the care of patients, the Scottish HPB Network (SHPBN) was established as the second national cancer network in Scotland. SHPBN developed guidelines (2005) for the management of these cancers based on available evidence. These guidelines are consistent with existing UK and international guidelines and are updated regularly (SHPBN HCC guidelines were ratified and published in July 2011). In addition, SHPBN has analysed audit data from 2009 and 2010, identified areas of variation in practice or outcome, and has identified key areas for improvement. Management of all these patients is complex and requires close cooperation of the multidisciplinary team, as well as regular re-appraisal of emerging evidence, sharing of best practice, audit and a commitment to involvement in new clinical trials.

Separate QPIs have been developed for Hepatocellular carcinoma (HCC). This is an increasingly common cancer in Scotland, which most commonly arises in association with chronic liver disease. There is a rising prevalence of chronic liver disease in Scotland and it is expected that the incidence of HCC will also continue to increase.

The HPB Quality Performance Indicators aim to assess the performance of NHS Scotland services throughout the patient care pathway and are consistent with the recommendations of the SHPBN guidelines.

HPB Cancer QPI Development Group Subgroup Lead Clinicians
Colin J McKay, Consultant Surgeon, NHS Greater Glasgow and Clyde
James Powell, Consultant Surgeon, NHS Lothian

NOTES FOR IMPLEMENTATION OF CHANGES

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

Changes to definitions fall into the following categories:

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

General enquiries on the collection of the National Minimum Core Dataset:

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

Please contact: NSS.ISDCANCERAUDIT@NHS.NET.

CONVENTIONS

The layout for each item is standard as shown below:

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

In addition, 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

Revisions to Dataset Outwith Review (June 2016)

Date of Definitive Treatment {HPB Cancer} – Radiotherapy added to the list of definitive treatments.

New Data Items Added

Page 55: 'Radiotherapy {HPB}'
Page 56: 'Date Treatment Started (Radiotherapy)'
Page 57: 'Date Treatment Completed (Radiotherapy)'

Revisions to Dataset Outwith Review (June 2015)

Location of Diagnosis - X9999=Not Recorded added.

Staging Investigations Complete (Pre-treatment) – removed all references to 'triple phase'

Type of First Cancer Treatment – code 7 "Supportive care" remove "includes stenting" from the explanatory notes; code 5 "Endoscopic" insert "does not include stenting"

Main Type of Definitive Operation – J39.9 moved from under 'Pancreas' and inserted under 'Ampulla of Vater'

Revisions to Dataset Following Baseline Review (May 2015)

Staging Investigations Complete (Pre-treatment) – 'triple phase' and 'contrast enhanced' deleted

Morphology of Tumour code - added 8032/8 Spindle Cell Carcinoma - Pancreas

Main Type of Definitive Operation - added J39.9, Other therapeutic endoscopic operations on ampulla of Vater, Endoscopic Ampullectomy

Type of first Cancer Treatment – add new data item code '20' TACE; explanatory notes "endoscopic first treatment" should read: endoscopic ampullectomy and "supportive care" should read, includes stenting

Revisions (11/2014):

Change in version number due to measurability changes

Revisions to Dataset Out-With Review (June 2014)

New Data Items Added:

Page 27: 'Date of Definitive Treatment {HPB Cancer}'

Database Specification:

Date of Definitive Treatment {HPB Cancer} data item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.

Dataset:

Size of Largest Lesion on Imaging {HCC}

i. Amendment to definition replace radiologically with by MRI or CT scan

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

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

Revisions (02/2014):

Criteria for Inclusion of Patients in Audit:

Type of First Cancer Treatment:

i. Added new code '16: Ablative Therapy'.

Revisions (12/2013):

Criteria For Inclusion of Patients in Audit:

Exclusion criteria added:

- 'Patients with tumour type sarcoma or lymphoma'

New Data Items Added:

Page 'Type of First Cancer Treatment'
Page 'Type of Systemic Anti Cancer Therapy (SACT) 1-3'

Data Items Removed:

Page 'Supportive Care Given'
Page 'Systemic Anti Cancer Therapy (SACT) Given {HCC}'

Database Specification:

'Supportive Care Given' replaced with 'Type of First Cancer Therapy'.
'Systemic Anti Cancer Therapy Given' replaced with 'Type of Systemic Anti Cancer Therapy (SACT)'.
'DateTreatment Started Systemic Anti Cancer Therapy (SACT) (1-3) updated with 3 fields for recording 3 treatment courses.
'Date Treatment Completed Systemic Anti Cancer Therapy (SACT) (1-3) updated with 3 fields for recording 3 treatment options.

Dataset:

Staging Investigations Complete (Pre-treatment):

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Amended notes for users 'Cholangiocarcinomas (C22.1) should be recorded as '96: Not applicable' to 'Intrahepatic cholangiocarcinomas (C22.1a) should be recorded as '96: Not applicable.''

iii. Added code '5: Complete – CT & MRI – Liver (HCC)' to table of codes and values.

Number of Tumours/Lesions on Imaging {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Size of Largest Lesion on Imaging {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Alpha-Fetoprotein Quantification {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Vascular Invasion on Imaging {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Child-Pugh Score {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Presence or Absence of Chronic Liver Disease {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Cause of Chronic Liver Disease (1-3) {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

UK Listing Criteria – Liver Transplant {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Referred to Scottish Liver Transplant Unit {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Most Valid Basis of Diagnosis (Cancer):

i. 'Notes for users' updated to reflect changes to QPI numbering.

Site of Origin of Primary Tumour (Cancer):

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Amended explanatory notes for code 'C221: Intrahepatic Bile Duct' to state 'peripheral cholangiocarcinoma'.
iii. Amended explanatory notes for code 'C240A: Proximal extrahepatic bile duct' to state 'Klatskin/hilar cholangiocarcinoma'.
iv. Amended explanatory notes for code 'C240B: Distal extrahepatic bile duct' to state 'Distal cholangiocarcinoma'.

Date Discussed by Care Team (MDT):

i. 'Notes for users' updated to reflect changes to QPI numbering.

Type of First Cancer Treatment:

ii. New data item to replace 'Supportive Care Given' from prior version.

Date of First Cancer Treatment:

i. New data item to replace 'Date of Supportive Care' from prior version.

Location Code (Cancer Surgery):

i. Notes for users updated: 'This is the hospital of first definitive surgery for the treatment of HPB cancer.
ii. 'Notes for users' updated to reflect changes to QPI numbering.

Operating Consultant Surgeon (1-2) {HPB Cancer}

i. 'Notes for users' updated to reflect changes to QPI numbering.

Main Type of Definitive Operation {HPB Cancer}:

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Removed code 'J12.4: Percutaneous radiofrequency ablation of lesion of liver'.
iii. Removed code 'J12.7: Percutaneous microwave ablation of lesion of liver'.
iv. Removed code 'J40.2: Endoscopic retrograde insertion of tubal prosthesis into bile duct NEC'.
v. Removed code 'J40.6: Endoscopic retrograde insertion of expanding metal stent into bile duct NEC'.
vi. Added code: 'J27.1: Excision of ampulla of Vater and replantation of common bile duct into duodenum'
vii. Added code: 'J36.1: Excision of ampulla of Vater using duodenal approach'
viii. Added code: 'J36.8: Other specified operations on ampulla of Vater using duodenal approach'
ix. Added code: 'J36.9: Unspecified other operations on ampulla of Vater using duodenal approach'

Date of Definitive Surgery {HPB Cancer}:

i. 'Notes for users' updated to reflect changes to QPI numbering.

Total Number of Lymph Nodes Examined Microscopically (Cancer):

i. 'Notes for users' updated to reflect changes to QPI numbering.

TNM Tumour Classification (Final) {HPB}:

i. Amended notes for users: 'This is a clinical/pathological classification and should be documented. In the absence of pathological T, clinical T should be recorded, prior to pre-definitive treatment. If no T is documented, do not deduce from other information and record as 'not recorded'.'

TNM Nodal Classification (Final) {HPB}:

i. Amended notes for users: 'This is a clinical/pathological classification and should be documented. In the absence of pathological N, clinical N should be recorded, prior to pre-definitive treatment. If no N is documented, do not deduce from other information and record as 'not recorded'.'

TNM Metastasis Classification (Final) {HPB}:

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Amended notes for users: 'This is a clinical/pathological classification and should be documented. In the absence of pathological M, clinical M should be recorded, prior to pre-definitive treatment. If no M is documented, do not deduce from other information and record as 'not recorded'.'

Location Code (Non-Surgical Treatment):

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Amended notes for users: 'This is the hospital of first non-surgical treatment based on date of first cancer treatment, date of ablation {HCC}, date of first transarterial chemoembolisation treatment (TACE) {HCC} or date of systemic anti cancer therapy (SACT) (1).'
iii. Removed reference to 'Supportive Care Given'.
iv. Removed reference to 'Date of Supportive Care'

Ablation Treatment Given {HCC}:

i. 'Notes for users' updated to reflect changes to QPI numbering.
ii. Added code '96: Not applicable' to table of codes and values.

Date of Ablation {HCC}:

i. ‘Notes for users’ updated to reflect changes to QPI numbering.

First Transarterial Chemoembolisation Treatment Given {HCC}:

i. ‘Notes for users’ updated to reflect changes to QPI numbering.
ii. Added code ’96: Not applicable’ to table of codes and values.

Date of First Transarterial Chemoembolisation Treatment {HCC}:

i. ‘Notes for users’ updated to reflect changes to QPI numbering.

Date of Last Transarterial Chemoembolisation Treatment {HCC}:

i. ‘Notes for users’ updated to reflect changes to QPI numbering.

Type of Systemic Anti Cancer Therapy (SACT) 1-3:

i. New data item to replace ‘Supportive Care Given’ from prior version.

Date Treatment Started Systemic Anti Cancer Therapy (SACT) 1-3

i. ‘Notes for users’ updated to reflect changes to QPI numbering.
ii. Data item name amended to include 3 separate fields for recording treatments.
iii. Added additional field ‘SACTDATE3’.
iv. Added note to state that up to 3 courses can now be recorded.

Date Treatment Completed Systemic Anti Cancer Therapy (SACT) 1-3

i. ‘Notes for users’ updated to reflect changes to QPI numbering.
ii. Data item name amended to include 3 separate fields for recording treatments.
iii. Added additional field ‘SACTENDATE3’.
iv. Added note to state that up to 3 courses can now be recorded.

Date of Death:

i. ‘Notes for users’ updated to reflect changes to QPI numbering.

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 duodenum, liver and intrahepatic bile duct, gallbladder, other and unspecified parts of biliary tract, pancreas (ICD-O(3)) C17.0, C22.0,C22.1, C23.9, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8 and C25.9. See page 22 - Site of Origin of Primary Tumour {Cancer} for further information.
- Including all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Multiple independent primary tumours should be recorded separately.

Exclude:

- Patients with metastatic liver cancer from a primary site out with the liver tract.
- Patients with tumour type sarcoma or lymphoma.
- Patients with carcinoma in situ or dysplasia.
- Benign tumours.
- Neuroendocrine tumours.
- Patients where the origin of the primary is uncertain.
- Patients with recurrent disease (as opposed to a new primary).
- Patients, at date of diagnosis, under 16 years of age i.e. up to 15 years 364 days.
- Patients where the only record of their cancer is from a death certificate (DCO).
- Patients with normal residence outwith Scotland.
- Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland.

DOWNLOAD FORMAT

To assist with downloading data to 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: Demographics				**1**
Person Family Name (at Diagnosis)	PATSNAME	Character	35	2
Person Given Name	PATFNAME	Character	35	3
Patient Postcode at Diagnosis (Cancer)	PATPCODE	Character	8	4
Date of Birth	DOB	DD/MM/CCYY	10	5
Person Sex at Birth	SEX	Integer	2	6
CHI Number	CHINUM	Character	10	7
Section 2: Pre-treatment Imaging & Staging Investigations				**8**
Staging Investigations Complete (Pre-treatment)	SINVEST	Integer	2	9
Number of Tumours/Lesions on Imaging (HCC)	NUMTUMOUR	Integer	4	10
Size of Largest Lesion on Imaging {HCC}	TUMSIZE	Integer	4	11
Alpha-Fetoprotein Quantification {Liver Cancer}	AFP	Integer	8	12
Vascular Invasion on Imaging {HCC}	VASCULAR	Integer	2	13
Child-Pugh Score {HCC}	CHILDPUGH	Integer	2	14
Presence or Absence of Chronic Liver Disease	CHRONAB	Integer	2	15
Cause of Chronic Liver Disease (1-3) {HPB}	CHRONC1	Integer	2	16
	CHRONC2	Integer	2	16
	CHRONC3	Integer	2	16
UK Listing Criteria – Liver Transplant {HCC}	LISTCRIT	Integer	2	17
Referred to Scottish Liver Transplant Unit {HCC}	SLTUREFER	Integer	2	18
Location of Diagnosis (Cancer)	HOSP	Characters	5	19
Date of Diagnosis (Cancer)	DIAGDATE	DD/MM/CCYY	10	20
Most Valid Basis of Diagnosis (Cancer)	VALID	Integer	2	21
Site of Origin of Primary Tumour (Cancer)	ICDSITE	Characters	5	22
Date Discussed by Care Team (MDT)	MDTDATE	DD/MM/CCYY	10	24
Type of First Cancer Treatment	FIRSTTREATMODE	Integer	2	25
Date of First Cancer Treatment	FIRSTTREATDATE	DD/MM/CCYY	10	26
Date of Definitive Treatment {HPB Cancer}	DEFTREATDATE	DD/MM/CCYY	10	27
Section 3: Surgery				**28**
Location Code (Cancer Surgery)	HOSPSURG	Characters	5	29
Operating Consultant Surgeon (1-2) {HPB Cancer}	OPSURG1	Characters	20	30
	OPSURG2	Characters	20	30
Main Type of Definitive Operation {HPB Cancer}	OPCODE1	Characters	5	31
	OPCODE2	Characters	5	31

Date of Definitive Surgery {HPB Cancer}	DSURG	DD/MM/CCYY	10	34
Section 4: Pathology Details				**35**
Total Number of Lymph Nodes Examined Microscopically (Cancer)	EXNODES	Integer	4	36
Morphology of Tumour	MORPHOL	Characters	6	37
TNM Tumour Classification (FINAL) {HPB}	FINALT	Characters	3	40
TNM Nodal Classification (FINAL) {HPB}	FINALN	Character	3	44
TNM Metastasis Classification (FINAL) {HPB}	FINALM	Character	2	47
Section 5: Non-Surgical Treatment				**48**
Location Code (Non-Surgical Treatment)	HOSPNONSURG	Characters	5	49
Ablation Treatment Given {HCC}	ABLAT	Integer	2	51
Date of Ablation	ABDATE	DD/MM/CCYY	10	50
First Transarterial Chemoembolisation Treatment Given {HCC}	TACEG	Integer	2	52
Date of First Transarterial Chemoembolisation Treatment {HCC}	TACEDATE	DD/MM/CCYY	10	53
Date of Last Transarterial Chemoembolisation Treatment {HCC}	TACEDATE	DD/MM/CCYY	10	54
Radiotherapy {HPB}	RADIOTYPE1	Integer	2	55
Date Treatment Started (Radiotherapy)	RSRTDATE1	DD/MM/CCYY	10	56
Date Treatment Completed (Radiotherapy)	RCOMPDATE1	DD/MM/CCYY	10	57
Type of Systemic Anti Cancer Therapy (SACT) (1-3)	SACTTYPE1	Integer	2	58
	SACTTYPE2	Integer	2	58
	SACTTYPE3	Integer	2	58
Date Treatment Started Systemic Anti Cancer Therapy (SACT) (1-3)	SACTDATE1	DD/MM/CCYY	10	59
	SACTDATE2	DD/MM/CCYY	10	59
	SACTDATE3	DD/MM/CCYY	10	59
Date Treatment Completed Systemic Anti Cancer Therapy (SACT) (1-3)	SACTENDATE1	DD/MM/CCYY	10	60
	SACTENDATE2	DD/MM/CCYY	10	60
	SACTENDATE3	DD/MM/CCYY	10	60
Section 6: Clinical Trial Entry				**61**
Patient Entered into Clinical Trial {HPB Cancer}	TRIAL	Integer	2	62
Section 7: Death Details				**63**
Date of Death	DOD	DD/MM/CCYY	10	64

Section 1: Demographic Items

Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

From SMR Definitions and Codes

Related Data Items:

Notes by Users:

Person Given Name

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

Main Source of Data Item Standard: Government Data Standards Catalogue

Definition: The forename or given name of a person.

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

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

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

Related Data Items:

Notes by Users:

Patient Postcode at Diagnosis (Cancer)

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

Related Data Items:
Date of Diagnosis (Cancer)

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 Items:
CHI Number

Notes by Users:

Person Sex at Birth

Common Name(s): Sex at Birth

Main Source of Data Item 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 recorded	

Related Data Items:
CHI Number

Notes by Users:

CHI Number

Main Source of Data Item 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 Items: Date of Birth, Person Sex at Birth.

Notes by Users:

Section 2: Pre-treatment Imaging & Staging Investigations

Staging Investigations Complete (Pre-treatment)

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 staging investigations were completed.

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

Notes for Users: Required for QPI(s): 2, 6.

Complete staging of pancreatic, duodenal or biliary tract cancer is CT of chest, abdomen and pelvis (and no other combination).

Complete staging of HCC is CT liver or MRI of liver.

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

Intrahepatic cholangiocarcinomas (C22.1a) should be recorded as '96 – Not applicable'.

Codes and Values:

Code	Value	Explanatory Note
1	Complete - CT chest, abdomen and pelvis (pancreas, biliary tract, duodenum)	Biliary tract includes gall bladder
2	Complete - CT – Liver (HCC)	
3	Complete - MRI – Liver (HCC)	
4	Incomplete	When some or all of the required staging investigations were not carried out
5	Complete – CT & MRI – Liver (HCC)	If patient with HCC undergoes CT & MRI of liver
95	Patient refused investigations	
96	Not applicable	
99	Not recorded	

Related Data Items:

Notes by Users:

Number of Tumours/Lesions on Imaging {HCC}

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

Definition: The number of liver lesions detected radiologically for patients with hepatocellular carcinoma {HCC} (C22.0).

Field Name: NUMTUMOUR
Field Type: Integer
Field length: 4

Notes for Users: Required for cross-check of QPI(s) 2

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

If not a HCC tumour record as 1010 Not applicable.

Related Data Items:
Size of Largest Lesion on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Size of Largest Lesion on Imaging {HCC}

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

Definition: This is the maximum diameter of the largest lesion as detected by MRI or CT scan for patients with HCC (C22.0).

Field Name: TUMSIZE
Field Type: Integer
Field length: 4

Notes for Users: Required for cross-check of QPI(s) 2

The size of the lesion should be recorded in millimetres and rounded up if 0.5 or over or <0.5 down. If there is more than one lesion the size of the largest should be recorded.

If the size of the tumour is not recorded record as '9999'.

If not a HCC tumour record as '1010' Not applicable.

Related Data Items:
Number of Tumours/Lesions on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease {HCC}
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Alpha-Fetoprotein Quantification {HCC}

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

Definition: An indicator of the level of alpha-fetoprotein (AFP) detected in the patient's blood when investigated for HCC.

Field Name: AFP
Field Type: Integer
Field length: 8

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

The AFP should be recorded in kU/L.

If no test has been performed, record as 10101010

If not a HCC tumour record as 10101010 Not applicable.

If the result is not known record as 99999999.

The level recorded should normally be the first result after referral and before transfusion or treatment.

Related Data Items:
Number of Tumours/Lesions on Imaging (HCC)
Size of Largest Lesion on Imaging {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Vascular Invasion on Imaging {HCC}

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

Definition: The presence or absence of vascular invasion detected radiologically for patients with HCC.

Field Name: VASCULAR
Field Type: Integer
Field Length: 2

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

If not a HCC tumour record as '96' Not applicable.

Codes and Values:

Code	Value	Explanatory Note
1	Not present	
2	Present	
3	Uncertain	
96	Not applicable	e.g. Not HCC
99	Not recorded	

Related Data Items:
Number of Tumours/Lesions on Imaging (HCC)
Size of Largest Lesion on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Child-Pugh Score {HCC}

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 the presence and severity of underlying chronic liver disease, as assessed by the Child-Pugh score, for patients with HCC.

Field Name: CHILDPUGH
Field Type: Integer
Field length: 2

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

Child-Pugh score (value or number) should be recorded as stated by clinicians.

Codes and Values:

Code	Value	Explanatory Note
1	A	Score < 7
2	B	Score 7-9
3	C	Score > 9
96	Not applicable	e.g. Not HCC
99	Not recorded	

Related Data Items:
Number of Tumours/Lesions on Imaging (HCC)
Size of Largest Lesion on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Presence or Absence of Chronic Liver Disease
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Presence or Absence of Chronic Liver Disease {HCC}

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 indicating the presence of chronic liver disease for patients with HCC.

Field Name: CHRONAB
Field Type: Integer
Field Length: 2

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

Codes and Values:

Code	Value	Explanatory Notes
1	Present	
2	Absent	
96	Not applicable	e.g. Not HCC
99	Not recorded	

Related Data Items:
Number of Tumours/Lesions on Imaging (HCC)
Size of Largest Lesion on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Cause of Chronic Liver Disease {HCC}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

Cause of Chronic Liver Disease (1-3) {HCC}

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 of the underlying aetiology (cause) of chronic liver disease.

Field Name: CHRONC1
CHRONC2
CHRONC3
Field Type: Integer
Field Length: 2

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

Up to 3 multiple factors can be recorded separately

Codes and Values:

Code	Value	Explanatory Notes
1	Alcohol	
2	Hepatitis B virus	
3	Hepatitis C virus	
4	Non-alcoholic fatty liver disease	
5	Primary biliary cirrhosis	
6	Haemachromatoisis,	
7	Primary sclerosing cholangitis	
8	Autoimmune hepatitis	
9	Other	e.g. Wilson's disease, Alpha-1-antitrypsin deficiency
10	Unknown origin	Includes cryptogenic cirrhosis
96	Not applicable	e.g., Not HCC
99	Not recorded	Includes not documented

Related Data Items:
Number of Tumours/Lesions on Imaging (HCC)
Size of Largest Lesion on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

UK Listing Criteria – Liver Transplant {HCC}

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 patients with HCC meet the UK listing criteria for consideration of liver transplantation.

Field Name: LISTCRIT
Field Type: Integer
Field Length: 2

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

Current UK listing criteria includes:

- Single tumour ≤5cm diameter
- Up to 5 tumours all ≤3cm
- Single tumour 5-7cm which shows no significant progression over 6 months.

Clinicians should clearly indicate whether or not a patient has met the UK listing criteria.

For non HCC patients record as 96 – Not applicable.

Codes and Values:

Code	Value	Explanatory Notes
1	Yes	
2	No	
96	Not applicable	e.g., Not HCC
99	Not recorded	

Related Data Items:

Notes by Users:

Referred to Scottish Liver Transplant Unit {HCC}

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 patients with HCC were referred to the Scottish Liver Transplant Unit (SLTU).

Field Name: SLTUREFER
Field Type: Integer
Field Length: 2

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

Codes and Values:

Code	Value	Explanatory Notes
1	Yes	
2	No	
95	Patient refused	
96	Not applicable	e.g. Not HCC
99	Not recorded	

Related Data Items:

Notes by Users:

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

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

Notes for Users: Required for clarifying responsibility for data collection and national comparative analysis. QPI 12.

This may also be a GP surgery code if a biopsy was taken by a GP. This will be the hospital/GP surgery where the sample was taken or the hospital at which the patient was managed when the diagnosis was made.

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). http://www.natref.scot.nhs.uk/

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at 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/
The first character denotes the health board, the next three are assigned and the fifth denotes the type of location (H=hospital) e.g.

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

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

Related Data Item(s):
Date of Diagnosis

Notes by Users:

Date of Diagnosis (Cancer)

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

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

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

Notes for Users: Required for QPI 1 - 12

Required for national survival analysis and national comparative analysis.

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

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

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

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

Related Data Item(s):
Date of Birth
Location of Diagnosis (Cancer)

Notes by Users:

Most Valid Basis of Diagnosis (Cancer)

Main Source of Data Item 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 QPIs 4, 7

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.

The most valid basis of diagnosis may not relate to date of diagnosis.

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 recorded	

Related Data Item(s):

Notes by Users:

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 (ICD-O(3))

Field Name: ICDSITE
Field Type: Characters ICD-10
Field length: 5

Notes for Users: Required for QPIs 1 -12
Tumours should be assigned to the subcategory that includes the point of origin of the tumour. A tumour that overlaps the boundaries of two or more subcategories and whose point of origin cannot be determined should be classified as subcategory '8'. It should be noted that this subcategory should only be used where it is impossible to identify the specific site of origin of the tumour.

ICD-O(3) code 'C240 has been subdivided into 'A' (Proximal extra hepatic bile duct) and 'B' (Distal extra hepatic bile duct have) to meet QPI requirements.

Codes and Values:

ICD-O(3) Code	Value	Explanatory Notes
SMALL INTESTINE		
C170	Duodenum	
LIVER AND INTRAHEPATIC BILE DUCT		
C220	Liver Cell Carcinoma	Hepatocellular Carcinoma (HCC) Hepatoma
C221	Intrahepatic Bile Duct	e.g. Peripheral cholangiocarcinoma
GALLBLADDER		
C23X	Gallbladder	
OTHER AND UNSPECIFIED PARTS OF BILIARY TRACT		
C240A	Proximal extra hepatic bile duct	e.g. Klatskin/hilar cholangiocarcinoma
C240B	Distal extra hepatic bile duct	e.g. Distal cholangiocarcinoma Biliary duct or passage NOS Common bile duct Cystic duct Hepatic duct Sphincter of Oddi
C241	Ampulla of Vater	Periampullary
C248	Overlapping lesions of biliary tract	Neoplasms involving both intrahepatic and extrahepatic bile ducts.
C249	Biliary tract, NOS	
PANCREAS		
C250	Head of pancreas	
C251	Body of pancreas	
C252	Tail of pancreas	

C253	Pancreatic duct	Duct of Santorini Duct of Wirsung
C254	Islets of Langerhans	Islands of Langerhans Endocrine pancreas
C257	Other specified parts of pancreas	Neck of pancreas
C258	Overlapping lesion of pancreas	
C259	Pancreas, NOS	Not Otherwise Specified
OTHER		
C99X	Not recorded	

Related Data Item(s):

Notes by Users:

Date Discussed by Care Team (MDT)

Common name: Date discussed by multidisciplinary team (MDT)

Main source of data 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 (also known as the multidisciplinary team) 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): 1

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

A cancer multidisciplinary care team may include surgeons, oncologists, radiologists, pathologists, nurses, speech language therapists, physiotherapists and others relevant to the treatment of 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 should be recorded.

If the date of the MDT meeting is unknown record as 09/09/0909 or if the patient has not been discussed by the MDT, record as Not applicable 10/10/1010.

Related Data Item(s):

Notes by Users:

Type of First Cancer Treatment

Common name: Mode of first treatment

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

Definition: This denotes the first specific treatment administered to a patient for their cancer.

Field Name: FIRSTTREATMODE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI 1

Required to ensure capture of all treatment options.

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	Value	Explanatory Notes
1	Surgery	
2	Radiotherapy	
3	Chemotherapy	
15	Chemoradiotherapy	
5	Endoscopic	Endoscopic Ampullectomy, does not include stenting
16	Ablative Therapy	
13	Biological Therapy	
20	TACE	Transarterial chemoembolization
7	Supportive care	
12	Watchful waiting	
11	Other therapy	
94	Patient died before first treatment	
95	Patient refused all therapies	
99	Not recorded	

Related Data Item(s):
Date of First Cancer Treatment
Location Code {Non-Surgical Treatment}

Notes by Users:

Date of First Cancer Treatment

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

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

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

Notes for Users:
This field should be recorded for all patients including those with supportive care only ('No active treatment') (see below).

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

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

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

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

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

Notes by Users:

Date of Definitive Treatment {HPB 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: 1

For patients with HPB cancer definitive treatment will be either:

- Surgery;
- Transarterial Chemoembolisation (TACE);
- Radiotherapy
- Ablation; or
- Systemic Anti Cancer Therapy (SACT).

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

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

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

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

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

Related Data Item(s):

Section 3: Surgery

Location Code (Cancer Surgery)

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

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

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

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

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

This is the hospital of first definitive surgery for the treatment of HPB cancer. 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.

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). http://www.natref.scot.nhs.uk/

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at 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/
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

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.

Related Data Item(s):
Date of Definitive Surgery
Operating Consultant Surgeon (1-2) {HPB}
Main Type of Operation {HPB Cancer}

Notes by Users:

Operating Consultant Surgeon (1-2) {HPB Cancer}

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

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

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

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

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

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

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

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

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

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

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

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

Notes by Users:

Main Type of Definitive Operation {HPB Cancer}

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

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

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

Notes for Users: Required for QPI(s) 3, 4, 5, 7 - 12

Where OPCS codes have been recorded in the patient notes by the surgeon, this code should be used. Where no OPCS code has been recorded, the table below should be used. For queries or issues regarding recording OPCS please contact NSS.terminologyhelp@nhs.net.

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

Coding instructions and a full list of codes are included in the OPCS4 manual. It should be noted that it may be necessary to record two codes in order to fully specify the operation e.g. double bypass could be recorded as:

J29.2 = Hepaticojejunostomy, Anastomosis of hepatic duct to jejunum NEC.
G33.1 = Bypass of stomach by anastomosis of stomach to jejunum NEC.

Key = NEC – Not elsewhere classified

Pancreas

OPCS	Description	Explanatory notes
G51.1	Bypass of duodenum by anastomosis of stomach to jejunum.	Includes: Gastric bypass
J19.3	Anastomosis of gall bladder to jejunum	Includes: Biliary bypass, gallbladder to jejunum and cholecystantrostromy NEC.
G33.1	Bypass of stomach by anastomosis of stomach to jejunum NEC	Includes: Double bypass, gastroenterostomy NEC Excludes: Connection of stomach to jejunum when associated with concurrent excision of stomach NEC (G27.5, G28.3)
J29.2	Anastomosis of hepatic duct to jejunum NEC	Includes: Hepaticojejunostomy, biliary bypass
J55.1	Total pancreatectomy and excision of surrounding tissue	Includes: Total pancreatectomy
J56.1	Pancreaticoduodenectomy and excision of surrounding tissue	Includes: Pylorus preserving pancreatico-duodenectomies (PPPD)
J56.2	Pancreaticoduodenectomy and resection of antrum of stomach	Includes: Classic pancreatico-duodenectomies (PD) Whipple
J57.3	Left pancreatectomy NEC	Includes: Distal pancreatectomy
J57.9	Unspecified other partial excision of pancreas	Includes: Pancreatectomy NEC

Duodenum

OPCS	Description	Explanatory notes
G49.3	Partial excision of duodenum	Includes: Partial excision of duodenum Excludes: Pancreaticoduodenectomy (J56)
G50.1	Excision of lesion of duodenum	Includes: Excision of lesion of duodenum
G51.1	Bypass of duodenum by anastomosis of stomach to jejunum	Includes: Bypass of duodenum

Bile Duct

OPCS	Description	Explanatory notes
J27.1	Excision of ampulla of Vater and replantation of common bile duct into duodenum	
J27.3	Partial excision of bile duct and anastomosis of bile duct to jejuenum	Includes: Bile duct resection (if segmentectomy also carried out use code J02.3 - Resection of segment of liver, in second field. If hepatectomy also carried out use code J02.1- Right hemihepatectomy NEC in second field.
J29.2	Anastomosis of hepatic duct to jejunum NEC	Includes: Bile duct bypass, palliative bypass, hepaticojejunostomy, biliary bypass

Gallbladder

OPCS	Description	Explanatory notes
J18.1	Total cholecystectomy and excision of surrounding tissue	Includes: Radical cholecystectomy
J18.3	Total cholecystectomy NEC	Includes: Cholecystectomy, cholecystectomy NEC
J18.5	Partial cholecystectomy NEC	Includes: Subtotal cholecystectomy NEC

Liver

OPCS	Description	Explanatory notes
J01.1	Orthotopic transplantation of liver NEC	Includes: Total hepatectomy with liver transplantation
J02.1	Right hemihepatectomy NEC	Includes: Right hepatectomy
J02.2	Left hemihepatectomy NEC	Includes: Left hepatectomy
J02.3	Resection of segment of liver	Includes: Sectionectomy, trisectorectomy, trisectionectomy, left lateral sectorectomy, left lobectomy, unisegmentectomy or plurisegmentectomy, Resection of segments of liver, Resection of section of liver
J02.4	Wedge excision of liver	Includes: Wedge resection
J02.6	Extended right hemihepatectomy	
J02.7	Extended left hemihepatectomy	
J02.8	Other specified partial excision of liver	
J03.1	Excision of lesion of liver NEC	
J03.2	Destruction of lesion of liver NEC	
J03.5	Excision of multiple lesions of liver	
J12.1	Percutaneous drainage of liver	
J48.6	Percutaneous transhepatic biliary drainage single	Includes: Percutaneous transhepatic biliary drainage single NEC

Ampulla of Vater

OPCS	Description	Explanatory notes
J36.1	Excision of ampulla of Vater using duodenal approach	
J36.8	Other specified operations on ampulla of Vater using duodenal approach	
J36.9	Unspecified other operations on ampulla of Vater using duodenal approach	
J39.9	Other therapeutic endoscopic operations on ampulla of Vater	Includes Endoscopic Ampullectomy

Other Codes

OPCS	Description	Explanatory notes
Y75.1	Laparoscopic assisted approach to abdominal cavity	
Y75.2	Laparoscopic approach to abdominal cavity NEC	
Y75.4	Hand assisted minimal access approach to abdominal cavity	
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 Items:
Location Code (Cancer Surgery)
Date of Definitive Surgery {HPB Cancer}
Operating Consultant Surgeon (1-2) {HPB Cancer}

Notes by Users:

Date of Definitive Surgery {HPB 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 date of the operative procedure described elsewhere.

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

Notes for Users: Required for QPI(s) 5, 8, 11

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

If no surgical procedure is carried out, code as 10/10/1010 (Not applicable).

Related Data Items:
Main Type of Operation {HPB Cancer]
Location Code (Cancer Surgery)
Operating Consultant Surgeon (1-2) {HPB Cancer}

Notes by Users:

Section 4: Pathology Details

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: EXNODES
Field Type: Integer
Field length: 4

Notes for Users: Required for QPI(s): 10

If surgery is performed but no lymph nodes are taken/examined record as 0

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

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

Related Data Items:

Notes by Users:

Morphology of Tumour

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

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

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

Notes for Users: Required for sub-analysis and inclusion criteria.

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

Morphology codes are shown below.

This list is not exhaustive and if a code is not on the list please contact NSS.isdCANCERAUDIT@nhs.net for advice.

Examples of Morphology codes

Code	Description	Explanatory Notes
8010/3	Carcinoma nos; epithelial tumour malignant	Liver/Bile Duct/Gallbladder/Pancreas
8020/3	Undifferentiated Carcinoma	Liver/Bile Duct/Pancreas/Small Intestine
8032/3	Spindle Cell Carcinoma	Pancreas
8035/3	Undifferentiated Carcinoma with Osteoclast-like Giant Cells	Pancreas
8041/3	Small Cell Carcinoma	Gallbladder/Extrahepatic Bile Duct/ Small Intestine
8070/3	Squamous Cell Carcinoma; Epidermoid carcinoma; nos; Squamous carcinoma; Squamous cell epithelioma	Gallbladder/Extrahepatic Bile Duct/ Small Intestine
8140/3	Adenocarcinoma	Gallbladder/Extrahepatic Bile Duct/ Small Intestine
8144/3	Adenocarcinoma, Intestinal Type; Adenocarcinoma, Gastirc Foveolar Type	Gallbladder/Extrahepatic Bile Duct
8150/3	Islet cell tumour	Pancreas
8154/3	Mixed Ductal-Endocrine Carcinoma; Mixed Acinar-Endocrine Carcinoma	Pancreas
8160/3	Cholangiocarcinoma (C22.1, C24.0); Bile duct carcinoma (C22.1, C24.0); Bile duct Adenocarcinoma (C22.1, C24.0)	Intrahepatic Bile Duct/ Extrahepatic Bile Duct
8161/3	Bile Duct Cystadenocarcinoma (C22.1, C24.0)	Intrahepatic Bile Duct/ Extrahepatic Bile Duct
8170/3	Hepatocellular carcinoma nos (C22.0) Hepatocarcinoma (C22.0); Liver cell carcinoma (C22.0):	Liver

	Hepatoma: malignant (C22.0); Hepatoma; nos (C22.0)	
8171/3	Hepatocellular carcinoma, fibrolamellar (C22.0)	Liver
8172/3	Hepatocellular carcinoma, Scirrhous (C22.0); Sclerosing Hepatic Carcinoma C22.0)	Liver
8173/3	Hepatocellular carcinoma, Spindle Cell Variant (C22.0); Hepatocellular Carcinoma, sarcomatoid (C22.0)	Liver
8174/3	Hepatocellular Carcinoma, Clear Cell Type (C22.0)	Liver
8175/3	Hepatocellular Carcinoma, Pleomorphic Type (C22.0)	Liver
8180/3	Combined hepatocellular carcinoma and cholangiocarcinoma (C22.0); Mixed hepatocellular and bile duct carcinoma (C22.0); Hepatocholangiocarcinoma (C22.0)	Liver
8241/3	EC-cell, Serotonin-producing neoplasm; L-cell, Glucagon-like peptide and PP/YY producing tumour	Small Intestine
8244/3	Mixed Carcinoid-Adenocarcinoma	Gallbladder/Extrahepatic Bile Duct/ Small Intestine
8260/3	Papillary Adenocarcinoma	Gallbladder/Extrahepatic Bile Duct
8310/3	Clear Cell Adenocarcinoma	Gallbladder/Extrahepatic Bile Duct
8441/3	Serous Cystadenocarcinoma	Pancreas
8452/3	Solid-Pseudopapillary Carcinoma	Pancreas
8453/3	Intraductal Papillary-Mucinous Carcinoma, Invasive	Pancreas
8470/3	Cystadenocarcinoma mucinous, nos	Pancreas
8480/3	Mucinous Adenocarcinoma; Mucinous Non-Cystic Carcinoma	Gallbladder/Extrahepatic Bile Duct/Pancreas/ Small Intestine
8481/3	Mucin-producing adenocarcinoma	Liver/Bile Duct/Gallbladder/Pancreas
8490/3	Signet-Ring Cell Carcinoma	Gallbladder/Extrahepatic Bile Duct /Pancreas/ Small Intestine
8500/3	Ductal Adenocarcinoma	Pancreas
8510/3	Medullary Carcinoma	Small Intestine
8550/3	Acinar Cell Carcinoma	Pancreas
8551/3	Acinar Cell Cystadenocarcinoma	Pancreas
8560/3	Adenosquamous Carcinoma	Gallbladder/Extrahepatic Bile Duct /Pancreas/ Small Intestine
8970/3	Hepatoblastoma	Liver
8971/3	Pancreatoblastoma	Pancreas
8980/3	Carcinosarcoma	Liver/Intrahepatic Bile Duct
9071/3	Yolk Sac Tumour (Endodermal Sinus Tumour)	Liver/Intrahepatic Bile Duct
8000/3	Neoplasm; malignant; tumour; malignant; nos; malignancy; cancer; unclassified tumour; malignant	Liver/Bile Duct/Gallbladder/Pancreas
1111/1	Not assessable	

8888/8	Negative Pathology	
9999/9	Not recorded	
1010/0	Not applicable	

Related Data Items:

Notes by Users:

TNM Tumour Classification (Final) {HPB}

Common Name: TNM Tumour stage {HPB}

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

Definition: A record of the size and extent of the primary cancer.

Field Name: FINALT
Field Type: Characters
Field Length: 3

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

This is a clinical/pathological classification and should be documented. In the absence of pathological T, clinical T should be recorded, prior to definitive treatment. If no T is documented do not deduce from other information and record as 'not recorded'.

Codes and Values:

Duodenum ICD-0(3) C17

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour invades lamina propria, muscularis mucosae or submucosa	
T1a	Tumour invades lamina propria or muscularis mucosae	
T1b	Tumour invades submucosa	
T2	Tumour invades muscularis propria	
T3	Tumour invades subserosa or non-peritonealized perimuscular tissue (mesentery or retroperitoneum*) with extension 2cm or less	* The non-peritonealized perimuscular tissue is, for jejunum and ileum, part of the mesentery and, for duodenum in areas where serosa is lacking, part of the retroperitoneum.
T4	Tumour perforates visceral peritoneum or directly invades other organs or structures (includes other loops of small intestine, mesentery or retroperitoneum more than 2cm and abdominal wall by way of serosa; for duodenum only, invasion of pancreas)	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	

Pancreas ICD-0(3) C25

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour limited to the pancreas, 2cm or less in greatest dimension	

T2	Tumour limited to the pancreas, > 2cm in greatest dimension	
T3	Tumour extends beyond pancreas, but without involvement of coeliac axis or superior mesenteric artery	
T4	Tumour involves coeliac axis or superior mesenteric artery	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not recorded

Ampulla of Vater ICD-0(3) C24.1

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour limited to ampulla of Vater or sphincter of Oddi	
T2	Tumour invades duodenal wall	
T3	Tumour invades pancreas	
T4	Tumour invades peripancreatic soft tissues, or other adjacent organs or structures	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not recorded

Proximal (Perihilar) extrahepatic bile duct ICD-0(3) C24.0

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour confined to bile duct, with extension up to the muscle layer or fibrous tissue	
T2a	Tumour invades beyond the wall of the bile duct to surrounding adipose tissue	
T2b	Tumour invades adjacent hepatic parenchyma	
T3	Tumour invades unilateral branches of the portal vein or hepatic artery	
T4	Tumour invades the main portal vein or its branches bilaterally; or the common hepatic artery; or the second-order biliary radicals bilaterally; or unilateral second-order biliary radicals with contralateral portal vein or hepatic artery involvement	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not known

Distal extra hepatic bile duct ICD-0(3) C24.0

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour confined to bile duct	
T2	Tumour invades beyond the wall of the bile duct	
T3	Tumour invades the gallbladder, liver, pancreas, duodenum, or other adjacent organs	
T4	Tumour involves the coeliac axis or the superior mesenteric artery	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not known

Gallbladder ICD-0(3) C23

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Tumour invades lamina propria or muscular layer	
T1a	Tumour invades lamina propria	
T1b	Tumour invades muscular layer	
T2	Tumour invades perimuscular connective tissue, no extension beyond serosa or into liver	
T3	Tumour perforates serosa (visceral peritoneum) and/or directly invades the liver and/or one other adjacent organ or structure, such as stomach, duodenum, colon, pancreas, omentum, extrahepatic bile ducts	
T4	Tumour invades main portal vein or hepatic artery, or invades two or more extrahepatic organs or structures	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not recorded

Liver - Hepatocellular Carcinoma (HCC) ICD-0(3) C22.0

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Solitary tumour without vascular invasion	
T2	Solitary tumour with vascular invasion or multiple tumours, none more than 5 cm in greatest dimension	
T3	Multiple tumours any more than 5 cm *or* tumour involving a major branch of the portal or hepatic vein(s)	
T3a	Multiple tumours any more than 5 cm	
T3b	Tumour involving a major branch of the portal or hepatic vein(s)	
T4	Tumour(s) with direct invasion of adjacent organs other than the gallbladder *or* with perforation of visceral peritoneum	
TX	Primary tumour cannot be assessed	

96	Not applicable	
99	Not recorded	Includes Not known

Liver – Intrahepatic Bile Ducts (IHCC) ICD-0(3) C22.1

Code	Value	Explanatory Notes
T0	No evidence of primary tumour	
T1	Solitary tumour without vascular invasion	
T2a	Solitary tumour with vascular invasion	
T2b	Multiple tumours, with or without vascular invasion	
T3	Tumour perforates the visceral peritoneum or directly invades adjacent extrahepatic structures	
T4	Tumour wit periductal invasion (periductal growth invasion)	
TX	Primary tumour cannot be assessed	
96	Not applicable	
99	Not recorded	Includes Not known

Related Data Items:
TNM Nodal Classification (Final) {HPB}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

TNM Nodal Classification (Final) {HPB}

Common Name: TNM Nodal stage {HPB}

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

Definition: A record of the extent of regional lymph node metastases.

Field Name: FINALN
Field Type: Characters
Field Length: 3

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

This is a clinical/pathological classification and should be documented. In the absence of pathological N, clinical N should be recorded, prior to definitive treatment. If no N is documented do not deduce from other information and record as 'not recorded'.

Codes and Values:

Duodenum ICD-0(3) C17

Code	Value
N0	No regional lymph node metastasis
N1	Metastasis in 1-3 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

Pancreas ICD-0(3) C25

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional lymph node metastasis
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Ampulla of Vater ICD-0(3) C24.1

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional lymph node metastasis
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Proximal (Perihilar) extrahepatic bile duct ICD-0(3) C24.0

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional lymph node metastasis including nodes along the cystic duct, common bile duct, common hepatic artery, and portal vein
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Distal extra hepatic bile duct ICD-0(3) C24.0

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional lymph node metastasis
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Gallbladder ICD-0(3) C23

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional lymph node metastasis (including nodes along the cystic duct, common bile duct, common hepatic artery, and portal vein)
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Liver - Hepatocellular Carcinoma (HCC) ICD-0(3) C22.0

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional nodes metastasis
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Liver – Intrahepatic Bile Ducts (IHCC) ICD-0(3) C22.1

Code	Value
N0	No regional lymph nodes metastasis
N1	Regional nodes metastasis
NX	Regional lymph nodes cannot be assessed (e.g. previously removed)
96	Not applicable
99	Not recorded

Related Data Items:
TNM Tumour Classification (Final) {HPB}
TNM Metastasis Classification (Final) {HPB}

Notes by Users:

TNM Metastasis Classification (Final) {HPB}

Common Name: TNM Metastasis Classification {HPB}

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

Definition: A record of the extent of metastatic spread of the tumour.

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

Notes for Users: Required for QPI(s): 2 and required to allow adjustments for stage when undertaking survival analysis.

This is a clinical/pathological classification and should be documented. In the absence of pathological M, clinical M should be recorded, prior to definitive treatment. If no M is documented do not deduce from other information and record as 'not recorded'.

This is a clinical/pathological classification as defined by the MDT.

Codes and Values:
Duodenum ICD-0(3) C17; Pancreas ICD-0(3) C25; Ampulla of Vater ICD-0(3) C24.1; Proximal (Perihilar) extrahepatic bile duct ICD-0(3) C24.0; Distal extra hepatic bile duct ICD-0(3) C24.0; Gallbladder ICD-0(3) C23; Liver - Hepatocellular Carcinoma (HCC) ICD-0(3) C22.0; Liver – Intrahepatic Bile Ducts (IHCC) ICD-0(3) C22.1

Code	Value
M0	No distant metastases
M1	Distant metastases
96	Not applicable
99	Not recorded

Related Data Items:
TNM Tumour Classification (Final) {HPB}
TNM Nodal Classification (Final) {HPB}
Number of Tumours/Lesions on Imaging {HCC}
Alpha-Fetoprotein Quantification {HCC}
Vascular Invasion on Imaging {HCC}
Child-Pugh Score {HCC}
Presence or Absence of Chronic Liver Disease {HCC}
Cause of Chronic Liver Disease {HCC}
Size of Largest Lesion on Imaging {HCC}

Notes for Users:

Section 5: Non-Surgical Treatment

Location Code (Non-Surgical Treatment)

Common Name(s): Location

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

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

Field Name: HOSPNONSURG
Field Type: Characters
Field Length: 5

Notes for Users:
This is the hospital of first non-surgical treatment based on date of first cancer treatment, date of ablation {HCC}, date of first transarterial chemoembolisation treatment (TACE) {HCC} or date of systemic anti cancer therapy (SACT) (1).

Location codes for hospitals are five character codes maintained by ISD and the General Register Office (Scotland). http://www.natref.scot.nhs.uk/

Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at 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/
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

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 no non-surgical treatment has not been performed or the patient has refused non-surgical treatment, record as Not applicable, X1010.

Related Data Item(s):
Date of Ablation {HCC}
Ablation Treatment Given {HCC}
Date of First Transarterial Chemoembolisation Treatment (TACE) {HCC}
First Transarterial Chemoembolisation Treatment Given (TACE) {HCC}
Date of Systemic Anti Cancer Therapy (SACT) (1-3)
Type of Systemic Anti Cancer Therapy (SACT) (1-3)

Notes by Users:

Ablation Treatment Given {HCC}

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 ablation was given as treatment for Hepatocellular carcinoma.

Field Name: ABLAT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 3, 4, 5, 7

Codes and Values:

Code	Value	Explanatory Notes
1	Yes	
2	No	No ablation given
94	Patient died before treatment	
95	Patient refused treatment	
96	Not applicable	For non-HCC patients
99	Not recorded	

Related data item:
Date of Ablation {HCC}

Notes by Users:

Date of Ablation {HCC}

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 ablation was performed.

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

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

Types of ablation include:
- Chemical
- Microwave
- Radiofrequency
- Thermal

If ablation is not carried out, record as 10/10/1010 (Not applicable).

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

Related Data Items:
Location Code (Non-Surgical Treatment)
Ablation Treatment Given {HCC}

Notes by Users:

First Transarterial Chemoembolisation Treatment Given {HCC}

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 Transarterial Chemoembolisation Treatment (TACE) was given as treatment for hepatocellular carcinoma.

Field Name: TACEG
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 3, 4, 5, 7

This relates to the date of first Transarterial Chemoembolisation Treatment given.

Codes and Values:

Code	Value	Explanatory Notes
1	Yes	
2	No	No TACE given
94	Patient died before treatment	
95	Patient refused treatment	
96	Not applicable	For non-HCC patients
99	Not recorded	

Related Data Item(s):
Date of First Transarterial Chemoembolisation Treatment {HCC}
Date of Last Transarterial Chemoembolisation Treatment {HCC}

Notes by Users:

Date of First Transarterial Chemoembolisation Treatment {HCC}

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

Definition: The date the first transarterial chemoembolisation (TACE) treatment was given.

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

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

This is the first treatment date of TACE given.

If the date of TACE treatment started is not known or not documented, record as 09/09/0909 (Not recorded).

If TACE treatment is not carried out, record as 10/10/1010 (Not applicable).

Related Data Item(s):
Date Transarterial Chemoembolisation Treatment Completed {HCC}
Location Code {Non-Surgical Treatment}
Transarterial Chemoembolisation Treatment Given {HCC}

Notes by Users:

Date of Last Transarterial Chemoembolisation Treatment {HCC}

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

Definition: The date a course of transarterial chemoembolisation (TACE) ended.

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

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

Patients may receive multiple TACE treatments which will depend on how the patients respond to the treatment. Therefore, record the date of the last TACE treatment given within the first 12 months of first TACE treatment.

Date of First Transarterial Chemoembolisation Treatment {HCC} can be the same day as the date TACE treatment commenced.

If the date of TACE treatment started is not known or not documented, record as 09/09/0909 (Not recorded).

If TACE treatment is not carried out, record as 10/10/1010 (Not applicable).

Related Data Item(s):
Date of First Transarterial Chemoembolisation Treatment {HCC}
Transarterial Chemoembolisation Treatment Given {HCC}

Notes by Users:

Radiotherapy {HPB}

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 radiotherapy (external beam or internal) has been administered for the treatment of the cancer.

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

Notes for Users:

Combined treatments may be administered concurrently/synchronously e.g. chemotherapy and radiotherapy.

All treatments given as part of the initial treatment plan should be recorded, including consolidation radiotherapy.

Treatment received for initial management and not treatment of recurrence or relapse. If the patients type of first treatment was 'supportive care only' or 'watchful waiting' then subsequently proceeds to active treatment at a later date, only record if treatment occurs within 6 months of diagnosis.

Codes and Values:

Code	Value	Explanatory Notes
01	Yes	
02	No	
93	Patient contraindicated in treatment	
94	Patient died before treatment	
95	Patient refused treatment	
99	Not recorded	

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

Date Treatment Started {Cancer} (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: RSRTDATE1
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users:

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.

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

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

Date Treatment Completed {Cancer} (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: RCOMPDATE1
Field Type: Date (DD/MM/CCYY)
Field Length: 10

Notes for Users:

This is the last fraction of a course of radiotherapy.

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

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

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

Related Data Item(s):
Radiotherapy {HPB}
Date Treatment Started {Cancer} (Radiotherapy)

Type of Systemic Anti-Cancer Therapy (SACT) (1-3)

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

Definition: The type of course of cytotoxic or biological drugs administered for the treatment of cancer.

Field Name: SACTTYPE1
SACTTYPE2
SACTTYPE3
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 3, 4, 5, 7, 8

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

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

Codes and Values:

Code	Value	Explanatory Notes
1	Neoadjuvant	
2	Adjuvant	Chemotherapy given after surgery, within 3 months of surgery
4	Palliative	Systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis
5	Chemoradiotherapy	For curative/radical treatment.
7	Biological therapy	
94	Patient died before SACT treatment	i.e. Patient died before receiving planned SACT treatment.
95	Patient refused SACT treatment	
96	Not applicable	i.e. SACT not given as part of primary therapy.
99	Not recorded	

Related data item:
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-3)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-3)
Location Code {Non-Surgical Treatment}

Notes by Users:

Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-3)

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

Definition: The date cancer treatment course commenced.

Field Name: SACTDATE1
SACTDATE2
SACTDATE3
Field Type: Date (DD/MM/CCYY)
Field length: 10

Notes for Users: Required for QPI(s): 5, 8

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

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

Up to 3 courses may be recorded.

If the date of SACT treatment started is not known or not documented, record as 09/09/0909 (Not recorded).

If SACT treatment is not carried out, record as 10/10/1010 (Not applicable).

Related Data Items(s):
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-3)
Location Code (Non-Surgical Treatment)
Type of Systemic Anti-Cancer Therapy (SACT (1-3)

Notes by Users:

Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-3)

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

Definition: The date cancer treatment course ended.

Field Name: SACTENDATE1
SACTENDATE2
SACTENDATE3
Field Type: Date (DD/MM/CCYY).
Field length: 10

Notes for Users: Required for QPI(s):

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

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

Up to 3 courses may be recorded.

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

If the date treatment started is not known or not documented, record as 09/09/0909.

Related Data Item(s):
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-3)
Type of Systemic Anti Cancer Therapy (SACT) (1-3)
Location Code (Non-Surgical Treatment)

Notes by Users:

Section 6: Clinical Trial Entry

Patient Entered into Clinical Trial {HPB 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 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 National Cancer Research Network (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 recorded

Related Data Items:

Notes by Users:

Section 7: Death Details

Date of Death

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

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

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

Notes for Users: Required for QPIs: 5, 8, 11

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

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

Related Data Items:

Notes by Users: