Epithelial Ovarian Cancer

Data Definitions for the National Minimum Core Dataset to Support the Introduction of Epithelial Ovarian Quality Performance Indicators

Definitions developed by ISD Scotland in collaboration with the Ovarian Quality Performance Indicators Development Group

Version 2.3: March 2016

To be used in conjunction with:

1. Ovarian Quality Performance Indicators V1 (latest published version)
2. Epithelial Ovarian QPI Dataset Validations (latest Published Version)
3. Epithelial Ovarian Measurability of Quality Performance Indicators (latest Published Version)

DOCUMENT CONTROL SHEET

Key Information

Title	**Ovarian Cancer – Data Definitions for Minimum Core Dataset for Quality Performance Indicators (QPIs)**
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Cross References	**Ovarian Cancer Quality Performance Indicators Ovarian Cancer Measurability of Quality Performance Indicators**
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Revision History

Version	Date	Summary of Changes	Name	Changes Marked
1.1	07/2014	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st October 2013	Charlotte Anthony ISD	See page iii
2.0	09/2014	Changes to be applied for patients diagnosed from 1st October 2014	Charlotte Anthony ISD	See page iii
2.1	04/2015	Changes agreed out with review during validation QA to support data collection**.**	Charlotte Anthony ISD	See page iii
2.2	06/2015	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1st October 2014	Charlotte Anthony ISD	See page iii
2.3	03/2016	Changes agreed following the Baseline Review	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 1 October 2014.

NOTES FOR IMPLEMENTATION OF CHANGES

The following changes should be implemented for all patients who are diagnosed with epithelial ovarian cancer on or after 1 October 2014, who are eligible for inclusion in the OVARIAN 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 Improvement Indicators to be measured and reported against

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

CONVENTIONS

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

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

Revisions to Dataset following Baseline Review (March 2016)

Risk of Malignancy Index (RMI I) (Pre-Treatment) – inserted the following text within Notes for Users – 'If the patient has had no ultrasound preformed record as 101010 (Not applicable)

Date of Diagnosis – removed 'The date recorded is the date of the first investigative procedure that confirms a diagnosis of ovarian cancer whether done radiologically or histologically' and inserted 'The date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (Where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat.'

Measurement of Macroscopic Residual Disease – Removed explanatory notes for Codes 01 – 'Complete', 02 – 'Optimal', 03 – 'Sub Optimal'

REVISIONS TO DATASET OUT-WITH REVIEW (June 2015)

Location of Diagnosis {Cancer} – inserted X9999=Not Recorded

REVISIONS TO DATASET OUTWITH REVIEW:

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

Dataset:

CHI Number: Field Type changed from Characters to Integer
Site of Origin of Primary Tumour {Epithelial Ovarian Cancer}: Field Type changed from Characters ICD-0(3) to Characters
Histopathology Report Complete {Epithelial Ovarian Cancer} remove "Microinvasion" from Full Information required list within notes for users.
Final FIGO Stage: Field Length changed from 2 to 3

Database Specification:

CHI Number: Field Type changed from Characters to Integer
Measurement of Macroscopic Residual Disease: Field Length changed from 4 to 2
Final FIGO Stage: Field Length changed from 2 to 3
Patient Entered into Clinical Trial {Cancer}: Field Type changed from Characters to Integer

REVISIONS TO DATASET FROM 9MONTH REVIEW (September 2014)

New Data Item Added

Page 17: Morphology of Tumour – Pre-Operative Biopsy

Deleted Data Items

Date of Histological/Cytological Diagnosis {Cancer}
Microinvasion {Epithelial Ovarian Cancer}
Cause of Death

Database Specification

Data Items Removed;
Date of Histological/Cytological Diagnosis {Cancer} - HDIAG
Microinvasion {Epithelial Ovarian Cancer} - MICROI
Cause of Death – COD

Data Items Added

Morphology of Tumour – Pre-Operative Biopsy Field Name: BIOMORPHOL, Field type: Characters, Field Length: 6

Dataset

Abdomen and Pelvis Imaging Investigations Completed code and values: 96 Not Applicable removed, complete added to Yes and Not complete added to No.

Risk of Malignancy Index (RMI I) (Pre-Treatment) remove "stage 1" and "If not applicable, record as 101010(Not applicable) from Notes for Users.

Type of Staging Primary Operation {Epithelial Ovarian Cancer} codes and values: Omental biopsy added into explanatory notes of 01 – Complete staging operation.

Morphology of Tumour added Post Operative to title; added "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)." to Notes for Users.

Morphology codes added "mixed mesodermal" to 8950/3; added "8010/3 – Carcinoma, not otherwise specified"

Tumour Grade the following text inserted to Notes for Users "low or high grade" and "take back to MDT for clarification".

Patient entered into Clinical Trial {Cancer} Field Type changes from Characters to Integer.

REVISIONS TO DATASET OUT-WITH REVIEW (July 2014)

New Data Item Added:

Page 17: Type of First Cancer Treatment
Page 18: Date of First Cancer Treatment
Page 19: Date of Definitive Treatment {Renal Cancer}

Database Specification:

Type of First Cancer Treatment data item added: Field Name: FIRSTTREATMODE, Field type: Integer, Field Length: 2
Date of First Cancer Treatment data item added: Field Name: FIRSTTREATDATE, Field Type: Date, Field Length: 10
Date of Definitive Treatment {Renal Cancer} data item added: Field Name: DEFTREATDATE, Field Type: Date, Field Length: 10.

Dataset

Final Figo Stage

i. New Codes and Values 1st January 2014 – to date

Code	Value	
	Ovarian Primary	**Fallopian Tube Primary**
Stage 1	Tumour confined to ovaries	
1a	Tumour in one ovary, capsule intact, no tumour on surface, negative washings.	Limited to lining of one fallopian tube (intra-luminal)
1b	Tumour involves both ovaries, capsule intact, no tumour on surface, negative washings.	Limited to inner linings of both tubes (intra-luminal)
1c	Tumour limited to one or both ovaries	Invasion beyond the inner lining of the tube, or positive ascites or peritoneal washings
1c1	Surgical spill	
1c2	Capsule rupture before surgery or tumor on ovarian surface	
1c3	Malignant cells in the ascites or peritoneal washings.	
Stage 2	Tumour involves one or both ovaries with pelvic extension (below the pelvic brim) or primary peritoneal cancer	
2a	Extension and/or implant on uterus and/or Fallopian tubes	Spread to the ovary and / or the uterus. No malignant ascites or peritoneal washings (can have benign ascites)
2b	Extension to other pelvic intraperitoneal tissues	Spread to other parts of the pelvis. No malignant ascites or peritoneal washings
Stage 3	Tumour involves one or both ovaries withcytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis to the retroperitoneal lymph nodes	
3a	Positive retroperitoneal lymph nodes and/or microscopic metastasis beyond the pelvis.	Microscopic tumour on the surfaces of abdominal organs (e.g bowel, hepatic surface)
3a1	Positive retroperitoneal lymph nodes only (i) Metastasis ≤ 10mm (ii) Metastasis > 10mm	

3a2	Microscopic, extrapelvic (above the brim) peritoneal involvement ± positive retroperitoneal lymph nodes	
3b	Macroscopic, extrapelvic, peritoneal metastasis ≤ 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.	Tumour deposits < 2 cm on organ surfaces
3c	Macroscopic, extrapelvic, peritoneal metastasis > 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.	Tumour deposits > 2 cm and / or spread to local lymph nodes.
Stage 4	Distant metastasis excluding peritoneal metastasis	
4a	Pleural effusion with positive cytology	Distant solid organ metastases (e.g intra-hepatic).
4b	Hepatic and/or splenic parenchymal metastasis, metastasis to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity)	
96	Not applicable	Not applicable
99	Not recorded	Not recorded

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 epithelial ovarian (ICD-O(3) C56), primary peritoneal (ICD-O(3) C48) and fallopian tube (ICD-O(3) C57) malignancies See page 33 for morphology codes to be included. Including those 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 borderline ovarian cancers
- Patients with Pseudomyxoma peritonei
- Patients with sarcoma
- Patients with Benign tumours.
- Patients with Neuroendocrine tumours.
- Patients with Germ cell 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.

DATABASE SPECIFICATION

DOWNLOAD FORMAT

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

Data Item	Field Name	Field Type	Size	Page
Section 1: Demographic Items				**1**
Person Family Name (at Diagnosis)	PATSNAME	Characters	35	2
Person Given Name	PATFNAME	Characters	35	3
Patient Postcode at Diagnosis {Cancer}	PATPCODE	Characters	8	4
Date of Birth	DOB	Date (DD/MM/CCYY)	10	5
CHI Number	CHINUM	Integer	10	6
Section 2: Pre-treatment Imaging & Staging Investigations				**7**
Abdomen and Pelvis Imaging Investigations Completed	SINVEST	Integer	2	8
Date Abdomen and Pelvis Imaging Investigations Completed	SINVESTDATE	Date (DD/MM/CCYY)	10	9
Risk of Malignancy Index (RMI I) (Pre-Treatment)	RMISCORE	Integer	6	10
Location of Diagnosis {Cancer}	HOSP	Characters	5	11
Date of Diagnosis {Cancer}	DIAGDATE	Date (DD/MM/CCYY)	10	12
Date of Histological/Cytological Confirmation Prior to Treatment	HCONF	Date (DD/MM/CCYY)	10	13
Histocytological/Cytological Confirmation Prior to Treatment	HCCONF	Integer	2	14
Site of Origin of Primary Tumour {Epithelial Ovarian Cancer}	SITE	Characters	5	15
Date Discussed by Care Team (MDT)	MDTDATE	Date (DD/MM/CCYY)	10	16
Morphology of Tumour – Pre-Operative Biopsy	BIOMORPHOL	Characters	6	17
Type of First Cancer Treatment	FIRSTTREATMODE	Integer	2	19
Date of First Cancer Treatment	FIRSTTREATDATE	Date (DD/MM/CCYY)	10	20
Date of Definitive Treatment {Ovarian Cancer}	DEFTREATDATE	Date (DD/MM/CCYY)	10	21
Section 3: Surgery				**22**
Location Code {Cancer Surgery}	HOSPSURG	Characters	5	23
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}	OPSURG1	Characters	14	24
Date of Staging Primary Surgery {Cancer}	DSURG	Date (DD/MM/CCYY)	10	25
Histocytological/Cytological Confirmation of Epithelial Ovarian Cancer	HCDIAG	Integer	2	26
Presentation Type	PRESENT	Integer	2	27
Type of Staging Primary Operation {Epithelial Ovarian Cancer}	SURGTYPE	Integer	2	28
Second Operation to Complete	SECOP	Integer	2	29
Measurement of Macroscopic Residual Disease	TUMSIZE	Integer	2	30

Section 4: Pathology Details				**31**
Histopathology Report Complete {Epithelial Ovarian Cancer}	PATHCOMPL	Integer	2	32
Morphology of Tumour - Post-Operative	MORPHOL	Characters	6	33
Tumour Grade	GRADE	Integer	2	35
Peritoneal Biopsy Involvement {Epithelial Ovarian Cancer}	PERIBIOP	Integer	2	36
Omentum Involvement {Epithelial Ovarian Cancer}	OMENTINV	Integer	2	37
Fallopian Tube Involvement {Epithelial Ovarian Cancer}	FALLOP	Integer	2	38
Malignant Presence in Peritoneal/Ascitic Fluid {Epithelial Ovarian Cancer}	PAWASH	Integer	2	39
Number of Lymph Nodes Involved {Cancer}	LNINVOLVE	Integer	4	40
Final Total Number of Lymph Nodes Examined Microscopically {Cancer}	LNEXAMINE	Integer	4	41
Final FIGO Stage	FIGO2	Characters	3	42
Section 5: Oncological Treatment				**44**
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)	SACT1	Integer	2	45
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)	SACT2	Integer	2	45
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)	SACTAGENT1	Integer	2	46
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)	SACTAGENT2	Integer	2	46
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)	SACTDATE1	Date (DD/MM/CCYY)	10	47
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)	SACTDATE2	Date (DD/MM/CCYY)	10	47
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)	SACTENDATE1	Date (DD/MM/CCYY)	10	48
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)	SACTENDATE2	Date (DD/MM/CCYY)	10	48
Section 6: Clinical Trial Entry				**49**
Patient Entered into Clinical Trial {Cancer}	TRIAL	Integer	2	50
Section 7: Death Details				**51**
Date of Death	DOD	Date (DD/MM/CCYY)	10	52

Section 1: Demographic Items

Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

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

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

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

From SMR Definitions and Codes

Codes and Values:

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.

Codes and Values:

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

Codes and Values: N/A

Related Data Items:
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.

Codes and Values: N/A

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: Integer
Field Length: 10

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

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

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

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

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

Codes and values: N/A

Related Data Items:
Date of Birth

Notes by Users:

Section 2: Pre-treatment Imaging & Staging Investigations

Abdomen and Pelvis Imaging Investigations Completed

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

Definition: A record to show that scanning of the abdomen and pelvis was assessed using computed tomography (CT) or magnetic resonance imaging (MRI). From the superior aspect of the diaphragm as far as the inferior border of the pubic symphisis.

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

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

A MRI or CT scan should be carried out prior to treatment.

Imaging of the pelvis and abdomen should be carried out to establish the extent of disease.

Chest CT is not routinely part of this assessment.

Codes and Values:

Code	Value	Explanatory Notes
01	Yes - Complete	Both abdomen and pelvis assessed.
02	No – Not Complete	Abdomen and/or pelvis not assessed.
95	Patient declined investigations	
99	Not recorded	

Related Data items:-
Date Abdomen and Pelvis Imaging Investigations Completed

Notes by Users:

Date Abdomen and Pelvis Imaging Investigations Completed

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

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

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

Notes for Users:

Date of Procedure to be recorded.

Complete staging is where both abdomen and pelvis is assessed.

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

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

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

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

Related Data Item(s):
Abdomen and Pelvis Imaging Investigations Completed
Date of Staging Primary Surgery {Cancer}

Notes by Users:

Risk of Malignancy Index (RMI I) (Pre-Treatment)

Main Source of Data Item Standard:

Definition: A record of the Risk of Malignancy Index (RMI I) as recorded in the patient's notes or at MDT prior to treatment.

Field Name: RMISCORE
Field Type: Integer
Field Length: 6

Notes for Users: Required for QPI 1, 4

The Risk of Malignancy Index (RMI I) score should be recorded by a clinician for all patients at MDT pre-treatment. This should not be deduced.

For information the ultrasound result is scored 1 point for each of the following characteristics: multilocular cysts, solid areas, metastases, ascites, and bilateral lesions. U = 0 for an ultrasound score of 0 points, U = 1for an ultrasound score of 1 point, U = 3 for an ultrasound score of 2–5 points.

Menopausal status is scored as 1 = pre-menopausal and 3 = post-menopausal. The classification of 'post-menopausal' is a woman who has had no period for more than 1 year or a woman over 50 who has had a hysterectomy.

Serum CA125 is measured in IU/ml.

If it is not documented in notes do not deduce from other information and record as '999999' '(Not recorded).

If the patient has had no ultrasound performed record as 101010 (Not applicable).

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.

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 QPIs 1-9

Required for national survival analysis and national comparative analysis.

The date recorded is the date on which the suspicion of cancer was first raised by the earliest relevant investigation (where the diagnosis was subsequently confirmed), i.e. the investigation which led to the decision to treat.

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

Histological and cytological confirmation refers specifically to pre-treatment.

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:

Date of Histological/Cytological Confirmation Prior to Treatment

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

Definition: This is the date that the histological/cytological microscopic examination of the specimen to determine the presence of malignancy and the classification of the malignant tumour was confirmed prior to the start of treatment.

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

Notes for Users: Required for QPIs 7

There may be more than one biopsy/histology report. If there is a discrepancy between reports of cytology and histology, the histology report should be recorded as the definitive report if prior to treatment.

If no cytological or histological diagnosis was made, record as 10/10/1010 (Not applicable). E.g. surgical patients

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

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

Related Data Items:
Location of Diagnosis {Cancer}
Histocytological/Cytological Confirmation Prior to Treatment

Histocytological/Cytological Confirmation Prior to Treatment

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

Definition: Confirmation if a histological or cytological examination was carried out to diagnose a cancer prior to treatment.

Field Name: HCCONF
Format: Integer
Field length: 2

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

Codes and Values:

Code	Value	Explanatory Notes
01	Histological	
02	Cytological	
96	Not applicable	Diagnosis based on other clinical investigations only, eg imaging”
98	Clinically inappropriate	e.g not suitable
99	Not recorded	

Related Data Items:
Location of Diagnosis {Cancer}
Date of Histological/Cytological Confirmation Prior to Treatment

Site of Origin of Primary Tumour {Epithelial Ovarian Cancer}

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

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

Field Name: SITE
Field Type: Characters
Field length: 5

Notes for Users: Required for QPIs 1-9

All ovarian cancers should be collected through the audit process. Only epithelial type cancers (assumed for all cases by default) should be included, other tumour type will be excluded based on explicit histological confirmation.

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 'C48.8'. It should be noted that this subcategory should only be used where it is impossible to identify the specific site of origin of the tumour.

Codes and Values:

ICD-O(3) Code	Value	Explanatory Notes
C56.9	Ovary	Periadrenal tissue Perinephric tissue Peripancreatic tissue Perirenal tissue Retrocecal tissue Retroperitoneal tissue
C57.0	Fallopian Tube	
C48.0	Retroperitoneum	Periadrenal tissue Perinephric tissue Peripancreatic tissue Perirenal tissue Retrocecal tissue Retroperitoneal tissue
C48.1	Specified parts of peritoneum	Pelvic peritoneum Pouch of Douglas Cul de sac Rectouterine pouch Mesocolon Mesoappendix Mesentery Omentum
C48.2	Peritoneum, NOS	Peritoneal cavity
C48.8	Overlapping lesion of retroperitoneum and peritoneum	
C99.X	Not recorded	

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 3.

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

The first MDT meeting 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):

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:

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	Description
Serous tumours- malignant	
8441/3	Adenocarcinoma
8461/3	Surface papillary adenocarcinoma
9014/3	Adenocarcinofibroma (malignant adenofibroma)
Mucinous tumours- malignant	
8480/3	Adenocarcinoma
9015/3	Adenocarcinofibroma (malignant adenofibroma)
Endometrioid tumours including variants with squamous differentiation- malignant	
8380/3	Adenocarcinoma, not otherwise specified
8381/3	Adenocarcinofibroma (malignant adenofibroma)
8950/3	Malignant Mullerian mixed tumour (carcinosarcoma), mixed mesodermal
8933/3	Adenosarcoma
Clear cell tumours- malignant	
8310/3	Adenocarcinoma
8313/3	Adenocarcinofibroma (malignant adenofibroma)
Transitional cell tumours - malignant	
8120/3	Transitional cell carcinoma (non-Brenner type)
9000/3	Malignant Brenner tumour
Squamous cell tumours- malignant	
8070/3	Squamous cell carcinoma
Mixed epithelial tumours (specify components)	
8323/3	Malignant
Undifferentiated and unclassified tumours - malignant	

8010/3 Carcinoma, not otherwise specified
8020/3 Undifferentiated carcinoma
8140/3 Adenocarcinoma, not otherwise specified
1111/1 Not assessable
8888/8 Negative Pathology
9999/9 Not recorded
1010/0 Not applicable

Related Data Items:

Type of First Cancer Treatment

Common name: Mode of first treatment

Main source of data 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 QPIs 3

This field is included in the data standards to enable the accurate recording of waiting times. For any particular modality it is the first treatment and not specifically the definitive treatment i.e. this does not include purely diagnostic biopsies such as incisional biopsies, needle biopsies or core biopsies. Some biopsies, such as excisional biopsies and cone biopsies may be included as these may have some therapeutic benefits i.e. the removal of the tumour.
Record patients as having 'no active treatment' if a decision was taken not to give the patient treatment as part of their primary therapy (some patients that have 'no active treatment' may subsequently have treatment when symptoms develop but this is not primary therapy). No active treatment includes watchful waiting and supportive care but not palliative chemotherapy and/or radiotherapy.
Radiotherapy includes teletherapy (external beam radiotherapy) and brachytherapy.
Endoscopic treatment includes photodynamic therapy, transurethral resection (TUR), laparoscopic treatment, endomucosal resection (EMR) and insertion of stents. Dilatations without other treatment is not considered as active treatment.
Biological therapies such as Interferon, Interlukin 2, BCG vaccine etc. should be recorded under other therapy.

Codes and values:

Code	Value	
01	Surgery	
02	Radiotherapy	
03	Chemotherapy	
04	Synchronous Chemoradiotherapy	
05	Endoscopic	
06	Hormone therapy	
07	Supportive care	No active treatment
11	Other therapy	
95	Patient refused all therapies	
94	Patient died before treatment	
99	Not recorded	

Related data item: Date of first cancer treatment

Date of First Cancer Treatment

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 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 'no active treatment' (see below).

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

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

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

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

Related data item: Type of first cancer treatment.

Date of Definitive Treatment {Ovarian Cancer}

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

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

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

Notes for Users: Required for QPI: 3

For patients with ovarian cancer definitive treatment will be either:

- Surgery; 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 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.

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 Staging Primary Surgery {Cancer}
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

Notes by Users:

Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

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

Definition: The GMC number of the consultant in charge at operation performing the definitive surgery as described elsewhere.

Field Name: OPSURG1
Field Type: Characters
Field Length: 14

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

The GMC number of the Consultant in charge at the operation 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 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}
Date of Staging Primary Surgery {Cancer}

Notes by Users:

Date of Staging Primary Surgery {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 primary operative procedure described elsewhere;

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

Notes for Users: Required for QPI(s) 8

Surgery may be staging, primary and delayed primary surgery or following neo-adjuvant chemotherapy.

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).

Codes and values: N/A

Related data items:
Location Code {Cancer Surgery}
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

Notes by Users:

Histocytological/Cytological Confirmation of Epithelial Ovarian Cancer

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

Definition: Confirmation if a histological or cytological examination was carried out to diagnose a cancer.

Field Name: HCDIAG
Format: Integer
Field length: 2

Notes for Users:
Codes and Values:

Code	Value	Explanatory Notes
01	Histological	
02	Cytological	
96	Not applicable	
98	Clinically inappropriate	e.g not suitable
99	Not recorded	

Related Data Items:
Location Code {Cancer Surgery}

Presentation Type

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

Definition: How the patient presented for surgery.

Field Name: PRESENT
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s): 1, 2, 4

Both categories incorporate:

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

Codes and Values:

Code	Value	Explanatory Notes
01	Elective (routine)	A patient who presents for surgery as planned.
02	Emergency	A patient, who for clinical reasons, presents unplanned for surgery. If presentation is classed as 'urgent', code as 'emergency' only if surgery is performed within 72 hours of admission
96	Not applicable	If no operation was performed.
99	Not recorded	

Type of Staging Primary Operation {Epithelial Ovarian 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 operation performed on the patient for treatment of ovarian cancer.

Field Name: SURGTYPE
Field Type: Integer
Field Length: 2

Notes for Users: Required for QPI(s) 1, 4, 5, 8

Complete staging patients may have organs absent due to previous surgeries for benign conditions.

If code 02 or 03 is being recorded please verify with the clinician if the patient had undergone a previous operation to remove an ovary or had a sub total Hysterectomy.

Codes and Values:

Code	Value	Explanatory Notes
01	Complete staging operation	Complete staging patients may have organs absent due to previous surgeries. Complete staging = Total abdominal hysterectomy (TAH), Bilateral salpingoopherectomy (BSO), Omental biopsy, Omentectomy + peritoneal or ascites washings.
02	Incomplete staging	Unilateral oopherectomy, no omentectomy, hysterectomy
03	Incomplete staging – fertility sparing	Unilateral oopherectomy. Fertility conserving surgery is where only the ovary containing the tumour and connecting fallopian tube is removed. The remaining healthy ovary and fallopian tube is retained.
04	Delayed Primary Operation - complete	Surgery following Neoadjuvant therapy
05	Delayed Primary Operation - incomplete	Surgery following Neoadjuvant therapy
93	Patient unfit for surgery	
94	Patient died before surgery	
95	Patient declined surgery	
96	Not applicable	e.g. patient with advanced disease
99	Not recorded	

Related data items:
Location Code {Cancer Surgery}
Date of Staging Primary Surgery {Cancer}
Operating Consultant Gynaecologist {Epithelial Ovarian Cancer}

Second Operation to Complete

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 show if there was a second operation to complete the staging.

Field Name: SECOP
Field Type: Integer
Field Length: 2

Notes for Users:

Some patients may have had a previous operation where incomplete staging is identified and then gone on to have a second operation in an attempt to complete staging.

A second operation should be recorded in this section if there has been no chemotherapy given following the initial procedure and the time interval has not exceeded 3 months.

Codes and Values:

Code	Value	Explanatory Notes
01	Yes :- Staging complete	Second operation undertaken to complete staging
02	Yes :- Staging Incomplete	Second operation undertaken in an attempt to complete staging
96	Not applicable	
99	Not recorded	

Related data items:-
Type of Staging Primary Operation

Notes by Users:

Measurement of Macroscopic Residual Disease

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

Definition: The measurement of macroscopic residual disease for patients undergoing surgery as defined by the main type of definitive operation.

Field Name: TUMSIZE
Field Type: Integer
Field length: 2

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

This is the total residual disease – as defined in the surgical notes.

The measurements for the largest deposit(s) should be recorded (cm in diameter).

Although the objective of surgery is to resect all visible disease this is not always possible in patients with advanced disease because of widespread involvement of peritoneal surfaces, bowel mesentery and serosa of bowel. In these instance or if no surgery was carried out record as 96 (Not applicable).

Codes and Values:

Code	Description	Explanatory Notes
01	No residual disease	
02	<1cm	
03	1-5cm	
04	>5cm	
96	Not applicable	
99	Not recorded	Residual disease present, not documented.

Related Data Items:

Notes by Users:

Section 4: Pathology Details

Histopathology Report Complete {Epithelial Ovarian Cancer}

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 all information required in the pathology report is complete.

Field Name: PATHCOMPL
Field Type: Integer
Field Length: 2

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

Full Information Required:
- Tumour type
- Tumour grade
- Lymph node status
- Peritoneal biopsies
- Omentum
- Peritoneal washings or ascitic fluid
- Fallopian tubes
- Staging – FIGO stage

Pathology report should include complete information for all relevant tissue samples received by pathology, for example if no lymph node or omental tissue is received by pathology it is not expected that this would be reported by the pathologist; therefore, if all other information noted, this report should be recorded as complete.

Codes and Values:

Code	Value	Explanatory Notes
01	Complete	
02	Not complete	e.g. not all data items completed.
96	Not applicable	e.g. patient did not have surgery
99	Not recorded	

Notes by Users:

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.

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

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

Notes for Users: Required for QPI: 9

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 mailto:NSS.isdCANCERAUDIT@nhs.net for advice.

Morphology codes:

Code	Value
Serous tumours- malignant	
8441/3	Adenocarcinoma
8461/3	Surface papillary adenocarcinoma
9014/3	Adenocarcinofibroma (malignant adenofibroma)
Mucinous tumours- malignant	
8480/3	Adenocarcinoma
9015/3	Adenocarcinofibroma (malignant adenofibroma)
Endometrioid tumours including variants with squamous differentiation- malignant	
8380/3	Adenocarcinoma, not otherwise specified
8381/3	Adenocarcinofibroma (malignant adenofibroma)
8950/3	Malignant Mullerian mixed tumour (carcinosarcoma), mixed mesodermal
8933/3	Adenosarcoma
Clear cell tumours- malignant	
8310/3	Adenocarcinoma
8313/3	Adenocarcinofibroma (malignant adenofibroma)
Transitional cell tumours - malignant	
8120/3	Transitional cell carcinoma (non-Brenner type)
9000/3	Malignant Brenner tumour
Squamous cell tumours- malignant	
8070/3	Squamous cell carcinoma

Mixed epithelial tumours (specify components)	
8323/3	Malignant
Undifferentiated and unclassified tumours - malignant	
8010/3	Carcinoma, not otherwise specified
8020/3	Undifferentiated carcinoma
8140/3	Adenocarcinoma, not otherwise specified
1111/1	Not assessable
8888/8	Negative Pathology
9999/9	Not recorded
1010/0	Not applicable

Tumour Grade

Main Source of Data Item Standard:

Definition: A record of the grade of tumour as recorded in the pathological report.

Field Name: GRADE
Field Type: Integer
Field Length: 2

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

If the tumour is described as having mixed differentiation (e.g. moderate to well) the option with the poorer prognosis is recorded (moderate).

If low or high grade is not documented do not deduce from other information, take back to MDT for clarification or record as 'not recorded'.

Codes and Values:

Code	Description	Explanatory Notes
01	Non Serous	Well Differentiated
02	Non Serous	Moderately Differentiated
03	Non Serous	Poorly Differentiated
04	Serous	Low Grade
05	Serous	High Grade
96	Not applicable	
99	Not recorded	

Peritoneal Biopsy Involvement {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

Definition: A record to determine presence or absence of malignant cells in the peritoneum.

Field Name: PERIBIOP
Field Type: Integer
Field Length: 2

Notes for Users:

Codes and Values:

Code	Description
01	Involved
02	Not involved
96	Not applicable
99	Not recorded

Omentum Involvement {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

Definition: A record to determine if there is omental involvement.

Field Name: OMENTINV
Field Type: Integer
Field Length: 2

Notes for Users:

Codes and Values:

Code	Description
01	Involved
02	Not involved
96	Not applicable
99	Not recorded

Fallopian Tube Involvement {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

Definition: A record to determine if there is Fallopian Tube involvement.

Field Name: FALLOP
Field Type: Integer
Field Length: 2

Notes for Users:

Codes and Values:

Code	Description
01	Involved
02	Not involved
96	Not applicable
99	Not recorded

Malignant Presence in Peritoneal/Ascitic Fluid {Epithelial Ovarian Cancer}

Main Source of Data Item Standard:

Definition: The presence or absence of malignant cells in peritoneal and/or ascitic fluid.

Field Name: PAWASH
Field Type: Integer
Field Length: 2

Notes for Users:

Cytological assessment of peritoneal fluid forms part of the staging system for ovarian carcinoma and in stage I tumours the presence or absence of tumour cells in peritoneal washings may be critical in determining the need for adjuvant therapy.

Codes and Values:

Code	Description
01	Present
02	Not present
96	Not applicable
99	Not recorded

Number of Lymph Nodes Involved {Cancer}

Main Source of Data Item Standard:

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

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

Field Name: LNINVOLVE
Field Type: Integer
Field Length: 4

Notes for Users:

If no surgery is performed or no attempt to sample/dissect nodes code as ‘1010’, not applicable.
If the total number examined is not known or not recorded, code as 9999.

Final Total Number of Lymph Nodes Examined Microscopically {Cancer}

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

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

Field Name: LNEXAMINE
Field Type: Integer
Field Length: 4

Notes for Users:

If no surgery is performed or no attempt to sample/dissect nodes code as ‘1010’, not applicable.

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

Notes by Users:

Final FIGO Stage

Main Source of Data Item Standard: International Federation of Obstetricians and Gynaecologists (FIGO)

Definition: The stage of the disease of the ovary as recorded in the patient's notes at the time of the MDT meeting.

Field Name: FIGO2
Field Type: Characters
Field Length: 3

Notes for Users: Required for QPI: 1, 4, 5, 8, 9
Final stage is clinical/pathological correlation as agreed by the MDT.

Primary peritoneal carcinomas are staged in a similar manner to ovarian carcinomas.

If there are two conflicting stages record the worse case scenario.

Original Codes and Values 1st October 2013 – 31st December 2013

Code	Value	
	Ovarian Primary	**Fallopian Tube Primary**
1a	Tumour in one ovary, no ascites, capsule intact, no tumour on surface	Limited to lining of one fallopian tube (intra-luminal)
1b	Tumour in both ovaries, no ascites capsule intact, no tumour on surface	Limited to inner linings of both tubes (intra-luminal)
1c	Tumour in one or two ovaries, ascites with tumour cells or capsule ruptured or tumour on surface or positive washings	Invasion beyond the inner lining of the tube, or positive ascites or peritoneal washings
2a	Extension or metastases to uterus or tubes	Spread to the ovary and / or the uterus. No malignant ascites or peritoneal washings (can have benign ascites)
2b	Extension to other pelvic organs	Spread to other parts of the pelvis. No malignant ascites or peritoneal washings
2c	Extension to uterus or tubes or other pelvic organs, ascites with tumour cells or positive washings	Either Iia or Iib with malignant ascites or positive peritoneal washings.
3	Tumour involving one or both ovaries with evidence of disease outside the pelvis and/or positive regional lymph nodes and/or superficial liver disease and/or involvement of bowel or omentum	
3a	Tumour grossly limited to pelvis, micro implants on abdominal peritoneum, negative nodes	Microscopic tumour on the surfaces of abdominal organs (e.g bowel, hepatic surface)
3b	Tumour grossly limited to pelvis, abdominal implants <=2cms, negative nodes	Tumour deposits < 2 cm on organ surfaces
3c	Abdominal implants >2cms. +/- nodal metastases	Tumour deposits > 2 cm and / or spread to local lymph nodes.
4	Growth involving one or both ovaries with distant metastases. If pleural effusion is present, there must be positive cytology to allot a case to Stage IV. Parenchymal liver metastasis equals Stage IV	Distant solid organ metastases (e.g intra-hepatic).
96	Not applicable	Not applicable
99	Not recorded	Not recorded

New Codes and Values 1st January 2014 – to date

Code	Value	
	Ovarian Primary	**Fallopian Tube Primary**
Stage 1	Tumour confined to ovaries	
1a	Tumour in one ovary, capsule intact, no tumour on surface, negative washings.	Limited to lining of one fallopian tube (intra-luminal)
1b	Tumour involves both ovaries, capsule intact, no tumour on surface, negative washings.	Limited to inner linings of both tubes (intra-luminal)
1c	Tumour limited to one or both ovaries	Invasion beyond the inner lining of the tube, or positive ascites or peritoneal washings
1c1	Surgical spill	
1c2	Capsule rupture before surgery or tumor on ovarian surface	
1c3	Malignant cells in the ascites or peritoneal washings.	
Stage 2	Tumour involves one or both ovaries with pelvic extension (below the pelvic brim) or primary peritoneal cancer	
2a	Extension and/or implant on uterus and/or Fallopian tubes	Spread to the ovary and / or the uterus. No malignant ascites or peritoneal washings (can have benign ascites)
2b	Extension to other pelvic intraperitoneal tissues	Spread to other parts of the pelvis. No malignant ascites or peritoneal washings
Stage 3	Tumour involves one or both ovaries withcytologically or histologically confirmed spread to the peritoneum outside the pelvis and/or metastasis to the retroperitoneal lymph nodes	
3a	Positive retroperitoneal lymph nodes and/or microscopic metastasis beyond the pelvis.	Microscopic tumour on the surfaces of abdominal organs (e.g bowel, hepatic surface)
3a1	Positive retroperitoneal lymph nodes only (i) Metastasis ≤ 10mm (ii) Metastasis > 10mm	
3a2	Microscopic, extrapelvic (above the brim) peritoneal involvement ± positive retroperitoneal lymph nodes	
3b	Macroscopic, extrapelvic, peritoneal metastasis ≤ 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.	Tumour deposits < 2 cm on organ surfaces
3c	Macroscopic, extrapelvic, peritoneal metastasis > 2cm ± positive retroperitoneal lymph nodes. Includes extension to capsule of liver/spleen.	Tumour deposits > 2 cm and / or spread to local lymph nodes.
Stage 4	Distant metastasis excluding peritoneal metastasis	
4a	Pleural effusion with positive cytology	Distant solid organ metastases (e.g intra-hepatic).
4b	Hepatic and/or splenic parenchymal metastasis, metastasis to extra-abdominal organs (including inguinal lymph nodes and lymph nodes outside of the abdominal cavity)	
96	Not applicable	Not applicable
99	Not recorded	Not recorded

Related Data Items:

Notes by Users:

Section 5: Oncological Treatment

Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian 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 type of course of cytotoxic drugs administered for the treatment of the cancer. Cytotoxic drugs are drugs which destroy cells.

Field Name: SACT1
SACT2
Field Type: Integer
Field Length: 2

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

Patients may have ongoing SACT both before and after surgery. These patients should be recorded under neo-adjuvant Type. If a patient is prescribed 6 cycles and then after 3 cycles is deemed appropriate for surgery and recommences the last 3 cycles following their surgery this would be considered one treatment package.

Some patients may have separate completion SACT post-operatively. This may be recorded as two courses neo-adjuvant and adjuvant.

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

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

Codes and Values:

Code	Value	Explanatory Notes
01	Neoadjuvant	Therapy given prior to definitive surgery to reduce tumour size, even when there is intent for surgery but no surgery is done.
02	Adjuvant	The start of adjuvant SACT is after the date of the first surgery where there is no overt evidence of remaining disease.
04	Palliative/Primary	Primary systemic therapy given for symptom control without curative intent e.g. for patients with metastatic disease at time of diagnosis
05	Hormone Therapy	Letrozole would be used on relapsed and low grade tumours
93	SACT contraindicated in patient	
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. not given as part of primary therapy
99	Not recorded	

Related Data Item(s):
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)

Systemic Therapy Agent {Epithelial Ovarian 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 type of chemotherapy or biological therapy used either alone or in combination to treat epithelial ovarian cancer.

Field Name: SACTAGENT1
SACTAGENT2
Field Type: Integer
Field length: 2

Notes for Users: Required for QPIs: 9

Chemotherapy drugs can be given in or outwith the context of a clinical trial.

Up to two courses may be recorded, i.e. neo-adjuvant and adjuvant therapies.

All treatments given as part of the initial treatment plan plus second-line treatment received within six months of diagnosis should be recorded.

Codes and Values:

Code	Value
01	Paclitaxel in combination with platinum based compound
02	Carboplatin single agent
03	Other SACT agent
95	Patient declined SACT treatment
96	Not applicable
98	Other
99	Not recorded

Related Data Item(s):
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)

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

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

Definition: The date cancer treatment course commenced.

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

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

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 (10/10/1010) (Not applicable).

Related Data Items(s):
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
Date Treatment Completed Systemic Anti-Cancer Therapy (SACT) (1-2)

Notes by Users:

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

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

Definition: The date cancer treatment course ended.

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

Notes for Users:

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.

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

If the date treatment started is unknown, or patient is receiving maintenance end date should be recorded as 09/09/0909 (not recorded).

Related Data Item(s):
Systemic Anti-Cancer Therapy (SACT) {Epithelial Ovarian Cancer} (1-2)
Systemic Therapy Agent {Epithelial Ovarian Cancer} (1-2)
Date Treatment Started Systemic Anti-Cancer Therapy (SACT) (1-2)

Notes by Users:

Section 6: Clinical Trial Entry

Patient Entered into Clinical Trial {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:

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
01	Yes
02	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:

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).

Codes and Values: N/A

Related Data Items:

Notes by Users: