



Prostate Cancer

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

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

Version 2.5: July 2015

To be used in conjunction with:

1. Prostate Cancer Clinical Quality Performance Indicators V2.0 (November 2013)
2. Prostate Cancer QPI Dataset Validations (latest published version)
3. Prostate Cancer Measurability of Quality Performance Indicators (latest published version)

DOCUMENT CONTROL SHEET

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Author	Information Services Division of NHS National Services Scotland

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Version	Date	Summary of Changes	Name	Changes Marked
2.5	17/07/15	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1 st July 2014.	Jane Garrett	See page iii
2.4	09/03/15	Baseline Review changes	Karen Heatlie ISD	See page iii
2.3	28/11/14	Baseline Review procedure code changes	Karen Heatlie ISD	See page iii
2.2	02/07/14	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1 st July 2014.	Karen Heatlie ISD	See page iii
2.1	07/01/14	Additional review changes. Changes to be applied for patients diagnosed from 1 st July 2014.	David Early, ISD	See page iii.
2.0	20/12/13	Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1 st July 2014.	David Early, ISD	See page iii.

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PREFACE

Following the completion of the Scottish Urological Cancer Audit (SUCA) in 2004 and as a requirement of the *Cancer in Scotland: Action for Change*, a national urological cancer data set was developed by ISD in collaboration with the three cancer networks.

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 and the accompanying measurability document were agreed in public engagement and are now ready for implementation for patients diagnosed from 1st July 2012.

Mr Sudhir Borganokar, Consultant Urologist, NHS Highland
Mr Prasad Bollina, Consultant Urologist, NHS Lothian
Dr Phyllis Windsor, Consultant Clinical Oncologist, NHS Tayside
Prostate Cancer QPI Development Group Subgroup Lead Clinicians

NOTES FOR IMPLEMENTATION OF CHANGES

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

Changes to definitions fall into the following categories:

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

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

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

Please contact: NSS.ISDCANCERAUDIT@NHS.NET.

CONVENTIONS

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

Common Name(s):

Main Source of Data Item Standard:

Definition:

Field Name:

Field Type:

Field Length:

Notes for Users:

Codes and Values:

Related Data Item(s):

Notes by Users:

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

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

Revisions to Dataset Following Change Outwith Review (July 2015)

Prostate Specimen Tumour Type - remove the following tumour types from explanatory notes under 'code 98': Adenosquamous, Basaloid, Adenoid Cystic, Neuroendocrine, Transitional cell
Location of Diagnosis – add 'X9999=Not recorded'

Revisions to Dataset Following Baseline Review

HORMDATE

It was agreed at the Baseline Review that immediate therapy would be within 31 days of the patient being discussed at MDT meeting not 14 days.

OPCODE1 & OPCODE2 remove the word 'Bilateral' from table of codes and values

Database Specification: Change 'OPCODE' to 'OPCODE1'. Add 'OPCODE2'

Definitive Operative Procedure {Prostate Cancer} data item:

Change 'OPCODE' to 'OPCODE1'

Add 'OPCODE2'

Remove Note for Users: 'If an operation to relieve symptoms and a further operation which aims to remove the tumour is performed the second operation is the one that should be coded in this field.'

'If any operation is not listed then please contact ISD Scotland as described elsewhere so that standard codes can be allocated throughout Scotland.'

'Coding instructions and a full list of codes are included in the OPCS4 manual. If operation is not listed below, please contact ISD to obtain coding details before entering details to the local database.

e.g.

M02.1 = Nephrectomy and excision of perirenal tissue

M61.1 = Total excision of prostate and capsule of prostate

N06.3 = Orchidectomy nec

T87.7 = Excision or biopsy of inguinal lymph node.'

Add Note for Users 'OPCODE 2 for lymphadenectomy. For example a patient undergoing a laparoscopic radical prostatectomy with lymphadenectomy would be coded as follows:

OPCODE1 = M61.1, OPCODE2 = T87.8 and SURGAPPR = 2A'

In the table of codes and values:

Remove code M61.4 Perineal prostatectomy (added at 9-month review)

Remove code M61.2 Retropubic prostatectomy

Remove code M61.8 Other specified open excision of prostate

Remove code N05.1 Bilateral subcapsular orchidectomy

Remove code N05.2 Bilateral orchidectomy NEC

Remove code N06.3 Orchidectomy

Add code T87.8 Other specified lymphadenectomy (with explanatory text Bilateral pelvic lymphadenectomy)

Add explanatory text 'Radical prostatectomy' to code M61.1 Total excision of prostate and capsule of prostate

Revisions to Dataset Following Change Outwith Review

Adipose Tissue Invasion Seen

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Addition of 'extraprostatic extension' to notes for users - made at the request of the Scottish Urology Pathology Group.

Date of Definitive Treatment

Additional data item.

Gleason Total Score (Needle Biopsy)

Notes for Users: Additional note - The purpose of the guidance to record this data item as 'Not recorded' is to measure when it has been omitted on the Scottish Prostate Needle Biopsy Dataset (as required by QPI 3).

TNM Nodal Classification (Pathological) (Prostate)

Notes for Users: Deletion of note - Metastasis no larger than 0.2 cm can be designated pN1mi.

DATABASE SPECIFICATION

Additional data item – Date of Definitive Treatment

Revisions to Dataset Following 9-Month Review

The following changes have been made following the review of Prostate Cancer Data Definitions for the National Minimum Core Data Set. Changes to take effect for patients diagnosed from 01/07/2014.

Criteria For Inclusion of Patients in Audit:

Inclusion criteria removed:

- *'All patients who have received any part of their diagnosis / treatment within the NHS even if part of their treatment was carried out privately or outwith Scotland.'*
- *'All patients aged 16 years and over'*

Exclusion criteria added:

- 'Patients with metastatic prostatic disease from another primary cancer site'
- 'Patients with tumour type sarcoma or lymphoma'
- 'Patients with carcinoma in situ or prostatic intraepithelial neoplasia'
- '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'
- 'Patients with normal residence outwith Scotland'
- 'Patients whose definitive cancer treatment was privately funded or undertaken outwith NHS Scotland'

Exclusion criteria removed:

- 'Patients with prostate sarcomas'
- 'Death Certificate Only (DCO) cases'
- 'All patients under 16 years of age'
- 'Carcinoma in-situ'
- 'Prostatic Intraepithelial Neoplasia (PIN)'

New Data Items Added:

Page 'Primary Gleason Grade (Pathology)'

Page 'Secondary Gleason Grade (Pathology)'

Page 'Tertiary Gleason Grade (Pathology)'

Page 'Gleason Total Score (Pathology)'

Data Items Removed:

None

Other minor changes include:

Database Specification:

'Primary Gleason Grade' renamed 'Primary Gleason Grade (Needle Biopsy)'

'Secondary Gleason Grade' renamed 'Secondary Gleason Grade (Needle Biopsy)'

'Gleason Total Score' renamed 'Gleason Total Score (Needle Biopsy)'

Primary Gleason Grade (Pathology) data item added: Field Name: MAJGGRADEPATH,
Field Type: Integer, Field Length: 2.

Secondary Gleason Grade (Pathology) data item added: Field Name: MINGGRADEPATH,
Field Type: Integer, Field Length: 2.

Tertiary Gleason Grade (Pathology) data item added: Field Name: TERTGRADEPATH,
Field Type: Integer, Field Length: 2.

Gleason Total Score (Pathology) data item added: Field Name: GTOTALPATH, Field Type:
Integer, Field Length: 2.

Dataset:

Imaging Investigations Complete:

- i. 'Notes for users' updated to reflect changes to QPI numbering.
- ii. Added note to 'Notes for users' to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.
- iii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

Prostate Specific Antigen at Diagnosis:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended note within 'Notes for users' to state that '1010101.0' is 'not applicable'.

Type of Specimen for Histological Diagnosis:

- i. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

TNM Tumour Classification (Clinical) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Added to notes for users: 'Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.'
- iii. Added to notes for users: 'In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.'

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- iv. Added to notes for users: 'If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.
- v. Added note to 'Notes for users' to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.
- vi. Added new code '96: Not applicable' to table of codes and values.
- vii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

TNM Nodal Classification (Clinical) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Added to notes for users: 'Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.'
- iii. Added to notes for users: 'In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.'
- iv. Added to notes for users: 'If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.
- v. Added note to 'Notes for users' to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.
- vi. Added new code '96: Not applicable' to table of codes and values.
- vii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

TNM Metastasis Classification (Clinical) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Added to notes for users: 'Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.'
- iii. Added to notes for users: 'In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.'
- iv. Added to notes for users: 'If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.
- v. Added note to 'Notes for users' to state that pre-treatment and staging investigations can be considered complete if carried out within 6 weeks of hormone therapy starting.
- vi. Added new code '96: Not applicable' to table of codes and values.
- vii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

Date First Discussed by Care Team (MDT)

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'notes for users': 'inapplicable 10/10/1010' is now 'Not applicable 10/10/1010'.

Most Valid Basis of Diagnosis:

- i. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

Type of First Cancer Treatment:

- i. Updated QPI references in notes for users to reflect new QPI number specification.

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- ii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

Date of First Cancer Treatment:

- i. Updated QPI references in notes for users to reflect new QPI number specification.

Location Code {Cancer Surgery}:

- i. Amended notes for users: 'Inapplicable, X1010' to 'Not applicable, X1010'.
- ii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.

Definitive Operative Procedure {Prostate Cancer}:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended notes for users: 'Inapplicable, 96' to 'Not applicable, 96'.
- iii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.
- iv. Added new code 'M34.1: Cystoprostatectomy' to table of codes and values.
- v. Added new code 'M61.1: Total excision of prostate and capsule of prostate' to table of codes and values.
- vi. Added new code 'M61.4: Perineal prostatectomy' to table of codes and values.
- vii. Removed code 'M61.3: Transvesical prostatectomy' from table of codes and values as this is not a radical treatment for cancer.
- viii. Corrected code 'M61.8: Other specified open excision of prostate'.
- ix. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.
- x. Amended code '96: Inapplicable' to '96: Not applicable', in table of codes and values.

Type of Surgery:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.
- iii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Surgical Procedure Approach:

- i. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
ii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.
iii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Date of Definitive Surgery:

- i. Amended notes for users: '10/10/1010 (Inapplicable) to '10/10/1010 (Not applicable)'.
ii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.

Operating Consultant Surgeon (1-2)

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended notes for users: 'Inapplicable (1010)' to 'Not applicable (1010)'
iii. Removed 'Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI' from notes for users.

Prostate Specimen Tumour Type:

- i. Removed code '3: High Grade Prostatic Intraepithelial Neoplasia' from table of codes and values.
ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Total Percentage of Tumour Involvement in Needle Core:

- i. Amended notes for users: '999 Not known' to '999 Not recorded'.

Greatest Percentage of Tumour Involvement in Needle Core:

- i. Amended notes for users: '999 Not known' to '999 Not recorded'.

Adipose Tissue Invasion Seen:

- i. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Perineural Invasion Seen:

- i. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Primary Gleason Grade (Biopsy):

- i. Data item renamed from 'Primary Gleason Grade' to 'Primary Gleason Grade (Biopsy)'.
- ii. Amended definition to clarify that this data item is for needle biopsy specimens.
- iii. Removed 'For all radical prostatectomy specimens, record the most prevalent pattern for each tumour.' from notes for users.
- iv. Updated 'Related Data Items' to reflect changes made elsewhere in dataset.

Secondary Gleason Grade:

- i. Data item renamed from 'Secondary Gleason Grade' to 'Secondary Gleason Grade (Needle Biopsy)'.
- ii. Amended definition to clarify that this data item is for needle biopsy specimens.
- v. Removed 'There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded.' from notes for users.
- vi. Updated 'Related Data Items' to reflect changes made elsewhere in dataset.

Gleason Total Score:

- i. Data item renamed from 'Gleason Total Score' to 'Gleason Total Score (Needle Biopsy)'.
- ii. Amended definition to clarify that this data item is for needle biopsy specimens.
- iii. Amended notes for users 'Not known (99)' to 'Not recorded (99)'.
- iv. Amended notes for users: 'If there is a tertiary grade (of higher Gleason score than the primary or secondary grade), the total Gleason score is derived from the sum of the primary (major) and tertiary Gleason grades.'
- v. Removed 'Exceptions for Radical Prostatectomies: Gleason score by prevalence and the presence of a tertiary grade' from notes for users.
- vi. Updated 'Related Data Items' to reflect changes made elsewhere in dataset.

Primary Gleason Grade (Pathology):

- i. New data item.

Secondary Gleason Grade (Pathology):

- i. New data item.

Tertiary Gleason Grade (Pathology):

- i. New data item.

Gleason Total Score (Pathology):

- i. New data item.

TNM Tumour Classification (Pathological) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
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- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

TNM Nodal Classification (Pathological) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

TNM Metastasis Classification (Pathological) (Prostate):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Margin Status (Prostatectomy):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

External Beam Radiotherapy Course Type:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Date Treatment Started (External Beam Radiotherapy):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended notes for users: 'Inapplicable (10/10/1010)' to 'Not applicable (10/10/1010)'.

Date Treatment Completed (External Beam Radiotherapy):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended notes for users: 'Inapplicable (10/10/1010)' to 'Not applicable (10/10/1010)'.

Date Treatment Started (Brachytherapy):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended notes for users: 'Inapplicable (10/10/1010)' to 'Not applicable (10/10/1010)'.

Type of Hormone Therapy

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended notes for users: 'Inapplicable (96)' to 'Not applicable (96)'.
- iv. Amended code '96: Inapplicable' to '99: Not applicable' in table of codes and values.

Date Treatment Started (Hormone Therapy):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to remove reference to 'National Clinical Dataset Development Programme (NCDDP)'.
Clinical Dataset Development Programme (NCDDP).
- iii. Amended notes for users: 'Inapplicable (10/10/1010)' to 'Not applicable (10/10/1010)'.

Hormonal Therapy Agent {Prostate Cancer}:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Added to notes for users: 'If more than one hormone therapy agent is administered, record the main agent'.
- iii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Patient Entered into Clinical Trial {Prostate Cancer}:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Post-Surgical Continence at One Year:

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Radiotherapy Post-Treatment Related Morbidity (Urinary):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to correct reference to RTOG scoring schema.
- iii. Amended definition to clarify that this data item relates only to urinary morbidity directly attributable to radiation therapy.
- iv. Amended notes for users: 'Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).'
- v. Amended notes for users: 'Details on the criteria for each grade can be found at the RTOG website:
<http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx>'
- vi. Amended references to RTOG website in table of codes and values.
- vii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Radiotherapy Post-Treatment Related Morbidity (Bowel):

- i. Updated QPI references in notes for users to reflect new QPI number specification.
- ii. Amended 'Main Source of Data Item Standard' to correct reference to RTOG scoring schema.
- iii. Amended definition to clarify that this data item relates only to bowel morbidity directly attributable to radiation therapy.
- iv. Amended notes for users: 'Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).'
- v. Amended notes for users: 'Details on the criteria for each grade can be found at the RTOG website:
<http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEORTCLateRadiationMorbidityScoringSchema.aspx>'
- vi. Amended references to RTOG website in table of codes and values.
- vii. Amended code '99: Not known' to '99: Not recorded' in table of codes and values.

Date of Death:

- i. Amended notes for users: 'Inapplicable (10/10/1010)' to 'Not applicable (10/10/1010)'.

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 invasive adenocarcinoma of the prostate (International Classification of Diseases, Tenth Revision [ICD 10] code C61).
 - This includes patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

Exclude

- Patients with metastatic prostatic disease from another primary cancer site.
- Patients where the origin of the primary is uncertain.
- Patients with tumour type sarcoma or lymphoma.
- Patients with recurrent disease (as opposed to a new primary).
- Patients with carcinoma in situ or prostatic intraepithelial neoplasia.
- 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

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Person Given Name	PATFNAME	Characters	35	3
Patient Postcode at Diagnosis {Cancer}	PATPCODE	Characters	8	4
Date of Birth	DOB	Date	10	5
CHI Number	CHINUM	Integer	10	6
Section 2: Pre-treatment Imaging & Staging Investigations				7
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Prostate Specific Antigen at Diagnosis {Prostate Cancer}	PSA	Numeric	9	9
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<i>Type of Specimen for Histological Diagnosis {Prostate Cancer} – Other, Specify</i>	<i>SPECTYPE98</i>	<i>Characters</i>	<i>150</i>	<i>10</i>
TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)	cT	Characters	3	11
TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)	cN	Characters	2	13
TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)	cM	Characters	3	14
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Section 1: Demographic Items

Person Family Name (at Diagnosis)

Common Name(s): Surname, Family name

Main Source of Data Item Standard: Government Data Standards Catalogue

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

Field Name: PATSNAME

Field Type: Characters

Field Length: 35

Notes for Users:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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

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

From SMR Definitions and Codes

Notes by Users:

Person Given Name

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

Main Source of Data Item Standard: 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:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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

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

Notes by Users:

Patient Postcode at Diagnosis {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:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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

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

Related Data Item(s):

Date of Diagnosis

Notes by Users:

Date of Birth

Main Source of Data Item Standard: Government Data Standards Catalogue

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

Field Name: DOB

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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

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

Related Data Item(s):

CHI Number

Notes by Users:

CHI Number

Main Source of Data Item Standard: 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:

Required, in association with other demographic items, in order to locate patient records and as a means of linking to other patient level data sources, such as inpatient records and death information.

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

From Designed to Care - Scottish Office

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

(ISD, Information Services, NHS National Services Scotland)

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

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

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

Related Data Item(s):

Date of Birth

Notes by Users:

Section 2: Pre-treatment Imaging & Staging Investigations

Imaging Investigations Complete

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

Definition: An indicator of whether or not imaging investigations were completed by Magnetic Resonance Imaging (MRI) and isotope bone scan, or whole body MRI.

Field Name: IMAGE

Field Type: Characters

Field Length: 2

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

Pre-treatment imaging and staging investigations are considered complete if carried out within 6 weeks of hormone therapy being started.

Codes and Values:

Code	Value	Explanatory Notes
1	Complete MRI and Isotope Bone Scan or Whole Body MRI	
2	Incomplete – Reason not Documented	
2A	Incomplete - Contraindicated	Generally acknowledged clinical contraindication to performing assessment exists. e.g. Pacemaker or other MRI incompatible implanted device, Cerebral aneurysm clip, Metal in eye, claustrophobia, Unable to fit bore of scanner, Too heavy for MRI table.
2B	Incomplete - Bone Scan Only	
2C	Incomplete – MRI of Prostate only	
95	Patient declined	Patient chose not to have assessment
96	Not applicable	e.g. Low risk patients
99	Not recorded	Includes not known

Notes by Users:

Prostate Specific Antigen at Diagnosis {Prostate Cancer}

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

Definition: This denotes the levels of prostate specific antigen (PSA) as detected by a biochemical test.

Field Name: PSA

Field Type: Float (nnnnnnn.n)

Field Length: 9

Notes for Users: Required for QPI(s) 2, 10

The level of PSA as measured on the date of diagnosis or at the time diagnostic procedures were undertaken. If there are multiple PSA results available at the time of diagnosis, record the result closest prior to the date of diagnosis.

PSA is a protein produced by the prostate and a small amount is normally found in the blood. Men with cancer of the prostate tend to have more PSA in the blood. This test is not always reliable as PSA levels also increase as men get older and due to other conditions of the prostate such as infection or Benign Prostatic Hyperplasia (BPH). Recent prostate biopsies, prostate or bladder surgery and prostatic massage can also raise the level of PSA.

Normal levels of PSA are less than 3-4 nanogrammes per millilitre of blood depending on age. Levels between 4-10 suggest a possibility of prostate cancer and a biopsy may be recommended. Levels of 10 and above should be investigated.

Once the cancer has been treated the level of PSA will fall. For this reason, measuring PSA levels can be a helpful way of assessing the progress of the disease and the effectiveness of treatment.

PSA levels should be recorded in µg/l. If the actual level is 'not recorded' state as 9999999.9 (not recorded) or no measurement is made record as 1010101.0 (Not applicable).

This field is also required to determine the risk level i.e.

Value	Explanatory Notes
Low Risk	Clinical Stage T1-T2a and Gleason Score ≤ 6 and PSA at diagnosis <10ng/ml
Intermediate Risk	Clinical Stage T2b or T2c or Gleason Score 7 or PSA at diagnosis 10-20 ng/ml
High Risk	Clinical Stage T3-T4 or Gleason Score 8-10 or PSA at diagnosis >20ng/ml

Related Data Item(s):

Date of Diagnosis

Notes by Users:

Type of Specimen for Histological Diagnosis (Prostate Cancer)

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

Definition: The type of specimen submitted for histological diagnosis.

Field Name: SPECTYPE

Field Type: Integer

Field length: 2

Notes for Users: Required for QPI(s): 1, 3.

In the case of multiple specimens, it is the specimen where cancer is first diagnosed that should be recorded.

Users should augment code '98 – Other (specify)' with a free text field for recording other values of this item.

Codes and Values:

Code	Value	Explanatory Notes
1	Transrectal Ultrasound Guided Biopsy	TRUS
2	Transurethral Resection of Prostate.	TURP
96	Not applicable	
98	Other, specify	
99	Not recorded	

Related Data Item(s):

Number of Needle Cores Received (Right-Left)

Notes by Users:

TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)

Common name: Clinical TNM Tumour Classification (Cancer of the Prostate).

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

Definition: A record of the size and extent of the tumour of the prostate as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, 2002).

Field Name: cT

Field Type: Characters

Field length: 3

Notes for Users: Required for QPI(s): 2, 7, 10

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 'Not recorded'.

Codes and Values:

Code	Explanatory Notes
T0	No evidence of primary tumour.
T1	Clinically inapparent tumour not palpable or visible by imaging.
T1a	Tumour incidental histological finding in 5% or less of tissue resected.
T1b	Tumour incidental histological finding in more than 5% of tissue resected.
T1c	Tumour identified by needle biopsy (e.g., because of elevated PSA).
T2	Tumour confined within prostate.
T2a	Tumour involves one half of one lobe or less.
T2b	Tumour involves more than half of one lobe, but not both lobes.
T2c	Tumour involves both lobes.
T3	Tumour extends through the prostatic capsule.
T3a	Extra capsular extension (unilateral or bilateral).
T3b	Tumour invades seminal vesicle(s).
T4	Tumour is fixed or invades adjacent structures other than seminal vesicles: bladder neck, external sphincter, rectum, levator muscles, or pelvic wall.
TX	Primary tumour cannot be assessed.
96	Not applicable.
99	Not recorded.

This field is also required to determine the risk level i.e.

Value	Explanatory Notes
Low Risk	Clinical Stage T1-T2a and Gleason Score \leq 6 and PSA at diagnosis $<$ 10ng/ml
Intermediate Risk	Clinical Stage T2b or T2c or Gleason Score 7 or PSA at diagnosis 10-20 ng/ml
High Risk	Clinical Stage T3-T4 or Gleason Score 8-10 or PSA at diagnosis $>$ 20ng/ml

Related Data Item(s):

TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)

TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)

TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)

Common name: Clinical TNM Nodal Classification (Cancer of the Prostate).

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

Definition: A record of the extent of regional lymph node of the prostate metastasis as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, 2002).

Field Name: cN

Field Type: Characters

Field length: 2

Notes for Users: Required for QPI(s): 2, 7, 10.

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 'Not recorded'.

Codes and Values:

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

Related Data Item(s):

TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)

TNM Metastasis Classification (Clinical) (Prostate) (Pre-treatment)

Notes by Users:

TNM Metastasis Classification (Clinical) (Prostate) Pre-treatment

Common name: Clinical TNM Metastases Classification (Cancer of the Prostate).

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

Definition: A record of the extent of metastatic spread of the tumour of the prostate as determined by pre-treatment investigations (not pathological), coded according to the official TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, 2002).

Field Name: cM

Field Type: Characters

Field length: 3

Notes for Users: Required for QPI(s): 2, 7, 10.

This is a pre/non-operative classification as defined by the Multidisciplinary Team Meeting (MDT), based on best knowledge. This may be at any MDT meeting up until first treatment.

Clinical TNM is derived from all clinical, radiological, and biochemical results prior to treatment, including clinical examination and imaging. N.B. Pathological classification for this data item refers to those made from biopsies only.

In cases where there are multiple tumours, the tumour with the worst prognosis should be used for TNM classification. If in doubt, check with pathology.

If stage is unable to be definitively determined from information in case notes/clinical systems, do not deduce from other information and record as 'not recorded'.

If the patient started hormone therapy within 6 weeks prior to clinical staging, clinical stage can be recorded. If the patient commenced hormone therapy more than 6 weeks prior to clinical staging, record as 99 'Not recorded'.

Codes and Values:

Code	Value
M0	No distant metastasis.
M1	Distant metastasis.
M1a	Non-regional lymph node(s).
M1b	Bone(s).
M1c	Other site(s).
MX	Distant metastasis cannot be assessed.
96	Not applicable.
99	Not recorded

Related Data Item(s):

TNM Tumour Classification (Clinical) (Prostate) (Pre-treatment)

TNM Nodal Classification (Clinical) (Prostate) (Pre-treatment)

Notes by Users:

Date First Discussed by Care Team (MDT)

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

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

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

Field Name: MDTDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI: 4?, 7

The first MDT meeting date will be recorded.

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.

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

Notes by Users:

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.

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.

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

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

A111H=Crosshouse Hospital

G107H=Glasgow Royal Infirmary

X9999=Not recorded

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

Related Data Item(s):

Date of Diagnosis

Notes by Users:

Date of Diagnosis

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

Definition: The date of diagnosis is the date on which there was first confirmation of the diagnosis of prostate cancer whether by histology, cytology or clinical (including radiological) methods.

Field Name: DIAGDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required to define patient cohorts for local QPI, and national survival, analysis.

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

If multiple histological or cytological findings have been carried out, the date of the first procedure that confirmed a positive diagnosis of prostate cancer is taken.

If no histological or cytological procedures were undertaken, the date of diagnosis will be the date of any imaging procedure performed that confirmed a diagnosis of prostate cancer; otherwise the date will be based on clinical findings and will be the first date upon which the clinician concludes a diagnosis of prostate cancer.

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

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:

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 are listed in essentially ascending order of validity, microscopic methods having greater validity than non-microscopic methods.

NB: With the emergence of molecular markers etc., there are plans to review the definition of this variable in the context of updating the IARC monograph, Cancer Registration Principles and Methods.

Codes and Values:

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

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 modality administered to a patient.

Field Name: FIRS TTREATMODE

Field Type: Integer

Field length: 2

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

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.

NB: Transurethral Resection of Prostate (TURP) is not a legitimate first treatment for cancer of the prostate. If no further treatment is given following TURP, then record as supportive care only.

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.

Radiotherapy includes Teletherapy (external beam radiotherapy) and brachytherapy.

Steroids etc should not be recorded as first treatment if more substantive treatment such as chemotherapy or surgery is given. If no further treatment is given, then record as supportive care only.

Codes and Values:

Code	Description	Explanatory notes
1	Surgery	
2	Radiotherapy	
6	Hormone Therapy	
7	Supportive Care Only	Not for active treatment
95	Patient refused all therapies	
12	Active Surveillance	Intense follow-up including repeat clinic visits, tests and biopsies after an interval until the disease progresses or the grade of the tumour changes.
15	Watchful Waiting	When patients with advanced or metastatic prostate cancer (not suitable for radical therapy) are not started on immediate androgen deprivation therapy, then the treatment is reserved until the time when the patient develops symptomatic progression. This is the traditional "watch and wait" situation.
14	Patient died before treatment	
99	Not recorded	

Related Data Item(s): Date of First Cancer 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: FIRS TTREATDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

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

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(s): Type of First Cancer Treatment

Notes by Users:

Date of Definitive Treatment {Prostate 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 prostate cancer definitive treatment will be either:

- Surgery;
- Radiotherapy;
- Primary Hormone Therapy; or
- Brachytherapy.

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.

If an operation to relieve symptoms and a further operation which aims to remove the tumour is performed the date of the second operation is the one that should be coded in this field.

For patients undergoing no active treatment (e.g. active surveillance, watchful waiting or 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:

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

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

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

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

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

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

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

Examples of codes are given below:

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

Related Data Item(s):

Date of Definitive Surgery

Notes by Users:

Definitive Operative Procedure {Prostate 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 surgical procedure(s) performed for treatment of cancer.

Field Name: OPCODE1
 OPCODE2

Field Type: Characters

Field Length: 5

Notes for Users: OPCODE1 Required for QPI(s): 5, 8.

The field OPCODE2 has been added to allow the recording of concurrent lymphadenectomy. For example a patient undergoing a laparoscopic radical prostatectomy with lymphadenectomy would be coded as follows:

OPCODE1 = M61.1

OPCODE2 = T87.8

SURGAPPR = 2A

Operation is coded to the 4-digit code according to the Fourth Revision of the OPCS Classification of Surgical Operations (OPCS4). Centres using READ codes may continue provided the codes can be mapped to OPCS.

If the patient refused treatment code as '95' or did not undergo surgery for other reasons code as Not applicable '96'.

Codes and Values:

OPCS4 Code	Description	Explanatory Note
M34.1	Cystoprostatectomy	
M61.1	Total excision of prostate and capsule of prostate.	Radical prostatectomy
T87.8	Other specified lymphadenectomy	Pelvic lymphadenectomy
95	Patient refused surgery	
96	Not applicable	
99	Not recorded	

Related Data Item(s):

Date of Definitive Surgery

Surgical Procedure Approach

Notes by Users:

Type of Surgery

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

Definition: The type of operative procedure performed.

Field Name: TYPESURG

Field Type: Integer

Field Length: 2

Notes for Users: Required for QPI(s): 5, 6, 8

Codes and Values

Code	Value	Explanatory Notes
1	Radical Surgery	Surgery to remove entire prostate.
2	Conservative Surgery	e.g. nerve sparing.
3	Salvage Surgery	Surgery performed if the cancer has not responded to other treatments.
96	Not applicable	e.g. surgery not performed
99	Not recorded	

Related Data Item(s):

Definitive Operative Procedure {Prostate Cancer}

Date of Definitive Surgery

Surgical Procedure Approach

Notes by Users:

Surgical Procedure Approach

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

Definition: The approach of surgical procedure(s) performed for treatment of cancer.

Field Name: SURGAPPR

Field Type: Characters

Field Length: 2

Notes for Users:

If the patient's first treatment was 'active surveillance', then subsequently proceeds to active treatment at a later date, record if surgery occurs within six months of diagnosis.

Codes and Values:

Code	Value	Explanatory Notes
1	Open	
2A	Laparoscopic - Completed	
2B	Laparoscopic - Converted	
3	Perineal	
4	Robotic	
96	Not applicable	e.g. Surgery not performed.
99	Not recorded	

Related Data Item(s):

Definitive Operative Procedure {Prostate Cancer}

Date of Definitive Surgery

Notes by Users:

Date of Definitive Surgery

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

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

Field Name: SURGDATE

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for QPI(s): 1, 3

The date format should be DDMMCCYY.

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

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

Related Data Item(s):

Definitive Operative Procedure {Prostate Cancer}

Notes by Users:

Operating Consultant Surgeon (1-2)

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

Definition: The 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): 6

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 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}

Definitive Operative Procedure

Date of Definitive Surgery

Notes by Users:

Section 4: Pathology Details

Number of Needle Cores Received (Right-Left)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The number of needle cores received by the pathologist.

Field Name: NUMCORESRECR
NUMCORESRECL

Field Type: Integer (nn)

Field Length: 2

Notes for Users: Required for QPI(s): 1, 3

If the number of needle cores received is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Related Data Items:

Type of Specimen for Histological Diagnosis {Prostate Cancer}

Notes by Users:

Transurethral Resection of Prostate (TURP) Weight

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

Common Name: Weight of Specimen

Definition: A record of the weight of the TURP specimen in grams.

Field Name: TURPWT

Field Type: Numeric float (nnnn.dd)

Field Length: 7

Notes for Users: Required for QPI: 3

The weight of the specimen will be described in the pathology report and should be recorded in grams.

If the TURP weight is not recorded on the pathology report, record as 9999.99.

If there is no histological diagnosis, or TURP has not been performed prior to surgery, record as 1010.10, not applicable.

Notes by Users:

Prostate Specimen Tumour Type

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The type of tumour present in the specimen

Field Name: TUMTYPE

Field Type: Integer

Field Length: 2

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

Users may wish to augment code '98 – Other, specify' with a free text field for recording this item.

If the tumour type is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Codes and Values:

Codes	Value	Explanatory Notes
1	None	
2	Microacinar	Adenocarcinoma
96	Not applicable	
98	Other (specify)	Users should augment this code with a free text field, e.g. Prostatic duct, Mucinous, Signet Ring, , etc.
99	Not recorded	

Notes by Users:

Number of Needle Cores Involved (Right-Left)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The number of needle cores received by the pathologist.

Field Name: NUMCORESINVR
NUMCORESINVL

Field Type: Integer (nn)

Field Length: 2

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

If the number of needle cores involved is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Related Data Items:

Type of Specimen for Histological Diagnosis {Prostate Cancer}

Number of Needle Cores Received (Right-Left)

Notes by Users:

Total Percentage of Tumour Involvement in Needle Core

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: A record of the overall percentage of needle cores involved with tumour. (total cancer length/total core lengths)

Field Name: TOTPERCINV

Field Type: Integer (nnn).

Field Length: 3

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

The total cancer length expressed as a percentage of the total lengths of the needle cores.

If the total percentage of tumour involvement is not recorded on the pathology report, record as 999.

If the pathologist has recorded only the greatest percentage of tumour involvement, record this field as '999' Not recorded.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 966, not applicable.

Notes by Users:

Greatest Percentage of Tumour Involvement in Needle Core

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: A record of the percentage of tumour in the core most involved by cancer.

Field Name: GRTPERCINV

Field Type: Integer (nnn).

Field Length: 3

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

The core with the highest percentage involvement by cancer as determined by the total length of cancer relative to the total length of that core.

If the greatest percentage of tumour involvement is not recorded on the pathology report, record as 999.

If the pathologist has recorded only the total percentage of tumour involvement, record this field as '999' Not recorded.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 966, not applicable.

Notes by Users:

Adipose Tissue Invasion Seen

Definition: An indication of whether or not adipose tissue invasion was seen in the specimen.

Field Name: ADIPOSE

Field Type: Integer

Field Length: 2

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

If invasion of adipose tissue (or extraprostatic extension) is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Codes and Values:

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

Notes by Users:

Perineural Invasion Seen

Definition: An indication of whether or not perineural invasion was seen in the specimen.

Field Name: PERINEURAL

Field Type: Integer

Field Length: 2

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

If perineural invasion is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, or needle core biopsies have not been performed prior to surgery, record as 96, not applicable.

Codes and Values:

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

Notes by Users:

Primary Gleason Grade (Needle Biopsy)

Common Name: Major Gleason

Main Source of Data Item Standard: ISUP Consensus Conference 2005. American Journal of Surgical Pathology. 2005(29:9) 1228.

Definition: The predominant histological pattern of disease in a needle biopsy specimen, based on low power visualisation of prostatic tissue.

Field Name: MAJGGRADE

Field Type: Integer (nn).

Field length: 2

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

For needle biopsies Gleason scores of 1 or 2 should not be recorded.

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If the major Gleason grade is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, record as 96, not applicable.

Related Data Item(s):

Secondary Gleason Grade (Needle Biopsy)

Gleason Total Score (Needle Biopsy)

Notes by Users:

Secondary Gleason Grade (Needle Biopsy)

Common Name: Minor Gleason

Main Source of Data Item Standard: ISUP Consensus Conference 2005. American Journal of Surgical Pathology. 2005(29:9) 1228.

Definition: The next most common histological pattern of disease in a needle biopsy specimen after the Major Gleason Grade, based on low power visualisation of prostatic tissue.

Field Name: MINGGRADE

Field Type: Integer (nn)

Field Length: 2

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

For needle biopsies Gleason scores of 1 or 2 should not be recorded.

- 1) The highest Gleason score in a core biopsy should always be reported.
- 2) A second tumour grade, no matter its extent should always be reported.

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If the minor Gleason grade is not recorded on the pathology report, record as 99.

If there is no histological diagnosis, record as 96, not applicable

Related Data Item(s):

Primary Gleason Grade (Needle Biopsy)

Gleason Total Score (Needle Biopsy)

Notes by Users:

Gleason Total Score (Needle Biopsy)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The sum of the “Major” and “Minor” Gleason grades in a needle biopsy specimen. See Notes for Users.

Field Name: GTOTAL

Field Type: Integer (nn).

Field length: 2

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

Gleason Grade should be recorded at biopsy as it is required to assess risk category.

If there is no histological diagnosis, record as ‘Not applicable’ (96).

If the Gleason score is not recorded on the pathology report, record as ‘Not recorded’ (99). The purpose of the guidance to record this data item as ‘Not recorded’ is to measure when it has been omitted on the Scottish Prostate Needle Biopsy Dataset (as required by QPI 3).

Exceptions:

If there is a tertiary grade (of higher Gleason score than the primary or secondary grade), the total Gleason score is derived from the sum of primary (major) and tertiary Gleason grades.

This field is also required to determine the risk level i.e.

Value	Explanatory Notes
Low Risk	Clinical Stage T1 – T2a and Gleason score \leq 6 and PSA at diagnosis $<$ 10 ng/ml
Intermediate Risk	Clinical Stage T2b or T2c or Gleason score 7 or PSA at diagnosis 10-20 ng/ml
High Risk	Clinical Stage T3 – T4 or Gleason score 8-10 or PSA at diagnosis $>$ 20 ng/ml

Related Data Item(s):

Primary Gleason Grade (Needle Biopsy)

Secondary Gleason Grade (Needle Biopsy)

Notes by Users:

Primary Gleason Grade (Pathology)

Common Name: Major Gleason

Main Source of Data Item Standard: ISUP Consensus Conference 2005. American Journal of Surgical Pathology. 2005(29:9) 1228.

Definition: The predominant histological pattern of disease in a surgical specimen, based on low power visualisation of prostatic tissue.

Field Name: MAJGGRADEPATH

Field Type: Integer (nn).

Field length: 2

Notes for Users:

For all radical prostatectomy specimens record the most prevalent pattern for each tumour.

There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded.

If the primary (major) Gleason grade is not recorded on the pathology report, record as 99.

If the patient has not undergone a radical prostatectomy, record as 96, not applicable.

Related Data Item(s):

Secondary Gleason Grade (Pathology)

Tertiary Gleason Grade (Pathology)

Gleason Total Score (Pathology)

Notes by Users:

Secondary Gleason Grade (Pathology)

Common Name: Minor Gleason

Main Source of Data Item Standard: ISUP Consensus Conference 2005. American Journal of Surgical Pathology. 2005(29:9) 1228.

Definition: The next most common histological pattern of disease in a surgical specimen after the Major Gleason Grade, based on low power visualisation of prostatic tissue.

Field Name: MINGGRADEPATH

Field Type: Integer (nn)

Field Length: 2

Notes for Users:

For all radical prostatectomy specimens record the most prevalent pattern for each tumour.

There is no consensus for radical prostatectomy regarding the amount of tumour of minor grade that needs to be present before it is recorded.

If the secondary (minor) Gleason grade from a radical prostatectomy is not recorded on the pathology report, record as 99.

If the patient has not undergone a radical prostatectomy, record as 96, not applicable.

Related Data Item(s):

Primary Gleason Grade (Pathology)

Tertiary Gleason Grade (Pathology)

Gleason Total Score (Pathology)

Notes by Users:

Tertiary Gleason Grade (Pathology)

Main Source of Data Item Standard: ISUP Consensus Conference 2005. American Journal of Surgical Pathology. 2005(29:9) 1228.

Definition: The score of any area of a radical prostatectomy specimen with a higher Gleason grade than either the primary or secondary grade, based on low power visualisation of prostatic tissue.

Field Name: TERTGGRADEPATH

Field Type: Integer (nn)

Field Length: 2

Notes for Users:

The tertiary Gleason score as recorded from a radical prostatectomy on the pathology report, where any area of the specimen contains a third, higher Gleason grade histological pattern of disease than either the primary or secondary grade.

If the tertiary Gleason grade is not recorded on the pathology report, record as 99, not recorded.

If there was no surgical specimen, record as 96, not applicable

Related Data Item(s):

Primary Gleason Grade (Pathology)

Secondary Gleason Grade (Pathology)

Gleason Total Score (Pathology)

Notes by Users:

Gleason Total Score (Pathology)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The sum of the “Major” and “Minor” Gleason grades in a radical prostatectomy specimen. See Notes for Users.

Field Name: GTOTALPATH

Field Type: Integer (nn).

Field length: 2

Notes for Users:

Gleason Total Score in radical prostatectomy specimens should be based on the primary and secondary patterns, with a note on any tertiary (higher grade) pattern present.

If the Gleason grade from a radical prostatectomy specimen is not recorded on the pathology report, record as 99.

If there was no surgical specimen, record as 96, not applicable

Related Data Item(s):

Primary Gleason Grade (Pathology)

Secondary Gleason Grade (Pathology)

Tertiary Gleason Grade (Pathology)

Notes by Users:

TNM Tumour Classification (Pathological) (Prostate)

Common name: Pathological TNM Tumour stage (Prostate)

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

Definition: A record of the size and extent of the tumour of the prostate following resection of the primary cancer.

Field Name: pT

Field Type: Characters

Field length: 4

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

This classification applies only to adenocarcinoma of prostate. There is no pT1 category as there is insufficient tissue to access the highest pT category.

Codes and values:

Code	Value	Explanatory Notes
pT0	No evidence of primary tumour	
pT2	Tumour confined within the prostate. *	* Tumour found in one or both lobes by needle biopsy but not palpable or visible by imaging, is classified as T1c.
pT2a	Tumour involves one half of one lobe or less	
pT2b	Tumour involves more than half of one lobe but not both lobes.	
pT2c	Tumour involves both lobes.	
pT3	Tumour extends through the prostatic capsule †	† Invasion into the prostatic apex or into (but not beyond) the prostatic capsule is not classified as T3 but as T2.
pT3a	Extracapsular extension (unilateral or bilateral)	
pT3b	Tumour invades seminal vesicle(s)	
pT4	Tumour is fixed or invades adjacent structures other than seminal vesicles: bladder neck, external sphincter, rectum, levator muscles, or pelvic wall.	
pTX	Primary tumour cannot be assessed	
96	Not applicable	e.g. no surgery
99	Not recorded	

Related Data Item(s):

TNM Nodal Classification: (Pathological) (Prostate),
TNM Metastases Classification (Pathological) (Prostate),
Date of Staging {Cancer}.

Notes by Users:

TNM Nodal Classification (Pathological) (Prostate)

Common name: Pathological TNM Nodal stage (Prostate)

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

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

Field Name: pN

Field Type: Characters

Field length: 3

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

Codes and Values:

Code	Value	Explanatory Notes
pN0	No regional lymph node metastasis.	
pN1	Regional lymph node metastasis.	
pNX	Regional lymph nodes cannot be assessed.	
96	Not applicable	e.g. No surgery
99	Not recorded	

Related Data Item(s):

TNM Tumour Classification (Pathological) (Prostate)

TNM Metastases Classification (Pathological) (Prostate)

Notes by Users:

TNM Metastasis Classification (Pathological) (Prostate)

Common name: Pathological TNM Metastases Classification (Prostate)

Main Source of Data Item Standard: TNM Classification (TNM Classification of Malignant Tumours, Sixth Edition, UICC, 2002).

Definition: A record of the extent of metastatic spread of the tumour as detected by microscopy.

Field Name: pM

Field Type: Characters

Field length: 4

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

Codes and Values:

Code	Value	Explanatory Notes
pM0	No distant metastasis.	
pM1	Distant metastasis present.	
pM1a	Non-regional lymph node(s)	
pM1b	Bone(s)	
pM1c	Other site(s)	
pMX	Presence of distant metastasis cannot be assessed.	
96	Not applicable	e.g. No Surgery
99	Not recorded	

Related Data Item(s):

TNM Nodal Classification (Pathological) (Prostate)

TNM Tumour Classification (Pathological) (Prostate)

Notes by Users:

Margin Status (Prostatectomy)

Main Source of Data Item Standard: The Royal College of Pathologists, Minimum Dataset for Prostate Cancer Histopathology Reports, 2009.

Definition: The presence or absence of margin involvement following prostatectomy.

Field Name: MARGIN

Field Type: Integer

Field length: 2

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

If reported in another format e.g. < 1 mm, clarify with local pathologist.

Codes and Values:

Code	Value	Explanatory Notes
1	Positive	Tumour present at the surgical margin.
2	Negative	Tumour not present at the surgical margin.
96	Not applicable	e.g. prostatectomy not performed
99	Not recorded	

Notes by Users:

Section 5: Radiotherapy

External Beam Radiotherapy Course Type

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

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

Field Name: RADIO

Field Type: Integer

Field length: 2

Notes for Users: Required for QPI(s): 8, 9, 10

Codes and Values:

Code	Value	Explanatory Notes
2	Adjuvant	It is given after potentially curative surgery.
3	Radical	It is primary treatment and is given with curative intent.
4	Palliative	The aim is solely to relieve symptoms e.g. bone metastases.
95	Patient declined	
96	Not applicable	e.g. no external beam radiotherapy given.
99	Not recorded	

Related Data Item(s):

Date Treatment Started (External Beam Radiotherapy)

Date Treatment Completed (External Beam Radiotherapy)

Notes by Users:

Date Treatment Started (External Beam 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 commenced.

Field Name: RADDATE

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

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

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

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

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

This may be up to one year from date of diagnosis.

Related Data Item(s):

External Beam Radiotherapy Course Type

Date Treatment Completed (External Beam Radiotherapy)

Notes by Users:

Date Treatment Completed (External Beam 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 a cancer treatment course ended.

Field Name: RCOMPDATE

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

Field Length: 10

Notes for Users: Required for QPI(s): 9, 10

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

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

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

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

Data to support reporting of QPIs 8 and 9 will not be required to be collected in all Boards in year 1 of implementation as these QPIs will be piloted in some Boards and subsequently reviewed.

Related Data Item(s):

External Beam Radiotherapy Course Type

Date Treatment Started (External Beam Radiotherapy)

Notes by Users:

Date Treatment Started (Brachytherapy)

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. This date will also be utilised as completion date.

Field Name: BRACHYDATE

Field Type: Date (DD/MM/CCYY)

Field length: 10

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

This is the date an implant was inserted for brachytherapy.

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

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

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

Data to support reporting of QPIs 8 and 9 will not be required to be collected in all Boards in year 1 of implementation as these QPIs will be piloted in some Boards and subsequently reviewed.

Related Data Item(s):

Brachytherapy Type {Cancer}

Notes by Users:

Section 6: Hormone Therapy

Type of Hormone Therapy

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

Definition: Hormonal therapy is the use of agents, which manipulate hormone levels, by using drugs, surgery or radiotherapy. Hormones are 'chemical messengers' released by the organs and dispersed by the blood to produce effects on target organs e.g. oestrogens.

Field Name: HORMTYPE

Field Type: Integer

Field Length: 2

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

This is also known as Androgen Deprivation Therapy (ADT).

Patients may have hormone therapy both before and after definitive treatment. Where it is radiotherapy, it is given beforehand to reduce the size of the tumour (neo-adjuvant) and may be continued afterwards (adjuvant).

- **Neo-adjuvant:** Hormone therapy is given for a defined period before curative treatment (approximately three months).
- **Adjuvant:** Hormone therapy is given for a defined period after primary treatment.
- **Neo-adjuvant & Adjuvant:** Hormone therapy given in combination before and after primary treatment.
- **Primary:** Hormone therapy is used as initial treatment usually for locally advanced or metastatic disease. Orchiectomy may be used as primary treatment.

If hormonal therapy was not given as part of primary therapy, code as 96 (Not applicable).

Codes and Values:

Code	Value
1	Neo-adjuvant
2	Adjuvant
3	Neo-adjuvant & Adjuvant
4	Primary
95	Patient Refused
96	Not applicable
98	Other (Specify)
99	Not recorded

Related Data Item(s):

Date Treatment Started (Hormone Therapy)

Hormonal therapy Agent {Prostate Cancer}

Notes by Users:

Date Treatment Started (Hormone Therapy)

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

Definition: The date hormone treatment course commenced.

Field Name: HORMDATE

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

Field Length: 10

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

This is the first dose of hormonal therapy or the date an implant was inserted for hormonal therapy.

It is not always clearly documented when hormone therapy starts.

If the patient is given the prescription directly at the clinic then that date should be used as the date treatment started.

If the GP is asked to prescribe hormone therapy, record the date as two days from the day of the discharge letter being typed or from the date the patient is given a handwritten note to take to the GP, whichever is the earlier.

Immediate therapy would be within 31 days of the patient being discussed at MDT meeting.

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

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

Related Data Item(s):

Type of Hormone Therapy

Hormonal Therapy Agent {Prostate Cancer}

Date First Discussed by Care Team (MDT)

Notes by Users:

Hormonal Therapy Agent {Prostate Cancer}

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

Definition: The type of hormonal therapy delivered.

Field Name: HORMAGENT

Field Type: Integer

Field length: 2

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

If any hormonal therapy agent is not listed then please contact ISD Scotland as described elsewhere so that standard codes can be allocated throughout Scotland.

Users may wish to augment code '98 – Other (specify)' and sub-codes 'Z - Other (specify)' with a free text field for recording other values of this item.

If more than one hormone therapy agent is administered, record the main agent.

Codes and Values:

Code	Value	Explanatory Notes
1	Gonadorelin Agonist (GnRH)	Includes drugs: Buserelin; Goserelin Histrelin; Leuprorelin; Triptorelin;
2	Gonadorelin Antagonist	Includes drugs: Degarelix
3	Anti-androgen	Includes drugs: Cyproterone; Flutamide; Bicalutamide;
7	Orchidectomy	
10	Maximum Androgen Blockade (MAB)	Combination of anti-androgen and GnRH regulators
96	Not applicable	
98	Other (specify)	
99	Not recorded	

Related Data Item(s):

Type of Hormone Therapy

Date Treatment Started (Hormone Therapy)

Notes by Users:

Section 7: Clinical Trials

Patient Entered into Clinical Trial {Prostate 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: Characters

Field Length: 2

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

This relates only to participation in clinical trials which may be national or international multi-centred trials.

The majority of non-commercial multi-centred trials available in Scotland are NCRN badged or equivalent.

Some academic and university units may have ongoing local trials which should not be included here. These can be recorded on local trials databases.

Codes and Values:

Code	Value
1	Yes
2	No
99	Not recorded

Notes by Users:

Section 8: Follow-up and Death Details

Post-Surgical Continence at One Year

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

Definition: An indication of the patient's continence status one year after radical prostatectomy as recorded by the clinician managing the patient's care.

Field Name: CONTINENT

Field Type: Integer

Field Length: 2

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

This may be between 10-14 months following surgery.

Codes and Values:

Code	Value	Explanatory Notes
1	0 pads per day	
2	1 pad per day	
3	2-3 pads per day	
4	Incontinent	
96	Not applicable	e.g. No surgery performed.
99	Not recorded	

Related Data Item(s):

Date of Definitive Surgery

Follow-up Date

Notes by Users:

Radiotherapy Post-Treatment Related Morbidity (Urinary)

Main Source of Data Standard: [RTOG/EORTC](http://www.rtog.org) Late Radiation Morbidity Scoring Schema.
URL: <http://www.rtog.org>

Definition: An indication of the extent of urinary morbidity that is directly attributable to radiation therapy.

Field Name: URIMORBID

Field Type: Integer

Field length: 2

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

This relates to urinary toxicity occurring within six to 12 months after completion of the radiotherapy (as toxicity following the radiotherapy would be expected to have been resolved by six months after treatment completion).

Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).

Details on the criteria for each grade can be found at the RTOG website:

<http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOG/EORTC/LateRadiationMorbidityScoringSchema.aspx>

Codes and Values:

Code	Value	Explanatory Notes
6	Grade 0 – None	None is a positively recorded response e.g. patient has no treatment related morbidity.
1	Grade 1	See RTOG website for detail on grades.
2	Grade 2	See RTOG website for detail on grades.
3	Grade 3	See RTOG website for detail on grades.
4	Grade 4	See RTOG website for detail on grades.
5	Grade 5 - Death	See RTOG website for detail on grades.
96	Not applicable	e.g. Radiotherapy not given.
98	Other (specify)	
99	Not recorded	

Related Data Item(s):

Date Treatment Completed (External Beam Radiotherapy)

Date Treatment Started (Brachytherapy)

External Beam Radiotherapy Course Type

Brachytherapy Type

Notes by Users:

Radiotherapy Post-Treatment Related Morbidity (Bowel)

Main Source of Data Standard: [RTOG/EORTC](http://www.rtog.org) Late Radiation Morbidity Scoring Schema.
URL: <http://www.rtog.org>

Definition: An indication of the extent of urinary morbidity that is directly attributable to radiation therapy.

Field Name: BOWMORBID

Field Type: Integer

Field length: 2

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

This relates to bowel toxicity occurring within six to 12 months after completion of the radiotherapy (as toxicity following the radiotherapy would be expected to have been resolved by six months after treatment completion).

Values conform to the structure of the RTOG/EORTC Late Radiation Morbidity Scoring Scheme, which relates to effects of radiation therapy that first occur 90 days or more following the initiation of radiation therapy. The Late Radiation Morbidity Scoring System grades the severity of adverse events that are directly attributable to radiation therapy from Grade 0 (None) to Grade 5 (Death).

Details on the criteria for each grade can be found at the RTOG website:

<http://www.rtog.org/ResearchAssociates/AdverseEventReporting/RTOGEOORTCLateRadiationMorbidityScoringSchema.aspx>

Codes and Values:

Code	Value	Explanatory Notes
6	Grade 0 – None	None is a positively recorded response e.g. patient has no treatment related morbidity.
1	Grade 1	See RTOG website for detail on grades.
2	Grade 2	See RTOG website for detail on grades.
3	Grade 3	See RTOG website for detail on grades.
4	Grade 4	See RTOG website for detail on grades.
5	Grade 5 - Death	See RTOG website for detail on grades.
96	Not applicable	e.g. Radiotherapy not given.
98	Other (specify)	
99	Not recorded	

Related Data Item(s):

Date Treatment Completed (External Beam Radiotherapy)

Date Treatment Started (Brachytherapy)

External Beam Radiotherapy Course Type

Brachytherapy Type

Notes by Users:

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: The certified date of death as recorded by the National Records of Scotland (NRS) (previously General Register Office Scotland (GRO(S)))

Field Name: DOD

Field Type: Date (DD/MM/CCYY)

Field Length: 10

Notes for Users: Required for national survival analysis.

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

If the patient is still alive, record as 10/10/1010 (Not applicable)

Related Data Item(s):

Underlying Cause of Death

Notes by Users: