



# **Renal Cancer**

## **Data Definitions for the National Minimum Core Dataset to Support the Introduction of Renal Quality Performance Indicators**

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

**Version 2.2: April 2015**

### **To be used in conjunction with:**

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

## DOCUMENT CONTROL SHEET

### Key Information

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Author	Information Services Division of NHS National Services Scotland

### Revision History

Version	Date	Summary of Changes	Name	Changes Marked
2.0	16/09/13	Changes agreed at 9 month review. Changes to be applied for patients diagnosed from 1 <sup>st</sup> January 2014.	David Early, ISD	<a href="#">See page iii.</a>
2.1	20/06/14	Changes agreed outwith review. Changes to be applied for patients diagnosed from 1 <sup>st</sup> January 2014	Charlotte Anthony, ISD	<a href="#">See page iii.</a>
2.2	27/02/15	Changes agreed at Baseline Review. Changes to be applied for patients diagnosed from 1 <sup>st</sup> January 2014.	Karen Heatlie ISD	<a href="#">See page iii.</a>

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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 national cancer 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 01/01/2012.

Dr John Brush, Consultant Radiologist, NHS Lothian  
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***Renal 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 renal cancer on or after 1<sup>st</sup> January 2014, who are eligible for inclusion in the renal 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](mailto: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 FROM BASELINE REVIEW (April 2015)

**Staging Investigations Complete (Pre-treatment) & Date Staging Investigations Complete (Pre-treatment)** - Definition updated to state '+/- pelvis' as per Baseline Review.

**Location of Diagnosis {Cancer}** – add code for not recorded as per query 608 on query log.

**Location Code {Cancer Surgery}** – update link to reference files.

## REVISIONS TO DATASET OUT-WITH REVIEW (June 2014)

### New Data Item Added:

*Page 26: 'Date of Definitive Treatment {Renal Cancer}'*

### Database Specification:

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

### Dataset

#### **Staging Investigations Complete (Pre-treatment)**

- i. 'Notes for Users' revised to "When in any doubt about whether staging of a patient can be considered complete, this should be checked with radiology using the criteria outlined in the dataset."

#### **Date Staging Investigations Complete (Pre-treatment)**

- i. 'Notes for Users' revised to "**ALL**" and added "When in any doubt about whether staging of a patient can be considered complete, this should be checked with radiology using the criteria outlined in the dataset."

#### **Date of Diagnosis**

- i. 'Notes for Users' revised to "This may be the date of the CT scan where suspicion of renal cancer was raised and subsequently confirmed."

#### **Laterality**

- i. 'Notes for Users' removed "Two tumours of the same morphology diagnosed simultaneously in paired organs should be recorded separately (i.e. right and left) unless stated to have originated from a single primary tumour."

Tumours in paired organs of completely different histology should be recorded separately (i.e. right and left).

If there are two tumours in the same kidney, record only the details of the tumour with the worst prognosis e.g. highest TNM stage."

- ii. Added "In cases where there are multiple tumours, the tumour with the worst prognosis should be used e.g. highest TNM stage."

#### **Definitive Operative Procedure**

*Data Definitions for the National Minimum Core Dataset for Renal Cancer.  
Developed by ISD Scotland, 2013*

- i. 'Notes for Users' removed "Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI"
- ii. Added 'Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is 'Watch and Wait' can also be recorded.'

#### **Date of Definitive Surgery**

- i. 'Notes for Users' removed "Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI"
- ii. Added "Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

#### **Fuhrman Grade (Kidney)**

- i. 'Notes for Users' revised to "As of 1<sup>st</sup> April 2014 this is also known as ISUP (Vancouver) Grading System.
- ii. **Inserted - New Codes and Values 1<sup>st</sup> April 2014 – to date**

Code	Value	Explanatory Notes
1	Grade 1	Nucleoli: None
2	Grade 2	Nucleoli: Visible at high power x 400 magnification.
3	Grade 3	Nucleoli: Prominent visible at x 100 magnification.
4	Grade 4	Nuclear shape: Bizarre and multilobed nuclei +/- spindle or rhabdoid shaped cells. Nucleoli: Prominent.
96	Not applicable	e.g. Non-clear cell or Non Papillary carcinomas
99	Not recorded	

#### **Revisions To Dataset Following 9-Month Review (September 2013)**

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

#### **Criteria For Inclusion of Patients in Audit:**

Inclusion criteria removed:

- *'Multiple independent primary tumours should be recorded separately'*
- *'Patients diagnosed within NHS Scotland but who have received any part of their treatment privately or outwith Scotland'*
- *'All patients aged 16 years and over'*

Exclusion criteria added:

- *'Patients with other tumour types, such as sarcoma or lymphoma'*
- *'Patients with carcinoma in situ'*

- *'Patients where the only record of their cancer is from a death certificate (DCO)'*
- *'Patients whose definitive cancer treatment was privately funded or undertaken outwith Scotland'*

Exclusion criteria removed:

- *'Patients with tumour types other than renal cell carcinomas'*
- *'Patients diagnosed in the private sector'*
- *'Death Certificate Only (DCO) cases'*

### **New Data Items Added:**

*Page 19: 'Date of Histological Diagnosis'*

### **Data Items Removed:**

None

*Other minor changes include:*

### **Database Specification:**

*Date of Histological Diagnosis data item added: Field Name: HDIAG, Field Type: Date, Field Length: 10.*

### **Dataset:**

#### **Person Sex at Birth:**

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

#### **WHO /ECOG Performance Status at Time of Diagnosis:**

- Definition changed to 'An overall assessment of the functional/physical performance of the patient at the time of diagnosis, and before first treatment.'
- 'Notes for Users' updated to reflect changes to QPI numbering.
- Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

#### **Staging Investigations Complete (Pre-treatment):**

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

#### **Date Staging Investigations Complete (Pre-treatment):**

- Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

#### **Contrast Agent Administered Status (Pre-treatment):**

- Notes for Users revised to: "Although imaging investigations may be done separately at different times, it is usual practice for CT of chest, abdomen and pelvis to be carried out together and for contrast to be administered for all three imaging procedures.

If contrast is administered for CT of abdomen and CT pelvis, but not for CT chest, record as '2: Imaging with contrast agent'".



- ii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.
- iii. Amended code '96: inapplicable' to '96: Not applicable'.

**TNM Tumour Classification (Clinical) (Kidney) (Pre-treatment) AND  
TNM Nodal Classification (Clinical) (Kidney) (Pre-treatment) AND  
TNM Metastasis Classification (Clinical) (Kidney) (Pre-treatment):**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. 'Notes for Users' revised to: "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 any 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'."

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

**Date of Diagnosis:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Location of Diagnosis:**

- i. 'Notes for Users' revised to "Required for analysis purposes & clarifying responsibility for data collection."
- ii. Amended code 'X1010: inapplicable' to 'X1010: Not applicable'.

**Most Valid Basis of Diagnosis:**

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

**Date Discussed by Care Team (MDT Pre-treatment):**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. 'Notes for Users' amended to remove requirement for MDT date to be recorded as inapplicable if date is after the date of first treatment.
- iii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Type of First Cancer Treatment:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Note appended to 'notes for users': "Supportive care only' includes watchful waiting, but not palliative chemotherapy and/or radiotherapy."
- iii. Changes to 'Codes & Values':
  - a. Added 'radiofrequency ablation', and 'embolisation' to explanatory notes for 'supportive care only'.
  - b. Added 'refusal of primary therapies' to explanatory notes for 'patient refused all therapies'.
  - c. Added code '99: not recorded' to list of codes and values.

**Date of First Cancer Treatment:**

*Data Definitions for the National Minimum Core Dataset for Renal Cancer.  
Developed by ISD Scotland, 2013*

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. 'Notes for Users' amended to "If type of first cancer treatment is 'supportive care only', the date recorded should be the date of the MDT that this decision was made."
- iii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Definitive Operative Procedure:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Changes to 'Codes & Values':
  - a. Added 'M02.2: Nephroureterectomy NEC'
  - b. Amended '99: Not known' to '99: Not recorded'
- iii. Amended code '96: inapplicable' to '96: Not applicable'.

**Date of Definitive Surgery:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Location Code {Cancer Surgery}:**

- i. Updated 'Main Source of Data Item Standard'
- ii. 'Notes for Users' updated to reflect changes to QPI numbering.
- iii. 'Notes for Users' updated with correct links to location codes and 'LOC-NEW' form.
- iv. Amended code '96: inapplicable' to '96: Not applicable'.

**Surgical Procedure Type:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

**Surgical Presentation Type:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.

**Date of Cryotherapy:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Morphology of Tumour:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. 'Notes for Users' updated with correct email address to request morphology codes from.

**Fuhrman Grade (Kidney):**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

**TNM Tumour Classification (Pathological) (Kidney) AND TNM Nodal Classification (Pathological) (Kidney) AND TNM Metastasis Classification (Pathological) (Kidney):**

- i. 'Notes for Users' revised to: "In the case of multiple tumours, the tumour with the worst prognosis should be used for classification. If in doubt, check with pathology."
- ii. Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

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

**Systemic Anti Cancer Therapy Agent (Renal Cancer):**

- i. Definition amended to "The type of cytotoxic or biological agent used either alone or in combination to treat renal cancer."
- ii. 'Notes for Users' updated to reflect changes to QPI numbering.
- iii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

**Date Treatment Started (Systemic Anti Cancer Therapy):**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Patient Entered into Clinical Trial (Renal Cancer):**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '99: Not known' to '99: Not recorded', in table of codes and values.

**Date of Death:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. Amended code '10/10/1010: inapplicable' to '10/10/1010: Not applicable'.

**Underlying Cause of Death:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.

**Date Record Considered Complete:**

- i. 'Notes for Users' updated to reflect changes to QPI numbering.
- ii. 'Notes for Users' revised: "This relates only to patients with advanced and/or metastatic disease at diagnosis, as SACT may be given to locally advanced disease without metastases."
- iii. Added '96: Not applicable' option.

## **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 renal cell carcinoma of the kidney (See Morphology of Tumour in dataset (p.34).
- Including, all patients who have had a previous primary malignancy of any site or a concurrent primary malignancy of another site.

### **Exclude**

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

## DOWNLOAD FORMAT

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

## DATABASE SPECIFICATION

Data item	Field name	Field type	Size	Page
<b>Section 1: Demographics</b>				<b>1</b>
Person Family Name (at Diagnosis)	PATSNAME	Characters	35	2
Person Given Name	PATFNAME	Characters	35	3
Patient Postcode at Diagnosis {Cancer}	PATPCODE	Characters	8	4
Date of Birth	DOB	Date	10	5
Person Sex at Birth	SEX	Integer	2	6
CHI Number	CHINUM	Integer	10	7
<b>Section 2: Pre-treatment Imaging &amp; Staging Investigations</b>				<b>8</b>
WHO/ ECOG Performance Status at Time of Diagnosis	PSTATUS	Integer	1	9
Staging Investigations Complete	SINVEST	Integer	2	10
Date Staging Investigations Complete	SINVESTDATE	Date	10	11
Contrast Agent Administered Status	CONAGENT	Integer	2	12
TNM Tumour Classification (Clinical) (Kidney) (Pre-treatment)	cT	Characters	3	13
TNM Nodal Classification (Clinical) (Kidney) (Pre-treatment)	cN	Characters	2	15
TNM Metastases Classification (Clinical) (Kidney) (Pre-treatment)	cM	Characters	2	16
Date of Diagnosis	DIAGDATE	Date	10	17
Location of Diagnosis {Cancer}	HOSP	Characters	5	18
Date of Histological Diagnosis	HDIAG	Date	10	19
Most Valid Basis of Diagnosis	VALID	Integer	2	20
Laterality	SIDE	Integer	2	21
Date Discussed by Care Team (Pre-treatment)	MDTDATE	Date	10	22
Type of First Cancer Treatment	FIRSTTREATMODE	Integer	2	23
Date of First Cancer Treatment	FIRSTTREATDATE	Date	10	25
Date of Definitive Treatment {Renal Cancer}	DEFTREATDATE	Date	10	26
<b>Section 3: Surgery</b>				<b>27</b>
Definitive Operative Procedure	OPCODE1 OPCODE2	Characters	5 5	28
Date of Definitive Surgery	SURGDATE	Date	10	30
Location Code (Cancer Surgery)	HOSPSURG	Characters	5	31
Surgical Procedure Type	SURGTYPE	Characters	2	33
Surgical Presentation Type	PRESENT	Integer	2	34

Date of Cryotherapy	CRYODATE	Date	10	35
<b>Section 4: Pathology Details</b>				36
Morphology of Tumour	MORPHOL	Characters	6	37
Fuhrman Grade (Kidney)	FUHRMAN	Integer	2	38
TNM Tumour Classification (Pathological) (Kidney)	pT	Characters	4	39
TNM Nodal Classification (Pathological) (Kidney)	pN	Characters	3	40
TNM Metastases Classification (Pathological) (Kidney)	pM	Characters	3	41
<b>Section 5: Systemic Anti-Cancer Therapy</b>				42
Systemic Anti Cancer Therapy Agent	SYSTAGENT	Integer	2	43
Date Treatment Started (Systemic Anti Cancer Therapy)	SYSTDATE	Date	10	44
<b>Section 6: Clinical Trials &amp; Death Details</b>				45
Patient Entered into Clinical Trial {Renal Cancer}	TRIAL	Characters	2	46
Date of Death	DOD	Date	10	47
Underlying Cause of Death	COD	Character	5	48
Date Record Considered Complete	DATECOMP	Date	10	49

## **Section 1: Demographic Items**

## **Person Family Name (at Diagnosis)**

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**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 patients 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**

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**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}**

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**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 Items:**

Date of Diagnosis

### **Notes by Users:**

## **Date of Birth**

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**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 Items:**

CHI Number

**Notes by Users:**

## Person Sex at Birth

---

**Common Name(s):** Sex at Birth

**Main Source of Data Item Standard:** Derived from the nearest equivalent Government Data Standards Catalogue standard 'Person Gender at Registration'

**Definition:** This is a factual statement, as far as is known, about the phenotypic (biological) sex of the person at birth

**Field Name:** SEX

**Field Type:** Integer

**Field Length:** 2

**Notes for Users:**

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.

A person's sex has clinical implications, both in terms of the individual's health and the health care provided to them.

In the majority of cases, the phenotypic (biological) sex and genotypic sex are the same and the phenotypic sex is usually easily determined. In a small number of cases, accurate determination of genotype may be required.

**Codes and Values:**

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

**Related Data Items:**

CHI Number

**Notes by Users:**

## **CHI Number**

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**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 Items:**

Date of Birth

Person Sex at Birth

### **Notes by Users:**

## **Section 2: Pre-treatment Imaging & Staging Investigations**

## WHO/ECOG Performance Status at Time of Diagnosis

---

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

**Definition:** An overall assessment of the functional/physical performance of the patient at the time of diagnosis, and before first treatment.

**Field Name:** PSTATUS

**Field Type:** Integer

**Field Length:** 1

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

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

### Codes and Values:

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

**Notes by Users:**

## Staging Investigations Complete (Pre-treatment)

---

**Definition:** An indication of whether or not staging investigations were completed by CT of the chest and abdomen and +/- pelvis.

**Field Name:** SINVEST

**Field Type:** Integer

**Field Length:** 2

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

Complete staging is CT chest and abdomen and +/- pelvis (and no other combination). These investigations may be done separately at different times but before first treatment.

**When in any doubt about whether staging of a patient can be considered complete, this should be checked with radiology using the criteria outlined in the dataset.**

### Codes and Values:

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

### Related Data Item(s):

Date Staging Investigations Complete (Pre-treatment)

Contrast Agent Administered Status (Pre-treatment)

### Notes by Users:



## **Date Staging Investigations Complete (Pre-treatment)**

---

**Definition:** The date that staging investigations were completed by CT of the chest and abdomen and +/- pelvis.

**Field Name:** SINVESTDATE

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

**Field Length:** 10

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

Complete staging is CT chest and abdomen and +/- pelvis (and no other combination). These investigations may be done separately at different times but before first treatment. Record the date that **ALL** items are complete, e.g. if done on separate days then record the final date.

**When in any doubt about whether staging of a patient can be considered complete, this should be checked with radiology using the criteria outlined in the dataset.**

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

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

**Related data item(s):**

Staging Investigations Complete (Pre-treatment)

**Notes by Users:**

## **Contrast Agent Administered Status (Pre-treatment)**

---

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

**Definition:** An indicator of whether or not a contrast agent was administered for each of the three imaging procedures (CT of chest, abdomen and pelvis).

**Field Name:** CONAGENT

**Field Type:** Integer

**Field length:** 2

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

Although imaging investigations may be done separately at different times, it is usual practice for CT of chest, abdomen and pelvis to be carried out together and for contrast to be administered for all three imaging procedures.

If contrast is administered for CT of abdomen and CT pelvis, but not for CT chest, record as '2: Imaging with contrast agent'.

### **Codes and Values:**

<b>Code</b>	<b>Value</b>
1	Imaging without contrast agent
2	Imagine with contrast agent
96	Not applicable
99	Not recorded

### **Related Data Item(s):**

Staging Investigations Complete (Pre-treatment)

### **Notes by Users:**

## **TNM Tumour Classification (Clinical) (Kidney) (Pre-treatment)**

---

**Common Name:** Clinical TNM Tumour Classification (Kidney).

**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 kidney 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): 3, 6, 7, and 9.

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 any 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'.

**Codes and Values:**

Code	Value
T0	No evidence of primary tumour
T1	Tumour 7cm or less: limited to the kidney
T1a	Tumour $\leq$ 4cm
T1b	Tumour > 4cm to 7cm
T2	Tumour more than 7cm: limited to the kidney
T3	Tumour invades into major veins: adrenal or perinephric invasion not beyond Gerota's fascia
T3a	Directly invades adrenal gland or perinephric tissues (includes renal sinus (peripelvic) fat)
T3b	Grossly extends into renal vein(s) or vena cava or its wall beyond diaphragm (includes segmental (muscle-containing) branches)
T3c	Grossly extends into vena cava or its wall above diaphragm
T4	Tumour invades beyond Gerota's fascia
TX	Primary tumour cannot be assessed
96	Not applicable
99	Not recorded

**Related Data Item(s):**

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

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

**Notes by Users:**

## TNM Nodal Classification (Clinical) (Kidney) (Pre-treatment)

---

**Common Name:** Clinical TNM Nodal Classification (Kidney).

**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 kidney 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): 3, 6, 7, and 9.

This is a pre/non-operative classification as defined by the 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 the case of multiple tumours, the tumour with the worst prognosis should be used for 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'.

**Codes and Values:**

Code	Value
N0	No regional lymph node metastasis.
N1	Metastasis in a single regional lymph node.
N2	Metastasis in more than one regional lymph node.
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) (Kidney) (Pre-treatment)

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

**Notes by Users:**

## TNM Metastasis Classification (Clinical) (Kidney) (Pre-treatment)

---

**Common Name:** Clinical TNM Metastasis Classification (Kidney).

**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 kidney 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:** 2

**Notes for Users:** Required for QPI(s): 3, 6, 7, and 9.

This is a pre/non-operative classification as defined by the 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 the case of multiple tumours, the tumour with the worst prognosis should be used for 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'.

### Codes and Values:

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

### Related Data Item(s):

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

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

### 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 renal 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 for QPI(s): 1 - 9.

The date recorded is the date of the first investigative procedure that confirms a diagnosis of kidney cancer whether done radiologically or histologically. The date recorded is the date the procedure was performed, not the date the report was issued.

This may be the date of the CT scan where suspicion of renal cancer was raised and subsequently confirmed.

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

**Related Data Item(s):**

Location of Diagnosis {Cancer}

**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 analysis purposes & 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 Histological 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 histological diagnosis is the date on which there was confirmation of the diagnosis of cancer by histology.

**Field Name:** HDIAG

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

**Field Length:** 10

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

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

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

If no invasive diagnostic procedures were undertaken, record as Not applicable (10/10/1010),

**Related Data Item(s):**

Most Valid Basis of Diagnosis

**Notes by Users:**

## Most Valid Basis of Diagnosis {Cancer}

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

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

**Field Name:** VALID

**Field Type:** Integer

**Field Length:** 2

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

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.

If a patient is diagnosed on a CT scan but then goes on to have surgery and there is histology available then you would record Histology of Primary, as this is the most valid, regardless of the fact the diagnosis was made on CT scan.

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.
10	Death Certificate only	The only information available to the registry is from a death certificate.
99	Not recorded	

### Notes by Users:

## Laterality

---

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

**Definition:** This indicates the side or laterality (i.e. left or right) of the body in which the tumour is located.

**Field Name:** SIDE

**Field Type:** Integer

**Field Length:** 2

**Notes for Users:**

Clinically relevant data item which can influence treatment decisions and prognosis.

Required for sub-group analysis as incidence and survival may be associated with laterality.

It is important that this be recorded for paired organs (e.g. kidney, testis). Only the following codes to be used:

In cases where there are multiple tumours, the tumour with the worst prognosis should be used e.g.highest TNM stage.

**Codes and Values:**

Code	Value	Explanatory notes
1	Right	
2	Left	
96	Not applicable	e.g. Congenital fusion anomalies for example, horseshoe kidney.
99	Not recorded	

**Notes by Users**

## Date Discussed by Care Team (MDT Pre-treatment)

---

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

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

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

**Field Name:** MDTDATE

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

**Field Length:** 10

**Notes for Users:** Required for QPI 4

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

The first MDT meeting date will be recorded.

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

If the date of the MDT meeting is unknown record as (09/09/0909).

**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): 1, 2, 4, 6, 7, and 8.

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. It also does not include open and close procedures. Some biopsies, such as excisional biopsies and cone biopsies, may be included as these may have some therapeutic benefits i.e. the removal of the tumour.

Record patients as having 'supportive care only' if a decision was taken not to give the patient any active treatment as part of their primary therapy. 'Supportive care only' includes watchful waiting, but not palliative chemotherapy and/or radiotherapy.

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

**Codes and Values:**

Code	Value	Explanatory notes
1	Surgery	
2	Radiotherapy	Includes Teletherapy (external beam radiotherapy, proton beam therapy) and Brachytherapy.
7	Supportive Care Only	Not for active treatment. May include: terminal care patients, radiofrequency ablation, embolisation, and watchful waiting
11	Other therapy	
12	Active Surveillance	Scheduled follow-up including repeat clinic visits, tests and biopsies after an interval until the disease progresses or the grade of the tumour changes.
13	Systemic Anti-Cancer Therapy (SACT)	Includes biological therapies: Sunitinib (Sutent), Pazopanib (Votrient), Bevacizumab (Avastin), Interferon (Roferon or Intron), Temsirolimus (Torisel)
14	Patient died before treatment	
15	Radiofrequency Ablation	
16	Cryotherapy	
17	Embolisation	
95	Patient refused all therapies	Refusal of Primary Therapies.
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:** FIRSTTREATDATE

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

**Field Length:** 10

**Notes for Users:** Required for QPI(s): 1, 2, 8.

This field should be recorded for all patients including those with 'supportive care only' (see below).

If type of first cancer treatment is 'supportive care only', the date recorded should be the date of the MDT that this decision was made. 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 patient died before treatment or the patient refused treatment, record as (10/10/1010).

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

**Related Data Item(s):**

Type of First Cancer Treatment

**Notes by Users:**

## **Date of Definitive Treatment {Renal 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: 4

For patients with renal cancer definitive treatment will be either:

- Surgery;
- Radiofrequency Ablation (RFA);
- Cryotherapy; or
- Systemic Anti Cancer Therapy (SACT).

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

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

For patients undergoing no active treatment (e.g. active surveillance 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**

## Definitive Operative Procedure

---

**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 investigation and treatment of cancer. This also includes nodal and reconstructive surgery performed on the patient for treatment of cancer.

**Field Name:** OPCODE1  
                  OPCODE2

**Field Type:** Characters

**Field Length:** 5

**Notes for Users:** Required for QPI(s): 1, 5, 6, 7 and 8.

Only the definitive procedure i.e. main type of surgery should be recorded here. For example; if patient has partial nephrectomy followed by radical nephrectomy it is the radical nephrectomy that should be recorded (if this occurs within six months of first treatment).

Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

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

However 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.

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.

Coding instructions and a full list of codes are included in the OPCS4 manual. It should be noted that it may be necessary to record two or more codes in order to fully specify the operation. **If only one operative procedure is performed then OPCODE2 should be set to 96 by default.**

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.

The most radical surgical procedure received during the first six months following diagnosis should be recorded.

**Codes and Values:**

OPCS4 Code 1	OPCS4 Code 2	Value
M02.1		Nephrectomy & excision of perirenal tissue
M02.2		Nephroureterectomy NEC
M02.3		Bilateral nephrectomy
M02.4		Excision of half of horseshoe kidney
M02.5		Radical nephrectomy
M02.5	B22.3	Radical nephrectomy with adrenalectomy
M02.5	T87.9	Radical nephrectomy with lymphadenectomy
M03.9		Partial nephrectomy
M04.2		Open excision of lesion of kidney NEC (Tumour enucleation)
M04.3		Open destruction of lesion of kidney
M10.1		Endoscopic extirpation of lesion of kidney
M13.7		Percutaneous radiofrequency ablation of lesion of kidney
95		Patient refused surgery
96		Not applicable
99		Not recorded

**Related Data Item(s):**

Date of Definitive Surgery  
Surgical Procedure Type

**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):

The date format should be DD/MM/CCYY.

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

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

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.

Patients treated within 6 months of a patient initially refusing investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

**Related Data Item(s):**

Definitive Operative Procedure

**Notes by Users:**

## **Location Code {Cancer Surgery}**

---

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

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

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

**Field Name:** HOSPSURG

**Field Type:** Characters

**Field Length:** 5

**Notes for Users:** May be used for sub-analysis presentation of QPI(s) 6, 7 and 8.

This is the hospital of definitive surgery which removes the primary renal 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 definitive surgery.

Each location has a location code, which is maintained by ISD:

<http://www.isd-n3.scot.nhs.uk/National-Reference-Files/Nat-Ref-Files/location?84577144>  
Location must be viewed as an address and not a code. If any new locations arise where NHS healthcare is delivered/administered, please ensure that the Reference Files Team at ISD is informed using form LOC-NEW (which can be downloaded from the website below) so that a new code may be issued as appropriate.

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

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

If the 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.

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

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

Examples of codes are given below.

<b>Code</b>	<b>Institution</b>
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:**

## Surgical Procedure Type

---

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

**Definition:** The type of surgical procedure(s) performed for investigation and/or treatment of cancer. This also includes nodal and reconstructive surgery performed on the patient for treatment of cancer.

**Field Name:** SURGTYPE

**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.

**Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI.**

**Codes and Values:**

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

**Related Data Item(s):**

Definitive Operative Procedure

Date of Definitive Surgery

**Notes by Users:**

## Surgical Presentation Type

---

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

**Definition:** How the patient presented for surgery.

**Field Name:** PRESENT

**Field Type:** Integer

**Field Length:** 2

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

Both categories incorporate:

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

If 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.

**Please note that only surgery occurring within six months of diagnosis should be included in the analysis against the relevant QPI.**

### Codes and Values:

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

### Related Data Item(s):

Definitive Operative Procedure

Date of Definitive Surgery

### Notes by Users:



## **Date of Cryotherapy**

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**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 Cryotherapy was performed.

**Field Name:** CRYODATE

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

**Field Length:** 10

### **Notes for Users:**

This is freezing of the tumour.

**Please note that only cryotherapy received within six months of diagnosis should be included in the analysis against the relevant QPI.**

If cryotherapy is not carried out, code as (10/10/1010) (Not applicable).

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

### **Notes by Users:**

## **Section 4: Pathology Details**

## Morphology of Tumour

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

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

**Field Name:** MORPHOL

**Field Type:** Characters

**Field Length:** 6

**Notes for Users:** Required for QPI(s): 1, 2, 3, 4, 5, 6, 7 and 8.

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

If material supplied cannot be assessed or if the pathology report is negative then record as 6666/6 (Clinical/Radiological only diagnosis of renal cell carcinoma).

If two descriptions/qualifiers (and possibly two morphology codes) are given by the pathologist, e.g. clear cell/sarcomatoid renal cell carcinoma, use the higher morphology rule. **The exception to this is renal cell/clear cell renal cell carcinoma. This should be coded as M\_8310/3.**

**As there is currently no ICD code for Tubulocystic Carcinoma, record as Collecting Duct (M\_8319/3) meantime.**

**As there is currently no ICD code for Translocation Carcinomas, record as Renal Cell Carcinoma (M\_8312/3) meantime.**

Morphology codes are shown below. This list is not exhaustive and if a code is not on the list please contact [NSS.ISDCANCERAUDIT@NHS.NET](mailto:NSS.ISDCANCERAUDIT@NHS.NET) for advice.

### Codes and Values:

Code	Value	Explanatory Notes
<b>Renal Cell Tumours</b>		
8310/3	Clear Cell Renal Cell Carcinoma; Clear cell carcinoma; clear cell adenocarcinoma, mesonephroid	Conventional renal cell carcinoma.
8260/3	Papillary Renal Cell Carcinoma	
8312/3	Renal cell carcinoma; renal cell adenocarcinoma; Grawitz tumour; Hypernephroma	
8316/3	Cyst-associated renal cell carcinoma	
8317/3	Chromophobe cell renal carcinoma	
8318/3	Sarcomatoid renal cell carcinoma; Spindle cell renal cell carcinoma	
8319/3	Collecting duct carcinoma; Renal Medullary Carcinoma	
6666/6	Clinical/Radiological only diagnosis of renal cell carcinoma, not assessable or negative	Code only to be used if there is no histology.
9999/9	Not Recorded	

### Notes by Users:

## **Fuhrman Grade (Kidney)**

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**Main Source of Data Item Standard:** Fuhrman SA. Lasky LC. Limas C. Prognostic significance of morphologic parameters in renal cell carcinoma. *American Journal of Surgical Pathology*. 6(7):655-63, 1982 Oct.

**Definition:** Application of the Fuhrman grading system

**Field Name:** FUHRMAN

**Field Type:** Integer

**Field Length:** 2

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

As of 1<sup>st</sup> April 2014 this is also known as ISUP (Vancouver) Grading System.

This is a qualitative assessment of nuclear pleomorphism.

**Fuhrman Grade should be recorded for clear cell renal carcinoma (M-8310/3) only.**

Grade should be assigned according to the worst grade regardless of extent.

### **Original Codes and Values 1<sup>st</sup> January 2014 – 31<sup>st</sup> March 2014**

<b>Code</b>	<b>Value</b>	<b>Explanatory Notes</b>
1	Grade 1	Nuclear shape: Round, uniform. Nucleoli: None
2	Grade 2	Nuclear shape: Slightly irregular. Nucleoli: Visible at high power x 400 magnification.
3	Grade 3	Nuclear shape: Very irregular outlines. Nucleoli: Prominent visible at x 100 magnification.
4	Grade 4	Nuclear shape: Bizarre and multilobed spindle shaped cells. Nucleoli: Prominent.
96	Not applicable	e.g. Non-clear cell carcinoma
99	Not recorded	

### **New Codes and Values 1<sup>st</sup> April 2014 – to date**

<b>Code</b>	<b>Value</b>	<b>Explanatory Notes</b>
1	Grade 1	Nucleoli: None
2	Grade 2	Nucleoli: Visible at high power x 400 magnification.
3	Grade 3	Nucleoli: Prominent visible at x 100 magnification.
4	Grade 4	Nuclear shape: Bizarre and multilobed nuclei +/- spindle or rhabdoid shaped cells. Nucleoli: Prominent.
96	Not applicable	e.g. Non-clear cell or Non Papillary carcinomas
99	Not recorded	

### **Related Data Item(s):**

Morphology of Tumour

## TNM Tumour Classification (Pathological) (Kidney)

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**Common Name:** Pathological TNM Tumour stage (Kidney)

**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 kidney following resection of the primary cancer. **This classification only applies to renal cell carcinoma.**

**Field Name:** pT

**Field Type:** Characters

**Field Length:** 4

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

In the case of multiple tumours, the tumour with the worst prognosis should be used for classification. If in doubt, check with pathology.

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

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'.

### Codes and Values:

Code	Value
pT0	No evidence of primary tumour
pT1	Tumour 7cm or less: limited to the kidney
pT1a	Tumour ≤ 4cm
pT1b	Tumour > 4cm to 7cm
pT2	Tumour more than 7cm: limited to the kidney
pT3	Tumour invades into major veins: adrenal or perinephric invasion not beyond Gerota's fascia
pT3a	Directly invades adrenal gland or perinephric tissues (includes renal sinus (peripelvic fat))
pT3b	Grossly extends into renal vein(s) or vena cava or its wall beyond diaphragm (includes segmental (muscle-containing) branches)
pT3c	Grossly extends into vena cava or its wall above diaphragm
pT4	Tumour invades beyond Gerota's fascia
pTX	Primary tumour cannot be assessed
96	Not applicable
99	Not recorded

### Related data items:

TNM Nodal Classification: (Pathological) (Kidney),

TNM Metastasis Classification (Pathological) (Kidney)

### Notes by Users:

## TNM Nodal Classification (Pathological) (Kidney)

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**Common Name:** Pathological TNM Nodal stage (Kidney)

**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. **This classification only applies to renal cell carcinoma.**

**Field Name:** pN

**Field Type:** Characters

**Field Length:** 3

**Notes for Users:**

Required to allow adjustments for stage when undertaking survival analysis.

In the case of multiple tumours, the tumour with the worst prognosis should be used for classification. If in doubt, check with pathology.

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

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'.

**Codes and Values:**

Code	Value	Explanatory Notes
pN0	No regional lymph node metastases	
pN1	Metastasis in a single regional lymph node	
pN2	More than one regional lymph node involved	
pNX	Regional lymph nodes cannot be assessed	
96	Not applicable	e.g. if nodal dissection not performed.
99	Not recorded	

**Related Data items:**

TNM Tumour Classification (Pathological) (Kidney)

TNM Metastasis Classification (Pathological) (Kidney)

**Notes by Users:**

## TNM Metastasis Classification (Pathological) (Kidney)

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**Common Name:** Pathological TNM Metastasis Classification (Kidney)

**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. **This classification only applies to renal cell carcinoma.**

**Field Name:** pM

**Field Type:** Characters

**Field length:** 3

**Notes for Users:**

Required to allow adjustments for stage when undertaking survival analysis.

In the case of multiple tumours, the tumour with the worst prognosis should be used for classification. If in doubt, check with pathology.

Pathology taken within 6 months of a patient initially refusing further investigation or whose initial treatment is 'Watch and Wait' can also be recorded.

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'.

**Codes and Values:**

Code	Value
pM0	No distant metastasis
pM1	Distant metastasis present.
pMX	Presence of distant metastasis cannot be assessed
96	Not applicable
99	Not recorded

**Related data items:**

TNM Tumour Classification (Pathological) (Kidney)

TNM Nodal Classification (Pathological) (Kidney)

**Notes by Users:**

## **Section 5: Systemic Anti-Cancer Therapy**



## Systemic Anti Cancer Therapy Agent (Renal Cancer)

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**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 cytotoxic or biological agent used either alone or in combination to treat renal cancer.

**Field Name:** SYSTAGENT

**Field Type:** Integer

**Field length:** 2

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

If the patient's first treatment was 'active surveillance', then subsequently proceeds to active treatment at a later date, record if systemic therapy occurs within one year of diagnosis.

**Please note that only systemic anti-cancer therapy received within twelve months of diagnosis should be included in the analysis against the relevant QPI.**

If any systemic anti cancer therapy agent is not listed then please contact ISD Scotland as described elsewhere so that standard codes can be allocated throughout Scotland. NB: Non-licensed therapies are not included in the national dataset.

### Codes and values:

Code	Value	Explanatory notes
<b>Biological Therapies</b>		
1	Sunitinib	Sutent
2	Pazopanib	Votrient
3	Bevacizumab *	Avastin
4	Interferon	Roferon or Intron
5	Temsirolimus	Torisel
95	Patient refused systemic anti-cancer therapy	
96	Not applicable	
98	Other	Including clinical trials
99	Not recorded	

\* If used in combination with another agent, record only Bevacizumab.

### Related Data Item(s):

Date Treatment Started (Systemic Anti Cancer Therapy)

### Notes by Users:

## **Date Treatment Started (Systemic Anti Cancer Therapy)**

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

**Definition:** The date systemic treatment course commenced.

**Field Name:** SYSTDATE

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

**Field Length:** 10

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

If the patient's first treatment was 'active surveillance', then subsequently proceeds to active treatment at a later date, record if systemic therapy occurs within one year of diagnosis.

**Please note that only systemic anti-cancer therapy received within twelve months of diagnosis should be included in the analysis against the relevant QPI.**

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

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

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

**Related Data Item(s):**

Systemic Anti-Cancer Therapy Agent (Renal Cancer)

**Notes by Users:**

## **Section 6: Clinical Trials and Death Details**

## **Patient Entered into Clinical Trial {Renal Cancer}**

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**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): 9.

**This would be during a specified time period – one year after diagnosis.**

This relates only to participation in clinical trials which may be national or international multi-centred trials. This is restricted to clinical trials which involve administration of systemic anti-cancer drugs for renal cancer.

The majority of non-commercial multi-centred trials available in Scotland are National Cancer Research Network (NCRN) badged or equivalent.

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

### **Codes and Values:**

<b>Code</b>	<b>Value</b>	<b>Sub-values</b>
1A	Yes - Systemic therapy	Entered into a clinical trial involving systemic therapy
1B	Yes - Non-systemic therapy	Entered into a clinical trial not involving systemic therapy
1C	Yes - Not known	Entered into a clinical trial but type of therapy not known
2	No	Not entered into a clinical trial
99	Not recorded	Not recorded whether or not patient received treatment within the context of a clinical trial

### **Notes by Users:**

## Date of Death

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

**Definition:** This is the certified date of death as recorded by the 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 QPI(s): 8.

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

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

**Related Data Item(s):**

Underlying Cause of Death

**Notes by Users:**

## Underlying Cause of Death

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**Common name:** Cause of Death

**Main Source of Data Item Standard:** National Records of Scotland (NRS) (previously General Register Office Scotland (GRO(S)))

**Definition:** The underlying cause of death as recorded by NRS in Part I of the death certificate.

**Field Name:** COD

**Format:** Character. (ICD10 code, ann.n or ann.a e.g. C34.9).

**Field length:** 5

**Notes for Users:** Required for cause-specific sub-analysis of QPI 7.

This refers only to the underlying cause of death, which is the condition recorded in the lowest completed line of Part I of the death certificate and is shown in the first column in the NRS download.

In cases where a post mortem examination has been performed, the underlying cause of death recorded by the pathologist should replace any preceding entry. In cases where the Procurator Fiscal has been involved, the final underlying cause of death recorded by them should supersede any previous entry.

The mode of dying, such as cardiac arrest or asphyxia, should not be recorded here. Other significant conditions contributing to the death but not related to the disease or condition causing it, as recorded in Part II of the death certificate, should not be recorded here.

**If the patient is still alive, record as not applicable (96).  
If the cause of death is unknown record as (99).**

**Related Data Item(s):**

Date of Death

**Notes by Users:**

## **Date Record Considered Complete**

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**Definition:** The date the auditor considers all relevant information is completed and can validate that 12 months have elapsed.

**Field Name:** DATECOMP

**Format:** Date (DD/MM/CCYY)

**Field length:** 10

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

This relates only to patients with advanced and/or metastatic disease at diagnosis, as SACT may be given to locally advanced disease without metastases. Therefore only these patients would require to be followed up for a maximum of 12 months after diagnosis to establish whether they had received Systemic Anti-Cancer Therapy (SACT) or died. However, not all of these patients will require a full 12 months follow-up as this would cease when they either received SACT or died and these dates were established. The completion of this data item ensures that the person extracting the data has confidence that all relevant patients have been followed-up for the required time period at the time of data extraction.

However, this may be a useful data item for all patients depending on how the data validations were being implemented locally. For example not all the individual validations for individual data items could be run at data entry as some rely on the completed values for other fields across the data set, which may be entered later. Therefore, this data item could be used to indicate batches of records where the auditor is satisfied that all the required information has been recorded fully before running the full data validations across all data items.

**Related Data Item(s):**

Date of Diagnosis

**Notes by Users:**