Northern Ireland Cancer Network
Colorectal Cancer Dataset

Title: N. Ireland Colorectal Cancer Dataset
Version: Final
Date: 04/12/08
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Northern Ireland Cancer Network
Colorectal Cancer Dataset version: based on ACP Dataset/ National Bowel Cancer Audit (NBCA) Dataset & NCDS V4.5

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL E =Essential NBCA	**Description**	**Purpose**	**Codes and Classifications**
1	**Demographics**			* required for Cancer Registration MDS # required for analysis of waiting times	
1.1	Health & Care Number [H&C number]	M	Patients unique 10 digit new format number equivalent to NHS number in England and Wales	*Used for unique identification to match records from different service providers	
1.2	LOCAL PATIENT IDENTIFIER [Hospital Number]	M	There may be different hospital numbers collected for the patient at different points in the pathway	* Used for unique identification to link events within a single service provider	HPSS Data dictionary
1.2	SITE CODE [PROVIDER FIRST SEEN]	M	Unique 5 digit code of unit where patient first seen	*To enable analysis by Provider code	HPSS Data dictionary
1.4	CARE SPELL IDENTIFIER	M	to link all activities for the patient to the same care spell. Allocated on diagnosis, at the organisation where the diagnosis takes place and communicated to all organisations providing care	* # Used to link all activities for the patient to the same care spell	HPSS Data dictionary
1.5	PATIENT FAMILY OR SURNAME	M	* Used for unique identification to link records where the new H&C number is not available (e.g. to previous tumours, genetic requests, events carried out in private hospitals,		HPSS Data dictionary
1.6	PATIENT FORNAME OR PERSONAL NAME	M	* Used for unique identification to link records where the new H&C number is not available (e.g. to previous tumours, genetic requests, events carried out in private hospitals		HPSS Data dictionary
1.7	PATIENT USUAL ADDRESS (AT DIAGNOSIS)	M			
1.8	POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS)	M		* To enable analysis by locality	HPSS Data dictionary
1.9	SEX	M		* To enable analysis by	HPSS Data dictionary

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				sex	0-Not Known 1-Male 2-Female 9-Not Specified
1.10	BIRTH DATE	M		* To calculate age at diagnosis for epidemiological and survival analysis	Date format DD/MM/YYYY
1.11	CODE OF GP PRACTICE	M	Practice with whom patient is registered	* To enable analysis by GP practice code	HPSS Data dictionary
2	**Referral**				
2.1	REFERRAL SOURCE FOR CANCER	O	Diagnostic route to Colorectal Service		01- Screening (NHS) 02- Interval cancer 03- Symptomatic cancer 04- Screening (Non-NHS) 05-Other 99- Not known

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2.3	CANCER REFERRAL PRIORITY	M	This field is submitted with item 2.2 Source of referral for outpatients in order to differentiate those records that fall within the 2 week wait standard.This data item refers to the initial referral into the 1st secondary care unit on pathway	# For analysis of waiting times.	1 - Urgent referral for suspected cancer from a General Medical Practitioner or General Dental Practitioner 2 - Other referral source or urgency 3-Consultant Upgrade of GP referral to Suspect Cancer
2.4	REFERRAL REQUEST RECEIVED DATE [Date of Receipt of Referral]	M	The date that the referral request is received by the provider: Date when letter/fax/electronic form is Received. Date of verbal request	To establish the start date for the specialist-based diagnosis and management process. To identify length of delay in the handling of referrals. #For analysis of waiting times.	Date format DD/MM/YYYY
2.5	REFERRER CODE	O	For referrals from other consultants		HPSS Data dictionary
2.6	REFERRER SPECIALITY	O			1-Gastroenterologist 2-General Surgeon 3-Physician 4-Gynaecologist 5-Other, specify
2.7	CONSULTANT CODE [Referred to]	O	The person to whom the referral is made. If the referral is to a team, then this refers to the first consultant seen.		HPSS Data dictionary
2.8	SITE CODE (PROVIDER FIRST seen)	M	Provider code of unit where the patient was first seen	# For analysis of waiting times.	HPSS Hospital provider codes
2.9	DATE FIRST SEEN	M	The date that the patient is seen by the person 'referred to 2.6 above: Date of first out-patient appointment .Date of first diagnostic procedure, if this precedes the first out-patient	. #For analysis of waiting times.	Date format DD/MM/YYYY

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
			appointment .Date first seen as an emergency, if the patient was first seen as an emergency. Date the patient was first seen following recall by screening unit		
2.10	CANCER SPECIALIST REFERRAL DECISION DATE	M	The date on which the referral was made: Date on the letter/fax/proforma/e-mail from referring GP or other hospital department. Date of telephone call from referring GP or other hospital department Date of cross-referral, where patient is already in hospital Date of admission to hospital, in the case of patients coming in as emergencies. Date of the first out-patient appointment, if the referral was a self-referral Date on the recall letter for patients recalled following a routine screening appointment	To establish the date on which the referring clinician first initiates referral to the specialist involved in the diagnostic process. To identify length of delay in the handling of referrals	Date format DD/MM/YYYY
2.11	CANCER SPECIALIST CONSULTANT CODE [COLORECTAL CANCER SPECIALIST Referred to]	M	The person to whom the referral is made. If the referral is to a team, then this refers to the first consultant seen.	To monitor the proportion of cancer patients referred to a cancer site specialist or a cancer site specific team.	HPSS Data dictionary

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
2.12	DATE FIRST SEEN BY COLORECTAL CANCER SPECIALIST [Date First Seen]	M	The date that the patient is seen by the person 'referred to 2.10 above: Date of first out-patient appointment .Date of first diagnostic procedure, if this precedes the first out-patient appointment .Date first seen as an emergency, if the patient was first seen as an emergency. Date the patient was first seen following recall by screening unit	To measure any delay between referral and first assessment by the specialist team. #For analysis of waiting times.	Date format DD/MM/YYYY
3	**Diagnosis**				
3.1	DIAGNOSIS DATE (CANCER) [Date of diagnosis]	M		*To calculate annual incidence rates and to determine the start date for survival analysis. NBCA	Order of declining priority: 1. Date of first histological or cytological confirmation of this malignancy (with the exception of histology or cytology at autopsy). This date should be, in the following order: a. date when the specimen was taken, or b. date of receipt by the pathologist, or c. date of the pathology report 2. Date of admission to hospital because of this malignancy. 3. When evaluated at an out-patient clinic only: date of first consultation at the out-patient clinic because of this malignancy. 4. Date of diagnosis, other than 1, 2 or 3. 5. Date of death, if no information is available other than the fact that the patient has died because of malignancy. 6. Date of death, if the malignancy is discovered at autopsy.

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3.2	HISTOLOGICALLY /CYTOLOGICALLY CONFIRMED			*To establish the certainty of diagnosis and in particular the histological confirmation rate for epidemiological analyses.	Y N
3.3	CONFIRMED BY	O	Multiple selection possible		1-Rigid sigmoidoscopy 2-Flexible sigmoidoscopy 3-Colonoscopy 4-CT Colonography 5-Barium enema 6-Other, specify
3.4	BASIS IF NO HISTOLOGY	O			1-Radiology 2-Clinical examination 3-Tumour marker 4-Other, specify
3.5	ICD MAJOR SITE CODE (ICD) [Primary Site]	E		NBCA	Mappable to ICD-10 1- C18.0: Caecum 2-C18.1: Appendix 3-C18.2: Ascending cloln 4-C18.3: Hepatic flexure 5-C18.4: Transverse 6-C18.5: Splenic flexure 7-C18.6: Descending colon 8-C18.7: Sigmoid colon 9-C19: colon with rectum Rectosigmoid 10-C20: Rectum 11-C21:Anus
3.6	SYNCHRONOUS SITE CAECUM	O	No Yes	NBCA	N Y
3.7	SYNCHRONOUS SITE APPENDIX	O	No Yes	NBCA	N Y
3.8	SYNCHRONOUS SITE ASC COLON	O	No Yes	NBCA	N Y
3.9	SYNCHRONOUS SITE TRAN COLON	O	No Yes	NBCA	N Y
3.10	SYNCHRONOUS SITE SPLENIC FLEX	O	No Yes	NBCA	N Y
3.11	SYNCHRONOUS SITE DESC COLON	O	No Yes	NBCA	N Y

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
3.12	SYNCHRONOUS SITE SIG COLON	O	No Yes	NBCA	N Y
3.13	SYNCHRONOUS SITE RECTO SIG	O	No Yes	NBCA	N Y
3.14	HEIGHT ABOVE ANAL VERGE	E	RECTAL CANCER ONLY Height of Tumour above Anal Verge (cm to nearest whlole number) measured by rigid/flexible sigmoidoscopy	NBCA	Numeric (2)
3.15	HEIGHT ABOVE ANAL VERGE MEASUED BY	O			1-Rigid sigmoidoscopy 2-Flexible sigmoisoscopy 3-Unknown
3.16	MODIFIED DUKES	E		NBCA	1-A 2-B 3-C1 4-C2 5-D 99-Not known
3.17	DATE COLONSCOPY	O			Date format DD/MM/YYYY
3.18	RESULT COLONOSCOPY	E		NBCA	1-Normal 2-Abnormal (cancer detected whether complete or not) 3-Inadequate (No cancer but incomplete examination) 4-Not done
3.19	REASON COLONOSCOPY INCOMPLETE	E		NBCA	1-Obstructing cancer 2-Poor bowel prep 4-Other 5-Patient intolerance 6-Technical reasons
3.20	COLONOSCOPY COMPLICATIONS	O		NBCA	1-Bleeding 2-Perforation 3-Other 4-No complication
3.21	COLONONOSCOPY FINDINGS	O			Text
3.22	DATE BARIUM ENEMA	O		NBCA	Date format DD/MM/YYYY
3.23	RESULT BARIUM ENEMA	O		NBCA	1-Normal 2-Abnormal (cancer) 3-Inadequate (bowel not fully visualised)

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
					4-Not done
3.24	BA ENEMA SUMMARY				Text
3.25	CT COLONOGRAPHY	O		NBCA	1-Normal 2-Abnormal (cancer or polyp detected) 3-Inadequate (incomplete or technically unsatisfactory examination) 4-Not done
3.26	DATE MRI SCAN 1	O	RECTAL CANCER ONLY	NBCA	Date format DD/MM/YYYY
3.27	T STAGE MRI SCAN 1	E	RECTAL CANCER ONLY	NBCA	Tx T1 T2 T3 T4
3.28	N STAGE MRI SCAN 1	E	RECTAL CANCER ONLY	NBCA	N0 N1 N2
3.29	MARGIN THREATENED	E	1st MRI Scan Margin Threatened - Result No Yes Uncertain RECTAL CANCER ONLY	NBCA	N (Clear) Y (Involved) U (Threatened)
3.30	DATE MRI SCAN 2	O	RECTAL CANCER ONLY	NBCA	Date format DD/MM/YYYY
3.31	RESULT MRI SCAN 2	O	RECTAL CANCER ONLY	NBCA	01-No change in bulk 02-Increase in bulk 03-Reduction in bulk
3.32	DATE ERUS	O	RECTAL CANCER ONLY	NBCA	Date format DD/MM/YYYY
3.33	RESULT ERUS	O	RECTAL CANCER ONLY	NBCA	TX T1 T2 T3 T4
3.34	DATE ABDO USS	O		NBCA	Date format DD/MM/YYYY

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
3.35	RESULT ABDO USS	O		NBCA	M0-Normal liver M1-Liver Mets 03-Liver uncertain
3.36	OTHER IMAGING SUMMARY	O			Text
3.37	OTHER ENDOSCOPY SUMMARY				Text
3.38	HEIGHT	E		NBCA	Numeric(CM)
3.39	WEIGHT	E		NBCA	Numeric(KG)
3.40	MRI SUMMARY	O	RECTAL CANCER ONLY		Text
3.41	DATE CT COLONOGRAPHY	O			Date format DD/MM/YYYY
3.42	CT COLONOGRAPHY SUMMARY				
3.43	DATE CT SCAN	O		NBCA	Date format DD/MM/YYYY
3.44	RESULT CT SCAN	E		NBCA	M0-(Normal liver) M1-(Liver Mets) 3-Liver uncertain
3.45	CT SUMMARY	O			Text
3.46	DATE PET SCAN				Date format DD/MM/YYYY
3.47	PET SUMMARY				Text
3.48	CLINICAL EXAMINATION FINDINGS				Text
3.49	CO-MORBIDITIES	O	Multiple options [details if present]		01-Ischaemic heart disease 02-CHF, Other cardiac 03-COPD 04-Chronic renal impairment 05-Diabetes 06-Dementia 07-Cerebro vascular disease 08-Peripheral vascular disease 09-Hypertension 10-Other malignancy 11-Other,specify
3.50	PERFORMANCE STATUS	O			**WHO** 0 - Able to carry out all normal activity without restriction 1 - Restricted in physically strenuous activity but able to walk and do light work 2 - Able to walk and capable of all self care but unable to carry out any work. Up and

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					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
4	**Pre treatment stage**				
4.1	FINAL PRE TREATMENT T CAT	O		NBCA	TX T1 T2 T4
4.2	FINAL PRE TREATMENT N CAT	O		NBCA	NX N0 N1 N2
4.3	FINAL PRE TREATMENT M CAT	O		NBCA	MX MO M1
4.4	DISTANT METS LIVER	E		NBCA	1-None 2-Uncertain 3-Certain
4.5	DISTANT METS LUNG	E		NBCA	1-None 2-Uncertain 3-Certain
4.6	DISTANT METS BONE	E		NBCA	1-None 2-Uncertain 3-Certain
4.7	DISTANT METS OTHER	E		NBCA	1-None 2-Uncertain 3-Certain
5	**Cancer Care Plan**				
5.1	WAS CANCER CARE PLAN DISCUSSED AT MDT MEETING	E	No Yes	NBCA	N Y
5.2	DATE MDT DECISSION TO TREAT	M	Date 1st treatment plan agreed by MDT		Date format
5.3	REASON FOR DISCUSSION	O			1-Pre-op

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
					2-Post-op 3-Post neoadjuvant therapy 4-Other
5.4	MDM UPDATE	O			Text
5.5	MDM ACTION	O			Text
5.6	ONWARD REFERRALS	O		Multiple selection	1-Oncology 2-Specialist Palliative medicine
5.7	PLANNED 1ST TREATMENT	M		Required for Analysis of Waiting Times.	01-Surgery 02-Teletherapy 03-Chemotherapy 04-Hormone Therapy 05-Specialist palliative care 06-Brachytherapy 07-Biological 08-Other 09-Active Monitoring 99-Unknown
5.8	CANCER CARE PLAN INTENT	M	**Curative-treatment** :given with the potential for cure (radical treatment) even if the proportion of patients achieving long term disease control is small **Palliative-anticancer treatment** Where the intent is life prolongation with disease control /disease–free episodes. **Palliative supportive treatment** Where the aim of treatment is symptom control or to improve quality of life or minimal life extension (weeks or months) in advanced progressive disease.	To enable analysis of treatment planned versus treatment given	01-Curative 02-Palliative anticancer 03-Palliative supportive treatment 04-No specific anti-cancer treatment 99-Not known
5.9	DATE PATIENT INFORMED OF CANCER DIAGNOSIS	M		Required for Analysis of Waiting Times	Date format
5.10	SEEN BY SPECIALIST NURSE [colorectal nurse/stoma therapist]	E	No Yes	NBCA	N Y
5.11	DATE SEEN BY SPECIALIST NURSE [colorectal	O			

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
	nurse /stoma therapist]				
5.12	FINAL DIAGNOSIS	O			1-Carcinoma of caecum 2-Carcinoma of ascending colon 3- Carcinoma of descending colon 4- Carcinoma of transverse colon 5- Carcinoma of sigmoid colon 6- Carcinoma of ascending colon 7- Carcinoma of splenic flexure 8- Carcinoma of hepatic flexure 9- Carcinoma of appendix 10- Carcinoma of rectum 11- Carcinoma of rectosigmoid junction 12-Carcinoma of anal canal 13-Uncertain at present 14-Inflammatory bowel disease 15-Other [free text]
6	**Surgery**				
6.1	SURGERY PERFORMED	O			01-No 02-Yes
6.2	REASON SURGERY NOT PERFORMED	O			01-Patient refuses treatment for whatever reason 02-Patient unfit 03-Advanced disease 08-Other
6.3	DECISION TO TREAT DATE (SURGERY) [Date of decision to operate]	M*	The date that it was decided that this patient should receive **surgery if surgery was the 1st treatment planned**. This is the date that the consultation between the patient and the clinician took place and a treatment plan for surgery was agreed.		Date format
6.4	ORGANISATION CODE [Provider of surgery]	M*	Required for analysis of waiting times *If surgery was 1st planned therapy*	*Required because different activities for a patient may be carried out at different service provider sites. To enable reports and analysis by hospital	HPSS Hospital provider codes

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
6.5	START DATE SURGERY [Date of surgery]	E	The date that the surgical procedure(s) below started.	*To determine the time interval between referral/diagnosis by the specialist team and start of surgical treatment.	Date format
6.6	RESPONSIBLE SURGEON	O	Consultant in charge of list		HPSS Consultant codes
6.7	MAIN OPERATING SURGEON	O			HPSS Consultant codes
6.8	OPERATING SURGEON GRADE	O		NBCA	1-Consultant 2-Associate specialist 3-Staff grade/Clinical assistant 4-SPR 5-SHO
6.9	ANAESTHETIST GRADE	O		NBCA	01-Consultant 02-NCCG 03-SPR 04-SHO 05-Other
6.10	START DATE 1ST PROCEDURE	O	Start date of 1st definitive procedure treatment	NBCA	Date format
6.11	POSSUM OPERATIVE SCORE	O			Numeric
6.13	POSSUM PHYSIOLOGIC SCORE	O			Numeric
6.14	ACP CRC SCORE	O			Numeric
6.15	POSSUM MORTALITY RISK %	O			Numeric
6.16	ACP MORTALITY RISK %	O			Numeric
6.17	ASA GRADE	E		NBCA	I-Fit II-Relevant disease III-Restrictive disease IV-Life threatening disease V-Moribund 99-Not known
6.18	SURGERY INTENT	M*		NBCA	C-Curative P-Palliative U-Uncertain 9-Unknown
6.19	START TIME OF SURGERY (24HRS)	O		NBCA	Numeric (00:00 FORMAT)
6.20	MODE OF SURGERY	E		NBCA	01-Elective 02-Scheduled 03-Urgent

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					04-Emergency 99-Urgency unknown
6.21	**PRIMARY PROCEDURE**	E		NBCA	Right hemicolectomy H07.9 Extended right hemicolectomy H06.9 Transverse colectomy H08.9 Left hemicolectomy H09.9 Sigmoid colectomy H10.9 Anterior resection H33.4 APER H33.1 Hartmann's procedure H33.5 Total colectomy and ileorectal anastomosis H051 Trans Anal Resection of Tumour [TART] H41.9 Total excision of colon and rectum H04.1 Tot. exc. colon & rectum + anast. ileum to anus + create pouch H04.2 TEMS H41.2 Stent H24.3 Polypectomy: End. Extirpation lesion colon (exc. sigmoid H20.1 Polypectomy:End. Extirpation lesion lower bowel (fibreoptic sigmoidoscopy) H23.9 EUA only with/without biopsy H44.4 Laparotomy only T30.9 Laparoscopy only T43.9 Stoma only ileostomy G74.9 Stoma only colostomy H15.9 Other 98
6.22	SURGICAL ACCESS	E		NBCA	1-Open operation 2-Laparoscopic then open 3-Laparoscopic converted to open 4-Laparoscopic completed

	Data Item	**Data Indicator** M = MANDATORY O = OPTIONAL	**Description**	**Purpose**	**Codes and Classifications**
6.23	COMPLICATIONS OF CANCER	O		NBCA	0-None 1-Pericolic abscess 2-Free perforation 3-Intestinal obstruction 98-Other
6.24	ANASTOMOSIS DONE	O	No Yes	NBCA	N Y
6.25	ANASTOMOSIS TYPE	O		NBCA	1-Intracorporeal 2-Extracorporeal 3-None
6.26	STOMA PROCEDURE	E		NBCA	0-Not done 1-Ileostomy temporary 2-Ileostomy permanent 3-Colostomy temporary 4-Colostomy permanent
6.27	DATE STOMA CLOSED	O			Date format
6.28	REASON DELAYED STOMA CLOSURE	O	> 3mths after surgery		Text
6.29	BOWEL DIVISION TYPE	O		NBCA	1-Intracorporeal 2-Extracorporeal 3-None
6.30	DATE OF DEATH/DISCHARGE	E		NBCA	Date format
6.31	MAJOR POSTOP COMPLICATION	E		NBCA	01-None 02-Leak 03-Abscess 04-Bleed 05-Obstruction 06-Readmission 07-Other
6.32	LAPAROSCOPIC COMPLICATIONS	O		NBCA	1-None 2-Surgical emphysema 3-Pulmonary insufficiency 4-Significant intraoperative haemorrhage 5-Duodenal injury 6-Small bowel injury 7-Ureteric injury 8-Major vessel injury 9-Gross faecal contamination 10-Bladder injury 11-Injury by trocar

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					12-Other injury by instrument
6.33	EARLY PORT SITE COMPLICATION	O		NBCA	1-No complication 2-Port site sepsis 3-Port site bleeding/haemangioma 4-Other
7	**Pathology**		Note: it is expected that all the data items on the minimum RCPath dataset will be collected. The pathology data items below are a subset of that dataset		
7.1	DATE SPECIMEN RECEIVED	O		NBCA	Date format
7.2	DATE SPECIMEN REPORTED	O		NBCA	Date format
7.3	SYNCHRONOUS CANCER	O	No Yes Not known	NBCA	N Y 9
7.4	MAXIMUM TUMOUR DIAMETER(mm)	O		NBCA	Numeric
7.5	SITE OF TUMOUR				Mappable to ICD10 As for 3.4
7.6	HISTOLOGY	M		NBCA	Mappable to SNOMED which in turn maps to ICD-O coding
7.7	POSITIVITY OF CUT COLON OR RECTUM	O		NBCA	0-Margin not involved 1-Margin involved 99-Not known
7.8	DISTANCE TO CUT MARGIN(mm)	O		NBCA	Numeric
7.9	CIRCUMFERENTIAL MARGIN	E		NBCA	0-Margin not involved 1-Margin involved 99-Not known
7.10	DISTANCE TO CIRCUMDERENTIAL MARGIN(mm)	O		NBCA	Numeric
7.11	TUMOUR GRADE	M		NBCA	GX - Grade of differentiation is not appropriate or cannot be assessed G1 - Well differentiated G2 - Moderately differentiated G3 - Poorly differentiated G4 - Undifferentiated/anaplastic
7.13	NODES EXAMINED	E		NBCA	Numeric

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7.14	NODES POSITIVE	E		NBCA	Numeric
7.15	TUMOUR PERFORATION	O	No Yes	NBCA	N Y, serosal Y, retro/infra peritoneal
7.16	DISTANCE LOWER END OF TUMOUR TO RESECTION MARGIN(mm)	O		NBCA	Numeric
7.17	DISTANCE LOWER END OF CANCER TO DENTATE LINE(mm)	O	RECTAL CANCER ONLY	NBCA	Numeric
7.18	QUALITY OF RECTAL TME	O	RECTAL CANCER ONLY		1-Grade1 2-Grade2 3-Grade3
7.19	RESPONSE TO NEOADJUVANT THERAPY	O	RECTAL CANCER ONLY		1-No residual tumour cells/musus lakes only 2-Minimal residual tumour 3-No marked regression 4-Not applicable
8	**Staging**				
8.1	RESECTION STATUS	O			R0 R1 R2
8.2	T CATEGORY (PATHOLOGICAL) [Pathological T category]	E	The extent of the primary tumour after excision or biopsy of the primary cancer.	NBCA	UICC 6th edition with optional Sub-divisions of T3 & T4 Tx (y)pT0 (y)pT1 (y)pT2 (y)pT3,3a,3b,3c,3d (y)pT4,4a,4b
8.3	N CATEGORY (PATHOLOGICAL) [Pathological N category]	E	The histological evidence of the absence or presence and extent of regional lymph node metastases.	NBCA	Nx (y)pN0 (y)pN1 (y)pN2
8.4	M CATEGORY(PATHOLOGICAL/CLINICAL)	E		NBCA	Mx (y)M0 (y)M1
8.5	PATHOLOGICAL DUKES STAGING	O		NBCA	A B C1 C2

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					99-Not known
8.6	TNM CATEGORY [stage group]	M	Overall clinical TNM stage of the tumour, derived from each T, N, M component prior to treatment	*To allow for this factor to be taken into account in the analysis of treatment and outcome.	UICC Coding

9	**Oncology: Chemotherapy/hormone therapy and other drugs**		Chemotherapy and/or other anti-Cancer and/or Supportive drugs given to the patient during their treatment.		
9.1	RESPONSIBLE ONCOLOGIST	M*		NBCA	HPSS Consultant codes
9.2	DATE 1st SEEN [oncology]	M*			Date format
9.3	DECISION TO TREAT DATE (ANTI-CANCER DRUG THERAPY) [Date of decision to treat]	M*	Definition as for surgery (8.1) Required for analysis of waiting times *if chemotherapy was the 1st treatment planned.*		Date format
9.4	HOSPITAL OF ANTI-CANCER DRUG THERAPY [Hospital]	M*	Required for analysis of waiting times If Chemotherapy was 1st planned therapy	*Required because different activities for a patient may be carried out at different service provider sites. To enable reports and analysis by hospital NBCA	
9.5	DRUG THERAPY TYPE	O	Multiple selection		01-Chemotherapy 02-Hormone/endocrine therapy 03-Immunotherapy 04-Other
9.6	DRUG REGIMEN ACRONYM	O			TEXT (as per COIS regimen list)
9.7	DRUG THERAPY TREATMENT INTENT	M*	The intended outcome of treatment	*To establish the frequency of different treatment intents. To monitor treatment related outcomes. To assess patterns of chemotherapy practice for comparison with best practice guidelines NBCA	01-Curative 02--Palliative 03- Adjuvant 04-Neoadjuvant 99- Not known (default)
9.8	START DATE (anti-cancer drug therapy]	M*	Record the date on which the first dose of the drug is administered to the patient.	*To enable the date of the first definitive treatment to be recorded. Cancer Registries only require the start date of the first chemotherapy course NBCA	Date format
9.9	DRUG THERAPY CLINICAL TRIAL STATUS	O		NBCA	Y-EE-eligible, consented and entered N-ED-eligible , declined trial
9.10	DRUG TREATMENT COURSE STATUS	O			01-Treatment completed as prescribed 02-Patient died 03-Progressive disease during chemotherapy

					04-Acute chemotherapy toxicity 05-Technical or organisation problems 06 - Patient choice (stopped or interrupted treatment) 99 – Not known (default) 02-Yes
9.11	RESPONSE TO DRUG TREATMENT		For chemotherapy: this should be assessed at the completion of the planned chemotherapy. For continuous treatment: record the maximum response.		01 - Complete Response 02 - Partial response 03 - Static Disease 04 - Progressive Disease 05 - Not assessed 06 - Unassessable
9.12	HOSPITAL OF RADIOTHERAPY [Hospital	M*	Required for analysis of waiting times *If Radiotherapy was 1st planned therapy*	NBCA	HPSS Hospital provider codes
9.13	DATE DECISION TO TREAT DATE(RADIOTHERAPY)	M*	Definition as for surgery (8.1) Required for analysis of waiting times *If Radiotherapy was 1st planned therapy*	To monitor delays.	Date format
9.14	RADIOTHERAPY TREATMENT INTENT	M*	The intended outcome of treatment	*To establish the frequency of each treatment intent. To monitor treatment related outcomes. To assess patterns of teletherapy practice for comparison with best practice guidelines	01-Curative Adjuvant 02-Curative neoadjuvant 03- Palliative 99- Not known (default)
9.15	RADIOTHERAPY ANATOMICAL TREATMENT SITE	O		NBCA	OPCS-Z code
9.16	RADIOTHERAPY TYPE	E		NBCA	1-None 2-Short course preoperative 3-Long course preoperative 4-Postoperative 5-Definitive 6-Palliative
9.18	START DATE (RADIOTHERAPY)	M*	Record the date on which the first fraction of radiotherapy administered to the patient.	*To enable the date of the first definitive treatment to be recorded. NBCA	Date format
9.19	RADIOTHERAPY CLINICAL TRIAL STATUS	O		NBCA	Y-EE-eligible, consented and entered N-ED-eligible , declined trial
9.20	RADIOTHERAPY ACTUAL DOSE	O			Numeric
9.21	RADIOTHERAPY ACTUAL FRACTIONS	O			Numeric
9.22	RADIOTHERAPY				01- Treatment completed as prescribed

	TREATMENT COURSE STATUS				02 -Not completed - Patient died 03- Course not completed - Progressive disease during radiotherapy 3 - Course not completed - Acute Radiotherapy toxicity 4 - Course not completed - Technical or organisational problems 5 - Treatment stopped or interrupted - Patient choice 99 – Not known (default)
10	**Palliative Care**				
10.1	PALLIATIVE CARE NEEDS ASSESSMENT				01-General palliative care 02-Specialist palliative care
10.2	DECISION TO TREAT DATE (SPECIALIST PALLIATIVE TREATMENT COURSE)	M*	This is the date that the consultation between the patient and the clinician took place and a treatment plan for palliative care was agreed.	For analysis of waiting times	Date format
10.3	START DATE (SPECIALIST PALLIATIVE TREATMENT COURSE)	M*	The date of the first treatment/support from Specialist Palliative Care	For analysis of waiting times	Date format
11	**Follow-up details**				
11.1	DATE FOLLOW-UP	M		NBCA	Date format
11.2	LOCAL RECURRENCE AT FOLLOW UP	O		NBCA	N-No evidence of primary tumour Y-Recurrent primary tumour
11.3	LOCAL RECURRENCE DIAGNOSED BY	O		NBCA	1-Histology 2-Imaging 3-Clinical 99-Other
11.4	WOUND RECURRENCE	O		NBCA	N-No Y-Yes
11.5	PORT SITE RECURRENCE	O		NBCA	N-No Y-Yes
11.6	METASTATIC STATUS	O		NBCA	N-No evidence of metastases Y-New distant metastases
11.7	SITE DISTANT SPREAD	O		NBCA	1-Liver 2-Lung 3-Bone 4-Other
11.8	LATE SURGICAL COMPLICATIONS	O			1-Bladder dysfunction 2-Sexual dysfunction 3-Other ,specify
11.9	DATE RELAPSE/PROGRESSION	O			Date format
11.10	TREATMENT FOR RELAPSE/PROGRESSION	O	Multiple selection possible		01-Surgery 02-Chemotherapy/anticancer drug therapy

					03-Radiotherapy 04-Immunotherapy
11.6	DEATH DATE	M*			Date format
11.7	PLACE OF DEATH	O			01-Hospital 02-NHS hospice/specialist palliative care unit 03-Voluntary hospice/ specialist palliative care unit 04-Patient's own home 05-Care home 99-Other
11.8	CAUSE OF DEATH	O			01- death by first registered primary 02- death by another primary 03- death by other causes/cancer known to be present 04- death by other causes, cancer not mentioned 05– indeterminate cause of death (more than one primary) 06 - death from metastatic disease where origin of primary is known 07 - death by metastatic disease where origin of primary is unknown