Public Health England

Protecting and improving the nation's health

Cancer Outcomes and Services Dataset (COSD) Version 7.0.8

User Guide

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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The intelligence networks

Public Health England operates a number of intelligence networks, which work with partners to develop world-class population health intelligence to help improve local, national and international public health systems.

National Cancer Intelligence Network

The National Cancer Intelligence Network (NCIN) was a UK-wide initiative, working to drive improvements in cancer awareness, prevention, diagnosis and clinical outcomes by improving and using the information collected about cancer patients for analysis, publication and research.

NCIN has now become part of the National Cancer Registration and Analysis Service (NCRAS), which is part of Public Health England (PHE). The NCIN website will be re-branded shortly to reflect these changes but will continue to publish additional information and updates on the COSD webpages.

National Cardiovascular Intelligence Network

The National cardiovascular intelligence network (NCVIN) analyses information and data and turns it into meaningful timely health intelligence for commissioners, policy makers, clinicians and health professionals to improve services and outcomes.

National Child and Maternal Health Intelligence Network

The National Child and Maternal Health Intelligence Networks (NCMHIN) provides information and intelligence to improve decision-making for high quality, cost effective services. Their work supports policy makers, commissioners, managers, regulators, and other health stakeholders working on children's, young people and maternal health.

National Mental Health Intelligence Network

The National Mental Health Intelligence Network (NMHIN) is a single shared network in partnership with key stakeholder organisations. The Network seeks to put information and intelligence into the hands of decision makers to improve mental health and wellbeing.

National End of Life Care Intelligence Network

The National End of Life Care Intelligence Network (NEoLCIN) aims to improve the collection and analysis of information related to the quality, volume and costs of care provided by the NHS, social services and the third sector to adults approaching the end of life. This intelligence will help drive improvements in the quality and productivity of services.

Version Control

Version	Date	Brief Summary of Change	Editor
Version 7.0	21.06.2016	Changes since publication of Version 6.0 of dataset, including any errata.	Andrew Murphy
Version 7.0.1	13.09.2016	Corrections to CR6480 & CR6490 to correct error	Andrew Murphy
Version 7.0.2	16.09.2016	Corrections to Recurrence Section 0.3 (pages 21-23)	Andrew Murphy
Version 7.0.3	04.01.2017	Corrections to Date of Recurrence field code (pg19), Ann Arbour Stage 4 (CTYA pg127 & Haem pg163) and Unplanned Return To Theatre (pg52) and UICC TNM version (pg264)	Andrew Murphy
Version 7.0.4	24.02.2017	Corrections to Breast Prognostic Index (Breast pg93)	Andrew Murphy
Version 7.0.5	08.05.2017	Corrections to Regional Anaesthetic Technique (Lung pg180), ICD-O-3 (9771/3 correction pg154), Skin recording corrections(pg194-195), Further explanation to support Site of Diagnosis (pg35-36)	Andrew Murphy
Version 7.0.6	10.05.2017	Update to Appendix B (Registrable Conditions) D04* is no longer required to be collected for COSD and added new mapping table for BA3160 (pg68)	Andrew Murphy
Version 7.0.7	10.08.2017	Update to Performance Status definition (pg37-pg38)	Andrew Murphy
Version 7.0.8	14.12.2017	Updated Appendix E, showing the staging requirements by tumour site from January 2018. This is when TNM 7 changes to TNM 8	Andrew Murphy

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Status – User Guide

Cancer Outcomes and Services Dataset – Version 7.0 Release (April 2017)

This User Guide is one of a suite of documents to aid Users in implementing the COSD Information Standard (ISN SCCI 1521)[1] which was mandated from January 2013. It includes all the data items in COSD, together with definitions, formats, codes and values and additional guidance on collection and implementation.

This User Guide is aligned with, and should be read in conjunction with version 7.0 of the dataset which is available to download on the NCIN website[2]. Other guidance and supporting documents are also available on the NCIN website and we are continuing to explore an online version of the Guide.

This revised version of the User Guide incorporates some amendments to the dataset, an extension of scope and a revision of the current schema specification in order to continue to meet the business objectives of the standard. It accompanies a change notice for the standard (Amd 01/2016) which has been accepted by the Standardisation Committee for Care Information (SCCI), see the section "What's changed" for a summary of changes.

Implementation of the Standard is carried out by the National Cancer Registration and Analysis Service (NCRAS) and queries regarding implementation should initially be raised with the Data Liaison staff at the local offices of the NCRAS.

Queries regarding the Standard itself should be addressed in the first instance to COSDenquiries@phe.gov.uk or your local NCRAS Liaison Manager (their details can be obtained from the CancerStats portal).

All Providers have access to their current monthly position via CancerStats[3] (NHS N3 connections only) which has been established by the NCRAS. This provides feedback on files submitted (Level 1) and completion for some key data items (Level 2), where the files are submitted in the prescribed XML format. It also now includes the next level of reports (Level 3), which covers data that has been processed and quality assured by the NCRAS.

In addition there are now reporting tools for the National Lung Cancer Audit (NLCA) and the National Prostate Cancer Audit (NPCA) as well as access to population level Incidence, Mortality and Survival data. It is expected that in 2017 there will be additional reporting of the National Radiotherapy dataset (RTDS), Clinical Headline Indicators (CHI) and COSD Pathology.

We would like to take this opportunity to thank all those who have been involved in the development and implementation of the Standard and encourage you to continue to send us your comments which help to identify necessary amendments and improvements. A new COSD Advisory Board has also been created which has Trust level representation to help manage change moving forward.

Andrew Murphy,

Head of Cancer Datasets

National Cancer Registration and Analysis Service (NCRAS),

Public Health England (PHE)

June 2016

[1] http://www.hscic.gov.uk/isce/publication/scci1521

[2] http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd

[3] https://nww.cancerstats.nhs.uk/users/sign_in

What's changed since User Guide 6.1

This updated version of the User Guide includes new data-items, re-alignment of data structure, amendments and contains corrections e.g. where there were errors in previous versions and updates where clinical coding or staging values changed from COSD Dataset v6.0, and should be used to help data collection.

Recurrences

There is now a new section to help and support MDT Coordinators and Cancer Service teams record more accurately recurrences. It is a national priority to record all recurrences and this was highlighted in sections 5.2.4 (Secondary cancer and recurrence) and 8.6 (Cancer Data and Intelligence) within the Achieving World-Class Cancer Outcomes, A Strategy for England 2015-20 (Cancer Taskforce Report).

Especially Recommendation 90:

> **Public Health England and NHS England should establish robust surveillance systems and, if possible, mandate the collection of data on recurrent and secondary cancer occurrences for all cancers and make this available for analysis and research.**

In addition there are plans for v8.0 to make the recording of recurrence, metastatic disease, relapse, progression and transformation easier and more logical with a new pathway selector.

Introduction

What is the Cancer Outcomes and Services Dataset?

The Cancer Outcomes and Services Dataset (COSD) is the national standard for reporting cancer in the NHS in England. It replaced the former National Cancer Dataset and the former Cancer Registration Dataset and includes additional site specific data items relevant to the different tumour types. It is aligned with other national cancer datasets, including Cancer Waiting Times(NCWTMDS)[4], Radiotherapy (RTDS)[5], Systemic Anti-Cancer Therapy (SACT)[6] and Diagnostic Imaging (DID)[7].

Why is it needed?

We needed to revise the National Cancer Dataset to ensure that we meet the current information requirements for the NHS. The Cancer Reform Strategy (2007) identified better information and stronger commissioning as two of the key drivers to achieve the goal that cancer services in this country should be amongst the best in the world. The subsequent Improving Outcomes: A Strategy for Cancer (January 2011) further supported this concept to demonstrate cancer outcomes using high quality data and intelligence for all stakeholders.

The Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020 (Taskforce Report) further strengthens the need to have strong cancer data collection and empowers both PHE and NHS England to enforce this through the mandate of data collection. These data will be the base for cancer analysis and research for the next five years.

What is included in the COSD data collection?

The COSD specifies the data items that need to be recorded for all cancer patients by the NHS in England. This includes all the items that Providers should submit electronically directly to the National Cancer Registration and Analysis Service on a monthly basis.

These items can be submitted from different systems such as Cancer Management Information System software, PAS (Patient Administration Systems) and Pathology.

Whilst some of these items are generic there are also a number of site specific items which are required in order to record and analyse services and outcomes. These items are also required locally by service providers for patient management and clinical care.

This Guide provides a description of the data items, the tumour sites or disease types to which they apply and any further information needed to collect them.

Some items in the COSD are submitted through other standard NHS routes such as Cancer Waiting Times and do not need to be submitted directly for COSD (although some key items, such as treatment details, need to be submitted for both). There are also some items which the NCRAS receive or derive from other sources and which do not therefore need to be submitted directly by Service Providers. Both subsets of items which do not need direct submission, but which are included in the full dataset, are shown in Appendices K and L.

Data from all sources, whether direct Provider submissions from other national collections or derived from other sources, are linked by the NCRAS at patient and tumour level using NHS Number to complete the full dataset.

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[4] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp?shownav=1

[5] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/radiotherapy_data_set_fr.asp?shownav=1

[6] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/systemic_anti-cancer_therapy_data_set_fr.asp?shownav=1

[7] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/diagnostic_imaging_data_set_fr.asp?shownav=1

Other guidance documentation

Technical Guidance and Implementation Guidance is provided separately and is available on the NCIN website.

Which diagnoses does COSD apply to?

For the purposes of COSD the term "cancer" relates to all conditions defined as registerable by the UK and Ireland Association of Cancer Registries (UKIACR) and these are listed in Appendix B. This covers all new diagnoses and secondary/metastatic breast cancer from 1st January 2013.

All recurrences diagnosed from 1st July 2015 must now be included. All recurrences diagnosed from 1st April to 31st June 2015 can be included if available.

What data items should be completed?

All registerable conditions should be reported as defined in Appendices A and B. This includes submitting all pathology reports for these cases.

For Non Melanoma Skin Cancer's (NMSC) which do not require discussion at MDT, only pathology reports are required to be included in the submitting organisation's monthly pathology feed to the NCRAS. No other information needs to be submitted for COSD[8].

For all other new cases (as a minimum) the core dataset should be completed, including all applicable data items. In addition to the core dataset, most cases will also require a site specific dataset to be completed.

For under 25s, there may be two "site specific" datasets completed (CTYA and disease specific), depending on the nature of the disease and where the patient is treated. Please see CTYA section 5.1 of this Guide for further details[9].

For breast recurrences see the Breast section, for all other recurrences a new record should be submitted (see new recurrence section). A new section to help and support cancer service teams and MDT/Patient Pathway Coordinators has been created starting on pg.19

How is Pathology recorded?

There is also a separate schema for reporting pathology data items. These data should be reported by the pathologist, directly from their Laboratory Information Management Systems (LIMS), and sent monthly to the NCRAS (from the pathology department) in structured COSD XML.

It is not expected therefore that MDT Coordinators or other non-clinical staff, should attempt to read and transcribe these reports and information into COSD. The reduction in their workload by removing this duplication is estimated to be approximately 30%, and this time should be used to ensure full compliance for data collection across all other data-items.

[8] Please see section **11. Skin** for more information and definition of tumours that fall under the NMSC header.

[9] There are plans to improve the collection of CTYA data items across the dataset to help reduce duplication.

Schema Specification

Mandatory

The CORE LINKAGE items are Mandatory and must be submitted for all records. It is vital that these are always available so that the correct information can be linked to the right patient and the correct tumour. ***A record will not be able to be submitted if any mandatory data item is missing***. These records should not be added to the main file otherwise the whole file will fail the schema.

Required

Most other data-items are set as 'Required'. This means that if they are applicable to the reported tumour or patient pathway, they **must** be completed and treated as a mandatory item. Not every data-item however will be applicable to every patient or tumour, by using 'Required', this allows for a more accurate and inclusive collection of data. Therefore all applicable data in each section marked as 'required' must be submitted for each record as soon as available.

Pilot

In some cases new data-items maybe piloted by a small group of Trusts. These data **do not** have to be completed by any other Trust unless you are part of the pilot. If you want to submit these data, please speak with your regional NCRAS liaison team(s). All pilot data-items are under review and may change in future version controls of COSD[10].

Optional

There are a few data-items that are optional, any Trust can submit these data, but there is no requirement to enforce this data collection at this point. All optional data-items are under review and may change in future version controls of COSD.

Items marked as "X"

In the schema specification items marked as "X" should not be submitted as part of the COSD data flow from Providers. These items will be collected from other sources such as ONS (See Appendix L) or are submitted under other standards such as Cancer Waiting Times and RTDS (See Appendix K). Items that are shared specifically with the Cancer Waiting Times dataset (NCWTMDS) are marked as (CWT) in the relevant descriptions. However for COSD these items are all extended to relate to all registerable conditions. Definitions within these items for "primary cancer" are therefore also extended to cover all registerable conditions.

Meaning of "NOT KNOWN" value

"Not known" includes both "not recorded" and for example "test not done". This is usually coded 9 or 99 (depending on the data item format).

List of Registerable Diseases

The ICD10 disease codes lists for all registerable conditions (C & D codes) are provided in Appendices A and B. The Haematology ICDO3 codes list can be found in Section 7.2 ICD codes and WHO disease groups.

When should the data be submitted?

The deadline for first submitting a record is 25 working days after the end of month of Diagnosis. All available relevant data items should be included and additional information or updates not available at the time should be uploaded with ensuing monthly submissions. Treatments not submitted with the initial record should also be submitted within 25 working days of the end of month of the Treatment Start Date. See Appendix H for further details.

It is important to note that COSD and CWT will no longer be reported on the same day. CWT are planning to reduce the reporting time following the end of each month, whereas (due to the size and complexity of the data), COSD will continue to use the full 25 working days.

The reporting dates can be found on the CancerStats website.

[10] There are currently no new data-items being piloted by Trusts.

Online Training

A free online training course, “Understanding Cancer”, aimed primarily at non clinical staff, is available to support those involved in collecting the data. See Appendix M for further details.

Feedback and Queries

This User Guide provides additional information to support the COSD Specification and should also be used in conjunction with the COSD Dataset v7.0. Implementation and Technical Guidance documents are also available for further information on the NCIN website.

Feedback and questions relating to the COSD are welcomed and should be emailed to COSDenquiries@phe.gov.uk

I would like to express my thanks to all those who have participated and continue to provide support and guidance in the development of this information standard. Specific thanks goes to the COSD Advisory Group and SSCRG members for helping to guide COSD and continue to ensure all data is clinically relevant and not out-of-date.

Andrew Murphy, Head of Cancer Datasets, (NCRAS) PHE

0. How to record a Recurrence

0.1 Cancer Patients Pathway for a Recurrence

How to record a recurrence for COSD

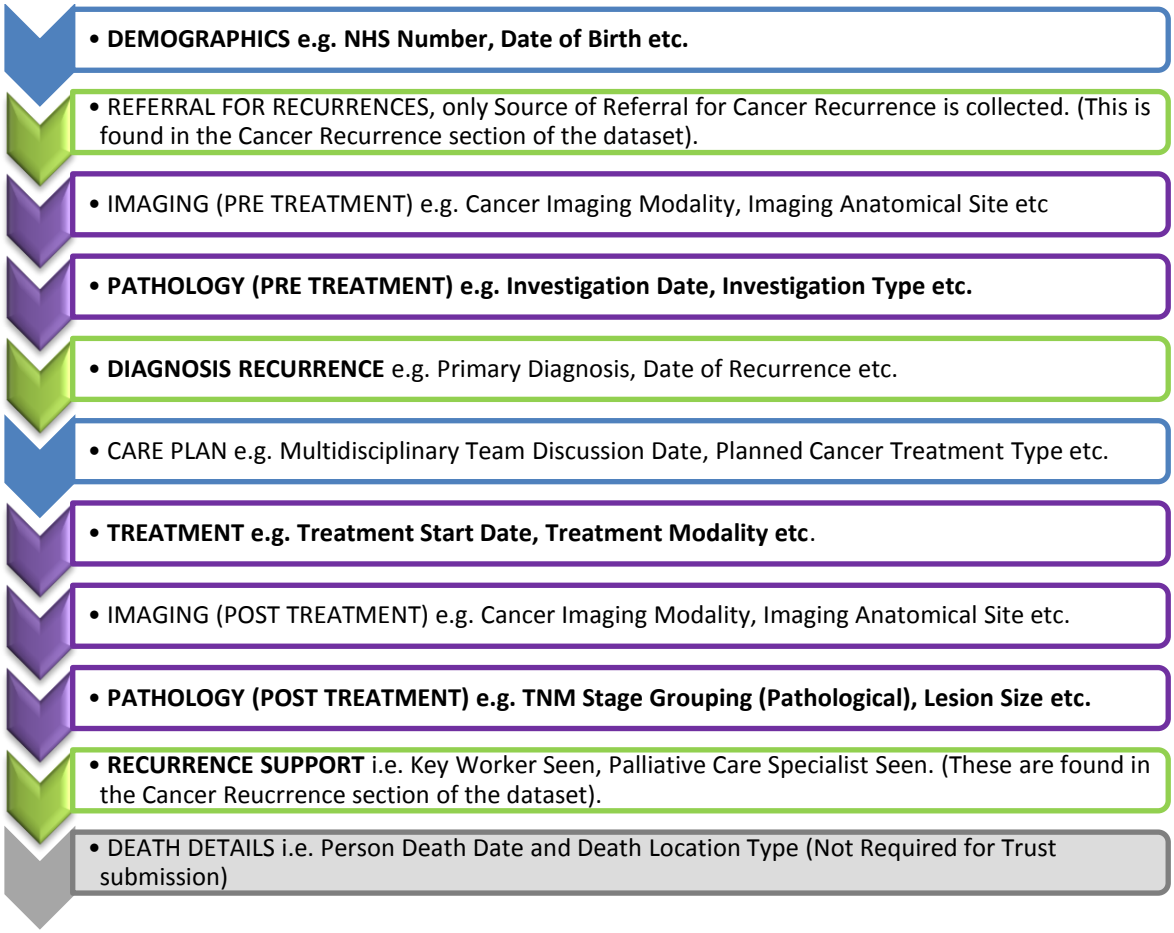
Many of the CORE data sections and items are collected for recurrences as for primary cancers – demographics, diagnosis, imaging, pathology, care plan, treatment (the details required for Breast cancer recurrences are listed below).

There is no need to record all the previous treatment details as the registry should already have this information, however all new treatments for the recurrent episode must be recorded.

The date of recurrence (CR0440) should be recorded. The ICD 10 (CR0370) site should be the same as the original primary tumour site. Patients can have MULTIPLE primary tumours so it is important that the recurrence is attributed to the correct primary tumour.

The diagram below illustrates the main sections of the cancer patient's pathway applicable to recurrences. The sections in bold are expected to be submitted for all recurrences, either under the previous guidance or as part of the extended scope.

The sections highlighted in **green** include different data items from the primary diagnosis record. The sections highlighted in **purple** may be collected more than once.



COSD v8.0 will create a new and more accurate way of recording recurrence, secondary, progression, metastases and CUP, including better definition of these pathways.

0.2 Recording Recurrences

What is a recurrent cancer?

Cancer recurrence can be defined as the return of cancer after treatment and after a period of time during which the cancer cannot be detected. The length of time is not clearly defined; however, the patient would have previously been informed that they are free of the disease or that the disease is not detectable. The same cancer may come back where it first started or somewhere else in the body.

What are the types of recurrence?

The distinction between the types of recurrence of a previously treated tumour requires clinical interpretation. There are different types of cancer recurrence:

- Local recurrence means that the cancer has come back in the same place it first started.
- Regional recurrence means that the cancer has come back in the lymph nodes near the place it started.
- Distant recurrence means the cancer has come back in another part of the body, some distance from where it started (often the lungs, liver, bone marrow, or brain).

What are metastatic / secondary tumours?

Metastasis or metastatic disease is the spread of cancer from one part of the body to another.

Distant metastases are tumour cells that have spread from the primary tumour and formed as distant growth in a different organ

Patients that present with a new primary with distant metastatic disease should be recorded as a new primary with the distant metastatic site identified by COSD reference number (CR1590).

Can someone have a metastatic tumour without having a primary cancer?

No. A metastatic tumour is always caused by cancer cells from another part of the body. In most cases, when a metastatic tumour is found first, the primary cancer can also be found.

However, in some patients, a metastatic tumour is diagnosed but the primary tumour cannot be found. These cases are referred to as *unknown primaries* or occult (hidden) cancer, and the patient is said to have *cancer of unknown primary origin* (CUP). Such cases **should not** be recorded as a recurrence but as a primary cancer of an unknown origin. COSD Version 8 will address the recording of unknown primary cancer. For current guidance please refer to NICE guidance.

What is progression?

When cancer spreads (increase growth speed) or gets worse it is called *progression*. Sometimes it is hard to tell the difference between recurrence and progression. A recurrence is where a patient has previously been informed that they are free of the disease or that the disease is not detectable. Progression of a disease is where this has not happened.

What is remission?

A remission is a term that is given is when the tumour cancer cannot be detected in the body after first treatment is given. A remission can be temporary or permanent and does not need to be recorded within COSD.

Haematology recurrence

Haematology cancer does not spread the same way as solid tumours. The Cancer waiting time guide states it is for the clinical teams locally to decide, which is the most appropriate category to use for their haematology patients.

For cancer Waits, if the initial haematology condition had been within the remit of cancer waits and transforms then it would be classed as a recurrence. However, if the initial condition was not within the remit of Cancer Waits and the transforms the new condition it would be classed as a new primary

Head and Neck Cancers

For Head and neck cancer there is an incidence of second primary cancers that develop at the primary site due to mucosal field change.

The distinction between a recurrence of a previously treated tumour and a second primary requires clinical interpretation in making this distinction.

0.3 Core Data Items Required For Recurrence Record

The following identifies the sections and items which are essential in order to register recurrences accurately.

The sections in BOLD are required for <u>all recurrences</u>.

For <u>Breast recurrences only</u>, the non-bold sections and items listed are also required.

(The REFERRALS, CLINICAL TRIALS and STAGING Sections are not currently required for any recurrences).

SECTION	Specific Fields	Comments
CORE – PATIENT IDENTITY DETAILS	**ALL FIELDS including** **PRIMARY DIAGNOSIS (ICD)**	**Linkage to any other records or submissions for this patient.** **Note: The Primary Diagnosis field should <u>always</u> contain the original diagnosis code unless the primary is unknown.**
CORE – DIAGNOSTIC DETAILS	**ALL FIELDS - including** **DATE OF RECURRENCE (CLINICALLY AGREED)**	**Linkage to primary record, other submissions for this recurrence, and any other recurrences of this cancer. DATE OF RECURRENCE (CLINICALLY AGREED) is specific to recurrences and MUST be completed for all records submitted**
CORE – DEMOGRAPHICS	**ALL RELEVANT FIELDS**	**Patient details are essential for record matching and for data quality and assurance**
CORE – IMAGING	ALL FIELDS	(Pre/post treatment. To assist with staging and identification of regional recurrence)

CORE – DIAGNOSIS	ALL FIELDS – including METASTATIC SITE and CANCER RECURRENCE CARE PLAN INDICATOR	All fields should be completed if possible. METASTATIC SITE and CANCER RECURRENCE CARE PLAN INDICATOR are used, with Imaging and Pathology, to identify local, regional and distant recurrences where no treatment is received
CORE – CANCER CARE PLAN	ALL APPLICABLE FIELDS – including MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR and CLINICAL NURE SPECIALIST INDICATION CODE	To monitor service
CORE – TREATMENT	**ALL APPLICABLE FIELDS**	**All treatment details should be completed, including non-active treatments such as specialist or non-specialist palliative support**
CORE – SURGERY AND OTHER PROCEDURES, RADIOTHERAPY, ACTIVE MONITORING	ALL APPLICABLE FIELDS	These sections should be completed if applicable
CORE – PATHOLOGY	**ALL APPLICABLE FIELDS**	**All Pathology details should be completed and should normally be submitted directly from the pathology system.**
CORE – CANCER RECURRENCE	SOURCE OF REFERRAL FOR CANCER RECURRENCE KEY WORKER SEEN INDICATOR (CANCER RECURRENCE) PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE)	These fields are specific to recurrences and MUST be completed for all records submitted.

0.3.1 Additional Site Specific Data Items Required For Breast Recurrence Record

In addition to the CORE data items above, the following should also be completed from the site specific Breast dataset

SECTION	Specific Fields	Comments
BREAST - REFERRALS	ALL FIELDS	These fields relate to the assessment which led to the diagnosis of recurrence.
BREAST - IMAGING (MAMMOGRAM)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded

BREAST - IMAGING (ULTRASOUND)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded
BREAST - IMAGING (AXILLA ULTRASOUND)	ALL FIELDS IF APPLICABLE	Contribute to diagnosis and stage assessment where no treatment recorded
BREAST - PATHOLOGY	ALL FIELDS IF APPLICABLE	All Site Specific Pathology details should be completed and should normally be submitted directly from the pathology system. Free text reports containing the pathological data items will currently be accepted as long as the linkage fields can be identified.

1. CORE

Key to Data Item Tables

All data items are listed as follows

Data item No.	The reference number for the COSD data item
Data Item Section	The section in which the data item appears
Data Item Name	The name of the data item. This is followed by the *[DATA DICTIONARY ITEM NAME]* if different in purple
Format	Format required for submission of the data item
Schema specification (M/R/O/X/P)	The detailed schema for submission of the data is included in the Technical Guidance. This column identifies whether items are required for the extract to pass validation rules when submitted in XML format. (Note that all applicable data should be submitted as soon as possible) M = Mandatory: A section cannot be included in the record submitted unless it contains completed Mandatory items in that section. If there is other data in a section and the Mandatory items are not completed the record will not pass validation tests **Please note that items in the CORE LINKAGE section are Mandatory and must be included for the record to pass validation** R = Required: This data item (where applicable) should be submitted as soon as possible, but is not required to validate the submitted record. O = Optional: This item may be submitted at the discretion of the Provider. (It is either not currently required nationally or it will be obtained/derived by the National Cancer Registration Service from other sources). P = For use in a pilot project only. X = Not applicable for schema: This data item should not be included in the submission. (It will be obtained/derived by the National Cancer Registration Service from other sources).

Note: ***Data items shaded in grey in the User Guide and COSD Dataset do not need to be submitted directly by Providers for COSD. These are listed in Appendices K and L***

ICD-10 CODES

The core data items should be collected for all cancers and other registerable conditions where applicable. See Appendix A to C for the full lists of ICD10 codes.

Note: ***For diagnoses not included in the site specific datasets, the core items only should be completed. For some registerable conditions only pathology reports will be available at present e.g. BCC.***

1.1 CORE LINKAGE

These items are Mandatory for every record in order to link patient records.

In order to ensure that records submitted can be linked appropriately some key data fields must be completed for each record submitted. These are shown in the Core Linkage section.

There will be one linkage section completed each time the record is submitted.

Note: It is important to refer to the Pathology User Guide if reporting pathology direct from the LIMS as there are different linkage items required.

1.1.1 CORE – PATIENT IDENTITY DETAILS

This group will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0010	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER**	n10	M[11]
CR0020	CORE - PATIENT IDENTITY DETAILS	**LOCAL PATIENT IDENTIFIER** *[LOCAL PATIENT IDENTIFIER (EXTENDED)]*	max an20	M[12]
CR1350	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER STATUS INDICATOR CODE**	an2	M
CR0100	CORE - PATIENT IDENTITY DETAILS	**PERSON BIRTH DATE**	an10 ccyy-mm-dd	R
CR0030	CORE - PATIENT IDENTITY DETAILS	**ORGANISATION CODE (CODE OF PROVIDER)**	an3 or an5	M

NHS NUMBER: The NHS NUMBER is a unique identifier for a PATIENT within the NHS in England and Wales. This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

LOCAL PATIENT IDENTIFIER: For linkage purposes, NHS NUMBER and/or LOCAL PATIENT IDENTIFIER are required. This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.

Note: This has been extended to 'max an20' to help support Trusts where local numbers are now >10 and prevents data being truncated on upload.

NHS NUMBER STATUS INDICATOR CODE: The NHS NUMBER STATUS INDICATOR CODE indicates the verification status of the NHS number provided.

01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS Number or patient detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old)

PERSON BIRTH DATE: The date on which a PERSON was born or is officially deemed to have been born.

ORGANISATION CODE (CODE OF PROVIDER): The ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider. This is the three digit code of the organisation

[11] A combination of either **NHS NUMBER** and/or **LOCAL PATIENT IDENTIFIER** is Mandatory for the schema

[12] A combination of either **LOCAL PATIENT IDENTIFIER** and/or **NHS NUMBER** is Mandatory for the schema

submitting the demographic details. This will therefore normally be either the organisation where the referral is received or the treating organisation[13].

1.1.2 CORE – DIAGNOSTIC DETAILS:

This group will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0370	CORE – DIAGNOSTIC DETAILS	**PRIMARY DIAGNOSIS (ICD)**	min an4 max an6	M
CR0380	CORE – DIAGNOSTIC DETAILS	**TUMOUR LATERALITY**	an1	M
CR0440	CORE – DIAGNOSTIC DETAILS	**DATE OF RECURRENCE (CLINICALLY AGREED)** *[DATE OF RECURRENCE (CANCER CLINICALLY AGREED)]*	an10 ccyy-mm-dd	M[14]
CR2030	CORE – DIAGNOSTIC DETAILS	**DATE OF DIAGNOSIS (CLINICALLY AGREED)** *[DATE OF DIAGNOSIS (CANCER CLINICALLY AGREED)]*	an10 ccyy-mm-dd	M[15]

PRIMARY DIAGNOSIS (ICD): See DIAGNOSTIC CODING for details on coding and PRIMARY DIAGNOSES for the standardised definition of primary diagnosis.

The primary diagnosis is normally agreed at the MDT Meeting where the patient is discussed.

ICD10 is the International Statistical Classification of Diseases and Related Health Problems (ICD) and is a comprehensive classification of causes of morbidity and mortality. The primary diagnosis is the main condition treated or investigated during the relevant episode of healthcare.

> ***Note:*** ***Where the ICD10 code only has 3 characters, e.g. C01, please add "X" as a 'packing digit' to meet the validation rules. (e.g. C01.X, C07.X, C73.X etc.).***

DATE OF DIAGNOSIS (CLINICALLY AGREED)*:* This data item is **mandatory** for all new primary cancers as it is required for record linkage.

Record the date where Cancer was first confirmed or diagnosis agreed. Date of Diagnosis can usually be determined by one of the following three methods. You must use the date from the method which provides the **earliest** confirmation of a diagnosis.

- **Pathology Report**: This would normally be the date when the authorised pathology report confirms a cancer diagnosis.
- **Diagnosis Confirmed at MDT**: If the cancer is confirmed clinically (clinical decision or clinical investigation or pathology not yet authorised) then the date used should be that of the Multidisciplinary Team Meeting when the diagnosis was agreed.
- **Other:** For all other cases, record the date in which the clinical investigation was reported or clinical agreement that confirms the diagnosis of cancer.

[13] http://www.datadictionary.nhs.uk/data_dictionary/attributes/o/org/organisation_code_de.asp?query=organisation%20code&rank=100&shownav=1

[14] Either **DATE OF DIAGNOSIS ((CLINICALLY AGREED)** or **DATE OF RECURRENCE (CLINICALLY AGREED)** is Mandatory for the schema

[15] Either **DATE OF DIAGNOSIS ((CLINICALLY AGREED)** or **DATE OF RECURRENCE (CLINICALLY AGREED)** is Mandatory for the schema

DATE OF RECURRENCE (CLINICALLY AGREED)*:* THIS DATA ITEM APPLIES TO RECURRENCES ONLY. This is the only Diagnosis date which Providers are required to record for recurrences.

Record the date where Cancer recurrence was confirmed or diagnosis of recurrence was agreed. This will normally be one of the following three methods:

- **Pathology Report**: This would normally be the date when the authorised pathology report confirms a diagnosis of cancer recurrence.
- **Diagnosis Confirmed at MDT**: If the cancer recurrence is confirmed clinically (clinical decision or clinical investigation or pathology not yet authorised) then the date used should be that of the Multidisciplinary Team Meeting when the diagnosis was agreed.
- **Other:** For all other cases, record the date in which the clinical investigation was reported or clinical agreement that confirms the diagnosis of cancer recurrence.

TUMOUR LATERALITY (CWT)**:** Identifies the side of the body for a tumour relating to paired organs within a PATIENT (This refers to the side of the body on which the cancer originates).

For the Central Nervous System, the definition for bilateral is 'evidence that the tumour is crossing the midline'.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not known

1.2 CORE – DEMOGRAPHIC DETAILS

Demographics

Demographic details are required for every record in order to ensure that the correct patient can be identified and information can be correctly linked.

The Demographics section should be completed by every Provider the first time a record is submitted.

There will only be one Demographics section completed for each record. Demographic linkage items will be required each time the record is submitted. Almost all patients should have an NHS Number and this should always be included where available. For those who do not have an NHS Number, the hospital number (LOCAL PATIENT IDENTIFIER) must be provided.

It is anticipated that some of the demographic data items listed below will be collected by every provider with which the patient has contact. Where this information is exchanged, the appropriate data item name should be used.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0050	CORE - DEMOGRAPHICS	**PERSON FAMILY NAME**	max an35	R
CR0060	CORE - DEMOGRAPHICS	**PERSON GIVEN NAME**	max an35	R
CR0070	CORE - DEMOGRAPHICS	**PATIENT USUAL ADDRESS (AT DIAGNOSIS)**	an175 (5 lines each an35)	R
CR0080	CORE - DEMOGRAPHICS	**POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS)**	max an8	R
CR3170	CORE - DEMOGRAPHICS	**PERSON STATED GENDER CODE**	an1	R
CR0110	CORE - DEMOGRAPHICS	**GENERAL MEDICAL PRACTITIONER (SPECIFIED)**	an8	R
CR0120	CORE - DEMOGRAPHICS	**GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)**	an6	R
CR0140	CORE - DEMOGRAPHICS	**PERSON FAMILY NAME (AT BIRTH)**	max an35	R
CR0150	CORE - DEMOGRAPHICS	**ETHNIC CATEGORY**	max an2	R

PERSON FAMILY NAME: That part of a PERSON's name which is used to describe family, clan, tribal group, or marital association.

PERSON GIVEN NAME: The forename(s) or given name(s) of a PERSON.

PATIENT USUAL ADDRESS (AT DIAGNOSIS): The PATIENT USUAL ADDRESS of the PATIENT at the time of PATIENT DIAGNOSIS.

POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS): The POSTCODE OF USUAL ADDRESS of the PATIENT at the time of PATIENT DIAGNOSIS.

PERSON STATED GENDER CODE: Person's gender as self-declared (or inferred by observation for those unable to declare their PERSON STATED GENDER).

1	Male
2	Female
9	Indeterminate (Unable to be classified as either male or female)
X	Not known (PERSON STATED GENDER CODE not recorded)

GENERAL MEDICAL PRACTITIONER (SPECIFIED): This is the PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT. This GENERAL MEDICAL PRACTITIONER works within the General Medical Practitioner Practice with which the PATIENT is registered.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION): This is the code of the GP Practice that the PATIENT is registered with.

PERSON FAMILY NAME (AT BIRTH): The PATIENT's surname at birth.

ETHNIC CATEGORY: The ethnicity of a PERSON, as specified by the PERSON. The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

(The Office for National Statistics has developed a further breakdown of the group from that given, which may be used locally.)

White	
A	(White) British
B	(White) Irish
C	Any other White background
Mixed	
D	White and Black Caribbean
E	White and Black African
F	White and Asian
G	Any other mixed background
Asian or Asian British	
H	Indian
J	Pakistani
K	Bangladeshi
L	Any other Asian background
Black or Black British	
M	Caribbean
N	African
P	Any other Black background
Other Ethnic Group	
R	Chinese
S	Any other ethnic group
Z	Not stated
99	Not known

Note: The default option for this item is 99 "Not known"

1.3 CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY

This section includes details from referral up to the first appointment and is therefore to be recorded once for each cancer diagnosis. For some cases this is already recorded and submitted for Cancer Waiting Times. For the COSD this information is required for all new diagnoses and recurrent breast cancer cases. This is essential to support analysis for outcomes and work on presentation and routes to diagnosis. Further guidance on how various scenarios should be recorded is included in Appendix J.

There will only be one Referral section completed for each record.

These details include information relating to the first stage of the Patient Pathway.

Note: This section will only be completed for Primary cancer diagnoses. For Recurrent cancers, the section labelled CANCER RECURRENCE/SECONDARY CANCER will be completed instead.

SOURCE OF REFERRAL FOR OUT-PATIENTS *or* SOURCE OF REFERRAL FOR CANCER RECURRENCE *can be recorded.*

This section will be recorded once.

See Appendix J for Referral scenarios

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1600	CORE - REFERRALS	**SOURCE OF REFERRAL FOR OUT-PATIENTS**	an2	R
CR1580	CORE - REFERRALS	**REFERRAL TO TREATMENT PERIOD START DATE**	an10 ccyy-mm-dd	R
CR0230	CORE - REFERRALS	**DATE FIRST SEEN**	an10 ccyy-mm-dd	R
CR0210	CORE - REFERRALS	**CONSULTANT CODE (FIRST SEEN)**	an8	R
CR1410	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER FIRST SEEN)** *[SITE CODE (OF PROVIDER FIRST SEEN)]*	min an5 max an9	R
CR1360	CORE - REFERRALS	**DATE FIRST SEEN (CANCER SPECIALIST)**	an10 ccyy-mm-dd	R
CR1400	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER FIRST CANCER SPECIALIST)** *[SITE CODE (OF PROVIDER FIRST CANCER SPECIALIST)]*	min an5 max an9	R
CR0270	CORE - REFERRALS	**CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS**	an2	R
CR2000	CORE - REFERRALS	**CANCER SYMPTOMS FIRST NOTED DATE**	max an10 ccyy-mm-dd	R/O[16]

SOURCE OF REFERRAL FOR OUT-PATIENTS (CWT): This identifies the source of referral of each Consultant Out-Patient Episode. This is essential for every cancer diagnosis in order to identify emergency presentations. Please note that where patients first present as an emergency, codes 01, 10 or 04 are applicable.

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
01	following an emergency admission
02	following a Domiciliary Consultation
10	following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode
Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
03	referral from a GENERAL MEDICAL PRACTITIONER
92	referral from a GENERAL DENTAL PRACTITIONER
12	referral from a GENERAL PRACTITIONER with a Special Interest (GPwSI) or dentist with a Special Interest (DwSI)
04	referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)
05	referral from a CONSULTANT, other than in an Accident And Emergency Department
06	self-referral
07	referral from a Prosthetist
13	referral from a Specialist NURSE (Secondary Care)
14	referral from an Allied Health Professional
15	referral from an OPTOMETRIST
16	referral from an Orthoptist
17	referral from a National Screening Programme
93	referral from a Community Dental Service
97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

[16] Required for CTYA, Optional for all others

REFERRAL TO TREATMENT PERIOD START DATE (CWT)**:** The start date of a REFERRAL TO TREATMENT PERIOD. Date the initial referral which led to the cancer diagnoses was received by the Provider. If patient presented as an emergency it will be the date of the referral following that emergency presentation. This may be different from CANCER REFERRAL TO TREATMENT PERIOD START DATE if initial referral was not to the cancer services teams.

DATE FIRST SEEN (CWT)**:** This is the date that the PATIENT is first seen in the Provider that receives the first referral which leads to the cancer diagnosis. It is the date first seen in secondary care for this diagnosis.

CONSULTANT CODE (FIRST SEEN): This is the Code of the Consultant who first sees the patient following the initial referral which leads to the cancer diagnosis. The CONSULTANT CODE is derived from either the GENERAL MEDICAL COUNCIL REFERENCE NUMBER for GENERAL MEDICAL PRACTITIONERS or the GENERAL DENTAL COUNCIL REGISTRATION NUMBER for GENERAL DENTAL PRACTITIONERS (where the dentist doesn't have a GENERAL MEDICAL COUNCIL REFERENCE NUMBER). This is the Code of the Consultant who is responsible for the appointment recorded under DATE FIRST SEEN.

ORGANISATION CODE (PROVIDER FIRST SEEN) (CWT)**:** The ORGANISATION SITE CODE of the Health Care Provider at the first contact with the PATIENT. That is the Health Care Provider at the first Out-Patient Attendance Consultant, Imaging or Radiodiagnostic Event, CLINICAL INTERVENTION, Hospital Provider Spell, Accident and Emergency Attendance or Screening Test whichever is the earlier SERVICE related to the initial REFERRAL REQUEST. It is the date first seen in secondary care for this diagnosis.

DATE FIRST SEEN (CANCER SPECIALIST): This is the date that the PATIENT is first seen by the appropriate specialist for cancer care within a Cancer Care Spell. This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary tumour. If patient's first appointment is with the appropriate cancer specialist this will be the same as DATE FIRST SEEN.

ORGANISATION CODE (PROVIDER FIRST CANCER SPECIALIST)*:* The ORGANISATION SITE CODE of the ORGANISATION acting as Health Care Provider where the PATIENT is first seen by an appropriate cancer specialist on the DATE FIRST SEEN (CANCER SPECIALIST). If patient's first appointment is with the appropriate cancer specialist this will be the same as ORGANISATION CODE (PROVIDER FIRST SEEN).

CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS (CWT)**:** This is recorded to enable tracking of the status of REFERRAL REQUESTS for PATIENTS referred with a suspected cancer, or referred with breast symptoms with cancer not originally suspected. For COSD these definitions are extended to apply to all registerable conditions. However, those conditions not covered by Cancer Waits will need to be excluded from CWT uploads.

14	Suspected primary cancer
09	Under investigation following symptomatic referral, cancer not suspected (breast referrals only) (see note 1)
03	No new cancer diagnosis identified by the Healthcare Provider
10	Diagnosis of new cancer confirmed - first treatment not yet planned
11	Diagnosis of new cancer confirmed - English NHS first treatment planned
07	Diagnosis of cancer confirmed - no English NHS treatment planned
08	First treatment commenced (English NHS only)
12	Diagnosis of new cancer confirmed - subsequent treatment not yet planned
13	Diagnosis of new cancer confirmed - subsequent English NHS treatment planned
21	Subsequent treatment commenced (English NHS only)
15	Suspected recurrent cancer
16	Diagnosis of recurrent cancer confirmed - first treatment not yet planned
17	Diagnosis of recurrent cancer confirmed - English NHS first treatment planned
18	Diagnosis of recurrent cancer confirmed - no English NHS treatment planned
19	Diagnosis of recurrent cancer confirmed - subsequent treatment not yet planned
20	Diagnosis of recurrent cancer confirmed - subsequent English NHS treatment planned

CANCER SYMPTOMS FIRST NOTED DATE (MANDATORY FOR CTYA. OPTIONAL FOR ALL OTHERS):

Record the time when the symptoms were first noted related to this diagnosis as agreed between the consultant and the patient. This will normally be recorded by the consultant first seeing the patient in secondary care.

Depending on the length of time this should normally include at least the month and year. The day should also be included if known. If symptoms have been present for a long time then it may only be possible to record the year. In these various circumstances the Format/Length will be:

- ***DATE:*** *(including year, month and day): CCYY-MM-DD*
- ***YEAR AND MONTH:*** *YYYY-MM*
- ***YEAR ONLY:*** *YYYY*

1.4 CORE – IMAGING

Imaging procedures carried out to diagnose or stage the cancer are included in this section. Most of the fields in this section are also extracted for the Diagnostic Imaging Dataset (DIDS).

Generic (core) imaging data may be provided through alternative methods and should be discussed with the local office of the NCRAS.

Details of specific imaging procedures and outcomes required for specific disease groups are included in the appropriate site specific sections and must be included in monthly submissions.

There may be more than one Imaging section completed for each record.

Note: Imaging carried out post treatment should also be available

This section can be recorded more than once.

Imaging carried out post treatment should also be submitted as part of the treatment record.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0310	CORE - IMAGING	**SITE CODE (OF IMAGING)**	min an5 max n9	R
CR0320	CORE - IMAGING	**PROCEDURE DATE (CANCER IMAGING)**	an10 ccyy-mm-dd	R
CR1610	CORE - IMAGING	**IMAGING CODE (NICIP)**	max an6	R
CR0330	CORE - IMAGING	**CANCER IMAGING MODALITY**	an4	R
CR0340	CORE - IMAGING	**IMAGING ANATOMICAL SITE**	max an5	R
CR3000	CORE - IMAGING	**ANATOMICAL SIDE (IMAGING)**	an1	R
CR0160	CORE - IMAGING	**IMAGING REPORT TEXT**	max an270000	R
CR0350	CORE - IMAGING	**LESION SIZE (RADIOLOGICAL)**	max n3. max n2	R

Note: Image guided procedures (e.g. Image guided biopsies) should be recorded under surgery section.

SITE CODE (OF IMAGING): This is the ORGANISATION SITE CODE of the Organisation where the Imaging took place.

PROCEDURE DATE (CANCER IMAGING): The DATE the Cancer Imaging was carried out.

IMAGING CODE (NICIP): This is the National Interim Clinical Imaging Procedure Code Set code which is used to identify both the test modality and body site of the test. More information on NICIP can be found at the following link: http://systems.hscic.gov.uk/data/uktc/imaging/nicipfaqapr16.pdf.

CANCER IMAGING MODALITY: (*Note: This is only required if NICIP is not available).* The type of imaging procedure used during an Imaging or Radiodiagnostic Event for a Cancer Care Spell.

C01X	Standard Radiography
C01M	Mammogram
C02X	CT Scan
C02C	Virtual colonoscopy
C03X	MRI Scan
C04X	PET Scan
C05X	Ultrasound Scan
C06X	Nuclear Medicine imaging
C08A	Angiography
C08B	Barium
C08U	Urography (IV and retrograde)
C09X	Intervention radiography.
CXXX	Other

IMAGING ANATOMICAL SITE: (*Note: This is only required if NICIP is not available).*

A classification of the part of the body that is the subject of an Imaging or Radiodiagnostic Event. The coding frame used is the OPCS-4 'Z' coding, plus two additional local codes:

- Whole body CZ001
- Multiple sites CZ002

For the purposes of recording Imaging Site for COSD the following high level codes are sufficient, although more detailed codes can be used if preferred:

Z921	Head NEC
Z923	Neck NEC
Z924	Chest NEC
Z925	Back NEC
Z926	Abdomen NEC
Z927	Trunk NEC
Z899	Arm NEC
Z909	Leg NEC
Z019	Brain NEC
Z069	Spine NEC
Z929	Other

ANATOMICAL SIDE (IMAGING): (*Note: This is only required if NICIP is not available).* The side of the body that is the subject of an Imaging or Radiodiagnostic Event.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not Known

IMAGING REPORT TEXT *(optional):* This is the full text provided in the imaging report, this is required by registries to derive final stage and diagnosis date for registration.

LESION SIZE (RADIOLOGICAL): The size in millimetres of the maximum diameter of the primary lesion, largest if more than one.

1.4.1 CORE – IMAGING (Ultrasound)

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)	
CR6000	CORE - IMAGING (ULTRASOUND)	**ULTRASOUND EXAMINATION RESULT** *[ULTRASOUND RESULT CODE (CANCER)]*		an2	R

ULTRASOUND EXAMINATION RESULT: Result of the ultrasound examination. For example in Breast Cancer, this will normally be the result of the ultrasound examination of the breast undertaken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each ultrasound examination of the breast should be recorded.

U1	Normal
U2	Benign
U3	Indeterminate/probably benign
U4	Suspicious of malignancy
U5	Highly suspicious of malignancy

1.5 CORE – DIAGNOSIS

Diagnosis details in the linkage section are required for every record in order to ensure that the correct record can be identified and information can be correctly linked. The full diagnosis details section enables the disease to be correctly registered. All registerable conditions should be recorded – see Appendix B.

Recording an applicable diagnosis, including a Date of Diagnosis, triggers inclusion of the record in the submission. Please refer to site specific sections for applicable ICD10 and/or ICDO3 codes. This information will normally be confirmed by the Multidisciplinary Team at their MDT Meeting.

Both ICD10 codes and Morphology (SNOMED and/or ICD03) must be completed for all cases.

ICDO3 Topography Codes are only required to be submitted for CTYA cancers. In all other cases the ICDO3 Topography codes do not need to be completed by Providers and will be recorded by the NCRAS.

There will only be one Diagnosis section completed for each record. Diagnosis linkage items are required each time the record is submitted.

Note **For both new primaries and for recurrences the Primary Diagnosis should be recorded. There are separate data items to identify whether a recurrence is local or metastatic. These are METASTATIC SITE and CANCER RECURRENCE CARE PLAN INDICATOR.**

Note **The ICD10 codes for secondary cancer should only be used when the primary diagnosis is not known.**

This section will be agreed by the Multidisciplinary Team responsible for the patient and will probably be completed at the time the patient is discussed at the MDT meeting. The details may be different from those which appear in the Pathology data items.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR6230	CORE - DIAGNOSIS	**SITE CODE (OF DIAGNOSIS)**	min an5 max an9	R
CR0390	CORE - DIAGNOSIS	**BASIS OF DIAGNOSIS (CANCER)**	an1	R
CR6490	CORE - DIAGNOSIS	**SNOMED VERSION**	an2	R
CR6400	CORE - DIAGNOSIS	**MORPHOLOGY (SNOMED) DIAGNOSIS**	min n6 max n18	R

CR0180	CORE - DIAGNOSIS	**MORPHOLOGY (ICDO3)** *[MORPHOLOGY (ICD-O DIAGNOSIS)]*	min an5 max an7	R
CR0480	CORE - DIAGNOSIS	**TOPOGRAPHY (ICDO3)** *[TOPOGRAPHY (ICD-O)]*	min an5 max an7	R
CR0410	CORE - DIAGNOSIS	**GRADE OF DIFFERENTIATION (AT DIAGNOSIS)**	an2	R
CR1590	CORE - DIAGNOSIS	**METASTATIC SITE**	an2	R
CR2050	CORE – DIAGNOSIS	**CLINICAL NURSE SPECIALIST INDICATION CODE**	an2	R
CR0450	CORE - DIAGNOSIS	**CANCER RECURRENCE CARE PLAN INDICATOR**	an2	R
CR0510	CORE - DIAGNOSIS	**PERFORMANCE STATUS (ADULT)**	an1	R

SITE CODE (OF DIAGNOSIS): This is the ORGANISATION SITE CODE of the Organisation where the diagnosis took place.

The Trust who was responsible for the diagnosis of the patient should be entered here, using their 5 digit hospital code. It is important to take advice from the clinical teams if unsure before completing this field. Other scenarios around diagnoses could be (but not limited to):

Scenario 1:
If a patient was diagnosed at Trust A, but referred to Trust B for treatment, then Trust A is the diagnosing Trust.

Scenario 2:
If the definitive test that determines cancer is confirmed at Trust A, but the pathology was reported at Trust B, we would expect Trust A to be reported as the diagnosing Trust.

- Pathology reporting may be part of a pathology partnership, Trust A may no longer have a pathology department, Trust B therefore may report all pathology reports for several Trusts, this does not mean they are the diagnosing Trust.

Scenario 3:
If a request for a second opinion at Trust B is made to support the decision at Trust A, Trust A would be expect to be reported as the diagnosing Trust.

Scenario 4:
If the management of the patient was done at Trust A, but specific tests were required to support the diagnosis at Trust B (and Trust B has no further part in the diagnostic/treatment process), we would expect Trust A to be reported as the diagnosing Trust.

- Lung patient is sent to a specialist centre for specialist diagnostic testing which helps with the diagnosis but is part of Trust A's diagnostic process, then Trust A is still the diagnosing Trust

Scenario 5:
In most cases a histological diagnosis would trump a clinical diagnosis (providing this is prior to treatment commencing), however:

- If a patient was clinically diagnosed with cancer at Trust A, and treatment starts without a histological diagnosis, then the clinical diagnosis should be used as the date of diagnosis and Trust A as the diagnosing Trust.
- If a surgical treatment is then performed at a later date by any Trust, which resulted in a histologically confirmed diagnosis, we would expect the clinical diagnosis provided by Trust A to be reported as the date of diagnosis and Trust A as the diagnosing Trust.
- These can be difficult decisions and clinical advice from the consultants should be sought if there is confusion.
    - These decisions will help the NCRAS accurately map all diagnoses and future analyses

Scenario 6:

If the patient was referred to Trust A as a suspected cancer and then referred to another Trust (without a confirmed diagnosis of cancer) for diagnostics, treatment, and managed by Trust B, we would expect Trust B to be reported as the diagnosing Trust.

BASIS OF DIAGNOSIS (CANCER): This is the method used to confirm the cancer.

Non-microscopic	
0	Death Certificate: The only information available is from a death certificate
1	Clinical: Diagnosis made before death but without the benefit of any of the following (2-7)
2	Clinical Investigation: Includes all diagnostic techniques (e.g. X-rays, endoscopy, imaging, ultrasound, exploratory surgery and autopsy) without a tissue diagnosis
4	Specific tumour markers: Includes biochemical and/or immunological markers which are specific for a tumour site
Microscopic	
5	Cytology: Examination of cells whether from a primary or secondary site, including fluids aspirated using endoscopes or needles. Also including microscopic examination of peripheral blood films and trephine bone marrow aspirates
6	Histology of a metastasis: Histological examination of tissues from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological examination of tissue from the primary tumour, however obtained, including all cutting and bone marrow biopsies. Also includes autopsy specimens of a primary tumour
9	Unknown: No information on how the diagnosis has been made (e.g. PAS or HISS record only)

Either* MORPHOLOGY (SNOMED) *and/or* MORPHOLOGY (ICDO3) *are required

MORPHOLOGY (ICD03) must be completed for all Haematological diagnoses.

Note: ***MORPHOLOGY (SNOMED) & MORPHOLOGY (SNOMED CT)*** *have both been replaced by [CR6400] and supported by [CR6490] to help identify the version of SNOMED used by the provider Trust. This will allow for more accurate recording of Morphology (SNOMED) Pathology, using SNOMED CT from 01-04-2017 and SNOMED International for historically coded cases. Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017. They also becomes a multiple repeating data item, this will allow for multiple SNOMED Morphology codes to be submitted where more than one diagnosis is reported from multiple samples in on report.*

SNOMED VERSION: The version of SNOMED used to encode MORPHOLOGY (SNOMED) PATHOLOGY and TOPOGRAPHY (SNOMED) PATHOLOGY.

01	SNOMED II
02	SNOMED 3
03	SNOMED 3.5
04	SNOMED RT
05	SNOMED CT
99	Not Known

MORPHOLOGY (SNOMED) DIAGNOSIS: This is the PATIENT DIAGNOSIS using the SNOMED International / SNOMED CT code for the cell type of the malignant disease recorded as part of a Cancer Care Spell. This can be recorded as well as or instead of MORPHOLOGY (ICD03).

Note: Versions of SNOMED prior to SNOMED CT cease to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content.

MORPHOLOGY (ICDO3): The morphology code for the diagnosed cancer as defined by ICDO3.

TOPOGRAPHY (ICDO3)*:* (MANDATORY for CTYA cases, OPTIONAL for others). The topographical site code for the tumour as defined by ICDO3. For all cases except CTYA this will be derived by the National Cancer Registration Service. For CTYA cases this should be included in the submission by NHS Providers.

GRADE OF DIFFERENTIATION (AT DIAGNOSIS): is the definitive grade of the Tumour at the time of PATIENT DIAGNOSIS.

Note: ***Required for all Urological cancers except prostate and testis cancer. This data item is not applicable to CNS, Sarcoma or Haematology diagnosis.***

GX	Grade of differentiation is not appropriate or cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated / anaplastic

METASTATIC SITE (CWT)**:** The site of the metastatic disease, if any, at diagnosis.

(Note that for Cancer Waits this item cannot be reported for first treatments unless that first treatment is a first treatment of a metastatic cancer following an unknown primary cancer, for COSD this should be recorded for all cases where applicable at diagnosis).

Note: ***This is not applicable for Haematological diagnosis.***

02	Brain
03	Liver
04	Lung
06	Multiple metastatic sites
07	Unknown metastatic site
08	Skin
09	Distant lymph nodes
10	Bone (excluding bone marrow)
11	Bone marrow
99	Other metastatic site

CLINICAL NURSE SPECIALIST INDICATION CODE: Record if and when the patient saw an appropriate site specific clinical nurse specialist. Please therefore read all options in order to select the most appropriate code.

Y1	Yes - Clinical Nurse Specialist present when PATIENT given diagnosis
Y3	Yes - Clinical Nurse Specialist not present when PATIENT given diagnosis but saw PATIENT during same Consultant Clinic Session
Y4	Yes - Clinical Nurse Specialist not present during Consultant Clinic Session when PATIENT given diagnosis but saw PATIENT at other time
NI	No - PATIENT not seen at all by Clinical Nurse Specialist but Clinical Nurse Specialist informed of diagnosis
NN	No - PATIENT not seen at all by Clinical Nurse Specialist and Clinical Nurse Specialist not informed of diagnosis
99	Not known (not recorded)

CANCER RECURRENCE CARE PLAN INDICATOR: An indication of whether a diagnosis of recurrence has been recorded for which a new Cancer Care Plan is required. A new record should be completed for a recurrence.

YL	Yes, including local recurrence
YD	Yes, not including local recurrence
NN	No, not recurrence

PERFORMANCE STATUS (ADULT): A World Health Organisation classification indicating a PERSON's status relating to activity / disability.

Although most patients have their performance status assessed before each treatment, within COSD we need a single point to measure all patients and this item can only be recorded once.

Performance status is therefore requested to be recorded as close to the point of diagnosis as possible and the field has been moved to the diagnosis section to help support this, this should make the data item easier to collect from the clinical teams treating the patient.

Note: ***This data item is not applicable for Paediatric patients or Skin diagnoses, except for melanoma stage 4.***

Note: ***If a patient is on high dose steroid therapy (e.g. dexamethasone) which is clinically considered to have artificially and temporarily improved the patient's performance status, the performance status assessed prior to commencing on steroids should be recorded.***

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 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

Note: ***Code 5 (Dead) is not a valid classification under the WHO coding system***

1.6 CORE - PERSON OBSERVATION

This is a new section which will help record observation results across all tumour sites

Multiple occurrences of this data group are permitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR6430	CORE - PERSON OBSERVATION	**PERSON OBSERVSATION HEIGHT IN METRES[PERSON** *[HEIGHT IN METRES]*	n1.max n2	**R**
CR6440	CORE - PERSON OBSERVATION	**PERSON OBSERVATION (WEIGHT)** *[PERSON WEIGHT]*	max n3.max n3	**R**
CR6450	CORE - PERSON OBSERVATION	**BODY MASS INDEX**	n2.n1	**R**
CR6460	CORE - PERSON OBSERVATION	**DATE OBSERVATION MEASURED** *[OBSERVATION DATE]*	an10 ccyy-mm-dd	**M**

PERSON OBSERVSATION HEIGHT IN METRES: Height of the patient, in metres to 2 decimal places (n.nn).

PERSON OBSERVATION (WEIGHT): Weight of the patient, in kilograms with up to three decimal places (nnn.nnn).

BODY MASS INDEX: Estimate of a patient's Body Mass Index (BMI) at diagnosis. The Body Mass Index (BMI) can be derived by a calculation using the patient's height and weight. This data item would be obtained at presentation either in the outpatient clinic or on the ward.

DATE OBSERVATION MEASURED: Date the patient's weight was measured. This is a mandatory field and enables these data to be used for specific parts of the pathway.

Note (1) **This section replaces all other Height and Weight previously recorded in the Head & Neck Section and allows for any tumour site wanting to measure these as part of their patient pathway.**

Note (2) **This section replaces all other Body Mass Index previously recorded in the Colorectal and Upper GI Sections and allows for any tumour site wanting to measure this as part of their patient pathway.**

1.7 CORE - HOLISTIC NEEDS ASSESSMENT

Note: ***The items in this section have been changed from pilot to optional, to allow all Trusts to record these if part of the patient pathway. Discussions are underway to see if this should be a required item for v8.0.***

Multiple occurrences of this data group are permitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR3140	CORE – HOLISTIC NEEDS ASSESSMENT	**HOLISTIC NEEDS ASSESSMENT COMPLETED DATE**	an10 ccyy-mm-dd	O
CR3150	CORE – HOLISTIC NEEDS ASSESSMENT	**HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY** *[HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY (CANCER)]*	an2	O

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE: The date a Holistic Needs Assessment (HNA) is completed. Every HNA should be recorded

HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY: The point in the patient pathway when a Holistic Needs Assessment (HNA) is completed.

01	Initial cancer diagnosis
02	Start of treatment
03	During treatment
04	End of treatment
05	Diagnosis of recurrence
06	Transition to palliative care
98	Other

1.8 CORE – MULTIDISCIPLINARY TEAM MEETINGS

Record ALL Multidisciplinary Team Meetings where the patient was discussed.

Multiple occurrences of this data group are permitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR3080	CORE - MDT	**MULTIDISCIPLINARY TEAM MEETING DATE** *[MULTIDISCIPLINARY TEAM MEETING DATE (CANCER)]*	an10 ccyy-mm-dd	R
Start of repeating item – HOSPITAL SITE CODE OF MULTIDISCIPLINARY TEAM MEETING				
CR3090	CORE - MDT	**HOSPITAL SITE CODE OF MULTIDISCIPLINARY TEAM MEETING** *[SITE CODE (OF MULTIDISCIPLINARY TEAM MEETING)]*	min an5 max an9	R
End of repeating item - HOSPITAL SITE CODE OF MULTIDISCIPLINARY TEAM MEETING				
CR3190	CORE - MDT	**MULTIDISCIPLINARY TEAM MEETING TYPE** *[MULTIDISCIPLINARY TEAM MEETING TYPE (CANCER)]*	an4	R
CR3160	CORE - MDT	**MULTIDISCIPLINARY MEETING TYPE COMMENT** *[MULTIDISCIPLINARY TEAM MEETING TYPE COMMENT (CANCER)]*	max an60	R

MULTIDISCIPLINARY TEAM MEETING DATE: Record the date of each Multidisciplinary Team meeting where the patient was discussed.

(This will include but will not be limited to the date when a treatment planning decision was made which is covered specifically under MULTIDISCIPLINARY TEAM DISCUSSION DATE in the CANCER CARE PLAN SECTION)

HOSPITAL SITE CODE OF MULTIDISCIPLINARY TEAM MEETING: This is the ORGANISATION SITE CODE for the Multidisciplinary Team meeting. It should be used to record the Hospital or Trust which is responsible for the MDT, for joint MDTs additional codes may be recorded.

Note: This item is important in order to assign patients to the appropriate MDT at different points in the pathway. It should be set up in the reference data for the MDT and can then be automatically included for each MDT meeting where the patient is discussed.

MULTIDISCIPLINARY TEAM MEETING TYPE: Record the type of MDT meeting at which the patient was discussed. Please provide the most detailed level of information that is possible.

Note: The codes at the high level (shown in bold, 2 trailing zeros) are Tumour groups and the items below each high-level code are Multidisciplinary Teams. ORGANISATIONS should only use the high-level code if the Multidisciplinary Team type is not adequately listed. If this high level code is used please make sure that the MULTIDISCIPLINARY MEETING TYPE COMMENT field below is also completed.

0100	**Breast**
0101	Breast MDT
0200	**Brain/Central Nervous System**
0201	Brain Central Nervous System (CNS)/Neuroscience MDT
0202	Rehabilitation and Non-Surgical (Network) MDT
0203	Pituitary MDT
0204	Skull base MDT
0205	Spinal cord MDT
0206	Low grade glioma MDT
0207	Metastasis to brain MDT
0208	Stereotactic Radiosurgery (SRS) MDT
0209	Genetic subtypes MDT
0300	**Colorectal**
0301	Colorectal MDT
0302	Anal MDT
0400	**CTYA**
0401	Paediatric Combined Diagnostic and Treatment MDT
0402	Paediatric Haematology only MDT
0403	Paediatric non-CNS solid tumours only MDT
0404	Paediatric CNS malignancy only MDT
0405	Paediatric Late Effects MDT
0406	Paediatric (POSCU) MDT
0407	Teenage and Young Adult MDT
0408	Teenage and Young Adult Late Effects MDT
0500	**Gynaecology**
0501	Gynaecology local MDT
0502	Gynaecology Specialist MDT
0600	**Haematology**
0601	Haematology MDT
0602	Lymphoma MDT
0603	Plasma Cell MDT
0604	Myeloid MDT
0605	Bone marrow transplant MDT
0700	**Head and Neck (including Thyroid)**
0701	Upper Aerodigestive Tract (UAT) only MDT

0702	Upper Aerodigestive Tract (UAT) and Thyroid MDT
0703	Thyroid Only MDT
0800	**Lung**
0801	Lung MDT
0802	Mesothelioma Specialist MDT
0900	**Sarcoma**
0901	Bone and Soft tissue MDT
0902	Bone MDT
0903	Soft tissue MDT
1000	**Skin**
1001	Skin Local MDT
1002	Skin Specialist MDT
1003	Melanoma MDT
1004	Supra T-Cell Lymphoma MDT
1100	**Upper GI**
1101	Upper GI Local MDT
1102	Oesophago-Gastric Specialist MDT
1103	Hepatobiliary and Pancreatic (HPB) Specialist MDT
1104	Pancreatic/Biliary (PB) Specialist MDT
1105	Hepatic Specialist MDT
1200	**Urology**
1201	Urology Local MDT
1202	Urology Specialist MDT
1203	Testicular Supranetwork MDT
1204	Penile Supranetwork MDT
1300	**Other**
1301	CUP MDT
1302	Neuroendocrine MDT
1303	Palliative Care MDT

MULTIDISCIPLINARY MEETING TYPE COMMENT:

To provide additional information on the MDT Meeting type where not covered in the list provided (see also comments under MULTIDISCIPLINARY MEETING TYPE)

Note: This has been extended to 'max an60' to help support Trusts where local MDT's have a longer name than 30 characters and prevents data being truncated on upload.

1.9 CORE - CANCER CARE PLAN

This section includes details applicable to care planning, including performance status, prognostic factors and treatment options which are normally discussed at the MDT meeting. Many of the site specific data items will be recorded at this point in the patient pathway. See site specific sections for further details.

The Cancer Care Plan Date will be the MDT after all the investigations have been completed and the treatment plan is agreed. At this point all the information will be available to record the Final pre-treatment TNM and Stage Grouping too.

Note: There will only be one Cancer Care Plan section completed for each record. Most of the data items in this section will normally be available at the meeting at which the first definitive treatment was discussed. After treatment starts, the treatment plan may change due to medical reasons, this does not create a new cancer care plan, merely changes the treatment plan.

Some of the data items in the Care Plan sections of the site specific datasets will only be available after the initial treatment has been completed or at a subsequent MDT discussion. The items in this

section will not therefore necessarily relate to the date of the MDT recorded as MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER).

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0420	CORE - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR**	an1	R
CR0430	CORE - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)**	an10 ccyy-mm-dd	R
CR6470	CORE - CANCER CARE PLAN	**CONSULTANT CODE (MULTIDISCIPLINARY TEAM LEAD)**	an8	R
CR0460	CORE - CANCER CARE PLAN	**CANCER CARE PLAN INTENT**	an1	R
Start of repeating item - Planned Cancer Treatment Type				
CR0470	CORE - CANCER CARE PLAN	**PLANNED CANCER TREATMENT TYPE**	an2	R
End of repeating item - Planned Cancer Treatment Type				
CR0490	CORE - CANCER CARE PLAN	**NO CANCER TREATMENT REASON**	an2	R
CR2060	CORE - CANCER_CARE_PLAN	**ADULT COMORBIDITY EVALUATION - 27 SCORE**	an1	O

MULTIDISCIPLINARY TEAM DISCUSSION INDICATOR (CWT)**:** Please see Cancer Waiting Times dataset for definition.

MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER) (CWT)**:** Please see Cancer Waiting Times dataset for definition.

CONSULTANT CODE (MULTIDISCIPLINARY TEAM LEAD): The Consultant code of the Multidisciplinary Team (MDT) Lead responsible for the management and decisions made at MDT.

CANCER CARE PLAN INTENT: The intention of a Cancer Care Plan developed within a Cancer Care Spell.

This only needs to be recorded when the care plan is agreed and for Haematology, it is understood that for the majority of cases this would be [Z- Non Curative].

C	Curative
Z	Non Curative
X	No active treatment
9	Not known

PLANNED CANCER TREATMENT TYPE: This is the clinically proposed treatment, usually agreed at a Multidisciplinary Team Meeting, and may not be the same as the treatment which is subsequently agreed with the patient. More than one planned treatment type may be recorded and these may either be alternative or sequential treatments.

This only needs to be recorded when the first treatment planning decision is made.

01	Surgery
02	Teletherapy
03	Chemotherapy
04	Hormone therapy
05	Specialist palliative care
06	Brachytherapy Therapy
07	Biological Therapy
10	Other Active Treatment
11	No active treatment

12	Biphosphonates
13	Anti-Cancer Drug - Other
14	Radiotherapy - Other
99	Not known

Mapping against actual treatment. The following table shows how the treatment modality as defined in Cancer Waiting Times map to these proposed treatment types.

Overall treatment type	CODE	PLANNED CANCER TREATMENT TYPE	CODE	CANCER TREATMENT MODALITY	*Treatment Group as reported for CWT*
SURGERY	1	Surgery	1	Surgery	*SURGERY*
RADIOTHERAPY	2	Teletherapy	5	Teletherapy (Beam Radiation excluding Proton Therapy)	*RADIOTHERAPY*
	6	Brachytherapy	6	Brachytherapy	*RADIOTHERAPY*
	14	Radiotherapy - Other	4	Chemoradiotherapy *(Do not record planned treatment under chemotherapy)*	*RADIOTHERAPY*
			13	Proton Therapy	*RADIOTHERAPY*
			19	Radioisotope Therapy (including Radioiodine)	*(Not recorded in Radiotherapy for CWT reporting)*
			22	Radiosurgery	*(Not recorded in Radiotherapy for CWT reporting)*
ANTI CANCER DRUGS	3	Chemotherapy	2	Anti-cancer drug regimen (Cytotoxic Chemotherapy)	*DRUG TREATMENTS*
	4	Hormone therapy	3	Anti-cancer drug regimen (Hormone Therapy)	*DRUG TREATMENTS*
	7	Biological	21	Biological Therapies (excluding Immunotherapy)	*(Not recorded in Anti-Cancer Drug treatments for CWT reporting)*
			15	Anti-cancer drug regimen (Immunotherapy)	*DRUG TREATMENTS*
	13	Anti-Cancer Drug - Other	14	Anti-cancer drug regimen (other)	*DRUG TREATMENTS*
OTHER ACTIVE TREATMENTS	10	Other Active Treatment	12	Cryotherapy	*OTHER*
			16	Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy)	*OTHER*
			20	Laser Treatment (including Argon Beam therapy)	

Overall treatment type	CODE	PLANNED CANCER TREATMENT TYPE	CODE	CANCER TREATMENT MODALITY	*Treatment Group as reported for CWT*
			97	**Other Treatment** *(active treatment)*	*("Other treatment" does not distinguish between active and non-active for CWT reporting)*
			10	**Radio Frequency Ablation (RFA)**	*OTHER*
			11	**High Intensity Focussed Ultrasound (HIFU)**	*OTHER*
SPECIALIST PALLIATIVE TREATMENT	**5**	**Specialist palliative care**	**7**	**Specialist Palliative Care**	*PALLIATIVE TREATMENTS*
NON ACTIVE TREATMENT	**11**	**No active treatment (***Only record planned treatments as "no active treatment" if only non-active treatments are currently planned)*	**8**	**Active Monitoring (excluding non-specialist Palliative Care)**	*PALLIATIVE*
			9	**Non-specialist Palliative Care (excluding Active Monitoring)**	*PALLIATIVE*
			98	**All treatment declined**	*DECLINED*
			17	**Hyperbaric Oxygen Therapy (Only record here if there are no active treatments planned**	*OTHER*
			23	**Other Treatment** *(not active treatment.*	*("Other treatment" does not distinguish between active and non-active for CWT reporting)*
	12	**BIPHOSPHONATES**	**23**	**Other Treatment** *(biphosphonates)*	*OTHER*
NOT KNOWN	**99**	**Not known**			

NO CANCER TREATMENT REASON: The main reason why no active cancer treatment is specified within a Cancer Care Plan.

01	Patient declined treatment
02	Unfit: poor performance status
03	Unfit: significant co-morbidity
04	Unfit: advanced stage cancer
05	Unknown primary site

06	Died before treatment
07	No active treatment available
08	Other
10	Monitoring only
99	Not known

ACE – 27 SCORE (ADULT COMORBIDITY EVALUATION – 27 SCORE): Overall Comorbidity Score is defined according to the highest ranked single ailment, except in the case where two or more Grade 2 ailments occur in different organ systems. In this situation, the overall comorbidity score should be designated Grade 3.

Note: ***ACE 27 scoring relates to co-morbidities and should not therefore include the condition (Cancer) being treated.***

Note: ***This is not applicable for Skin diagnoses.***

Note: ***This data item is undergoing pilot testing to see if it feasible/appropriate to collect for all adult cancers and is currently optional for local use.***

0	None
1	Mild
2	Moderate
3	Severe
9	Not known

1.10 CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION

This is a new section in response to the Achieving World Class Cancer Outcomes, A Strategy For England 2015-2020 (Taskforce report), and to ensure that COSD maintains itself at the cutting end of technology in cancer diagnostics and treatments offered to patients.

To carry Molecular and Biomarkers (Germline Testing for Cancer Predisposition) details for a patient, where these have been offered by the clinical teams.

Multiple occurrences of this data group are permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR6100	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**GERMLINE GENETIC TESTING OFFERED** *[OFFER STATUS (GERMLINE GENETIC TEST)]*	an2	R
Start of repeating item - GERMLINE GENETIC TESTING OFFERED				
CR6110	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**GERMLINE GENETIC TEST OFFERED** *[GERMLINE GENETIC TEST TYPE OFFERED]*	an2	R
End of repeating item - GERMLINE GENETIC TESTING OFFERED				
CR6120	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**OTHER GERMLINE GENETIC TEST OFFERED** *[OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT]*	max an30	R
CR6130	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**GERMLINE ANALYSIS OFFERED DATE** *[ACTIVITY OFFER DATE]*	an10 ccyy-mm-dd	R
CR6140	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**ORGANISATION CODE OF REPORTING REGIONAL GENETICS LABORATORY** *[ORGANISATION CODE (REPORTING LABORATORY)]*	an3 or an5	R

CR6150	CORE - MOLECULAR AND BIOMARKERS - GERMLINE TESTING FOR CANCER PREDISPOSITION	**REFERRAL TO CLINICAL GENETICIST OFFERED** *[OFFER STATUS (REFERRAL TO REGIONAL CLINICAL GENETICS SERVICE)]*	an2	R

GERMLINE GENETIC TESTING OFFERED: An indication of whether a PATIENT has been offered a germline genetic test

01	Offered and Undecided
02	Offered and Declined
03	Offered and Accepted
04	Not Offered

GERMLINE GENETIC TEST OFFERED: Record the germline / genetic test offered to the Patient. More than one of these can be selected

01	Hereditary Breast and Ovarian Cancer (BRCA1 / BRCA2)
02	Lynch Syndrome / HNPCC (MLH1 / MSH2 / MSH6 / PMS2 / EPCAM)
98	Other

OTHER GERMLINE GENETIC TEST OFFERED: If [98-Other] is selected in the field CR6110 'Germline Genetic Test Offered' Specify the Gene or Syndrome that was offered

GERMLINE ANALYSIS OFFERED DATE: Record the date on which the germline genetic test was offered

ORGANISATION CODE OF REPORTING REGIONAL GENETICS LABORATORY: This is the ORGANISATION SITE CODE of the ORGANISATION where the reporting laboratory is based

REFERRAL TO CLINICAL GENETICIST OFFERED: Indicate whether the patient has been offered a referral to a Regional Clinical Genetics Service

01	Offered and Undecided
02	Offered and Declined
03	Offered and Accepted
04	Not Offered

1.11 CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE

This is a new section in response to the Achieving World Class Cancer Outcomes, A Strategy For England 2015-2020 (Taskforce report), and to ensure that COSD maintains itself at the cutting end of technology in cancer diagnostics and treatments offered to patients.

To carry Molecular and Biomarkers (Somatic Testing for Targeted Therapy and Personalised Medicine) details for a patient, where these have been performed by the clinical teams.

Multiple occurrences of this data group are permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR6160	CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE	**STRATIFIED MOLECULAR TEST PERFORMED** *[STRATIFIED MEDICINE MOLECULAR TEST PERFORMED INDICATOR]*	an1	R
Start of repeating item - GENE OR STRATIFICATION BIOMARKER ANALYSED				
CR6170	CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE	**GENE OR STRATIFICATION BIOMARKER ANALYSED** *[GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED]*	an2	R
End of repeating item - GENE OR STRATIFICATION BIOMARKER ANALYSED				
CR6180	CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE	**OTHER GENE OR STRATIFICATION BIOMARKER ANALYSED** *[OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT]*	max an30	R
CR6190	CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE	**DATE GENE OR STRATIFICATION BIOMARKER ANALYSED** *[GENE OR STRATIFICATION BIOMARKER ANALYSED DATE]*	an10 ccyy-mm-dd	R
CR6200	CORE - MOLECULAR AND BIOMARKERS - SOMATIC TESTING FOR TARGETED THERAPY AND PERSONALISED MEDICINE	**ORGANISATION CODE OF REPORTING LABORATORY** *[ORGANISATION CODE (REPORTING LABORATORY)]*	an3 or an5	R

STRATIFIED MOLECULAR TEST PERFORMED: An indication of whether a stratification molecular test has been performed on a tumour, for the purpose of determining suitability for a targeted therapy

Y	YES
N	NO
9	Not Known

GENE OR STRATIFICATION BIOMARKER ANALYSED: Record the specific Gene or Stratification Biomarker analysed for the Patient, regardless of test outcome. More than one of these can be selected

01	ALK Fusions
02	BCR-ABL Fusion
03	BRAF Mutation
04	BRCA1 Mutation
05	BRCA2 Mutation
06	EGFR Mutation
07	ERBB2 (HER2/neu) Amplification / Overexpression
08	JAK2
09	KIT (CD117) Mutation
10	KRAS Mutation
11	Microsatellite Instability (MSI) / Mismatch Repair Analysis
12	NGS Panel (specify in [CR6180] below)

13	NRAS Mutation
14	Oncotype DX Gene Expression Test
15	PDGFRA Mutation
16	PIK3CA Mutation
17	RET Fusions
18	ROS Fusions
98	Other

OTHER GENE OR STRATIFICATION BIOMARKER ANALYSED: If [98-Other] is selected in the field CR6170 'Gene or Stratification Biomarker Analysed'. Specify the Gene or Stratification Biomarker that was analysed

DATE GENE OR STRATIFICATION BIOMARKER ANALYSED: Record the date the Gene or Stratification Biomarker was analysed

ORGANISATION CODE OF REPORTING LABORATORY: This is the ORGANISATION SITE CODE of the ORGANISATION where the reporting laboratory is based

1.12 CORE - CLINICAL TRIALS

Only one instance will be recorded for each diagnosis.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1290	CORE - CLINICAL TRIALS	**PATIENT TRIAL STATUS (CANCER)**	an2	R
CR1260	CORE - CLINICAL TRIALS	**CANCER CLINICAL TRIAL TREATMENT TYPE**	an1	R

PATIENT TRIAL STATUS (CANCER): An indication of whether a PATIENT who is eligible for a cancer CLINICAL TRIAL is taking part in it.

EE	PATIENT eligible, consented to and entered trial
ED	PATIENT eligible, declined trial

CANCER CLINICAL TRIAL TREATMENT TYPE: The type of treatment covered by a cancer CLINICAL TRIAL. This is used to record the type(s) of treatment that are the subject of the cancer CLINICAL TRIAL into which the patient has been entered and does not necessarily mean the treatment that the patient will actually receive (which will be recorded only as part of the clinical trial documentation).

Note: Please record the FIRST trial related to this cancer diagnosis only for COSD, this is being reviewed for v8.0.

Where a trial covers more than one type of treatment, e.g. chemotherapy compared with radiotherapy, then the option for “combined treatment” should be selected. Where the trial covers a treatment type not specified here, e.g. biological therapies, ‘Other’ should be selected from the attribute list.

1	Surgery
2	Chemotherapy
3	Hormone therapy
4	Immunotherapy
5	Radiotherapy
6	Combination treatment
8	Other

1.13 CORE – STAGING

The stage of a cancer is a description of how far the cancer has spread. The International Union Against Cancer (UICC) TNM stage is the most widely used system for staging cancers.

For COSD the stage may be recorded at three points in the patient pathway:

- **Pre-treatment**:
  A clinical TNM (cTNM) stage based on evidence acquired before treatment. It is derived by the clinical team, based in physical examination, imaging, endoscopy, biopsy, surgical exploration and any other relevant examination. Usually assessed at the MDT meeting where the treatment options are agreed
- **Pathological stage:**
  A Pathology TNM (pTNM) stage is based on evidence acquired from a histopathology report from the surgical resection. (Recorded in the Pathology section)
- **Integrated stage:**
  This is the stage derived by the clinical team. It is determined from the integration of the pathology stage (pTNM) following surgical resection as the first definitive treatment and the basis of any other clinical information collected such as metastasis (cM)or final review of the case*

For most cancers TNM staging is used but see site specific sections for relevant TNM values and for other staging systems used.

The core staging section is not applicable to Haematology, Gynaecology and Skin diagnoses; however relevant site specific stage should be recorded.

There will only be one Staging section completed for each record. (Pathological stage may be recorded more than once).

General guidance on the recommended staging system by tumour type is included in Appendix E.

Use of MX and M0

The International Union Against Cancer (UICC) TNM version 7 edition states that M0 should be used if there is no positive evidence of distant metastases.

The International Union Against Cancer (UICC) TNM version 7 edition removed the not assessed category (x). Because the overuse of the Mx category meant that a large proportion of tumours were not staged (a TNM group stage cannot be applied if MX is used).

Neuroendocrine Tumours

These are currently staged using the European Neuroendocrine Tumour Society TNM Staging System (ENETS). Where this staging system is used, the values should be recorded in the generic TNM stage fields in the core dataset. The TNM EDITION NUMBER should be recorded as “E”.

Two values provided for the stage

Clinical teams may on occasion’s record two values for a stage field if there is a degree of uncertainty. If the patient has no further investigations to confirm the precise value then the LOWER value should be recorded for COSD.

For example, T1 / T2 would be recorded as T1. In these cases, it is vitally important that stage is confirmed with the clinician to ensure that the most up-to-date clinical decision is being recorded.

Neoadjuvant therapy

For Neoadjuvant patients only record the Clinical stage and the Pathology stage.

> ***Note:*** ***If the patient has had neoadjuvant therapy (i.e. Chemotherapy or Radiotherapy before surgical treatment) the integrated stage may be the same as the pre-treatment stage.***

Data Item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0520	CORE - STAGING	**T CATEGORY (FINAL PRETREATMENT)**	max an5	R
CR0540	CORE - STAGING	**N CATEGORY (FINAL PRETREATMENT)**	max an5	R
CR0560	CORE - STAGING	**M CATEGORY (FINAL PRETREATMENT)**	max an5	R
CR0580	CORE - STAGING	**TNM STAGE GROUPING (FINAL PRE TREATMENT)**	max an5	R
CR3120	CORE - STAGING	**STAGE DATE (FINAL PRETREATMENT STAGE)** *[TNM STAGE GROUPING DATE (FINAL PRETREATMENT)]*	an10 ccyy-mm-dd	R
CR0620	CORE - STAGING	**T CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0630	CORE - STAGING	**N CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0640	CORE - STAGING	**M CATEGORY (INTEGRATED STAGE)**	max an5	R
CR0610	CORE - STAGING	**TNM STAGE GROUPING (INTEGRATED)**	max an5	R
CR3130	CORE – STAGING	**STAGE DATE (INTEGRATED STAGE)** *[TNM STAGE GROUPING DATE (INTEGRATED)]*	an10 ccyy-mm-dd	R
CR2070	CORE - STAGING	**TNM EDITION NUMBER**	max an2	R

T CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the size and extent of the primary tumour before treatment.

N CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the absence or presence and extent of regional lymph node metastases before treatment.

M CATEGORY (FINAL PRETREATMENT): This is the UICC code which classifies the absence or presence of distant metastases before treatment.

TNM STAGE GROUPING (FINAL PRE TREATMENT): Record the overall clinical TNM stage grouping of the tumour, derived from each T, N and M component prior to treatment. This classification is based on all the evidence available to the clinician(s) with responsibility for assessing the patient and for the patient's treatment plan. Such evidence arises from physical examination, imaging, endoscopy, biopsy, surgical exploration and other relevant examinations. The overall pre-treatment TNM stage grouping indicates the tumour stage at the time the treatment plan was devised.

STAGE DATE (FINAL PRETREATMENT STAGE): The date of the TNM STAGE GROUPING (FINAL PRE TREATMENT).

T CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the size and extent of the primary tumour after treatment and/or after all available evidence has been collected.

N CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the absence or presence and extent of regional lymph node metastases after treatment and/or after all available evidence has been collected.

M CATEGORY (INTEGRATED STAGE): This is the UICC code which classifies the absence or presence of distant metastases after treatment and/or after all available evidence has been collected.

TNM STAGE GROUPING (INTEGRATED): Record the overall TNM stage grouping of the tumour, derived from each T, N and M component after treatment. This classification is based on all the evidence available to the clinician(s) with responsibility for assessing the patient. It will be determined on the basis of all the clinical, imaging and pathological data available following the first surgical procedure(s) i.e. this is the integration of the pathological staging with the clinical staging. The overall integrated TNM stage grouping indicates the tumour stage after treatment and/or after all available evidence has been collected.

STAGE DATE (INTEGRATED STAGE): The date of the TNM STAGE GROUPING (INTEGRATED)

TNM EDITION NUMBER: The UICC or AJCC edition number used for TNM staging for this cancer diagnosis. This is only recorded once for all the staging for each cancer diagnosis. It is expected that TNM EDITION will be consistent for all stage data for each diagnosis.

1.14 CORE – TREATMENT

The initial record is completed up to the first treatment but all subsequent treatments are also required. Treatments are also reported for cases covered by Cancer Waiting Times although some additional details are included in COSD in both generic core and site specific sections.

There may be more than one Treatment section completed for each record.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1340	CORE - TREATMENT	**CANCER TREATMENT EVENT TYPE**	an2	R
CR1370	CORE - TREATMENT	**TREATMENT START DATE (CANCER)**	an10 ccyy-mm-dd	R
CR2040	CORE - TREATMENT	**CANCER TREATMENT MODALITY**	an2	R
CR1450	CORE - TREATMENT	**ORGANISATION SITE CODE (PROVIDER TREATMENT START DATE (CANCER)** *[SITE CODE (OF PROVIDER CANCER TREATMENT START DATE)]*	min an5 max an9	R
CR0660	CORE - TREATMENT	**CONSULTANT CODE (TREATMENT)**	an8	R

CANCER TREATMENT EVENT TYPE (CWT)**:** The stage of treatment reached during a Cancer PATIENT PATHWAY for primary, recurrent or metastatic cancer. For COSD these definitions are extended to apply to all registerable conditions. However, those conditions not covered by Cancer Waits will need to be excluded from CWT uploads.

01	First Definitive Treatment for a new primary cancer
02	Second or subsequent treatment for a new primary cancer
03	Treatment for a local recurrence of a primary cancer
04	Treatment for a regional recurrence of cancer
05	Treatment for a distant recurrence of cancer (metastatic disease)
06	Treatment for multiple recurrence of cancer (local and/or regional and/or distant)
07	First treatment for metastatic disease following an unknown primary
08	Second or subsequent treatment for metastatic disease following an unknown primary
09	Treatment for relapse of primary cancer (second or subsequent)
10	Treatment for progression of primary cancer (second or subsequent)

TREATMENT START DATE (CANCER) (CWT)**:** This is the Start Date of the first, second or subsequent cancer treatment given to a PATIENT who is receiving care for a cancer condition.

Applicable to all registered cases but see Cancer Waiting Times for definition.

CANCER TREATMENT MODALITY (CWT)**:** Applicable to all registered cases but see Cancer Waiting Times for definition and values. Applicable for active and non-active treatments, and to record where a patient declines treatment. Applies to all treatments at all stages in the patient pathway, including both primary cancer and recurrence.

ORGANISATION SITE CODE (PROVIDER TREATMENT START DATE (CANCER) (CWT)**:** Applicable to all registered cases but see Cancer Waiting Times for definition and values.

CONSULTANT CODE (TREATMENT): The Consultant code of the consultant responsible for the treatment of the patient.

1.15 CORE – TREATMENT: SURGERY AND OTHER PROCEDURES

To carry the surgery and other procedures details and is not just for Surgery alone

Note: This can be adapted for other procedures including interventional radiology, laser treatment, endoscopies etc. and photo-dynamic procedures. This also includes procedures offered as supportive care.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0680	CORE - SURGERY AND OTHER PROCEDURES	**CANCER TREATMENT INTENT**	an1	R
CR0710	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE DATE**	an10 ccyy-mm-dd	R
Start of repeating item - CONSULTANT CODE (SURGEON)				
CR6300	CORE - SURGERY AND OTHER PROCEDURES	**CONSULTANT CODE (SURGEON)** *[CONSULTANT CODE (RESPONSIBLE SURGEON)]*	an8	R
End of repeating item - CONSULTANT CODE (SURGEON)				
CR0720	CORE - SURGERY AND OTHER PROCEDURES	**PRIMARY PROCEDURE (OPCS)**	an4	R
CR3040	CORE - SURGERY AND OTHER PROCEDURES	**PRIMARY PROCEDURE (SNOMED CT)**	min n6 max n18	O
Start of repeating item - Procedure (OPCS)				
CR0730	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE (OPCS)**	an4	R
End of repeating item - Procedure (OPCS)				
Start of repeating item - Procedure (SNOMED CT)				
CR3050	CORE - SURGERY AND OTHER PROCEDURES	**PROCEDURE (SNOMED CT)**	min n6 max n18	O
End of repeating item - Procedure (SNOMED CT)				
CR6480	CORE - SURGERY AND OTHER PROCEDURES	**RETURN TO THEATRE INDICATOR** *[ADDITIONAL UNPLANNED PROCEDURE REQUIRED INDICATOR]*	an1	R
CR0740	CORE - SURGERY AND OTHER PROCEDURES	**DISCHARGE DATE (HOSPITAL PROVIDER SPELL)**	an10 ccyy-mm-dd	R
CR0750	CORE - SURGERY AND OTHER PROCEDURES	**DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)** *[DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)]*	an2	R
CR6010	CORE - SURGERY AND OTHER PROCEDURES	**ASA SCORE** *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]*	an1	R

CR6310	CORE - SURGERY AND OTHER PROCEDURES	**SURGICAL ACCESS TYPE**	an1	R

CANCER TREATMENT INTENT: The original intention of the cancer treatment provided during a Cancer Care Spell.

C	Curative
D	Diagnostic
S	Staging
P	Palliative
9	Not known

PROCEDURE DATE: The date the procedure was carried out.

CONSULTANT CODE (SURGEON): The Consultant code of the consultant surgeon responsible for the treatment of the patient. If he/she is part of a surgical team, add all consultant surgeons responsible for the procedure.

PRIMARY PROCEDURE (OPCS): Primary procedure is the main procedure carried out.

PRIMARY PROCEDURE (SNOMED CT): Primary procedure is the main procedure carried out using SNOMED CT. This may be recorded in addition to PRIMARY PROCEDURE (OPCS).

Note: ***This field has been upgraded to Optional, therefore any Trust who can and wants to submit data in SNOMED CT, can now do so.***

PROCEDURE (OPCS): This is a procedure(s) other than the PRIMARY PROCEDURE (OPCS), carried out and recorded for CDS or Hospital Episode Statistics purposes. (This may occur more than once).

PROCEDURE (SNOMED CT): This is a procedure(s) other than the PRIMARY PROCEDURE, carried out and recorded for CDS or Hospital Episode Statistics purposes. (This may occur more than once).This maybe recorded in addition to PROCEDURE (OPCS).

Note: ***This field has been upgraded to Optional, therefore any Trust who can and wants to submit data in SNOMED CT, can now do so.***

UNPLANNED RETURN TO THEATRE INDICATOR: Whether or not the patient required a second (unplanned) operation during the same admission as the primary procedure.

Y	Yes
N	No
9	Not known

The proposed collection of this data item is:

- If it is a planned primary procedure, select N (as this is not an unplanned return to theatre)
- If this is an unplanned return to theatre (within the same admission/discharge period), create a completely new surgery treatment record for this and then select Y.
    - The admission and discharge dates for both however would be the same
    - The procedure date, OPCS procedures and possibly surgeon(s) may be different

DISCHARGE DATE (HOSPITAL PROVIDER SPELL): The date a PATIENT was discharged from a Hospital Provider Spell.

DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL): This records the destination of a PATIENT on completion of the Hospital Provider Spell. It can also indicate that the PATIENT died.

19	Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode.
29	Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)

30	Repatriation from high security psychiatric accommodation in an NHS Hospital Provider (NHS Provider)
37	Court
38	Penal establishment or police station
48	High Security Psychiatric Hospital, Scotland
49	NHS other hospital provider - high security psychiatric accommodation
50	NHS other hospital provider - medium secure unit
51	NHS other hospital provider - ward for general PATIENTS or the younger physically disabled
52	NHS other hospital provider - ward for maternity PATIENTS or neonates
53	NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities
54	NHS run Care Home
65	Local Authority residential accommodation i.e. where care is provided
66	Local Authority foster care
79	Not applicable - PATIENT died or still birth
84	Non-NHS run hospital - medium secure unit
85	Non-NHS (other than Local Authority) run Care Home
87	Non-NHS run hospital
88	Non-NHS (other than Local Authority) run Hospice
Default Codes	
98	Not applicable - hospital provider spell not finished at episode end (i.e. not discharged, or current episode unfinished)
99	Not known

ASA SCORE: The ASA physical status classification system is a system for assessing the fitness of patients before surgery. You would expect to find this information in the pre-operative notes or the Anaesthetist review section.

1	A normal healthy patient.
2	A patient with mild systemic disease.
3	A patient with severe systemic disease that limits function, but is not incapacitating.
4	A patient with severe systemic disease that is a constant threat to life.
5	A moribund patient who is not expected to survive without the operation.
6	A declared brain-dead patient whose organs are being removed for donor purposes.

SURGICAL ACCESS TYPE: Approach to surgery (laparoscopic, thoracoscopic, open or converted). Record the access used to perform the operation. Recording the surgical access is standard clinical practice and should be obtained from the operational notes.

1	Open operation
2	Laparoscopic/Thoracoscopic with planned conversion to open surgery
3	Laparoscopic/Thoracoscopic with unplanned conversion to open surgery
4	Laparoscopic/Thoracoscopic completed
Z	Not applicable

Note: ***This field has been created so that it can be used for any tumour site to record the surgical access type used by the surgeon.***

1.16 CORE – TREATMENT: RADIOTHERAPY

A course of radiotherapy is defined as a string of prescriptions which are consecutive. Only Brachytherapy is included here as all other Radiotherapy details are collected from other sources (RTDS).

This section will be recorded once per treatment where applicable and associated with a treatment modality [CR2040] of (06 – Brachytherapy).

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1200	CORE - RADIOTHERAPY	**BRACHYTHERAPY TYPE**	an2	R

BRACHYTHERAPY TYPE: The type of Brachytherapy Treatment Course being given.

BI	Interstitial
BC	Intra-cavity
BT	Not otherwise specified
US	Unsealed Source

Note: ***This data item is not applicable for Colorectal and Haematology diagnosis.***

1.17 CORE – TREATMENT: ACTIVE MONITORING

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1240	CORE - ACTIVE MONITORING	**MONITORING INTENT**	an1	R

MONITORING INTENT: The purpose of monitoring a patient. This may only be used for first definitive treatment.

1	Monitoring with future curative intent
2	Monitoring with future palliative intent
3	Monitoring with unknown or uncertain future intent

Note: ***This data item is not applicable for Gynaecology diagnosis, although is particularly relevant to Urology, Lung and some Haematology diagnosis.***

- ***For Urology 'future curative intent' is equivalent to 'active monitoring/active surveillance'.***
- ***For Urology and Lung use 'future palliative intent' for 'watchful waiting'.***
- ***For Haematology this is applicable to most CLL, some Follicular Lymphomas and Myelodysplasias.***

1.18 CORE - CANCER RECURRENCE / SECONDARY CANCER

A new record is required for each recurrence diagnosis. (At present this section is required to be completed for Breast cancers although it may be completed for other recurrences if available

This section will be recorded once where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0300	CORE - CANCER RECURRENCE / SECONDARY CANCER	**SOURCE OF REFERRAL FOR CANCER RECURRENCE** *[SOURCE OF REFERRAL (CANCER RECURRENCE)]*	an2	R
CR1540	CORE - CANCER RECURRENCE / SECONDARY CANCER	**KEY WORKER SEEN INDICATOR (CANCER RECURRENCE)**	an1	R
CR1550	CORE - CANCER RECURRENCE / SECONDARY CANCER	**PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE)**	an1	R

SOURCE OF REFERRAL FOR CANCER RECURRENCE: (Recurrences only). This identifies the source of referral for a recurrence of cancer.

Note: Either* SOURCE OF REFERRAL FOR OUT-PATIENTS *or* SOURCE OF REFERRAL FOR CANCER RECURRENCE *can be recorded.

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
01	Following an emergency admission
02	Following a Domiciliary Consultation
10	Following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
11	Other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode
Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	
03	Referral from a GENERAL MEDICAL PRACTITIONER
92	Referral from a GENERAL DENTAL PRACTITIONER
12	R03eferral from a GENERAL PRACTITIONER with a Special Interest (GPwSI) or dentist with a Special Interest (DwSI)
04	Referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)
05	Referral from a CONSULTANT, other than in an Accident And Emergency Department
06	Self-referral
07	Referral from a Prosthetist
13	Referral from a Specialist NURSE (Secondary Care)
14	Referral from an Allied Health Professional
15	Referral from an OPTOMETRIST
16	Referral from an Orthoptist
17	Referral from a National Screening Programme
93	Referral from a Community Dental Service
97	Other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

KEY WORKER SEEN INDICATOR (CANCER RECURRENCE): Record whether the patient was seen by a designated key worker who was neither the clinical nurse specialist nor a palliative care specialist. This applies specifically to a recurrence of cancer.

Y	Yes
N	No
9	Not known (not recorded)

PALLIATIVE CARE SPECIALIST SEEN INDICATOR (CANCER RECURRENCE): Record whether the patient was seen by a palliative care specialist. This would be a member of the specialist palliative care team led by a consultant in palliative medicine. This applies to specifically to a recurrence of cancer.

Y	Yes
N	No
9	Not known (not recorded)

1.19 CORE - DEATH DETAILS

Details of death are obtained by the National Cancer Registration Service from ONS but may be submitted by Providers where available. There may only be one Death section completed for each record.

This section may be recorded once, other data items on death will be collected by the NCRAS

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR1270	CORE - DEATH DETAILS	**PERSON DEATH DATE**	an10 ccyy-mm-dd	O
CR1280	CORE - DEATH DETAILS	**DEATH LOCATION TYPE** *[DEATH LOCATION TYPE CODE (ACTUAL)]*	an1	O

PERSON DEATH DATE: The date on which a PERSON died or is officially deemed to have died.

DEATH LOCATION TYPE: The type of LOCATION at which a PERSON died.

10	**Hospital**
20	**Private Residence**
21	Patient's own home
22	Other private residence (e.g. relative's home or carer's home
30	**Hospice**
40	**Care Home**
41	Care Home with nursing
42	Care Home without nursing
50	**Other**

Please note that the values for DEATH LOCATION TYPE have been amended to meet the needs of a number of different datasets and organisations. For COSD it is only expected that the high level values will be recorded (bold, ending with zero) and these data items are optional for inclusion in submissions. However the more granular detail can be submitted if known.

1.20 CORE – PATHOLOGY

As of January 2016, all pathology should be submitted to the NCRAS in structured xml. These reports will include all the data as prescribed below and would be submitted to the NCRAS directly from the pathology Laboratory Information Management Systems (LIMS). Once the pathologist has completed and signed off each report, they can be submitted either individually or as a monthly batch of data.

There is no expectation therefore for Providers to double enter these data by non-clinical MDT coordinators trying to read a pathology report and transcribe the relevant information correctly into their local cancer information system.

Pathological diagnosis and grade (where applicable) are recorded on biopsies and may be amended after surgical resection (if appropriate), when pathological staging should also be available. Full text pathology reports should be submitted to include these data items if structured coded extracts are not available.

There may be more than one Pathology section completed for each record.

To carry the pathology details. The core dataset includes general pathological items which are applicable to all tumour sites unless otherwise stated. Site specific pathology items relating to stage components are included in the site specific pathology sections. These core and site specific items are a subset of the RCPath cancer data sets which have been approved as Professional Standards by the College.

Where structured reporting systems are not available for pathology it is expected that many of the relevant data items will be included in the free text pathology report. Providers may also wish to submit these items from other structured systems such as MDT software, however the original pathology report should always be submitted and there is no expectation for Providers to double enter these data unless they have chosen to do so for local purposes.

A patient may have any number of pathology reports, and there may be more than one pathology report per specimen.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0780	CORE - PATHOLOGY DETAILS	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	R
CR0950	CORE - PATHOLOGY DETAILS	**SERVICE REPORT IDENTIFIER**	max an18	R
CR6220	CORE - PATHOLOGY DETAILS	**PATHOLOGY OBSERVATION REPORT IDENTIFIER**	max an18	R
CR0960	CORE - PATHOLOGY DETAILS	**SERVICE REPORT STATUS**	an1	R
CR0990	CORE - PATHOLOGY DETAILS	**CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY)**	an8	R
CR0980	CORE - PATHOLOGY DETAILS	**ORGANISATION SITE CODE (PATHOLOGY TEST REQUESTED BY)** *[SITE CODE (OF PATHOLOGY TEST REQUEST)]*	min an5 max an9	R
CR1010	CORE - PATHOLOGY DETAILS	**SAMPLE COLLECTION DATE**	an10 ccyy-mm-dd	R
CR0770	CORE - PATHOLOGY DETAILS	**SAMPLE RECEIPT DATE**	an10 ccyy-mm-dd	R
CR0800	CORE - PATHOLOGY DETAILS	**ORGANISATION CODE (OF REPORTING PATHOLOGIST)**	an3 or an5	R

CR0790	CORE - PATHOLOGY DETAILS	**CONSULTANT CODE (PATHOLOGIST)**	an8	R
CR0970	CORE - PATHOLOGY DETAILS	**SPECIMEN NATURE**	an1	R
CR6490	CORE - PATHOLOGY DETAILS	**SNOMED VERSION**	an2	R
Start of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
CR6410	CORE - PATHOLOGY DETAILS	**TOPOGRAPHY (SNOMED) PATHOLOGY** *[TOPOGRAPHY (SNOMED)]*	an8	R
End of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
Start of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
CR6420	CORE - PATHOLOGY DETAILS	**MORPHOLOGY (SNOMED) PATHOLOGY**	min n6 max n18	P
End of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
Start of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
CR0810	CORE - PATHOLOGY DETAILS	**PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)**	min an4 max an6	R
End of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
CR0820	CORE - PATHOLOGY DETAILS	**TUMOUR LATERALITY (PATHOLOGICAL)**	an1	R
CR0760	CORE - PATHOLOGY DETAILS	**PATHOLOGY INVESTIGATION TYPE**	an2	R
CR1020	CORE - PATHOLOGY DETAILS	**PATHOLOGY REPORT TEXT**	max an270000	R
CR0830	CORE - PATHOLOGY DETAILS	**LESION SIZE (PATHOLOGICAL)**	max n3.max n2	R
CR0860	CORE - PATHOLOGY DETAILS	**GRADE OF DIFFERENTIATION (PATHOLOGICAL)**	an2	R
CR0870	CORE - PATHOLOGY DETAILS	**CANCER VASCULAR OR LYMPHATIC INVASION**	an2	R
CR0880	CORE - PATHOLOGY DETAILS	**EXCISION MARGIN** *[EXCISION MARGIN INDICATION CODE]*	an2	R
CR0840	CORE - PATHOLOGY DETAILS	**SYNCHRONOUS TUMOUR INDICATOR**	an1	R
CR0890	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES EXAMINED**	max n3	R
CR0900	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES POSITIVE**	max n3	R
CR0910	CORE - PATHOLOGY DETAILS	**T CATEGORY (PATHOLOGICAL)**	max an5	R
CR0920	CORE - PATHOLOGY DETAILS	**N CATEGORY (PATHOLOGICAL)**	max an5	R
CR0930	CORE - PATHOLOGY DETAILS	**M CATEGORY (PATHOLOGICAL)**	max an5	R
CR0940	CORE - PATHOLOGY DETAILS	**TNM STAGE GROUPING (PATHOLOGICAL)**	max an5	R
CR1000	CORE - PATHOLOGY DETAILS	**NEOADJUVANT THERAPY INDICATOR**	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded e.g. the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

PATHOLOGY OBSERVATION REPORT IDENTIFIER: local identifier of an OBSERVATION REPORT.

Note: ***This differs from the Service Report Identifier as it identifies the specific RC Path Form used, multiple of these could be contained within a Service Report (where there are multiple tumours are identified). This was included after discussion with a major LIMS supplier.***

SERVICE REPORT STATUS: The status of the SERVICE REPORT.

1	Final (complete)
2	Preliminary (Interim)
3	Test not available
4	Unspecified
5	Supplementary/second opinion
6	Deleted

Note: ***This field has the addition of [6 – Deleted], included after discussion with a major LIMS supplier.***

CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY): The code of the CARE PROFESSIONAL who requests the pathology test. This is not required if the request comes from a GENERAL MEDICAL PRACTITIONER.

ORGANISATION SITE CODE (PATHOLOGY TEST REQUESTED BY) The ORGANISATION SITE CODE of the ORGANISATION at which the CARE PROFESSIONAL who requested the DIAGNOSTIC TEST REQUEST for suspected cancer is based.

SAMPLE COLLECTION DATE: The date that a SAMPLE collection takes place or the start of a period for SAMPLE collection. This is the same as the date the Sample is taken.

SAMPLE RECEIPT DATE: Date of receipt of a SAMPLE by a LABORATORY.

ORGANISATION CODE (OF REPORTING PATHOLOGIST): This is the ORGANISATION CODE of the ORGANISATION at which the authorising pathologist is based.

CONSULTANT CODE (PATHOLOGIST): The CONSULTANT CODE of the Pathologist who authorises the pathology report.

SPECIMEN NATURE: The nature of the specimen taken during a Clinical Investigation.

1	Primary tumour
2	Further excision of primary tumour
4	Regional Lymph Nodes
5	Metastatic site other than regional lymph nodes
9	Not known

Where none of the above options are applicable, 'Not known' maybe selected.

Note: ***TOPOGRAPHY (SNOMED) & TOPOGRAPHY (SNOMED) PATHOLOGY*** *have been replaced by [CR6410] and supported by [CR6490] to help identify the version of SNOMED used by the provider Trust. This will allow for more accurate recording of Topography (SNOMED) Pathology, using SNOMED CT from 01-04-2017 and SNOMED International for historically coded cases. Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017. They also becomes a multiple repeating data item, this will allow for multiple SNOMED Topography codes to be submitted where more than one diagnosis is reported from multiple samples in on report.*

Note: ***MORPHOLOGY (SNOMED) & MORPHOLOGY (SNOMED CT)*** *have been replaced by [CR6420] and supported by [CR6490] to help identify the version of SNOMED used by the provider Trust. This will allow for more accurate recording of Morphology (SNOMED) Pathology, using SNOMED CT from 01-04-2017 and SNOMED International for historically coded cases. Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017. They also becomes a multiple repeating data item, this will allow for multiple SNOMED Morphology codes to be submitted where more than one diagnosis is reported from multiple samples in on report.*

SNOMED VERSION: The version of SNOMED used to encode MORPHOLOGY (SNOMED) PATHOLOGY and TOPOGRAPHY (SNOMED) PATHOLOGY.

Note: ***Versions of SNOMED prior to SNOMED CT cease to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

01	SNOMED II
02	SNOMED 3
03	SNOMED 3.5
04	SNOMED RT

05	SNOMED CT
99	Not Known

TOPOGRAPHY (SNOMED) PATHOLOGY: This is the topographical site of the tumour as categorised by SNOMED International / SNOMED CT.

Note: ***Versions of SNOMED prior to SNOMED CT cease to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

MORPHOLOGY (SNOMED) PATHOLOGY: This is the morphology of the tumour as categorised by SNOMED International / SNOMED CT.

Note: ***Versions of SNOMED prior to SNOMED CT cease to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

PRIMARY DIAGNOSIS (ICD PATHOLOGICAL): The PRIMARY DIAGNOSIS based on the evidence from a pathological examination.

Format CXX.X or DXX.X

TUMOUR LATERALITY (PATHOLOGICAL): Tumour laterality identifies the side of the body for a tumour relating to paired organs within a PATIENT based on the evidence from a pathological examination.

L	Left
R	Right
M	Midline
B	Bilateral
8	Not applicable
9	Not known

PATHOLOGY INVESTIGATION TYPE: The type of pathology investigation procedure carried out.

Note: ***Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used.***

CY	Cytology
BU	Biopsy NOS
EX	Excision
PE	Partial Excision
RE	Radical Excision
FE	Further Excision
CU	Curettage
SB	Shave Biopsy
PB	Punch Biopsy
IB	Incisional Biopsy
99	Uncertain/other

PATHOLOGY REPORT TEXT: The full text from the pathology report which may be required by Registries to calculate diagnosis and staging details

LESION SIZE (PATHOLOGICAL): The size in millimetres of the diameter of a lesion, largest if more than one, if the histology of a SAMPLE proves to be invasive.

Note: ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***

Note: ***This data item is not applicable for Haematology diagnosis.***

Note: ***Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used.***

GRADE OF DIFFERENTIATION (PATHOLOGICAL): The definitive grade of the Tumour based on the evidence from a pathological examination.

GX	Grade of differentiation is not appropriate or cannot be assessed
G1	Well differentiated
G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated / anaplastic

Note: ***This data item is not applicable for CNS, Haematology and Sarcoma diagnosis.***

Note: ***Please see Skin site specific dataset for further information on collecting this data item, including the site specific values to be used, although this data item is not used for Melanoma, but is for Squamous Cell Carcinoma.***

Note: ***This data item is not required for Sarcoma cancers. The 3-grade system should be used for sarcoma cancers and therefore HISTOPATHOLOGICAL TUMOUR GRADE (SA11120) should be submitted instead of this item.***

CANCER VASCULAR OR LYMPHATIC INVASION: An indication of the presence or absence of unequivocal tumour in lymphatic and/or vascular spaces.

NU	No - vascular/lymphatic invasion not present
YU	Yes - vascular/lymphatic invasion present
YV	Vascular invasion only present
YL	Lymphatic invasion only present
YB	Both lymphatic and vascular invasion present
UU	Uncertain whether vascular/lymphatic invasion is present or not
XX	Cannot be assessed
99	Not known

Note: ***This data item is not applicable for Haematology diagnosis.***

EXCISION MARGIN: An indication of whether the excision margin was clear of the tumour and if so, by how much. Where there is more than one measurement, record the closest or closest relevant margin. Where actual measurements are not taken use options 01, 05 or 06.

01	Excision margins are clear (distance from margin not stated)
02	Excision margins are clear (tumour >5mm from the margin)
03	Excision margins are clear (tumour >1mm but less than or equal to 5mm from the margin
04	Tumour is less than or equal to 1mm of excision margin, but does not reach margin
05	Tumour reaches tumour margin
06	Uncertain
98	Not applicable
99	Not known
07	Margin not involved (equal to or greater than 1mm)
08	Margin not involved (less than 1mm)
09	Margin not involved (1 to 5 mm)

Note: Codes 07, 08 and 09 are only applicable for skin cancers. They have been included to align with the RCPath datasets for skin diagnoses.

Note: This data item is not applicable for Haematology diagnosis.

SYNCHRONOUS TUMOUR INDICATOR: An indicator of the presence of multiple tumours at a tumour site.

N	No, no synchronous tumours present
Y	Yes, synchronous tumours present
9	Not Known

Note: This data item is not applicable for Haematology diagnosis.

NUMBER OF NODES EXAMINED: The number of local and regional nodes examined.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.

NUMBER OF NODES POSITIVE: The number of local and regional nodes reported as being positive for the presence of Tumour metastases.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.

Note: The COSD Core TNM Staging data items below are not applicable for CNS, Gynaecology, Haematology, Skin and most CTYA diagnoses. Please see site specific datasets for further information on collecting applicable stage data, including the site specific values to be used for TNM where relevant.

T CATEGORY (PATHOLOGICAL): T CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the size and extent of the primary Tumour based on the evidence from a pathological examination.

N CATEGORY (PATHOLOGICAL): N CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the absence or presence and extent of regional lymph node metastases based on the evidence from a pathological examination.

M CATEGORY (PATHOLOGICAL): The Union for International Cancer Control (UICC) code which classifies the absence or presence of distant metastases based on the evidence from a pathological examination.

TNM STAGE GROUPING (PATHOLOGICAL): The Union for International Cancer Control (UICC) code which classifies the combination of Tumour, node and metastases into stage groupings based on the evidence from a pathological examination.

NEOADJUVANT THERAPY INDICATOR: Indicator of whether the pathological stage was recorded after the patient had received neoadjuvant therapy (i.e. chemotherapy or radiotherapy prior to surgery).

Note: If this is "Yes" the pathology stage fields should NOT be prefixed with the letter "y".

Y	Yes
N	No
9	Not known

1.20.1 BREAST – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4140	BREAST - PATHOLOGY	**MULTIFOCAL TUMOUR INDICATOR (BREAST)**	an1	R
BR4160	BREAST - PATHOLOGY	**DCIS GRADE** *[DUCTAL CARCINOMA IN SITU GRADE]*	an1	R
BR4170	BREAST - PATHOLOGY	**INVASIVE GRADE (BREAST)** *[BREAST INVASIVE GRADE]*	an1	R
BR4180	BREAST - PATHOLOGY	**NON INVASIVE TUMOUR SIZE**	max n3.max n2	R
BR4190	BREAST - PATHOLOGY	**WHOLE TUMOUR SIZE**	max n3.max n2	R
BR4200	BREAST - PATHOLOGY	**METASTASIS EXTENT CODE**	an1	R
BR4210	BREAST - PATHOLOGY	**DISTANCE TO MARGIN**	max n2.max n1	R
BR4230	BREAST - PATHOLOGY	**ER ALLRED SCORE** *[ALLRED SCORE (ESTROGEN RECEPTOR)]*	an1	R
BR4220	BREAST - PATHOLOGY	**ER STATUS** *[ESTROGEN RECEPTOR STATUS]*	an1	R
BR4300	BREAST - PATHOLOGY	**PR ALLRED SCORE** *[ALLRED SCORE (PROGESTERONE RECEPTOR)]*	an1	R
BR4290	BREAST - PATHOLOGY	**PR STATUS** *[PROGESTERONE RECEPTOR STATUS]*	an1	R
BR4280	BREAST - PATHOLOGY	**HER2 STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR STATUS]*	an1	R
BR4310	BREAST - PATHOLOGY	**HER2 ISH STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR IN-SITU HYBRIDIZATION RECEPTOR STATUS]*	an1	R
BR4240	BREAST - PATHOLOGY	**CYTOLOGY (BREAST)** *[CYTOLOGY RESULT CODE (BREAST)]*	an2	R
BR4250	BREAST - PATHOLOGY	**CYTOLOGY (NODE)** *[CYTOLOGY RESULT CODE (NODE)]*	an2	R
BR4260	BREAST - PATHOLOGY	**CORE BIOPSY (BREAST)** *[CORE BIOPSY RESULT CODE (BREAST)]*	max an3	R
BR4270	BREAST - PATHOLOGY	**CORE BIOPSY (NODE)** *[CORE BIOPSY RESULT CODE (NODE)]*	an2	R

MULTIFOCAL TUMOUR INDICATOR (BREAST)*:* Is there more than one discrete tumour identified in the same breast?

Y	Yes
N	No
9	Not Known

DCIS GRADE: If ductal carcinoma in situ is present, record the DCIS grade. This is the cytonuclear grade.

H	High
I	Intermediate
L	Low
X	Not assessable

INVASIVE GRADE (BREAST): The invasive histological grade of the tumour as defined by modified Bloom and Richardson system.

1	Grade 1
2	Grade 2
3	Grade 3
X	Not assessable

NON INVASIVE TUMOUR SIZE: The size of the non-invasive tumour in mm. This is only required if there is no invasive component.

Note: ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***

WHOLE TUMOUR SIZE: Whole size of tumour (invasive + surrounding DCIS, if DCIS extends >1mm beyond invasive) (mm) (For tumours without a DCIS component this will be the same as INVASIVE LESION SIZE).

Note: ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***

METASTASIS EXTENT CODE: For single node positivity, specify micrometastatic status as follows: Greater than 2mm = Metastases, 2mm to greater than 0.2mm = Micrometastasis, less than or equal to 0.2mm = Isolated tumour cells.

1	Metastasis
2	Micrometastasis
3	Isolated tumour cells
9	Not known

DISTANCE TO MARGIN: Distance to closest relevant margin (mm). Distance to nearest margin whether invasive or non-invasive. (For COSD measurement to the nearest mm is sufficient but may be recorded to nearest tenth of mm)

ER ALLRED SCORE: ER Allred score (range 0, 2 -8)

ER STATUS*:* Oestrogen Receptor (ER) status.

(A positive score means that oestrogen is causing the tumour to grow, and a negative score means that the tumour is not driven by oestrogen).

P	Positive
N	Negative
X	Not performed

PR ALLRED SCORE*:* Record the PR ALLRED score if known. (Range 0, 2-8)

PR STATUS*:* Progesterone Receptor Status. Record the PR status if known.

P	Positive
N	Negative
X	Not performed

HER2 STATUS: HER2 Immunohistochemical status (Human Epidermal Growth Factor Receptor 2). Where the initial result of this test is "Borderline", a further report will follow with result of the ISH test.

P	Positive
N	Negative
B	Borderline
X	Not performed

HER2 ISH STATUS*:* Record the result of the ISH (in-situ hybridization) test. This is only required if the initial HER2 status is "Borderline".

P	Positive
N	Negative

CYTOLOGY (BREAST)*:* Cytology opinion (Breast)

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CYTOLOGY (NODE)*:* Cytology opinion on axillary lymph node.

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CORE BIOPSY (BREAST)*:* Needle core biopsy opinion.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5a	Malignant (In situ)
B5b	Malignant (Invasive)
B5c	Malignant (Not assessable)

CORE BIOPSY (NODE)*:* Needle biopsy opinion on axillary lymph node.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5	Malignant

1.20.2 CENTRAL NERVOUS SYSTEM – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Molecular Diagnostics Code				
BA3070	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**MOLECULAR DIAGNOSTICS CODE**	an2	R
End of repeating item - Molecular Diagnostics Code				
Start of repeating item - Immunohistochemistry Hormone Expression Type				
BA3150	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE** *[HORMONE EXPRESSION TYPE]*	an1	R
End of repeating item - Immunohistochemistry Hormone Expression Type				
BA3160	CENTRAL NERVOUS SYSTEM - PATHOLOGY	**WHO TUMOUR GRADE (CNS)** *[WORLD HEALTH ORGANISATION CENTRAL NERVOUS SYSTEM TUMOUR GRADE]*	an1	R

MOLECULAR DIAGNOSTICS CODE: Chromosomal or genetic markers associated with the brain tumour. This may involve selection of more than one value for each tumour.

This table was extensively discussed by the Brain CNS SSCRG and has been based on the new 2016 WHO categories for Molecular Diagnostic Markers

~~01~~	~~Evidence of IDH1 or IDH2 mutation~~
~~02~~	~~Evidence of methylation of the MGMT gene CpG island~~
~~03~~	~~Evidence of total loss of 1p and 19q~~
~~04~~	~~Evidence of KIAA 1549-BRAF fusion gene~~
~~05~~	~~Other~~
06	Evidence of *ALK* rearrangement
07	Evidence of native *ALK*
08	Evidence of *ATRX* mutation
09	Evidence of wt *ATRX*
10	Evidence of *BRAF* V600E mutation
11	Evidence of wt *BRAF*
12	Evidence of *KIAA1549-BRAF* fusion
13	Evidence of *BRAF/RAF1* mutations, or fusions involving genes other than *KIAA1549*
14	Evidence of *C11orf95-RELA* fusion
15	Evidence of native *C11orf95* and *RELA*
16	Evidence of amplification or fusion of *C19MC* locus (chr.19q13.42)
17	Evidence of unaltered *C19MC* locus (chr.19q13.42)
18	Evidence of *CDK4/6* amplification
19	Evidence of *CDK4/6* normal copy number
20	Evidence of *CDKN2A* locus homozygous deletion
21	Evidence of *CDKN2A* locus normal copy number
22	Evidence of *CCND1/2/3* amplification
23	Evidence of *CCND1/2/3* normal copy number
24	Evidence of *CTNNB1* mutation
25	Evidence of wt *CTNNB1*
26	Evidence of amplification of *EGFR*
27	Evidence of mutation / rearrangement of *EGFR*
28	Evidence of unaltered *EGFR*
29	Evidence of *EWSR1-FLI1* fusion
30	Evidence of native *EWSR1* and *FLI1*
31	Evidence of *FGFR1* mutation / rearrangement / fusion
32	Evidence of unaltered *FGFR1*
33	Evidence of *H3F3A/H3F3B* (H3.3) K27M mutation
34	Evidence of *H3F3A/H3F3B* (H3.3) wt K27
35	Evidence of *H3F3A/H3F3B* (H3.3) G34R/V mutation
36	Evidence of *H3F3A/H3F3B* (H3.3) wt G34
37	Evidence of *HIST1H3B* K27M mutation
38	Evidence of *HIST1H3B* wt K27
39	Evidence of *HIST1H3C* K27M mutation
40	Evidence of *HIST1H3C* wt K27
41	Evidence of *ID2* amplification
42	Evidence of *ID2* normal copy number
43	*IDH1* (codon 132) or *IDH2* (codon 172) mutation identified
44	*IDH1* (codon 132) and *IDH2* (codon 172) wt confirmed
45	Evidence of *KLF4* K409Q and *TRAF7* mutations
46	Evidence of wt *KLF4* and *TRAF7*
47	Evidence of *MAP2K1* mutation
48	Evidence of wt *MAP2K1*
49	Evidence of *MET* amplification
50	Evidence of *MET* normal copy number
51	Evidence of significant *MGMT* promoter methylation
52	Evidence of unmethylated *MGMT* promoter
53	Evidence of *MYC/MYCN* amplification
54	Evidence of *MYC/MYCN* normal copy number

55	Evidence of *NF1* biallelic loss / mutation
56	Evidence of unaltered *NF1*
57	Evidence of *NF2* biallelic loss / mutation
58	Evidence of unaltered *NF2*
59	Evidence of *NKTR* fusions
60	Evidence of native *NKTR*
61	Evidence of *PTEN* biallelic loss / mutation
62	Evidence of unaltered *PTEN*
63	Evidence of *SDHB* or *SDHD* mutation
64	Evidence of wt *SDHB* and *SDHD*
65	Evidence of *SHH* pathway activation
66	Evidence of normal *SHH* pathway
67	Evidence of inactivation of *SMARCB1* (INI1)
68	Evidence of wt *SMARCB1* (INI1)
69	Evidence of inactivation of *SMARCA4*
70	Evidence of wt *SMARCA4*
71	Evidence of *TERT* promotor mutation
72	Evidence of wt *TERT* promotor
73	Evidence of *TP53* mutation
74	Evidence of wt *TP53*
75	Evidence of *TSC1* or *TSC2* mutation
76	Evidence of wt *TSC1* and *TSC2*
77	Evidence of *VHL* mutation
78	Evidence of wt *VHL* gene
79	Evidence of *WNT* pathway activation
80	Evidence of normal *WNT* pathway
81	Evidence of *WWTR1-CAMTA1* fusion
82	Evidence of native *WWTR1* and *CAMTA1*
83	Evidence of codeletion of chr.1p and chr.19q
84	Evidence of total chr.1p loss but normal copy number of chr.19q
85	Evidence of normal copy number of both chr.1p and chr.19q
86	Evidence of monosomy chr.6
87	Evidence of chr.6 normal copy number
88	Evidence of polysomy chr.7
89	Evidence of chr.7 normal copy number
90	Evidence of loss of chr.10 or chr.10q
91	Evidence of chr.10 normal copy number
92	Evidence of loss of chr.22 or chr.22q
93	Evidence of chr.22 or chr.22q normal copy number
98	Other
99	Not Known (Not Recorded)

The old codes can be mapped as follows to enable a seamless transition from v6.0 to v7.0.

Old Codes and Descriptions		**New Codes and Descriptions**	
01	Evidence of IDH1 or IDH2 mutation	**43**	IDH1 (codon 132) or IDH2 (codon 172) mutation identified
02	Evidence of methylation of the MGMT gene CpG island	**51**	Evidence of significant MGMT promoter methylation
03	Evidence of total loss of 1p and 19q	**83**	Evidence of codeletion of chr.1p and chr.19q
04	Evidence of KIAA 1549-BRAF fusion gene	**12**	Evidence of KIAA1549-BRAF fusion
05	Other	**98**	Other

IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE *[HORMONE EXPRESSION TYPE]:*
Hormone expression by immunohistochemistry. FOR PITUITARY ADENOMAS ONLY. (Multiple values may be recorded)

0	Non functioning
1	ACTH
2	LH
3	FSH
4	Alpha-subunit
5	TSH
6	Prolactin
7	Growth Hormone

WHO TUMOUR GRADE (CNS) [WORLD HEALTH ORGANISATION CENTRAL NERVOUS SYSTEM TUMOUR GRADE]: The grade of the tumour using WHO classification for tumours of the central nervous system. FOR INTRA AXIAL AND EXTRA AXIAL ONLY.

1	I
2	II
3	III
4	IV

1.20.3 COLORECTAL – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5190	COLORECTAL - PATHOLOGY	**POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
CO5210	COLORECTAL - PATHOLOGY	**DISTANCE TO CIRCUMFERENTIAL MARGIN** *[DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN]*	max n2.max n2	R
CO5260	COLORECTAL - PATHOLOGY	**PLANE OF SURGICAL EXCISION** *[PLANE OF SURGICAL EXCISION TYPE]*	an1	R
CO5270	COLORECTAL - PATHOLOGY	**DISTANCE FROM DENTATE LINE**	max n3.max n2	R
CO5280	COLORECTAL - PATHOLOGY	**DISTANCE BEYOND MUSCULARIS PROPRIA**	max n3.max n2	R
CO5290	COLORECTAL - PATHOLOGY	**RESPONSE TO PREOPERATIVE THERAPY** *[PREOPERATIVE THERAPY RESPONSE TYPE]*	an1	R
CO5300	COLORECTAL - PATHOLOGY	**STATUS OF CIRCUMFERENTIAL EXCISION MARGIN** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R

POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN: Record whether the proximal or distal resection margins were involved. If the minimal distance from the cut margin is less than or equal to 1 mm the margin is considered "involved".

0	Margin not involved
1	Margin involved

9	Not known

DISTANCE TO CIRCUMFERENTIAL MARGIN: Record the distance from the outer margin of the tumour to the closest non peritonealised circumferential resection margin in mm. RECTAL CANCERS ONLY.

Note: ***DISTANCE BETWEEN LOWER END OF TUMOUR AND DISTAL RESECTION MARGIN & PERFORATIONS OR SEROSAL INVOLVEMENT INDICATION CODE****: These two Colorectal data items have been removed from the dataset as they are no longer part of the RC Path minimum dataset, and as such they may not be collectable and we should not be adding data that are outside the scope of the RC Path. COSD and RC Path should be aligned (wherever possible).*

PLANE OF SURGICAL EXCISION: FOR RECTAL CANCERS ONLY. This is the quality of the surgical excision as seen by the pathologist. This grades the resection on its worst plane.

1	Mesorectal fascia
2	Intramesorectal
3	Muscularis propria

DISTANCE FROM DENTATE LINE: For abdominoperineal excision specimens only. Record the distance of the tumour from the dentate line in mm measured on the gross specimen.

DISTANCE BEYOND MUSCULARIS PROPRIA: Maximum distance of spread beyond muscularis propria in mm. If there is doubt about the sites of the muscularis propria estimate the distance as accurately as possible.

RESPONSE TO PREOPERATIVE THERAPY: If preoperative therapy was given what was the response.

1	No residual tumour cells/mucous lakes only
2	Minimal residual cancer
3	No marked regression

STATUS OF CIRCUMFERENTIAL EXCISION MARGIN: Record if the edge of the tumour is 1 mm or less from the circumferential resection margin (i.e. margin involved) Circumferential margin refers to the completeness of the surgeon's resection margin in the opinion of the histopathologist. In parts of the colon where it is completely surrounded by peritoneum, recording of the circumferential resection margin (CRM) is not appropriate.

0	Margin not involved
1	Margin involved
9	Not known

1.20.4 CTYA - RENAL PATHOLOGY (Paediatric Kidney)

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6610	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR RUPTURE** *[TUMOUR RUPTURE INDICATOR]*	an1	R
CT6620	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**ANAPLASTIC NEPHROBLASTOMA** *[ANAPLASTIC NEPHROBLASTOMA TYPE]*	an1	R
CT6630	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**PERIRENAL FAT INVASION** *[TUMOUR INVASION INDICATOR (PERIRENAL FAT)]*	an1	R
CT6640	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL SINUS INVASION** *[TUMOUR INVASION INDICATOR (RENAL SINUS)]*	an1	R

CT6650	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
CT6660	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**VIABLE TUMOUR** *[VIABLE TUMOUR INDICATOR]*	an1	R
CT6670	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR LOCAL STAGE (PATHOLOGICAL)** *[TUMOUR LOCAL STAGE]*	an1	R

TUMOUR RUPTURE: Integrity of tumour margins based on pathologist's assessment.

Y	Yes
N	No
X	Not stated

ANAPLASTIC NEPHROBLASTOMA: Is there evidence of anaplasia, focal or diffused, based on established pathological classification.

F	Focal Anaplasia
D	Diffused Anaplasia
U	Uncertain

PERIRENAL FAT INVASION: Are there areas of perirenal fat suspected for tumour infiltration.

Y	Yes
N	No
U	Uncertain

RENAL SINUS INVASION: Is there evidence of invasion of renal sinus by tumour.

Y	Yes
N	No
U	Uncertain

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein.

Y	Yes
N	No
U	Uncertain

VIABLE TUMOUR: Is there evidence of viable tumour in the renal sinus.

Y	Yes
N	No
U	Uncertain

TUMOUR LOCAL STAGE (PATHOLOGICAL): Local stage of the tumour as assessed by pathologist. Classification system used is International Society of Paediatric Oncology (SIOP).

1	Stage I
2	Stage II
3	Stage III

1.20.5 GYNAECOLOGY – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7050	GYNAECOLOGY - PATHOLOGY	**FALLOPIAN TUBE INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (FALLOPIAN TUBE)]*	an1	R
GY7120	GYNAECOLOGY - PATHOLOGY	**OVARIAN INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (OVARIAN)]*	an1	R
GY7130	GYNAECOLOGY - PATHOLOGY	**SEROSAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (SEROSA)]*	an1	R
GY7100	GYNAECOLOGY - PATHOLOGY	**OMENTAL INVOLVEMENT** *[OMENTUM INVOLVEMENT INDICATION CODE]*	an1	R

FALLOPIAN TUBE INVOLVEMENT: For endometrial and epithelial/ovarian cancers, is there microscopic involvement of fallopian tubes?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

OVARIAN INVOLVEMENT: For endometrial and fallopian cancers, is there microscopic involvement of ovaries?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

SEROSAL INVOLVEMENT: For endometrial, epithelial/ovarian and fallopian cancers, is there microscopic involvement of uterine serosa?

Y	Yes
N	No
X	Not assessable

OMENTAL INVOLVEMENT: For endometrium, ovary, fallopian tube and primary peritoneum cancers, is there involvement of the omentum?

1	Involved - deposit size not specified
2	Involved - deposit(s) 20mm or less
3	Involved - deposit(s) greater than 20mm
4	Not involved
X	Not assessable/not sent

1.20.5.1 GYNAECOLOGY – PATHOLOGY – FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

GY7140	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**CAPSULE STATUS**	an1	R
GY7190	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**OVARIAN SURFACE INVOLVEMENT** *[OVARY SURFACE INVOLVEMENT INDICATOR]*	an1	R
GY7150	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**TUMOUR GRADE** *[TUMOUR GRADE (GYNAECOLOGY]*	an1	R
GY7170	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL CYTOLOGY** *[PERITONEAL CYTOLOGY RESULT CODE]*	an1	R
GY7180	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL INVOLVEMENT** *[PERITONEAL INVOLVEMENT INDICATOR]*	an1	R
GY7450	GYNAECOLOGY - PATHOLOGY	**INVASIVE THICKNESS**	max n2.max n2	R

CAPSULE STATUS: Capsule status of ovaries (record the most severe)

1	Intact
2	Disrupted
3	Involved
X	Not assessable

OVARIAN SURFACE INVOLVEMENT: Is there involvement of the surface of either ovary?

Y	Yes
N	No
X	Not assessable

TUMOUR GRADE: Specify the grade of the tumour. For serous tumours specify whether High or Low grade; clear cell carcinomas and carcinosarcomas are all high grade; for all other tumours use three tier grading system.

L	Low
I	Intermediate
H	High

PERITONEAL CYTOLOGY: Result of peritoneal cytology.

1	Involved

2	Not involved
3	Equivocal
X	Not sent

PERITONEAL INVOLVEMENT: Is there peritoneal involvement?

Y	Yes
N	No
X	Not assessable / Not sent

INVASIVE THICKNESS: The thickness or depth of the invasive lesion in mm

1.20.5.2 GYNAECOLOGY – PATHOLOGY – ENDOMETRIAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7220	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**DISTANCE TO SEROSA**	max n2	O
GY7240	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**INVOLVEMENT OF CERVICAL STROMA** *[MICROSCOPIC INVOLVEMENT INDICATOR (CERVICAL STROMA)]*	an1	R
GY7260	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**MYOMETRIAL INVASION** *[MYOMETRIAL INVASION IDENTIFICATION CODE]*	an1	R
GY7270	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PARAMETRIUM INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (PARAMETRIUM)]*	an1	R
GY7280	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PERITONEAL WASHINGS** *[PERITONEAL WASHINGS IDENTIFIED]*	an1	R

Note: ***BACKGROUND ENDOMETRIUM & INVOLVEMENT OF CERVICAL SURFACE OR GLANDS****:*
These two Gynae data items have been removed from the dataset as they are no longer part of the RC Path minimum dataset, and as such they may not be collectable and we should not be adding data that are outside the scope of the RC Path. COSD and RC Path should be aligned (wherever possible).

DISTANCE TO SEROSA: Specify the tumour free distance to the serosa in millimetres (mm).

Note: **This is now downgraded from 'Required' to 'Optional', this will also be reviewed by the RC Path Working Group on Cancer Services later in 2016, to assess its ongoing suitability.**

INVOLVEMENT OF CERVICAL STROMA: Is there microscopic involvement of cervical stroma?

Y	Yes
N	No
X	Not assessable

MYOMETRIAL INVASION: Is there microscopic evidence of myometrial invasion?

1	None
2	Less than 50%
3	Greater than or equal to 50%

PARAMETRIUM INVOLVEMENT: Is there microscopic involvement of parametrium?

Y	Yes
N	No
X	Not assessable

PERITONEAL WASHINGS: Were peritoneal washings submitted and if so were malignant cells seen? These attributes have been changed after discussions with HSCIC (Data Dictionary Team).

~~1~~	~~Positive~~
~~2~~	~~Negative~~
P	Positive
N	Negative
X	Not sent/Not assessable

1.20.5.3 GYNAECOLOGY – PATHOLOGY - CERVICAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7290	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CGIN GRADE** *[CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7300	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CIN GRADE** *[CERVICAL INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7350	GYNAECOLOGY - PATHOLOGY - CERVICAL	**SMILE** *[SMILE INDICATION CODE]*	an1	R
GY7310	GYNAECOLOGY - PATHOLOGY - CERVICAL	**EXCISION MARGIN (PRE INVASIVE)** *[RESECTION MARGIN INVOLVEMENT INDICATOR]*	an1	R
GY7340	GYNAECOLOGY - PATHOLOGY - CERVICAL	**PARACERVICAL OR PARAMETRIAL INVOLVEMENT** *[PARACERVICAL OR PARAMETRIAL INVOLVEMENT INDICATOR]*	an1	R
GY7360	GYNAECOLOGY - PATHOLOGY - CERVICAL	**THICKNESS UNINVOLVED STROMA** *[UNINVOLVED CERVICAL STROMA THICKNESS]*	max n2.max n2	R
GY7370	GYNAECOLOGY - PATHOLOGY - CERVICAL	**VAGINAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (VAGINAL)]*	an1	R

CGIN GRADE: Specify presence and grade of CGIN (cervical glandular intraepithelial neoplasia)

1	Low
2	High
3	Not present
X	Not assessable

CIN GRADE: Specify presence and grade of CIN (cervical intra-epithelial neoplasia)

1	1
2	2
3	3
4	Not present
X	Not assessable

SMILE: Specify presence of SMILE (Stratified Mucin-Producing Intra-Epithelial Lesion)

1	Present
2	Absent
X	Not assessable

EXCISION MARGIN (PRE INVASIVE): Is there evidence of resection margin involvement by in situ/pre invasive disease (CIN, CGIN, and SMILE)

Y	Yes
N	No
X	Not assessable

Note: ***INVASIVE THICKNESS*** *has been retired from the dataset and replaced with a generic Invasive Thickness field [GY7450].*

PARACERVICAL OR PARAMETRIAL INVOLVEMENT: Is there evidence of paracervical and/or parametrial involvement?

Y	Yes
N	No
X	Not assessable

THICKNESS UNINVOLVED STROMA: Minimum thickness of uninvolved cervical stroma in millimetres (mm) (minimum tumour-free rim).

VAGINAL INVOLVEMENT: Is there evidence of microscopic vaginal involvement?

Y	Yes
N	No
X	Not assessable

1.20.5.4 GYNAECOLOGY – PATHOLOGY – VULVAL

Note: ***INVASIVE THICKNESS*** *has been retired from the dataset and replaced with a generic Invasive Thickness field [GY7450].*

1.20.5.5 GYNAECOLOGY – PATHOLOGY – NODES

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7020	GYNAECOLOGY - PATHOLOGY - NODES	**NODAL STATUS CERVICAL CANCER** *[CERVICAL NODE STATUS]*	an2	R

GY7060	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PARA-AORTIC)** *[NUMBER OF NODES EXAMINED (PARA-AORTIC)]*	max n2	R
GY7080	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PARA-AORTIC)** *[NUMBER OF NODES POSITIVE (PARA-AORTIC)]*	max n2	R
GY7070	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PELVIC)** *[NUMBER OF NODES EXAMINED (PELVIC)]*	max n2	R
GY7090	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PELVIC)** *[NUMBER OF NODES POSITIVE (PELVIC)]*	max n2	R
GY7410	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES EXAMINED (INGUINO-FEMORAL)]*	max n2	R
GY7420	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES POSITIVE (INGUINO-FEMORAL)]*	max n2	R
GY7230	GYNAECOLOGY - PATHOLOGY - NODES	**EXTRANODAL SPREAD** *[EXTRANODAL SPREAD INDICATOR]*	an1	R

NODAL STATUS CERVICAL CANCER: FOR CERVICAL CANCERS ONLY. Only required for surgically staged early FIGO stage cancers. Histological assessment of regional lymph nodes, including surgical excision or fine needle aspiration. (FIGO staging for cervical cancer is clinical, but nodal status may be an important prognostic factor and determinant of management options including the need for adjuvant therapy). This could be derived from NODES EXAMINED NUMBER (PELVIC) and NODES POSITIVE NUMBER (PELVIC) but may also be entered separately.

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Regional lymph node metastases

NODES EXAMINED NUMBER (PARA-AORTIC): The number of para-aortic nodes examined. (Not applicable for vulval cancers) Use 0 if nodes not sent.
NODES POSITIVE NUMBER (PARA-AORTIC): The number of para-aortic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers)
NODES EXAMINED NUMBER (PELVIC): The number of pelvic nodes examined (Not applicable for vulval cancers). Use 0 if nodes not sent
NODES POSITIVE NUMBER (PELVIC): The number of pelvic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers)
NODES EXAMINED NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes examined. (Only applicable to vulval cancers). Use 0 if nodes not sent
NODES POSITIVE NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes reported as being positive for the presence of tumour metastases. (Only applicable to vulval cancers)

EXTRANODAL SPREAD: Is there evidence of extranodal spread/extension?

Y	Yes
N	No
X	Not assessable

1.20.6 HEAD & NECK – PATHOLOGY – GENERAL

1 20.6.1 HEAD & NECK – PATHOLOGY – VARIOUS

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9300	HEAD & NECK - PATHOLOGY - VARIOUS	**MAXIMUM DEPTH OF INVASION**	max n3	R
HN9310	HEAD & NECK - PATHOLOGY - VARIOUS	**BONE INVASION** *[BONE INVASION INDICATION CODE]*	an1	R
HN9320	HEAD & NECK - PATHOLOGY - VARIOUS	**CARTILAGE INVASION** *[CARTILAGE INVASION INDICATION CODE]*	an1	R
HN9330	HEAD & NECK - PATHOLOGY - VARIOUS	**NECK DISSECTION LATERALITY** *[ANATOMICAL SIDE (NECK DISSECTION)]*	an1	R

MAXIMUM DEPTH OF INVASION: The maximum depth of invasion in mm. Record as 00 to indicate 'not applicable', (This is not applicable for nasopharynx, hypopharynx, nasal cavity or sinuses).

BONE INVASION [BONE INVASION INDICATION CODE]: Is there evidence of invasion into bone. This is not applicable to many sites as bone not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

CARTILAGE INVASION: Is there evidence of invasion into cartilage. This is not applicable to many sites as cartilage is not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

NECK DISSECTION LATERALITY: Identify laterality of neck dissection if performed.

1	Left
2	Right
3	Bilateral
4	Not performed
8	Not applicable

1 20.6.2 HEAD & NECK – PATHOLOGY – SALIVARY

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9380	HEAD & NECK - PATHOLOGY - SALIVARY	**HISTOLOGICAL GRADE (SALIVARY TUMOUR)** *[HISTOLOGICAL TUMOUR GRADE (SALIVARY)]*	an1	R
HN9390	HEAD & NECK - PATHOLOGY - SALIVARY	**MACROSCOPIC EXTRAGLANDULAR EXTENSION** *[MACROSCOPIC EXTRAGLANDULAR EXTENSION INDICATION CODE]*	an1	R

HISTOLOGICAL GRADE (SALIVARY TUMOUR): Specify the histological grade of the tumour.

1	Low
2	High
3	Not assessed
4	Not applicable

MACROSCOPIC EXTRAGLANDULAR EXTENSION: Macroscopic extension of tumour outside the capsule of the salivary gland.

1	Present
2	Absent

1.20.6.3 HEAD & NECK – PATHOLOGY - GENERAL and SALIVARY

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9400	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**POSITIVE NODES LATERALITY** *[ANATOMICAL SIDE (POSITIVE NODES)]*	an1	R
HN9410	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS LEFT NECK** *[LARGEST METASTASIS (LEFT NECK)]*	max n3	R
HN9420	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS RIGHT NECK** *[LARGEST METASTASIS (RIGHT NECK)]*	max n3	R
HN9430	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**EXTRACAPSULAR SPREAD** *[EXTRACAPSULAR SPREAD INDICATION CODE]*	an1	R

POSITIVE NODES LATERALITY: If nodes positive specify laterality.

1	Left
2	Right
3	Bilateral
8	Not applicable

LARGEST METASTASIS LEFT NECK: If Neck dissected on Left side, the size in mm of the largest metastasis

LARGEST METASTASIS RIGHT NECK: If Neck dissected on Right side, the size in mm of the largest metastasis.

EXTRACAPSULAR SPREAD: Invasion of metastatic tumour outside the capsule of a lymph node.

1	Present
2	Absent
3	Not assessable

1.20.7 LUNG – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10100	LUNG - PATHOLOGY	**PROXIMITY TO CARINA** *[TUMOUR PROXIMITY TO CARINA]*	an1	R
LU10110	LUNG - PATHOLOGY	**EXTENT OF ATELECTASIS**	an1	R
LU10120	LUNG - PATHOLOGY	**EXTENT OF PLEURAL INVASION**	an1	R
LU10130	LUNG - PATHOLOGY	**PERICARDIAL INVASION** *[TUMOUR INVASION INDICATOR (PERICARDIUM)]*	an1	R
LU10140	LUNG - PATHOLOGY	**DIAPHRAGM INVASION** *[TUMOUR INVASION INDICATOR (DIAPHRAGM)]*	an1	R
LU10150	LUNG - PATHOLOGY	**INVASION INTO GREAT VESSEL** *[TUMOUR INVASION INDICATOR (GREAT VESSELS)]*	an1	R
LU10160	LUNG - PATHOLOGY	**INVASION INTO HEART** *[TUMOUR INVASION INDICATOR (HEART)]*	an1	R
LU10170	LUNG - PATHOLOGY	**MALIGNANT PLEURAL EFFUSION** *[MALIGNANT PLEURAL EFFUSION INDICATOR]*	an1	R
LU10180	LUNG - PATHOLOGY	**SATELLITE TUMOUR NODULES LOCATION**	an1	R

PROXIMITY TO CARINA: Is the tumour within 20mm of carina (if known) or more than 20mm from carina.

1	< 20mm
2	>20mm

EXTENT OF ATELECTASIS: Extent of atelectasis/obstructive pneumonitis.

1	None or less than the two other categories
2	Involving hilar region but not whole lung
3	Involving whole lung

EXTENT OF PLEURAL INVASION: What is the extent of pleural invasion?

1	No pleural invasion
2	Visceral pleura only
3	Parietal pleura/chest wall
4	Mediastinal pleura

PERICARDIAL INVASION: Does the tumour invade the pericardium?

Y	Yes
N	No
9	Not known

DIAPHRAGM INVASION: Does the tumour invade the diaphragm?

Y	Yes
N	No
9	Not known

INVASION INTO GREAT VESSEL: Does the tumour invade the great vessels (aorta, central pulmonary artery or vein)?

Y	Yes
N	No
9	Not known

INVASION INTO HEART: Does the tumour invade the Atrium or Heart?

Y	Yes
N	No
9	Not known

MALIGNANT PLEURAL EFFUSION: Is there evidence of malignant pleural effusion?

Y	Yes
N	No
9	Not known

SATELLITE TUMOUR NODULES LOCATION: Record the most distant location of separate tumour nodules.

1	Separate tumour nodules in same lobe
2	Separate tumour nodules in a different ipsilateral lobe
3	Separate tumour nodules in a contralateral lobe
4	No separate tumour nodules
9	Not known

1.20.8 SARCOMA – PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11120	SARCOMA - PATHOLOGY	**HISTOPATHOLOGICAL TUMOUR GRADE**	an1	R
SA11170	SARCOMA - PATHOLOGY	**GENETIC CONFIRMATION INDICATOR**	an1	R

HISTOPATHOLOGICAL TUMOUR GRADE: Histopathological grade of tumour.

1	Low
2	Intermediate
3	High

Note: ***HISTOPATHOLOGICAL TUMOUR GRADE is to be submitted instead of the core data item GRADE OF DIFFERENTIATION (PATHOLOGICAL) for bone and soft tissue sarcomas.***

GENETIC CONFIRMATION INDICATOR: Are there any cytogenetic or molecular genetic data confirming the histological diagnosis?

Y	Yes, confirmed
N	No, not confirmed
X	Test not done

1.20.8.1 SARCOMA - PATHOLOGY – BONE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11130	SARCOMA - PATHOLOGY - BONE	**EXTENT OF LOCAL SPREAD (BONE)** *[TUMOUR BREACH IDENTIFIER]*	an1	R
SA11140	SARCOMA - PATHOLOGY - BONE	**TUMOUR NECROSIS**	max n3	R

EXTENT OF LOCAL SPREAD (BONE) [TUMOUR BREACH IDENTIFIER]: FOR MEDULLARY TUMOURS ONLY. Does the tumour breach the cortex? The extent of local spread will determine whether the tumour is intracompartmental or extracompartmental.

I	Intracompartmental
E	Extracompartmental

TUMOUR NECROSIS: Approximate percentage of tumour necrosis in response to pre-operative therapy.

Note: ***TISSUE TYPE AT NEAREST MARGIN****: This Sarcoma data items have been removed from the dataset as it is no longer part of the RC Path minimum dataset, and as such they may not be collectable and we should not be adding data that are outside the scope of the RC Path. COSD and RC Path should be aligned (wherever possible).*

1.20.8.2 SARCOMA – PATHOLOGY – SOFT TISSUE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11100	SARCOMA - PATHOLOGY - SOFT TISSUE	**TUMOUR DEPTH**	an1	R
SA11220	SARCOMA - PATHOLOGY - SOFT TISSUE	**MITOTIC RATE (SARCOMA)**	max n3	R

TUMOUR DEPTH: Record the deepest tissue compartment where the tumour is located.

1	Intradermal/cutaneous
2	Subcutaneous
3	Fascial/subfascial
9	Not known

MITOTIC RATE (SARCOMA): Mitotic rate per 5mm squared. Also known as mitotic index and mitotic count. Component used to stage GISTs. **Only applicable to GISTS**.

1.20.9 SKIN - GENERAL - BASAL CELL CARCINOMA (BCC), SQUAMOUS CELL CARCINOMA (SCC) and MALIGNANT MELANOMA (MM)

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12120	SKIN - GENERAL - BCC, SCC & MM	**SKIN CANCER LESION INDICATOR** *[SKIN CANCER LESION NUMBER]*	max an3	R

SKIN CANCER LESION INDICATOR: This is the specimen number or letter used to identify the specimen within a report. Where more than one primary skin cancer is reported on the same pathology report, record the lesion number or letter as specified on the pathology report.

Note: ***SITE CODE OF SPECIMEN*** *has been retired from the dataset as it is a duplication of [CR0810]*

1.20.9.1 SKIN - PATHOLOGY - BASAL CELL CARCINOMA (BCC) and SQUAMOUS CELL CARCINOMA (SCC)

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12530	SKIN - PATHOLOGY - BCC & SCC	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR]*	an1	R
SK12537	SKIN - PATHOLOGY - BCC & SCC	**LESION DIAMETER GREATER THAN 20MM INDICATOR** *[LESION DIAMETER GREATER THAN 20MM INDICATION CODE]*	an1	R
SK12650	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT3** *[TUMOUR INVASION INDICATOR (PT3)]*	an1	R
SK12660	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT4** *[TUMOUR INVASION INDICATOR (PT4)]*	an1	R

PERINEURAL INVASION: Is there perineural invasion (invasion into perineurium of nerve bundles-PNI)

Y	Yes (Present)
N	No (Not identified)
X	Cannot be assessed
9	Not known

LESION DIAMETER GREATER THAN 20MM INDICATOR: Is the diameter of the lesion greater than 20mm?

Y	Yes (Greater than 20mm)
N	No (Less than or equal to 20mm)
U	Uncertain
X	Cannot be assessed
9	Not known

DEEP INVASION INDICATOR FOR pT3: For Stage pT3 Tumours only: Tumour with invasion of maxilla, mandible, orbit or temporal bone.

Y	Yes
N	No
U	Uncertain
X	Cannot be assessed

DEEP INVASION INDICATOR FOR pT4: For Stage pT4 Tumours only: Tumour with invasion of skeleton (axial or appendicular) or perineural invasion of skull base.

Y	Yes
N	No
U	Uncertain
X	Cannot be assessed

1.20.9.2 SKIN - PATHOLOGY - SQUAMOUS CELL CARCINOMA (SCC)

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12545	SKIN - PATHOLOGY - SCC & MM	**CLARKS LEVEL IV INDICATOR** *[CLARKS LEVEL IV INDICATION CODE]*	an1	R
SK12565	SKIN - PATHOLOGY - SCC	**LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR** *[LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATION CODE]*	an1	R

CLARKS LEVEL IV INDICATOR: Greater than or equal to Clarks level IV.

Y	Yes
N	No
U	Uncertain
X	Cannot be assessed

Note: ***Clark level IV Indicator is only required to differentiate between T1a and T1b melanomas when mitotic rate cannot be measured AND in the absence of ulceration. In these cases Clarks level IV or above categorises the melanoma as stage T1b.***

LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR: Is the vertical thickness of the lesion greater than 2mm.

Y	Yes (Greater than 2mm)
N	No (Less than or equal to 2mm)
U	Uncertain
X	Cannot be assessed

9	Not known

1.20.9.3 SKIN - PATHOLOGY - MALIGNANT MELANOMA

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12580	SKIN - PATHOLOGY - MM	**ULCERATION INDICATOR** *[ULCERATION INDICATION CODE]*	an1	R
SK12590	SKIN - PATHOLOGY - MM	**MITOTIC RATE (SKIN)**	max n3	R
SK12600	SKIN - PATHOLOGY - MM	**MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR** *[MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATION CODE]*	an1	R
SK12620	SKIN - PATHOLOGY - MM	**TUMOUR REGRESSION INDICATOR** *[TUMOUR REGRESSION INDICATION CODE]*	an1	R
SK12630	SKIN - PATHOLOGY - MM	**BRESLOW THICKNESS**	max n2.max n2	R
SK12430	SKIN - PATHOLOGY - MM	**TUMOUR INFILTRATING LYMPHOCYTES (TILS)** *[TUMOUR INFILTRATING LYMPHOCYTE TYPE]*	an1	R
SK12450	SKIN - PATHOLOGY - MM	**FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION**	max n2.max n2	R
SK12460	SKIN - PATHOLOGY - MM	**SENTINEL NODES EXAMINED NUMBER** *[NUMBER OF SENTINEL NODES SAMPLED]*	max n2	R
SK12470	SKIN - PATHOLOGY - MM	**SENTINEL NODES POSITIVE NUMBER** *[NUMBER OF SENTINEL NODES POSITIVE]*	max n2	R
SK12480	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER** *[NUMBER OF NODES SAMPLED (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R
SK12490	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER** *[NUMBER OF NODES POSITIVE (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R

ULCERATION INDICATOR: Loss of full thickness of epidermis associated with reactive changes (ulceration).

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

MITOTIC RATE (SKIN): Mitotic rate per square millimetres (mm).

Note: ***May also be known as Mitotic Index or Count.***

MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR: Is there evidence of Microsatellite or in transit metastases.

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

TUMOUR REGRESSION INDICATOR: Area of loss of tumour associated with reactive changes.

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

BRESLOW THICKNESS: Breslow thickness in mm, can be recorded to nearest 0.01mm where clinically appropriate.

Note: ***Breslow thickness should be measured to a minimum of one decimal place but at times to a greater degree of precision as to allow accurate AJCC staging.... it is essential that the thickness in mm that is recorded in a database should accurately reflect the stated AJCC7 stage.'*** *(Dataset for the histological reporting of primary cutaneous malignant melanoma and regional lymph nodes (2nd edition) November 2012)*

TUMOUR INFILTRATING LYMPHOCYTES (TILS): Type of TILS. Tumour infiltrating lymphocytes (TILS) are white blood cells that have left the bloodstream and migrated into a tumour.

N	Non-brisk
B	Brisk
A	Absent

FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION: Record the final margin of excision, in millimetres (mm's), after wide local excision procedure. This is an amalgamation of clinical and histopathological data.

SENTINEL NODES EXAMINED NUMBER: Number of sentinel nodes sampled.

SENTINEL NODES POSITIVE NUMBER: Number of sentinel nodes positive.

POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER: Post SNB completion lymphadenectomy, number of nodes sampled. This procedure is not carried out in all cases.

POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER: Post SNB completion lymphadenectomy, number of nodes positive. This procedure is not carried out in all cases.

1.20.10 UPPER GI - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG14470	UPPER GI - PATHOLOGY - LIVER METS	**NUMBER OF COLORECTAL METASTASES IN LIVER CODE**	an1	R
UG14480	UPPER GI - PATHOLOGY - OESOPHAGEAL AND STOMACH	**EXCISION MARGIN (PROXIMAL, DISTAL)** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
UG14490	UPPER GI - PATHOLOGY - OESOPHAGEAL, OG JUNCTION, PANCREAS, BILE DUCT, LCC, LIVER HCC AND LIVER METS	**EXCISION MARGIN (CIRCUMFERENTIAL)** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R

NUMBER OF COLORECTAL METASTASES IN LIVER CODE: Number of colorectal metastases identified in resected liver.

0	None
1	1
2	2
3	3
4	4
5	5
M	Greater than 5

EXCISION MARGIN (PROXIMAL, DISTAL): Identify whether either proximal or distal margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved
1	Margin involved
9	Not known

EXCISION MARGIN (CIRCUMFERENTIAL): Identify whether circumferential margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved
1	Margin involved
9	Not known

1.20.11 UROLOGY – PATHOLOGY

1.20.11.1 UROLOGY – PATHOLOGY – BLADDER

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15120	UROLOGY - PATHOLOGY - BLADDER	**DETRUSOR MUSCLE PRESENCE INDICATOR** *[DETRUSOR MUSCLE PRESENCE INDICATION CODE]*	an1	R

UR15290	UROLOGY - PATHOLOGY - BLADDER	**TUMOUR GRADE (UROLOGY)**	an1	R

DETRUSOR MUSCLE PRESENCE INDICATOR: BLADDER ONLY. Presence or absence of detrusor muscle in the specimen.

TUMOUR GRADE (UROLOGY): BLADDER ONLY. Specify whether LOW, HIGH Grade or PUNLMP (Papillary Urothelial Neoplasm of Low Malignant Potential).

L	Low
H	High
P	PUNLMP
X	Not applicable

1.20.11.2 UROLOGY – PATHOLOGY – KIDNEY

This section will be recorded once is permitted per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15130	UROLOGY - PATHOLOGY - KIDNEY	**TUMOUR NECROSIS INDICATOR**	an1	R
UR15140	UROLOGY - PATHOLOGY - KIDNEY	**PERINEPHRIC FAT INVASION** *[TUMOUR INVASION INDICATOR (PERINEPHRIC FAT)]*	an1	R
UR15150	UROLOGY - PATHOLOGY - KIDNEY	**ADRENAL INVASION** *[TUMOUR INVASION INDICATOR (ADRENAL)]*	an1	R
UR15160	UROLOGY - PATHOLOGY - KIDNEY	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
UR15170	UROLOGY - PATHOLOGY - KIDNEY	**GEROTA'S FASCIA INVASION** *[TUMOUR INVASION INDICATOR (GEROTAS FASCIA)]*	an1	R

TUMOUR NECROSIS INDICATOR: Is there evidence of coagulative tumour necrosis?

Y	Yes
N	No

PERINEPHRIC FAT INVASION: Is there evidence of perinephric fat invasion?

Y	Yes
N	No

ADRENAL INVASION: Is there evidence of direct adrenal invasion?

Y	Yes
N	No

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein?

Y	Yes
N	No
U	Uncertain

GEROTA'S FASCIA INVASION: Is there evidence of invasion into Gerota's fascia?

Y	Yes
N	No

1.20.11.3 UROLOGY – PATHOLOGY – PENIS

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15180	UROLOGY-PATHOLOGY - PENIS	**CORPUS SPONGIOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS SPONGIOSUM)]*	an1	R
UR15190	UROLOGY-PATHOLOGY - PENIS	**CORPUS CAVERNOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS CAVERNOSUM)]*	an1	R
UR15200	UROLOGY-PATHOLOGY - PENIS	**URETHRA OR PROSTATE INVASION** *[TUMOUR INVASION INDICATOR (URETHRA OR PROSTATE)]*	an1	R

CORPUS SPONGIOSUM INVASION: Is there evidence of invasion into corpus spongiosum?

Y	Yes
N	No

CORPUS CAVERNOSUM INVASION: Is there evidence of invasion into corpus cavernosum?

Y	Yes
N	No

URETHRA OR PROSTATE INVASION: Is there evidence of invasion into the urethra or prostate?

Y	Yes
N	No

1.20.11.4 UROLOGY – PATHOLOGY – PROSTATE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15210	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (PRIMARY)**	an1*	R
UR15220	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (SECONDARY)**	an1*	R
UR15230	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (TERTIARY)**	an1*	R

UR15240	UROLOGY - PATHOLOGY - PROSTATE	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (UROLOGY)]*	an1	R
UR15250	UROLOGY - PATHOLOGY - PROSTATE	**ORGAN CONFINED** *[ORGAN CONFINED INDICATOR]*	an1	R
UR15260	UROLOGY - PATHOLOGY - PROSTATE	**SEMINAL VESICLES INVASION** *[TUMOUR INVASION INDICATOR (SEMINAL VESICLES)]*	an1	R
UR15270	UROLOGY - PATHOLOGY - PROSTATE	**TURP TUMOUR PERCENTAGE**	max n3	R

**Format an1 used to align with Data Dictionary rules.*

Applies to the next three data items:

The Gleason Grading System is used to help evaluate the prognosis of men with prostate cancer.

A pathologist assigns a Gleason grade to the most common tumour pattern in a biopsy specimen (Primary Grade) then the second most common (Secondary Grade). The grades are added together to give the Gleason Score. Sometimes pathologists will also give a grade to a third component of the specimen (Tertiary Grade) although this recorded separately and is not added to the score.

GLEASON GRADE (PRIMARY): What is the most extensive Gleason grade?

1 - 5	Range 1-5

GLEASON GRADE (SECONDARY): If additional grades are present, what is the highest grade (biopsy) or the second most extensive grade (TURP and radicals)? If no additional grades are present, primary and secondary grades are the same.

1 - 5	Range 1-5

GLEASON GRADE (TERTIARY): Is there a different third grade in addition the primary and secondary grades and what is its value? Note that this is only applicable to about 5% of prostate cases. ***It is important to note that the Tertiary Grade is not the added value of the Primary and Secondary Gleason***.

1 - 5	Range 1 – 5
8	Not applicable

PERINEURAL INVASION: Is there perineural invasion (invasion into perineurium of nerve bundles-PNI)

Y	Yes
N	No
X	Cannot be assessed
9	Not known

ORGAN CONFINED: If prostatectomy was performed, is the tumour confined to the prostate?

Y	Yes
N	No
X	Not applicable

SEMINAL VESICLES INVASION: If prostatectomy was performed, is there invasion into Seminal Vesicles?

Y	Yes
N	No
X	Not applicable

TURP TUMOUR PERCENTAGE: For TURP only, what percentage of tumour if clinically unsuspected tumour. Range 0 - 100

1.20.11.5 UROLOGY – PATHOLOGY – TESTICULAR

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15310	UROLOGY - PATHOLOGY - TESTICULAR	**RETE TESTES INVASION** *[TUMOUR INVASION INDICATOR (RETE TESTIS)]*	an1	R

RETE TESTES INVASION: For Seminoma only, does the tumour invade the rete testis?

Y	Yes
N	No
X	Not applicable

2. BREAST

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C50.0	Nipple and areola	Breast	●			
C50.1	Central portion of breast	Breast	●			
C50.2	Upper-inner quadrant of breast	Breast	●			
C50.3	Lower-inner quadrant of breast	Breast	●			
C50.4	Upper-outer quadrant of breast	Breast	●			
C50.5	Lower-outer quadrant of breast	Breast	●			
C50.6	Axillary tail of breast	Breast	●			
C50.8	Overlapping lesion of breast	Breast	●			
C50.9	Breast, unspecified	Breast	●			
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			
D48.6	Neoplasm of uncertain or unknown behaviour of Breast	Breast			●	

2.1 BREAST – REFERRALS

This section can be recorded more than once within a referral.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4000	BREAST - REFERRALS	**DATE OF CLINICAL ASSESSMENT**	an10 ccyy-mm-dd	R
BR4010	BREAST - REFERRALS	**ORGANISATION SITE CODE (OF CLINICAL ASSESSMENT)** *[SITE CODE (OF CLINICAL ASSESSMENT)]*	min an5, max an9	R
BR4020	BREAST - REFERRALS	**CLINICAL ASSESSMENT RESULT (BREAST)** *[CLINICAL ASSESSMENT RESULT CODE (BREAST CANCER)]*	an2	R

DATE OF CLINICAL ASSESSMENT: Date of clinical/physical examination. This will normally be the date of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the date of each clinical examination undertaken should be recorded.

ORGANISATION SITE CODE (OF CLINICAL ASSESSMENT)*:* Provider code where clinical/physical examination was carried out. This will normally be the site code of the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the site code of each breast clinic where a clinical/physical examination was undertaken should be recorded.

CLINICAL ASSESSMENT RESULT (BREAST)*:* Result of the clinical/physical examination of the breast for which a cancer is registered. This will normally be the result of an assessment of a patient's clinical history and physical examination undertaken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each clinical/physical examination undertaken should be recorded.

P1	Normal
P2	Benign
P3	Uncertain
P4	Suspicious
P5	Malignant

2.2 BREAST – IMAGING

These sections can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BREAST - IMAGING (MAMMOGRAM)				
Multiple occurrences of this data group are permitted				
BR4050	BREAST - IMAGING (MAMMOGRAM)	**MAMMOGRAM RESULT** *[MAMMOGRAM RESULT CODE]*	an2	R

MAMMOGRAM RESULT: Result of the mammogram. This will normally be the result of the mammogram taken at the first outpatient appointment at the breast clinic. If the patient attends more than one breast clinic, the result of each mammogram should be recorded.

R1	Normal
R2	Benign
R3	Uncertain
R4	Suspicious
R5	Malignant

PROCEDURE DATE (MAMMOGRAM) & ORGANISATION SITE CODE (MAMMOGRAM)*:* have been retired as these can be collected by using either [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C01M), in combination with [CR0320] Procedure Date (Cancer Imaging). This will in turn reduce duplication as these should already be captured there anyway and reduce the burden of data collection.

PROCEDURE DATE (BREAST ULTRASOUND), ORGANISATION SITE CODE (BREAST ULTRASOUND) & have now been replaced and a NEW data item [CR6000] Ultrasound Examination Result created in CORE - Imaging. This allows for both [BR4060] + [BR4070] to be replaced as these can be collected by using either [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C05X) and [CR0340] Imaging Anatomical Site (Z159), in combination with [CR0320] Procedure Date (Cancer Imaging). This will in turn reduce duplication as these should already be captured there anyway and reduce the burden of data collection.

BREAST ULTRASOUND EXAMINATION RESULT, PROCEDURE DATE (AXILLA ULTRASOUND) & ORGANISATION SITE CODE (OF AXILLA ULTRASOUND): has now been replaced and a NEW data item [CR6000] Ultrasound Examination Result created in CORE - Imaging. This allows for both [BR4090] + [BR4100] to be replaced as these can be collected by using either [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C05X) and [CR0340] Imaging Anatomical Site (Z613), in combination with [CR0320] Procedure Date (Cancer Imaging). This will in turn reduce duplication as these should already be captured there anyway and reduce the burden of data collection.

2.3 BREAST – PROGNOSTIC INDEX

This data will be recorded once, in a new section called Prognostic Index. This replaces the Cancer Care Plan, and although this data may be collected from these meeting, that may not be the case for every patient.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4120	BREAST – PROGNOSTIC INDEX	**NPI SCORE** *[NOTTINGHAM PROGNOSTIC INDEX SCORE]*	max n2.max n2	R

NPI SCORE: NPI Score should be collected for invasive breast cancers. Nottingham Prognostic Index Score (calculated from invasive tumour size, grade and lymph node involvement).

Where:

- **S** is the maximum diameter of the index lesion in centimetres (invasive carcinoma)
- **N** is the number of axillary lymph nodes involved: 0 nodes = 1, 1-3 nodes = 2, >4 = 3
- **G** is the grade of tumour: Grade 1 = 1, Grade 2 = 2, Grade 3 = 3

The index is calculated using the formula:

NPI = [0.2 x S] + N + G

Note: ***It is important to record all relevant information to ensure that NPI following neoadjuvant therapy can be identified. This includes NEOADJUVANT THERAPY INDICATOR in the core pathology section and use of y prefixes if appropriate in TNM stage fields.***

ASA SCORE*:* has been replaced and a NEW data item [CR6010] ASA Score created in CORE Surgery and Other Procedures. This reduces the burden of data collection throughout the dataset. This data can be collected now only once but can be collected for any tumour site, where they feel this is appropriate.

2.5 BREAST – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[17] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[18].

[17] https://nww.cancerstats.nhs.uk/cosd/staging

[18] http://www.wileyanduicc.com/

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

3. CENTRAL NERVOUS SYSTEM (CNS)

OVERVIEW

For the COSD benign brain cancers are included in the Central Nervous System Dataset, although they are excluded from Cancer Waits.

ICD-10 codes C47 and C69 are grouped under Brain/Central Nervous System for Cancer Waits but are excluded from the COSD Central Nervous System dataset. For diseases coded under C47 (peripheral nerves and autonomic nervous system) or C69 (eye and adnexa) only the CORE dataset needs to be completed.

ICD-10 CODES

Note: That for Central Nervous System full details are required for benign and uncertain tumours as well as malignant diseases.

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*

C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C69.0	*Conjunctiva*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.1	*Cornea*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.2	*Retina*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.3	*Choroid*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.4	*Ciliary body*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.5	*Lachrymal gland and duct*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. Maybe treated by Sarcoma MDT.*
C69.8	*Overlapping lesion of eye and adnexa*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.9	*Eye, unspecified*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C70.0	Cerebral meninges	Brain/Central Nervous System	●			
C70.1	Spinal meninges	Brain/Central Nervous System	●			
C70.9	Meninges, unspecified	Brain/Central Nervous System	●			
C71.0	Cerebrum, except lobes and ventricles	Brain/Central Nervous System	●			
C71.1	Frontal lobe	Brain/Central Nervous System	●			
C71.2	Temporal lobe	Brain/Central Nervous System	●			
C71.3	Parietal lobe	Brain/Central Nervous System	●			

C71.4	Occipital lobe	Brain/Central Nervous System	●			
C71.5	Cerebral ventricle	Brain/Central Nervous System	●			
C71.6	Cerebellum	Brain/Central Nervous System	(●) (*)			CTYA dataset collected for Medulloblastoma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	●			
C71.8	Overlapping lesion of brain	Brain/Central Nervous System	●			
C71.9	Brain, unspecified	Brain/Central Nervous System	●			
C72.0	Spinal cord	Brain/Central Nervous System	●			
C72.1	Cauda equina	Brain/Central Nervous System	●			
C72.2	Olfactory nerve	Brain/Central Nervous System	●			
C72.3	Optic nerve	Brain/Central Nervous System	●			
C72.4	Acoustic nerve	Brain/Central Nervous System	●			
C72.5	Other and unspecified cranial nerves	Brain/Central Nervous System	●			
C72.8	Overlapping lesion of brain and other parts of central nervous system	Brain/Central Nervous System	●			
C72.9	Central nervous system, unspecified	Brain/Central Nervous System	●			
C75.1	Pituitary gland	Other	*			Usually treated by CNS MDT.
C75.2	Craniopharyngeal duct	Other	*			Usually treated by CNS MDT.
C75.3	Pineal gland	Other	*			Usually treated by CNS MDT.

C79.3	Secondary malignant neoplasm of brain and cerebral meninges	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.4	Secondary malignant neoplasm of other and unspecified parts of nervous system	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D32.0	benign neoplasm of cerebral meninges	Brain/Central Nervous System	●			
D32.1	benign neoplasm of spinal meninges	Brain/Central Nervous System	●			
D32.9	benign neoplasm of meninges, unspecified	Brain/Central Nervous System	●			
D33.0	Benign neoplasm of brain, supratentorial	Brain/Central Nervous System	●			
D33.1	Benign neoplasm of brain, infratentorial	Brain/Central Nervous System	●			
D33.2	Benign neoplasm of brain, unspecified	Brain/Central Nervous System	●			
D33.3	Benign neoplasm of cranial nerves	Brain/Central Nervous System	●			
D33.4	Benign neoplasm of spinal cord	Brain/Central Nervous System	●			
D33.7	Benign neoplasm of other specified parts of central nervous system	Brain/Central Nervous System	●			
D33.9	Benign neoplasm of central nervous system, unspecified	Brain/Central Nervous System	●			
D35.2	Benign neoplasm of Pituitary gland	Brain/Central Nervous System	●			
D35.3	Benign neoplasm of Craniopharyngeal duct	Other	*			Usually treated by CNS MDT.
D35.4	Benign neoplasm of Pineal gland	Brain/Central Nervous System	●			

D42.0	Neoplasm of uncertain or unknown behaviour of cerebral meninges	Brain/Central Nervous System	●			
D42.1	Neoplasm of uncertain or unknown behaviour of spinal meninges	Brain/Central Nervous System	●			
D42.9	Neoplasm of uncertain or unknown behaviour of meninges, unspecified	Brain/Central Nervous System	●			
D43.0	Neoplasm of uncertain or unknown behaviour of brain, supratentorial	Brain/Central Nervous System	●			
D43.1	Neoplasm of uncertain or unknown behaviour of brain, infratentorial	Brain/Central Nervous System	●			
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified	Brain/Central Nervous System	●			
D43.3	Neoplasm of uncertain or unknown behaviour of cranial nerves	Brain/Central Nervous System	●			
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord	Brain/Central Nervous System	●			
D43.7	Neoplasm of uncertain or unknown behaviour of other parts of central nervous system	Brain/Central Nervous System	●			
D43.9	Neoplasm of uncertain or unknown behaviour of central nervous system, unspecified	Brain/Central Nervous System	●			

D44.3	Neoplasm of uncertain or unknown behaviour of pituitary gland	Brain/Central Nervous System	●			
D44.4	Neoplasm of uncertain or unknown behaviour of Craniopharyngeal duct	Brain/Central Nervous System	●			
D44 .5	Neoplasm of uncertain or unknown behaviour of pineal gland	Brain/Central Nervous System	●			

3.1 CENTRAL NERVOUS SYSTEM – IMAGING

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3000	CENTRAL NERVOUS SYSTEM - IMAGING	**LESION LOCATION (RADIOLOGICAL)**	an2	R
BA3020	CENTRAL NERVOUS SYSTEM - IMAGING	**NUMBER OF LESIONS (RADIOLOGICAL)**	max n2	R
BA3030	CENTRAL NERVOUS SYSTEM - IMAGING	**LESION SIZE (RADIOLOGICAL)**	max n3.max n2	R
Start of repeating item - Features of Lesions (Radiological)				
BA3040	CENTRAL NERVOUS SYSTEM - IMAGING	**FEATURES OF LARGEST LESION (RADIOLOGICAL)** *[LARGEST LESION FEATURES (RADIOLOGICAL)]*	an2	R
End of repeating item - Features of Lesions (Radiological)				
BA3050	CENTRAL NERVOUS SYSTEM - IMAGING	**PRINCIPAL DIAGNOSTIC IMAGING TYPE**	an1	R

LESION LOCATION (RADIOLOGICAL): Radiologically determined anatomical location of lesion (largest lesion if more than one) or where centred. This is recorded prior to treatment.

01	Frontal lobe
02	Temporal lobe
03	Parietal lobe
04	Occipital lobe
05	Pineal region
06	Hypothalamic
07	Basal ganglia/thalamic
08	Cerebellar
09	Midbrain
10	Pons
11	Medulla
12	Fourth ventricle
13	Third ventricle
14	Lateral ventricle

15	Parasagittal/parafalcine dura
16	Posterior fossa convexity dura
17	Convexity dura
18	Petrous temporal bone
19	Orbital roof
20	Skull vault
21	Scalp
22	Anterior cranial fossa
23	Middle cranial fossa
25	Infratemporal fossa
26	Pterygopalatine fossa
27	Anterior clinoid dura
28	Sphenoid wing dura
29	Subfrontal dura
30	Suprasellar dura
31	Clival dura
32	Cavernous sinus
33	Cerebellopontine angle
34	Jugular bulb
35	Venous angle dura
36	Foramen magnum
37	Cervical intramedullary
38	Cervical intradural
39	Cervical extradural
40	Cervical bony
41	Thoracic intramedullary
42	Thoracic intradural
43	Thoracic extradural
44	Thoracic bony
45	Lumbar intramedullary
46	Lumbar intradural
47	Lumbar extradural
48	Lumbar bony
98	Other

NUMBER OF LESIONS (RADIOLOGICAL): Radiologically determined number of lesions.

LESION SIZE (RADIOLOGICAL): Radiological estimate in millimetres (mm) of the maximum diameter of the tumour measured prior to treatment (largest lesion if more than one). Record as "0" to indicate not assessable for diffuse tumours (e.g. gliomatosis cerebri).

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

FEATURES OF LARGEST LESION (RADIOLOGICAL)*:* Radiologically identified features of the largest lesion such as density, necrosis recorded pre-treatment. This may involve selection of more than one value.

01	Contrast-enhancement
02	Calcification
03	Mass effect
04	Hydrocephalus
05	Haemorrhage
06	Cystic/multi-cystic
07	Dural tail

08	Brain oedema
09	Cord signal change
10	Cord compression

PRINCIPAL DIAGNOSTIC IMAGING TYPE: Indicate the principal imaging procedure undertaken to diagnose the tumour.

Please note that the value PET Scan includes PET-CT Scan.

1	CT Scan
2	MRI Scan
3	PET Scan

3.2 CENTRAL NERVOUS SYSTEM – CANCER CARE PLAN

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3060	CENTRAL NERVOUS SYSTEM - CANCER CARE PLAN	**PRIMARY DIAGNOSIS (ICD RADIOLOGICAL)**	min an4 max an6	R
BA3080	CENTRAL NERVOUS SYSTEM - CANCER CARE PLAN	**MDT PROVISIONAL DIAGNOSIS (ICD)** *[PROVISIONAL DIAGNOSIS (ICD)]*	min an4 max an6	R

PRIMARY DIAGNOSIS (ICD RADIOLOGICAL): Primary diagnosis based on imaging. In many cases this will be the definitive clinical diagnosis, but needs to be distinguished from the subsequent pathological diagnosis - if it becomes available. You may be able to identify this information at the MDT meeting during the imaging review.

MDT PROVISIONAL DIAGNOSIS (ICD)*:* Working diagnosis as defined at MDT where the first definitive treatment is agreed. This is the clinical opinion which may also be informed by biopsy, radiological and/or other investigations.

3.3 CENTRAL NERVOUS SYSTEM – SURGERY & OTHER PROCEDURES

This section will be recorded once per treatment.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BA3100	CENTRAL NERVOUS SYSTEM - SURGERY & OTHER PROCEDURES	**TUMOUR LOCATION (SURGICAL)**	an2	R
BA3200	CNS - SURGERY & OTHER PROCEDURES	**BIOPSY TYPE** *[BIOPSY TYPE (CENTRAL NERVOUS SYSTEM TUMOURS)]*	an1	R
BA3210	CNS - SURGERY & OTHER PROCEDURES	**EXCISION OR PROCEDURE TYPE** *[EXCISION TYPE (CENTRAL NERVOUS SYSTEM TUMOURS)]*	an1	R

ASA SCORE *[ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE]:* has been replaced and a NEW data item [CR6010] ASA Score created in CORE Surgery and Other Procedures. This reduces the burden of data collection throughout the dataset. This data can be collected now only once but can be collected for any tumour site, where they feel this is appropriate.

TUMOUR LOCATION (SURGICAL): Surgically determined anatomical location of lesion(s) or where centred.

01	Frontal lobe	26	Pterygopalatine fossa
02	Temporal lobe	27	Anterior clinoid dura
03	Parietal lobe	28	Sphenoid wing dura
04	Occipital lobe	29	Subfrontal dura
05	Pineal region	30	Suprasellar dura
06	Hypothalamic	31	Clival dura
07	Basal ganglia/thalamic	32	Cavernous sinus
08	Cerebellar	33	Cerebellopontine angle
09	Midbrain	34	Jugular bulb
10	Pons	35	Venous angle dura
11	Medulla	36	Foramen magnum
12	Fourth ventricle	37	Cervical intramedullary
13	Third ventricle	38	Cervical intradural
14	Lateral ventricle	39	Cervical extradural
15	Parasagittal/parafalcine dura	40	Cervical bony
16	Posterior fossa convexity dura	41	Thoracic intramedullary
17	Convexity dura	42	Thoracic intradural
18	Petrous temporal bone	43	Thoracic extradural
19	Orbital roof	44	Thoracic bony
20	Skull vault	45	Lumbar intramedullary
21	Scalp	46	Lumbar intradural
22	Anterior cranial fossa	47	Lumbar extradural
23	Middle cranial fossa	48	Lumbar bony
25	Infratemporal fossa	98	Other

BIOPSY TYPE: Identify type of biopsy (where performed)

1	Frame-based stereotactic biopsy
2	Frameless stereotactic biopsy
3	Open biopsy
4	Percutaneous biopsy
5	Endoscopic biopsy
6	Other Biopsy
9	Not Known

EXCISION OR PROCEDURE TYPE: Identify type of excision or procedure (where performed)

1	Limited (<50%)
2	Partial (50-69%)
3	Subtotal (70-95%)
4	Total Macroscopic
5	Extent Uncertain
6	CSF Division Procedure
9	Not Known

3.4 CENTRAL NERVOUS SYSTEM – RADIOSURGERY

RADIOSURGERY PERFORMED INDICATOR & PROCEDURE DATE (RADIOSURGERY): have both been retired from the dataset because 'Radiosurgery' already exists in CORE Treatment as a treatment modality [22 - Radiosurgery]. If this is selected it then allows for all other treatment options to also be collected e.g. Where it took place, the date, the consultant treating them and the OPCS code of the treatment, in this case A107 Shortdesc: OTHER OPERATIONS ON TISSUE OF BRAIN Description: STEREOTACTIC RADIOSURGERY ON TISSUE OF BRAIN.

Note: **Stereotatic brain radiotherapy would not be recorded in the Trust with an OPCS code of A107 and would be recorded in RTDS. If this is the case then a record these treatments, with a Treatment Modality of 'Radiosurgery' and a date but no OPCS code should be recorded.**

4. COLORECTAL

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C18.0	Caecum	Colorectal	●			
C18.1	Appendix	Colorectal		●		
C18.2	Ascending colon	Colorectal	●			
C18.3	Hepatic flexure	Colorectal	●			
C18.4	Transverse colon	Colorectal	●			
C18.5	Splenic flexure	Colorectal	●			
C18.6	Descending colon	Colorectal	●			
C18.7	Sigmoid colon	Colorectal	●			
C18.8	Overlapping lesion of colon	Colorectal	●			
C18.9	Colon, unspecified	Colorectal	●			

C19	Malignant neoplasm of rectosigmoid junction	Colorectal	●			
C20	Malignant neoplasm of rectum	Colorectal	●			
C21.0	Anus, unspecified	Colorectal		●		
C21.1	Anal canal	Colorectal		●		
C21.2	Cloacogenic zone	Colorectal		●		
C21.8	Overlapping lesion of rectum, anus and anal canal	Colorectal		●		
C26.0	Intestinal tract, part unspecified	Colorectal	●			
C26.1	Spleen	Colorectal		●		
C26.8	Overlapping lesion of digestive system	Colorectal		●		
C26.9	Ill-defined sites within the digestive system	Colorectal		●		
C78.4	Secondary malignant neoplasm of small intestine	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.5	Secondary malignant neoplasm of large intestine and rectum	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D01.0	Carcinoma in situ of Colon	Colorectal			●	

D01.1	Carcinoma in situ of Rectosigmoid junction	Colorectal			●	
D01.2	Carcinoma in situ of Rectum	Colorectal			●	
D01.3	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.4	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.7	Other specified digestive organs	Colorectal			●	
D01.9	Carcinoma in situ of Digestive organ, unspecified	Colorectal			●	
D37.3	Neoplasm of uncertain or unknown behaviour of Appendix	Colorectal			●	
D37.4	Neoplasm of uncertain or unknown behaviour of Colon	Colorectal			●	
D37.5	Neoplasm of uncertain or unknown behaviour of Rectum	Colorectal			●	
D37.7	Other digestive organs	Colorectal/Upper Gastrointestinal			●	
D37.9	Digestive organ, unspecified	Colorectal/Upper Gastrointestinal			●	

4.1 COLORECTAL – IMAGING

PROCEDURE DATE (FIRST CT SCAN), **PROCEDURE DATE (FIRST MRI SCAN OF RECTUM)** *&*

PROCEDURE DATE (SECOND MRI SCAN OF RECTUM)*:* are all dates that can be inferred by using the date [CR0320] provided within the CORE - Imaging section and a combination of [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C02X) CT Scan or (C06X) MRI Scan + [CR0340] Imaging Anatomical Site (Z291).

DATE OF ENDOANAL ULTRASOUND*:* can be inferred by using the date [CR0320] provided within the CORE - Imaging section and a combination of [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C05X) Ultrasound Scan + [CR0340] Imaging Anatomical Site (Z292).

4.2 COLORECTAL – DIAGNOSIS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - SYNCHRONOUS TUMOUR INDICATOR				
CO5400	COLORECTAL - DIAGNOSIS	**SYNCHRONOUS TUMOUR INDICATOR** *[SYNCHRONOUS TUMOUR COLON LOCATION]*	An2	R
End of repeating item - SYNCHRONOUS TUMOUR INDICATOR				
CO5160	COLORECTAL - DIAGNOSIS	**TUMOUR HEIGHT ABOVE ANAL VERGE**	max n2	R

SYNCHRONOUS TUMOUR INDICATOR (CAECUM): Record any synchronous tumours in the Colon as identified by the clinician at presentation. Synchronous tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue.

1	CAECUM
2	APPENDIX
3	ASCENDING COLON
4	HEPATIC FLEXURE
5	TRANSVERSE COLON
6	SPLENIC FLEXURE
7	DESCENDING COLON
8	SIGMOID COLON
9	RECTOSIGMOID
10	RECTUM

TUMOUR HEIGHT ABOVE ANAL VERGE: Record the approximate height in centimetres of the lower limit of the tumour above anal verge as measured by rigid sigmoidoscopy only.

4.3 COLORECTAL - CANCER CARE PLAN

BODY MASS INDEX: has been replaced and a NEW data item [CR6440] Body Mass Index created in CORE - Diagnosis. This reduces the burden of data collection throughout the dataset. This data can be collected now multiple times but has to be supported with a Mandatory Date field and can be collected for any tumour site, where they feel this is appropriate.

4.4 COLORECTAL – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[19] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[20].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

This section will be recorded once.

[19] https://nww.cancerstats.nhs.uk/cosd/staging

[20] http://www.wileyanduicc.com/

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5170	COLORECTAL - STAGING	**MODIFIED DUKES** *[MODIFIED DUKES CLASSIFICATION CODE]*	max an2	R
CO5340	COLORECTAL - STAGING	**MODIFIED DUKES STAGE DATE**	an10 ccyy-mm-dd	R

MODIFIED DUKES [MODIFIED DUKES CLASSIFICATION CODE]: Dukes' stage of disease at diagnosis (based on pathological evidence but upgraded to Stage D if there is clinical evidence of metastasis). Stage "D" should be recorded if metastatic spread is identified either in the preoperative staging process, e.g. on CT scanning, MRI, USS, chest x-ray or at the time of operation. It is accepted that a small number of "D" cases are cured by further treatment such as liver resection, but for COSD metastatic spread distant from the primary should always be recorded as "D".

A	Dukes A Tumour confined to wall of bowel, nodes negative
B	Dukes B Tumour penetrates through the muscularis propria to involve extramural tissues, nodes negative
C1	Dukes C1 Metastases confined to regional lymph nodes (node/s positive but apical node
C2	Dukes C2 Metastases present in nodes at mesenteric artery ligature (apical node positive)
D	Dukes D Metastatic spread outside the operative field
99	Not known

MODIFIED DUKES STAGE DATE: The date on which the Modified Dukes Stage was recorded.

Note: ***Recording stage following neoadjuvant therapy. For cases of rectal cancer, particular problems will be encountered where neoadjuvant therapy is used. If a patient has received neoadjuvant treatment, then Dukes Stage cannot be used.***

4.5 COLORECTAL - SURGERY & OTHER PROCEDURES

SURGICAL ACCESS: has been retired and a new data item [CR6310] has been created to replace this. This reduces duplication across the dataset and allows for better more inclusive data collection.

1	Mesorectal fascia
2	Intramesorectal
3	Muscularis propria

5. CHILDREN TEENAGERS AND YOUNG ADULTS

OVERVIEW

There is no nationally agreed standardised categorisation by age and the following groupings are used for COSD:

- Paediatric = under 16 years at time of diagnosis
- Teenage = 16 – 18 years (under 19) at time of diagnosis
- Young Adult = 19 – 24 at time of diagnosis

For all patients under 25 more than one dataset may be required depending on the nature of the disease and the management of the patient. The following guidelines are intended to support the decision on which datasets should be submitted.

Where the patient is discussed by an age specific (paediatric or TYA) MDT at a designated paediatric or TYA Principal Treatment Centre (PTC), the responsibility for completing the CTYA dataset rests with the PTC. For patients (of any age) who are also discussed at a site specific MDT, or where the disease is not specified in the CTYA dataset, (for example the diagnosis of a colorectal carcinoma), the appropriate site specific dataset should also be completed by the relevant MDT.

National guidance offers TYA aged 19-24 years the option of referral to a TYA PTC, although the guidance also indicates that all such patients should be discussed at a TYA MDT even if they are not referred to the PTC for treatment. If, despite this, the patient is only discussed by a site specific MDT, that team should complete the appropriate site specific dataset *and* the relevant additional (non disease-specific) items in the CTYA dataset.

Where a disease is covered by both the CTYA and a site specific dataset (such as some haematological diseases), only one set of disease specific items needs to be completed (either CTYA or site specific according to the speciality of the treating team). The non disease-specific items in the CTYA dataset should however be completed as per the preceding paragraphs.

Please note that CANCER SYMPTOMS FIRST NOTED DATE, which records when symptoms were first noted, is included in the Referral section of the Core dataset and should be completed for all under 25s.

ICD-10 CODES

Any applicable ICD10 code where the patient is under 25 at the time of diagnosis (see Appendices A and B).

5.1 CTYA – TABLES OF DATA ITEMS TO BE COMPLETED

5.1.1 Data items applicable to all cases (any diagnosis)

√ = to be completed for all cases (√) = to be completed for all cases where applicable

Data item No.	Data Item Name	All cases
CT6050	SPECIALTY (REFERRER TO SPECIALIST)	√
CT6060	PRIMARY DIAGNOSIS SUBSIDIARY COMMENT	(√)
CT6070	SECONDARY DIAGNOSIS (ICD)	(√)

CT6080	OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT	(√)
CT6090	FAMILIAL CANCER SYNDROME	(√)
CT6100	FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT	(√)
CT6030	CONSULTANT SPECIALTY (AT DIAGNOSIS)	√
CT6040	CONSULTANT AGE SPECIALTY (AT DIAGNOSIS)	√
CT6110	MULTIDISCIPLINARY TEAM AGE CATEGORY	√
CT6150	STEM CELL INFUSION DATE	(√)
CT6130	STEM CELL INFUSION SOURCE	(√)
CT6140	STEM CELL INFUSION DONOR	(√)
CT6160	SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT)	√

5.1.2 Disease specific Data items

The following table shows which data items are applicable to each specific diagnosis.

√ = to be completed for all disease specific cases

(√) = to be completed for all disease specific cases if applicable

Data item No.	Data Item Name	ALL (Acute lymphoblastic Leukaemia)	AML	NHL	Hodgkin Lymphoma	Neuroblastoma	Renal	Rhabdomyosarcoma and other Soft Tissue Sarcomas	STS excluding Rhabdomyosarcoma	Osteosarcoma	Ewings	Germ Cell CNS	Germ Cell Non CNS	Medulloblastoma	Hepatoblastoma	Retinoblastoma
CT6210	EXTRAMEDULLARY DISEASE	√	√													
CT6220	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)	√	√													
CT6230	CYTOGENETIC RISK CODE	√	√													
CT6240	CYTOGENETICS SUBSIDIARY COMMENT	√	√													
CT6250	MURPHY (ST JUDE) STAGE			√												
CT6710	MURPHY (ST JUDE) STAGE DATE			√												
CT6260	ALK-1 STATUS FOR ALCL			√												

CT6270	ANN ARBOR STAGE				√											
CT6720	ANN ARBOR STAGE DATE				√											
CT6280	ANN ARBOR SYMPTOMS				√											
CT6290	ANN ARBOR EXTRANODALITY				√											
CT6300	INTERNATIONAL NEUROBLASTOMA PATHOLOGIC CLASSIFICATION					√										
CT6310	CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA)					√										
CT6320	INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM					√										
CT6730	INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM DATE					√										
CT6330	WILMS TUMOUR STAGE						√									
CT6740	WILMS TUMOUR STAGE DATE						√									
CT6680	RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY						√									
CT6340	RISK CLASSIFICATION (PATHOLOGICAL)AFTER PREOPERATIVE CHEMOTHERAPY						√									
CT6350	IRS POST SURGICAL GROUP							√								
CT6750	IRS POST SURGICAL GROUP DATE							√								
CT6360	CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA							√								
CT6370	RHABDOMYOSARCOMA SITE PROGNOSIS CODE							√								
CT6380	SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA)								√							

Data item No.	Data Item Name	ALL (Acute lymphoblastic Leukaemia)	AML	NHL	Hodgkin Lymphoma	Neuroblastoma	Renal	Rhabdomyosarcoma and other Soft Tissue	STS excluding Rhabdomyosarcoma	Osteosarcoma	Ewings	Germ Cell CNS	Germ Cell Non CNS	Medulloblastoma	Hepatoblastoma	Retinoblastoma
CT6390	SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA								√							
CT6400	PRIMARY TUMOUR SIZE (RADIOLOGICAL)									√						
CT6410	EXTENT OF NECROSIS AFTER CHEMOTHERAPY									√						
CT6420	SARCOMA SURGICAL MARGIN ADEQUACY									√						
CT6450	TUMOUR VOLUME AT DIAGNOSIS										√					
CT6460	CYTOGENETICS FOR EWINGS SARCOMA										√					
CT6470	SARCOMA TUMOUR SITE (BONE)									√	√					
CT6440	SARCOMA TUMOUR SUBSITE (BONE)									√	√					
CT6530	ALPHA FETOPROTEIN (CEREBROSPINAL FLUID)											√				
CT6550	BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID)											√				
CT6590	TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS												√			
CT6580	BETA HUMAN CHORIONIC GONADOTROPIN (SERUM)											√	√			
CT6520	ALPHA FETOPROTEIN (SERUM)											√	√		√	
CT6560	CHANG STAGING FOR MEDULLOBLASTOMA													√		
CT6760	CHANG STAGING FOR MEDULLOBLASTOMA DATE													√		
CT6500	PRETEXT STAGING SYSTEM STAGE														√	
CT6510	PRETEXT STAGING OUTSIDE LIVER														√	
CT6770	RETINOBLASTOMA ASSESSMENT DATE															√
CT6780	RETINOBLASTOMA ASSESSMENT LATERALITY															√
CT6790	INTERNATIONAL CLASSIFICATION FOR INTRAOCULAR RETINOBLASTOMA															√
CT6800	INTERNATIONAL CLASSIFICATION FOR INTRAOCULAR RETINOBLASTOMA															√
CT6690	INVESTIGATION RESULT DATE						√									
CT6610	TUMOUR RUPTURE						√									

CT6620	ANAPLASTIC NEPHROBLASTOMA						√									
CT6630	PERIRENAL FAT INVASION						√									
CT6640	RENAL SINUS INVASION						√									
CT6650	RENAL VEIN TUMOUR						√									
CT6660	VIABLE TUMOUR						√									
CT6670	TUMOUR LOCAL STAGE (PATHOLOGICAL)						√									

Note: ***This data item is also in the core for all pathology. This is an additional use of this data item to enable the Renal dataset to be identified.***

5.2 CTYA – REFERRALS (All cases)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6050	CTYA - MAIN - REFERRALS	**SPECIALTY (REFERRER TO SPECIALIST)** *[CARE PROFESSIONAL MAIN SPECIALTY CODE (CANCER REFERRAL)]*	an3	R

SPECIALTY (REFERRER TO SPECIALIST): The specialty of the person referring to the patients Principal Treatment Centre or age specific Specialist TYA MDT.

5.3 CTYA – DIAGNOSIS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6060	CTYA - DIAGNOSIS	**PRIMARY DIAGNOSIS SUBSIDIARY COMMENT** *[PRIMARY DIAGNOSIS (CANCER COMMENT)]*	max an50	R
Start of repeating item - Secondary Diagnosis (ICD)				
CT6070	CTYA - DIAGNOSIS	**SECONDARY DIAGNOSIS (ICD)**	an6	R
End of repeating item - Secondary Diagnosis (ICD)				
CT6080	CTYA - DIAGNOSIS	**OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT** *[SECONDARY DIAGNOSIS (CANCER COMMENT)]*	max an50	R
CT6090	CTYA - DIAGNOSIS	**FAMILIAL CANCER SYNDROME** *[FAMILIAL CANCER SYNDROME INDICATOR]*	an1	R
CT6100	CTYA - DIAGNOSIS	**FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT** *[FAMILIAL CANCER SYNDROME COMMENT]*	max an50	R
CT6030	CTYA - DIAGNOSIS	**CONSULTANT SPECIALTY (AT DIAGNOSIS)** *[CARE PROFESSIONAL MAIN SPECIALTY CODE (DIAGNOSIS)]*	an3	R
CT6040	CTYA - DIAGNOSIS	**CONSULTANT AGE SPECIALTY (AT DIAGNOSIS)** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (CONSULTANT AT DIAGNOSIS)]*	an1	R
CT6990	CTYA - DIAGNOSIS	**BANKED TISSUE AT DIAGNOSIS** *[TISSUE BANKED AT DIAGNOSIS INDICATOR]*	an1	R

Start of repeating item - TYPE OF TISSUE BANKED AT DIAGNOSIS				
CT7020	CTYA - DIAGNOSIS	**TYPE OF TISSUE BANKED AT DIAGNOSIS**	an1	R
End of repeating item - TYPE OF TISSUE BANKED AT DIAGNOSIS				

PRIMARY DIAGNOSIS SUBSIDIARY COMMENT: (Optional)

Additional comments on diagnosis where coding is difficult or imprecise.

(Examples of this would be: "papillary glioneuronal tumour" or "angiocentric glioma" to specify recently described diagnoses which do not have ICD10 or ICD-O-3 coding. "Anaplastic ependymoma" or "ependymoblastoma" to distinguish between these two diagnoses which may have different treatment decisions or outcomes but which cannot be distinguished in ICD10 or ICD-O-3 coding.)"

SECONDARY DIAGNOSIS (ICD): Optional. Types (ICD10 codes) of other significant conditions (e.g. Down Syndrome, NF1, Fanconi anaemia) which may predispose to cancer or influence treatment. Possible multiple entries. This information should be available for the MDT discussion but will only apply to a small number of cases. See Appendix D for list of Associated Conditions to be recorded on Childhood Cancer Registration Forms.

OTHER SIGNIFICANT DIAGNOSIS SUBSIDIARY COMMENT: (Optional) Additional comments on other significant conditions where coding is difficult or imprecise. (For example “NF1” or “NF2” to distinguish between these two distinct conditions which may have different treatment decisions or outcomes but cannot be coded separately.) This information should be available for the MDT discussion but will only apply to a small number of cases.

FAMILIAL CANCER SYNDROME: Indicate whether there is a possible or confirmed familial cancer syndrome. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

Y	Yes
N	No
P	Possible
9	Not Known

FAMILIAL CANCER SYNDROME SUBSIDIARY COMMENT: (Optional)

Where Familial Cancer Syndrome is coded as “Yes” or “Possible”, this field can be used to provide further details. For example “Li-Fraumeni”, “Rhabdoid tumour predisposition syndrome” or “Biallelic PMS2 mutation” to identify distinct syndromes which may have different treatment decisions or outcomes but cannot be coded separately.

CONSULTANT SPECIALTY (AT DIAGNOSIS): The specialty of the consultant responsible for the patient at the time of diagnosis.

BANKED TISSUE AT DIAGNOSIS: Indicate whether any tissue was banked at diagnosis.

Y	Yes
N	No
9	Not Known

TYPE OF TISSUE BANKED AT DIAGNOSIS: Indicate what tissue was banked at diagnosis.

1	Tumour
2	Blood
3	CSF
4	Bone Marrow

5.3.1 CTYA – DIAGNOSIS - MIXED PHENOTYPE ACUTE LEUKAEMIA

These are New data items, requested after long discussions and consultation with the SSCRG

One occurrence of this data group is permitted.

Data	Data Item Section	Data Item Name	Format	Schema

item No.				specification (M/R/O/X)
Start of repeating item – Multidisciplinary Team Age Category				
CT7200	CTYA - DIAGNOSIS - MIXED PHENOTYPE ACUTE LEUKAEMIA	**MIXED PHENOTYPE SYMPTOMS (AT DIAGNOSIS)** *[MIXED PHENOTYPE ACUTE LEUKAEMIA SYMPTOMS (AT DIAGNOSIS)]*	an1	R
Start of repeating item – Multidisciplinary Team Age Category				
CT7240	CTYA - DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA	**EGIL SCORE** *[EUROPEAN GROUP FOR THE IMMUNOLOGICAL CLASSIFICATION OF LEUKAEMIA SCORING SYSTEM SCORE]*	an1	R

MIXED PHENOTYPE SYMPTOMS (AT DIAGNOSIS): Record if any of the associated symptoms were present at Diagnosis.

1	Hepatomegaly
2	Splenomegaly
3	Lymphadenopathy
4	Mediastinal Mass

EGIL SCORE: The EGIL Score (European Group for the Immunological Classification of Leukaemia) assigns score points to major antigens to determine if certain lineage is present.

1	2 - Points
2	1 - Point
3	0.5 - Point

5.3.2 CTYA – DIAGNOSIS - ACUTE MYELOID LEUKAEMIA

These are New data items, requested after long discussions and consultation with the SSCRG

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7160	CTYA - DIAGNOSIS - ACUTE MYELOID LEUKAEMIA	**FAB CLASSIFICATION** *[FRENCH AMERICAN BRITISH CLASSIFICATION (ACUTE MYELOID LEUKAEMIA)]*	max an5	R
CT7170	CTYA - DIAGNOSIS - ACUTE MYELOID LEUKAEMIA	**PAEDIATRIC CYTOGENETIC / MOLECULAR GENETIC RISK GROUP** *[CYTOGENETIC RISK GROUP (PAEDIATRIC MOLECULAR GENETIC ABNORMALITIES)]*	an1	R
CT7180	CTYA - DIAGNOSIS - ACUTE MYELOID LEUKAEMIA	**AML RISK FACTORS** *[ACUTE MYELOID LEUKAEMIA RISK FACTORS (AT DIAGNOSIS)]*	an1	R

FAB CLASSIFICATION: FAB classification of AML used during diagnosis of acute myeloid leukaemia (AML).

M0	Undifferentiated acute myeloblastic leukaemia
M1	Acute myeloblastic leukaemia with minimal maturation
M2	Acute myeloblastic leukaemia with maturation
M3	Acute promyelocytic leukaemia
M4	Acute myelomonocytic leukaemia
M4EOS	Acute myelomonocytic leukaemia with eosinophilia
M5	Acute monocytic leukaemia

M6	Acute erythroid leukaemia
M7	Acute megakaryocytic leukaemia

PAEDIATRIC CYTOGENETIC / MOLECULAR GENETIC RISK GROUP: Risk groups for ages 0-18 - cytogenetic and molecular genetic abnormalities.

1	Good Risk
2	Intermediate Risk
3	Poor Risk
9	Not Known

AML RISK FACTORS: Record if any of these risk factors are present in a patient at diagnosis.

1	Denovo
2	High Risk MDS
3	Secondary AML

5.3.3 CTYA – DIAGNOSIS - LOW GRADE GLIOMA

These are New data items, requested after long discussions and consultation with the SSCRG

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – VISUAL ACUITY AT PRESENTATION				
CT7030	CTYA - DIAGNOSIS - LOW GRADE GLIOMA	**VISUAL ACUITY AT PRESENTATION** *[VISUAL ACUITY TEST RESULT (AT DIAGNOSIS)]*	an1	R
Start of repeating item – VISUAL ACUITY AT PRESENTATION				
Start of repeating item – VISUAL FIELDS AT PRESENTATION				
CT7400	CTYA - DIAGNOSIS - LOW GRADE GLIOMA	**VISUAL FIELDS AT PRESENTATION** *[VISUAL FIELD TEST RESULT (AT DIAGNOSIS)]*	an1	R
Start of repeating item – VISUAL FIELDS AT PRESENTATION				

VISUAL ACUITY AT PRESENTATION: Record the visual acuity at presentation on the patient, this can be a repeating data item.

1	Left - Normal
2	Right - Normal
3	Left - Abnormal
4	Right - Abnormal
9	Not Known

VISUAL FIELDS AT PRESENTATION: Record the visual fields at presentation on the patient, this can be a repeating data item.

1	Left - Normal
2	Right - Normal
3	Left - Abnormal
4	Right - Abnormal
9	Not Known

5.3.4 CTYA – DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA

These are New data items, requested after long discussions and consultation with the SSCRG

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – PAEDIATRIC MYELODYSPLASIA				
CT7260	CTYA - DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA	**PAEDIATRIC MYELODYSPLASIA** *[PAEDIATRIC MYELODYSPLASIA CLINICAL FINDINGS (AT DIAGNOSIS)]*	an1	R
Start of repeating item – PAEDIATRIC MYELODYSPLASIA				
Start of repeating item – UNDERLYING DISEASE ASSOCIATED WITH MDS				
CT7270	CTYA - DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA	**UNDERLYING DISEASE ASSOCIATED WITH MDS** *[UNDERLYING DISEASE ASSOCIATED WITH MYELODYSPLASIA (AT DIAGNOSIS)]*	an1	R
Start of repeating item – UNDERLYING DISEASE ASSOCIATED WITH MDS				
Start of repeating item – CONGENITAL ANOMALIES				
CT7380	CTYA - DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA	**CONGENITAL ANOMALIES** *[CONGENITAL ANOMALIES COMMENTS]*	Max300	R
Start of repeating item – CONGENITAL ANOMALIES				
Start of repeating item – MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS				
CT7310	CTYA - DIAGNOSIS - PAEDIATRIC MYELODYSPLASIA	**MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS** *[OTHER MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS]*	an1	R
Start of repeating item – MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS				

PAEDIATRIC MYELODYSPLASIA: Record the Paediatric Myelodysplasia clinical findings at Diagnosis.

1	De Novo MDS
2	Refractory Cytopenia
3	Refractory Cytopenia with Ringed Sideroblasts
4	Refractory Cytopenia with Excess Blasts
5	RAEB in Transformation

UNDERLYING DISEASE ASSOCIATED WITH MDS: Record any underlying disease associated with MDS present at diagnosis.

1	IBFMS
2	Previous Malignancy
3	Radiation
4	Toxic Insult
5	Mitochondrial Disorder
6	Other Systematic Disorder
7	Congenital Anomalies
9	No underlying disease
1	IBFMS

CONGENITAL ANOMALIES: Record any Congenital Anomalies associated with the MDS at Diagnosis.

MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS: Record any other Myelodysplasia symptoms present at diagnosis.

1	Consanguinity
2	Organomegaly at Diagnosis
3	Lymphadenopathy at Diagnosis

4	Severe Infections Prior to Diagnosis
5	Immunodeficiency at Diagnosis

5.3.5 CTYA – DIAGNOSIS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS

These are moved data items, to make recording and reporting more logical.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6350	CTYA - DIAGNOSIS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS	**IRS POST SURGICAL GROUP** *[INTERGROUP RHABDOMYOSARCOMA STUDY POST-SURGICAL GROUP]*	an1	R
CT6750	CTYA - DIAGNOSIS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS	**IRS POST SURGICAL GROUP DATE** *[INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE]*	an10 ccyy-mm-dd	R
CT6380	CTYA - DIAGNOSIS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS	**SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA)** *[SARCOMA TUMOUR SITE (SOFT TISSUE)]*	An4	R
CT6390	CTYA - DIAGNOSIS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS	**SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA** *[SARCOMA TUMOUR SUBSITE (SOFT TISSUE)]*	An2	R

IRS POST SURGICAL GROUP: IRS group defines the post-surgical disease status at diagnosis. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

- Group 1 = primary complete resection
- Group 2 = microscopic residual disease or primary complete resection with (completely resected) lymph node involvement
- Group 3 = macroscopic residual disease
- Group 4 = distant metastases

1	Group 1
2	Group 2
3	Group 3
4	Group 4

IRS POST SURGICAL GROUP: The date on which the IRS Post Surgical Group was recorded

SARCOMA TUMOUR SITE (SOFT TISSUE OTHER THAN RHABDOMYOSARCOMA): Location of the soft tissue sarcoma within the body (more specific than ICD10/ICDO3 sites).

Z272	Stomach
Z301	Liver
Z459	Uterus
Z533	Peritoneum
Z891	Shoulder
Z892	Upper Arm
Z893	Forearm
Z894	Hand

Z898	Specified Arm Region (to include wrist and elbow)
Z901	Buttock
Z903	Upper Leg (to include thigh)
Z904	Lower Leg (to include calf)
Z905	Foot
Z908	Specified leg region (to include groin, knee, ankle)
Z921	Head
Z923	Neck
Z924	Chest (to include Intrathoracic)
Z927	Trunk (to include upper and lower)
Z928	Multiple
Z929	Unknown

SARCOMA TUMOUR SUBSITE (SOFT TISSUE) OTHER THAN RHABDOMYOSARCOMA): Sublocation of the soft tissue sarcoma within the tumour site. This is additional detail to enable a more precise localisation of the tumour site.

RP	Retroperitoneal (subsite of Z53.3)
IP	Intraperitoneal (subsite of Z53.3)
WR	Wrist (subsite of Z89.8)
EB	Elbow (subsite of Z89.8)
UT	Upper Trunk (subsite of Z92.7)
LT	Lower Trunk (subsite of Z92.7)
AD	Adductors (subsite of Z90.3 & Z90.4)
AN	Anterior (subsite of Z90.3 & Z90.4)
PO	Posterior (subsite of Z90.3 & Z90.4)
LA	Lateral (subsite of Z90.3 & Z90.4)
NK	Not Known
NA	Not Applicable

5.3.6 CTYA – DIAGNOSIS – EWINGS

These are moved data items, to make recording and reporting more logical.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6450	CTYA - DIAGNOSIS - EWINGS	**TUMOUR VOLUME AT DIAGNOSIS** *[TUMOUR VOLUME AT DIAGNOSIS CODE]*	An1	R

TUMOUR VOLUME AT DIAGNOSIS: Radiologically calculated estimate of tumour volume at diagnosis which has value in determining treatment.

L	Less than 200ml
M	200ml or greater

5.3.7 CTYA – DIAGNOSIS – OSTEOSARCOMA and EWINGS

These are moved data items, to make recording and reporting more logical.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6470	CTYA - DIAGNOSIS - OSTEOSARCOMA and	**SARCOMA TUMOUR SITE (BONE)**	an4	R

	EWINGS			
CT6440	CTYA - DIAGNOSIS - OSTEOSARCOMA and EWINGS	**SARCOMA TUMOUR SUBSITE (BONE)**	an2	R

SARCOMA TUMOUR SITE (BONE): Location of the bone sarcoma within the body (more specific than ICD10/ICDO3 sites).

Z639	Cranium
Z649	Face
Z659	Jaw
Z663	Cervical Spine
Z664	Thoracic Spine
Z665	Lumbar Spine
Z681	Clavicle
Z684	Glenoid
Z685	Scapula
Z699	Humerus
Z709	Radius
Z719	Ulna
Z724	Carpal
Z732	Metacarpal
Z733	Thumb
Z734	Finger
Z742	Sternum
Z746	Rib
Z751	Sacrum
Z753	Ileum
Z754	Ischium
Z755	Pubis
Z756	Acetabulum
Z757	Coccyx
Z769	Femur
Z779	Tibia
Z786	Fibula
Z787	Patella
Z799	Tarsus
Z802	Metatarsus
Z803	Great toe
Z804	Toe
Z928	Multiple

SARCOMA TUMOUR SUBSITE (BONE): Sublocation of the bone sarcoma within the tumour site.

PR	Proximal
DS	Distal
DP	Diaphyseal (Middle)
TO	Total
OO	Other
NK	Not Known

5.3.8 CTYA – DIAGNOSIS – ACUTE LYMPHOBLASTIC LEUKAEMIA and ACUTE MYELOID LEUKAEMIA

These are moved data items, to make recording and reporting more logical.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – EXTRAMEDULLARY DISEASE				
CT6210	CTYA - DIAGNOSIS - ACUTE LYMPHOBLASTIC LEUKAEMIA and ACUTE MYELOID LEUKAEMIA	**EXTRAMEDULLARY DISEASE** *[EXTRAMEDULLARY DISEASE SITE]*	an1	R
Start of repeating item – EXTRAMEDULLARY DISEASE				
CT6220	CTYA - DIAGNOSIS - ACUTE LYMPHOBLASTIC LEUKAEMIA and ACUTE MYELOID LEUKAEMIA	**WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)**	max n3.n1	R
CT6230	CTYA - DIAGNOSIS - ACUTE LYMPHOBLASTIC LEUKAEMIA and ACUTE MYELOID LEUKAEMIA	**CYTOGENETIC RISK CODE** *[CYTOGENETIC FINDINGS COMMENT]*	an1	R
CT6240	CTYA - DIAGNOSIS - ACUTE LYMPHOBLASTIC LEUKAEMIA and ACUTE MYELOID LEUKAEMIA	**CYTOGENETICS SUBSIDIARY COMMENT**	max an50	R

EXTRAMEDULLARY DISEASE: Site/s of disease identified outside bone marrow, including presence of blasts within CFS. These have got new/updated attributes on the advice of the SSCRG Chair and extended clinical team members.

~~T~~	~~Testes~~
~~C~~	~~CNS~~
~~O~~	~~Other~~
1	CNS1 (Without Blasts)
2	CNS2 (< 5 WBC in the CSF with blasts)
3	CNS3 (≥5 WBC in the CSF with blasts)
4	Testes
9	Other

WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT): Highest white blood cell count pre-treatment (x 10 to the power of 9 g per litre)

CYTOGENETIC RISK CODE: Risk allocation based on cytogenetic findings.

F	Favourable
A	Adverse
I	Intermediate
N	No result
O	Other

CYTOGENETICS SUBSIDIARY COMMENT: Description of cytogenetic findings.

5.3.9 CTYA – DIAGNOSIS – ACUTE LYMPHOBLASTIC LEUKAEMIA

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7150	CTYA - ACUTE LYMPHOBLASTIC LEUKAEMIA	**RISK GROUP ALLOCATION** *[RISK GROUP ALLOCATION (ACUTE LYMPHOBLASTIC LEUKAEMIA)]*	an1	R

RISK GROUP ALLOCATION: Indicates the risk group allocation (as per the trial risk groups).

1	Good
2	Standard
3	High

5.3.10 CTYA – DIAGNOSIS – NEUROBLASTOMA

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7070	CTYA - DIAGNOSIS - NEUROBLASTOMA	**LIFE THREATENING SYMPTOMS AT PRESENTATION** *[LIFE THREATENING SYMPTOMS AT DIAGNOSIS INDICATOR (NEUROBLASTOMA)]*	an1	R

LIFE THREATENING SYMPTOMS AT PRESENTATION: Record if there were any life threatening symptoms at presentation.

Y	Yes
N	No

5.4 CTYA - CANCER CARE PLAN

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – Multidisciplinary Team Age Category				
CT6110	CTYA - CANCER CARE PLAN	**MULTIDISCIPLINARY TEAM AGE CATEGORY** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (MULTIDISCIPLINARY TEAM)]*	an1	R
Start of repeating item – Multidisciplinary Team Age Category				

MULTIDISCIPLINARY TEAM AGE CATEGORY: Type(s) of MDT where the care plan for the patient was discussed. More than one option can be recorded. This field defines the nature of each MDT at which the patient's care plan is discussed.

P	Paediatric
T	Teenage and Young Adult
A	Adult

5.5 CTYA - SURGERY AND OTHER PROCEDURES

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7000	CTYA - SURGERY AND OTHER PROCEDURES	**TREATED ACCORDING TO CCLG GUIDELINES** *[PATIENT TREATED TO CHILDRENS*	an1	R

		CANCER AND LEUKAEMIA GROUP GUIDELINES INDICATOR]		
CT7010	CTYA - SURGERY AND OTHER PROCEDURES	**CCLG GUIDELINE NAME** *[CHILDRENS CANCER AND LEUKAEMIA GROUP GUIDELINE NAME]*	Max an100	R

TREATED ACCORDING TO CCLG GUIDELINES: Record whether a patient was treated according to the Children's Cancer and Leukaemia Group guidelines.

Y	Yes
N	No
9	Not Known

CCLG GUIDELINE NAME: Record the name of the Children's Cancer and Leukaemia Group guideline

5.5.1 CTYA - SURGERY AND OTHER PROCEDURES - ACUTE LEUKAEMIAS

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7110	CTYA - SURGERY AND OTHER PROCEDURES - ACUTE LEUKAEMIAS	**PRIMARY INDUCTION FAILURE** *[PRIMARY INDUCTION CHEMOTHERAPY FAILURE INDICATOR]*	an1	R

PRIMARY INDUCTION FAILURE: Did the patient fail to achieve morphological remission after induction chemotherapy?

Y	Yes
N	No
9	Not Known

5.5.2 CTYA - SURGERY AND OTHER PROCEDURES - ACUTE LEUKAEMIAS

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7190	CTYA - SURGERY AND OTHER PROCEDURES - ALL/AML/MPAL	**RELAPSE - METHOD OF DETECTION** *[RELAPSE METHOD DETECTION TYPE]*	an1	R

RELAPSE - METHOD OF DETECTION: Indicate the method of detection for the patients relapse.

1	Morphology
2	Flow
3	Molecular
4	Clinical Examination
9	Other

5.5.3 CTYA - SURGERY AND OTHER PROCEDURES - CNS

These are New data items, requested after long discussions and consultation with the SSCRG.

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7390	CTYA - SURGERY AND OTHER PROCEDURES - CNS	**RESECTION STATUS**	an1	R

RESECTION STATUS: The Resection Status of the tumour. This is determined at MDT by a combination of surgical history and postop imaging.

1	Complete resection
2	Incomplete resection (< 1.5 cm2 remaining)
3	Incomplete resection (≥ 1.5 cm2 remaining)
9	Not Applicable, Biopsy only

5.5.4 CTYA - SURGERY AND OTHER PROCEDURES - STEM CELL TRANSPLANTATION

These are a combination of new data items, requested after long discussions and consultation with the SSCRG and moved data to make recording and reporting more logical.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6130	CTYA - SURGERY AND OTHER PROCEDURES - STEM CELL TRANSPLANTATION	**STEM CELL INFUSION SOURCE** *[STEM CELL INFUSION SOURCE CODE]*	an1	R
CT6140	CTYA - SURGERY AND OTHER PROCEDURES - STEM CELL TRANSPLANTATION	**STEM CELL INFUSION DONOR** *[STEM CELL INFUSION DONOR TYPE]*	an1	R
CT7370	CTYA - SURGERY AND OTHER PROCEDURES - STEM CELL TRANSPLANTATION	**CONDITIONING REGIMEN** *[STEM CELL TRANSPLANT CONDITIONING REGIMEN]*	an1	R

***STEM CELL INFUSION DATE**: has been retired as if this is recorded as a surgical procedure in Core Treatment Modality [CR2040] 01 - Surgery, then the date would be provided from the CORE section too using [CR0710] Procedure Date. This reduces duplication and improves the quality of the data submitted.*

STEM CELL INFUSION SOURCE: Source of stem cells for infusion

B	Bone Marrow
P	Peripheral Blood
C	Cord
9	Not known

STEM CELL INFUSION DONOR: Donor for stem cell infusion.

1	Autologous
2	Allogeneic - Sibling
3	Allogeneic - Haplo
4	Allogeneic - Unrelated
9	Not Known

CONDITIONING REGIMEN: Record the MDS Stem Cell Transplant Conditioning Regimen.

1	Myeloablative
2	Reduced Intensity
3	Minimal Intensity

5.6 CTYA – CHEMOTHERAPY

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6160	CTYA - MAIN - CHEMOTHERAPY	**SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT)** *[CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY (CONSULTANT PRESCRIBING CHEMOTHERAPY)]*	an1	R

SPECIALTY SUB CODE (CHEMOTHERAPY CONSULTANT): The age group specialty of the consultant responsible for prescription of chemotherapy.

P	Paediatric
T	Teenage and Young Adult
A	Adult Only

5.7 CTYA – ACUTE LYMPHOBLASTIC LEUKAEMIA - RESPONSE

These are New data items, requested after long discussions and consultation with the SSCRG.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7120	CTYA - ACUTE LYMPHOBLASTIC LEUKAEMIA - RESPONSE	**D29 BM** *[D29 BONE MARROW TEST RESULT]*	an2	R
CT7130	CTYA - ACUTE LYMPHOBLASTIC LEUKAEMIA - RESPONSE	**D29 MRD** *[D29 MINIMAL RESIDUAL DISEASE RESULT]*	n1. max an4	R
CT7140	CTYA - ACUTE LYMPHOBLASTIC LEUKAEMIA - RESPONSE	**D29 STATUS OF EXTRAMEDULLARY** *[D29 STATUS OF EXTRAMEDULLARY DISEASE]*	an1	R

D29 BM: Record the Bone Marrow result

M1	<5% lymphoblasts
M2	5 to <25% lymphoblasts
M3	≥25% lymphoblasts

D29 MRD: Highest white blood cell count pre-treatment (x 10 to the power of 9g per litre).

D29 STATUS OF EXTRAMEDULLARY: Status of the extramedullary disease at end of induction in childhood and TYA acute lymphoblastic leukaemia.

1	CNS CR
2	CNS non-CR
3	Testis CR
4	Testis non-CR
5	Other CR

6	Other non-CR

5.8 CTYA – NON HODGKIN LYMPHOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6260	CTYA – NON-HODGKIN LYMPHOMA	**ALK-1 STATUS FOR ALCL** *[ALK-1 STATUS]*	an1	R

ALK-1 STATUS FOR ALCL: Activin Receptor-like Kinase 1 (ALK-1) is a gene expression protein which distinguishes prognostically important subsets of this diagnosis.

This should be available for the MDT discussion but will only apply to a small number of cases.

P	ALK - positive
N	ALK - negative
9	Not known

5.8 CTYA – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[21] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[22].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

These are moved data items, to make recording and reporting more logical.

5.8.1 CTYA – STAGING - NON HODGKIN LYMPHOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6250	CTYA – NON-HODGKIN LYMPHOMA	**MURPHY (ST JUDE) STAGE**	an1	R
CT6710	CTYA – NON-HODGKIN LYMPHOMA	**MURPHY (ST JUDE) STAGE DATE**	an10 ccyy-mm-dd	R

[21] https://nww.cancerstats.nhs.uk/cosd/staging

[22] http://www.wileyanduicc.com/

MURPHY (ST JUDE) STAGE: The St. Jude Children's Research Hospital model (Murphy Staging), which separates patients on the basis of limited versus extensive disease. (http://www.cancer.gov/cancertopics/pdq/treatment/child-non-hodgkins/HealthProfessional/page3).

It is essential to record the disease specific stage for this group of patients. This information should be available to the MDT. The following definitions are used:

- Stage 1 - disease is limited to a single tumour or to one lymph node group (e.g., neck, axilla, groin, etc.) outside of the abdomen or mediastinum.
- Stage 2 - disease is limited to one tumour with local lymph node involvement; or to two or more tumours or lymph node groups on the same side of the diaphragm; or to a completely resected primary tumour of the gastrointestinal tract with/without involvement of local lymph nodes.
- Stage 3 - disease includes tumours or lymph node groups involved on both sides of the diaphragm; or any primary intrathoracic tumour (mediastinal, pleural or thymic disease); or extensive NHL within the abdomen; or any paraspinal or epidural tumours.
- Stage 4 - disease involves the bone marrow and / or central nervous system (CNS), with/without other sites of involvement. Bone marrow involvement in NHL is defined as >5% - <25% malignant cells in an otherwise normal bone marrow. (> 25% malignant cells in the bone marrow is defined as leukaemia).

1	Stage 1
2	Stage 2
3	Stage 3
4	Stage 4

MURPHY (ST JUDE) STAGE DATE: The date on which the Murphy (St Jude) Stage was recorded.

5.8.2 CTYA – STAGING - NON HODGKIN LYMPHOMA

This section will be recorded once.

Note: This includes Nodular Lymphocyte Predominant Hodgkin Lymphoma (ICDO3 code 9659/3) for which the staging is the same.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6270	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR STAGE**	an1	R
CT6720	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR STAGE DATE**	an10 ccyy-mm-dd	R
CT6280	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR SYMPTOMS** *[ANN ARBOR SYMPTOMS INDICATION CODE]*	an1	R
CT6290	CTYA - (HODGKIN LYMPHOMA)	**ANN ARBOR EXTRANODALITY** [ANN *ARBOR EXTRANODALITY INDICATION CODE]*	an1	R

ANN ARBOR STAGE: Staging based on location and extent of detected disease. It is essential to record the stage for this group of patients. This information should be available to the MDT.

1	I = One region of lymph nodes, or spleen or thymus or Waldeyer's ring enlarged
2	II = 2 regions of lymph nodes enlarged, on same side of diaphragm
3	III = lymph nodes enlarged on both sides of diaphragm
4	IV = disease outside lymph nodes e.g. liver, bone marrow

ANN ARBOR STAGE DATE: The date on which the Ann Arbor Stage was recorded.

ANN ARBOR SYMPTOMS: Additional stage designation based on presence or absence of specific symptoms.

A	No Symptoms
B	Presence of any of the following: unexplained persistent or recurrent fever (greater than 38°C / 101.5°F), drenching night sweats, unexplained weight loss of 10% or more within the last 6 months

ANN ARBOR EXTRANODALITY: Additional staging designation based on extranodal involvement.

Code "E" if there is involvement of a single extranodal site that directly adjoins or is next to the known nodal group.

E	E (Extranodal involvement)
0	No extranodal involvement

5.8.3 CTYA – STAGING - NEUROBLASTOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7050	CTYA - STAGING - NEUROBLASTOMA	**INTERNATIONAL NEUROBLASTOMA RISK GROUP (INRG) STAGING SYSTEM** *[INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE]*	max an2	R
CT7060	CTYA - STAGING - NEUROBLASTOMA	**INTERNATIONAL NEUROBLASTOMA RISK GROUP (INRG) STAGING SYSTEM DATE** *[INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE]*	an10 ccyy-mm-dd	R

Note: ***INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM & INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM DATE****: have been retired and replaced with a new staging system for Neuroblastoma [CT7050] & [CT7060] on the advice of the SSCRG Chair and extended clinical team members*

INTERNATIONAL NEUROBLASTOMA RISK GROUP (INRG) STAGING SYSTEM: The International Neuroblastoma Risk Group Staging System (INRGSS) was designed for the International Neuroblastoma Risk Group (INRG) pre-treatment classification system. Unlike the INSS (above), the INRGSS uses only the results of imaging tests taken before surgery. It does not include surgical results or spread to lymph nodes to determine the stage. Knowledge regarding the presence or absence of image defined risk factors (IDRF) are required for this staging system.

L1	Stage L1: The Tumour is located only in the area where it started; no IDRFs are found on imaging scans, such as CT or MRI
L2	Stage L2: The tumour has not spread beyond the area where it started and the nearby tissue; IDRFs are found on imaging scans, such as CT or MRI
M	Stage M: The tumour has spread to other parts of the body (except stage MS, see below)
MS	Stage MS: The tumour has spread to only the skin, liver, and/or bone marrow (less than 10% marrow involvement) in patients less than 18 months

INTERNATIONAL NEUROBLASTOMA RISK GROUP (INRG) STAGING SYSTEM DATE: The date on which the International Neuroblastoma Staging System stage was recorded.

5.8.4 CTYA – STAGING – RENAL TUMOURS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6330	CTYA (RENAL TUMOURS)	**WILMS TUMOUR STAGE**	an1	R
CT6740	CTYA (RENAL TUMOURS)	**WILMS TUMOUR STAGE DATE**	an10 ccyy-mm-dd	R

WILMS TUMOUR STAGE: Stage is determined by the results of the imaging studies and both the surgical and pathologic findings at nephrectomy. It is essential to record the stage for this group of patients and this information should be available to the MDT following treatment.

- Stage 1 - tumour is limited to the kidney and completely resected.
- Stage 2 - tumour is completely resected, and there is no evidence of tumour at or beyond the margins of resection but the tumour extends beyond the kidney (penetration of capsule, invasion of blood vessels outside renal parenchyma).
- Stage 3 - there is residual tumour following surgery that is confined to the abdomen.
- Stage 4 - there are distant metastases (lung, liver, bone, brain), or lymph node metastases outside the abdominopelvic region.
- Stage 5 - involvement of both kidneys is present at diagnosis.

1	Stage 1
2	Stage 2
3	Stage 3
4	Stage 4
5	Stage 5

WILMS TUMOUR STAGE DATE: The date on which the Wilms Tumour Stage was recorded.

5.8.5 CTYA – STAGING – GERM CELL NON CNS TUMOURS

To carry Germ Cell Non CNS Tumours details for CTYA. (Non-CNS germ-cell tumours are defined as ICD10 C00.0-C69.9, C73-C75.0, C75.4-C80.9, D00.0-D31.9, D34-D35.1, D35.5-D41.9, D44.0-D44.2, D44.6-D48.9 combined with Morphology 9060-9104.)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6590	CTYA (GERM CELL NON CNS TUMOURS)	**TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS** *[TNM STAGE GROUPING (NON CENTRAL NERVOUS SYSTEM GERM CELL TUMOURS)]*	an1	R

TNM STAGE GROUPING FOR NON CNS GERM CELL TUMOURS: TNM classification for Germ Cell Non CNS Tumours. This information should be available for the MDT discussion but will only apply to a small number of cases. Staging is an important prognostic and outcomes analysis factor. The following definitions are used:

1	Clinical stage 1 : T1, N0 or Nx, M0
2	Clinical stage 2 : T2 or T3, N0 or Nx, M0
3	Clinical stage 3 : T1-3, N0, M0 or T4 with any N, M0
4	Clinical stage 4 : All T with any N, M1

5.8.6 CTYA – STAGING – CSF (Cerebrospinal Fluid)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6560	CTYA - STAGING - CSF (Cerebrospinal Fluid)	**CHANG STAGING SYSTEM STAGE**	an1	R
CT6760	CTYA - STAGING - CSF (Cerebrospinal Fluid)	**CHANG STAGING SYSTEM STAGE DATE**	an10 ccyy-mm-dd	R

CHANG STAGING SYSTEM STAGE: Chang staging is now a standard staging procedure for Medulloblastoma, CNS PNET, ATRT, ependymoma and CNS germ cell tumours.

M0	No evidence of metastatic disease
M1	microscopic tumour cells found in CSF
M2	gross nodular seeding in cerebellum, cerebral subarachnoid space, or in the third or fourth ventricles
M3	gross nodular seeding in spinal subarachnoid space

CHANG STAGING SYSTEM STAGE DATE: The date on which Chang Staging was recorded

5.8.7 CTYA – STAGING – HEPATOBLASTOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6500	CTYA - STAGING - HEPATOBLASTOMA	**PRETEXT STAGING SYSTEM STAGE**	an1	R
CT6510	CTYA - STAGING - HEPATOBLASTOMA	**PRETEXT STAGING OUTSIDE LIVER** *[PRETEXT STAGING SYSTEM STAGE (OUTSIDE LIVER)]*	an1	R

PRETEXT STAGING SYSTEM STAGE: Pretext 1 – 4 refers to sectors of liver involved.

1	Stage 1: tumour involves only 1 quadrant
2	Stage 2: tumour involves 2 adjoining quadrants; 2 adjoining sections free
3	Stage 3: tumour involves 3 adjoining quadrants; only 1 quadrant free or 2 non-adjoining quadrants free
4	Stage 4: tumour involves all 4 quadrants

PRETEXT STAGING OUTSIDE LIVER: Additional Pretext staging used to describe disease outside the liver.

V	"extension" into the vena cava and/or all three hepatic veins
P	"extension" into the main and/or both left and right branches of the portal vein
E	extra-hepatic disease
M	presence of distant metastases

5.8.8 CTYA – STAGING – RETINOBLASTOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6770	CTYA - STAGING - RETINOBLASTOMA	**RETINOBLASTOMA ASSESSMENT DATE**	an10 ccyy-mm-dd	R
CT6800	CTYA - STAGING - RETINOBLASTOMA	**INTERNATIONAL STAGING SYSTEM FOR RETINOBLASTOMA**	an1	R

RETINOBLASTOMA ASSESSMENT DATE: The date on which retinoblastoma details were recorded.

INTERNATIONAL STAGING SYSTEM FOR RETINOBLASTOMA: The international staging system stage for intraocular and extraocular retinoblastoma.

0	**Stage 0** Patients treated conservatively, grouped according to intraocular classification
1	**Stage 1** Eye enucleated, completely resected histologically
2	**Stage 2** Eye enucleated, microscopic residual tumour
3	**Stage 3** Regional extension a) Overt orbital disease b) Pre-auricular or cervical lymph node extension
4	**Stage 4** Metastatic disease a) Haematogenous metastasis 1. Single lesion 2. Multiple lesions b) CNS extension 1. Prechiasmatic lesion 2. CNS mass 3. Leptomeningeal disease

5.9 CTYA – LABORATORY RESULTS - GENERAL

These are New data items, requested after long discussions and consultation with the SSCRG.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7040	CTYA - LABORATORY RESULTS - GENERAL	**LDH VALUE** *[LACTATE DEHYDROGENASE LEVEL (NORMAL UPPER LIMIT)]*	an2 max n6	R

LDH VALUE: This is the peak LDH (Lactate Dehydrogenase Level) at diagnosis.

5.9.1 CTYA – LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA

These are New data items, requested after long discussions and consultation with the SSCRG.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT7320	CTYA - LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA	**BLASTS ON PB** *[PERIPHERAL BLOOD BLASTS PERCENTAGE]*	an max n3	R
CT7330	CTYA - LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA	**BONE MARROW BLASTS** *[BONE MARROW BLAST CELLS PERCENTAGE (PAEDIATRIC MYELODYSPLASIA)]*	an max n3	R

CT7340	CTYA - LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA	**CELLULARITY** *[CELLULARITY PERCENTAGE]*	an max n3	R
CT7350	CTYA - LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA	**DEB TEST** *[DIEPOXYBUTANE TEST RESULT]*	an1	R
CT7360	CTYA - LABORATORY RESULTS - PAEDIATRIC MYELODYSPLASIA	**DYSPLASTIC HAEMOPOIESIS** *[DYSPLASTIC HAEMOPOIESIS TYPE]*	an1	R

BLASTS ON PB: Percentage value of Peripheral Blood Blasts.

BONE MARROW BLASTS: Percentage value of Bone Marrow Blasts.

CELLULARITY: Percentage value of Cellularity.

DEB TEST: Record the outcome of DEB Test.

P	POSITIVE
N	NEGATIVE
9	Not Known

DYSPLASTIC HAEMOPOIESIS: Record if the bone marrow produced (HAEMOPOIESIS) is Unilineage, Bilineage or Trilineages dysplastic.

1	Unilineage
2	Bilineage
3	Trilineage

5.9.2 CTYA – LABORATORY RESULTS - NEUROBLASTOMA

These are a combination of New data items, requested after long discussions and consultation with the SSCRG, and moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6310	CTYA - LABORATORY RESULTS - NEUROBLASTOMA	**CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA)** *[CYTOGENETIC RISK CODE (NEUROBLASTOMA)]*	an1	R
CT7080	CTYA - LABORATORY RESULTS - NEUROBLASTOMA	**FERRITIN VALUE**	an max n3	R
CT7090	CTYA - LABORATORY RESULTS - NEUROBLASTOMA	**URINE VMA / CREATININE RATIO** *[URINEVANILLYLMANDELIC ACID CREATININE RATIO]*	max n2.n1	R

CYTOGENETIC RISK CLASSIFICATION (NEUROBLASTOMA): Risk allocation based on cytogenetic findings.

F	Favourable
U	Unfavourable
O	Other
X	Non informative
9	Not Known

FERRITIN VALUE: Normal Ferritin levels change with age, but they typically fall between 6-55 ng/mall Abnormal levels can indicate imbalances in iron metabolism that happen with problems like anaemia.

URINE VMA / CREATININE RATIO: Urinary vanillylmandelic acid (VMA) used to evaluate to evaluate catecholamine production, useful in the diagnosis of pheochromocytoma and neuroblastoma and in confirmation of elevated catecholamine levels

5.9.3 CTYA – LABORATORY RESULTS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS

These are moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6360	CTYA -LABORATORY RESULTS - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS	**CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA** *[CYTOGENETIC PRESENCE TYPE (RHABDOMYOSARCOMA)]*	an1	R

CYTOGENETICS FOR ALVEOLAR RHABDOMYOSARCOMA: Presence of a specific cytogenetic abnormality. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

P	Fusion positive
N	Fusion negative
X	Non informative
9	Not known (Not available)

5.9.4 CTYA – LABORATORY RESULTS - EWINGS

These are moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6460	CTYA - LABORATORY RESULTS - EWINGS	**CYTOGENETICS FOR EWINGS SARCOMA** *[CYTOGENETIC ANALYSIS CODE]*	an2	R

CYTOGENETICS FOR EWINGS SARCOMA: Cytogenetic analysis.

11	t(11;22)
VT	Variant Translocation
NG	Negative
NA	Not Available

5.9.5 CTYA – LABORATORY RESULTS - GERM CELL CNS TUMOURS

These are moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification

				(M/R/O/X)
CT6530	CTYA - LABORATORY RESULTS - GERM CELL CNS TUMOURS	**ALPHA FETOPROTEIN (CEREBROSPINAL FLUID)**	max n6	R
CT6550	CTYA - LABORATORY RESULTS - GERM CELL CNS TUMOURS	**BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID)**	max n3	R

ALPHA FETOPROTEIN (CEREBROSPINAL FLUID): Maximum level of alpha feto protein in the Cerebro Spinal Fluid at diagnosis. AFP units recorded in kU/l (values > 100,000 are recorded. (Measured only for CNS germ cell tumours.).

BETA HUMAN CHORIONIC GONADOTROPIN (CEREBROSPINAL FLUID): Maximum CSF level of HCG at diagnosis in IU/l. (Measured only for CNS germ cell tumours).

5.9.6 CTYA – LABORATORY RESULTS - GERM CELL CNS and GERM CELL NON CNS TUMOURS

These are moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6580	CTYA - LABORATORY RESULTS - GERM CELL CNS and GERM CELL NON CNS TUMOURS	**BETA HUMAN CHORIONIC GONADOTROPIN (SERUM)** *[BETA HUMAN CHORIONIC GONADOTROPIN (MAXIMUM AT DIAGNOSIS)]*	max n6	R

BETA HUMAN CHORIONIC GONADOTROPIN (SERUM): Maximum Serum level of HCG at diagnosis in IU/l (measured only for CNS germ cell tumours.)

5.9.7 CTYA – LABORATORY RESULTS - GERM CELL CNS, GERM CELL NON CNS TUMOURS, HEPATOBLASTOMA and HEPATOCELLULAR CERCINOMA

These are moved data items to make recording and reporting more logical.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6520	CTYA - LABORATORY RESULTS - GERM CELL CNS, GERM CELL NON CNS TUMOURS, HEPATOBLASTOMA and HEPATOCELLULAR CERCINOMA	**ALPHA FETOPROTEIN (SERUM)** *[ALPHA FETOPROTEIN (MAXIMUM AT DIAGNOSIS)]*	max n6	R

ALPHA FETOPROTEIN (SERUM): Maximum Serum level of alpha feto protein at diagnosis. AFP units recorded in kU/l (values > 100,000 are recorded)

5.10 CTYA - NEUROBLASTOMA

INTERNATIONAL NEUROBLASTOMA PATHOLOGY CLASSIFICATION: *This data item has been retired on the advice of the Chair of the SSCRG*

5.10 CTYA - RENAL TUMOURS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6680	CTYA (RENAL TUMOURS)	**RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY** *[PATHOLOGICAL RISK CLASSIFICATION CODE (AFTER NEPHRECTOMY)]*	an1	R
CT6340	CTYA (RENAL TUMOURS)	**RISK CLASSIFICATION (PATHOLOGICAL) AFTER PREOPERATIVE CHEMOTHERAPY** *[PATHOLOGICAL RISK CLASSIFICATION CODE (AFTER PREOPERATIVE CHEMOTHERAPY)]*	an1	R

RISK CLASSIFICATION (PATHOLOGICAL) AFTER IMMEDIATE NEPHRECTOMY: Classification and timing of surgery determine histological risk. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

- Favourable histology: non-anaplastic Wilms tumour (all subtypes); cystic partially differentiated nephroblastoma; mesoblastic nephroma; diffuse nephroblastomatosis.
- Unfavourable histology: Anaplastic Wilms tumour (focal and diffuse); malignant rhabdoid tumour of kidney; clear cell sarcoma of the kidney; renal cell carcinoma.

F	FAVOURABLE
U	UNFAVOURABLE

RISK CLASSIFICATION (PATHOLOGICAL) AFTER PREOPERATIVE CHEMOTHERAPY: Classification after preoperative chemotherapy determines histological risk. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases. The following definitions are used:

• Low risk: cystic partially differentiated nephroblastoma; completely necrotic nephroblastoma; mesoblastic nephroma; diffuse nephroblastomatosis

• Intermediate risk: nephroblastoma type – epithelial; stromal; mixed; regressive; focal anaplasia

• High risk: nephroblastoma blastemal type; nephroblastoma with anaplasia; malignant rhabdoid tumour of the kidney; clear cell sarcoma of the kidney; renal cell carcinoma

L	Low
I	Intermediate
H	High

5.11 CTYA - RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6370	CTYA (RHABDOMYOSARCOMA and OTHER STS)	**RHABDOMYOSARCOMA SITE PROGNOSIS CODE**	an1	R

RHABDOMYOSARCOMA SITE PROGNOSIS CODE: Grouping of anatomical sites which imply prognostic significance. This information should be available for the MDT discussion but will only apply to a small number of cases. The following definitions are used:

Favourable sites: Orbit; genitourinary Non Bladder Prostate; Non-Parameningeal Head and Neck

Unfavourable sites: All other sites of disease

F	Favourable
U	Unfavourable

5.12 CTYA – OSTEOSARCOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6400	CTYA OSTEOSARCOMA	**PRIMARY TUMOUR SIZE (RADIOLOGICAL)**	max n3.max n2	R
CT6410	CTYA OSTEOSARCOMA	**EXTENT OF NECROSIS AFTER CHEMOTHERAPY** *[TUMOUR NECROSIS]*	max n3	R
CT6420	CTYA OSTEOSARCOMA	**SARCOMA SURGICAL MARGIN ADEQUACY** *[SARCOMA SURGICAL MARGIN]*	an1	R

PRIMARY TUMOUR SIZE (Radiological): Maximum dimension in mm recorded on diagnostic imaging as agreed at MDT. This information should be available for the MDT discussion but will only apply to a small number of cases.

Note: For COSD reporting purposes, this data item is not required to be submitted to two decimal places.

EXTENT OF NECROSIS AFTER CHEMOTHERAPY: Pathologically assessed effect of chemotherapy on the resected tumour specimen as a percentage. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases.

SARCOMA SURGICAL MARGIN ADEQUACY: Pathological assessment of completeness of resection. This information should be available for the MDT discussion following treatment but will only apply to a small number of cases.

I	Intralesional
M	Marginal
W	Wide
C	Compartmental
O	Other
9	Not known

5.13 CTYA – RETINOBLASTOMA

This section can be recorded more than once.

For many years the Rees-Ellsworth intraocular classification system was used to stage patients according to their likelihood of successful treatment with external beam radiotherapy. As treatment approaches have evolved and chemotherapy has replaced radiotherapy as the mainstay of conservative management, a new intraocular classification has been introduced and has been received with widespread approval from the international community.

The staging of extra-ocular disease is less well established although recently a panel of international experts have proposed a system which is gaining acceptance in published literature.

All cases of Retinoblastoma are referred to the national specialist centres who are requested to record this section in addition to TNM staging.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6780	CTYA - RETINOBLASTOMA	**RETINOBLASTOMA ASSESSMENT LATERALITY**	an1	R
CT6790	CTYA - RETINOBLASTOMA	**INTERNATIONAL CLASSIFICATION FOR INTRAOCULAR RETINOBLASTOMA**	an1	R

RETINOBLASTOMA ASSESSMENT LATERALITY: The laterality for which the retinoblastoma details were recorded

INTERNATIONAL CLASSIFICATION FOR INTRAOCULAR RETINOBLASTOMA: The intraocular classification for retinoblastoma as approved by the international community

A	**Group A** Small tumours away from the foveola and disc: • Tumours less than 3mm in greatest dimension confined to the retina and • Located at least 3mm from the foveola and 1.5mm from the optic disc
B	**Group B** All remaining tumours confined to the retina: • All tumours confined to the retina not in group A • Subretinal fluid (without subretinal seeding) less than 3mm from the base of the tumour
C	**Group C** Local subretinal fluid or seeding • Subretinal fluid alone greater than 3mm to less than 6mm from the tumour • Vitreous seeding or subretinal seeding less than 3mm from tumour
D	**Group D** Diffuse subretinal fluid or seeding • Subretinal fluid alone greater than 6mm from the tumour • Vitreous seeding or subretinal seeding greater than 3 mm from tumour
E	**Group E** Presence of one or more of the these poor prognosis features: • Greater than 2/3 globe filled with tumour • Tumour in anterior segment • Tumour in or on the ciliary body • Iris neovascularisation • Neovascular glaucoma • Opaque media from haemorrhage • Tumour necrosis with septic orbital cellulitis • Pthisis bulbi

6. GYNAECOLOGY

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C51.0	*Labium majus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.1	*Labium minus*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			** Gynaecology and Skin Datasets to be collected where applicable.*

C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C52	Malignant neoplasm of vagina	Gynaecological	●			
C53.0	Endocervix	Gynaecological	●			
C53.1	Exocervix	Gynaecological	●			
C53.8	Overlapping lesion of cervix uteri	Gynaecological	●			
C53.9	Cervix uteri, unspecified	Gynaecological	●			
C54.0	Isthmus uteri	Gynaecological	●			
C54.1	Endometrium	Gynaecological	●			
C54.2	Myometrium	Gynaecological	●			
C54.3	Fundus uteri	Gynaecological	●			
C54.8	Overlapping lesion of corpus uteri	Gynaecological	●			
C54.9	Corpus uteri, unspecified	Gynaecological	●			
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	●			
C56	Malignant neoplasm of ovary	Gynaecological	●			
C57.0	Fallopian tube	Gynaecological	●			
C57.1	Broad ligament	Gynaecological	●			
C57.2	Round ligament	Gynaecological	●			
C57.3	Parametrium	Gynaecological	●			
C57.4	Uterine adnexa, unspecified	Gynaecological	●			
C57.7	Other specified female genital organs	Gynaecological	●			
C57.8	Overlapping lesion of female genital organs	Gynaecological	●			
C57.9	Female genital organ, unspecified	Gynaecological	●			
C58	Malignant neoplasm of placenta	Gynaecological	●			

C79.6	Secondary malignant neoplasm of ovary	Gynaecological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D06.0	carcinoma in situ of endocervix	Gynaecological			●	
D06.1	carcinoma in situ of exocervix	Gynaecological			●	
D06.7	carcinoma in situ of other parts of cervix	Gynaecological			●	
D06.9	carcinoma in situ of cervix, unspecified	Gynaecological			●	
D07.0	carcinoma in situ of endometrium	Gynaecological			●	
D07.1	carcinoma in situ of vulva	Gynaecological			●	
D07.2	carcinoma in situ of vagina	Gynaecological			●	
D07.3	carcinoma in situ of other and unspecified female genital organs	Gynaecological			●	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			●	
D39.1	Neoplasm of uncertain or unknown behaviour of Ovary	Gynaecological			●	
D39.2	Neoplasm of uncertain or unknown behaviour of Placenta	Gynaecological			●	
D39.7	Neoplasm of uncertain or unknown behaviour of Other female genital organs	Gynaecological			●	
D39.9	Neoplasm of uncertain or unknown behaviour of Female genital organ, unspecified	Gynaecological			●	

6.1 GYNAECOLOGY – SURGERY

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7000	GYNAECOLOGY - SURGERY	**SURGEON GRADE** *[CARE PROFESSIONAL SENIOR OPERATING SURGEON GRADE (CANCER)]*	an1	R
GY7460	GYNAECOLOGY - SURGERY & OTHER PROCEDURES	**RESIDUAL DISEASE** *[RESIDUAL DISEASE SIZE (GYNAECOLOGICAL CANCER)]*	an1	R

SURGEON GRADE: Grade of senior surgeon present at operation.

Note: Colposcopist - NOS (not otherwise specified) should be recorded where the procedure is a colposcopy that was carried out by a qualified colposcopist who is not a surgeon and cannot be otherwise classified in this list

S	Sub-specialist Gynaecological Oncologist
C	Consultant Gynaecologist (not sub-specialist)
F	Sub-Specialty Fellow
A	Associate Specialist / Staff Grade
R	SPR / ST3+
O	SHO / ST1 or ST2
G	General Surgeon / other surgical specialty
Z	Colposcopist NOS

RESIDUAL DISEASE: The estimated size of the residual disease (tumour) left after the surgery, as documented by the surgeon at the completion of the procedure, and would be captured by the MDT. This data item would apply to ovarian, fallopian tube and peritoneal cancers managed surgically.

1	0cm
2	>0 and <1cm
3	=>1cm

6.2 GYNAECOLOGY – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[23] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[24].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7010	GYNAECOLOGY - STAGING	**FINAL FIGO STAGE**	max an7	R
GY7440	GYNAECOLOGY - STAGING	**FINAL FIGO STAGE DATE**	an10 ccyy-mm-dd	R

[23] https://nww.cancerstats.nhs.uk/cosd/staging

[24] http://www.wileyanduicc.com/

FINAL FIGO STAGE: The FIGO stage is generally confirmed at pathology review in MDT meetings following surgery for uterine and vulval malignancies and for ovarian malignancies undergoing primary surgery.
For ovarian malignancies planned to undergo neoadjuvant chemotherapy and for cases of cervical cancer (which is staged clinically), the final FIGO stage is determined at the time of review of clinical findings, imaging, cytology and biopsy histology at the MDT meeting.
FINAL FIGO STAGE DATE: The date on which the Final FIGO Stage was recorded.

7. HAEMATOLOGY

OVERVIEW

In order to ensure that all the data items can be collected it is essential to discuss the process with clinicians responsible for treating the patients.

For all haematology patients it is essential to record the ICD03 MORPHOLOGY CODE (see Core Dataset).

STAGE/Prognostic Indicators

TNM Staging is not collected for Haematological cancers. However the following staging data items are required for all relevant cases:

CLL: Binet stage and stage date (including all component data items). This can be derived if components are recorded.

Myeloma; ISS and stage date

All Lymphomas: Ann Arbor Stage and stage date, Ann Arbor Symptoms, Ann Arbor Extranodality, Ann Arbor Bulk and Ann Arbor Splenic Involvement

Additionally, the following **prognostic indicators** are also required:

CML: Sokal index (including all component data items). This can be calculated if components are recorded.

Myelodysplasia: IPSS

Follicular lymphoma: FLIPI index

DLBCL: (R)IPI index

Hodgkin Lymphoma: Hasenclever index (Only applicable to advanced Stage 3 and 4 disease)

ICD CODES AND WHO DISEASE GROUPS

The following table shows the full list of ICD10 codes which are applicable for Haematology mapped against the relevant ICDO3 codes as well as the dataset which should be completed for each disease and the WHO Disease Group. (Please see Appendix C for Description of Disease Groups). Changes from Version 1.9 of the User Guide are shown in red.

IMPORTANT NOTE: Where a suffix has been added this should be used consistently as shown to ensure that diseases with the same ICDO3 code can be correctly distinguished. To ensure that consistent coding continues to be applied nationally, please advise the COSD team if you identify potential changes or additional coding requirements. (For visual clarity the ICDO3 codes in the table are formatted differently from the specification. Records should be submitted according to the format in the specification, either “MXXXXX”, or “MXXXXXX” with suffix)

Where marked as “CORE ONLY” there is no disease specific dataset so only the core dataset will be completed. Please also note that every record must include the relevant ICDO3 code.

LYMPHOBLASTIC LEUKAEMIA/LYMPHOBLASTIC LYMPHOMA CODING

Lymphoblastic lymphoma and lymphoblastic leukaemia are now known to be the same entity. This is reflected in the latest ICDO3 coding update which assigns the same morphology code to both and uses the combined term 'lymphoblastic leukaemia/lymphoma'. Historically different codes were assigned to lymphoblastic lymphoma and leukaemia and ICD10 coding still distinguishes between these two groups. The coding list below therefore retains the separate ICD10 codes (C83.5 and C91.0) but assigns the same ICDO3 codes to each pair of diseases. (Further detail can be provided if required.)

RECORDING AMYLOIDOSIS FOR COSD

The aim is to register patients presenting with symptoms referable to an underlying diagnosis of amyloidosis in the absence of a known, registerable plasma cell or lymphoid neoplasm.

Amyloidosis may be associated with plasma cell neoplasms such as multiple myeloma, other B cell neoplasms (such as lymphoplasmacytic lymphoma), or with paraproteinaemias (which are not associated with identified myeloma or lymphoma (i.e. MGUS).

If amyloidosis is identified in association with a registerable condition (such as multiple myeloma, plasmacytoma, lymphoplasmacytic lymphoma, Waldenstroms macroglobulinaemia etc), only the data for the associated registerable condition should be submitted through COSD and this will be registered as a new diagnosis by the cancer registries. Amyloidosis should not be submitted for COSD in these circumstances.

Amyloid deposition associated with chronic infection, medullary carcinoma of the thyroid, insulinoma, prolactinoma, Alzheimer disease, prion diseases and other non-AL types of amyloid, is considered to be secondary amyloidosis and should not be submitted for COSD.

If amyloidosis is identified in the absence of a registerable condition or before the identification of a registerable condition, then data for Primary Amyloidosis* should be submitted for COSD and this will be registered as a new diagnosis by the cancer registries.

Please note that for the purpose of COSD, MGUS (monoclonal gammopathy of unknown significance) is not a registerable disease and therefore amyloidosis associated with a paraprotein/MGUS should be submitted for COSD and will be registered as a new diagnosis.

Amyloidosis as identified above should be recorded for COSD and coded as follows:

ICD10 code: E85.9 (Amyloidosis unspecified)

ICDO3 morphology code: M9769/1

*Primary Amyloidosis is composed of abnormal immunoglobulin light chains (or rarely heavy chains) which deposit (either intact or in fragments) in various tissues. These form B-pleated sheets (AL amyloid) that bind Congo Red dye with characteristic birefringence.

Note: ICD-O-3 codes 9678/3 and 9712/3 have been realigned to ICD10 code C83.8 since the previous version of this table

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9740/1 A	Cutaneous mastocytosis	D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	CORE ONLY	1
9740/1 B	Extracutaneous mastocytoma	D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	CORE ONLY	1
9740/3	Mast Cell Sarcoma	C96.2	Malignant mast cell tumour	CORE ONLY	1
9741/1	Indolent systemic mastocytosis	D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	CORE ONLY	1
9741/3	Systemic mastocytosis (including systemic mastocytosis with AHNMD or aggressive systemic mastocytosis)	C96.2	Malignant mast cell tumour	CORE ONLY	1
9742/3	Mast Cell Leukaemia	C94.3	Mast cell leukaemia	CORE ONLY	1

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9875/3	Chronic Myelogenous Leukaemia, BCR-ABL1 positive	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9875/3 A	Chronic Myelogenous Leukaemia, Accelerated Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9875/3 B	Chronic Myelogenous Leukaemia, Blastic Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9875/3 C	Chronic Myelogenous Leukaemia, Chronic Phase	C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	CML	1
9876/3	Atypical chronic myeloid leukaemia, BCR-ABL1 negative	C92.2	Atypical chronic myeloid leukaemia, BCR/ABL-negative	MDS	1
9950/3	Polycythaemia vera*	D45	Polycythaemia vera	CORE ONLY	1
9961/3	Primary myelofibrosis*	D47.4	Osteomyelofibrosis	CORE ONLY	1
9962/3	Essential Thrombocythaemia*	D47.3	Essential (haemorrhagic) thrombocythaemia	CORE ONLY	1
9963/3	Chronic neutrophilic leukaemia	D47.1	Chronic myeloproliferative disease	CORE ONLY	1
9964/3	Chronic eosinophilic leukaemia, NOS*	D47.5	Chronic eosinophilic leukaemia [hypereosinophilic syndrome]	CORE ONLY	1
9975/3	Myeloproliferative neoplasm, unclassifiable*	D47.1	Chronic myeloproliferative disease	CORE ONLY	1
9965/3	Myeloid and lymphoid neoplasms with PDGFRA re-arrangement	C92.7	Other myeloid leukaemia	CORE ONLY	2
9966/3	Myeloid neoplasms with PDGFRB	C92.7	Other myeloid leukaemia	CORE ONLY	2
9967/3	Myeloid and lymphoid neoplasms with FGFR1 abnormalities	C92.7	Other myeloid leukaemia	CORE ONLY	2
9945/3	Chronic myelomonocytic leukaemia	C93.1	Chronic myelomonocytic leukaemia	MDS	3
9946/3	Juvenile myelomonocytic leukaemia	C93.3	Juvenile myelomonocytic leukaemia	MDS	3
9975/3 A	Myelodysplastic/Myeloproliferative neoplasm, unclassifiable	C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	CORE ONLY	3
9980/3	Refractory anaemia*	D46.4	Refractory anaemia, unspecified	MDS	4
9982/3 A	Refractory anaemia with ring sideroblasts*	D46.1	Refractory anaemia with ringed sideroblasts	MDS	4
9982/3 B	Refractory anaemia with ring sideroblasts associated with marked thrombocytosis*	D46.1	Refractory anaemia with ringed sideroblasts	MDS	4
9983/3	Refractory anaemia with excess blasts*	D46.2	Refractory anaemia with excess of blasts	MDS	4
9985/3	Refractory cytopenia with multilineage dysplasia*	D46.5	Refractory anaemia with multi-lineage dysplasia	MDS	4
9985/3 A	Refractory cytopenia of childhood*	D46.5	Refractory anaemia with multi-lineage dysplasia	MDS	4
9986/3	Myelodysplastic syndrome associated with isolated del(5q)*	D46.6	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	MDS	4
9989/3	Myelodysplastic syndrome, unclassifiable*	D46.9	Myelodysplastic syndrome, unspecified	MDS	4
9991/3	Refractory neutropenia*	D46.7	Other Myelodysplastic syndromes	MDS	4

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9992/3	Refractory thrombocytopenia*	D46.7	Other Myelodysplastic syndromes	MDS	4
9727/3	Blastic plasmacytoid dendritic cell neoplasm	C86.4	Blastic NK-cell lymphoma	AML	5
9840/3	Acute erythroid leukaemia	C94.0	Acute erythroid leukaemia	AML	5
9861/3 A	AML with mutated CEBPA	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9861/3 B	AML with mutated NPM1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9861/3 C	Acute myeloid leukaemia, NOS	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9865/3	AML with t(6;9)(p23;q34) DEK-NUP214	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9866/3	Acute promyelocytic leukaemia with t(15;17)(q22;q12) PML-RARA	C92.4	Acute promyelocytic leukaemia [PML]	AML	5
9867/3	Acute myelomonocytic leukaemia	C92.5	Acute myelomonocytic leukaemia	AML	5
9869/3	AML with inv(3)(q21q26.2) or t(3;3)(q21;q26.2) RPRN1-EVI1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9870/3	Acute basophilic leukaemia	~~C92.7~~ C94.7	~~Other myeloid leukaemia.~~ Other specified leukaemia	AML	5
9871/3	AML with inv(16)(p13.1;q22) or t(16;16)(p13.1;q22) CBFB-MYH11	C92.5	Acute myelomonocytic leukaemia	AML	5
9872/3	AML with minimal differentiation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9873/3	AML without maturation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9874/3	AML with maturation	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9891/3	Acute monoblastic and monocytic leukaemia	C93.0	Acute monoblastic/monocytic leukaemia	AML	5
9895/3	AML with myelodysplasia-related changes	C92.8	Acute myeloid leukaemia with multilineage dysplasia	AML	5
9896/3	AML with t(8;21)(q22;q22) RUNX1-RUNX1T1	C92.0	Acute myeloblastic leukaemia [AML]	AML	5
9897/3	AML with t(9;11)(p22;q23) MLLT3-MLL	C92.6	Acute myeloid leukaemia with 11q23-abnormality	AML	5
9898/1	Transient abnormal myelopoiesis	D47.1	Chronic myeloproliferative disease	CORE ONLY	5
9898/3	Myeloid leukaemia associated with Down syndrome	C92.7	Other myeloid leukaemia	AML	5
9910/3	Acute megakaryoblastic leukaemia	C94.2	Acute megakaryoblastic leukaemia	AML	5
9911/3	AML (megakaryoblastic) with t(1;22)(p13;q13) RBM15-MKL1	C94.2	Acute megakaryoblastic leukaemia	AML	5
9920/3	t-AML	C92.0	Acute myeloblastic leukaemia [AML]	AML	5

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9920/3 A	t-MDS/MPN	C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	MDS	5
9920/3 B	t-MDS	D46.7	Other myelodysplastic syndromes	MDS	5
9930/3	Myeloid sarcoma	C92.3	Myeloid sarcoma	CORE ONLY	5
9931/3	Acute panmyelosis with myelofibrosis	C94.4	Acute panmyelosis with myelofibrosis	CORE ONLY	5
9801/3	Acute undifferentiated leukaemia	C95.0	Acute leukaemia of unspecified cell type	AML	6
9805/3	Mixed phenotype acute leukaemia NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9806/3	Mixed phenotype acute leukaemia with t(9;22)(q34;q11.2) BCR-ABL1	C95.0	Acute leukaemia of unspecified cell type	AML	6
9807/3	Mixed phenotype acute leukaemia with t(v;11q23) MLL re-arranged	C95.0	Acute leukaemia of unspecified cell type	AML	6
9808/3	Mixed phenotype acute leukaemia, B/myeloid, NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9809/3	Mixed phenotype acute leukaemia, T/myeloid, NOS	C95.0	Acute leukaemia of unspecified cell type	AML	6
9811/3 A	B lymphoblastic lymphoma, NOS	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9811/3 B	B lymphoblastic leukaemia, NOS	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9812/3 A	B lymphoblastic lymphoma with t(9;22)(q34;q11.2);BCR-ABL1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9812/3 B	B lymphoblastic leukaemia with t(9;22)(q34;q11.2);BCR-ABL1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9813/3 A	B lymphoblastic lymphoma with t(v;11q23);MLL re-arranged	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9813/3 B	B lymphoblastic leukaemia with t(v;11q23);MLL re-arranged	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9814/3 A	B lymphoblastic lymphoma with t(12;21)p13;q22);ETV6-RUNX1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9814/3 B	B lymphoblastic leukaemia with t(12;21)p13;q22);ETV6-RUNX1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9815/3 A	B lymphoblastic lymphoma with hyperdiploidy	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9815/3 B	B lymphoblastic leukaemia with hyperdiploidy	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9816/3 A	B lymphoblastic lymphoma with hypodiploidy (hypodiploid ALL)	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9816/3 B	B lymphoblastic leukaemia with hypodiploidy (hypodiploid ALL)	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9817/3 A	B lymphoblastic lymphoma with t(5;14)(q31;q32);IL3-IGH	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9817/3 B	B lymphoblastic leukaemia with t(5;14)(q31;q32);IL3-IGH	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9818/3 A	B lymphoblastic lymphoma with t(1;19)(q23;p13.3);TCF3-PBX1	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	7
9818/3 B	B lymphoblastic leukaemia with t(1;19)(q23;p13.3);TCF3-PBX1	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	7
9729/3	T lymphoblastic lymphoma	C83.5	Lymphoblastic (diffuse) lymphoma	ALL	8

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9837/3	T lymphoblastic leukaemia	C91.0	Acute lymphoblastic leukaemia [ALL]	ALL	8
9591/3 A	Hairy cell leukaemia variant	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 B	Splenic diffuse red pulp small B-cell lymphoma	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 C	Splenic B-cell lymphoma/leukaemia, unclassifiable	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9591/3 D	B cell lymphoma, NOS	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9596/3	B-cell lymphoma, intermediate between DLBCL/Classical Hodgkins	C85.1	B-cell lymphoma, unspecified	Other Lymphomas	9
9597/3	Primary cutaneous follicle centre lymphoma	C82.6	Cutaneous follicle centre lymphoma	Follicular	9
9671/3	Lymphoplasmacytic lymphoma	C83.0	Diffuse large B-cell lymphoma	Other Lymphomas	9
9673/3	Mantle cell lymphoma	C83.1	Mantle cell lymphoma	Other Lymphomas	9
9678/3	Primary effusion lymphoma	C83.8	Diffuse large B-cell lymphoma	Other Lymphomas	9
9679/3	Primary mediastinal (thymic) large B-cell lymphoma	C85.2	Mediastinal (thymic)large B-cell lymphoma	Other Lymphomas	9
9680/3	Diffuse large B-cell lymphoma (DLBCL), NOS	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 A	Primary DLBCL of the CNS	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 B	EBV positive DLBCL of the elderly	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 C	B-cell lymphoma, intermediate between DLBCL /Burkitt lymphoma	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 D	Primary cutaneous DLBCL, leg type	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9680/3 E	DLBCL associated with chronic inflammation	C83.3	Diffuse large B-cell lymphoma	DLBCL	9
9687/3	Burkitt lymphoma	C83.7	Burkitt lymphoma	Other Lymphomas	9
9688/3	T-cell/histiocyte rich large B-cell lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9689/3	Splenic marginal zone lymphoma	C83.0	Small cell B-cell lymphoma	Other Lymphomas	9
9690/3	Follicular lymphoma	C82.9	Follicular lymphoma, unspecified	Follicular	9
9691/3	Follicular lymphoma Grade 2	C82.1	Follicular lymphoma grade II	Follicular	9
9695/3	Follicular lymphoma Grade 1	C82.0	Follicular lymphoma grade I	Follicular	9
9698/3	Follicular lymphoma Grade 3	C82.2	Follicular lymphoma grade III, unspecified	Follicular	9
9698/3 A	Follicular lymphoma Grade 3A	C82.3	Follicular lymphoma grade IIIa	Follicular	9

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9698/3 B	Follicular lymphoma Grade 3B	C82.4	Follicular lymphoma grade IIIb	Follicular	9
9699/3 A	Extranodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT)	C88.4	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]	Other Lymphomas	9
9699/3 B	Nodal marginal zone lymphoma	C83.0	Small cell B-cell lymphoma	Other Lymphomas	9
9712/3	Intravascular large B-cell lymphoma	~~C83.3~~ C83.8	~~Diffuse large B-cell lymphoma~~ Other non-follicular lymphoma	Other Lymphomas	9
9731/3	Solitary plasmacytoma of bone	C90.3	Solitary plasmacytoma	CORE ONLY	9
9732/3	Plasma cell myeloma	C90.0	Multiple myeloma	Myeloma	9
9733/3	Plasma cell leukaemia	C90.1	Plasma cell leukaemia	Myeloma	9
9734/3	Extraosseous plasmacytoma	C90.2	Extramedullary plasmacytoma	CORE ONLY	9
9735/3	Plasmablastic lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9737/3	ALK positive large B-cell lymphoma	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9738/3	Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease	C83.3	Diffuse large B-cell lymphoma	Other Lymphomas	9
9760/3	Immunoproliferative disease, NOS	C88.9	Malignant immunoproliferative disease, unspecified	CORE ONLY	9
9761/3	Waldenström macroglobulinaemia	C88.0	Waldenström macroglobulinaemia	Other Lymphomas	9
9762/3	Heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9762/3 A	Alpha heavy chain disease	C88.3	Immunoproliferative small intestinal disease	CORE ONLY	9
9762/3 B	Gamma heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9762/3 C	Mu heavy chain disease	C88.2	Other heavy chain disease	CORE ONLY	9
9764/3	Immunoproliferative small intestinal disease	C88.3	Immunoproliferative small intestinal disease	Other Lymphomas	9
9766/1	Lymphomatoid granulomatosis	~~D47.7~~ C83.8	~~Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoetic and related tissue~~ Other non-follicular lymphoma	CORE ONLY	9
9769/1	Primary Amyloidosis	E85.9	Amyloidosis, unspecified	CORE ONLY	9
9823/3	Chronic lymphocytic leukaemia/small lymphocytic lymphoma	C91.1	Chronic lymphocytic leukaemia of B-cell type	CLL	9
9826/3	Burkitt cell leukaemia	C91.8	Mature B-cell leukaemia Burkitt-type	Other Lymphomas	9
9833/3	B-cell prolymphocytic leukaemia	C91.3	Prolymphocytic leukaemia of B-cell type	CORE ONLY	9

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9940/3	Hairy cell leukaemia	C91.4	Hairy-cell leukaemia	CORE ONLY	9
9700/3	Mycosis fungoides	C84.0	Mycosis fungoides	Other Lymphomas	10
9701/3	Sézary syndrome	C84.1	Sézary disease	Other Lymphomas	10
9702/3 A	Peripheral T-cell lymphoma, NOS	C84.4	Peripheral T-cell lymphoma, not elsewhere classified	Other Lymphomas	10
9702/3 B	Anaplastic large cell lymphoma, ALK negative	C84.7	Anaplastic large cell lymphoma, ALK-negative	Other Lymphomas	10
9705/3	Angioimmunoblastic T-cell lymphoma	C86.5	Angioimmunoblastic T-cell lymphoma	Other Lymphomas	10
9708/3	Subcutaneous panniculitis-like T-cell lymphoma	C86.3	Subcutaneous panniculitis-like T-cell lymphoma	Other Lymphomas	10
9709/3 A	Primary cutaneous CD8+ aggressive epidermotropic cytotoxic T-cell lymphoma	C84.8	Cutaneous T-cell lymphoma, unspecified	Other Lymphomas	10
9709/3 B	Primary cutaneous CD4 positive small/medium T-cell lymphoma	C84.8	Cutaneous T-cell lymphoma, unspecified	Other Lymphomas	10
9714/3	Anaplastic large cell lymphoma, ALK positive	C84.6	Anaplastic large cell lymphoma, ALK-positive	Other Lymphomas	10
9716/3	Hepatosplenic T-cell lymphoma	C86.1	Hepatosplenic T-cell lymphoma	Other Lymphomas	10
9717/3	Enteropathy-associated T-cell lymphoma	C86.2	Enteropathy-type (intestinal) T-cell lymphoma	Other Lymphomas	10
9718/3	Primary cutaneous anaplastic large cell lymphoma	C86.6	Primary cutaneous CD30-positive T-cell proliferations	Other Lymphomas	10
9719/3	Extranodal NK/T cell lymphoma, nasal type	C86.0	Extranodal NK/T-cell lymphoma, nasal type	Other Lymphomas	10
9719/3 A	T/NK-cell lymphoma	C84.9	Mature T/NK-cell lymphoma, unspecified	CORE ONLY	10
9724/3	Systemic EBV positive T-cell lymphoproliferative disease of childhood	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9725/3	Hydroa vacciniforme-like lymphoma	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9726/3	Primary cutaneous gamma-delta T-cell lymphoma	C84.5	Other mature T/NK-cell lymphomas	Other Lymphomas	10
9827/3	Adult T-cell leukaemia/lymphoma	C91.5	Adult T-cell lymphoma/leukaemia (HTLV-1-associated)	Other Lymphomas	10
9831/3	T-cell large granular lymphocytic leukaemia	C91.7	Other lymphoid leukaemia	CORE ONLY	10
9831/3 A	Chronic lymphoproliferative disorder of NK-cells	C91.7	Other lymphoid leukaemia	CORE ONLY	10
9834/3	T-cell prolymphocytic leukaemia	C91.6	Prolymphocytic leukaemia of T-cell type	CORE ONLY	10
9948/3	Aggressive NK cell leukaemia	C95.0	Acute leukaemia of unspecified cell type	CORE ONLY	10
9650/3	Classical Hodgkin lymphoma	C81.9	Hodgkin lymphoma, unspecified	Hodgkin	11
9651/3	Lymphocyte-rich classical Hodgkin lymphoma	C81.4	Lymphocyte-rich classical Hodgkin lymphoma	Hodgkin	11
9652/3	Mixed cellularity classical Hodgkin lymphoma	C81.2	Mixed cellularity classical Hodgkin lymphoma	Hodgkin	11

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9653/3	Lymphocyte-depleted classical Hodgkin lymphoma	C81.3	Lymphocytic depleted classical Hodgkin lymphoma	Hodgkin	11
9659/3	Nodular lymphocyte predominant Hodgkin lymphoma	C81.0	Nodular lymphocyte predominant Hodgkin lymphoma	Hodgkin	11
9663/3	Nodular sclerosis classical Hodgkin lymphoma	C81.1	Nodular sclerosis classical Hodgkin lymphoma	Hodgkin	11
9751/3 A	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	CORE ONLY	12
9751/3 B	Multifocal and unisystemic (disseminated) Langerhans-cell histiocytosis	C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	CORE ONLY	12
9751/3 C	Unifocal Langerhans-cell histiocytosis	C96.6	Unifocal Langerhans-cell histiocytosis	CORE ONLY	12
9755/3	Histiocytic sarcoma	C96.8	Histiocytic sarcoma	CORE ONLY	12
9756/3	Langerhans cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9757/3	Interdigitating dendritic cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9757/3 A	Dendritic cell tumour, NOS	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9758/3	Follicular dendritic cell sarcoma	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9759/3	Fibroblastic reticular cell tumour	C96.4	Sarcoma of dendritic cells (accessory cells)	CORE ONLY	12
9971/1 A	Early lesions plasmacytic hyperplasia	~~D47.9~~ D47.7	~~Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified.~~ Other specified neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	CORE ONLY	13
9971/1 B	Early lesions infectious mononucleosis-like PTLD	~~D47.9~~ D47.7	~~Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified.~~ Other specified neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	CORE ONLY	13

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
9971/3 A	Polymorphic PTLD*	~~D47.9~~ D47.7	~~Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified~~. Other specified neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	CORE ONLY	13
9971/3 B	Monomorphic PTLD (B- and T/NK-cell types)*	~~D47.9~~ D47.7	~~Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified.~~ Other specified neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	CORE ONLY	13
9971/3 C	Classical Hodgkin lymphoma type PTLD*	C81.9	Hodgkin lymphoma, unspecified	CORE ONLY	13
9591/3	Malignant lymphoma, non-Hodgkin, NOS	C85.9	Non-Hodgkin lymphoma, unspecified	Other Lymphomas	(No applicable group)
9800/3	Leukaemia, NOS	C95.9	Leukaemia, unspecified	CORE ONLY	
9860/3	Myeloid leukaemia, NOS	C92.9	Myeloid leukaemia, unspecified	CORE ONLY	
		C81.7	Other classical Hodgkin lymphoma	Redundant (reclassified)**	
		C82.5	Diffuse follicle centre lymphoma	Redundant (reclassified)**	
		C82.7	Other types of follicular lymphoma	Redundant (reclassified)**	
		C83.9	Non-follicular (diffuse) lymphoma, unspecified	Redundant (reclassified)**	
		C88.7	Other malignant immunoproliferative diseases	Redundant (reclassified)**	
		C93.7	Other monocytic leukaemia	Redundant (reclassified)**	
		C93.9	Monocytic leukaemia, unspecified	Redundant (reclassified)**	
		C94.7	Other specified leukaemias	Redundant (reclassified)**	
		C95.1	Chronic leukaemia of unspecified cell type	Redundant (reclassified)**	
		C95.7	Other leukaemia of unspecified cell type	Redundant (reclassified)**	
		C96.7	Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue	Redundant (reclassified)**	
		C96.9	Malignant neoplasms of lymphoid, haematopoietic and related tissue, unspecified	Redundant (reclassified)**	

ICD-O-3	ICD-O-3 WHO Description	ICD-10 (4th Edition)	ICD10 Description	Clinical dataset	WHO DISEASE GROUP
	not used in ICD-O-3 (D46.4 used instead)	D46.0	Refractory anaemia without ringed sideroblasts, so stated	Redundant (reclassified)**	
		D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	Redundant (reclassified)**	

*** There is a behaviour discrepancy between the ICD10 site code and the new ICD-O-3 morphology code - although these diseases are now coded with a behaviour code of 3 they are still recorded with a D code in ICD10**

**** Redundant - disease has been reclassified under other codes**

7.1 HAEMATOLOGY – CLINICAL DATASETS AND APPLICABLE DATA ITEMS

The following table shows which of the site specific data items are applicable to each clinical dataset.

Note: There are also some core data items which are used to calculate some of the indices, e.g. Age, gender, performance status)

Clinical Dataset		DATA ITEM #	SITE SPECIFIC DATA ITEM
AML	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Cytogenetics group	HA8160	CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA)
ALL	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Extramedullary disease	HA8270	EXTRAMEDULLARY DISEASE
CML*	Spleen	HA8000	SPLEEN CM BELOW COSTAL MARGIN
	Platelets	HA8030	PLATELET COUNT
	Blood Myeloblasts	HA8040	BLOOD MYELOBLASTS
	Blood Basophils	HA8050	BLOOD BASOPHILS PERCENTAGE
	Blood Eosinophils	HA8060	BLOOD EOSINOPHILS PERCENTAGE
	Hasford score*	HA8010	SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA)
	Sokal score*	HA8020	HASFORD INDEX (CHRONIC MYELOID LEUKAEMIA)
CLL	Hepatomegaly	HA8200	HEPATOMEGALY INDICATOR
	Splenomegaly	HA8210	SPLENOMEGALY INDICATOR
	Lymphadenopathy	HA8220	NUMBER OF LYMPHADENOPATHY AREAS
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Platelets	HA8030	PLATELET COUNT
	Binet	HA8240	BINET STAGE
	Binet stage date	HA8700	BINET STAGE DATE
	Rai	HA8230	RAI STAGE
	Rai stage date	HA8690	RAI STAGE DATE
Myelodysplasia (MDS)	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Platelets	HA8030	PLATELET COUNT
	Neutrophils	HA8130	NEUTROPHIL COUNT
	Marrow blasts	HA8120	BONE MARROW BLASTS PERCENTAGE
	Karyotype	HA8110	BONE MARROW KARYOTYPE
	IPSS index	HA8080	IPSS (MYELODYSPLASIA)
Myeloma	Albumin	HA8550	ALBUMIN LEVEL
	Beta 2 microglobulin	HA8540	BETA2 MICROGLOBULIN LEVEL
	ISS stage date	HA8710	ISS STAGE FOR MYELOMA DATE
	ISS Stage	HA8560	ISS STAGE for MYELOMA

***CML data items:** Where the Sokal and/or Hasford scores are calculated and recorded in Cancer Management Systems these two data items should be submitted for COSD along with the other data items listed. Where these scores are not currently calculated, the other (component) data items are sufficient as the scores can be derived. Please note that providers are asked to submit all the component items in order that Sokal and/or Hasford scores can be derived.

Clinical Dataset		DATA ITEM #	SITE SPECIFIC DATA ITEM
Follicular	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor stage date	HA8720	ANN ARBOR STAGE DATE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Splenic involvement	HA8680	ANN ARBOR SPLENIC INVOLVEMENT
	Nodal areas	HA8320	NUMBER OF ABNORMAL NODAL AREAS
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
	FLIPI	HA8360	FLIPI INDEX SCORE
DLBCL	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor stage date	HA8720	ANN ARBOR STAGE DATE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Splenic involvement	HA8680	ANN ARBOR SPLENIC INVOLVEMENT
	Extranodal sites	HA8420	NUMBER OF EXTRANODAL SITES CODE
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
	(R)IPI	HA8450	(R)IPI INDEX for DLBCL SCORE
Other Lymphomas	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor stage date	HA8720	ANN ARBOR STAGE DATE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Splenic involvement	HA8680	ANN ARBOR SPLENIC INVOLVEMENT
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	LDH	HA8350	LACTATE DEHYDROGENASE LEVEL
Hodgkin	Ann Arbor stage	HA8280	ANN ARBOR STAGE
	Ann Arbor stage date	HA8720	ANN ARBOR STAGE DATE
	Ann Arbor symptoms	HA8290	ANN ARBOR SYMPTOMS
	Ann Arbor extranodality	HA8300	ANN ARBOR EXTRANODALITY
	Ann Arbor Bulk	HA8310	ANN ARBOR BULK
	Splenic involvement	HA8680	ANN ARBOR SPLENIC INVOLVEMENT
	Primary Extranodal Site	HA8330	PRIMARY EXTRANODAL SITE
	Hb	HA8100	BLOOD HAEMOGLOBIN CONCENTRATION
	Albumin	HA8550	ALBUMIN LEVEL
	WBC	HA8150	WHITE BLOOD CELL COUNT (HIGHEST PRE TREATMENT)
	Lymphocytes	HA8660	BLOOD LYMPHOCTYE COUNT
	Hasenclever index	HA8670	HASENCLEVER INDEX

7.2 HAEMATOLOGY – LABORATORY RESULTS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8030	HAEMATOLOGY - LABORATORY RESULTS - CML, CLL, MYELODYSPLASIA	**PLATELET COUNT** *[PLATELETS COUNT]*	max n4	R
HA8150	HAEMATOLOGY - LABORATORY RESULTS - AML, ALL, HODGKIN	**WHITE BLOOD CELL COUNT *(HIGHEST PRETREATMENT)***	max n3.n1	R
HA8100	HAEMATOLOGY - LABORATORY RESULTS - CLL, MYELODYSPLASIA, HODGKIN, FOLLICULAR	**BLOOD HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE)** *[HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE)]*	max n3	R
HA8110	HAEMATOLOGY - - LABORATORY RESULTS - MYELODYSPLASIA	**BONE MARROW KARYOTYPE** *[KARYOTYPE TEST OUTCOME]*	an1	R
HA8120	HAEMATOLOGY - LABORATORY RESULTS - MYELODYSPLASIA -	**BONE MARROW BLASTS PERCENTAGE** *[BONE MARROW BLAST CELLS PERCENTAGE (MYELODYSPLASIA)]*	max n2	R
HA8130	HAEMATOLOGY - LABORATORY RESULTS - MYELODYSPLASIA	**NEUTROPHIL COUNT**	max n3.n1	R
HA8550	HAEMATOLOGY - LABORATORY RESULTS - MYELOMA, HODGKIN	**ALBUMIN LEVEL**	n2	R
HA8540	HAEMATOLOGY - LABORATORY RESULTS - MYELOMA	**BETA2 MICROGLOBULIN LEVEL**	max n3.n1	R
HA8660	HAEMATOLOGY LABORATORY RESULTS - - HODGKIN	**BLOOD LYMPHOCYTE COUNT**	max n3.n1	R
HA8350	HAEMATOLOGY - LABORATORY RESULTS - FOLLICULAR, DLBCL, OTHER LYMPHOMAS	**LACTATE DEHYDROGENASE LEVEL**	an1	R
HA8040	HAEMATOLOGY - LABORATORY RESULTS -CML	**BLOOD MYELOBLASTS PERCENTAGE**	max n3	R
HA8050	HAEMATOLOGY - LABORATORY RESULTS - CML	**BLOOD BASOPHILS PERCENTAGE**	max n3	R
HA8060	HAEMATOLOGY - LABORATORY RESULTS - CML	**BLOOD EOSINOPHILS PERCENTAGE**	max n3	R
HA8160	HAEMATOLOGY - LABORATORY RESULTS - AML	**CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA)** *[CYTOGENETIC RISK CODE (ACUTE MYELOID LEUKAEMIA HAEMATOLOGY)]*	an1	R

PLATELET COUNT: Level of platelets in blood as n x 10^9 per litre, to be collected at diagnosis. Normally provided by Haematology lab before transfusion/treatment.

Range: 0 – 5000

WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT): Highest White blood cell count pre-treatment (x 10^9 per litre). Normally provided by Haematology lab before transfusion/treatment.

Range 0.0 to 999.9 (to 1dp)

BLOOD HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE): Blood haemoglobin concentration g/l.

Normally provided by Haematology lab before transfusion/treatment.

BONE MARROW KARYOTYPE: Karyotype of marrow sample as classified by MDT from laboratory result of sample taken pre-treatment. From Cytogenetics laboratory (maybe as part of integrated haematopathology report). Classification/coding may be done by the lab or the MDT.

Classify as:

- Good - if normal.-Y, del (5q), del (20q)
- Intermediate - if any other abnormalities
- Poor - if complex (more than 2 abnormalities) or chromosome7 abnormalities

G	Good
I	Intermediate
P	Poor
N	No result

BONE MARROW BLASTS PERCENTAGE: Blast cells in bone marrow aspirate as percentage of all nucleated cells. Normally taken from laboratory report on diagnostic bone marrow.

(%) Range 0 – 20

NEUTROPHIL COUNT: Blood neutrophil count n/dl. Normally provided by Haematology lab before transfusion/treatment.

Range 0.0 to 999.9 (to 1dp)

Range 10 to 80

ALBUMIN LEVEL: Level in serum of albumin as g per litre measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

BETA2 MICROGLOBULIN LEVEL: Level in serum of beta 2 microglobulin as mg per litre measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

The range has been increased on clinical advice to 0.0 to 999.9 (to 1dp)

BLOOD LYMPHOCYTE COUNT: Number of lymphocytes in blood measured pre-treatment. Normally provided by Haematology lab before transfusion/treatment.

The range has been increased on clinical advice to 0.0 to 999.9 (to 1dp)

LACTATE DEHYDROGENASE LEVEL: Lactate Dehydrogenase level in serum measured pre-treatment. Normally provided from Biochemistry laboratory before treatment.

A	Above normal
B	Not above normal
9	Test not done

BLOOD MYELOBLASTS PERCENTAGE: Myeloblasts as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0-100

BLOOD BASOPHILS PERCENTAGE: Basophils as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0 – 100

BLOOD EOSINOPHILS PERCENTAGE: Eosinophils as percentage of total white cells. Normally provided by Haematology lab before transfusion/treatment.

(% Range) 0 – 100

CYTOGENETIC GROUP (ACUTE MYELOID LEUKAEMIA): Cytogenetic analysis of bone marrow (preferably) or blood sample. From Cytogenetics laboratory (maybe as part of integrated haematopathology report). Classification/coding may be done by the lab or the MDT.

Classify as:

- Favourable - if t(8;21), t(15;17), inv(16) irrespective of other abnormalities;
- Adverse - if monosomy 5, monosomy 7, del (5q), abnormality of 3q, more than 4 abnormalities;
- Intermediate - if any other abnormality, or normal karyotype.

F	Favourable
A	Adverse
I	Intermediate
N	No result

Note: "No Result" includes "Test not done"

7.3 HAEMATOLOGY – CANCER CARE PLAN – VARIOUS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8320	HAEMATOLOGY - FOLLICULAR	**NUMBER OF ABNORMAL NODAL AREAS**	max n2	R
HA8330	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL, OTHER LYMPHOMAS, HODGKIN	**PRIMARY EXTRANODAL SITE**	an2	R
HA8420	HAEMATOLOGY - CANCER CARE PLAN - DLBCL	**NUMBER OF EXTRANODAL SITES CODE**	an1	R

NUMBER OF ABNORMAL NODAL AREAS: Number of abnormal nodal areas detected clinically and radiologically.

PRIMARY EXTRANODAL SITE: Site of origin of lymphoma if believed to be outside lymph nodes as agreed by MDT based on clinical and radiological findings.

01	Blood
02	Bone
03	CNS
04	GIT
05	GU
06	Liver
07	Marrow
08	Muscle
09	Orbit
10	Pericardium
11	Pulmonary
12	Salivary gland
13	Skin
14	Thyroid
15	Other

NUMBER OF EXTRANODAL SITES CODE: Number of sites with Lymphoma outside lymph nodes (clinical assessment).

0	0
1	1
2	More than 1

7.3.1 HAEMATOLOGY – CANCER CARE PLAN – CHRONIC MYELOID LEUKAEMIA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8000	HAEMATOLOGY - CANCER CARE PLAN - CML	**SPLEEN CM BELOW COSTAL MARGIN**	max n2	R
HA8010	HAEMATOLOGY - CANCER CARE PLAN - CML	**SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA)** *[CHRONIC MYELOID LEUKAEMIA INDEX SCORE (SOKAL)]*	n1.n1	R

SPLEEN CM BELOW COSTAL MARGIN: Maximum distance from the costal margin in centimetres. Measured (not estimated) by person examining patient.

Range 0 - 50 (cm)

SOKAL INDEX (CHRONIC MYELOID LEUKAEMIA): Index derived from age, spleen size, platelet count, myeloblasts %.

$$e^{\left(0.0116(Age\ [in\ years]-43.4)+0.0345(Spleen\ [size\ in\ cm\ below\ costal\ region]-7.51)+0.188\left(\left(\frac{Platelets\ [*10^9/L]}{700}\right)^2-0.563\right)+0.0877(blasts\ [\%]-2.1)\right)}$$

Note: ***HASFORD INDEX (CHRONIC MYELOID LEUKAEMIA)****: has now been retired on the advice of the SSCRG*

7.3.2 HAEMATOLOGY – CANCER CARE PLAN – MYELODYSPLASIA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8080	HAEMATOLOGY - CANCER CARE PLAN - MYELODYSPLASIA	**IPSS (MYELODYSPLASIA)** *[INTERNATIONAL PROGNOSTIC SCORING SYSTEM SCORE]*	n1.n1	R

IPSS (MYELODYSPLASIA): INTERNATIONAL PROGNOSTIC SCORING SYSTEM for myelodysplasia. Index derived from BM blasts %, Karyotype, Platelet count, Hb, Neutrophils

- Score 0 for BM Blasts % less than 5, 0.5 for 5-10, 1.5 for 11-20.
- Score 0 for Karyotype Good, 0.5 for Intermediate, 1 for Poor.
- Score 0 for 0/1 cytopenias, 0.5 for 2/3 cytopenias.
- (Cytopenia Yes if Platelet count less than 100 and Haemoglobin less than 100 and Neutrophils less than 1.8)
- Score range 0 to 3.0

The use of IPSS will be reviewed in light of the recently published IPSS- R scoring system. IPSS as described above will be retained until any changes are agreed.

7.3.3 HAEMATOLOGY – CANCER CARE PLAN – CHRONIC LYMPHOCYTIC LEUKAEMIA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8200	HAEMATOLOGY - CANCER CARE PLAN - CLL	**HEPATOMEGALY INDICATOR**	an1	R
HA8210	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**SPLENOMEGALY INDICATOR**	an1	R
HA8220	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**NUMBER OF LYMPHADENOPATHY AREAS**	n1	R

HEPATOMEGALY INDICATOR: Liver enlargement identified from clinical examination.

Y	Yes
N	No

SPLENOMEGALY INDICATOR: Spleen enlargement identified from clinical examination.

Y	Yes
N	No

NUMBER OF LYMPHADENOPATHY AREAS: Number of enlarged lymph node areas (neck, axilla, groins) identified from clinical assessment.

Range 0-3

7.3.4 HAEMATOLOGY – CANCER CARE PLAN – FOLLICULAR LYMPHOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8360	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR	**FLIPI INDEX SCORE** *[FOLLICULAR LYMPHOMA INTERNATIONAL PROGNOSTIC INDEX SCORE]*	n1	R

FLIPI INDEX SCORE: Follicular Lymphoma International Prognostic Index Score (FLIPI), derived from age, Hb, number of nodal areas, LDH, Ann Arbor stage.

Score 1 for age >60 years, Hb < 120 g/l, more than 4 nodal areas, LDH above normal, Stage III or IV.

Range 0 - 5

7.3.5 HAEMATOLOGY – CANCER CARE PLAN – DIFFUSE LARGE B CELL LYMPHOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8450	HAEMATOLOGY - CANCER CARE PLAN - DLBCL	**(R)IPI INDEX for DLBCL SCORE** *[REVISED INTERNATIONAL PROGNOSTIC INDEX SCORE]*	n1	R

(R)IPI INDEX for DLBCL SCORE: Revised International Prognostic Index Score, derived from Age, performance status, LDH, extranodal sites, Ann Arbor Stage.

Score 1 for each of age >60, PS ≥ 2, LDH above Normal, >1 extranodal site, stage III or IV.

Range 0 – 5

Either (R)IPI or IPI may currently be used as prognostic indicators. However the scores calculated as above apply to both indices and can be grouped to provide either the IPI or the (R)IPI Groupings.

7.3.6 HAEMATOLOGY – CANCER CARE PLAN – HODGKIN LYMPHOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8670	HAEMATOLOGY - CANCER CARE PLAN - HODGKIN	**HASENCLEVER INDEX** *[HASENCLEVER INDEX SCORE]*	n1	M

HASENCLEVER INDEX: Index derived from age, gender, Hb, Albumin, white blood count, Lymphocyte count, Ann Arbor stage. (Score 1 for each of Age >44, Male gender, Hb<105, Albumin <40, White blood count >14.9, Lymphocyte count<0.6 (or Lymphocyte percentage of white blood cells <8%), Ann Arbor Stage IV)

Note: Hasenclever Index is only required for lymphomas with Ann Arbor Stage 3 or 4.

Range 0-7

7.3.7 HAEMATOLOGY – CANCER CARE PLAN – ACUTE LYMPHOBLASTIC LEUKAEMIA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item – Extramedullary Disease				
HA8270	HAEMATOLOGY - CANCER CARE PLAN - ACUTE LYMPHOBLASTIC LEUKAEMIA	**EXTRAMEDULLARY DISEASE** *[EXTRAMEDULLARY DISEASE SITE]*	an1	R
End of repeating item - Extramedullary Disease				

EXTRAMEDULLARY DISEASE: Site/s of disease identified outside bone marrow, including presence of blasts within CFS

(More than one option can be recorded)

~~T~~	~~Testes~~
~~C~~	~~CNS~~
~~O~~	~~Other~~
1	CNS1 (Without Blasts)
2	CNS2 (< 5 WBC in the CSF with blasts)
3	CNS3 (≥5 WBC in the CSF with blasts)
4	Testes
9	Other

7.4 HAEMATOLOGY – STAGING – ANN ARBOR

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet

for your tumour type[25] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[26].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8280	HAEMATOLOGY - STAGING - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR STAGE**	an1	R
HA8720	HAEMATOLOGY - STAGING - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR STAGE DATE**	an10 ccyy-mm-dd	R
HA8290	HAEMATOLOGY - STAGING - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR SYMPTOMS** *[ANN ARBOR SYMPTOMS INDICATION CODE]*	an1	R
HA8300	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR EXTRANODALITY** *[ANN ARBOR EXTRANODALITY INDICATION CODE]*	an1	R
HA8310	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR BULK** *[ANN ARBOR BULKY DISEASE INDICATION CODE]*	an1	R
HA8680	HAEMATOLOGY - CANCER CARE PLAN - FOLLICULAR, DLBCL OTHER LYMPHOMAS, HODGKIN	**ANN ARBOR SPLENIC INVOLVEMENT** *[ANN ARBOR SPENIC INDICATION CODE]*	an1	R

ANN ARBOR STAGE: Staging based on location of detected disease.

1	I = One region of lymph nodes, or spleen or thymus or Waldeyer's ring enlarged
2	II = 2 regions of lymph nodes enlarged, on same side of diaphragm
3	III = lymph nodes enlarged on both sides of diaphragm
4	IV = disease outside lymph nodes e.g. liver, bone marrow

ANN ARBOR STAGE DATE: The date on which the Ann Arbor Stage was recorded.

ANN ARBOR SYMPTOMS: Additional stage designation based on presence or absence of specific symptoms.

A	No Symptoms
B	Presence of any of the following: unexplained persistent or recurrent fever (greater than 38°C / 101.5°F), drenching night sweats, unexplained weight loss of 10% or more within the last 6 months

[25] https://nww.cancerstats.nhs.uk/cosd/staging

[26] http://www.wileyanduicc.com/

ANN ARBOR EXTRANODALITY Additional staging designation based on extranodal involvement.

E	E (Extranodal involvement)
0	No Extranodal involvement)

For Primary Nodal lymphoma, code "E" if there is involvement of a single extranodal site by contiguous spread (i.e. directly adjoining) from the known nodal group.

For Primary Extranodal lymphoma, code “E” if there is a single extranodal lesion with or without lymphatic involvement in the draining area (e.g. a thyroid lymphoma with draining cervical lymph node involvement = “IIE”).

The designation of Stage 4 for nodal disease implies disseminated disease involving (distant) extranodal sites.

Multiple extranodal deposits should be considered Stage IV and “E” should not be used.

However, by convention, involvement of the bone marrow, liver, lung, pleura and CSF are always considered Stage 4 even if the disease is isolated to that organ.

ANN ARBOR BULK: Additional staging designation based on presence of bulky disease. Code “X” if there is presence of “bulky” disease, that is, a nodal mass whose greatest dimension is more than 10 centimetres in size, and/or a widening of the mediastinum (middle chest) by more than one-third.

X	X (“Bulky” disease present)
0	No “bulky” disease present)

ANN ARBOR SPLENIC INVOLVMENT: Additional staging designation based on splenomegaly or normal spleen size with confirmed disease involvement.

Code "S" if either is true

S	Spleen involvement or spenomegaly
0	No spleen involvement or splenomegaly

7.4 HAEMATOLOGY – STAGING – CLL

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8240	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**BINET STAGE**	an1	R
HA8700	HAEMATOLOGY -- CANCER CARE PLAN - CLL	**BINET STAGE DATE**	an10 ccyy-mm-dd	R

BINET STAGE: Applicable to Chronic Lymphocytic Leukaemia

Prognostic index derived from platelet count, Hb, lymphadenopathy, hepatomegaly, and splenomegaly. Note that immune cytopenias are not included when calculating the Stage (i.e. if Platelet count is below 100 and/or Haemoglobin levels are below 110 as a result of immune cytopenia). Also please see note on calculations below.*

(Rai Stage and Binet Stage “both solely rely on physical examination and standard laboratory tests, and do not require ultrasound, computed tomography, or magnetic resonance imaging.” http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2972576/?tool=pubmed)

A	Stage A: if Platelet count > 99 and Hb >99 and 0, 1or 2 areas of organ enlargement (number of lymph node groups plus score 1 for hepatomegaly, 1 for splenomegaly)
B	Stage B: if Platelet count> 99 and Hb>99 and 3, 4 or 5 areas of organ enlargement
C	Stage C: if Hb<100 or platelet count <100

BINET STAGE DATE: The date on which the Binet Stage was recorded.

Notes on Rai Stage and Binet Stage calculations:

"Platelet count >99" is more fully described as "Platelet count > 99 x 10^9/L"

"Hb >109" is more fully described as "Hb >109 g/L"

Note: ***RAI STAGE & RAI STAGE DATE*** *have both been retired on the advice of the SSCRG*

7.4 HAEMATOLOGY – STAGING – MYELOMA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HA8560	HAEMATOLOGY - CANCER CARE PLAN - MYELOMA	**ISS STAGE for MYELOMA** *[MYELOMA INTERNATIONAL STAGING SYSTEM STAGE]*	an1	R
HA8710	HAEMATOLOGY - CANCER CARE PLAN - MYELOMA	**ISS STAGE for MYELOMA DATE** *[MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE]*	an10 ccyy-mm-dd	R

ISS STAGE for MYELOMA: International Staging System for Myeloma derived from Beta2 Microglobulin and Albumin lab results.

1	Stage 1: Beta 2 M less than 3.5 and Albumin greater than 34
2	Stage 2: Beta 2 M less than 3.5 and albumin less than 35, OR Beta 2 M 3.5 - 5.5
3	Stage 3: Beta 2 M greater than 5.5

ISS STAGE for MYELOMA DATE: The date on which the ISS Stage was recorded.

8. HEAD and NECK

OVERVIEW

In the first phase of implementing the COSD, the site specific Head and Neck data items will be collected once pre-treatment and at least once post treatment. The assessment information should be recorded 12 months post diagnosis as a minimum, and annually thereafter, if possible.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0	External upper lip	Head and Neck		●		
C00.1	External lower lip	Head and Neck		●		
C00.2	External lip, unspecified	Head and Neck		●		
C00.3	Upper lip, inner aspect	Head and Neck	●			
C00.4	Lower lip, inner aspect	Head and Neck	●			
C00.5	Lip, unspecified, inner aspect	Head and Neck	●			
C00.6	Commissure of lip	Head and Neck	●			
C00.8	Overlapping lesion of lip	Head and Neck	●			
C00.9	Lip, unspecified	Head and Neck	●			
C01	Malignant neoplasm of base of tongue	Head and Neck	●			
C02.0	Dorsal surface of tongue	Head and Neck	●			
C02.1	Border of tongue	Head and Neck	●			
C02.2	Ventral surface of tongue	Head and Neck	●			
C02.3	Anterior two-thirds of tongue, part unspecified	Head and Neck	●			
C02.4	Lingual tonsil	Head and Neck	●			
C02.8	Overlapping lesion of tongue	Head and Neck	●			
C02.9	Tongue, unspecified	Head and Neck	●			

C03.0	Upper gum	Head and Neck	●			
C03.1	Lower gum	Head and Neck	●			
C03.9	Gum, unspecified	Head and Neck	●			
C04.0	Anterior floor of mouth	Head and Neck	●			
C04.1	Lateral floor of mouth	Head and Neck	●			
C04.8	Overlapping lesion of floor of mouth	Head and Neck	●			
C04.9	Floor of mouth, unspecified	Head and Neck	●			
C05.0	Hard palate	Head and Neck	●			
C05.1	Soft palate	Head and Neck	●			
C05.2	Uvula	Head and Neck	●			
C05.8	Overlapping lesion of palate	Head and Neck	●			
C05.9	Palate, unspecified	Head and Neck	●			
C06.0	Cheek mucosa	Head and Neck	●			
C06.1	Vestibule of mouth	Head and Neck	●			
C06.2	Retromolar area	Head and Neck	●			
C06.8	Overlapping lesion of other and unspecified parts of mouth	Head and Neck	●			
C06.9	Mouth, unspecified	Head and Neck	●			
C07	Malignant neoplasm of parotid gland	Head and Neck	●			
C08.0	Submandibular gland	Head and Neck	●			
C08.1	Sublingual gland	Head and Neck	●			
C08.8	Overlapping lesion of major salivary glands	Head and Neck	●			
C08.9	Major salivary gland, unspecified	Head and Neck	●			
C09.0	Tonsillar fossa	Head and Neck	●			
C09.1	Tonsillar pillar (anterior) (posterior)	Head and Neck	●			
C09.8	Overlapping lesion of tonsil	Head and Neck	●			
C09.9	Tonsil, unspecified	Head and Neck	●			
C10.0	Vallecula	Head and Neck	●			
C10.1	Anterior surface of epiglottis	Head and Neck	●			

C10.2	Lateral wall of oropharynx	Head and Neck	●			
C10.3	Posterior wall of oropharynx	Head and Neck	●			
C10.4	Branchial cleft	Head and Neck	●			
C10.8	Overlapping lesion of oropharynx	Head and Neck	●			
C10.9	Oropharynx, unspecified	Head and Neck	●			
C11.0	Superior wall of nasopharynx	Head and Neck	●			
C11.1	Posterior wall of nasopharynx	Head and Neck	●			
C11.2	Lateral wall of nasopharynx	Head and Neck	●			
C11.3	Anterior wall of nasopharynx	Head and Neck	●			
C11.8	Overlapping lesion of nasopharynx	Head and Neck	●			
C11.9	Nasopharynx, unspecified	Head and Neck	●			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	●			
C13.0	Postcricoid region	Head and Neck	●			
C13.1	Aryepiglottic fold, hypopharyngeal aspect	Head and Neck	●			
C13.2	Posterior wall of hypopharynx	Head and Neck	●			
C13.8	Overlapping lesion of hypopharynx	Head and Neck	●			
C13.9	Hypopharynx, unspecified	Head and Neck	●			
C14.0	Pharynx, unspecified	Head and Neck	●			
C14.2	Waldeyer's ring	Head and Neck	●			
C14.8	Overlapping lesion of lip, oral cavity and pharynx	Head and Neck	●			
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C30.0	Nasal cavity	Head and Neck	●			
C30.1	Middle ear	Head and Neck	●			
C31.0	Maxillary sinus	Head and Neck	●			
C31.1	Ethmoidal sinus	Head and Neck	●			
C31.2	Frontal sinus	Head and Neck	●			

C31.3	Sphenoidal sinus	Head and Neck	●			
C31.8	Overlapping lesion of accessory sinuses	Head and Neck	●			
C31.9	Accessory sinus, unspecified	Head and Neck	●			
C32.0	Glottis	Head and Neck	●			
C32.1	Supraglottis	Head and Neck	●			
C32.2	Subglottis	Head and Neck	●			
C32.3	Laryngeal cartilage	Head and Neck	●			
C32.8	Overlapping lesion of larynx	Head and Neck	●			
C32.9	Larynx, unspecified	Head and Neck	●			
C73	Malignant neoplasm of thyroid gland	Head and Neck		●		
C77.0	Lymph nodes of head, face and neck	Head and Neck	●			Secondary - only use if unable to code to specific primary site
D00.0	Carcinoma in situ of Lip, oral cavity and pharynx	Head and Neck			●	
D02.0	Carcinoma in situ of Larynx	Head and Neck			●	
D09.3	carcinoma in situ of thyroid and other endocrine glands	Head and Neck			●	
D37.0	Neoplasm of uncertain or unknown behaviour of lip, oral cavity and pharynx	Head and Neck			●	
D38.0	Neoplasm of uncertain or unknown behaviour of Larynx	Head and Neck			●	
D44.0	Neoplasm of uncertain or unknown behaviour of thyroid gland	Head and Neck			●	

8.1 HEAD & NECK - PRE TREATMENT ASSESSMENT

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9060	HEAD & NECK - PRE TREATMENT ASSESSMENT	**CANCER DENTAL ASSESSMENT DATE**	an10 ccyy-mm-dd	R
HN9050	HEAD & NECK - PRE TREATMENT ASSESSMENT	**CARE CONTACT DATE (DIETICIAN INITIAL)**	an10 ccyy-mm-dd	R
HN9140	HEAD & NECK - PRE TREATMENT ASSESSMENT	**PLANNED POST-OPERATIVE COMMUNICATION METHOD** *[SURGICAL VOICE RESTORATION COMMUNICATION METHOD (PLANNED POST OPERATIVE)]*	an1	R

Note: ***DATE HEIGHT MEASURED:*** *has been retired and replaced with [CR6460]. This allows for the accurate date of observations to be applied across all patients as required.*

Note: ***PERSON HEIGHT IN METRES:*** *have been retired and replaced with [CR6430]. This allows for the accurate height to be applied across all patients as required, used in conjunction with [CR6460] this can be recorded Pre or Post treatment.*

Note ***DATE WEIGHT MEASURED****: has been retired and replaced with [CR6460]. This allows for the accurate date of observations to be applied across all patients as required.*

Note ***PERSON OBSERVATION (WEIGHT)****: have been retired and replaced with [CR6440]. This allows for the accurate weight to be applied across all patients as required, used in conjunction with [CR6460] this can be recorded Pre or Post treatment.*

CANCER DENTAL ASSESSMENT DATE: The date of the first dental assessment by a dentally qualified practitioner, which contributes to preparation for treatment. (This is a person who the Multi-Disciplinary Team considers suitably qualified to carry out the pre-treatment dental assessment of the patient).

CARE CONTACT DATE (DIETICIAN INITIAL): The date that the patient was first assessed by a dietician.

PLANNED POST-OPERATIVE COMMUNICATION METHOD: (Only applicable to head and neck cancer prior to laryngectomy). The patient's proposed method of communication following laryngectomy.

P	PSVR – Primary SVR
S	SSVR – Secondary SVR
E	E – Electrolarynx
O	O – Oesophageal voice
M	M – Mouthing
W	W – Writing or AAC aid
9	9 – Not known

8.2 HEAD & NECK – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[27] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[28].

[27] https://nww.cancerstats.nhs.uk/cosd/staging

[28] http://www.wileyanduicc.com/

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

8.3 HEAD & NECK – POST TREATMENT ASSESSMENT

This section can be recorded more than once. The assessment information should be recorded 12 months post diagnosis as a minimum, and annually thereafter, if possible.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9000	HEAD & NECK - POST TREATMENT ASSESSMENT	**CLINICAL STATUS ASSESSMENT DATE (CANCER)**	an10 ccyy-mm-dd	R
HN9010	HEAD & NECK - POST TREATMENT ASSESSMENT	**PRIMARY TUMOUR STATUS**	an1	R
HN9020	HEAD & NECK - POST TREATMENT ASSESSMENT	**NODAL STATUS**	an1	R
HN9030	HEAD & NECK - POST TREATMENT ASSESSMENT	**METASTATIC STATUS**	an1	R
HN9150	HEAD & NECK - POST TREATMENT ASSESSMENT	**SVR COMMUNICATION PRIMARY METHOD** *[SURGICAL VOICE RESTORATION COMMUNICATION METHOD (PRIMARY)]*	an1	R
HN9080	HEAD & NECK - POST TREATMENT ASSESSMENT	**SPEECH & LANGUAGE ASSESSMENT DATE** *[SPEECH AND LANGUAGE ASSESSMENT DATE]*	an10 ccyy-mm-dd	R

CLINICAL STATUS ASSESSMENT DATE (CANCER): The date on which a clinical assessment was performed.

Note: ***PERSON HEIGHT IN METRES:*** *have been retired and replaced with [CR6430]. This allows for the accurate height to be applied across all patients as required, used in conjunction with [CR6460] this can be recorded Pre or Post treatment.*

Note: ***PERSON OBSERVATION (WEIGHT)****: have been retired and replaced with [CR6440]. This allows for the accurate weight to be applied across all patients as required, used in conjunction with [CR6460] this can be recorded Pre or Post treatment.*

PRIMARY TUMOUR STATUS: The status of the primary tumour at this follow-up contact.

1	Residual primary tumour
2	No evidence of primary tumour
3	Recurrent primary tumour
4	Not assessed
5	Uncertain

NODAL STATUS: The status of the regional nodal metastases at this follow-up contact.

1	Residual regional nodal metastases
2	No evidence of regional nodal metastases
3	New regional nodal metastases
4	Not assessed
5	Uncertain

METASTATIC STATUS: The status of the distant metastases at this follow-up contact.

1	Residual distant metastases
2	No evidence of metastases
3	New distant metastases
4	Not assessed
5	Uncertain

SVR COMMUNICATION PRIMARY METHOD: (Only applicable to head and neck cancer following laryngectomy). The patient's primary method of communication at post-operative contact.

P	VP – Voice prosthesis professionally changed.
S	VS – Voice prosthesis self changed.
E	E – Electrolarynx
O	O – Oesophageal voice
M	M – Mouthing
W	W – Writing or AAC aid

SPEECH & LANGUAGE ASSESSMENT DATE: Record the date of contact where assessment swallowing occurs following completion of treatment. Whilst ideally data is entered at each contact after completion of treatment, key point of recording is at 6 months post cancer care plan agreed date. (Please note this is not the same data item as First SALT Contact Date which is included in the DAHNO dataset from November 2012).

9. LUNG

OVERVIEW

Some items in the Lung site specific dataset may not be available until sometime after the initial record has been uploaded. For surgery patients, treatment record and pathology details may be completed by a different Provider from the First Seen Provider.

Site specific data items have been aligned between the COSD and the National Lung Cancer Audit.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C33	Malignant neoplasm of trachea	Lung	●			
C34.0	Main bronchus	Lung	●			
C34.1	Upper lobe, bronchus or lung	Lung	●			
C34.2	Middle lobe, bronchus or lung	Lung	●			
C34.3	Lower lobe, bronchus or lung	Lung	●			
C34.8	Overlapping lesion of bronchus and lung	Lung	●			
C34.9	Bronchus or lung, unspecified	Lung	●			
C37	Malignant neoplasm of thymus	Lung	●			
C38.0	Heart	Lung		●		
C38.1	Anterior mediastinum	Lung		●		
C38.2	Posterior mediastinum	Lung		●		
C38.3	Mediastinum, part unspecified	Lung		●		
C38.4	Pleura	Lung		●		
C38.8	Overlapping lesion of heart, mediastinum and pleura	Lung		●		

C39.0	Upper respiratory tract, part unspecified	Lung		●		
C39.8	Overlapping lesion of respiratory and intrathoracic organs	Lung		●		
C39.9	Ill-defined sites within the respiratory system	Lung		●		
C45.0	Mesothelioma of pleura	Lung		●		
C45.1	Mesothelioma of peritoneum	Lung		●		
C45.2	Mesothelioma of pericardium	Lung		●		
C45.7	Mesothelioma of other sites	Lung		●		
C45.9	Mesothelioma, unspecified	Lung		●		
C78.0	Secondary malignant neoplasm of lung	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.1	Secondary malignant neoplasm of mediastinum	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.2	Secondary malignant neoplasm of pleura	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D02.1	Carcinoma in situ of Trachea	Lung			●	

D02.2	Carcinoma in situ of Bronchus and lung	Lung			●	
D02.3	Carcinoma in situ of Other parts of respiratory system	Lung			●	
D02.4	Carcinoma in situ of Respiratory system, unspecified	Lung			●	
D38.1	Neoplasm of uncertain or unknown behaviour of Trachea, bronchus and lung	Lung			●	
D38.2	Neoplasm of uncertain or unknown behaviour of Pleura	Lung			●	
D38.3	Neoplasm of uncertain or unknown behaviour of Mediastinum	Lung			●	
D38.4	Neoplasm of uncertain or unknown behaviour of Thymus	Lung			●	
D38.5	Neoplasm of uncertain or unknown behaviour of Other respiratory organs	Lung			●	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			●	

9.1 LUNG - DIAGNOSIS - National Lung Cancer Audit (NLCA)

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10300	LUNG - DIAGNOSIS - NLCA	**DIFFUSION CAPACITY (DLCO or TLCO) DATE** *[PROCEDURE DATE (DIFFUSION CAPACITY TEST)]*	an10 ccyy-mm-dd	R
LU10310	LUNG - DIAGNOSIS - NLCA	**DIFFUSION CAPACITY (DLCO or TLCO) RESULT** *[DIFFUSION CAPACITY TEST RESULT]*	Max n3	R

DIFFUSION CAPACITY (DLCO or TLCO) DATE: Date the Diffusion Capacity test (DLCO) or Transfer factor of the lungs for carbon monoxide (TLCO) was performed
DIFFUSION CAPACITY (DLCO or TLCO) RESULT: The Diffusion Capacity (DLCO) or Transfer factor of the lungs for carbon monoxide (TLCO) result (% predicted)

9.2 DIAGNOSIS – IMAGING - NLCA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10340	LUNG - IMAGING - NLCA	**TRANSTHORACIC ECHOCARDIOGRAM DATE** *[PROCEDURE DATE (TRANSTHORACIC ECHOCARDIOGRAM TEST)]*	an10 ccyy-mm-dd	R
LU10350	LUNG - IMAGING - NLCA	**TRANSTHORACIC ECHOCARDIOGRAM RESULT** *[TRANSTHORACIC ECHOCARDIOGRAM TEST RESULT]*	Max n3	R

TRANSTHORACIC ECHOCARDIOGRAM DATE: Date the Transthoracic Echocardiogram test was performed
TRANSTHORACIC ECHOCARDIOGRAM RESULT: The Transthoracic Echocardiogram left ventricular ejection fraction result (%)

9.2.1 LUNG – IMAGING CT & PET SCAN

Note ***PROCEDURE DATE (CT SCAN) & PROCEDURE DATE (PET CT SCAN):*** *[LU10000] & [LU10010] are all dates that can be inferred by using the date [CR0320] provided within the CORE - Imaging section and a combination of [CR1610] Imaging Code (NICIP) or [CR0330] Cancer Imaging Modality (C04X) PET Scan.*

Note: ***SCAN PERFORMED INDICATOR (CT) & SCAN PERFORMED INDICATOR (PET)*** *[LU10020] + [LU10030] are indicator codes agreed 4 years ago and should not be required now? This will prevent duplication and reduce the burden of data collection.*

9.3 LUNG – CANCER CARE PLAN

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10040	LUNG - CANCER CARE PLAN	**FEV1 PERCENTAGE** *[FORCED EXPIRATORY VOLUME IN 1 SECOND (PERCENTAGE)]*	max n3	R
LU10050	LUNG - CANCER CARE PLAN	**FEV1 ABSOLUTE VALUE** *[FORCED EXPIRATORY VOLUME IN 1 SECOND (ABSOLUTE AMOUNT)]*	n1.n2	R
LU10190	LUNG - CANCER CARE PLAN	**SMOKING STATUS** *[SMOKING STATUS CODE]*	an1	R
LU10060	LUNG - CANCER CARE PLAN	**MEDIASTINAL SAMPLING INDICATOR**	an1	R

FEV1 PERCENTAGE: The Forced Expiratory Volume in the first second as a percentage of the predicted value.
Must be an integer in the range of 1 to 150

FEV1 ABSOLUTE VALUE: The absolute value of the patient's Forced Expiratory Volume in the first second in litres.
Must be numeric in the range of 0.10 to 9.99.

SMOKING STATUS: Specify the current smoking status of the patient. This data item could be collected at presentation either in the outpatients or on the ward.

1	Current smoker
2	Ex-smoker
3	Non-smoker - history unknown
4	Never smoked
Z	Not Stated (PERSON asked but declined to provide a response)
9	Not known

MEDIASTINAL SAMPLING INDICATOR: Record if the patient had a mediastinoscopy, mediastinotomy, open mediastinal sampling or other type of mediastinal biopsy (e.g. Endobronchial ultrasound or transbronchial needle aspiration biopsy). This data item will be recorded by the specialist centres.

Y	Yes
N	No
9	Not known

9.4 LUNG – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[29] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[30].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

9.5 LUNG – SURGERY AND OTHER PROCEDURES – BRONCHOSCOPY

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10070	LUNG - BRONCHOSCOPY	**PROCEDURE DATE BRONCHOSCOPY** *[PROCEDURE DATE (BRONCHOSCOPY)]*	an10 ccyy-mm-dd	R
LU10080	LUNG - BRONCHOSCOPY	**BRONCHOSCOPY PERFORMED INDICATOR**	an1	R

PROCEDURE DATE BRONCHOSCOPY: Date bronchoscopy was performed which informed management of patient at time of MDT"

[29] https://nww.cancerstats.nhs.uk/cosd/staging

[30] http://www.wileyanduicc.com/

BRONCHOSCOPY PERFORMED INDICATOR: Was a bronchoscopy performed on this patient?

Y	Yes
N	No
9	Not known

9.5.1 LUNG – SURGERY AND OTHER PROCEDURES – NLCA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10360	LUNG - SURGERY AND OTHER PROCEDURES - NLCA	**CARDIOPULMONARY EXERCISE TEST DATE** *[PROCEDURE DATE (CARDIOPULMONARY EXERCISE TEST)]*	an10 ccyy-mm-dd	R
LU10420	LUNG - SURGERY AND OTHER PROCEDURES - LCCOP	**CARDIOPULMONARY TEST TYPE** *[CARDIOPULMONARY EXERCISE TEST TYPE]*	an1	R
LU10370	LUNG - SURGERY AND OTHER PROCEDURES - NLCA	**CARDIOPULMONARY EXERCISE TEST RESULT (NLCA)** *[CARDIOPULMONARY EXERCISE TEST RESULT]*	Max n3	R

CARDIOPULMONARY EXERCISE TEST DATE: Date the Cardiopulmonary Exercise test was performed

CARDIOPULMONARY TEST TYPE: Indicate which cardiopulmary test was used.

1	Incremental Shuttle Walk Test (ISWT)
2	Oxygen Consumption (VO2)

CARDIOPULMONARY EXERCISE TEST RESULT (NLCA): The Cardiopulmonary Exercise Test result (% predicted)

9.5.2 LUNG – SURGERY AND OTHER PROCEDURES – NLCA

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10390	LUNG - SURGERY AND OTHER PROCEDURES - LCCOP	**REGIONAL ANAESTHETIC TECHNIQUE** *[REGIONAL ANAESTHETIC TECHNIQUE (CANCER)]*	an1	R

REGIONAL ANAESTHETIC TECHNIQUE: Record the regional anaesthetic technique used on the patient.

1	Epidural
2	Paravertebral Catheter
3	Other Technique
4	No Regional Anaesthesia
9	Not Known

9.6 LUNG – BIOMARKERS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10090	LUNG - BIOMARKERS	**EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS**	an1	R

EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS: Epidermal Growth Factor Receptor Mutational Status. This would be available on the results report.

~~1~~	~~Wild type~~
~~2~~	~~Mutation~~
3	Failed analysis
4	Not assessed
5	Wild type/non-sensitising mutation
6	Sensitising/activating mutation

10. SARCOMA

OVERVIEW

Sarcomas can arise within any site of the body, and should have the ICD site code of that part of the body and the morphology code stated for Sarcoma.

The Cancer Waiting Times and COSD datasets have consistent inclusion criteria for sarcomas, although the COSD also includes C78.6 ("Secondary malignant neoplasm of retroperitoneum and peritoneum").

As much information as possible is required in order to accurately reflect the sarcoma subsite. For tumours coded under the C46 ICD-10 codes only the CORE dataset needs to be completed.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C40.0	Scapula and long bones of upper limb	Sarcoma	●			
C40.1	Short bones of upper limb	Sarcoma	●			
C40.2	Long bones of lower limb	Sarcoma	●			
C40.3	Short bones of lower limb	Sarcoma	●			
C40.8	Overlapping lesion of bone and articular cartilage of limbs	Sarcoma	●			
C40.9	Bone and articular cartilage of limb, unspecified	Sarcoma	●			
C41.0	Bones of skull and face	Sarcoma	●			
C41.1	Mandible	Sarcoma	●			
C41.2	Vertebral column	Sarcoma	●			
C41.3	Ribs, sternum and clavicle	Sarcoma	●			
C41.4	Pelvic bones, sacrum and coccyx	Sarcoma	●			
C41.8	Overlapping lesion of bone and articular cartilage	Sarcoma	●			

C41.9	Bone and articular cartilage, unspecified	Sarcoma	●			
C46.0	Kaposi sarcoma of skin	Sarcoma		●		
C46.1	Kaposi sarcoma of soft tissue	Sarcoma		●		
C46.2	Kaposi sarcoma of palate	Sarcoma		●		
C46.3	Kaposi sarcoma of lymph nodes	Sarcoma		●		
C46.7	Kaposi sarcoma of other sites	Sarcoma		●		
C46.8	Kaposi sarcoma of multiple organs	Sarcoma		●		
C46.9	Kaposi sarcoma, unspecified	Sarcoma		●		
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C48.0	*Retroperitoneum*	*Sarcoma*	●			*Usually treated by Sarcoma MDT.*

C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.8	Overlapping lesion of retroperitoneum and peritoneum	Sarcoma	●			
C49.0	Connective and soft tissue of head, face and neck	Sarcoma	●			
C49.1	Connective and soft tissue of upper limb, including shoulder	Sarcoma	●			
C49.2	Connective and soft tissue of lower limb, including hip	Sarcoma	●			
C49.3	Connective and soft tissue of thorax	Sarcoma	●			
C49.4	Connective and soft tissue of abdomen	Sarcoma	●			
C49.5	Connective and soft tissue of pelvis	Sarcoma	●			
C49.6	Connective and soft tissue of trunk, unspecified	Sarcoma	●			
C49.8	Overlapping lesion of connective and soft tissue	Sarcoma	●			
C49.9	Connective and soft tissue, unspecified	Sarcoma	●			
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. May be treated by Sarcoma MDT.*

C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.5	Secondary malignant neoplasm of bone and bone marrow	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D48.0	Neoplasm of uncertain or unknown behaviour of Bone and articular cartilage	Sarcoma			●	
D48.1	Neoplasm of uncertain or unknown behaviour of Connective and other soft tissue	Sarcoma			●	Only applicable for GISTs

10.1 SARCOMA – DIAGNOSIS

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11000	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SITE (BONE)**	an4	R
SA11010	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SUBSITE (BONE)**	an2	R
SA11080	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SITE (SOFT TISSUE)**	an4	R
SA11090	SARCOMA - DIAGNOSIS	**SARCOMA TUMOUR SUBSITE (SOFT TISSUE)**	an2	R
SA11025	SARCOMA - DIAGNOSIS	**MULTIFOCAL OR SYNCHRONOUS TUMOUR INDICATOR**	an1	R

SARCOMA TUMOUR SITE (BONE): Location of the bone sarcoma within the body as defined by OPCS4 code. This is (more specific than ICD10/ICDO3 sites).
Note: Other Z codes may be used if they are felt more appropriate.

Z639	Cranium
Z649	Face
Z659	Jaw
Z663	Cervical Spine
Z664	Thoracic Spine

Z665	Lumbar Spine
Z681	Clavicle
Z684	Glenoid
Z685	Scapula
Z699	Humerus
Z709	Radius
Z719	Ulna
Z724	Carpal
Z732	Metacarpal
Z733	Thumb
Z734	Finger
Z742	Sternum
Z746	Rib
Z751	Sacrum
Z753	Ileum
Z754	Ischium
Z755	Pubis
Z756	Acetabulum
Z757	Coccyx
Z769	Femur
Z779	Tibia
Z786	Fibula
Z787	Patella
Z799	Tarsus
Z802	Metatarsus
Z803	Great toe
Z804	Toe
Z928	Multiple

Note: Use Cranium (Z639) for instances of Sarcoma of the Skull.

SARCOMA TUMOUR SUBSITE (BONE): Sub-location of the bone sarcoma within the tumour site. This gives a more details location of the tumour and should be recorded by specialist centres treating the patient.

PR	Proximal
DS	Distal
DP	Diaphyseal (Middle)
TO	Total
OO	Other
NK	Not known

SARCOMA TUMOUR SITE (SOFT TISSUE): Location of the soft tissue sarcoma within the body as defined by OPCS4 code. This is (more specific than ICD10/ICDO3 sites).

Z272	Stomach
Z301	Liver
Z459	Uterus
Z533	Peritoneum
Z891	Shoulder
Z892	Upper Arm
Z893	Forearm
Z894	Hand
Z898	Specified Arm Region (to include wrist and elbow)

Z901	Buttock
Z903	Upper Leg (to include thigh)
Z904	Lower Leg (to include calf)
Z905	Foot
Z908	Specified leg region (to include groin, knee, ankle)
Z921	Head
Z923	Neck
Z924	Chest (to include Intrathoracic)
Z927	Trunk (to include upper and lower)
Z928	Multiple
Z929	Unknown

Note: Other Z codes may be used if they are felt more appropriate.

SARCOMA TUMOUR SUBSITE (SOFT TISSUE): Sub-location of the soft tissue sarcoma within the tumour site. This gives a more details location of the tumour and should be recorded by specialist centres treating the patient.

RP	Retroperitoneal (subsite of Z53.3)
IP	Intraperitoneal (subsite of Z53.3)
WR	Wrist (subsite of Z89.8)
EB	Elbow (subsite of Z89.8)
UT	Upper Trunk (subsite of Z92.7)
LT	Lower Trunk (subsite of Z92.7)
AD	Adductors (subsite of Z90.3 & Z90.4)
AN	Anterior (subsite of Z90.3 & Z90.4)
PO	Posterior (subsite of Z90.3 & Z90.4)
LA	Lateral (subsite of Z90.3 & Z90.4)
NK	Not Known (No record or Test not carried out)
NA	Not Applicable

MULTIFOCAL OR SYNCHRONOUS TUMOUR INDICATOR: An indicator of the presence of tumours at multiple sites arising synchronously/concurrently.

Y	Yes
N	No
9	Not known

10.2 SARCOMA – STAGE

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[31] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[32].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

[31] https://nww.cancerstats.nhs.uk/cosd/staging

[32] http://www.wileyanduicc.com/

11. SKIN

OVERVIEW

Where applicable, the **AJCC STAGE GROUP**, not the UICC **TNM Stage Grouping**, should be collected for stageable skin cancers. Therefore the TNM stage fields which are included in the core dataset are not generally applicable for skin cancers (although basic TNM for skin cancer will still be included in Histopathology Reports.) Please see section 11.1 SKIN – STAGING for further information on how to record AJCC Stage Group.

For Melanomas the full Core and Site Specific datasets must be submitted.

For SCCs and BCCs which require MDT discussion, the full Core and Site Specific datasets must be submitted.

For other non-melanoma* cases which require MDT discussion, only the Core dataset should be submitted. (Where stage is applicable for these cases (e.g. Merkel Cell tumours and Adnexal carcinomas) the AJCC Stage Group should also be recorded as specified in Section 11.3).

For all skin cancers that do not require MDT discussion, the minimum requirement is for the pathology report to be submitted. For skin cancers that do require MDT discussion it is acceptable for the pathology stage to be taken to be the integrated stage when submitting COSD. Providers are encouraged to submit more complete datasets if possible.

Grade of Differentiation is not applicable for skin cancers other than SCC and therefore the two core dataset items, **GRADE OF DIFFERENTIATION (AT DIAGNOSIS)** and **GRADE OF DIFFERENTIATION (PATHOLOGICAL)** are not applicable for Melanoma, BCCs or Merkel Cell tumours.

For **PATHOLOGY INVESTIGATION TYPE,** which is a Core dataset item, the following site specific values should be used for skin: Curettage, Shave Biopsy, Punch Biopsy, Incisional Biopsy and Excision.

*Note: Non-melanoma skin cancers include:

- BCC
- SCC
- Merkel Cell tumours
- Adnexal (primary malignant adnexal carcinomas of eccrine, apocrine, follicular and sebaceous subtypes)
- Other NMSC

For **EXCISION MARGIN** which is a Core dataset item the following site specific values have been added for use where applicable for skin cases:

07	Margin not involved (equal to or greater than 1mm)
08	Margin not involved (less than 1mm)
09	Margin not involved (1 to 5 mm)

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	

C43.0	Malignant melanoma of lip	Skin	●			
C43.1	Malignant melanoma of eyelid, including canthus	Skin	●			
C43.2	Malignant melanoma of ear and external auricular canal	Skin	●			
C43.3	Malignant melanoma of other and unspecified parts of face	Skin	●			
C43.4	Malignant melanoma of scalp and neck	Skin	●			
C43.5	Malignant melanoma of trunk	Skin	●			
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	●			
C43.7	Malignant melanoma of lower limb, including hip	Skin	●			
C43.8	Overlapping malignant melanoma of skin	Skin	●			
C43.9	Malignant melanoma of skin, unspecified	Skin	●			
C44.0	Skin of lip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.1	Skin of eyelid, including canthus	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

C44.2	Skin of ear and external auricular canal	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.3	Skin of other and unspecified parts of face	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.4	Skin of scalp and neck	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.5	Skin of trunk	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.6	Skin of upper limb, including shoulder	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

C44.7	Skin of lower limb, including hip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.8	Overlapping lesion of skin	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.9	Malignant neoplasm of skin, unspecified	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C51.0	*Labium majus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.1	*Labium minus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*

C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C79.2	Secondary malignant neoplasm of skin	Skin		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D03.0	Melanoma in situ of lip	Skin		●		
D03.1	Melanoma in situ of eyelid, including canthus	Skin		●		
D03.2	Melanoma in situ, of ear and external auricular canal	Skin		●		
D03.3	Melanoma in situ of other and unspecified parts of face	Skin		●		
D03.4	Melanoma in situ of scalp and neck	Skin		●		
D03.5	Melanoma in situ of trunk	Skin		●		
D03.6	Melanoma in situ of upper limb, including shoulder	Skin		●		
D03.7	Melanoma in situ of lower limb, including hip	Skin		●		
D03.9	Melanoma in situ, unspecified	Skin		●		
D48.5	Neoplasm of uncertain or unknown behaviour of Skin	Skin			●	

Note: ***Malignant neoplasm of the anus should be coded as:***

- ***Margin (C43.5, C44.5)***
- ***Skin (C43.5, C44.5)***
- ***Perianal skin (C43.5, C44.5)***

11.1 SKIN – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[33] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[34].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

Note: ***TNM stage fields in the Core dataset will not be completed for skin cancers. For Melanoma, SCC and BCC the AJCC Stage Group (7th Edition) is included in the site specific dataset. For other skin cancers (e.g. Merkel Cell tumours and Adnexal carcinomas) the AJCC Stage Group field is the only site specific item that needs to be recorded in addition to the Core dataset.***

This section will be recorded once.*

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12510	SKIN - STAGING	**AJCC STAGE GROUP** *[AMERICAN JOINT COMMITTEE ON CANCER STAGE]*	max an4	R
SK12670	SKIN - STAGING	**AJCC STAGE GROUP DATE** *[AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE]*	an10 ccyy-mm-dd	R

AJCC STAGE GROUP*:*: American Joint Committee on Cancer staging of tumour at diagnosis. This is the final integrated stage as agreed by MDT.

Note: ***The dataset has also changed in that you can now record the stage without a prescriptive list, which may be out-of-date before the next COSD edition is released.***

AJCC STAGE GROUP DATE*: The date on which the AJCC Stage was recorded.

Note: ***AJCC Stage Group to be recorded for all skin cancers where applicable. The remaining site specific fields are only currently applicable for Melanoma, SCC and BCC.***

11.2 SKIN - DIAGNOSIS - BCC, SCC & MM

One occurrence of this data group is permitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12030	SKIN - DIAGNOSIS - BCC, SCC & MM	**CLINICAL DIAGNOSIS (PRE-HISTOLOGICAL RESULT - SKIN)** *[SKIN CANCER LESION DIAGNOSIS]*	an2	R

CLINICAL DIAGNOSIS (PRE-HISTOLOGICAL RESULT - SKIN): What is the clinical diagnosis of the patient's lesion/rash.

01	BCC

[33] https://nww.cancerstats.nhs.uk/cosd/staging

[34] http://www.wileyanduicc.com/

02	SCC
03	MELANOMA
04	ATYPICAL MOLE
05	Melanocytic tumour (atypical tumour of unknown malignant potential)
06	OTHER
99	Not Known

11.2.1 SKIN - DIAGNOSIS – MM

This is a combination of New and Moved data items, as agreed with and/or requested by the SSCRG

One occurrence of this data group is permitted

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12710	SKIN - DIAGNOSIS - MM	**SENTINEL NODE BIOPSY** *[SENTINEL LYMPH NODE BIOPSY PERFORMED INDICATOR]*	an1	R
SK12720	SKIN - DIAGNOSIS - MM	**SENTINEL NODE BIOPSY DATE** *[PROCEDURE DATE (SENTINEL LYMPH NODE BIOPSY)]*	an10 ccyy-mm-dd	R
SK12730	SKIN - DIAGNOSIS - MM	**ORGANISATION SITE CODE OF REPORTING LABORATORY** *[ORGANISATION CODE (REPORTING LABORATORY)]*	min an3 max an5	R
SK12740	SKIN - DIAGNOSIS - MM	**SENTINEL NODE BIOPSY OUTCOME** *[SENTINEL LYMPH NODE BIOPSY OUTCOME]*	an1	R
SK12450	SKIN - DIAGNOSIS - MM	**FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION**	max n2.max n2	R

SENTINEL NODE BIOPSY: Has the patient had a Sentinel Node Biopsy Performed.

Y	Yes
N	No
9	Not Known

SENTINEL NODE BIOPSY DATE: The date on which the Sentinel Node Biopsy Performed.

ORGANISATION SITE CODE OF REPORTING LABORATORY: This is the ORGANISATION SITE CODE of the ORGANISATION where the reporting laboratory is based

SENTINEL NODE BIOPSY OUTCOME: Record the outcome of the Sentinel Node Biopsy.

P	Positive
N	Negative

FINAL EXCISION MARGIN AFTER WIDE LOCAL EXCISION: Record the final margin of excision after wide local excision procedure. This is an amalgamation of clinical and histopathological data.

11.2 SKIN - SURGERY AND OTHER PROCEDURES - BCC, SCC & MM

This is a combination of New and Moved data items, as agreed with and/or requested by the SSCRG

One occurrence of this data group is permitted.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12010	SKIN - SURGERY AND OTHER PROCEDURES - BCC, SCC & MM	**GRADE OF CLINICIAN/SURGEON OPERATING** *[CARE PROFESSIONAL OPERATING SURGEON TYPE (CANCER)]*	Max an3	R
SK12700	SKIN - SURGERY AND OTHER PROCEDURES - BCC, SCC & MM	**MEMBER OF SPECIALIST MDT** *[MEMBER OF SPECIALIST MULTIDISCIPLINARY TEAM INDICATOR]*	an1	R

GRADE OF CLINICIAN/SURGEON OPERATING: This is the level of training reached of the actual operating Clinician or Surgeon, and not necessarily the responsible Clinician.

NU	NURSE
TS	TRAINEE SPECIALIST DOCTOR
CS	CONSULTANT SURGEON (other than Plastic Surgeon)
CD	CONSULTANT DERMATOLOGIST
CPS	CONSULTANT PLASTIC SURGEON
HP	HOSPITAL PRACTITIONER
SI	GP WITH SPECIAL INTEREST
GP	GENERAL PRACTITIONER
OO	OTHER CARE PROFESSIONAL

MEMBER OF SPECIALIST MDT: Is the actual operating Clinician or Surgeon a member of the Specialist MDT?

Y	Yes
N	No
9	Not Known

12. UPPER GI

OVERVIEW

ICD-10 codes C17.1, C17.2, C17.3, C17.8 and C17.9 are grouped under Upper GI for Cancer Waits but are excluded from the COSD Upper GI dataset. For diseases coded under C17.1, C17.2, C17.3, C17.8 and C17.9 only the CORE dataset needs to be completed.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C15.1	Thoracic part of oesophagus	Upper Gastrointestinal	●			
C15.2	Abdominal part of oesophagus	Upper Gastrointestinal	●			
C15.3	Upper third of oesophagus	Upper Gastrointestinal	●			
C15.4	Middle third of oesophagus	Upper Gastrointestinal	●			
C15.5	Lower third of oesophagus	Upper Gastrointestinal	●			
C15.8	Overlapping lesion of oesophagus	Upper Gastrointestinal	●			
C15.9	Oesophagus, unspecified	Upper Gastrointestinal	●			
C16.0	Cardia	Upper Gastrointestinal	●			
C16.1	Fundus of stomach	Upper Gastrointestinal	●			
C16.2	Body of stomach	Upper Gastrointestinal	●			
C16.3	Pyloric antrum	Upper Gastrointestinal	●			
C16.4	Pylorus	Upper Gastrointestinal	●			
C16.5	Lesser curvature of stomach, unspecified	Upper Gastrointestinal	●			

C16.6	Greater curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.8	Overlapping lesion of stomach	Upper Gastrointestinal	●			
C16.9	Stomach, unspecified	Upper Gastrointestinal	●			
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C22.0	Liver cell carcinoma	Upper Gastrointestinal	●			Liver cell carcinoma is also known as HCC.
C22.1	Intrahepatic bile duct carcinoma	Upper Gastrointestinal	●			
C22.2	Hepatoblastoma	Upper Gastrointestinal	●			
C22.3	Angiosarcoma of liver	Upper Gastrointestinal	●			
C22.4	Other sarcomas of liver	Upper Gastrointestinal	●			
C22.7	Other specified carcinomas of liver	Upper Gastrointestinal	●			
C22.9	Liver, unspecified	Upper Gastrointestinal	●			
C23	Malignant neoplasm of gallbladder	Upper Gastrointestinal	●			
C24.0	Extrahepatic bile duct	Upper Gastrointestinal	●			
C24.1	Ampulla of Vater	Upper Gastrointestinal	●			

C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	●			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	●			
C25.0	Head of pancreas	Upper Gastrointestinal	●			
C25.1	Body of pancreas	Upper Gastrointestinal	●			
C25.2	Tail of pancreas	Upper Gastrointestinal	●			
C25.3	Pancreatic duct	Upper Gastrointestinal	●			
C25.4	Endocrine pancreas	Upper Gastrointestinal	●			
C25.7	Other parts of pancreas	Upper Gastrointestinal	●			
C25.8	Overlapping lesion of pancreas	Upper Gastrointestinal	●			
C25.9	Pancreas, unspecified	Upper Gastrointestinal	●			
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct	Upper Gastrointestinal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D00.1	Carcinoma in situ of Oesophagus	Upper Gastrointestinal			●	
D00.2	Carcinoma in situ of Stomach	Upper Gastrointestinal			●	
D01.5	Carcinoma in situ of Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D37.1	Neoplasm of uncertain or unknown behaviour of Stomach	Upper Gastrointestinal			●	
D37.2	Neoplasm of uncertain or unknown behaviour of Small intestine	Upper Gastrointestinal			●	
D37.6	Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	

12.1 UPPER GI – CANCER CARE PLAN

Note ***BODY MASS INDEX h****as been replaced and a NEW data item [CR6440] Body Mass Index created in CORE - Diagnosis. This reduces the burden of data collection throughout the dataset. This data can be collected now multiple times but has to be supported with a Mandatory Date field and can be collected for any tumour site, where they feel this is appropriate.*

12.2 UPPER GI – CANCER CARE PLAN – LIVER METASTASES

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13630	UPPER GI - CANCER CARE PLAN - LIVER METS	**NUMBER OF LIVER METASTASES (PRE-OPERATIVE IMAGING)**	an1	R

NUMBER OF LIVER METASTASES (PRE-OPERATIVE IMAGING): Total number of liver metastases seen on preoperative imaging.

1	1 to 3
2	4 or more
U	Number uncertain

12.3 UPPER GI – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[35] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[36].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

See also Barcelona Clinic Liver Cancer Stage and Clinical Stage (Pancreatic Cancer) in following sections

Note: **TNM7 staging is not recommended for GISTs (Gastrointestinal tumours) although if submitted it will be recorded by the NCRAS.**

12.4 UPPER GI – STAGING – LIVER HCC

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG14520	UPPER GI - STAGING - LIVER HCC	**BARCELONA CLINIC LIVER CANCER (BCLC) STAGE** *[BARCELONA CLINIC LIVER CANCER STAGE]*	an1	R
UG14570	UPPER GI - STAGING - LIVER	**BARCELONA CLINIC LIVER CANCER (BCLC) STAGE DATE** *[BARCELONA CLINIC LIVER CANCER STAGE DATE]*	an10 ccyy-	R

[35] https://nww.cancerstats.nhs.uk/cosd/staging

[36] http://www.wileyanduicc.com/

	HCC		mm-dd	
UG14530	UPPER GI - STAGING - LIVER HCC	**CHILD-PUGH SCORE**	an1	R
UG14540	UPPER GI - STAGING - LIVER HCC	**NUMBER OF LESIONS (RADIOLOGICAL)**	max n2	R
UG14550	UPPER GI - STAGING - LIVER HCC	**PORTAL INVASION** *[PORTAL VEIN INVASION INDICATOR]*	an1	R

BARCELONA CLINIC LIVER CANCER (BCLC) STAGE: The Barcelona Clinic Liver Cancer (BCLC) Stage includes both anatomic and non-anatomic factors and is widely used within the UK to predict prognosis and determine treatment.

0	Very early
A	Early
B	Intermediate
C	Advanced
D	Terminal

BARCELONA CLINIC LIVER CANCER (BCLC) STAGE DATE: The date on which the Barcelona Clinic Liver Cancer (BCLC) Stage was recorded
CHILD-PUGH SCORE: Record the overall Child-Pugh score. This is the level of disease of the liver.

A	Child-Pugh A
B	Child-Pugh B
C	Child-Pugh C

NUMBER OF LESIONS (RADIOLOGICAL): Radiologically determined number of lesions.
PORTAL INVASION: Record whether there is involvement of the portal vein.

Y	Present
N	Not present
9	Not known

12.4.1 UPPER GI – STAGING - PANCREATIC

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG14560	UPPER GI - STAGING - PANCREAS	**CLINICAL STAGE (PANCREATIC CANCER)**	an2	R
UG14580	UPPER GI - STAGING - PANCREAS	**CLINICAL STAGE (PANCREATIC CANCER) DATE** *[CLINICAL STAGE DATE (PANCREATIC CANCER)]*	an10 ccyy-mm-dd	R

CLINICAL STAGE (PANCREATIC CANCER): Clinically agreed stage based on radiological findings of tumour extent in order to offer treatment recommendations. The category selected depends on tumour location within the pancreas and the arterial or venous involvement

10	Localised and resectable
20	Borderline resectable
30	Unresectable (locally advanced or metastatic)
31	Unresectable (locally advanced)
32	Unresectable (metastatic)

Please note:
Code 32- Unresectable (metastatic) should be used if metastatic disease is present with or without locally advanced disease
Code 31 – Unresectable (locally advanced) should be used if there is locally advanced disease without metastatic disease
Code 30 –Unresectable (locally advanced or metastatic) should only be used if locally advanced disease has been identified but it is not possible to identify whether there is also metastatic disease

CLINICAL STAGE (PANCREATIC CANCER) DATE: The date on which the Clinical Stage for Pancreatic Cancer was recorded.

12.5 UPPER GI – SURGERY AND OTHER PROCEDURES – GENERAL

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13100	UPPER GI - SURGICAL PROCEDURES	**STAGING LAPAROSCOPY PERFORMED** *[STAGING LAPAROSCOPY PERFORMED INDICATOR]*	an1	R
UG13810	UPPER GI - SURGICAL PROCEDURES	**PALLIATIVE TREATMENT REASON (UPPER GI)** *[PALLIATIVE TREATMENT REASON CODE (UPPER GASTROINTESTINAL)]*	an1	R

Note: ***ASA SCORE****: has been replaced and a NEW data item [CR6010] ASA Score created in CORE Surgery and Other Procedures. This reduces the burden of data collection throughout the dataset. This data can be collected now only once but can be collected for any tumour site, where they feel this is appropriate.*

STAGING LAPAROSCOPY PERFORMED: Record whether a staging laparoscopy was performed. This may include an intraoperative ultrasound which is performed at some centres.

Y	Yes
N	No
9	Not known

Note ***SURGICAL ACCESS TYPE (ABDOMINAL):*** *has been retired and a new data item [CR6310] has been created to replace this. This reduces duplication across the dataset and allows for better more inclusive data collection.*

Note ***UNPLANNED RETURN TO THEATRE INDICATOR****: has been retired and replaced with [CR6480] in CORE Surgery & Other Procedures.*

PALLIATIVE TREATMENT REASON (UPPER GI): Rationale for palliative treatment.

1	Extensive intrahepatic disease
2	Widespread disease
3	Both extensive intrahepatic and widespread disease

4	Biliary obstruction
5	Gastric outlet obstruction
6	Pain

12.5.1 UPPER GI – SURGERY AND OTHER PROCEDURES – O-G

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Surgical complications				
UG14210	UPPER GI - O-G - SURGICAL PROCEDURES	**SURGICAL COMPLICATIONS** *[SURGICAL COMPLICATION TYPE]*	an2	R
End of repeating item - Surgical complications				
UG14230	UPPER GI - O-G - SURGICAL PROCEDURES	**POST OPERATIVE TUMOUR SITE (UPPER GI)** *[POST OPERATIVE TUMOUR SITE (UPPER GASTROINTESTINAL)]*	an2	R

Note: ***SURGICAL ACCESS (THORACIC)****: has been retired and a new data item [CR6310] has been created to replace this. This reduces duplication across the dataset and allows for better more inclusive data collection.*

SURGICAL COMPLICATIONS: The types of post-operative complications that the patient experiences between the time of the operation, and his / her discharge from hospital or death. A complication is defined as a development of clinical significance that requires intervention (i.e. alteration in the patient's management plan). NB re-operation, radiological intervention or readmission to critical care is NOT required.

00	No complications
01	Pneumonia
02	Acute respiratory distress syndrome (ARDS)
03	Pulmonary embolism
04	Pleural effusion
05	Anastomotic leak
06	Chyle leak
07	Haemorrhage
08	Cardiac complication
09	Acute renal failure
10	Wound infection
11	liver failure
13	gastric outlet obstruction
14	pancreatic leak
15	biliary leak
16	gastric anastomotic leak
17	pancreatic endocrine insufficiency
18	pancreatic exocrine insufficiency
19	early delayed gastric emptying
20	Duodenal suture line leak
21	Anastomotic stricture
98	Other
99	Not known

POST OPERATIVE TUMOUR SITE (UPPER GI): The main cancer site for which the patient is receiving care, as established in the resected specimen. Please note that "Cardia" should no longer be used to describe adenocarcinomas located at the gastro-oesophageal junction. Instead, these tumours should be described by the appropriate Siewert type.

01	Oesophagus upper third
02	Oesophagus middle third
03	Oesophagus lower third
04	Siewert 1
05	Siewert 2
06	Siewert 3
07	Fundus
08	Body of stomach
09	Antrum
10	Pylorus

12.5.2 UPPER GI – SURGERY AND OTHER PROCEDURES – LIVER CHOLANGIOCARCINOMA and PANCREATIC

These data have been moved and re-aligned to enable better recording and reporting.

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13240	UPPER GI - LIVER CHOLANGIOCARCINOMA and PANCREATIC - SURGICAL PROCEDURES	**SURGICAL PALLIATION TYPE**	an1	R

SURGICAL PALLIATION TYPE: Type of surgical palliation performed if any e.g. Hepaticojejunostomy

0	None
1	gastric bypass
2	biliary bypass
3	gastric/biliary bypass
4	celiac plexus block
9	Not known

12.5.3 UPPER GI – SURGERY AND OTHER PROCEDURES – LIVER HCC

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13590	UPPER GI - LIVER HCC - SURGICAL PROCEDURES	**LIVER TRANSPLANTATION** *[LIVER TRANSPLANT PERFORMED INDICATOR]*	an1	R

LIVER TRANSPLANTATION: Was a liver transplant performed?

Y	Yes
N	No

12.5.4 UPPER GI – SURGERY AND OTHER PROCEDURES – ENDOSCOPIC OR RADIOLOGICAL PROCEDURES - PANCREATIC and O-G

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Endoscopic Procedure Type				
UG14290	UPPER GI - PANCREATIC and O-G - SURGERY & OTHER PROCEDURES	**ENDOSCOPIC PROCEDURE TYPE**	an1	R
End of repeating item - Endoscopic Procedure Type				

Note: ***PROCEDURE DATE (ENDOSCOPIC OR RADIOLOGICAL), ORGANISATION SITE CODE (PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)*** *&* ***CONSULTANT CODE (ENDOSCOPIC OR RADIOLOGICAL PROCEDURE):*** *These could be collected using either CORE Imaging or CORE Treatment/Surgery & Other Procedures, this would reduce the burden of data collection and duplication throughout the dataset.*

ENDOSCOPIC PROCEDURE TYPE: The main endoscopic procedures carried out. More than one procedure can be entered. Repeating Item. For pancreas only values 1, 4 and 8 are valid.
The OG National Audit definition: the main endoscopic techniques performed as part of the first therapeutic endoscopic procedure.

1	Stent insertion
2	Laser therapy
3	Argon plasma coagulation
4	Photodynamic therapy
5	Gastrostomy
6	Brachytherapy
7	Dilation
8	other

12.5.5 UPPER GI – SURGERY AND OTHER PROCEDURES – ENDOSCOPIC OR RADIOLOGICAL PROCEDURES - LIVER CHOLANGIOCARCINOMA

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Endoscopic/Radiological Complications				
UG13090	UPPER GI - MAIN - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE**	an2	R
End of repeating item - Endoscopic/Radiological Complications				

ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE: The types of complications that the patient experiences during the admission for the endoscopic procedure. More than one option can be selected.

00	No complications
02	Perforation
03	Haemorrhage
09	Pancreatitis
10	Cholangitis
88	Other

12.5.6 UPPER GI – SURGERY AND OTHER PROCEDURES – ENDOSCOPIC OR RADIOLOGICAL PROCEDURES - LIVER CHOLANGIOCARCINOMA

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13250	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**RADIOLOGICAL PROCEDURE TYPE**	an1	R
UG13070	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**INTENT FOR BILIARY STENT** *[BILIARY STENT INSERTION REASON]*	an1	R
UG13080	UPPER GI - LIVER CHOLANGIOCARCINOMA - ENDOSCOPIC OR RADIOLOGICAL PROCEDURES	**SUCCESS OF DEPLOYMENT** *[STENT DEPLOYED SUCCESS INDICATOR]*	an1	R

RADIOLOGICAL PROCEDURE TYPE: Type of stent or drain inserted by radiological procedure.

1	plastic stent
2	metal stent
3	external biliary drain

INTENT FOR BILIARY STENT: Reason for biliary stent insertion

1	Bridge to surgery
2	Palliation
9	Not known

SUCCESS OF DEPLOYMENT: Whether or not the stent was deployed successfully.

Y	Yes
N	No
9	Not known

12.5.7 UPPER GI – SURGERY AND OTHER PROCEDURES – LIVER METS and LIVER HCC

These data have been moved and re-aligned to enable better recording and reporting.
This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG13560	UPPER GI - LIVER METS and LIVER HCC	**ABLATIVE THERAPY TYPE**	an1	R
UG13580	UPPER GI - LIVER METS and LIVER HCC	**TRANS ARTERIAL CHEMOEMBOLISATION** *[TRANS ARTERIAL CHEMOEMBOLISATION PERFORMED INDICATOR]*	an1	R

ABLATIVE THERAPY TYPE: Describe type of ablative (i.e. locally destructive treatment) therapy used if any. This procedure would be performed in the endoscopy unit. Please check local policies.

N	None
R	Radiofrequency ablation
O	Other ablative treatment
9	Not known

TRANS ARTERIAL CHEMOEMBOLISATION: Was Trans Arterial Chemoembolisation (TACE) carried out? This procedure would be performed in the specialist centres.

Y	Yes
N	No
9	Not known

13. UROLOGY

OVERVIEW

The site specific Urology dataset applies additionally to in situ Bladder cancers (D09.0) and pTa Bladder cancers (D41.4), although these are excluded from Cancer Waits.

Watchful Waiting and Active Surveillance
A treatment (CANCER TREATMENT MODALITY) of "Active Monitoring" should be recorded for all patients who are largely asymptomatic and may progress to active treatment if the status of the disease progresses. (This covers all patients who are being monitored only and will include "watchful waiting" as used clinically). In order to distinguish between the above two groups of patients, the field MONITORING INTENT should be completed as follows:

- Active surveillance/monitoring - Use Code 1 "Monitoring with future curative intent"
- Watchful waiting - Use Code 2 "Monitoring with future palliative intent"
- If unable to distinguish, use Code 3 "Monitoring with unknown or uncertain future intent"

For symptomatic patients who are not receiving active treatment , the selected treatment type (CANCER TREATMENT MODALITY) will be either "Specialist Palliative Care" or "Non specialist Palliative Care" depending on whether the patient is under the care of a specialist in palliative medicine.

ICD-10 CODES

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C60.0	*Prepuce*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.1	*Glans penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.2	*Body of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*

C60.8	*Overlapping lesion of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.9	*Penis, unspecified*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C61	Malignant neoplasm of prostate	Urological	●			
C62.0	Undescended testis	Urological	●			
C62.1	Descended testis	Urological	●			
C62.9	Testis, unspecified	Urological	●			
C63.0	Epididymis	Urological	●			
C63.1	Spermatic cord	Urological	●			
C63.2	Scrotum	Urological	● *			** Skin Dataset to be collected where applicable.*
C63.7	Other specified male genital organs	Urological		●		
C63.8	Overlapping lesion of male genital organs	Urological		●		
C63.9	Male genital organ, unspecified	Urological		●		
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	●			
C65	Malignant neoplasm of renal pelvis	Urological	●			
C66	Malignant neoplasm of ureter	Urological	●			
C67.0	Trigone of bladder	Urological	●			
C67.1	Dome of bladder	Urological	●			
C67.2	Lateral wall of bladder	Urological	●			
C67.3	Anterior wall of bladder	Urological	●			
C67.4	Posterior wall of bladder	Urological	●			
C67.5	Bladder neck	Urological	●			
C67.6	Ureteric orifice	Urological	●			

C67.7	Urachus	Urological	●			
C67.8	Overlapping lesion of bladder	Urological	●			
C67.9	Bladder, unspecified	Urological	●			
C68.0	Urethra	Urological	●			
C68.1	Paraurethral glands	Urological		●		
C68.8	Overlapping lesion of urinary organs	Urological		●		
C68.9	Urinary organ, unspecified	Urological		●		
C79.0	Secondary malignant neoplasm of kidney and renal pelvis	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.1	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
D07.4	carcinoma in situ of penis	Urological			●	
D07.5	carcinoma in situ of prostate	Urological			●	
D07.6	carcinoma in situ of other and unspecified male genital organs	Urological			●	
D09.0	Carcinoma in situ of Bladder	Urological	●			
D09.1	carcinoma in situ of other and unspecified urinary organs	Urological			●	
D40.0	Neoplasm of uncertain or unknown behaviour of prostate	Urological			●	
D40.1	Neoplasm of uncertain or unknown behaviour of testis	Urological			●	

D40.7	Neoplasm of uncertain or unknown behaviour of other male genital organs	Urological			●	
D40.9	Neoplasm of uncertain or unknown behaviour of male genital organs, unspecified	Urological			●	
D41.0	Neoplasm of uncertain or unknown behaviour of kidney	Urological			●	
D41.1	Neoplasm of uncertain or unknown behaviour of renal pelvis	Urological	●			
D41.2	Neoplasm of uncertain or unknown behaviour of ureter	Urological	●			
D41.3	Neoplasm of uncertain or unknown behaviour of urethra	Urological	●			
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	●			
D41.7	Neoplasm of uncertain or unknown behaviour of other urinary organs	Urological			●	
D41.9	Neoplasm of uncertain or unknown behaviour of urinary organs, unspecified	Urological			●	

*For tumours in unusual sites where there is overlap between a dataset based on anatomy and another based on the disease description it is recommended that both datasets are completed. For example, for a melanoma of the penis both the penile and the melanoma dataset should be completed.

13.1 UROLOGY - CANCER CARE PLAN

These data should only be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)

UR15000	UROLOGY - CANCER CARE PLAN	**ESTIMATED GLOMERULAR FILTRATION RATE**	max n2	R
UR15010	UROLOGY - CANCER CARE PLAN	**HYDRONEPHROSIS** *[HYDRONEPHROSIS CODE]*	an1	R
UR15020	UROLOGY - CANCER CARE PLAN	**NORMAL LDH** *[LACTATE DEHYDROGENASE LEVEL (NORMAL UPPER LIMIT)]*	max n6	R
UR15030	UROLOGY - CANCER CARE PLAN	**S-CATEGORY** *[S CATEGORY CODE]*	an2	R
UR15040	UROLOGY - CANCER CARE PLAN	**S-CATEGORY AFP** *[S CATEGORY (ALPHA FETOPROTEIN)]*	max n6	R
UR15050	UROLOGY - CANCER CARE PLAN	**S-CATEGORY HCG** *[S CATEGORY (HUMAN CHORIONIC GONADOTROPIN)]*	max n7	R
UR15060	UROLOGY - CANCER CARE PLAN	**S-CATEGORY LDH** *[S CATEGORY (LACTATE DEHYDROGENASE)]*	max n6	R
UR15070	UROLOGY - CANCER CARE PLAN	**PSA (DIAGNOSIS)** *[PROSTATE SPECIFIC ANTIGEN (DIAGNOSIS)]*	max n5.n1	R

ESTIMATED GLOMERULAR FILTRATION RATE: RENAL ONLY. This is the estimated Glomerular Filtration Rate. It is a measurement of kidney function in mls/min/1.73m2. This is to be collected once at diagnosis. Note that this should be recorded as part of standard renal function test. Positive values. Numerical value to be recorded (categories can be derived from this at a later stage) (0-99)

HYDRONEPHROSIS [HYDRONEPHROSIS CODE]: BLADDER ONLY. Consequence of reduced outflow of urine from Kidney. May be present in one or both kidneys.

0	None
L	Left
R	Right
B	Bilateral
8	Not Applicable (No Kidneys)
9	Not Known

NORMAL LDH: TESTICULAR ONLY. This is the upper limit of normal for the LDH (Lactate Dehydrogenase Level) assay which is used to calculate S Category. Range 0 – 999999.
S-CATEGORY: TESTICULAR ONLY. Based on serum tumour markers AFP, HCG and LDH. For Testicular Cancer S category is an additional prognostic factor.
See below for further details of values to be recorded.

SX	Tumour marker studies not available or not performed
S0	Tumour marker levels within normal limits
S1	LDH < 1.5 X Normal and HCG (mIu/ml) < 5000 and AFP (ug/ml) < 1000
S2	LDH 1.5-10 X Normal or HCG (mIu/ml) 5000-50,000 or AFP (ug/ml) 1000-10,000
S3	LDH > 10 X Normal or HCG (mIu/ml) > 50,000 or AFP (ug/ml) > 10,000

S-CATEGORY AFP: TESTICULAR ONLY. Alpha Feto-Protein (AFP) is a serum tumour marker. Where normal are values recorded this will be collected once at diagnosis by specialist MDT. If

abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. Range 0 – 999999.

S-CATEGORY HCG: TESTICULAR ONLY. Human Chorionic Gonadotropin (HCG) is a serum tumour marker. Where normal values are recorded this will be collected once at diagnosis by specialist MDT. If abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. To be collected once at diagnosis by specialist MDT. Range 0 – 999999.

S-CATEGORY LDH: TESTICULAR ONLY. Serum Lactate Dehydrogenase (LDH) is a serum tumour marker. Where normal values are recorded this will be collected once at diagnosis by specialist MDT. If abnormal at diagnosis the lowest measurement prior to chemotherapy or radiotherapy should be recorded. If no chemotherapy or radiotherapy is given, where markers are abnormal record lowest measurement post orchidectomy. Range 0 – 999999.

PSA (DIAGNOSIS): PROSTATE ONLY. Prostate Specific Antigen blood level in ng/ml, measured at time of diagnosis.

13.2 UROLOGY – STAGING

With both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[37] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[38].

National Guidance is expected at the end of 2016, regarding migration to TNM version 8.

13.2.1 – Testicular

For testicular cancer ideally RMH stage grouping and TNM stage components should both be collected. (UICC stage groupings should not be used as they do not map to RMH stage.) Pre-treatment TNM Stage components are optional. S category (the IGCCCG classification for testicular cancer) should be collected separately. First CT Scan performed (usually after orchidectomy) prior to chemotherapy/radiotherapy should be reported in the Core Imaging section.

> ***Note:*** ***Although International Germ Cell Consensus (IGCC) Prognostic Groupings largely supersedes RMH Staging for testicular cancer (except for seminomas), the NCIN Urology SSCRG has agreed that RMH Staging should continue to be used for staging testicular cancer for the near future. Further consideration on how stage is collected for testicular cancers in the future will be considered again when the COSD is next reviewed.***

First CT Scan performed (usually after orchidectomy) prior to chemotherapy/radiotherapy should be reported in the Core Imaging section.

S category is recorded separately.

(Submission of the pre-treatment TNM stage components is optional for testicular)

This section will be recorded once.

[37] https://nww.cancerstats.nhs.uk/cosd/staging

[38] http://www.wileyanduicc.com/

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15300	UROLOGY - STAGING – TESTICULAR	**STAGE GROUPING (TESTICULAR)** *[STAGE GROUPING (TESTICULAR CANCER)]*	max an2	R
UR15400	UROLOGY - STAGING - TESTICULAR	**UROLOGY - STAGING - TESTICULAR DATE**	an10 ccyy-mm-dd	R
Start of repeating item - Extra-nodal metastases				
UR15320	UROLOGY - STAGING – TESTICULAR	**EXTRANODAL METASTASES** *[EXTENT OF METASATIC SPREAD]*	an1	R
End of repeating item - Extra-nodal metastases				
UR15330	UROLOGY - STAGING – TESTICULAR	**LUNG METASTASES SUB-STAGE GROUPING**	an2	R

STAGE GROUPING (TESTICULAR): (TESTICULAR ONLY). Nationally agreed anatomical stage groupings as defined by The Royal Marsden Hospital (RMH).

1	Stage 1	Confined to testis
1S	Stage 1S	(Not used)
1M	Stage 1M	Rising post orchidectomy markers only
2A	Stage 2A	Abdominal lymphadenopathy < 2cm
2B	Stage 2B	Abdominal lymphadenopathy 2cm – 5cm
2C	Stage 2C	Abdominal lymphadenopathy > 5cm
3A	Stage 3A	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy < 2cm
3B	Stage 3B	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy 2cm – 5cm
3C	Stage 3C	Supradiaphragmatic lymphadenopathy with abdominal lymphadenopathy > 5cm
4A	Stage 4A	Extralymphatic metastases with abdominal lymphadenopathy < 2cm
4B	Stage 4B	Extralymphatic metastases with abdominal lymphadenopathy 2cm – 5cm
4C	Stage 4C	Extralymphatic metastases with abdominal lymphadenopathy > 5cm

UROLOGY - STAGING - TESTICULAR DATE: The date on which the Testicular Stage was recorded
EXTRANODAL METASTASES: (TESTICULAR STAGE 4 ONLY). Indicate the extent of metastatic spread (multiple items can be selected).

Note: This data item only applies to a small cohort of patients.

H	Liver involvement
B	Brain involvement
M	Mediastinal involvement
N	Neck nodes
L	Lung involvement

LUNG METASTASES SUB-STAGE GROUPING: (TESTICULAR CANCER ONLY). Where lung metastases are identified, specify the RMH grouping.
Note: This only applies to a very small sub group with Extra-Nodal Metastases.

L1	Less than or equal to 3 metastases
L2	Greater than 3 metastases
L3	Greater than 3 metastases, one or more greater than or equal to 2cm diameter

13.2 Urethra (Additional Staging Notes)

Note: ***Most verrucous carcinomas arise from penile skin rather than urethra; readers are referred to the penile dataset for clarification.***

Note: ***Recording Urethra stage following neoadjuvant therapy***

Note ***For cases of bladder or urethral cancer treated by cystectomy, problems will be encountered where neoadjuvant therapy is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.***

13.2 Prostate (Additional Staging Notes)

Note: ***Recording Prostate stage following neoadjuvant therapy***

Note ***For cases of prostate cancer treated by prostatectomy, problems will be encountered where neoadjuvant therapy (usually hormones) is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the neo-adjuvant treatment and an integrated TNM stage decided based on the radiological appearances.***

13.2 Kidney (Additional Staging Notes)

Note ***Recording Kidney stage following preoperative drug therapy***

Note ***For cases of kidney cancer treated with surgery, problems will be encountered where preoperative drug therapy (usually biological targeted therapy) is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after preoperative drug therapy and an integrated TNM stage decided based on the radiological appearances.***

13.2 Penis (Additional Staging Notes)

Note: ***Recording Penis stage following neoadjuvant therapy***

Note: ***For cases of penis cancer treated with surgery, problems will be encountered where preoperative chemotherapy is used. TNM stage will be dependent on histological examination of the resected specimen together with information obtained from radiological imaging etc. Wherever possible TNM with the "y" prefix (NEOADJUVANT THERAPY INDICATOR) should be used for pathology stage fields. For all other cases, where no operation is performed, staging will have to be based on radiological appearances either before or after the preoperative chemotherapy and an integrated TNM stage decided based on the radiological appearances.***

13.3 UROLOGY – TREATMENT – BLADDER

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15100	UROLOGY - TREATMENT - BLADDER	**INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR**	an1	R
UR15110	UROLOGY - TREATMENT - BLADDER	**INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR**	an1	R

Note: Either* INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR *or* INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR *is required for patients having anti-cancer therapy treatment in order to distinguish between modes of delivery. Only one will be applicable for each treatment.

INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR: BLADDER ONLY. (Only required for patients having chemotherapy). Record as YES for patients having intravesical chemotherapy to distinguish from intravenous. This data item requires clinical involvement to ensure completeness.

Y	Yes
N	No
9	Not known

INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR: BLADDER ONLY. (Only required for patients having immunotherapy). Record as YES for patients having immunotherapy to distinguish from systemic. This data item requires clinical involvement to ensure completeness.

Y	Yes
N	No
9	Not known

13.4 UROLOGY – TREATMENT – PROSTATE

This section will be recorded once per treatment where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15080	UROLOGY - TREATMENT - PROSTATE	**PSA (PRE-TREATMENT)** *[PROSTATE SPECIFIC ANTIGEN (PRE TREATMENT)]*	max n5.n1	R

PSA (PRE-TREATMENT): PROSTATE ONLY. Prostate Specific Antigen blood level in ng/ml, measured before treatment (including second and subsequent treatments). This is the PSA taken prior to EACH treatment (because some curative treatments may be delivered years after diagnosis.

Appendix A – Cancer Waiting Times ICD10 Codes and Tumour Groups for Primary Diagnoses

(Applicable from April 2012) *These are registerable conditions for the purposes of Cancer Waiting Times and used within Cancer Registration i.e. NCRAS mandatory fields*

Notes:

- ***The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.***
- ***This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.***
- ***Further guidance is available from your local cancer registration service office.***

Key:

() = if applicable

* = different dataset from CWT group specified

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0	External upper lip	Head and Neck		●		
C00.1	External lower lip	Head and Neck		●		
C00.2	External lip, unspecified	Head and Neck		●		
C00.3	Upper lip, inner aspect	Head and Neck	●			
C00.4	Lower lip, inner aspect	Head and Neck	●			
C00.5	Lip, unspecified, inner aspect	Head and Neck	●			
C00.6	Commissure of lip	Head and Neck	●			
C00.8	Overlapping lesion of lip	Head and Neck	●			
C00.9	Lip, unspecified	Head and Neck	●			
C01	Malignant neoplasm of base of tongue	Head and Neck	●			
C02.0	Dorsal surface of tongue	Head and Neck	●			
C02.1	Border of tongue	Head and Neck	●			
C02.2	Ventral surface of tongue	Head and Neck	●			
C02.3	Anterior two-thirds of tongue, part unspecified	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C02.4	Lingual tonsil	Head and Neck	●			
C02.8	Overlapping lesion of tongue	Head and Neck	●			
C02.9	Tongue, unspecified	Head and Neck	●			
C03.0	Upper gum	Head and Neck	●			
C03.1	Lower gum	Head and Neck	●			
C03.9	Gum, unspecified	Head and Neck	●			
C04.0	Anterior floor of mouth	Head and Neck	●			
C04.1	Lateral floor of mouth	Head and Neck	●			
C04.8	Overlapping lesion of floor of mouth	Head and Neck	●			
C04.9	Floor of mouth, unspecified	Head and Neck	●			
C05.0	Hard palate	Head and Neck	●			
C05.1	Soft palate	Head and Neck	●			
C05.2	Uvula	Head and Neck	●			
C05.8	Overlapping lesion of palate	Head and Neck	●			
C05.9	Palate, unspecified	Head and Neck	●			
C06.0	Cheek mucosa	Head and Neck	●			
C06.1	Vestibule of mouth	Head and Neck	●			
C06.2	Retromolar area	Head and Neck	●			
C06.8	Overlapping lesion of other and unspecified parts of mouth	Head and Neck	●			
C06.9	Mouth, unspecified	Head and Neck	●			
C07	Malignant neoplasm of parotid gland	Head and Neck	●			
C08.0	Submandibular gland	Head and Neck	●			
C08.1	Sublingual gland	Head and Neck	●			
C08.8	Overlapping lesion of major salivary glands	Head and Neck	●			
C08.9	Major salivary gland, unspecified	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C09.0	Tonsillar fossa	Head and Neck	●			
C09.1	Tonsillar pillar (anterior) (posterior)	Head and Neck	●			
C09.8	Overlapping lesion of tonsil	Head and Neck	●			
C09.9	Tonsil, unspecified	Head and Neck	●			
C10.0	Vallecula	Head and Neck	●			
C10.1	Anterior surface of epiglottis	Head and Neck	●			
C10.2	Lateral wall of oropharynx	Head and Neck	●			
C10.3	Posterior wall of oropharynx	Head and Neck	●			
C10.4	Branchial cleft	Head and Neck	●			
C10.8	Overlapping lesion of oropharynx	Head and Neck	●			
C10.9	Oropharynx, unspecified	Head and Neck	●			
C11.0	Superior wall of nasopharynx	Head and Neck	●			
C11.1	Posterior wall of nasopharynx	Head and Neck	●			
C11.2	Lateral wall of nasopharynx	Head and Neck	●			
C11.3	Anterior wall of nasopharynx	Head and Neck	●			
C11.8	Overlapping lesion of nasopharynx	Head and Neck	●			
C11.9	Nasopharynx, unspecified	Head and Neck	●			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	●			
C13.0	Postcricoid region	Head and Neck	●			
C13.1	Aryepiglottic fold, hypopharyngeal aspect	Head and Neck	●			
C13.2	Posterior wall of hypopharynx	Head and Neck	●			
C13.8	Overlapping lesion of hypopharynx	Head and Neck	●			
C13.9	Hypopharynx, unspecified	Head and Neck	●			
C14.0	Pharynx, unspecified	Head and Neck	●			
C14.2	Waldeyer's ring	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C14.8	Overlapping lesion of lip, oral cavity and pharynx	Head and Neck	●			
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C15.1	Thoracic part of oesophagus	Upper Gastrointestinal	●			
C15.2	Abdominal part of oesophagus	Upper Gastrointestinal	●			
C15.3	Upper third of oesophagus	Upper Gastrointestinal	●			
C15.4	Middle third of oesophagus	Upper Gastrointestinal	●			
C15.5	Lower third of oesophagus	Upper Gastrointestinal	●			
C15.8	Overlapping lesion of oesophagus	Upper Gastrointestinal	●			
C15.9	Oesophagus, unspecified	Upper Gastrointestinal	●			
C16.0	Cardia	Upper Gastrointestinal	●			
C16.1	Fundus of stomach	Upper Gastrointestinal	●			
C16.2	Body of stomach	Upper Gastrointestinal	●			
C16.3	Pyloric antrum	Upper Gastrointestinal	●			
C16.4	Pylorus	Upper Gastrointestinal	●			
C16.5	Lesser curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.6	Greater curvature of stomach, unspecified	Upper Gastrointestinal	●			
C16.8	Overlapping lesion of stomach	Upper Gastrointestinal	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C16.9	Stomach, unspecified	Upper Gastrointestinal	●			
C17.0	*Duodenum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.2	*Ileum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		●		*Usually treated by Upper GI MDT*
C18.0	Caecum	Colorectal	●			
C18.1	Appendix	Colorectal		●		
C18.2	Ascending colon	Colorectal	●			
C18.3	Hepatic flexure	Colorectal	●			
C18.4	Transverse colon	Colorectal	●			
C18.5	Splenic flexure	Colorectal	●			
C18.6	Descending colon	Colorectal	●			
C18.7	Sigmoid colon	Colorectal	●			
C18.8	Overlapping lesion of colon	Colorectal	●			
C18.9	Colon, unspecified	Colorectal	●			
C19	Malignant neoplasm of rectosigmoid junction	Colorectal	●			
C20	Malignant neoplasm of rectum	Colorectal	●			
C21.0	Anus, unspecified	Colorectal		●		
C21.1	Anal canal	Colorectal		●		
C21.2	Cloacogenic zone	Colorectal		●		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C21.8	Overlapping lesion of rectum, anus and anal canal	Colorectal		●		
C22.0	Liver cell carcinoma	Upper Gastrointestinal	●			Liver cell carcinoma is also known as HCC.
C22.1	Intrahepatic bile duct carcinoma	Upper Gastrointestinal	●			
C22.2	Hepatoblastoma	Upper Gastrointestinal	●			
C22.3	Angiosarcoma of liver	Upper Gastrointestinal	●			
C22.4	Other sarcomas of liver	Upper Gastrointestinal	●			
C22.7	Other specified carcinomas of liver	Upper Gastrointestinal	●			
C22.9	Liver, unspecified	Upper Gastrointestinal	●			
C23	Malignant neoplasm of gallbladder	Upper Gastrointestinal	●			
C24.0	Extrahepatic bile duct	Upper Gastrointestinal	●			
C24.1	Ampulla of Vater	Upper Gastrointestinal	●			
C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	●			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	●			
C25.0	Head of pancreas	Upper Gastrointestinal	●			
C25.1	Body of pancreas	Upper Gastrointestinal	●			
C25.2	Tail of pancreas	Upper Gastrointestinal	●			
C25.3	Pancreatic duct	Upper Gastrointestinal	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C25.4	Endocrine pancreas	Upper Gastrointestinal	●			
C25.7	Other parts of pancreas	Upper Gastrointestinal	●			
C25.8	Overlapping lesion of pancreas	Upper Gastrointestinal	●			
C25.9	Pancreas, unspecified	Upper Gastrointestinal	●			
C26.0	Intestinal tract, part unspecified	Colorectal	●			
C26.1	Spleen	Colorectal		●		
C26.8	Overlapping lesion of digestive system	Colorectal		●		
C26.9	Ill-defined sites within the digestive system	Colorectal		●		
C30.0	Nasal cavity	Head and Neck	●			
C30.1	Middle ear	Head and Neck	●			
C31.0	Maxillary sinus	Head and Neck	●			
C31.1	Ethmoidal sinus	Head and Neck	●			
C31.2	Frontal sinus	Head and Neck	●			
C31.3	Sphenoidal sinus	Head and Neck	●			
C31.8	Overlapping lesion of accessory sinuses	Head and Neck	●			
C31.9	Accessory sinus, unspecified	Head and Neck	●			
C32.0	Glottis	Head and Neck	●			
C32.1	Supraglottis	Head and Neck	●			
C32.2	Subglottis	Head and Neck	●			
C32.3	Laryngeal cartilage	Head and Neck	●			
C32.8	Overlapping lesion of larynx	Head and Neck	●			
C32.9	Larynx, unspecified	Head and Neck	●			
C33	Malignant neoplasm of trachea	Lung	●			
C34.0	Main bronchus	Lung	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C34.1	Upper lobe, bronchus or lung	Lung	●			
C34.2	Middle lobe, bronchus or lung	Lung	●			
C34.3	Lower lobe, bronchus or lung	Lung	●			
C34.8	Overlapping lesion of bronchus and lung	Lung	●			
C34.9	Bronchus or lung, unspecified	Lung	●			
C37	Malignant neoplasm of thymus	Lung	●			
C38.0	Heart	Lung		●		
C38.1	Anterior mediastinum	Lung		●		
C38.2	Posterior mediastinum	Lung		●		
C38.3	Mediastinum, part unspecified	Lung		●		
C38.4	Pleura	Lung		●		
C38.8	Overlapping lesion of heart, mediastinum and pleura	Lung		●		
C39.0	Upper respiratory tract, part unspecified	Lung		●		
C39.8	Overlapping lesion of respiratory and intrathoracic organs	Lung		●		
C39.9	Ill-defined sites within the respiratory system	Lung		●		
C40.0	Scapula and long bones of upper limb	Sarcoma	●			
C40.1	Short bones of upper limb	Sarcoma	●			
C40.2	Long bones of lower limb	Sarcoma	●			
C40.3	Short bones of lower limb	Sarcoma	●			
C40.8	Overlapping lesion of bone and articular cartilage of limbs	Sarcoma	●			
C40.9	Bone and articular cartilage of limb, unspecified	Sarcoma	●			
C41.0	Bones of skull and face	Sarcoma	●			
C41.1	Mandible	Sarcoma	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C41.2	Vertebral column	Sarcoma	●			
C41.3	Ribs, sternum and clavicle	Sarcoma	●			
C41.4	Pelvic bones, sacrum and coccyx	Sarcoma	●			
C41.8	Overlapping lesion of bone and articular cartilage	Sarcoma	●			
C41.9	Bone and articular cartilage, unspecified	Sarcoma	●			
C43.0	Malignant melanoma of lip	Skin	●			
C43.1	Malignant melanoma of eyelid, including canthus	Skin	●			
C43.2	Malignant melanoma of ear and external auricular canal	Skin	●			
C43.3	Malignant melanoma of other and unspecified parts of face	Skin	●			
C43.4	Malignant melanoma of scalp and neck	Skin	●			
C43.5	Malignant melanoma of trunk	Skin	●			
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	●			
C43.7	Malignant melanoma of lower limb, including hip	Skin	●			
C43.8	Overlapping malignant melanoma of skin	Skin	●			
C43.9	Malignant melanoma of skin, unspecified	Skin	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.0	Skin of lip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.1	Skin of eyelid, including canthus	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.2	Skin of ear and external auricular canal	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.3	Skin of other and unspecified parts of face	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.4	Skin of scalp and neck	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.5	Skin of trunk	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.6	Skin of upper limb, including shoulder	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.7	Skin of lower limb, including hip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.8	Overlapping lesion of skin	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.9	Malignant neoplasm of skin, unspecified	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C45.0	Mesothelioma of pleura	Lung		●		
C45.1	Mesothelioma of peritoneum	Lung		●		
C45.2	Mesothelioma of pericardium	Lung		●		
C45.7	Mesothelioma of other sites	Lung		●		
C45.9	Mesothelioma, unspecified	Lung		●		
C46.0	Kaposi sarcoma of skin	Sarcoma		●		
C46.1	Kaposi sarcoma of soft tissue	Sarcoma		●		
C46.2	Kaposi sarcoma of palate	Sarcoma		●		
C46.3	Kaposi sarcoma of lymph nodes	Sarcoma		●		
C46.7	Kaposi sarcoma of other sites	Sarcoma		●		
C46.8	Kaposi sarcoma of multiple organs	Sarcoma		●		
C46.9	Kaposi sarcoma, unspecified	Sarcoma		●		
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C48.0	*Retroperitoneum*	*Sarcoma*	●			*Usually treated by Sarcoma MDT.*
C48.1	*Specified parts of peritoneum*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	● *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.8	Overlapping lesion of retroperitoneum and peritoneum	Sarcoma	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C49.0	Connective and soft tissue of head, face and neck	Sarcoma	●			
C49.1	Connective and soft tissue of upper limb, including shoulder	Sarcoma	●			
C49.2	Connective and soft tissue of lower limb, including hip	Sarcoma	●			
C49.3	Connective and soft tissue of thorax	Sarcoma	●			
C49.4	Connective and soft tissue of abdomen	Sarcoma	●			
C49.5	Connective and soft tissue of pelvis	Sarcoma	●			
C49.6	Connective and soft tissue of trunk, unspecified	Sarcoma	●			
C49.8	Overlapping lesion of connective and soft tissue	Sarcoma	●			
C49.9	Connective and soft tissue, unspecified	Sarcoma	●			
C50.0	Nipple and areola	Breast	●			
C50.1	Central portion of breast	Breast	●			
C50.2	Upper-inner quadrant of breast	Breast	●			
C50.3	Lower-inner quadrant of breast	Breast	●			
C50.4	Upper-outer quadrant of breast	Breast	●			
C50.5	Lower-outer quadrant of breast	Breast	●			
C50.6	Axillary tail of breast	Breast	●			
C50.8	Overlapping lesion of breast	Breast	●			
C50.9	Breast, unspecified	Breast	●			
C51.0	*Labium majus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C51.1	*Labium minus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C52	Malignant neoplasm of vagina	Gynaecological	●			
C53.0	Endocervix	Gynaecological	●			
C53.1	Exocervix	Gynaecological	●			
C53.8	Overlapping lesion of cervix uteri	Gynaecological	●			
C53.9	Cervix uteri, unspecified	Gynaecological	●			
C54.0	Isthmus uteri	Gynaecological	●			
C54.1	Endometrium	Gynaecological	●			
C54.2	Myometrium	Gynaecological	●			
C54.3	Fundus uteri	Gynaecological	●			
C54.8	Overlapping lesion of corpus uteri	Gynaecological	●			
C54.9	Corpus uteri, unspecified	Gynaecological	●			
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C56	Malignant neoplasm of ovary	Gynaecological	●			
C57.0	Fallopian tube	Gynaecological	●			
C57.1	Broad ligament	Gynaecological	●			
C57.2	Round ligament	Gynaecological	●			
C57.3	Parametrium	Gynaecological	●			
C57.4	Uterine adnexa, unspecified	Gynaecological	●			
C57.7	Other specified female genital organs	Gynaecological	●			
C57.8	Overlapping lesion of female genital organs	Gynaecological	●			
C57.9	Female genital organ, unspecified	Gynaecological	●			
C58	Malignant neoplasm of placenta	Gynaecological	●			
C60.0	*Prepuce*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.1	*Glans penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.2	*Body of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.8	*Overlapping lesion of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.9	*Penis, unspecified*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C61	Malignant neoplasm of prostate	Urological	●			
C62.0	Undescended testis	Urological	●			
C62.1	Descended testis	Urological	●			
C62.9	Testis, unspecified	Urological	●			
C63.0	Epididymis	Urological	●			
C63.1	Spermatic cord	Urological	●			
C63.2	Scrotum	Urological		●		
C63.7	Other specified male genital organs	Urological	●			
C63.8	Overlapping lesion of male genital organs	Urological	●			
C63.9	Male genital organ, unspecified	Urological	●			
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	●			
C65	Malignant neoplasm of renal pelvis	Urological	●			
C66	Malignant neoplasm of ureter	Urological	●			
C67.0	Trigone of bladder	Urological	●			
C67.1	Dome of bladder	Urological	●			
C67.2	Lateral wall of bladder	Urological	●			
C67.3	Anterior wall of bladder	Urological	●			
C67.4	Posterior wall of bladder	Urological	●			
C67.5	Bladder neck	Urological	●			
C67.6	Ureteric orifice	Urological	●			
C67.7	Urachus	Urological	●			
C67.8	Overlapping lesion of bladder	Urological	●			
C67.9	Bladder, unspecified	Urological	●			
C68.0	Urethra	Urological	●			
C68.1	Paraurethral glands	Urological	●			
C68.8	Overlapping lesion of urinary organs	Urological	●			
C68.9	Urinary organ, unspecified	Urological	●			
C69.0	*Conjunctiva*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C69.1	*Cornea*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.2	*Retina*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.3	*Choroid*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.4	*Ciliary body*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.5	*Lachrymal gland and duct*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. Maybe treated by Sarcoma MDT.*
C69.8	*Overlapping lesion of eye and adnexa*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.9	*Eye, unspecified*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C70.0	Cerebral meninges	Brain/Central Nervous System	●			
C70.1	Spinal meninges	Brain/Central Nervous System	●			
C70.9	Meninges, unspecified	Brain/Central Nervous System	●			
C71.0	Cerebrum, except lobes and ventricles	Brain/Central Nervous System	●			
C71.1	Frontal lobe	Brain/Central Nervous System	●			
C71.2	Temporal lobe	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C71.3	Parietal lobe	Brain/Central Nervous System	●			
C71.4	Occipital lobe	Brain/Central Nervous System	●			
C71.5	Cerebral ventricle	Brain/Central Nervous System	●			
C71.6	Cerebellum	Brain/Central Nervous System	(●) (*)			CTYA dataset collected for Medulloblastoma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	●			
C71.8	Overlapping lesion of brain	Brain/Central Nervous System	●			
C71.9	Brain, unspecified	Brain/Central Nervous System	●			
C72.0	Spinal cord	Brain/Central Nervous System	●			
C72.1	Cauda equina	Brain/Central Nervous System	●			
C72.2	Olfactory nerve	Brain/Central Nervous System	●			
C72.3	Optic nerve	Brain/Central Nervous System	●			
C72.4	Acoustic nerve	Brain/Central Nervous System	●			
C72.5	Other and unspecified cranial nerves	Brain/Central Nervous System	●			
C72.8	Overlapping lesion of brain and other parts of central nervous system	Brain/Central Nervous System	●			
C72.9	Central nervous system, unspecified	Brain/Central Nervous System	●			
C73	Malignant neoplasm of thyroid gland	Head and Neck		●		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C74.0	Cortex of adrenal gland	Other		●		
C74.1	Medulla of adrenal gland	Other		●		
C74.9	Adrenal gland, unspecified	Other		●		
C75.0	Parathyroid gland	Other		●		
C75.1	*Pituitary gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.2	*Craniopharyngeal duct*	*Other*	*			*Usually treated by CNS MDT.*
C75.3	*Pineal gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.4	Carotid body	Other		●		
C75.5	Aortic body and other paraganglia	Other		●		
C75.8	Pluriglandular involvement, unspecified	Other		●		
C75.9	Endocrine gland, unspecified	Other		●		
C76.0	Head, face and neck	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.1	Thorax	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.2	Abdomen	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.3	Pelvis	Other		●		Other and ill defined - use only if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C76.4	Upper limb	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.5	Lower limb	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.7	Other ill-defined sites	Other		●		Other and ill defined - use only if unable to code to specific primary site
C76.8	Overlapping lesion of other and ill-defined sites	Other		●		Other and ill defined - use only if unable to code to specific primary site
C77.0	Lymph nodes of head, face and neck	Head and Neck	●			Secondary - only use if unable to code to specific primary site
C77.1	Intrathoracic lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.2	Intra-abdominal lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.3	Axillary and upper limb lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C77.4	Inguinal and lower limb lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.5	Intrapelvic lymph nodes	Other		●		Secondary - only use if unable to code to specific primary site
C77.8	Lymph nodes of multiple regions	Other		●		Secondary - only use if unable to code to specific primary site
C77.9	Lymph node, unspecified	Other		●		Secondary - only use if unable to code to specific primary site
C78.0	Secondary malignant neoplasm of lung	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.1	Secondary malignant neoplasm of mediastinum	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.2	Secondary malignant neoplasm of pleura	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs	Lung		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.4	Secondary malignant neoplasm of small intestine	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.5	Secondary malignant neoplasm of large intestine and rectum	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct	Upper Gastrointestinal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs	Colorectal		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.0	Secondary malignant neoplasm of kidney and renal pelvis	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.1	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	Urological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.2	Secondary malignant neoplasm of skin	Skin		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.3	Secondary malignant neoplasm of brain and cerebral meninges	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.4	Secondary malignant neoplasm of other and unspecified parts of nervous system	Brain/Central Nervous System		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.5	Secondary malignant neoplasm of bone and bone marrow	Sarcoma		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.6	Secondary malignant neoplasm of ovary	Gynaecological		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.7	Secondary malignant neoplasm of adrenal gland	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.8	Secondary malignant neoplasm of other specified sites	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.9	Secondary malignant neoplasm, unspecified site	Other		●		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C80.0	Malignant neoplasm, primary site unknown, so stated	Other		●		Only use if unable to code to specific primary site.
C80.9	Malignant neoplasm, unspecified	Other		●		Only use if unable to code to specific primary site.
C81.0	Nodular lymphocyte predominant Hodgkin lymphoma	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			
C81.1	Nodular sclerosis classical Hodgkin lymphoma	Haematological				
C81.2	Mixed cellularity classical Hodgkin lymphoma	Haematological				
C81.3	Lymphocytic depleted classical Hodgkin lymphoma	Haematological				
C81.4	Lymphocyte-rich classical Hodgkin lymphoma	Haematological				
C81.7	Other classical Hodgkin lymphoma	Haematological				
C81.9	Hodgkin lymphoma, unspecified	Haematological				
C82.0	Follicular lymphoma grade i	Haematological				
C82.1	Follicular lymphoma grade ii	Haematological				
C82.2	Follicular lymphoma grade iii, unspecified	Haematological				
C82.3	Follicular lymphoma grade iiia	Haematological				
C82.4	Follicular lymphoma grade iiib	Haematological				
C82.5	Diffuse follicle centre lymphoma	Haematological				
C82.6	Cutaneous follicle centre lymphoma	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C82.7	Other types of follicular lymphoma	Haematological				
C82.9	Follicular lymphoma, unspecified	Haematological				
C83.0	Small cell B-cell lymphoma	Haematological				
C83.1	Mantle cell lymphoma	Haematological				
C83.3	Diffuse large B-cell lymphoma	Haematological				
C83.5	Lymphoblastic (diffuse) lymphoma	Haematological				
C83.7	Burkitt lymphoma	Haematological				
C83.8	Other non-follicular lymphoma	Haematological				
C83.9	Non-follicular (diffuse) lymphoma, unspecified	Haematological				
C84.0	Mycosis fungoides	Haematological				
C84.1	Sezéry disease	Haematological				
C84.4	Peripheral T-cell lymphoma, not elsewhere classified	Haematological				
C84.5	Other mature T/NK-cell lymphomas	Haematological				
C84.6	Anaplastic large cell lymphoma, ALK-positive	Haematological				
C84.7	Anaplastic large cell lymphoma, ALK-negative	Haematological				
C84.8	Cutaneous T-cell lymphoma, unspecified	Haematological				
C84.9	Mature T/NK-cell lymphoma, unspecified	Haematological				
C85.1	B-cell lymphoma, unspecified	Haematological				
C85.2	Mediastinal (thymic) large B-cell lymphoma	Haematological				
C85.7	Other specified types of non-Hodgkin lymphoma	Haematological				
C85.9	Non-Hodgkin lymphoma, unspecified	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C86.0	Extranodal NK/T-cell lymphoma, nasal type	Haematological				
C86.1	Hepatosplenic T-cell lymphoma	Haematological				
C86.2	Enteropathy-type (intestinal) T-cell lymphoma	Haematological				
C86.3	Subcutaneous panniculitis-like T-cell lymphoma	Haematological				
C86.4	Blastic N/K-cell lymphoma	Haematological				
C86.5	Angioimmunoblastic T-cell lymphoma	Haematological				
C86.6	Primary cutaneous CD30-positive T-cell proliferations	Haematological				
C88.0	Waldenström macroglobulinaemia	Haematological				
C88.2	Other heavy chain disease	Haematological				
C88.3	Immunoproliferative small intestinal disease	Haematological				
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa associated lymphoid tissue (MALT-lymphoma)	Haematological				
C88.7	Other malignant immunoproliferative diseases	Haematological				
C88.9	Malignant immunoproliferative disease, unspecified	Haematological				
C90.0	Multiple myeloma	Haematological				
C90.1	Plasma cell leukaemia	Haematological				
C90.2	Extramedullary plasmacytoma	Haematological				
C90.3	Solitary plasmacytoma	Haematological				
C91.0	Acute lymphoblastic leukaemia [ALL]	Haematological				
C91.1	Chronic lymphocytic leukaemia of B-cell type	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C91.3	Prolymphocytic leukaemia of B-cell type	Haematological				
C91.4	Hairy-cell leukaemia	Haematological				
C91.5	Adult T-cell lymphoma/leukaemia (HTLV-1-associated)	Haematological				
C91.6	Prolymphocytic leukaemia of T-cell type	Haematological				
C91.7	Other lymphoid leukaemia	Haematological				
C91.8	Mature B-cell leukaemia Burkitt-type	Haematological				
C91.9	Lymphoid leukaemia, unspecified	Haematological				
C92.0	Acute myeloid leukaemia [AML]	Haematological				
C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	Haematological				
C92.2	Atypical chronic myeloid leukaemia, BCR/ABL-negative	Haematological				
C92.3	Myeloid sarcoma	Haematological				
C92.4	Acute promyelocytic leukaemia [PML]	Haematological				
C92.5	Acute myelomonocytic leukaemia	Haematological				
C92.6	Acute myeloid leukaemia with 11q23-abnormality	Haematological				
C92.7	Other myeloid leukaemia	Haematological				
C92.8	Acute myeloid leukaemia with multilineage dysplasia	Haematological				
C92.9	Myeloid leukaemia, unspecified	Haematological				
C93.0	Acute monoblastic/monocytic leukaemia	Haematological				
C93.1	Chronic myelomonocytic leukaemia	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C93.3	Juvenile myelomonocytic leukaemia	Haematological				
C93.7	Other monocytic leukaemia	Haematological				
C93.9	Monocytic leukaemia, unspecified	Haematological				
C94.0	Acute erythroid leukaemia	Haematological				
C94.2	Acute megakaryoblastic leukaemia	Haematological				
C94.3	Mast cell leukaemia	Haematological				
C94.4	Acute panmyelosis with myelofibrosis	Haematological				
C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	Haematological				
C94.7	Other specified leukaemias	Haematological				
C95.0	Acute leukaemia of unspecified cell type	Haematological				
C95.1	Chronic leukaemia of unspecified cell type	Haematological				
C95.7	Other leukaemia of unspecified cell type	Haematological				
C95.9	Leukaemia, unspecified	Haematological				
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	Haematological				
C96.2	Malignant mast cell tumour	Haematological				
C96.4	Sarcoma of dendritic cells (accessory cells)	Haematological				
C96.5	Multifocal and unisystemic (disseminated) Langerhans-cell histiocytosis	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C96.6	Unifocal Langerhans-cell histiocytosis	Haematological				
C96.7	Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue	Haematological				
C96.8	Histiocytic sarcoma	Haematological				
C96.9	Malignant neoplasms of lymphoid, haematopoietic and related tissue, unspecified	Haematological				
C97	Malignant neoplasms of independent (primary) multiple sites	Other		●		
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			

Appendix B – Mandatory Registerable Conditions

MANDATORY REGISTERABLE CONDITIONS

Further details to be provided regarding applicable data fields for each disease. These are additional Cancer Registration i.e. NCRAS mandatory registerable conditions

Notes:

- ***The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.***
- ***This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.***
- ***Further guidance is available from your local cancer registration service office.***

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0 – C97	Malignant neoplasms (See Appendix A for full list)					
D00.0	Carcinoma in situ of Lip, oral cavity and pharynx	Head and Neck			●	
D00.1	Carcinoma in situ of Oesophagus	Upper Gastrointestinal			●	
D00.2	Carcinoma in situ of Stomach	Upper Gastrointestinal			●	
D01.0	Carcinoma in situ of Colon	Colorectal			●	
D01.1	Carcinoma in situ of Rectosigmoid junction	Colorectal			●	
D01.2	Carcinoma in situ of Rectum	Colorectal			●	
D01.3	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.4	Carcinoma in situ of Anus and anal canal	Colorectal			●	
D01.5	Carcinoma in situ of Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D01.7	Other specified digestive organs	Colorectal			●	
D01.9	Carcinoma in situ of Digestive organ, unspecified	Colorectal			●	
D02.0	Carcinoma in situ of Larynx	Head and Neck			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D02.1	Carcinoma in situ of Trachea	Lung			●	
D02.2	Carcinoma in situ of Bronchus and lung	Lung			●	
D02.3	Carcinoma in situ of Other parts of respiratory system	Lung			●	
D02.4	Carcinoma in situ of Respiratory system, unspecified	Lung			●	
D03.0	Melanoma in situ of lip	Skin		●		
D03.1	Melanoma in situ of eyelid, including canthus	Skin		●		
D03.2	Melanoma in situ, of ear and external auricular canal	Skin		●		
D03.3	Melanoma in situ of other and unspecified parts of face	Skin		●		
D03.4	Melanoma in situ of scalp and neck	Skin		●		
D03.5	Melanoma in situ of trunk	Skin		●		
D03.6	Melanoma in situ of upper limb, including shoulder	Skin		●		
D03.7	Melanoma in situ of lower limb, including hip	Skin		●		
D03.8	Melanoma in situ of other sites	Other			●	
D03.9	Melanoma in situ, unspecified	Skin		●		
D05.0	Lobular carcinoma in situ	Breast	●			
D05.1	Intraductal carcinoma in situ	Breast	●			
D05.7	Other carcinoma in situ of breast	Breast	●			
D05.9	Carcinoma in situ of breast, unspecified	Breast	●			
D06.0	carcinoma in situ of endocervix	Gynaecological			●	
D06.1	carcinoma in situ of exocervix	Gynaecological			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D06.7	carcinoma in situ of other parts of cervix	Gynaecological			●	
D06.9	carcinoma in situ of cervix, unspecified	Gynaecological			●	
D07.0	carcinoma in situ of endometrium	Gynaecological			●	
D07.1	carcinoma in situ of vulva	Gynaecological			●	
D07.2	carcinoma in situ of vagina	Gynaecological			●	
D07.3	carcinoma in situ of other and unspecified female genital organs	Gynaecological			●	
D07.4	carcinoma in situ of penis	Urological			●	
D07.5	carcinoma in situ of prostate	Urological			●	
D07.6	carcinoma in situ of other and unspecified male genital organs	Urological			●	
D09.0	Carcinoma in situ of Bladder	Urological	●			
D09.1	carcinoma in situ of other and unspecified urinary organs	Urological			●	
D09.2	carcinoma in situ of eye	Other			●	
D09.3	carcinoma in situ of thyroid and other endocrine glands	Head and Neck			●	
D09.7	carcinoma in situ of other specified sites	Other			●	
D09.9	carcinoma in situ, unspecified	Other			●	
D32.0	benign neoplasm of cerebral meninges	Brain/Central Nervous System	●			
D32.1	benign neoplasm of spinal meninges	Brain/Central Nervous System	●			
D32.9	benign neoplasm of meninges, unspecified	Brain/Central Nervous System	●			
D33.0	Benign neoplasm of brain, supratentorial	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D33.1	Benign neoplasm of brain, infratentorial	Brain/Central Nervous System	●			
D33.2	Benign neoplasm of brain, unspecified	Brain/Central Nervous System	●			
D33.3	Benign neoplasm of cranial nerves	Brain/Central Nervous System	●			
D33.4	Benign neoplasm of spinal cord	Brain/Central Nervous System	●			
D33.7	Benign neoplasm of other specified parts of central nervous system	Brain/Central Nervous System	●			
D33.9	Benign neoplasm of central nervous system, unspecified	Brain/Central Nervous System	●			
D35.2	Benign neoplasm of Pituitary gland	Brain/Central Nervous System	●			
D35.3	*Benign neoplasm of Craniopharyngeal duct*	*Other*	●			*Usually classified as CNS*
D35.4	Benign neoplasm of Pineal gland	Brain/Central Nervous System	●			
D37.0	Neoplasm of uncertain or unknown behaviour of lip, oral cavity and pharynx	Head and Neck			●	
D37.1	Neoplasm of uncertain or unknown behaviour of Stomach	Upper Gastrointestinal			●	
D37.2	Neoplasm of uncertain or unknown behaviour of Small intestine	Upper Gastrointestinal			●	
D37.3	Neoplasm of uncertain or unknown behaviour of Appendix	Colorectal			●	
D37.4	Neoplasm of uncertain or unknown behaviour of Colon	Colorectal			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D37.5	Neoplasm of uncertain or unknown behaviour of Rectum	Colorectal			●	
D37.6	Liver, gallbladder and bile ducts	Upper Gastrointestinal			●	
D37.7	Other digestive organs	Colorectal/Upper Gastrointestinal			●	
D37.9	Digestive organ, unspecified	Colorectal/Upper Gastrointestinal			●	
D38.0	Neoplasm of uncertain or unknown behaviour of Larynx	Head and Neck			●	
D38.1	Neoplasm of uncertain or unknown behaviour of Trachea, bronchus and lung	Lung			●	
D38.2	Neoplasm of uncertain or unknown behaviour of Pleura	Lung			●	
D38.3	Neoplasm of uncertain or unknown behaviour of Mediastinum	Lung			●	
D38.4	Neoplasm of uncertain or unknown behaviour of Thymus	Lung			●	
D38.5	Neoplasm of uncertain or unknown behaviour of Other respiratory organs	Lung			●	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			●	
D39.1	Neoplasm of uncertain or unknown behaviour of Ovary	Gynaecological			●	
D39.2	Neoplasm of uncertain or unknown behaviour of Placenta	Gynaecological			●	
D39.7	Neoplasm of uncertain or unknown behaviour of Other female genital organs	Gynaecological			●	
D39.9	Neoplasm of uncertain or unknown behaviour of Female genital organ, unspecified	Gynaecological			●	
D40.0	Neoplasm of uncertain or unknown behaviour of prostate	Urological			●	
D40.1	Neoplasm of uncertain or unknown behaviour of testis	Urological			●	
D40.7	Neoplasm of uncertain or unknown behaviour of other male genital organs	Urological			●	
D40.9	Neoplasm of uncertain or unknown behaviour of male genital organs, unspecified	Urological			●	
D41.0	Neoplasm of uncertain or unknown behaviour of kidney	Urological			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D41.1	Neoplasm of uncertain or unknown behaviour of renal pelvis	Urological	●			
D41.2	Neoplasm of uncertain or unknown behaviour of ureter	Urological	●			
D41.3	Neoplasm of uncertain or unknown behaviour of urethra	Urological	●			
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	●			
D41.7	Neoplasm of uncertain or unknown behaviour of other urinary organs	Urological			●	
D41.9	Neoplasm of uncertain or unknown behaviour of urinary organs, unspecified	Urological			●	
D42.0	Neoplasm of uncertain or unknown behaviour of cerebral meninges	Brain/Central Nervous System	●			
D42.1	Neoplasm of uncertain or unknown behaviour of spinal meninges	Brain/Central Nervous System	●			
D42.9	Neoplasm of uncertain or unknown behaviour of meninges, unspecified	Brain/Central Nervous System	●			
D43.0	Neoplasm of uncertain or unknown behaviour of brain, supratentorial	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D43.1	Neoplasm of uncertain or unknown behaviour of brain, infratentorial	Brain/Central Nervous System	●			
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified	Brain/Central Nervous System	●			
D43.3	Neoplasm of uncertain or unknown behaviour of cranial nerves	Brain/Central Nervous System	●			
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord	Brain/Central Nervous System	●			
D43.7	Neoplasm of uncertain or unknown behaviour of other parts of central nervous system	Brain/Central Nervous System	●			
D43.9	Neoplasm of uncertain or unknown behaviour of central nervous system, unspecified	Brain/Central Nervous System	●			
D44.0	Neoplasm of uncertain or unknown behaviour of thyroid gland	Head and Neck			●	
D44.1	Neoplasm of uncertain or unknown behaviour of adrenal gland	Other			●	
D44.2	Neoplasm of uncertain or unknown behaviour of parathyroid gland	Other			●	
D44.3	Neoplasm of uncertain or unknown behaviour of pituitary gland	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D44.4	Neoplasm of uncertain or unknown behaviour of Craniopharyngeal duct	Brain/Central Nervous System	●			
D44 .5	Neoplasm of uncertain or unknown behaviour of pineal gland	Brain/Central Nervous System	●			
D44 .6	Neoplasm of uncertain or unknown behaviour of carotid body	Other			●	
D44 .7	Neoplasm of uncertain or unknown behaviour of aortic body and other paraganglia body	Other			●	
D44 .8	Neoplasm of uncertain or unknown behaviour of pluriglandular involvement	Other			●	
D44 .9	Neoplasm of uncertain or unknown behaviour of endocrine gland, unspecified	Other			●	
D45	Polycythaemia vera	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			
D46.0	Refractory anaemia without ringed sideroblasts, so stated	Haematological				
D46.1	Refractory anaemia with ringed sideroblasts	Haematological				
D46.2	Refractory anaemia with excess of blasts	Haematological				
D46.4	Refractory anaemia, unspecified	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D46.5	Refractory anaemia with multi-lineage dysplasia	Haematological				
D46.6	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	Haematological				
D46.7	Other myelodysplastic syndromes	Haematological				
D46.9	Myelodysplastic syndrome, unspecified	Haematological				
D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	Haematological				
D47.1	Chronic myeloproliferative disease	Haematological				
D47.3	Essential (haemorrhagic) thrombocythaemia	Haematological				
D47.4	Osteomyelofibrosis	Haematological				
D47.5	Chronic eosinophilic leukaemia (hypereosinophilic syndrome)	Haematological				
D47.7	Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	Haematological				
D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D48.0	Neoplasm of uncertain or unknown behaviour of Bone and articular cartilage	Sarcoma			●	
D48.1	Neoplasm of uncertain or unknown behaviour of Connective and other soft tissue	Sarcoma			●	Only applicable for GISTs
D48.2	Neoplasm of uncertain or unknown behaviour of Peripheral nerves and autonomic nervous system	Other			●	
D48.3	Neoplasm of uncertain or unknown behaviour of Retroperitoneum	Other			●	
D48.4	Neoplasm of uncertain or unknown behaviour of Peritoneum	Other			●	
D48.5	Neoplasm of uncertain or unknown behaviour of Skin	Skin			●	
D48.6	Neoplasm of uncertain or unknown behaviour of Breast	Breast			●	
D48.7	Neoplasm of uncertain or unknown behaviour of Other specified sites	Other			●	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D48.9	Neoplasm of uncertain or unknown behaviour unspecified	Other			●	
E85.9[39]	Amyloidosis, unspecified	Haematology	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			

[39] Although Primary amyloidosis (E85.9) is listed as an E ICD code in the World Health Organisation (WHO) disease classification, amongst clinicians it is widely acknowledged and subsequently treated as a cancer, receiving Chemotherapy in cases. Whilst we await the WHO disease classification being updated to reflect this fact, it's inclusion as a registerable condition requiring collection via the COSD has been agreed with the National Cancer Registration Service of Public Health England.

Appendix C – Who Classification of Tumours of Haematopoetic and Lymphoid Tissue

Group numbers have been assigned for ease of reference as used in Section 7.2 ICD Codes and WHO Disease Groups in the Haematology section of the User Guide. (WHO Classification does not distinguish Groups 7 & 8 as separate disease groups)

GROUP #	Description
GROUP 1	*Myeloproliferative neoplasms*
GROUP 2	*Myeloid and lymphoid neoplasms with eosinophilia and abnormalities of PDGFRA, PDGFRB or FGFR1*
GROUP 3	*Myelodysplastic/myeloproliferative neoplasms*
GROUP 4	*Myelodysplastic syndromes*
GROUP 5	*Acute myeloid leukaemia (AML) and related Precursor neoplasms*
GROUP 6	*Acute leukaemias of ambiguous lineage*
GROUP 7	*Precursor B lymphoid neoplasms*
GROUP 8	*Precursor T lymphoid neoplasms*
GROUP 9	*Mature B cell neoplasms*
GROUP 10	*Mature T-cell and NK-cell neoplasms*
GROUP 11	*Hodgkin lymphoma*
GROUP 12	*Histiocytic and dendritic cell neoplasm*
GROUP 13	*Post-transplant lymphoproliferative disorders (PTLD)*

Appendix D – CTYA – Associated conditions

Associated Conditions to be recorded on Childhood Cancer Registration Forms

The associated conditions in the patient should include any medical condition that could be related to aetiology of the child's cancer or could affect treatment or outcome. The main categories that are likely to be of interest and should therefore be recorded are as follows, listed by Chapter within ICD-10.

ICD10 Chapter	ICD 10 Codes	Conditions	Examples
I	B15-B19	Viral hepatitis	
	B20-B24	HIV disease	
II	C00-C97	Malignant neoplasms	Any malignancy diagnosed before the subject of the current registration
	D00-D48	Benign and unspecified neoplasms	Melanocytic naevus, neurofibroma
III	D50-D98	Diseases of blood, blood-forming organs & immune system	Thalassaemia, sickle-cell disease or trait, spherocytosis, Diamond-Blackfan anaemia, Fanconi anaemia, aplastic anaemia, Von Willebrand disease, severe combined immune deficiency, Wiskott-Aldrich syndrome
IV	E00-E90	Endocrine, nutritional & metabolic diseases	Goitre, diabetes, congenital adrenal hyperplasia, albinism, cystic fibrosis
V	F70-F79	Mental retardation	
	F80-F89	Disorders of psychological development	Autism
	F90-F98	Early-onset behavioural & emotional disorders	Attention deficit hyperactivity disorder
VI	G11	Hereditary ataxia	Ataxia telangiectasia
	G25.3	Opsoclonus-myoclonus	
	G40	Epilepsy	
	G51.0	Bell's palsy	
	G71.0	Muscular dystrophy	

ICD10 Chapter	ICD 10 Codes	Conditions	Examples
	G90	Autonomic nervous system disorders	Horner syndrome
VII	H50	Strabismus	
XI	K40	Inguinal hernia	
XII	L20-L30	Dermatitis & eczema	
	L81.3	Café au lait spots	
XIII	M08	Juvenile arthritis	
XVI	P00-P96	Conditions originating in perinatal period	Extreme prematurity, birth asphyxia, congenital rubella syndrome, neonatal jaundice, congenital hydrocele
XVII	Q00-Q89	Congenital malformations	Coloboma, aniridia, cardiac defects, cleft lip or palate, Hirschsprung disease, cryptorchism, hypospadias, (pseudo-)hermaphroditism, congenital malformations of kidney, neurofibromatosis, tuberous sclerosis, hemihypertrophy, Beckwith-Wiedmann syndrome
	Q90-Q99	Constitutional chromosomal abnormalities	Down syndrome, Turner syndrome, Klinefelter syndrome, gonadal dysgenesis, fragile X chromosome
XVIII	R01	Heart murmur	
	R62	Developmental delay	

The list given above is not meant to be exhaustive. Where examples are given, these are simply the most frequent or important conditions within a given category. The overriding rule should be that, if it is believed that a condition might be relevant to aetiology, produce significant comorbidity, or otherwise affect treatment or prognosis, and then it should be recorded.
In particular, it is suggested that any heritable condition included in *Online Mendelian Inheritance in Man (OMIM)*, http://www.ncbi.nlm.nih.gov/omim, should be recorded.

Appendix E – Recommended Staging to be collected by Cancer Registries

The National Staging Panel for Cancer Registration recommends that the staging systems recorded by the cancer registries follow the guidance issued by the Royal College of Pathologists and the Cancer Outcomes Services Dataset.

It is also important to note that both UICC and AJCC coding systems updating to v8.0 (late 2016, for collection early 2017), please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[40] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[41].

Note: ***Below is the updated staging list, please let your MDT Leads know that the change from TNM 7 to TNM 8 take effect from 1st January 2018 unless otherwise stated.***

TUMOUR TYPE	***STAGING SYSTEM (up-to 31st December 2017)***	***STAGING SYSTEM (from 1st January 2018)***
ADRENAL CORTEX TUMOURS	UICC TNM 7	UICC TNM 8
AMPULLA OF VATER - CARCINOMA	UICC TNM 7	UICC TNM 8
AMPULLA OF VATER - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
ANAL CANAL	UICC TNM 7	UICC TNM 8
APPENDIX - CARCINOMA	UICC TNM 7	UICC TNM 8
APPENDIX - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
BONE	UICC TNM 7	UICC TNM 8
BREAST	UICC TNM 7	UICC TNM 8
CERVIX	FIGO and N STAGE	FIGO (2009) and N STAGE
CHRONIC LYMPHOCYTIC LEUKAEMIA	BINET	BINET
COLON AND RECTUM - CARCINOMA	UICC TNM 5 & DUKES	UICC TNM 8
COLON AND RECTUM – GIST	UICC TNM 7	UICC TNM8
COLON AND RECTUM - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
CONJUNCTIVA - CARCINOMA	UICC TNM 7	UICC TNM 8
CONJUNCTIVA – MELANOMA	UICC TNM 7	UICC TNM 8
CUTANEOUS SQUAMOUS CELL CARCINOMA AND OTHER CUTANEOUS CARCINOMA	AJCC TNM 7	UICC TNM 8
EXTRAHEPATIC BILE DUCT - PERIHILAR	UICC TNM 7	UICC TNM 8
EXTRAHEPATIC BILE DUCTS - DISTAL	UICC TNM 7	UICC TNM 8
FALLOPIAN TUBE	FIGO	FIGO (2013)***
GALLBLADDER	UICC TNM 7	UICC TNM8
GLOTTIS	UICC TNM 7	UICC TNM 7
HEPATOBLASTOMA (CTYA)	PRETEXT STAGING SYSTEM STAGE	PRETEXT STAGING SYSTEM STAGE

[40] https://nww.cancerstats.nhs.uk/cosd/staging

[41] http://www.wileyanduicc.com/

HODGKIN LYMPHOMA	ANN-ARBOR	ANN-ARBOR
HYPOPHARYNX	UICC TNM 7	UICC TNM 7
KIDNEY	UICC TNM 7*	UICC TNM 8
KIDNEY, WILMS	WILMS TUMOUR STAGE (NWTSG)	WILMS TUMOUR STAGE (NWTSG)
LACRIMAL GLAND - CARCINOMA	UICC TNM 7	UICC TNM 8
LIP	UICC TNM 7	UICC TNM 7
LIVER - INTRAHEPATIC BILE DUCTS	UICC TNM 7 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LIVER - HEPATOCELLULAR	UICC TNM 7 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LUNG	UICC TNM 7	UICC TNM 8
MAJOR SALIVARY GLANDS	UICC TNM 7	UICC TNM 7
MAXILLARY SINUS	UICC TNM 7	UICC TNM 7
MEDULLOBLASTOMA	CHANG STAGING SYSTEM	CHANG STAGING SYSTEM
MYELOMA	INTERNATIONAL STAGING SYSTEM (ISS)	INTERNATIONAL STAGING SYSTEM (ISS)
NASAL CAVITY AND PARANASAL SINUSES	UICC TNM 7	UICC TNM 7
NASOPHARYNX	UICC TNM 7	UICC TNM 7
NEUROBLASTOMA	INTERNATIONAL NEUROBLASTOMA RISK GROUP	INTERNATIONAL NEUROBLASTOMA RISK GROUP
NON-HODGKIN LYMPHOMA (ADULT)	ANN-ARBOR	ANN-ARBOR
NON-HODGKIN LYMPHOMA (CHILDREN)	MURPHY ST. JUDE STAGING SYSTEM	MURPHY ST. JUDE STAGING SYSTEM
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – CARCINOMA	UICC TNM 7	UICC TNM 8
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)
ORAL CAVITY	UICC TNM 7	UICC TNM 7
OROPHARYNX	UICC TNM 7	UICC TNM 7
OMENTUM AND MESENTERY – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)
OVARY AND PERITONEUM	FIGO	FIGO (2013)***
PANCREAS	UICC TNM 7	UICC TNM 8
PANCREAS - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
PENIS	UICC TNM 7*	UICC TNM 8
PLEURAL MESOTHELIOMA	UICC TNM 7*	UICC TNM 8
PROSTATE	UICC TNM 7	UICC TNM 8
RENAL PELVIS AND URETER	UICC TNM 7	UICC TNM 8
RETINOBLASTOMA	UICC TNM 7	UICC TNM 8
RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS (CTYA)	IRS POST SURGICAL GROUP	UICC TNM 8 & IRS POST SURGICAL GROUP
HEPATOBLASTOMA (CTYA)	PRETEXT STAGING SYSTEM STAGE	PRETEXT STAGING SYSTEM STAGE
SARCOMA OF ORBIT	UICC TNM 7	UICC TNM 8
SKIN - MALIGNANT MELANOMA	AJCC TNM 7	UICC TNM 8
SKIN - MERKEL CELL CARCINOMA**	AJCC TNM 7	UICC TNM 8
SKIN OF EYELID - CARCINOMA	UICC TNM 7	UICC TNM 8
SMALL INTESTINE - GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)

SMALL INTESTINE - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
SMALL INTESTINE - CARCINOMA	UICC TNM 7	UICC TNM 8
SOFT TISSUE	UICC TNM 7	UICC TNM 8
STOMACH - CARCINOMA	UICC TNM 7	UICC TNM 8
STOMACH – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)
STOMACH - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
SUBGLOTTIS	UICC TNM 7	UICC TNM 7
SUPRAGLOTTIS	UICC TNM 7	UICC TNM 7
TESTIS	UICC TNM 7 & ROYAL MARSDEN STAGING SYSTEM*	UICC TNM 8 & ROYAL MARSDEN STAGING SYSTEM*
THYMUS	----------	UICC TNM 8
THYROID	UICC TNM 7	UICC TNM 7
UPPER AERODIGESTIVE TRACT - MALIGNANT MELANOMA	UICC TNM 7	UICC TNM 7
URETHRA	UICC TNM 7	UICC TNM 8
URINARY BLADDER	UICC TNM 7	UICC TNM 8
UTERUS - ENDOMETRIUM	FIGO	FIGO (2009)
UTERUS - UTERINE SARCOMA	FIGO	FIGO (2009)
UVEA - MALIGNANT MELANOMA	UICC TNM 7	UICC TNM 8
VAGINA	FIGO	FIGO
VULVA	FIGO	FIGO (2009)
VULVA – MALIGNANT MELANOMA	AJCC TNM 7	UICC TNM 8

Note: The use of preferred staging systems (which should be used), is under frequent review and may change in the future:

- *** - this staging system is recognised as currently being discussed and new guidance will be available if changes are required**
- **** - see Section 1.10 Stage of COSD User Guide for further advice on how to record Neuroendocrine tumours for COSD**
- ***** FIGO 2013 was implemented in January 2014**

Appendix F – Skin Dataset – AJCC Stage group additional information

American Joint Committee on Cancer (AJCC) Additional Information

AJCC STAGE GROUP [AMERICAN JOINT COMMITTEE ON CANCER STAGE]: MELANOMA STAGING 7TH EDITION

Clinical Staging[1]				**Pathological Staging[2]**			
AJCC stage Group	**T value**	**N value**	**M value**	**AJCC stage Group**	**T value**	**N value**	**M value**
Stage 0	Tis	N0	M0	Stage 0	Tis	N0	M0
Stage IA	T1a	N0	M0	Stage IA	T1a	N0	M0
Stage IB	T1b	N0	M0	Stage IB	T1b	N0	M0
	T2A	N0	M0		T2A	N0	M0
Stage IIA	T2b	N0	M0	Stage IIA	T2b	N0	M0
	T3a	N0	M0		T3a	N0	M0
Stage IIB	T3b	N0	M0	Stage IIB	T3b	N0	M0
	T4a	N0	M0		T4a	N0	M0
Stage IIC	T4b	N0	M0	Stage IIC	T4b	N0	M0
Stage III	Any T	≥N1	M0	Stage IIIA	T1-4a	N1a	M0
					T1-4a	N2a	M0
				IIIB	T1-4b	N1a	M0
					T1-4b	N2a	M0
					T1-4a	N1a	M0
					T1-4a	N2b	M0
					T1-4a	N2c	M0
				IIIC	T1-4b	N1b	M0
					T1-4b	N2b	M0
					T1-4b	N2c	M0
					Any T	N3	M0
Stage IV	Any T	Any N	M1	IV	Any T	Any N	M1

Notes

1. ***Clinical staging includes microstaging of the primary melanoma and clinical/radiologic evaluation for metastases. By convention, it should be used after complete excision of the primary melanoma with clinical assessment for regional and distant metastases.***

2. ***Pathologic staging includes microstaging of the primary melanoma and pathologic information about the regional lymph nodes after partial or complete lymphadenectomy. Pathologic Stage 0 or Stage IA patients are the exception; they do not require pathologic evaluation of their lymph nodes.***
3. ***Histological measures of high risk differ between SCC and BCC and are fully covered by the RCPath data sets which are therefore recommended.***

AJCC STAGE GROUP ***[AMERICAN JOINT COMMITTEE ON CANCER STAGE]:NON-MELANOMA STAGING (BCC AND SCC) 7TH EDITION***

Stage	T	High risk features	N	M
0	Tis In situ			No distant metastases
I	T1 Tumour ≤2 cm in greatest dimension with <2 high-risk features	>2mm thickness Clarks level ≥ 4 Perineural invasion SCC site ear SCC site lip Poorly or un-differentiated	No Nodes	No distant metastases
II	T2 Tumour >2 cm in greatest dimension. or Tumour any size with ≥2 high-risk features	>2mm thickness Clarks level ≥ 4 Perineural invasion SCC site ear SCC site lip Poorly or un-differentiated	No Nodes	No distant metastases
III	T3 Tumour with invasion of maxilla, mandible, orbit, or temporal bone.		No Nodes	No distant metastases
III	T1, 2 or 3		Metastasis in a single ipsilateral lymph node, ≤3 cm in greatest dimension.	No distant metastases
IV	T1, T2 or T3		Metastasis in a single ipsilateral lymph node, >3 cm but ≤6 cm in greatest dimension; or in multiple ipsilateral lymph nodes, ≤6 cm in greatest dimension; or in bilateral or contralateral lymph nodes, ≤6 cm in greatest dimension.	No distant metastases
IV	Any T		Metastasis in a lymph node, >6 cm in greatest dimension.	No distant metastases

IV	Tumour with invasion of skeleton (axial or appendicular) or perineural invasion of skull base.		Any nodal status	No distant metastases
IV	Any tumour status		Any nodal status	Distant metastases

Appendix G – Timetable for Implementation of Version 7.0

Submissions are accepted as follows for Version 7.0

Diagnosis month	dataset	schema	Accepted MDT system submission format	Accepted Pathology submission format
January 2017	v6.0	v6-0	XML only	XML/other agreed
February	v6.0	v6-0	XML only	XML/other agreed
March	v6.0	v6-0	XML only	XML/other agreed
April	V6.0 or v7.0	V6.0 or v7.0	XML only	XML/other agreed
May	V6.0 or v7.0	V6.0 or v7.0	XML only	XML/other agreed
June	V6.0 or v7.0	V6.0 or v7.0	XML only	XML/other agreed
July	V7.0	V7-0	XML only	XML/other agreed
August	V7.0	V7-0	XML only	XML/other agreed
September	V7.0	V7-0	XML only	XML/other agreed
October	V7.0	V7-0	XML only	XML/other agreed
November	V7.0	V7-0	XML only	XML/other agreed
December 2017	V7.0	V7-0	XML only	XML/other agreed
January 2018	V7.0	V7-0	XML only	XML only

***SITE SPECIFIC STAGE ITEMS TO BE SUBMITTED FROM START OF IMPLEMENTATION**

COLORECTAL
- Modified Dukes

CTYA
- Murphy (St Jude) Stage
- **Ann Arbor** – Stage; Symptoms; Extranodality,
- International Neuroblastoma Risk Group (INGR) Staging System
- Wilms Tumour Stage
- TNM Stage Grouping For Non CNS Germ Cell Tumours
- Chang Staging System Stage

Gynae
- Final Figo Stage

Haematology
- Binet Stage
- ISS Stage For Myeloma,
- **Ann Arbor** – Stage; Symptoms; Extranodality; Bulk; Splenic Involvement

Skin
- AJCC Stage Group

Urology
- Stage Group (Testicular)

Appendix H – When to complete and submit the data

The following table shows the point in the pathway (event) when the different sections of the dataset are expected to be completed and submitted. Once the relevant Pathway Event ("Trigger") has occurred, the related field (see Key to Pathway Events) should be completed along with other applicable data items in the sections noted.

Data items marked as 'Mandatory' in the relevant section of the dataset must be submitted for the record to pass validation rules. Items marked 'Required' should be submitted where applicable and as soon as possible after the initial record is uploaded. Once the trigger event has occurred the record should be sent in the next submission (25 working days after month end).

Every effort should be made to complete all the applicable items in that section before submission where possible. Any missing items should ideally be completed and submitted within three months of diagnosis (or of subsequent treatment), however the final deadline for completion of relevant items is six months after month of diagnosis (or subsequent treatment).

Note: (Although the final deadline for completion of relevant items is six months after month of diagnosis (or subsequent treatment), the English National Cancer Registration Service follows principles and procedures defined internationally, which advise that registrations are obtained from a variety of multiple sources and can be updated continuously and in a systematic manner (IARC, 1991). For this reason, any information made available to the NCRAS will always be used to update a record even if this is made after the date that a registration is declared complete for analytical purposes or for submission to ONS).

There is no requirement to combine data fields extracted from different systems prior to submission. Extracts may be uploaded from different systems as long as the linkage items are included for each record and the schema rules for Mandatory items in each section are adhered to. (Any problems with this should be discussed with the National Cancer Registration and Analysis Service receiving the extracts).

	PATHWAY EVENT ("TRIGGER")										
KEY ●Must be submitted for this event OShould be submitted for this event if available/applicable **#CORE LINKAGE: IF ANY OF THESES ITEMS CHANGE AFTER SUBMISSION, CONTACT THE REGISTRY**	**NEW DIAGNOSIS***	**FIRST TREATMENT****	**SUBSEQUENT TREATMENT****	**TERTIARY REFERRAL***	**TERTIARY FIRST TREATMENT****	**TERTIARY SUBSEQUENT TREATMENT****	**RECURRENCE – NEW DIAGNOSIS*****	**RECURRENCE – TREATMENT****	**REC' – TTERTI'Y REFERRAL*****	**REC' – TTERTI'Y TREATMENT****	**ANY OTHER DATA CHANGES**
SECTION											
CORE - LINKAGE (Patient Identity and Diagnostic Details)#	●	●	●	●	●	●	●	●	●	●	#
CORE - DEMOGRAPHICS	●			●			●		●		O
CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY	●										O
CORE – IMAGING (pre-treatment)	O			O			O		O		O
CORE - PATHOLOGY DETAILS (Pre-treatment, e.g. biopsies)	●			O			O		O		O
CORE - DIAGNOSIS	●			O			●		O		O
CORE - CANCER CARE PLAN	O			O			●		O		O
CORE - CLINICAL TRIALS	O		O	O		O					O
CORE – STAGING (Pre-treatment)	●			O							O

KEY ●Must be submitted for this event OShould be submitted for this event if available/applicable **#CORE LINKAGE: IF ANY OF THESES ITEMS CHANGE AFTER SUBMISSION, CONTACT THE REGISTRY**	PATHWAY EVENT ("TRIGGER")										
SECTION	**NEW DIAGNOSIS***	**FIRST TREATMENT****	**SUBSEQUENT TREATMENT****	**TERTIARY REFERRAL***	**TERTIARY FIRST TREATMENT****	**TERTIARY SUBSEQUENT TREATMENT****	**RECURRENCE – NEW DIAGNOSIS*****	**RECURRENCE – TREATMENT****	**REC' – TTIERTI'Y REFERRAL***	**REC' – TTIERTI'Y TREATMENT****	**ANY OTHER DATA CHANGES**
CORE - TREATMENT		●	●		●	●		●		●	O
CORE - SURGERY AND OTHER PROCEDURES		O	O		O	O		O		O	O
CORE - RADIOTHERAPY		O	O		O	O		O		O	O
CORE - ACTIVE MONITORING		O			O			O		O	O
CORE - PATHOLOGY DETAILS (Post treatment, e.g. resection)		O	O		O	O		O		O	O
CORE – STAGING (Post treatment)		●			O					O	O
CORE – IMAGING (post treatment)		●	O		●	O		O		O	O
CORE - DEATH DETAILS	O	O	O	O	O	O	O	O	O	O	O
CORE - CANCER RECURRENCE / SECONDARY CANCER							●	O	●	O	O

KEY TO PATHWAY EVENTS ("TRIGGER" DATA ITEMS)
* NEW DIAGNOSIS = DATE OF DIAGNOSIS (CLINICALLY AGREED)
** TREATMENT = TREATMENT START DATE (CANCER)
***RECURRENCE DIAGNOSIS = DATE OF RECURRENCE (CLINICALLY AGREED)
#CORE LINKAGE: IF ANY OF THESES ITEMS CHANGE AFTER SUBMISSION, CONTACT THE REGISTRY

Appendix I – Patients diagnosed prior to 2013

Additional information on Scenarios for patients diagnosed prior to Jan 2013

For patients with a diagnosis before 1st Jan 2013 the COSD is not applicable. Providers should aim to complete the registration dataset for these patients by end of February 2013.

Scenario 1. Patient diagnosed with Cancer pre Jan 2013 receiving first treatment for this primary cancer after Jan 1st 2013.
COSD is not applicable.
Cancer Waiting Times record to be completed as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (e.g. SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 2. Patient diagnosed with Cancer pre Jan 2013 receiving subsequent treatment for this primary cancer after Jan 1st 2013.
COSD is not applicable.
Cancer Waiting Times record to be completed as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (e.g. SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 3. Patient diagnosed with Cancer pre Jan 2013. Diagnosed with a different cancer after 1st Jan 2013.
COSD is applicable for the new cancer and relevant site specific and core data items should be completed.
Cancer Waiting Times record to be completed if applicable as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (e.g. SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Scenario 4. Patient diagnosed with Cancer pre Jan 2013. Diagnosed with a recurrence of this cancer after 1st Jan 2013.
COSD is applicable for the recurrence.
Cancer Waiting Times record to be completed if applicable as per NCWTMDS guidance.
All other cancer datasets to be completed in accordance with specific guidance (e.g. SACT for patients treated with Chemotherapy, RTDS for patient treated with Radiotherapy)

Appendix J – Referral Scenarios

Referral information is required once for each cancer diagnosis and is completed by the Provider which diagnosed the cancer. This should therefore be recorded from the beginning of the referral pathway within the Provider which led to the cancer diagnosis. It will normally begin at the referral to outpatients from primary care, from emergency services or from another Provider.

Cancer Waiting Times only requires this information for 2ww and screening referrals but for COSD it is essential that details of the referral section of the pathway are recorded for all cases.

Data items from Referral to First Seen Date

The following data items should be completed according to the scenarios following:

PRIORITY TYPE CODE
SOURCE OF REFERRAL FOR OUTPATIENTS
DATE FIRST SEEN
CONSULTANT CODE
ORGANISATION CODE (PROVIDER FIRST SEEN)

SCENARIOS

SCENARIO 1. 2 WEEK WAIT AND SCREENING CASES –details as covered by Cancer Waiting Times guidance

SCENARIO 2: PATIENTS INITIALLY REFERRED TO OUTPATIENTS:

SOURCE OF REFERRAL FOR OUT-PATIENTS will normally be

03	referral from a GENERAL MEDICAL PRACTITIONER
92	referral from a GENERAL DENTAL PRACTITIONER
12	referral from a GENERAL PRACTITIONER with Special Interest

Or if referred from another Hospital

05	referral from a CONSULTANT, other than in an Accident And Emergency Department

Other referral sources listed may also be applicable

SCENARIO 3: PATIENTS INITIALLY SEEN AS EMERGENCIES BUT THEN REFERRED TO ANOTHER CONSULTANT:

SOURCE OF REFERRAL FOR OUT-PATIENTS will be either:

01	following an emergency admission
10	following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)
04	referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)

- *DATE FIRST SEEN will be the first outpatient appointment following the emergency presentation or the first consultation with the specialist if patient remained as an inpatient.*
- *CONSULTANT CODE relates to Date First Seen so will be the consultant who the patient was referred to following the emergency presentation.*
- *ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation the patient was referred to following the emergency presentation.*

SCENARIO 4: PATIENTS WHERE CANCER WAS INITIALLY DIAGNOSED AND FIRST TREATED AS AN EMERGENCY:

- *SOURCE OF REFERRAL FOR OUT-PATIENTS will normally be one of the emergency codes above*
- *DATE FIRST SEEN will be the date of the emergency first treatment*

- *CONSULTANT CODE relates to Date First Seen so will be the consultant carrying out the first treatment*
- *ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation carrying out the first treatment*

SCENARIO 5: PATIENTS WHERE CANCER WAS AN INCIDENTAL FINDING OF ANOTHER TREATMENT OR PROCESS

- *SOURCE OF REFERRAL FOR OUT-PATIENTS will be*

11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

- *DATE FIRST SEEN will be the date of the incidental finding*
- *CONSULTANT CODE relates to Date First Seen so will be the consultant who made the incidental findings during another treatment or process*
- *ORGANISATION CODE (PROVIDER FIRST SEEN) relates to the Date First Seen so will be the organisation where the incidental findings were made*

Data items for Cancer Specialist

The following data items should be completed according to the scenarios following:

- *FIRST SEEN BY SPECIALIST DATE (CANCER)*
- *ORGANISATION CODE (PROVIDER FIRST CANCER SPECIALIST)*

SCENARIO 1: PATIENT WAS FIRST SEEN BY THE APPROPRIATE CANCER SPECIALIST
Use same details as DATE FIRST SEEN and ORGANISATION CODE (PROVIDER FIRST SEEN)

SCENARIO 2: INITIAL REFERRAL WAS NOT TO THE APPROPRIATE CANCER SPECIALIST
Record details for the first appointment with the appropriate cancer specialist to progress this cancer diagnosis.

Appendix K – Data items from other standards (for reference)

The following data items are included in the full COSD Information Standard as they are part of the dataset required for reporting cancer in the NHS in England. They are however already collected centrally for other Information Standards and therefore do not need to be submitted by individual trusts for COSD. These items are not included in the schema.

	CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY To carry patient referral details to the Provider that receives the first referral.					
CR1380	CORE - REFERRALS	**PATIENT PATHWAY IDENTIFIER**		PATIENT PATHWAY IDENTIFIER	CWT	X
CR1390	CORE - REFERRALS	**ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)**		SITE CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	CWT	X
CR0260	CORE - REFERRALS	**TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE**		TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE	CWT	X
CR0190	CORE - REFERRALS	**DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)**		DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)	CWT	X
CR2020	CORE - REFERRALS	**PRIORITY TYPE CODE**		PRIORITY TYPE CODE	CWT	X
CR0200	CORE - REFERRALS	**CANCER REFERRAL TO TREATMENT PERIOD START DATE**		CANCER REFERRAL TO TREATMENT PERIOD START DATE	CWT	X
CR1620	CORE - REFERRALS	**CONSULTANT UPGRADE DATE**		CONSULTANT UPGRADE DATE	CWT	X
CR3010	CORE - REFERRALS	**ORGANISATION SITE CODE (PROVIDER CONSULTANT UPGRADE)**		SITE CODE (OF PROVIDER CONSULTANT UPGRADE)	CWT	X
CR0280	CORE - REFERRALS	**WAITING TIME ADJUSTMENT (FIRST SEEN)**		WAITING TIME ADJUSTMENT (FIRST SEEN)	CWT	X
CR0290	CORE - REFERRALS	**WAITING TIME ADJUSTMENT REASON (FIRST SEEN)**		WAITING TIME ADJUSTMENT REASON (FIRST SEEN)	CWT	X
CR0250	CORE - REFERRALS	**DELAY REASON COMMENT (FIRST SEEN)**		DELAY REASON COMMENT (FIRST SEEN)	CWT	X
CR0240	CORE - REFERRALS	**DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)**		DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)	CWT	X

CR3210	*CORE - REFERRALS*	***REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)***[42]		*ORGANISATION CODE (PROVIDER DECISION TO TREAT CANCER)*	*CWT*	*X*
	CORE - TREATMENT To carry cancer treatment details.					
CR1420	CORE - TREATMENT	**ORGANISATION SITE CODE (PROVIDER DECISION TO TREAT CANCER)**		ORGANISATION CODE (PROVIDER DECISION TO TREAT CANCER)	CWT	X
CR1430	CORE - TREATMENT	**CANCER TREATMENT PERIOD START DATE**		CANCER TREATMENT PERIOD START DATE	CWT	X
CR1440	CORE - TREATMENT	**CANCER CARE SETTING (TREATMENT)**		CANCER CARE SETTING (TREATMENT)	CWT	X
CR1460	CORE - TREATMENT	**DELAY REASON COMMENT (DECISION TO TREATMENT)**		DELAY REASON COMMENT (DECISION TO TREATMENT)	CWT	X
CR1470	CORE - TREATMENT	**DELAY REASON (DECISION TO TREATMENT)**		DELAY REASON (DECISION TO TREATMENT)	CWT	X
CR1480	CORE - TREATMENT	**WAITING TIME ADJUSTMENT (TREATMENT)**		WAITING TIME ADJUSTMENT (TREATMENT)	CWT	X
CR1490	CORE - TREATMENT	**WAITING TIME ADJUSTMENT REASON (TREATMENT)**		WAITING TIME ADJUSTMENT REASON (TREATMENT)	CWT	X
CR1500	CORE - TREATMENT	**DELAY REASON COMMENT (REFERRAL TO TREATMENT)**		DELAY REASON COMMENT (REFERRAL TO TREATMENT)	CWT	X
CR1510	CORE - TREATMENT	**DELAY REASON REFERRAL TO TREATMENT (CANCER)**		DELAY REASON REFERRAL TO TREATMENT (CANCER)	CWT	X
CR1520	CORE - TREATMENT	**DELAY REASON COMMENT (CONSULTANT UPGRADE)**		DELAY REASON COMMENT (CONSULTANT UPGRADE)	CWT	X
CR1530	CORE - TREATMENT	**DELAY REASON (CONSULTANT UPGRADE)**		DELAY REASON (CONSULTANT UPGRADE)	CWT	X
CR1250	CORE - TREATMENT	**CLINICAL TRIAL INDICATOR**		CLINICAL TRIAL INDICATOR	CWT	X

[42] Please note that this data item is expected to be added to the CWT dataset from September 2015 and has therefore been included here to maintain future alignment

	CORE - RADIOTHERAPY					
	To carry the radiotherapy details. A course of radiotherapy is defined as a string of prescriptions which are consecutive.					
CR1560	CORE - RADIOTHERAPY	**RADIOTHERAPY PRIORITY**		RADIOTHERAPY PRIORITY	CWT / RTDS	X
CR1570	CORE - RADIOTHERAPY	**RADIOTHERAPY INTENT**		RADIOTHERAPY INTENT	CWT	X
CR1140	CORE - RADIOTHERAPY	**ANATOMICAL TREATMENT SITE (RADIOTHERAPY)**		ANATOMICAL TREATMENT SITE (RADIOTHERAPY)	RTDS	X
	CORE - CHEMOTHERAPY AND OTHER DRUGS To carry the details of chemotherapy and/or other anti- cancer and/or supportive drugs given to the patient during their treatment. One occurrence of this data group is permitted per treatment where applicable.					
CR1070	CORE - CHEMOTHERAPY AND OTHER DRUGS	**DRUG TREATMENT INTENT**		DRUG TREATMENT INTENT	SACT	X
CR1080	CORE - CHEMOTHERAPY AND OTHER DRUGS	**DRUG REGIMEN ACRONYM**		DRUG REGIMEN ACRONYM	SACT	X

Appendix L – Data items from other sources (for reference)

The following data items are included in the full COSD Information Standard as they are part of the dataset required for reporting cancer in the NHS in England. They are however collected or derived centrally from other sources, and therefore do not need to be submitted by individual trusts for COSD. These items are not included in the schema.

Data item No.	Data Item Section	Data Item Name	Description	Format	National Code	National Code Definition	Data Dictionary Element	Source
	CORE - DEMOGRAPHICS **One occurrence of this group is permitted**							
CR3080	CORE - DEMOGRAPHICS	**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)**	The ORGANISATION CODE of the ORGANISATION responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.	an3	see ORGANISATION SITE CODE		ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	ONS
CR3090	CORE - DEMOGRAPHICS	**ORGANISATION CODE (RESIDENCE RESPONSIBILITY)**	The ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS.	an3	see ORGANISATION SITE CODE		ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	ONS
	CORE - DIAGNOSIS To carry diagnosis details One occurrence of the group is permitted							
CR0360	CORE - DIAGNOSIS	**DATE OF DIAGNOSIS (CANCER REGISTRATION)**	The registry agreed internationally comparable diagnosis date as defined by the UKACR library of Recommendations. This will be derived by Cancer Registries.	an10 ccyy-mm-dd			DATE OF DIAGNOSIS (CANCER REGISTRATION)	CANCER REGISTRY
CR0170	CORE - DIAGNOSIS	**DATE OF RECURRENCE (CANCER REGISTRATION)**	The registry agreed internationally comparable date of recurrence of a cancer as defined by the UKACR library of Recommendations. This will be derived by Cancer Registries.	an10 ccyy-mm-dd			DATE OF RECURRENCE (CANCER REGISTRATION)	NEW

	CORE - REFERRALS AND FIRST STAGE OF PATIENT PATHWAY To carry patient referral details to the Trust that receives the first referral. These details include information relating to the first stage of the Patient Pathway. One occurrence of this group is permitted							
CR0220	CORE - REFERRALS	**CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN)**[43]	The MAIN SPECIALTY CODE of the CONSULTANT who first sees the PATIENT following the initial referral which leads to the cancer diagnosis. NB: Codes 501 (Obstetrics) and 502 (Gynaecology) should be used and not the combined code 500 (Obstetrics and Gynaecology); this is in common with the requirements for central returns, including Hospital Episode Statistics.	an3		Main Specialty Code	CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN)	CANCER REGISTRY
	CORE - TREATMENT To carry the cancer treatment details. Multiple occurrences of this data group are permitted							
CR0670	CORE - TREATMENT	**CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT)**[44]	The MAIN SPECIALTY CODE of the CONSULTANT responsible for the treatment of the PATIENT. NB: Codes 501 (Obstetrics) and 502 (Gynaecology) should be used and not the combined code 500 (Obstetrics and Gynaecology); this is in common with the requirements for central returns, including Hospital Episode Statistics.	an3		Main Specialty Code	CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT)	CANCER REGISTRY

[43] This data item has been moved from the schema as it is no longer required for direct submission from trusts

[44] This data item has been moved from the schema as it is no longer required for direct submission from trusts

	CORE - RADIOTHERAPY DETAILS To carry radiotherapy details One occurrence of this group is permitted per treatment							
CR2080	CORE - RADIOTHERAPY	**RADIOTHERAPY TOTAL DOSE**	The total actual absorbed radiation dose received during a course of treatment.	max n3.n2	5 (including 2 decimal places)		RADIOTHERAPY TOTAL DOSE	RTDS
CR2090	CORE - RADIOTHERAPY	**RADIOTHERAPY TOTAL FRACTIONS**	The total number of Fractions calculated based on attendances as part of a Radiotherapy Treatment Course.	max n2			RADIOTHERAPY TOTAL FRACTIONS	RTDS
	CORE - DEATH DETAILS To carry death details One occurrence of this group is permitted							
CR1270	CORE - DEATH DETAILS	**PERSON DEATH DATE**	The date on which a PERSON died or is officially deemed to have died.	an10 ccyy-mm-dd			PERSON DEATH DATE	ONS
CR1280	CORE - DEATH DETAILS	**DEATH LOCATION TYPE**[45]	The actual place where the PERSON died.	an2	10	Hospital	DEATH LOCATION TYPE CODE (ACTUAL)	ONS
					20	Private Residence		
					21	PATIENT'S own home		
					22	Other private residence (e.g. relatives home, carers home)		
					30	Hospice		
					40	Care Home		

[45] The codes and values of this data item have been standardised across a number of data standards and sources

					41	Care Home with Nursing		
					42	Care Home without Nursing		
					50	Other		
CR3020	CORE - DEATH DETAILS	**DEATH CAUSE IDENTIFICATION METHOD**	The source of information from which the cause of death was established.	an1	1	Death certificate	DEATH CAUSE IDENTIFICATION METHOD	ONS
					2	NHS Central Register Follow-up		
					3	Hospital records		
					4	Verbal communication		
					5	Post mortem		
CR1300	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (IMMEDIATE)**	The ICD code of the immediate cause of death as recorded on the death certificate.	an6			DEATH CAUSE ICD CODE (IMMEDIATE)	ONS
CR1310	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (CONDITION)**	The ICD code of the condition giving rise to death as recorded on the death certificate.	an6			DEATH CAUSE ICD CODE (CONDITION)	ONS
CR1320	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (UNDERLYING)**	The ICD code of the underlying condition leading to death as recorded on the death certificate.	an6			DEATH CAUSE ICD CODE (UNDERLYING)	ONS
CR1330	CORE - DEATH DETAILS	**DEATH CAUSE ICD CODE (SIGNIFICANT)**	The ICD code of a significant condition not directly related to death as recorded on the death certificate.	an6			DEATH CAUSE ICD CODE (SIGNIFICANT)	ONS
	BREAST - REFERRALS To carry referral details for breast cancer One occurrence of this group is permitted							

BR4025	BREAST - REFERRALS	**SCREENING STATUS FOR CANCER**	The screening status of a PATIENT at the time of diagnosis of cancer	an1	1	Screen-detected	CANCER SCREENING STATUS	SCREENING
					2	Interval cancer		
					4	Lapsed attender		
					5	Never attended		
					6	Never invited		
					7	Other		
					9	Not known (default). Cancers with unknown screening status.		
	GYNAECOLOGY - REFERRAL To carry referral details for Gynae cancer One occurrence of this group is permitted							
GY7030	GYNAECOLOGY - REFERRAL	**SCREENING STATUS FOR CANCER**	The screening status of a PATIENT at the time of diagnosis of cancer	an1	1	Screen-detected	CANCER SCREENING STATUS	SCREENING
					2	Interval cancer		
					4	Lapsed attender		
					5	Never attended		
					6	Never invited		
					7	Other		
					9	Not known (default). Cancers with unknown screening status.		
	COLORECTAL - REFERRALS To carry referral details for colorectal cancer One occurrence of this group is permitted							

CO5000	COLORECTAL - REFERRALS	**SCREENING STATUS FOR CANCER**	The screening status of a PATIENT at the time of diagnosis of cancer	an1	1	Screen-detected	CANCER SCREENING STATUS	SCREENING
					2	Interval cancer		
					4	Lapsed attender		
					5	Never attended		
					6	Never invited		
					7	Other		
					9	Not known (default). Cancers with unknown screening status.		

Appendix M – Understanding Cancer E-Learning

Understanding Cancer

Oncology Training for NHS and Public Health non-clinical staff

National Cancer Intelligence Network

Professionally accredited by the Institute of Healthcare Management

Free access for all UK users

Key features include:

- flexibility to work at your own pace from work or home
- ability to stop and resume at any point from any computer
- reference guides
- colourful images throughout
- glossary of terms
- learning objectives
- quizzes
- certificate of achievement
- free of charge to UK users

What to do next

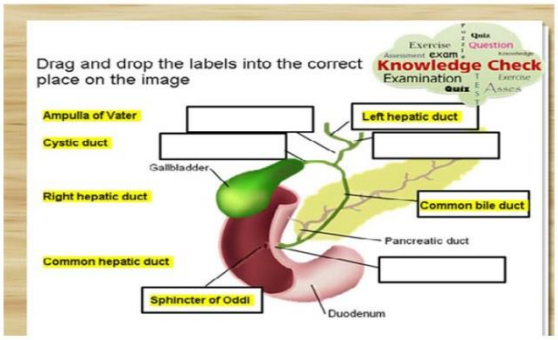
For more information, visit www.ncin.org.uk where you can self-register on to the mylearningspace website by creating a new account

Who it is for and what you will learn

This e-learning tool is aimed primarily at Multi-disciplinary Team Co-ordinators and Cancer Registration staff who need to know:

- about cancer – medical terminology, diagnoses, tests and treatments
- how cancer services are organised in the NHS
- about cancer types – key risks, including causes, risk factors, signs and symptoms, anatomy and physiology

Other NHS and Public Health staff can also use the course to improve their understanding of cancer



Public Health England

Institute of Healthcare Management

ukiacr

http://www.ncin.org.uk/cancer_information_tools/training/default.aspx