



# **The National Bowel Cancer Audit**

## **DATA MANUAL**

**Title: Data Manual**

**Version: 2.0**

**Date: 15 July 2009**

## VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
0.1	02 April 2007		Nancy Horseman, Data Manager (NCASP)
0.2	13 June 2007	Changes following feedback from Mike Thompson	Nancy Horseman, Data Manager (NCASP)
0.2.1	2 July 2007	Changes following feedback from Datasets team	Nancy Horseman, Data Manager (NCASP)
0.2.2	5 July 2007	Changes following feedback from Roz Stanley	Nancy Horseman, Data Manager (NCASP)
1.0	20 July 2007	Following approval from Mike Thompson	Nancy Horseman, Data Manager (NCASP)
1.1	25 July 2007	Following further comment from Steve Dean, Mike Thompson and final approval from Jason Smith	Nancy Horseman, Data Manager (NCASP)
2.0	15 July 2009	Changes made to update five organisation codes with mandatory status	Rose Napper, Project Support (NCASP)

For more information on the status of this document, please see the covering letter or contact:	<p>The Information Centre for health &amp; social care National Clinical Audit Support Programme 1 Trevelyan Square Boar Lane Leeds LS1 6AE</p> <p>E-mail:            <b>bowel@ic.nhs.uk</b></p> <p>Internet:</p> <p><a href="http://www.ic.nhs.uk/our-services/improving-patient-care/cancer">http://www.ic.nhs.uk/our-services/improving-patient-care/cancer</a></p>
Date of Issue	15 July 2009
© Crown Copyright 2009	

## TABLE OF CONTENTS

<b>INTRODUCTION .....</b>	<b>4</b>
Preface.....	4
How to use this manual.....	4
Organisation Codes and GMC Codes .....	4
<b>PATIENT DETAIL .....</b>	<b>5</b>
<b>TUMOUR.....</b>	<b>9</b>
Diagnosis .....	10
Referral Details .....	11
Tumour Site .....	13
Recording of Synchronous Tumours .....	14
Modified Dukes' Staging .....	16
Investigations .....	16
Pre-treatment Staging.....	20
Multidisciplinary Team (MDT) Discussion Indicator.....	23
<b>TREATMENT .....</b>	<b>23</b>
Pre-Operative Data .....	25
Procedure .....	26
Surgical Access .....	30
Post-Operative.....	31
Pathology .....	32
TNM Category (Pathological) Staging .....	36
Oncology.....	38
<b>FOLLOW-UP DETAIL.....</b>	<b>40</b>
<b>APPENDIX A: HOW TO OBTAIN A LIST OF HOSPITAL SITE CODES .....</b>	<b>44</b>
<b>APPENDIX B: HOW TO OBTAIN A LIST OF CONSULTANT CODES .....</b>	<b>45</b>
<b>APPENDIX C: NOTES ON CODING CLASSIFICATIONS .....</b>	<b>46</b>
International Statistical Classification of Diseases and Related Health Problems (ICD-10) .....	46
SNOMED CT ©.....	46
OPCS-4 - operation codes.....	46
UICC Coding.....	47
<b>APPENDIX D: ACKNOWLEDGEMENTS .....</b>	<b>48</b>

## INTRODUCTION

### Preface

This manual is designed to complement the National Bowel Cancer Audit dataset (version 2.1, released July 2007) and support national data collection for patients diagnosed with primary bowel cancer. The National Bowel Cancer Dataset is a subset of the National Cancer Dataset (NCDS version 4.5) plus a number of additional data items. The National Bowel Cancer Audit Dataset was developed and agreed by the Association of Coloproctology of Great Britain and Ireland in conjunction with the Information Centre for health and social care.

The manual describes each element of the dataset. It details the content of each data item, including its definition and purpose. For items from the National Cancer Dataset this manual takes information from the more comprehensive Cancer Data Manual based on Cancer Dataset version 4.5. Users are welcome to refer to this manual which includes many other data items relating to cancer. The National Cancer Data Manual is designed to support the full National Cancer Dataset and is a very large and comprehensive document, which can be reviewed on <http://www.ic.nhs.uk/webfiles/Services/Datasets/cancer/corecancerdatamanual.pdf>

In order to facilitate direct data entry, the organisation of this document corresponds with the order of screens and data items in the web-based National Bowel Cancer Audit system. Users who upload data via CSV or XML files should read this manual in conjunction with the relevant CSV / XML specification document, downloadable from <http://www.ic.nhs.uk/our-services/improving-patient-care/cancer/bowel>

### How to use this manual

- The organisation of this manual corresponds with the order of sections and fields in the National Bowel Cancer Audit system.
- Each section starts with a table listing the data items, reference numbers and the source of the definition.
- Data items with a reference number prefixed with 'B' are part of the National Bowel Cancer Audit Dataset (NBCA). All others are from the National Cancer Dataset (NCDS).
- After the table, each data item is listed with its format and specific guidance on its completion.
- Where the format is a Drop Down List, this is indicated using the acronym 'DDL'.
- Text in round brackets after data item description denotes the National Bowel Cancer Audit system screen names for the data items.

### Organisation Codes and GMC Codes

Several fields in National Bowel Cancer Audit system are used to record the unique five character organisation code of the unit at which a patient is seen or treated. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes, for a description of Organisation Codes. There are also codes for private organisations (independent providers).

See [Appendix A](#) for information on how to obtain the national list of site codes. Once identified, local Provider codes can be permanently held by systems and each provider should therefore only need to look up its code once and then make this permanently available to those staff responsible for compiling and reporting datasets.

Several fields in National Bowel Cancer Audit system are used to record the General Medical Council (GMC) Code for consultants responsible for care. The GMC Code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes for a description of the GMC Code.

See [Appendix B](#) for information on how to obtain the national list of consultant codes. A pick list of the most frequently used codes should be made available locally.

## PATIENT DETAIL

This section should be used to record details for patients who have a diagnosis of colorectal cancer, including patients who have been seen and treated privately. It should not be used to record the details of patients with anal cancer. The patient record will only be held once.

Field Name	Mandatory	Dataset Ref	Source of Definition
NHS Number	Yes	1.1	NHS Data Dictionary
Originating Organisation Code	Yes	B1	NBCA Dataset
Updating Organisation Code	Yes	B2	NBCA Dataset
Uploading Organisation Code		B3	NBCA Dataset
Batch ID		B4	NBCA Dataset
Batch Record ID		B5	NBCA Dataset
Patient Local Identifier Code		1.2	NCDS / ACP
Patient Forename	Yes	1.6	NCDS
Patient Surname	Yes	1.5	NCDS
Postcode		1.8	NCDS
Date of Birth		1.10	NCDS
Patient Sex	Yes	1.9	NCDS
Patient Height (m)		B6	NBCA Dataset
Patient Weight (kg)		B7	NBCA Dataset
Consultant Code		7.2	NCDS
Patient date of death		15.1	NCDS
Patient cause of death		15.4	NCDS
Post mortem		B8	NBCA Dataset

### 1.1 NHS NUMBER (NHS Number)

*10 digit numeric*

Record the patient's unique 10 digit new format NHS Number. It is mandatory to record the new NHS number for each patient.

Upon entering the NHS number, certain other data items in this section will be retrieved from the Open Exeter database, including Forename, Surname, and Date of Birth. These data items cannot be edited through the National Bowel Cancer Audit system.

If the NHS number is not available for a patient it can be accessed via the NHS Tracing Service. Access to the NSTS is via the secure website at <http://www.connectingforhealth.nhs.uk/nsts>

This can take some time but need only be done once for each patient and then the information shared as this is a permanent lifetime number which will not change.

### B1 ORIGINATING ORGANISATION CODE

*TEXT*

This is the unique five character organisation code of the unit responsible for creating the data record.

For records added via the data-entry screens, this field is automatically populated with the user's Open Exeter organisation code, which is their national organisation code appended with "CAB" (Clinical Audit: Bowel). For example, a national code of "AB123" would correspond to an Open Exeter organisation code of "AB123CAB".

For records added via CSV file import, this field is populated from the import file. For consistency with records added via the data-entry screens, it is recommended that this field is set to the submitting organisation's national organisation code appended with "CAB".

If an organisation is submitting data on behalf of another organisation then they must ensure that the check box under the file location field is ticked. This is on the import data screen.

### **B2 UPDATING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for updating the data, assigned automatically by the system.

### **B3 UPLOADING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for uploading the data. For records added via the data-entry screens, this field does not apply and is left blank. For records added via CSV file import, this field is automatically populated with the submitting user's Open Exeter organisation code.

### **B4 BATCH ID**

This is unique numeric identifier for a data file, assigned automatically by the system. This item only applies to records submitted via CSV.

### **B5 BATCH RECORD ID**

This is a unique numeric identifier for a record in a data file (unique across all files), assigned automatically. This item only applies to records submitted via CSV.

## **1.2 PATIENT LOCAL IDENTIFIER CODE**

*TEXT*

Record the local patient identifier used for the patient. This is a number used to identify a patient uniquely within a Health Care Provider. This may be hospital site-specific, that is, there may be different hospital numbers collected for the patient at different points in the pathway.

This may also be known as the hospital number, case-sheet number, case number or registration number.

This field is included for local use only.

## **1.6 PATIENT FORENAME**

Record the primary forename for the patient. This item is required to ensure the subject of the dataset is correct.

For records entered via direct entry, this item will be populated automatically from the Open Exeter System.

For records entered via CSV file import, it will be rejected if it does not match with the forename held in the Open Exeter System.

## **1.5 PATIENT SURNAME**

*TEXT*

Record the patient's surname. This item serves as a check item to ensure the subject of the dataset is correct.

If the patient's surname changes during care, it is essential that the surname at the date of diagnosis is provided.

For records entered via direct entry, this item will be populated automatically from the Open Exeter System.

For records entered via CSV file import, it will be rejected if it does not match with the surname held in the Open Exeter System.

## 1.8 POST CODE

*TEXT*

Record the postcode of the patient's address at diagnosis:

If a Patient has no fixed abode this should be recorded with the appropriate code (ZZ99 3VZ).

Note: If the patient's postcode changes after diagnosis, do not change the postcode.

## 1.10 DATE OF BIRTH

*DD/MM/YYYY*

Record the patient's date of birth, in date format DD/MM/YYYY

For records entered via direct entry, this item will be populated automatically from the Open Exeter System.

For records entered via CSV file import, it will be rejected if it does not match with the date of birth held in the Open Exeter System.

## 1.9 PATIENT SEX

*DDL*

Record the patient's sex.

VALID VALUE	DESCRIPTION
1	Male
2	Female
9	Not Specified
0	Not Known

For records entered via direct entry, this item will be populated automatically from the Open Exeter System.

For records entered via CSV file import, it will be rejected if it does not match with the date of birth held in the Open Exeter System.

## B6 PATIENT HEIGHT (m)

*3,2 digit numeric*

Record the height of the patient at the time of diagnosis. This is collected with item B7 to calculate the BMI.

## B7 PATIENT WEIGHT (kg)

*4,1 digit numeric*

Record the weight of the patient at the time of diagnosis. This is collected with item B6 to calculate the BMI.

**7.2 CONSULTANT CODE***TEXT*

Record the General Medical Council (GMC) Code for the consultant who is actually in overall charge of the patient's surgical treatment. Note that this may not be the person who actually performs the procedure.

Note: We acknowledge that on some occasions a patient may be entirely managed by a consultant gastro-intestinal physician following removal of a polyp cancer, or by an oncologist, even if the case has been discussed with a surgeon. The consultant managing the case can be recorded.

The GMC Code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes.

See Appendix B for information on how to obtain the national list of consultant codes. A pick list of the most frequently used codes should be made available locally.

**15.1 PATIENT DATE OF DEATH***DD/MM/YYYY*

Record the date the patient died, in date format.

**15.4 PATIENT CAUSE OF DEATH***DDL*

Record the indicated cause of death of the patient, related to their diagnosis of cancer.

VALID VALUE	DESCRIPTION
1	Death by first registered primary.
2	Death by another primary.
3	Death by other causes, cancer known to be present.
4	Death by other causes, cancer not mentioned.
5	Indeterminate cause of death (more than one primary)
6	Death from metastatic disease where origin of primary is known.
7	Death from metastatic disease where origin of primary is unknown.

**B8 POST MORTEM***DDL*

Record if a post mortem was performed.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

## TUMOUR

This section is used to record referral and diagnostic details for patients with a definitive diagnosis of primary bowel cancer. It does not include patients with a diagnosis of anal or appendiceal cancer.

Field Name	Mandatory	Dataset Ref	Source of Definition
NHS Number	Yes	1.1	NCDS
Care Spell Number	Yes	1.4	NCDS
Originating Organisation Code	Yes	B9	NBCA Dataset
Updating Organisation Code	Yes	B10	NBCA Dataset
Uploading Organisation Code		B11	NBCA Dataset
Batch ID		B12	NBCA Dataset
Batch Record ID		B13	NBCA Dataset

### 1.1 NHS NUMBER

*10 digit numeric*

(See 1.1/Patient) For records submitted via direct entry, the NHS number will automatically be displayed on screen. For records submitted via CSV upload, the NHS number is required in order to ensure that files are attached to the correct patient record.

### 1.4 CARE SPELL NUMBER

*Alphanumeric*

This item is the unique code used to link all activities for a patient to the same care spell. This will be allocated on diagnosis, at the organisation where the diagnosis takes place, and will be communicated to all organisations providing care to the patient.

For records submitted via direct entry this number will automatically be created within the system and displayed on screen when the tumour details are saved.

For records submitted via CSV upload, the correct format should be used. Care Spell numbers are generated as follows:

NHS number – ICD Major Site Code – Date of Diagnosis (YYYYMMDD)

For example: 1112223334-18-20070101.

Note that the ICD Major Site Code and the Date of Diagnosis cannot be changed as they are the key components of the Care Spell Number. ***It is therefore important to get the ICD site code correct the first time, which means that this data should not be entered for the patient until there is complete confidence on its accuracy.*** Note that if the major site code changes at operation the ICD Major Site Code will not change.

### B9 ORGANISATION CODE

*TEXT*

This is the unique five character organisation code of the unit responsible for creating the data record. For records added via the data-entry screens, this field is automatically populated with the user's Open Exeter organisation code, which is their national organisation code appended with "CAB" (Clinical Audit: Bowel). For example, a national code of "AB123" would correspond to an Open

Exeter organisation code of "AB123CAB".

For records added via CSV file import, this field is populated from the import file. For consistency with records added via the data-entry screens, it is recommended that this field is set to the submitting organisation's national organisation code appended with "CAB".

#### **B10 UPDATING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for updating the data, assigned automatically by the system.

#### **B11 UPLOADING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for uploading the data. For records added via the data-entry screens, this field does not apply and is left blank. For records added via CSV file import, this field is automatically populated with the submitting user's Open Exeter organisation code.

#### **B12 BATCH ID**

This is unique numeric identifier for a data file, assigned automatically by the system. This item only applies to records submitted via CSV file import.

#### **B13 BATCH RECORD ID**

This is a unique numeric identifier for a record in a data file (unique across all files), assigned automatically. This item only applies to records submitted via CSV file import.

Field Name	Mandatory	Dataset Ref	Source of Definition
Place first seen Organisation code	Yes	B14	NBCA Dataset
Date Of Clinical Diagnosis		B15	NBCA Dataset
Date Of Diagnosis	Yes	4.1	NCDS

#### **B14 PLACE FIRST SEEN ORGANISATION CODE**

*TEXT*

Record the organisation code of the Unit where the patient had first contact with the person or group first referred to when bowel cancer was first considered (in 2.9). This is a unique five-character code (see appendix A for how to obtain organisation codes).

### **Diagnosis**

#### **B15 DATE OF CLINICAL DIAGNOSIS**

*DD/MM/YYYY*

Record the date when a clinical diagnosis of cancer was made.

Order of declining priority:

1. Date of first clinical investigation, such as Barium Enema, Colonoscopy, CT colonography, or USS, that showed a likely malignancy
2. Date of first clinical investigation report that showed a likely malignancy
3. Date when the patient was evaluated at outpatient clinic and told of their probable diagnosis
4. Date of admission to hospital for that malignancy
5. Date of death if no information is available other than the fact that the patient has died because of malignancy

Record in date format.

#### 4.1 DATE OF DIAGNOSIS

*DD/MM/YYYY*

This field records the date of diagnosis of the tumour. It is required with the date of birth to derive the age at diagnosis and is used in the analysis of incidence trends and in the calculation of survival rates. The definition provided conforms with the international requirements specified by the European Network of Cancer Registries (ENCR).

Order of declining priority:

1. Date of first histological or cytological confirmation of this malignancy (with the exception of histology or cytology at autopsy). This date should be, in the following order:
  - a. date when the specimen was taken
  - b. or date of receipt by the pathologist
  - c. or date of the pathology report
2. Date of admission to hospital because of this malignancy.
3. When evaluated at an out-patient clinic only: date of first consultation at the out-patient clinic because of this malignancy.
4. Date of diagnosis, other than 1, 2 or 3.
5. Date of death, if no information is available other than the fact that the patient has died because of malignancy.
6. Date of death, if the malignancy is discovered at autopsy.

Record in date format.

## Referral Details

Field Name	Mandatory	Dataset Ref	Source of Definition
Referral Source		2.1	NCDS
Diagnostic Route		C.1	NCDS (Colorectal Appendix)
Date Of Referral Receipt		2.6	NCDS
Priority Of Referral to Outpatients		2.4	NCDS
Date Of First Hosp Appointment		2.9	NCDS

#### 2.1 REFERRAL SOURCE

*DDL*

Record the source of referral of the patient to the person or team who first saw the patient in secondary care for this care spell (in 2.9). Choose from the following drop down menu options. Please note that when a patient has been admitted to hospital via a GP as an emergency or through A&E

they may then go on to be referred to a bowel cancer specialist. In this scenario either code 01 or 05 could apply. Where possible, use code 05 unless the admission was straight to the bowel cancer specialist team in which case use code 01.

(Note that this data item is referring to the source of referral to the bowel cancer team and this is not necessarily the same as the source of referral to the hospital.)

VALID VALUE	DESCRIPTION
01	Following an emergency admission (includes all acute admissions via A&E, Medical Admissions Unit etc.)
02	Following a domiciliary visit by the consultant
03	Referral from General Medical Practitioner (for outpatient or other non-emergency referrals)
05	Referral from a consultant, other than in an A&E department. If the diagnosis took place within the screening services then this code applies.
06	Self-referral (i.e. the patient was not previously seen by a GP)
08	Other source of referral (will include referrals from Private Healthcare)
10	Following an A&E attendance (i.e. an out-patient clinic attendance following an A&E visit)
99	Not known

### C.1 DIAGNOSTIC ROUTE [Screening status]

Record the patient's screening status. This is intended to indicate the patient's route to diagnosis. Note: interval cancers cannot be identified here.

VALID VALUE	DESCRIPTION
1	Cancers detected by The National Bowel Cancer Screening Programme
2	Interval cancers occurring in patients screened by The National Bowel Cancer Screening Programme
3	Other cancers (bowel cancers detected in other screening programmes)
9	Not known

Note regarding recording '3 - Other Cancers': This is to distinguish patients with screen detected cancers in programmes other than the national bowel cancer screening programme, for example for strong family history of cancer, ulcerative colitis, follow-up after cancer resection or polyp removal.

### 2.6 DATE OF RECEIPT OF REFERRAL

*DD/MM/YYYY*

Record the date that the referral request is received by the provider e.g.

- the date when the letter/proforma or e-mail is received (date stamped at the receiving department)
- the date of a verbal request
- the date of admission to hospital, or date seen in the A&E Department, in the case of patients coming in as emergencies
- if the patient's diagnosis took place within the screening service, then leave this field blank (it is thought that no date would be relevant in this scenario)

Record the date in date format.

**2.4 CANCER REFERRAL PRIORITY TYPE [Priority of referral]**

DDL

This field is to be submitted in conjunction with "SOURCE OF REFERRAL FOR OUT-PATIENTS" in order to differentiate those records that fall within the boundaries of the two week wait standards. This data item is to refer to the initial referral into the first secondary care unit on the patient pathway:

VALID VALUE	DESCRIPTION
01	Urgent referral for suspected cancer from a General Medical Practitioner
02	Other referral source or urgency

**2.9 DATE OF FIRST HOSPITAL APPOINTMENT (Date first seen)**

DD/MM/YYYY

Record the date of the patient's first contact with the person or group first referred to in secondary care for this care spell.

- date of first out-patient appointment
- date of out-patient appointment for some other condition where (bowel) cancer was first considered
- date the patient is first seen by the specialist team in hospital for within-hospital referrals
- date of first diagnostic procedure if this precedes the first out-patient appointment
- date seen as an emergency, if the patient was first seen as an emergency
- the date the patient was first seen following recall by screening unit

Record this date in date format.

Please note that the ACP Data Dictionary defined this item as: "Date of the first outpatient attendance, date of emergency admission, date of OP visit when cancer was first considered (OP visit for some other condition), date seen by specialist team for within hospital referrals, date of first diagnostic procedure if this precedes the first OP appointment or date patient first seen following recall by screening unit."

**Tumour Site**

Field Name	Mandatory	Dataset Ref	Source of Definition
ICD10 Major Site Code	Yes	4.2	NCDS
Synchronous Sites Caecum		B16	NBCA Dataset
Synchronous Sites Appendix		B17	NBCA Dataset
Synchronous Sites Ascending Colon		B18	NBCA Dataset
Synchronous Sites Hepatic Flexure		B19	NBCA Dataset
Synchronous Sites Transverse Colon		B20	NBCA Dataset
Synchronous Sites Splenic Flexure		B21	NBCA Dataset
Synchronous Sites Descending Colon		B22	NBCA Dataset
Synchronous Sites Sigmoid Colon		B23	NBCA Dataset
Synchronous Sites Recto/Sigmoid		B24	NBCA Dataset

Synchronous Sites Rectum		B25	NBCA Dataset
Height of Tumour above Anal Verge (cm)		B26	NBCA Dataset

#### 4.2 ICD10 MAJOR SITE CODE [Primary site]

Record the cancer diagnosis that represents the main cancer site for which the patient is receiving care as identified by the clinician at presentation. Note that if the major site code changes at operation this code will not change.

Please be aware that anal cancers are not included in this audit. Note that although appendiceal cancer can be recorded it is currently not included in the audit analysis.

VALID VALUE	DESCRIPTION
1	C18.0: Caecum
2	C18.1: Appendix
3	C18.2: Ascending colon
4	C18.3: Hepatic flexure
5	C18.4: Transverse colon
6	C18.5: Splenic flexure
7	C18.6: Descending colon
8	C18.7: Sigmoid colon
9	C19: Colon with rectum Rectosigmoid (colon)
10	C20: Malignant neoplasm of rectum - rectal ampulla

**Definition of rectal cancer: Lower margin of cancer 15cm or less from anal verge at sigmoidoscopy.**

Note that the ICD Major Site Code and the Date of Diagnosis cannot be changed as they are the key components of the Care Spell Number. ***It is therefore important to get the ICD site code correct the first time, which means that this data should not be entered for the patient until there is complete confidence on its accuracy.***

#### Recording of Synchronous Tumours

Record any synchronous tumours as identified by the clinician at presentation (multiple responses are possible). Multifocal (or synchronous) tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue.

##### B16 SYNCHRONOUS SITES CAECUM

DDL

VALID VALUE	DESCRIPTION
N	No
Y	Yes

##### B17 SYNCHRONOUS SITES APPENDIX

DDL

VALID VALUE	DESCRIPTION
N	No
Y	Yes

##### B18 SYNCHRONOUS SITES ASCENDING COLON

DDL

VALID VALUE	DESCRIPTION
-------------	-------------

N	No
Y	Yes

**B19 SYNCHRONOUS SITES HEPATIC FLEXURE***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B20 SYNCHRONOUS SITES TRANSVERSE COLON***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B21 SYNCHRONOUS SITES SPLENIC FLEXURE***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B22 SYNCHRONOUS SITES DESCENDING COLON***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B23 SYNCHRONOUS SITES SIGMOID COLON***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B24 SYNCHRONOUS SITES RECTO/SIGMOID***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B25 SYNCHRONOUS SITES RECTUM***DDL*

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B26 HEIGHT OF TUMOUR ABOVE ANAL VERGE (cm)***2 digit numeric*

This field is compulsory for rectal cancer only (excluding recto-sigmoid). Record the height of the tumour above the anal verge (cm) measured either by rigid or flexible sigmoidoscopy.

## Modified Dukes' Staging

Field Name	Mandatory	Dataset Ref	Source of Definition
Modified Dukes' Staging		B27	NBCA Dataset

### B27 MODIFIED DUKES' STAGING

DDL

This is an essential field for risk adjustment based on the pathological examination of the excised specimen *and* the clinical evidence of distant metastases eg liver, lung, bone or intra-abdominal.

VALID VALUE	DESCRIPTION
A	A
B	B
C1	C1
C2	C2
D	D
99	Not Known

Dukes' A Tumour confined to wall of bowel, nodes negative

Dukes' B Tumour penetrates through the muscularis propria to involve extramural tissues, nodes negative

Dukes' C1 Metastases confined to regional lymph nodes (nodes positive but apical node negative)

Dukes' C2 Metastases present in nodes at mesenteric artery ligature (apical node positive)

Dukes D Metastatic spread and/or incomplete local removal of the primary cancer.

#### Further important notes regarding the recording of Dukes' "D":

**It is accepted that a small number of "D" cases are cured by further treatment such as liver resection, but for the purpose of the database spread distant from the primary should always be recorded as "D".**

**Dukes' "D" should be recorded if metastatic spread is identified either in the preoperative staging process, e.g. on CT scanning, MRI, USS, chest xray or at the time of operation, either due to residual local disease after surgical resection or distant spread.**

## Investigations

Field Name	Mandatory	Dataset Ref	Source of Definition
Clinical Intervention Date – Colonoscopy		B28	NBCA Dataset
Patient Procedure Result – Colonoscopy		C.5	NCDS (Colorectal Appendix)
Colonoscopy Incomplete Reason		C.6	NCDS (Colorectal Appendix)
Colonoscopy Complications		B29	NBCA Dataset
Clinical Intervention Date - Barium Enema		B30	NBCA Dataset
Patient Procedure Result - Barium Enema		B31	NBCA Dataset
CT Colonography		B32	NBCA Dataset
Clinical Intervention Date - CT Scan		B33	NBCA Dataset

Patient Procedure Result - CT Scan		B34	NBCA Dataset
Clinical Intervention Date - 1st MRI Scan		B35	NBCA Dataset
Patient Procedure Result - 1st MRI Scan T Stage		B36	NBCA Dataset
Patient Procedure Result - 1st MRI Scan N Stage		B37	NBCA Dataset
1st MRI Scan Margin Threatened – Result		B38	NBCA Dataset
Clinical Intervention Date - 2nd MRI Scan		B39	NBCA Dataset
Patient Procedure Result - 2nd MRI Scan T Stage		B40	NBCA Dataset
Clinical Intervention Date - Endoanal Ultrasound		B41	NBCA Dataset
Patient Procedure Result - Endoanal Ultrasound		B42	NBCA Dataset
Clinical Intervention Date - Abdominal Ultrasound		B43	NBCA Dataset
Patient Procedure Result - Abdominal Ultrasound		B44	NBCA Dataset

**B28 CLINICAL INTERVENTION DATE – COLONOSCOPY***DD/MM/YYYY*

Record the date on which colonoscopy carried out.

**C.5 PATIENT PROCEDURE RESULT – COLONOSCOPY***DDL*

Record the result of the colonoscopy procedure.

VALID VALUE	DESCRIPTION
1	Normal (no evidence of cancer)
2	Abnormal (cancer detected whether complete or not)
3	Inadequate (no cancer but incomplete examination)
4	Not done
9	Not known

**C.6 COLONOSCOPY INCOMPLETE REASON***DDL*

If the colonoscopy was incomplete record the reason that this.

VALID VALUE	DESCRIPTION
1	Obstructing cancer
2	Poor bowel preparation
4	Other
5	Patient intolerance
6	Technical reasons

**B29 COLONOSCOPY COMPLICATIONS***DDL*

Record any complications that occurred at the time of colonoscopy.

VALID VALUE	DESCRIPTION
1	Bleeding
2	Perforation
3	Other
4	No complication

**B30 CLINICAL INTERVENTION DATE - BARIUM ENEMA***DD/MM/YYYY*

Record the date on which barium enema was carried out.

**B31 PATIENT PROCEDURE RESULT - BARIUM ENEMA***DDL*

Record the result of the barium enema procedure.

VALID VALUE	DESCRIPTION
1	Normal (no evidence of cancer)
2	Abnormal (cancer)
3	Inadequate (bowel not fully visualized)
4	Not done
99	Not known

**B32 CT COLONOGRAPHY***DDL*

Record the result of the CT Colonography procedure. This may be both for diagnostic reasons and for detecting distant metastases. CT colonography when it is performed should report both on whether a cancer has been detected or not as well as the presence or absence of liver metastases. However a CT scan may be done simply to stage the cancer and will therefore be commenting only on the presence or absence of liver or other intra-abdominal metastases.

VALID VALUE	DESCRIPTION
1	Normal (no evidence of cancer)
2	Abnormal (cancer or polyp detected)
3	Inadequate (incomplete or technically unsatisfactory examination)
4	Not done
99	Not known

**B33 CLINICAL INTERVENTION DATE - CT SCAN***DD/MM/YYYY*

Record the date on which the CT scan was carried out.

**B34 PATIENT PROCEDURE RESULT - CT SCAN***DDL*

Record the result of the CT scan.

VALID VALUE	DESCRIPTION
M0	Normal liver
M1	Liver Metastases
03	Liver uncertain

**B35 CLINICAL INTERVENTION DATE - 1ST MRI SCAN***DD/MM/YYYY*

Record the date on which the first MRI scan was carried out.

**B36 PATIENT PROCEDURE RESULT - 1ST MRI SCAN T STAGE***DDL*

Record the T stage result of the first MRI scan.

VALID VALUE	DESCRIPTION
Tx	Tx
T1	T1
T2	T2
T3	T3
T4	T4

The 'T' component of the clinical TNM stage indicates the extent to which the tumour had spread and the size of the tumour at the time the treatment plan was devised. It is related to the site of the tumour.

Use the UICC coding for this data item. This refers to the International Union Against Cancer's TNM coding system (5th Edition, 1997– the global standard in cancer staging.)

T1 (confined to the submucosa)

T2 (into the muscularis propria)

T3 (beyond the muscularis propria)

T4 (the tumour has breached the peritoneal surface or invaded adjacent organs including beyond the mesorectal envelope in rectal cancers)

**B37 PATIENT PROCEDURE RESULT - 1ST MRI SCAN N STAGE***DDL*

Record the N stage result of the first MRI scan.

VALID VALUE	DESCRIPTION
N0	N0
N1	N1
N2	N2

N0 - No nodes involved

N1 - 1- 3 nodes involved

N2 - >=4

**B38 1ST MRI SCAN MARGIN THREATENED – RESULT***DDL*

Record the MRI result of the margin involvement. It is defined as being involved if the edge of the cancer is 1 mm or less from the edge of the mesorectal envelope.

VALID VALUE	DESCRIPTION
N	No
Y	Yes
U	Uncertain

**B39 CLINICAL INTERVENTION DATE - 2ND MRI SCAN**

Record the date on which the second MRI scan was carried out.

**B40 PATIENT PROCEDURE RESULT – 2ND MRI SCAN T STAGE***DDL*

Record the T result of the 2<sup>nd</sup> MRI Scan.

VALID VALUE	DESCRIPTION
01	No change in bulk
02	Increase in bulk
03	Reduction in bulk

**B41 CLINICAL INTERVENTION DATE - ENDOANAL ULTRASOUND***DD/MM/YYYY*

Record the date on which the endoanal ultrasound was carried out.

**B42 PATIENT PROCEDURE RESULT - ENDOANAL ULTRASOUND***DDL*

Record the result of the Endoanal Ultrasound procedure.

VALID VALUE	DESCRIPTION
Tx	Tx
T1	T1
T2	T2
T3	T3
T4	T4

The 'T' component of the clinical TNM stage indicates the extent to which the tumour had spread and the size of the tumour at the time the treatment plan was devised. It is related to the site of the tumour.

Use the UICC coding for this data item. This refers to the International Union Against Cancer's TNM coding system (5th Edition, 1997– the global standard in cancer staging.)

T1 (confined to the submucosa)

T2 (into the muscularis propria)

T3 (beyond the muscularis propria)

T4 (the tumour has breached the peritoneal surface or invaded adjacent organs including beyond the mesorectal envelope in rectal cancers)

**B43 CLINICAL INTERVENTION DATE - ABDOMINAL ULTRASOUND***DD/MM/YYYY*

Record the date on which the abdominal ultrasound was carried out.

**B44 PATIENT PROCEDURE RESULT - ABDOMINAL ULTRASOUND***DDL*

Record the result of the Abdominal Ultrasound procedure.

VALID VALUE	DESCRIPTION
M0	Normal liver
M1	Liver metastases
03	Liver uncertain

**Pre-treatment Staging**

Staging should be based on pre-operative chest x-ray, CT and MRI scanning.

Field Name	Mandatory	Dataset Ref	Source of Definition
Final Pre-treatment T category		6.1	NCDS

Final Pre-treatment N category		6.3	NCDS
Final Pre-treatment M category		6.5	NCDS
Distant metastases: Liver		B45	NBCA Dataset
Distant metastases: Lung		B46	NBCA Dataset
Distant metastases: Bone		B47	NBCA Dataset
Distant metastases: Other		B48	NBCA Dataset
MDT Discussion Indicator		5.1	NCDS

### 6.1 FINAL PRE-TREATMENT T CATEGORY

*DDL*

Record the 'T' part of the TNM classification used to describe the clinical stage of the tumour prior to any 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 'T' component of the clinical TNM stage indicates the extent to which the tumour had spread and the size of the tumour at the time the treatment plan was devised. It is related to the site of the tumour.

Use the UICC coding for this data item. This refers to the International Union Against Cancer's TNM coding system (5th Edition, 1997– the global standard in cancer staging.)

VALID VALUE	DESCRIPTION
Tx	Tx
T1	T1
T2	T2
T3	T3
T4	T4

T1 (confined to the submucosa)

T2 (into the muscularis propria)

T3 (beyond the muscularis propria)

T4 (the tumour has breached the peritoneal surface or invaded adjacent organs including beyond the mesorectal envelope in rectal cancers)

### 6.3 FINAL PRE-TREATMENT N CATEGORY

*DDL*

Record the 'N' part of the TNM classification used to describe the clinical stage of the tumour prior to any 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 'N' component of the clinical TNM stage indicates the extent to which the tumour had spread to regional lymph nodes at the time the treatment plan was devised. It is related to the site of the tumour. Note that micro-metastases should be considered to be positive.

Use the UICC coding (5th Edition, 1997) for this data item.

VALID VALUE	DESCRIPTION
N0	N0

N1	N1
N2	N2

N0 - No nodes involved  
 N1 - 1- 3 nodes involved  
 N2 - >=4 nodes involved

## 6.5 FINAL PRE-TREATMENT M CATEGORY

*DDL*

Record the 'M' part of the TNM classification used to describe the clinical stage of the tumour prior to any 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 'M' component of the clinical TNM stage indicates the extent to which the tumour has metastasised at the time the treatment plan was devised. It is related to the site of the tumour.

Use the UICC coding (5th Edition, 1997) for this data item.

VALID VALUE	DESCRIPTION
M0	M0
M1	M1

### B45 DISTANT METASTASES: LIVER

*DDL*

Record if distant metastases are present in the liver.

VALID VALUE	DESCRIPTION
1	None
2	Certain
3	Uncertain

### B46 DISTANT METASTASES: LUNG

*DDL*

Record if distant metastases are present in the lung.

VALID VALUE	DESCRIPTION
1	None
2	Certain
3	Uncertain

### B47 DISTANT METASTASES: BONE

*DDL*

Record if distant metastases are present in the bone.

VALID VALUE	DESCRIPTION
1	None
2	Certain
3	Uncertain

### B48 DISTANT METASTASES: OTHER

*DDL*

VALID VALUE	DESCRIPTION
1	None
2	Certain

3	Uncertain
---	-----------

## Multidisciplinary Team (MDT) Discussion Indicator

Field Name	Mandatory	Dataset Ref	Source of Definition
MDT Discussion Indicator		5.1	NCDS

An MDT meeting is defined for these purposes as “A regularly held meeting of the group of professionals who together make decisions regarding recommended treatment of individual patients, which can therefore be regarded as multi-disciplinary.”

### 5.1 MDT DISCUSSION INDICATOR

*DDL*

Record whether this cancer care plan was discussed at a Multidisciplinary Team (MDT) meeting. The cancer care plan may be drawn up at the MDT meeting or the MDT meeting may discuss a plan drawn up prior to the meeting. In either case, record ‘Y’ - Yes.

If the cancer care plan was not discussed at an MDT meeting, then record ‘N’ - No.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

## TREATMENT

Record all of the treatment details for a selected tumour. This should include treatment details such as surgery and pre and post-operative chemotherapy or radiotherapy.

Field Name	Mandatory	Dataset Ref	Source of Definition
NHS Number	Yes	1.1	NCDS
Care Spell Number	Yes	1.4	NCDS
Treatment ID	Yes	B49	NBCA Dataset
Originating Organisation Code	Yes	B50	NBCA Dataset
Updating Organisation Code	Yes	B51	NBCA Dataset
Uploading Organisation Code		B52	NBCA Dataset
Batch ID		B53	NBCA Dataset
Batch Record ID		B54	NBCA Dataset

### 1.1 NHS NUMBER

*10 digit numeric*

(See 1.1) For records submitted via direct entry, the NHS number will automatically be displayed on screen. For records submitted via CSV upload, the NHS number is required in order to ensure that files are attached to the correct patient record.

#### **1.4 CARE SPELL NUMBER**

*Alphanumeric*

This item is the unique code used to link all activities for a patient to the same care spell. This will be allocated on diagnosis, at the organisation where the diagnosis takes place, and will be communicated to all organisations providing care to the patient.

The unique Care Spell Number will ensure that data will be allocated to the appropriate dataset.

For records submitted via direct entry this number will automatically be created within the system and displayed on screen when the tumour details are saved.

For records submitted via CSV upload, the correct format should be used. Care Spell numbers are generated as follows:

NHS number – ICD Major Site Code – Date of Diagnosis (YYYYMMDD)  
For example: 1112223334-10-19900101.

Note that the ICD Major Site Code and the Date of Diagnosis cannot be changed as they are the key components of the Care Spell Number.

#### **B49 TREATMENT ID**

*Numeric*

This is a unique number to identify the treatment in terms of all treatments for the associated tumour. Note that the treatment ID must be unique for the given tumour, as identified by the care spell number, or the treatment will be rejected as a duplicate record. However, it does not have to be unique across all records in the system, just treatments for the tumour in question.

For records added via the data-entry screens, this field is automatically populated. For records added via CSV file import, this field is populated from the import file.

#### **B50 ORIGINATING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for creating the data record.

For records added via the data-entry screens, this field is automatically populated with the user's Open Exeter organisation code, which is their national organisation code appended with "CAB" (Clinical Audit: Bowel). For example, a national code of "AB123" would correspond to an Open Exeter organisation code of "AB123CAB".

For records added via CSV file import, this field is populated from the import file. For consistency with records added via the data-entry screens, it is recommended that this field is set to the submitting organisation's national organisation code appended with "CAB".

#### **B51 UPDATING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for updating the data, assigned automatically by the system.

#### **B52 UPLOADING ORGANISATION CODE**

*TEXT*

This is the unique five character organisation code of the unit responsible for uploading the data. For records added via the data-entry screens, this field does not apply and is left blank. For records added

via CSV file import, this field is automatically populated with the submitting user's Open Exeter organisation code.

### B53 BATCH ID

This is unique numeric identifier for a data file, assigned automatically by the system. This item only applies to records submitted via CSV file import.

### B54 BATCH RECORD ID

This is a unique numeric identifier for a record in a data file (unique across all files), assigned automatically. This item only applies to records submitted via CSV file import.

## Pre-Operative Data

Field Name	Mandatory	Dataset Ref	Source of Definition
Surgery Provider Organisation Code	Yes	B55	NBCA Dataset
Start Date of 1st Definitive Procedure Treatment		B56	NBCA Dataset
Reason No Surgery Performed		B57	NBCA Dataset
ASA Grade		B58	NBCA Dataset
Thromboembolism Prevention		B59	NBCA Dataset
Antibiotic Infection Prevention		B60	NBCA Dataset
Colorectal nurse or stoma therapist seen		C.2	NCDS (Colorectal Appendix)
Date seen by colorectal nurse or stoma therapist		C.7	NCDS (Colorectal Appendix)

### B55 SURGERY PROVIDER ORGANISATION CODE

TEXT

Record the unique five character organisation code of the unit responsible for providing surgery.

### B56 START DATE OF 1ST DEFINITIVE PROCEDURE TREATMENT

DD/MM/YYYY

Record the date of the start of the first definitive procedure, which may be surgery (including stoma alone), radiotherapy or chemotherapy but not examination under anaesthetic, which is considered as staging. For patients not receiving active treatment, the start date of palliative care or active monitoring should be entered here.

*Note that the definition for this data item is taken from the ACP data definitions that supported the national data collection for cases diagnosed between 1 April 2004 – 31 March 2005. It does **not** correspond to the NCDS 7.8 START DATE (SURGERY HOSPITAL PROVIDER SPELL) [Date of admission], which is defined as 'Where the procedure took place with the patient as an admitted patient – either as an in-patient or as a day case - record the date of admission for the hospital stay during which this procedure took place.' Details regarding the ACP data definitions dictionary, which is available with the download of the ACP database, please see [www.canceruk.net](http://www.canceruk.net).*

### B57 REASON NO SURGERY PERFORMED

If no surgery was carried out, record the reason.

VALID VALUE	DESCRIPTION
01	Patient refuses treatment for whatever reason

02	Patient unfit
03	Advanced disease
08	Other

**Note**

02 (high patient co-morbidity)

03 (advanced, incurable or irremovable disease)

**B58 ASA GRADE***DDL*

Record the ASA Grade as determined at the time of surgery.

VALID VALUE	DESCRIPTION
I	Fit
II	Relevant disease
III	Restrictive disease
IV	Life threatening disease
V	Moribund
99	Not known
7	Not applicable

**B59 THROMBOEMBOLISM PREVENTION***DDL*

Record if the patient had thromboembolism prevention.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B60 ANTIBIOTIC INFECTION PREVENTION***DDL*

Record if the patient had antibiotic infection prevention.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**C.2 COLORECTAL NURSE OR STOMA THERAPIST SEEN***DDL*

Record if the patient has seen a specialist colorectal nurse/stoma therapist. Record yes if a patient has been seen at any point in the care spell, either before or after treatment.

VALID VALUE	DESCRIPTION
N	No
Y	Yes
9	Not known

**C.7 DATE SEEN BY COLORECTAL NURSE OR STOMA THERAPIST***DD/MM/YYYY*

Record the date that the patient was first seen a specialist colorectal nurse/stoma therapist.

**Procedure**

Field Name	Mandatory	Dataset Ref	Source of Definition
Cancer Treatment Intent (Curability)		B61	NCDS
Procedure Date (Date of Surgery)		7.9	NCDS
Theatre Case Start Time (24hr)		C.9	NCDS
Surgical Urgency (Mode of Operation)		C.8	NCDS
Primary Procedure Name (OPCS)		7.10	NCDS
Complications Of Cancer		B62	NBCA Dataset
Code of Responsible HCP (Surgeon GMC Code)		C.3	NCDS
Grade of Responsible HCP (Grade of operating surgeon)		C.4	NCDS
Anaesthetist Grade		B63	NBCA Dataset
Patient Procedure (Anastomosis)		B64	NBCA Dataset
Patient Procedure (Stoma)		B65	NBCA Dataset
Date Stoma Closed		B66	NBCA Dataset

**B61 CANCER TREATMENT INTENT (CURABILITY)***DDL*

The surgeons' opinion of the completeness of the excision based on clinical findings at the time of operation which should not be revised in the light of subsequent histopathology reporting.

Record whether, at the time of surgery, in the surgeon's opinion the primary tumour was completely removed. Curative therefore means that no local tumour was visibly present after the surgical procedure; palliative means that visible tumour was left behind after the surgical resection.

This means that if the surgeon completely removes the primary tumour, this is termed a curative resection even in the presence of distant metastases.

VALID VALUE	DESCRIPTION
C	Curative
P	Palliative
U	Uncertain
9	Not known

*Note: this definition should be distinguished from the NCDS 7.4 CANCER TREATMENT INTENT (CURABILITY), defined as: 'Record the reason that the procedure is being carried out.'*

**7.9 PROCEDURE DATE (DATE OF SURGERY)***DD/MM/YYYY*

Record the date on which the procedure took place, in date format.

**C.9 THEATRE CASE START TIME [Start time of surgery]***TIME*

Record the time that the surgery was started.

Record in the 24 hour clock format.

**C.8 SURGICAL URGENCY (MODE OF OPERATION)***DDL*

Record the mode of surgery performed

CEPOD classification.

- Elective: Operation at a time to suit both patient and surgeon e.g. after an elective admission
- Scheduled: An early operation but not immediately life-saving. Operation usually within 3 weeks
- Urgent: As soon as possible after resuscitation and usually within 24 hours
- Emergency: Immediate and life-saving operation, resuscitation simultaneous with surgical treatment. Operation usually within 2 hours

VALID VALUE	DESCRIPTION
01	Elective
02	Scheduled
03	Urgent
04	Emergency
99	Urgency Unknown

### 7.10 PRIMARY PROCEDURE NAME (OPCS)

Record the main operative procedure carried out.

Do not record examination under anaesthetic as the primary procedure if the patient subsequently goes on to have a major resectional procedure. This means that only one procedure can be recorded.

VALID VALUE	DESCRIPTION
H07.9	Right hemicolectomy
H06.9	Extended right hemicolectomy
H08.9	Transverse colectomy
H09.9	Left hemicolectomy
H10.9	Sigmoid colectomy
H33.4	Anterior resection
H33.1	APER (Abdomino-perineal excision of the rectum)
H33.5	Hartmann's procedure
H051	Total Colectomy and ileorectal anastomosis
H41.9	TART (Trans-anal resection of the tumour)
H04.1	Total excision of colon and rectum
H04.2	Tot. exc. colon & rectum + anast. ileum to anus + create pouch
H41.2	TEMS (Trans-anal endoscopic micro- surgery)
H24.3	Stent
H20.1	Polypectomy: End. extirpation lesion colon (exc. sigmoid)
H23.9	Polypectomy: End. extirpation lesion lower bowel (fiberoptic sigmoidoscope)
H44.4	EUA only With/without biopsy ( <i>Examination under anaesthetic with or without biopsy as the only procedure performed on a patient i.e. not followed by any other procedure</i> )
T30.9	Laparotomy only ( <i>no excision of the tumour or stoma formation</i> )
T43.9	Laparoscopy only ( <i>no excision of the tumour or stoma formation</i> )
G74.9	Stoma only ileostomy ( <i>Laparoscopy or laparotomy with no excisional surgery but formation of ileostomy</i> )
H15.9	Stoma only colostomy ( <i>Laparotomy or laparoscopy with no excisional surgery but formation of a colostomy</i> )
98	OTHER

### B62 COMPLICATIONS OF CANCER

DDL

Record any local complication that existed at the time of the operation.

VALID VALUE	DESCRIPTION
0	None
1	Pericolic abscess
2	Free perforation
3	Intestinal obstruction
98	Other

### C.3 CODE OF RESPONSIBLE CARE PROFESSIONAL (SURGEON GMC CODE) *TEXT*

Record the GMC code of the surgeon who actually performed the operation.

The GMC Code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes for a description of the GMC Code.

See [Appendix B](#) for information on how to obtain the national list of consultant codes. A pick list of the most frequently used codes should be made available locally.

### C.4 GRADE OF RESPONSIBLE HEALTH CARE PROFESSIONAL (GRADE OF OPERATING SURGEON)

Record the grade of the operating surgeon(s) in C.3.

VALID VALUE	DESCRIPTION
1	Consultant
2	Assoc specialist
3	Staff grade / clinical assistant
4	SPR
5	SHO

### B63 ANAESTHETIST GRADE

*DDL*

Record the grade of the most senior anaesthetist present in theatre during the operation.

VALID VALUE	DESCRIPTION
1	Consultant
2	NCCG ( <i>Non-Consultant Clinical Grade</i> )
3	SPR ( <i>Specialist Registrar</i> )
4	SHO ( <i>Senior House Officer</i> )
98	Other

### B64 PATIENT PROCEDURE (ANASTOMOSIS)

Record if an anastomosis was done.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

### B65 PATIENT PROCEDURE (STOMA)

*DDL*

Record if a stoma was done at the time of operation and the type of stoma done.

VALID VALUE	DESCRIPTION
0	Not done
1	Ileostomy temporary
2	Ileostomy permanent
3	Colostomy temporary
4	Colostomy permanent

**B66 DATE STOMA CLOSED***DD/MM/YYYY*

If a temporary stoma was done at the time of operation, record the date on which it was closed.

**Surgical Access**

Field Name	Mandatory	Dataset Ref	Source of Definition
Surgical Access		B67	NBCA Dataset
Type of Bowel Division at Laparoscopy		B68	NBCA Dataset
Type of Anastomosis at Laparoscopy		B69	NBCA Dataset

**B67 SURGICAL ACCESS***DDL*

Record the access used to perform the operation.

VALID VALUE	DESCRIPTION
1	Open operation
2	Laparoscopic then planned open surgery
3	Laparoscopy converted to open (unplanned)
4	Laparoscopic not converted

The definition of 'Laparoscopic then planned open surgery' is targeted incision after laparoscopic assessment.

The definition of 'Laparoscopy converted to open' is inability to complete the intra-abdominal dissection laparoscopically, usually but not always requiring the use of a larger incision than that required to extract the specimen.

The definition of 'Laparoscopic not converted' is defined as laparoscopic dissection with small incision to extract the specimen.

**B68 TYPE OF BOWEL DIVISION AT LAPAROSCOPY***DDL*

Record the type of bowel division performed at laparoscopy.

VALID VALUE	DESCRIPTION
1	Intracorporeal
2	Extracorporeal
3	None

**B69 TYPE OF ANASTOMOSIS AT LAPAROSCOPY**

VALID VALUE	DESCRIPTION
-------------	-------------

1	Intracorporeal
2	Extracorporeal
3	None

## Post-Operative

Field Name	Mandatory	Dataset Ref	Source of Definition
Discharge Date (Hospital Provider Spell) (Date of discharge or Death)		7.12	NCDS
Morbidity Code Cancer Surgery (Major Postoperative Complication)		B70	NBCA Dataset
Morbidity Code (Major Laparoscopic specific complication)		B71	NBCA Dataset
Early Port Site Complication		B72	NBCA Dataset

### 7.12 DISCHARGE DATE (HOSPITAL PROVIDER SPELL) (DATE OF DISCHARGE OR DEATH) *DDL*

Where the procedure took place with the patient as an in-patient (including day cases), record the date of discharge. If the patient died during that admission, record the date of death.

### B70 MORBIDITY CODE CANCER SURGERY (MAJOR POSTOPERATIVE COMPLICATION) *DDL*

Record if there was a major complication following surgery, and if so the type of major complication.

Definition of 'Major complication' is a complication that required re-operation, interventional radiology, ITU/HDU care or delayed discharge by more than 72 hours. If there was more than one major complication the most severe should be recorded.

VALID VALUE	DESCRIPTION
N	None
T85.6	Leak
T81.4	Abscess
T81.0	Bleed
T91.3	Obstruction
K91.4	Stoma
Y	Readmission within 14 days
K91.9	Other

### B71 MORBIDITY CODE (MAJOR LAPAROSCOPIC SPECIFIC COMPLICATION) *DDL*

Record if there was no major complication following laparoscopic surgery or the type of major complication.

VALID VALUE	DESCRIPTION
1	None
2	Surgical emphysema
3	Pulmonary insufficiency
4	Significant intraoperative haemorrhage
5	Duodenal injury
6	Small bowel injury
7	Ureteric injury
8	Major vessel injury
9	Gross faecal contamination

10	Bladder injury
11	Injury by trocar
12	Other Injury by instrument

## B72 EARLY PORT SITE COMPLICATION IN LAPAROSCOPIC SURGERY *DDL*

Record if there was an early port site complication following laparoscopic surgery, and if so the type of early port site complication.

VALID VALUE	DESCRIPTION
01	No complication
02	Port site sepsis
03	Port site bleeding/ haematoma
98	Other

## Pathology

Record the histopathology details associated with the surgical procedure. Where a procedure is merely diagnostic or palliative in nature, and no specimen has been obtained, it will **not** be possible to complete this section in full.

For further information regarding recording of the pathological dataset please refer to:  
<http://www.rcpath.org/resources/pdf/colorectalcaner.pdf>

Field Name	Mandatory	Dataset Ref	Source of Definition
Organisation Code (Pathology Provider)	Yes	8.5	NCDS
Date Specimen Sample Received		8.2	NCDS
Investigation Result Date (Date of Report)		8.3	NCDS
Authorising Pathologist GMC Code		8.4	NCDS
Service Report Status		8.21	NCDS
Service Report Identifier		8.20	NCDS
Synchronous Cancer Indicator		8.9	NCDS
Invasive Lesion Size (Cancer size, mm)		8.8	NCDS
Excision Margin (Positivity of cut colon or rectum margin)		B73	NBCA Dataset
Distance of tumour to nearest cut bowel margin (mm)		B74	NBCA Dataset
Excision Margin (Circumferential margins)		B75	NBCA Dataset
Distance between cancer and circumferential margins (mm)		B76	NBCA Dataset

## 8.5 ORGANISATION CODE (PATHOLOGY PROVIDER)

Record the organisation code of the Unit at which the authorising pathologist is based. This is the five-character code.

See [Appendix A](#) for information on how to obtain the national list of site codes.

**8.2 DATE SPECIMEN SAMPLE RECEIVED***DD/MM/YYYY*

Record the date that the specimen was received by the pathology laboratory, in date format.

**8.3 INVESTIGATION RESULT DATE (DATE OF REPORT)***DD/MM/YYYY*

Record the date that the specimen was reported by the pathology laboratory, in date format.

**8.4 AUTHORISING PATHOLOGIST GMC CODE***TEXT*

Record the GMC code for the authorising pathologist.

The GMC Code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes for a description of the GMC Code.

See [Appendix B](#) for information on how to obtain the national list of consultant codes. A pick list of the most frequently used codes should be made available locally.

**8.21 SERVICE REPORT STATUS***DDL*

Record the status of the report on the tumour. If this field is set to 5, preference is given to this diagnostic event over others when deriving the definitive tumour details stored in the Diagnosis section.

VALID VALUE	DESCRIPTION
1	Final (complete)
2	Preliminary (interim)
3	Test not available
4	Unspecified
5	Second opinion/supplementary report

**8.20 SERVICE REPORT IDENTIFIER***TEXT*

Record the unique identifier allocated to the cytology, biopsy or excision report authorised by the pathologist.

**8.9 SYNCHRONOUS CANCER INDICATOR**

Record the presence of multiple tumours.

Multifocal (or synchronous) tumours are defined as discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue.

VALID VALUE	DESCRIPTION
N	No
Y	Yes
9	Not known

**8.8 INVASIVE LESION SIZE (CANCER SIZE, mm)***3-digit numeric*

Record maximum cancer diameter in mms.

**B73 EXCISION MARGIN (POSITIVITY OF CUT COLON OR RECTUM MARGIN)**

DDL

Record the positivity of the cut colon or rectum distal and proximal excision margins.

If the macroscopic distance from the cancer to the nearest cut end of the bowel is less than 3 cms that cut end should be examined histologically and the presence or absence of cancer should be recorded. If the minimal distance from the cut margin is less than or equal to 1 mm the margin is considered "involved".

VALID VALUE	DESCRIPTION
0	Margin not involved
1	Margin involved
99	Not known

**B74 DISTANCE OF TUMOUR TO NEAREST CUT BOWEL MARGIN (mm)**

3 digit numeric

Record the distance to the nearest cut margin in mms.

**B75 EXCISION MARGIN (CIRCUMFERENTIAL MARGINS)**

DDL

Circumferential margins refer 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. Involvement of the margin in this situation is recorded as serosal (see B79).

Positivity of margin: when the edge of the tumour is 1 mm or less from the circumferential resection margin.

VALID VALUE	DESCRIPTION
0	Margin not involved
1	Margin involved
99	Not known

**B76 DISTANCE BETWEEN CANCER AND CIRCUMFERENTIAL MARGIN (mm)**

3-digit numeric

Record the distance from the cancer to the circumferential margin in mms.

Field Name	Mandatory	Dataset Ref	Source of Definition
Grade Of Differentiation		8.11	NCDS
Histology (SNOMED)		8.10	NCDS
Nodes Examined Number (Number of lymph nodes found)		8.14	NCDS
Nodes Positive Number (Number of positive lymph nodes found)		8.15	NCDS
Cancer Vascular or Lymphatic Invasion (Extramural vascular invasion)		8.12	NCDS
Perforation or Serosal Involvement		B77	NBCA Dataset
Distance between lower end of tumour and resection margin in rectal and rectosigmoid tumours (mm)		B78	NBCA Dataset

Distance between lower end of cancer and dentate line in APER specimens (mm)		B79	NBCA Dataset
T Category (Pathological)		8.16	NCDS
N Category (Pathological)		8.17	NCDS
M Category (Pathological)		8.18	NCDS
Site Specific Staging Classification (Pathological Dukes' Staging)		B80	NBCA Dataset

### 8.11 GRADE OF DIFFERENTIATION

This field records the histopathological grade of the tumour as found in the specimen presented for examination. It is a qualitative assessment of the differentiation of the tumour expressed as the extent to which a tumour resembles the normal tissue at that site. In tumours containing several areas of different grade, the grade of the predominant component should be recorded.

The UICC differentiation grading system should be used and the field is defined as follows:

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

### 8.10 HISTOLOGY (SNOMED)

*DDL*

Record the histology of the tumour. Tumour histology is defined by SNOMed (ICDM) and is site specific.

VALID VALUE	DESCRIPTION
M8140/3	Adenocarcinoma
M8000/3	Other

### 8.14 NODES EXAMINED NUMBER (NUMBER OF LYMPH NODES FOUND) *6 digit numeric*

Record the number of local/regional nodes examined and reported.

### 8.15 NODES POSITIVE NUMBER (NUMBER OF POSITIVE LYMPH NODES FOUND)

*6 digit numeric*

Record the number of local/regional nodes reported as positive for the presence of tumour metastases.

### 8.12 CANCER VASCULAR OR LYMPHATAIC INVASION (EXTRAMURAL VASCULAR INVASION)

*TEXT*

Record the presence of unequivocal tumour in vascular spaces. This is recorded when tumour is present within an extramural endothelium-lined space that is *either* surrounded by a rim of muscle or contains red blood cells.

VALID VALUE	DESCRIPTION
N	No

Y	Yes
---	-----

### B77 PERFORATION OR SEROSAL INVOLVEMENT

Record if there were perforations or serosal involvement for cancer at sites with serosal cover.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

### B78 DISTANCE BETWEEN LOWER END OF TUMOUR AND RESECTION MARGIN IN RECTAL AND RECTOSIGMOID TUMOURS (mm)

*3 digit numeric*

Record the distance between the lower end of the tumour and the resection margin for rectal and rectosigmoid tumours only.

Distance should be measured in the fixed specimen (mm).

### B79 DISTANCE BETWEEN LOWER END OF CANCER AND DENTATE LINE IN APER SPECIMENS (mm)

*3 digit numeric*

Record the distance between the lower end of the cancer and the dentate line in APER specimens.

Distance should be measured in the fixed specimen (mm).

## TNM Category (Pathological) Staging

### 8.16 T CATEGORY (PATHOLOGICAL)

*DDL*

Record the extent of the primary tumour after excision based on the evidence from a pathological examination to evaluate the highest pT category.

VALID VALUE	DESCRIPTION
Tx	Tx
pT0	pT0
pT1	pT1
pT2	pT2
pT3	pT3
pT4	pT4

Tx Minimum requirements for tumour assessment not met

pT0 No evidence of primary tumour

pT1 Tumour extends into the sub-mucosa

pT2 Tumour extends into the muscularis propria

pT3 Tumour extends through muscularis propria into subserosa on into nonperitonealised pericolic or perirectal tissues

pT4 Tumour extends directly into the other organs or tissues, or tumour perforates the visceral peritoneum of the specimen

### 8.17 N CATEGORY (PATHOLOGICAL)

*DDL*

Record the histological absence or presence and extent of regional lymph node metastases. The pathological assessment of the regional lymph nodes (pN) requires removal of nodes adequate to validate the absence of regional lymph node metastasis (pN0) or sufficient to evaluate the highest pN category.

VALID VALUE	DESCRIPTION
Nx	Nx
pN0	pN0
pN1	pN1
pN2	pN2

- Nx Minimum requirements for lymph node assessment not met  
 pN0 No lymph node metastases  
 pN1 Metastatic tumour in 1 to 3 pericolic or perirectal lymph nodes  
 pN2 Metastatic tumour in 4 or more pericolic or perirectal lymph nodes  
 pN3 Metastatic to any lymph node along the course of a major named vascular trunk

### 8.18 M CATEGORY (PATHOLOGICAL)

DDL

Record the histological evidence of the absence or presence of distant metastases. Note that M0 should not be recorded as it is not applicable to pathological reporting.

Pathological M staging can only be based on distant metastases that are submitted for histology by the surgeon and will therefore tend to underestimate the true M stage. Pathologists will therefore only be able to use M1 (distant metastases present) or MX (distant metastases unknown). Note that metastatic deposits in lymph nodes distant from those surrounding the main tumour or its main artery in the specimen, which will usually be submitted separately by the surgeon (e.g. in para-aortic nodes or nodes surrounding the external iliac or common iliac arteries), are counted as distant metastases and hence pM1.

VALID VALUE	DESCRIPTION
Mx	Mx
M0	M0
M1	M1

- Mx Minimum requirements to assess distant metastasis cannot be met  
 M0 No distant metastases (not applicable to pathological reporting)  
 M1 Distant metastasis present

Summary of TNM staging from: CANCER Principles and Practice of Oncology 5th Edition, Vincent T. DeVita Jr, Samuel Hellmann, Steven A. Rosenberg; Lippincott-Raven.

### B80 SITE SPECIFIC STAGING CLASSIFICATION (PATHOLOGICAL DUKES' STAGING)

Record the final pathological Dukes' staging. If distant metastases are present based on either pathological or clinical grounds or on investigation (eg a CT scan), then Dukes' D should be recorded in the Modified Dukes Staging field in the Tumour section.

VALID VALUE	DESCRIPTION
A	A
B	B
C1	C1
C2	C2
99	Not Known

- Dukes' A Tumour confined to wall of bowel, nodes negative  
 Dukes' B Tumour penetrates through the muscularis propria to involve extramural tissues, nodes negative  
 Dukes' C1 Metastases confined to regional lymph nodes (nodes positive but apical node negative)  
 Dukes' C2 Metastases present in nodes at mesenteric artery ligature (apical node positive)

## Oncology

Field Name	Mandatory	Dataset Ref	Source of Definition
Site Code of Teletherapy Treatment	Yes	10.1	NCDS
Consultant Code		10.2	NCDS
Teletherapy Type Given		B81	NBCA Dataset
Start Date Teletherapy Treatment Course (Radiotherapy Start Date)		10.8	NCDS
Teletherapy Trial		B82	NBCA Dataset
Site Code (Of Cancer Drug Treatment) (Hospital)	Yes	9.1	NCDS
Consultant Code		9.2	NCDS
Drug Treatment Intent		9.8	NCDS
Start Date (Anti-cancer drug regimen)		9.10	NCDS
Chemotherapy Trial		B83	NBCA Dataset

### 10.1 SITE CODE OF TELETHERAPY TREATMENT

TEXT

Record the organisation code of the Unit providing the teletherapy to the patient. This is the five-character code of the organisation acting as a Health Care Provider.

See Appendix A for information on how to obtain the national list of site codes.

### 10.2 CONSULTANT CODE

TEXT

Record the GMC Code for the consultant who is in overall charge of the patient's teletherapy treatment. Note that this may not be the person who actually gives the treatment.

The GMC Code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit. See the NHS Data Dictionary (<http://www.datadictionary.nhs.uk>) under Supporting Information, Administrative Codes for a description of the GMC Code.

See Appendix B for information on how to obtain the national list of consultant codes. A pick list of the most frequently used codes should be made available locally.

### B81 TELETHERAPY TYPE GIVEN

DDL

Record the type of teletherapy given.

VALID VALUE	DESCRIPTION
1	None
2	Short course preoperative
3	Long course preoperative
4	Postoperative
5	Definitive ( <i>the only treatment given</i> )
6	Palliative

'Definitive' is defined as where radical RT/CRT given as the only treatment with no plan for surgical intervention.

'Palliative' can be with or without surgery.

### 10.8 START DATE TELETHERAPY TREATMENT COURSE (RADIOTHERAPY START DATE) DDL/MM/YYYY

Record the date on which the first fraction of teletherapy for this prescription is administered to the patient. Record in date format.

### B82 TELETHERAPY TRIAL DDL

Record if the patient was entered into a teletherapy trial.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

### 9.1 SITE CODE (OF CANCER DRUG TREATMENT) (HOSPITAL) TEXT

Record the organisation code of the Unit providing the cancer drug treatment to the patient. This is the five-character code Organisation Code of the Organisation acting as a Health Care Provider.

See [Appendix B](#) for information on how to obtain the national list of site codes.

### 9.2 CONSULTANT CODE

Record the GMC Code for the consultant who is actually in overall charge of the patient's drug treatment. Note that this may not be the person who actually gives the treatment.

The GMC code is an eight character alphanumeric code based on the GMC registration number; the first character will be the letter 'C'; characters 2 to 7 will be the doctor's GMC number; character 8 is a check digit (See the NHS Data Dictionary, Supporting Information, Administrative Codes).

### 9.8 DRUG TREATMENT INTENT

Record the reason that the drug treatment is being carried out.

VALID VALUE	DESCRIPTION
P	Palliative
A	Adjuvant
N	Neoadjuvant
98	Other

### 9.10 START DATE (ANTI-CANCER DRUG REGIMEN) DDL/MM/YYYY

Record the date on which the first dose of the drug is administered to the patient. Record in date format.

### B83 CHEMOTHERAPY TRIAL DDL

Record if the patient was entered into a chemotherapy trial.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

## FOLLOW-UP DETAIL

This section should be used to record follow-up details. Follow-up details should be obtained at least annually for five years after the date of surgery or other primary treatment, if excisional surgery is not performed.

Field Name	Mandatory	Dataset Ref	Source of Definition
NHS Number	Yes	1.1	NCDS
Care Spell Number	Yes	1.4	NCDS
Follow Up ID	Yes	B84	NBCA Dataset
Originating Organisation Code	Yes	B85	NBCA Dataset
Updating Organisation Code	Yes	B86	NBCA Dataset
Uploading Organisation Code		B87	NBCA Dataset
Batch ID		B88	NBCA Dataset
Batch Record ID		B89	NBCA Dataset
Organisation Code (Follow Up Provider)		B90	NBCA Dataset
Clinical Status Assessment Date (Cancer) (Date of Follow Up)		14.1	NCDS
Mode Of Follow Up		B91	NBCA Dataset
Primary Tumour Status (Local Recurrence)		B92	NBCA Dataset
Local Recurrence Diagnosed By		B93	NBCA Dataset
Wound Recurrence		B94	NBCA Dataset
Port Site Recurrence		B95	NBCA Dataset
Metastatic Status Distant Spread		14.4	NBCA Dataset
Site Of Distant Spread		B96	NBCA Dataset
Treatment Related Morbidity		14.1	NCDS

### 1.1 NHS NUMBER (NHS Number)

*10 digit numeric code*

(See 1.1/Patient) For records submitted via direct entry, the NHS number will automatically be displayed on screen. For records submitted via CSV upload, the NHS number is required in order to ensure that files are attached to the correct patient record.

### 1.4 CARE SPELL NUMBER

*Alphanumeric*

(See 1.4/Tumour) This item is the unique code used to link all activities for a patient to the same care spell. This is allocated on diagnosis, at the organisation where the diagnosis takes place, and should be communicated to all organisations providing care to the patient.

The unique Care Spell Number will ensure that data will be allocated to the appropriate dataset.

For records submitted via direct entry this number will automatically be created within the system and displayed on screen when the tumour details are saved. When the follow-up record is added to the correct tumour details this number will automatically be added to the follow-up table.

For records submitted via CSV upload, it is important to ensure that records link to the correct care spell number. the correct format should be used. Care Spell numbers are generated as follows:

NHS number – ICD Major Site Code – Date of Diagnosis (YYYYMMDD)

For example: 1112223334-10-19900101.

Note that the ICD Major Site Code and the Date of Diagnosis cannot be changed as they are the key components of the Care Spell Number.

**B84 FOLLOW-UP ID***Numeric code*

This is a unique number to identify the follow-up in terms of all follow-ups for the associated tumour.

For records added via the data-entry screens, this field is automatically populated. For records added via CSV file import, this field is populated from the import file.

**B85 ORIGINATING ORGANISATION CODE***TEXT*

This is the unique five character organisation code of the unit responsible for creating the data record.

For records added via the data-entry screens, this field is automatically populated with the user's Open Exeter organisation code, which is their national organisation code appended with "CAB" (Clinical Audit: Bowel). For example, a national code of "AB123" would correspond to an Open Exeter organisation code of "AB123CAB".

For records added via CSV file import, this field is populated from the import file. For consistency with records added via the data-entry screens, it is recommended that this field is set to the submitting organisation's national organisation code appended with "CAB".

If an organisation is submitting data on behalf of another organisation then they must ensure that the check box under the file location field is ticked. This is on the import data screen.

**B86 UPDATING ORGANISATION CODE***TEXT*

This is the unique five character organisation code of the unit responsible for updating the data, assigned automatically by the system.

**B87 UPLOADING ORGANISATION CODE***TEXT*

This is the unique five character organisation code of the unit responsible for uploading the data. For records added via the data-entry screens, this field does not apply and is left blank. For records added via CSV file import, this field is automatically populated with the submitting user's Open Exeter organisation code.

**B88 BATCH ID***Numeric code*

This is unique numeric identifier for a data file, assigned automatically by the system. This item only applies to records submitted via CSV.

**B89 BATCH RECORD ID***Numeric code*

This is a unique numeric identifier for a record in a data file (unique across all files), assigned automatically. This item only applies to records submitted via CSV.

**B90 ORGANISATION CODE (FOLLOW UP PROVIDER)***TEXT*

This is the unique five character organisation code of the unit providing the follow-up.

**14.1 CLINICAL STATUS ASSESSMENT DATE (CANCER) (DATE OF FOLLOW UP) DD/MM/YYYY**

Record the date that the patient was seen. Record in date format.

**B91 MODE OF FOLLOW UP**

Record the mode of follow-up.

VALID VALUE	DESCRIPTION
1	Outpatient (clinician)
2	Endoscopy
3	Nurse lead clinic
4	GP
5	Postal
98	Other

**B92 PRIMARY TUMOUR STATUS (LOCAL RECURRENCE)***DDL*

Record if recurrent primary tumour was detected (within the field of operation).

Local recurrence of rectal cancer is defined as any recurrent tumour at or below the pelvic brim down to the perineum.

Local recurrence of a colonic carcinoma is defined as any recurrent tumour occurring at or immediately either side of a colonic anastomosis in the wall of the bowel or in the associated mesentery.

Local recurrence does not include the development of a new metachronous primary cancer

VALID VALUE	DESCRIPTION
N	No local evidence of recurrence of primary tumour
Y	Local recurrence of primary tumour

**B93 LOCAL RECURRENCE DIAGNOSED BY***DDL*

If local recurrence was detected, record the means of diagnosis. Mode of diagnosis is in descending hierarchy.

VALID VALUE	DESCRIPTION
1	Histology
2	Imaging
3	Clinical
98	Other

**B94 WOUND RECURRENCE***DDL*

Record if wound recurrence was detected.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

**B95 PORT SITE RECURRENCE***DDL*

Record if port site recurrence was detected.

VALID VALUE	DESCRIPTION
N	No
Y	Yes

#### 14.4 METASTATIC STATUS DISTANT SPREAD

*DDL*

Record the status of the distant metastases at this contact.

VALID VALUE	DESCRIPTION
N	No evidence of metastases
Y	New distant metastases

#### B96 SITE OF DISTANT SPREAD

*DDL*

If distant spread was detected, record the site of metastases.

VALID VALUE	DESCRIPTION
1	Liver
2	Lung
3	Bone
4	Other

#### 14.10 TREATMENT RELATED MORBIDITY

*DDL*

Record any morbidity, relevant to previous treatments that the patient has received, recorded at any subsequent patient contact.

For chemotherapy, only long term adverse effects need to be recorded.

VALID VALUE	DESCRIPTION
2	Mild toxicity
3	Moderate toxicity
4	Severe toxicity
5	Death due to toxicity

## Appendix A: How to obtain a list of hospital site codes

The National Administrative Codes Service (NACS) is provided by NHS Connecting for Health. It is responsible for national policy and standards for organisation and practitioner codes, which form part of the NHS data standards. NHS Connecting for Health is also responsible for the day-to-day operation of the NACS and for its overall development.

The reference data covers not just healthcare organisations but also practitioners, post codes and other administrative details.

The NACS provides information via the NHSNet, via a quarterly release of data on CD-Rom and on the internet.

The NACS is supported by a number of agencies throughout the UK. Examples are the Prescription Pricing Agency (PPA) and the Dental Practice Board, who supply codes and data for GPs and dentists.

### To download a file containing hospital site codes

Access the National Administrative Codes Service web site: -  
<http://www.connectingforhealth.nhs.uk/nacs/>

Click 'Data Downloads'

Click 'Downloads Index'

Click 'NHS Trust sites'

Click 'etrust.zip' link against 'NHS Trusts and Trust sites'.

### To obtain a particular NHS Trust, NHS Trust site or non-NHS Organisation Code

Access the National Administrative Codes Service web site:  
<http://www.connectingforhealth.nhs.uk/nacs/>

Use the [Online enquiries](#), 'Search using name, address or postcode' link.

## Appendix B: How to obtain a list of consultant codes

The National Administrative Codes Service (NACS) is provided by NHS Connecting for Health. It is responsible for national policy and standards for organisation and practitioner codes, which form part of the NHS data standards. NHS Connecting for Health is also responsible for the day-to-day operation of the NACS and for its overall development.

The reference data covers not just healthcare organisations but also practitioners, post codes and other administrative details.

The NACS provides information via the NHSNet, via a quarterly release of data on CD-Rom and on the internet.

The NACS is supported by a number of agencies throughout the UK. Examples are the Prescription Pricing Agency (PPA) and the Dental Practice Board, who supply codes and data for GPs and dentists.

### **To download a file containing consultant codes**

Access the Connecting for Health website <http://connectingforhealth.nhs.uk/nacs>

Click on 'Data Downloads'

Click on 'Hospital Consultants'

## Appendix C: Notes on coding classifications

### ***International Statistical Classification of Diseases and Related Health Problems (ICD-10)***

The classification of neoplasms is broken down into categories based on their **point of origin**, and **behaviour**

Sites for **malignant neoplasms** are prefixed by C

C00 - C75 covers specified primary sites (but excludes lymphoid, haematopoietic and related tissues)  
 C76 - C80 cover ill-defined, secondary and unspecified sites  
 C81 - C96 are malignant neoplasms of lymphoid, haematopoietic and related issues  
 C97 are malignant neoplasms of multiple independent primary sites

**Sites for *in situ* and benign neoplasms are prefixed by D**, but grouped into much broader categories

D00 - D09 relate to in situ neoplasms  
 D10 - D36 relate to benign neoplasms  
 D37 - D48 relate to neoplasms of uncertain or unknown behaviour

For each anatomical site the initial three alphanumeric code is supplemented by a decimal point and an additional digit to identify sub-site 0 to 7.

Example

C18.0	Caecum
C18.1	Appendix
C18.2	Ascending colon
C18.3	Heaptic flexure
C18.4	Transverse colon
C18.5	Splenic flexure
C18.6	Descending colon
C18.7	Sigmoid colon
C19	Colon with rectum Rectosigmoid (colon)
C20	Malignant neoplasm of rectum – rectal ampulla

### ***SNOMED CT ©***

SNOMED CT® is a clinical terminology - the Systematised Nomenclature of Medicine. It is a common computerised language that will eventually be used by all computers in the NHS to facilitate communications between healthcare professionals.

The morphology section of SNOMED CT is identical to ICD–O, but it also gives a broader description of pathological terminology to aid coding.

### ***OPCS-4 - operation codes***

The basic structure of the classification comprises anatomically based chapters, each of which is given an alphabetic code. The next two digits describe the operation group, based on the largest operation first, descending to the smallest, followed by a decimal point and a fourth digit to identify the procedure itself. If the procedure described does not match the categories above then provided the procedure is recorded a .8 can be added, and where unspecified a .9 can be added.

Example:

H07.9	Right hemicolectomy
H06.9	Extended right hemicolectomy
H08.9	Transverse colectomy
H09.9	Left hemicolectomy
H10.9	Sigmoid colectomy
H33.4	Anterior resection
H33.1	APER (Abdomino-perineal excision of the rectum)
H33.5	Hartmann's procedure

### ***UICC Coding***

This refers to the International Union Against Cancer's TNM coding system (5th edition 1997) – the global standard in cancer staging.

## Appendix D: Acknowledgements

The National Clinical Audit Support Programme of the Information Centre for health and social care would like to thank the involvement of the Association of Coloproctology of Great Britain and Ireland for their clinical expertise in developing this document, and the National Bowel Cancer Audit User Group for their assistance in ensuring the document's suitability for purpose.

**Copyright for National Bowel Cancer Data Manual**

Copyright © 2007, The Information Centre for health and social care, National Clinical Audit Support Programme (NCASP). All rights reserved.

This work remains the sole and exclusive property of The Information Centre and may only be reproduced where there is explicit reference to the ownership of The Information Centre.

This work may be re-used by NHS and government organisations without permission. Commercial re-use of this work must be granted by The Information Centre.