



ROYAL COLLEGE
of PHYSICIANS



The National Clinical Lung Cancer Audit (LUCADA)

DATA MANUAL

Title: Data Manual

Version: 3.1.3

Date: Oct 2010

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
1.3	Sept 04		
2.0	18/10/2005	Released after extensive rewrite	LUCADA Implementation Group
3.0	01/02/07	Re-written to incorporate software update	LUCADA Project Team
3.1	07/07/07	Minor amendment to LCNS fields	LUCADA Project Team
3.1.2	31/07/10	Updated to include UICC 7 staging	LUCADA Project Team
3.1.3	27/10/10	Minor correction to UICC 7 staging	LUCADA Project Team

For more information on the status of this document, please contact:	<p>The Information Centre for health and social Care National Clinical Audit Support Programme (NCASP) 1 Trevelyan Square Leeds LS1 6AE</p> <p>E-mail: lucada@ic.nhs.uk Internet: http://www.icservices.nhs.uk/ncasp</p>
Date of Issue	July 2010
© Crown Copyright 2007	Ref: 14020107

TABLE OF CONTENTS

INTRODUCTION	4
Preface.....	4
How to use this Manual.....	4
Organisation Codes	4
PATIENT REFERRAL.....	5
Demographics.....	5
Referral	6
CARE PLAN / MDT	8
Diagnosis	8
Pre-treatment Staging.....	10
Cancer care plan / MDT details	14
Co-morbidity.....	16
KEY INVESTIGATIONS	17
NURSING CARE.....	19
TREATMENT	21
Planned Treatment	21
Clinical trial.....	21
Surgery	22
Post surgery pathology	23
Chemotherapy	27
Teletherapy (external beam radiotherapy).....	28
Brachytherapy.....	29
Palliative care.....	30
Active monitoring	31
OUTCOME	32
Death.....	32
Prophylactic cranial irradiation	33
Treatment plan.....	33
APPENDIX A: HOW TO OBTAIN A LIST OF HOSPITAL SITE CODES	34
APPENDIX B: NOTES ON CODING CLASSIFICATIONS	35
International Statistical Classification of Diseases and Related Health Problems (ICD-10)	35
International Classification of Diseases for Oncology, 2nd edition (ICD-O-2) Morphology codes ...	35
SNOMED CT ©.....	36
OPCS-4 - operation codes.....	36
UICC Coding.....	36

INTRODUCTION

Preface

The LUCADA dataset is a subset of the National Cancer Dataset (NCDS Version 4.5) plus a number of additional data items. The LUCADA dataset was developed and agreed by the Royal College of Physicians Intercollegiate Lung Cancer Group during the period September 2001 to May 2002 and was updated by the LUCADA user group during 2006.

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 data set this manual takes information from the more comprehensive Cancer Data Manual. 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.

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 LUCADA 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 www.icservices.nhs.uk/ncasp

How to use this Manual

- The organisation of this manual corresponds with the order of screens and fields in the LUCADA system.
- Each section starts with a table listing the data items, reference numbers and the source of the definition.
- Data items with reference number beginning with 'L' are part of the LUCADA dataset. 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 LUCADA screen names for the data items.

Organisation Codes

Several fields in LUCADA 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 under Supporting Information, Administrative Codes, for a description of Organisation Codes. There are codes for private organisations (independent providers).

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.

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

PATIENT REFERRAL

Demographics

Data Item	Dataset Ref.	Source
NHS NUMBER (NHS Number)	1.1	NHS Data Dictionary
PERSON FAMILY NAME (Surname)	1.5	Automatically populated
PERSON NAME GIVEN (Forenames)	1.6	Automatically populated
POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS) (Postcode)	1.8	Automatically populated
SEX (Sex)	1.9	Automatically populated
BIRTH DATE (Date of Birth)	1.10	Automatically populated

1.1 NHS NUMBER (NHS Number)

10 digit numeric code

Enter the patient's unique NHS Number. This is a required field.

Upon entering the NHS number, the remaining data items in this section will be retrieved from the Open Exeter database. These data items cannot be edited through LUCADA.

If the NHS number is not available for a patient it can be accessed via the NHS Tracing Service. This need only be done once for each patient as this is a permanent lifetime number which will not change.

The following data items are populated automatically. Users should cross-check them to ensure that it is the correct patient:-

1.5 PERSON FAMILY NAME (Surname)

1.6 PERSON NAME GIVEN (Forenames)

1.8 POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS) (Postcode)

If the patient changes postcode after diagnosis, do not change the postcode.

1.9 SEX (Sex)

The patient's sex will be recorded as:-

Patient's Sex	Code
Not known	0
Male	1
Female	2
Not specified – ambiguous or indeterminate	9

1.10 BIRTH DATE (Date of birth)

Record the patient's date of birth, in date format. For example, 19-08-1980

Referral

This section is used to record details about referral to a lung cancer specialist / team.

All data items in this section should be completed with reference to the lung cancer episode.

If the patient is referred under 2 week wait rules, complete “cancer referral decision date” also called “date of decision to refer” (section 2.5) but for non 2 week wait patients use “lung cancer specialist referral date” (section L24) field instead.

If the cancer is discovered only at post mortem, then do not record any referrals information.

Data Item	Dataset Ref.	Source
SOURCE OF REFERRAL (FOR CANCER) (Source of referral)	2.1	NCDS
CANCER REFERRAL DECISION DATE (Date of decision to refer)	2.5	NCDS
DATE FIRST SEEN (Date first seen)	2.9	NCDS
Lung Cancer Specialist Referral Date	L24	LUCADA dataset
ORGANISATION CODE (PROVIDER FIRST SEEN) (Place first seen)	1.3	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust

2.1 SOURCE OF REFERRAL FOR CANCER (Source of referral)

Drop Down List

Record the route of referral of the patient. Choose from 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 lung cancer specialist. In this scenario either code 01 or 05 could apply. Where possible, use code 05 unless the admission was straight to the lung cancer specialist team in which case use code 01.

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

Source of referral	Code
Following an emergency admission (includes all acute admissions via A&E, Medical Admissions Unit, etc)	01
Following a domiciliary visit	02
Referral from General Medical Practitioner (for out-patient or other non-emergency referrals)	03
Referral from a consultant, other than in an A&E department. If the diagnosis took place within the screening services, then this code applies.	05
Self-referral (i.e. the patient was not seen previously by a GP)	06
Other source of referral (will include referrals from Private Healthcare)	08
Following an A&E attendance (i.e. an out-patient clinic attendance after an A&E visit)	10
General Dental Practitioner	92
Community Dental Service	93
Not known (default)	99

2.5 CANCER REFERRAL DECISION DATE (Date of decision to refer) *DD/MM/YYYY***This data item should be collected for 2 week wait patients only**

Record the date on which the decision to refer to a lung cancer specialist was made, for example;

- The date on the letter, proforma or e-mail from the referring GP
- Where there is no date on the letter, proforma or email from the referring GP the date of transmission of the fax or the postmark should be used

Do not include patients referred with suspicion of another cancer that later turns out to be lung cancer e.g. two week wait referral was to the upper GI services but the cancer was later found to be a lung cancer.

L24 LUNG CANCER SPECIALIST REFERRAL DATE *DD/MM/YYYY***This date should be recorded for all non 2 week wait patients**

- The date of the letter, proforma, e-mail or referral note written in the patient's case notes for a referral from another hospital department (for lung cancer).
- For patients admitted as an emergency under the lung cancer team this date is the date of admission to hospital
- The date of the first out-patient appointment (for lung cancer) if the referral was a self referral.

Please note that X-rays are not referrals so the date of the referral document should be used, not the X-ray date.

2.9 DATE FIRST SEEN (Date first seen) *DD/MM/YYYY*

Record the date of the patient's first contact with the person or group in 'referred to' above, or the first contact with a member of the lung cancer specialist team:

- date of first outpatient appointment (for lung cancer)
- date of outpatient visit when a diagnosis of (lung) cancer was first considered
- date the patient is first seen by the (lung cancer) specialist team in hospital for within-hospital referrals
- date of first booked diagnostic procedure (for lung cancer) if this precedes the first outpatient appointment
- date seen as an emergency, if the patient was first seen as an emergency (within a lung cancer pathway)

Record this date in date format.

1.3 ORGANISATION CODE (PROVIDER FIRST SEEN) (Place first seen)*5 DIGIT ALPHA NUMERIC CODE*

Record the organisation code of the Unit at which the patient was first seen. This is a unique five-character code (see Appendix A for how to obtain organisation codes).

CARE PLAN / MDT

Diagnosis

This section should be used to record details of the lung cancer diagnosis. If the malignancy is discovered only at autopsy, or via details from a death certificate, then this section should be completed with as much information as is available.

Whenever possible these data items should be collected at the MDT meeting immediately prior to the patient commencing treatment.

Record the following details, which will provide a definitive description of the tumour based on the information available at the time the items were completed.

Data Item	Dataset Ref.	Source
DIAGNOSIS DATE (CANCER) (Date of diagnosis)	4.1	European Network of Cancer Registries
Site code (Place of diagnosis)	L26	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust
PRIMARY DIAGNOSIS (ICD) (Primary site diagnosis)	4.2	ICD-10 coding
TUMOUR LATERALITY (Laterality)	4.3	NCDS
BASIS OF DIAGNOSIS (CANCER) (Basis of diagnosis)	4.4	European Network of Cancer Registries

4.1 DIAGNOSIS DATE (Lung cancer pre-treatment) (Date of diagnosis) *DD/MM/YYYY*

This field records the date of diagnosis of the tumour.

The LUCADA hierarchy for diagnosis definition maps to the European Network of Cancer Registries (ENCR) definitions and the date recorded should follow these hierarchy rules

Order of declining priority for LUCADA:

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 diagnosis, other than 3, 4, 5 or 6. such as imaging from a CT, PET scan or other form of clinical diagnosis
3. Date of death, if no information is available other than the fact that the patient has died because of malignancy.
4. Date of death, if the malignancy is discovered at autopsy.
5. Date of admission to hospital because of this malignancy.
6. When evaluated at an out-patient clinic only: date of first consultation at the out-patient clinic because of this malignancy.

L26 Site code (place of diagnosis)

5 DIGIT ALPHA NUMERIC CODE

Record the organisation code of the place where the patient was diagnosed with lung cancer. This is a unique five-character code (See appendix A for how to obtain missing organisation codes).

4.2 PRIMARY DIAGNOSIS (ICD) (Primary site)

Record the ICD_10 code that best describes the anatomical site of the primary cancer reported in this record. Choose from the following list of anatomical site codes.

ICD-10 Codes for Primary Site

C34	Malignant neoplasm of bronchus or lung
C34.0	Main bronchus, Carina, Hilus of lung
C34.1	Upper lobe, bronchus or lung
C34.2	Middle lobe, bronchus or lung
C34.3	Lower lobe, bronchus or lung
C34.8	Overlapping lesion of bronchus and lung
C34.9	Bronchus or lung, unspecified
C33	Trachea
C38	Malignant neoplasm of heart, mediastinum and pleura
C38.4	Pleura
C38.3	Mediastinum, part unspecified
C38.8	Overlapping lesion of heart, mediastinum and pleura
C45	Mesothelioma
C45.0	Mesothelioma of pleura

4.3 TUMOUR LATERALITY (Laterality)

DDL

Record the side of the primary cancer; this is used to differentiate tumours in paired organs.

Note that for sites where laterality is not required (i.e. mediastinum), record '8' for 'Not applicable'.

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

4.4 BASIS OF DIAGNOSIS (CANCER) (Basis of diagnosis)

DDL

This field records the basis on which the lung cancer diagnosis was made. It is therefore an indicator of data quality, with microscopic histological verification being viewed as the 'gold standard' diagnosis. The definition provided conforms with the international requirements specified by the European Network of Cancer Registries (ENCR).

Code	Non-microscopic
0 (Death Certificate)	Information only available from a death certificate
1 (Clinical)	Diagnosis made before death, but without the benefit of any of the following (2-7)
2 (Clinical Investigation)	Diagnosis made with the aid of diagnostic techniques (e.g. X-rays, endoscopy, imaging, ultrasound, exploratory surgery and autopsy) without a tissue diagnosis
4 (Specific tumour markers)	Diagnosis made with the aid of biochemical and/or immunological markers, which are specific for a tumour site
	Microscopic
5 (Cytology)	Diagnosis made by 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 bone marrow aspirates.
6 (Histology of a metastases)	Diagnosis made by histological examination of tissues from a metastasis, including autopsy specimens
7 (Histology of a primary tumour)	Diagnosis made by 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
	Unknown
9 (Unknown)	Unknown: where there is no information on how the diagnosis has been made (e.g. PAS or HISS record only)

– Validation rule

If basis of diagnosis equals “5”, “6” or “7” a histology code (data item 4.5) must be also be completed.

If primary site coding (4.2) indicates mesothelioma, the histology coding (4.5) should also be a mesothelioma unless the diagnosis is a clinical one.

Pre-treatment Staging

The TNM staging data items record the definitive pre-treatment TNM stage. TNM refers to the International Union Against Cancer’s coding system (6th edition 1997, 7th edition 2009). This staging is usually agreed at the MDT meeting or cancer care plan meeting prior to treatment and based on the clinical and pathological data available. Such evidence arises from physical examination, imaging, endoscopy, biopsy, surgical exploration and other relevant examinations.

As a result of the changes in the UICC staging manual version 7, TNM staging of small cell carcinoma of the lung is now the preferred method and should be recorded wherever possible. However, the old staging classification of Limited disease or Extensive disease (US Veterans Administration) is acceptable, if preferred.

There is no accepted clinical classification for mesothelioma. Use of a surgical staging classification may be used at the discretion of individual organisations, but the data will not be used in any analysis.

If the malignancy is discovered only at autopsy, or via a death certificate, then no pre-treatment TNM stage should be recorded.

If a staging procedure other than imaging was undertaken this should be recorded. However, only staging resulting from surgery undertaken for diagnostic purposes only should be recorded here. If the surgery is undertaken with curative intent, the staging should be recorded in the treatment section.

Data Item	Dataset Ref.	Source
TNM Classification Version Number	L52	LUCADA
T CATEGORY (FINAL PRE-TREATMENT)	6.1	UICC coding
N CATEGORY (FINAL PRE-TREATMENT)	6.3	UICC coding
M CATEGORY (FINAL PRE-TREATMENT)	6.5	UICC coding
TNM CATEGORY (FINAL PRE-TREATMENT) (Pre-treatment stage group)	6.7	UICC coding Calculated by system
SITE-SPECIFIC STAGING CLASSIFICATION (Site-specific classification)	6.9	Site-specific coding
Pre Treatment Histology	4.5	SNOMED
Did the patient have a staging procedure	L43	LUCADA dataset
Did patient have mediastinal sampling	L22	LUCADA dataset
Did the patient have an FNA	L44	LUCADA dataset
Did the patient have any other staging procedure	L45	LUCADA dataset
Staging procedure performed but method unknown	L46	LUCADA dataset

L52 TNM Classification Version Number

Record the version of TNM used for staging. This applies to both pre -treatment and pathological stage. A patient must be staged throughout using UICC 6 or UICC 7, the two cannot be mixed within a single patient record

Staging Classification	6 (Version 6 of TNM) 7 (Version 7 of TNM)
-------------------------------	--

6.1 T CATEGORY (FINAL PRE-TREATMENT) (Final pre-treatment T category)

DDL

The tumour, 'T', component of the clinical TNM stage describes the size and location of the tumour at the time of diagnosis. This item is usually recorded pre-treatment.

6.3 N CATEGORY (FINAL PRE-TREATMENT) (Final pre-treatment N category)

DDL

The lymph node, 'N', component of the clinical TNM stage indicates any involvement of lymph nodes from the primary tumour described in 'T'. Note that micro-metastases should be considered to be positive.

6.5 M CATEGORY (FINAL PRE-TREATMENT) (Final pre-treatment M category)

DDL

The metastasis, 'M', component of the clinical TNM stage indicates the presence or absence of metastasis.

6.7 TNM CATEGORY (FINAL PRE-TREATMENT) (Overall pre-treatment stage group)

CALC

The pre-treatment stage is calculated from the TNM description of the cancer. This is calculated by using the "calculate" button. A stage is automatically assigned using the criteria in the tables below

Version 6

Stage	T	N	M
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T1	N1	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T1	N2	M0
	T2	N2	M0
	T3	N1, N2	M0
Stage IIIB	Any T	N3	M0
	T4	Any N	M0
Stage IV	Any T	Any N	M1

Version 7

Stage	T	N	M
Stage IA	T1A	N0	M0
Stage IA	T1B	N0	M0
Stage IB	T2A	N0	M0
Stage IIA	T2B	N0	M0
Stage IIA	T1A	N1	M0
Stage IIA	T1B	N1	M0
Stage IIA	T2A	N1	M0
Stage IIB	T2B	N1	M0
Stage IIB	T3	N0	M0
Stage IIIA	T1a	N2	M0
Stage IIIA	T1b	N2	M0
Stage IIIA	T2A	N2	M0
Stage IIIA	T2B	N2	M0
Stage IIIA	T3	N1	M0
Stage IIIA	T3	N2	M0
Stage IIIA	T4	N0	M0
Stage IIIA	T4	N1	M0
Stage IIIB	T4	N2	M0
Stage IIIB	Any T	N3	M0
Stage IV	Any T	Any N	M1 (A or B)
Uncertain	Any T	Nx	M0
Stage IV	Any T	Nx	M1 (A or B)
Occult Carcinoma	Tx	N0	M0

4.5 HISTOLOGY (SNOMED) (Histology)

Record the cell type, histology, of the primary cancer. LUCADA uses the SNOMED codings for this.

Note that there may be a number of pathology reports contributing to the diagnosis.

**SNOMed Codes for Histology (Pathology)
(SNOMed III (1993)/ICD-O-2 (1990) unless stated)**

M 8010/2	Carcinoma in situ	
M 8041/3	Small cell carcinoma	
M 8046/3	Non-small cell carcinoma (ICD-O-3) (includes adenosquamous carcinoma)	
M 8070/3	Squamous cell carcinoma NOS	

LUCADA Mapping**NSCLC****SCLC****NSCLC****NSCLC**

M 8140/3	Adenocarcinoma NOS (Adenocarcinoma without alveolar cell features)	NSCLC
M 8250/3	Bronchio-alveolar cell carcinoma (Adenocarcinoma with alveolar cell features)	NSCLC
M 8012/3	Large cell Carcinoma NOS	NSCLC
M 8020/3	Large cell – undifferentiated	NSCLC
M 8013/3	Large cell neuroendocrine (ICD-O-3)	NSCLC
M 8240/3	Carcinoid tumour NOS (includes atypical carcinoid)	Separate category
M 8980/3	Carcinosarcoma NOS	NSCLC
M 9050/3	Malignant Mesothelioma NOS	Mesothelioma
M 9052/3	Mesothelioma (epithelioid)	Mesothelioma
M 9051/3	Mesothelioma (sarcomatoid) (ICD-O-3)	Mesothelioma
M9053/3	Mesothelioma (biphasic)	Mesothelioma
M 8940/3	Mixed tumour (malignant)	NSCLC
M 9999/9	Other	NSCLC

6.9 SITE-SPECIFIC STAGING CLASSIFICATION (Site-specific classification) RADIO

As a result of the changes in the UICC staging manual version 7, TNM staging of small cell carcinoma of the lung is now the preferred method and should be recorded wherever possible. However, the old staging classification of Limited disease or Extensive disease (US Veterans Administration) is acceptable, if preferred..

(See also section L23 page 26)

Stage	Category
Stage unknown	X
Limited	1
Extensive	2

Limited disease	Extensive disease
Disease confined to one hemithorax including involvement of ipsi-and/or contralateral hilar, mediastinal or supraclavicular lymph nodes. Patients with ipsilateral pleural effusion, regardless of pleural cytology, should be included in this group.	Any disease beyond the definition of limited stage.

L43 Did the patient have a staging procedure

Record whether the patient underwent a procedure to stage the lung cancer (excluding imaging). If the staging was undertaken at the same time as a curative procedure this must be recorded in the treatment section.

L22 Did the patient have mediastinal sampling

Record if the patient had a mediastinoscopy mediastinotomy, open mediastinal sampling or other type of mediastinal biopsy

L44 Did the patient have an FNA (This includes trucut needle biopsies)

Record if the patient had an FNA staging procedure (Note needle biopsy of the primary lesion is recorded elsewhere)

L45 Did the patient have any other staging procedure

Record if the patient had a staging procedure other than mediastinal sampling or an FNA

L46 Staging procedure performed but method unknown

Record if the patient had a staging procedure but the nature of this procedure is unknown or not recorded

Cancer care plan / MDT details

Following a diagnosis of cancer, a cancer care plan will be drawn up for the patient's care. The cancer care plan will relate to this particular diagnosis. It is appreciated that a cancer care plan can change as the patient's disease progresses or as more information about the stage of the disease is ascertained.

Data items under this section would usually be recorded at the MDT meeting immediately prior to the start of any treatment.

If the malignancy is discovered only at autopsy, or via a death certificate, then there will be no care plan and no details under this section will need to be recorded.

Data Item	Dataset Ref.	Source
MDT DISCUSSION INDICATOR (Was this cancer care plan discussed at an MDT meeting?)	5.1	NCDS
MULTIDISCIPLINARY TEAM DISCUSSION DATE (The date of the MDT meeting at which this cancer care plan was discussed)	5.2	NCDS
CANCER CARE PLAN INTENT (Cancer care plan intent)	5.5	NCDS
FEV1 ABSOLUTE AMOUNT (FEV1 (Absolute))	L5	LUCADA dataset
FEV1 PERCENTAGE (FEV1 (Percentage of predicted))	L6	LUCADA dataset
PERFORMANCE STATUS (ADULT) (Performance status)	5.10	World Health Organisation coding

5.1 MDT DISCUSSION INDICATOR
(Was the patient discussed at an MDT meeting?)
RADIO

Record whether the patient was discussed at an MDT meeting.

If the patient was not discussed at an MDT meeting, then record no.

If unknown, then record unknown.

5.2 MULTIDISCIPLINARY TEAM DISCUSSION DATE
(The date of the MDT meeting at which the patient was discussed)
DD/MM/YYYY

If the patient was discussed at multiple MDT meetings, record the date of the MDT closest to the first treatment. If the patient was not discussed at an MDT meeting, then leave this field blank.

5.5 CANCER CARE PLAN INTENT (Cancer Care Plan Intent)

Record the intention of the treatment which is planned for the patient at this point in time.

Intent	Plan
'Curative'. Include here patients whose treatment includes: <ul style="list-style-type: none"> • Surgical resection (including 'open and close' but excluding all surgery on mesothelioma patients) • Radical radiotherapy to primary site with potential for cure • Chemotherapy in Limited Stage and/or Good Prognosis Small Cell Carcinoma (e.g. using 'Manchester' prognostic score) • Adjuvant (or neo-adjuvant) chemotherapy (combined with surgery) in Non-Small Cell Carcinoma • Adjuvant radiotherapy in Small Cell carcinoma • Prophylactic Cranial Irradiation 	C
'Palliative'. Include here patients whose treatment includes: <ul style="list-style-type: none"> • Specialist Palliative Care • Chemotherapy in Non-Small Cell Carcinoma (excepting Adjuvant and Neo-adjuvant therapy) • Radiotherapy to primary tumour with palliative intent • Radiotherapy to site of secondary cancer • Brachytherapy (Endobronchial radiotherapy) • Other endobronchial treatments (e.g. laser therapy, diathermy, cryotherapy, insertion of bronchial stent) • Chemotherapy in Extensive Stage and/or Poor Prognosis Small Cell Carcinoma (e.g. using the 'Manchester' prognostic score) • Surgery for mesothelioma (EPP, debulking surgery and pleurodesis) • Surgical Pleurodesis • Superior Vena Caval Stenting 	P
Palliative - supportive care only. This item implies follow up with the aim of identifying symptoms and treating these if and when appropriate. Follow up could be through primary care, secondary care and includes both doctors, nurses and Macmillan staff. The plan implies that no immediate treatment is to be given but does not exclude the patient from having treatment at a future date if the need arose.	S
No specific anti-cancer treatment	N
Unknown (Note: it is highly unlikely that any treatment plan would be drawn up, where the intention of the treatment is Unknown. The use of this code should be carefully monitored)	9

L.5 FEV1 ABSOLUTE AMOUNT (FEV1 (Absolute))

Numeric field

Record the absolute value of the patient's Forced Expiratory Volume in first second in litres. This is particularly important for patients with COPD.

L.6 FEV1 PERCENT (FEV1 percentage of predicted)

% Numeric field

Record the patient's Forced Expiratory Volume in first second as a percentage of the predicted value.

5.10 PERFORMANCE STATUS (ADULT) (Performance Status)

Use the coding as shown in the table below. This uses World Health Organisation (WHO) coding, with the addition of code 5 – Not recorded.

Performance Status	Code
Able to carry out all normal activity without restriction	0
Restricted in physically strenuous activity but able to walk and do light work	1
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	2
Capable of only limited self care, confined to bed or chair more than 50% of waking hours	3
Completely disabled. Cannot carry on any self care. Totally confined to bed or chair	4
Not recorded	5

Significant Co-morbidity / Treatment of Choice

If a patient did not receive the treatment of choice the reason should be recorded here.

If comorbidity (03) is selected as the reason why the patient did not receive the treatment of choice then the nature of the comorbidity must be recorded

For the purpose of the audit, significant co-morbidity is defined as any co-morbidity which in the opinion of the Lung Cancer specialist teams is of sufficient severity to contra-indicate referral for a therapy that would otherwise be the preferred option.

Data Item	Dataset Ref.	Source
Was there any reason why the patient did not receive the first choice of treatment	L32	LUCADA dataset

L32 Did the patient receive the treatment of choice (DDL)

Record why the patient did not receive the treatment of choice

Data Item	Code
Was there any reason why the patient did not receive the first choice treatment	01 Died
	03 Co-morbidity precluding treatment
	06 Refused
	L4 COPD

Co-morbidity

If co-morbidity (03) is selected as the reason why the patient did not receive the treatment of choice, the nature of the co-morbidity should be recorded

Data Item	Dataset Ref.	Source
Dementia/Cerebrovascular disease	L10	LUCADA dataset
Cardiovascular disease	L9	LUCADA dataset
Renal failure	L11	LUCADA dataset
Other malignancy	L12	LUCADA dataset
Severe weight loss	L13	LUCADA dataset
Other significant co-morbidity	L14	LUCADA dataset

Key Investigations

This section describes the key investigations used in establishing a diagnosis of lung cancer. Record all procedures used even if the result was negative. The purpose of this section is to establish what diagnostic techniques are being used, in what order and whether there are delays in accessing certain services

Data Item	Dataset Ref.	Source
Was a CT scan performed	3.3 (2A or 2B)	NCDS
Date of CT scan	3.2	NCDS
Was a PET / PET CT scan performed	3.3(4)	NCDS
Date of PET / PET CT scan	3.2	NCDS
Was a bronchoscopy performed	L33	LUCADA dataset
Date of bronchoscopy	L34	LUCADA dataset
Was a CT guided biopsy performed	L37	LUCADA dataset
Date of CT guided biopsy	L38	LUCADA dataset
Was an other diagnostic biopsy performed	L35	LUCADA dataset
Date of other diagnostic biopsy	L36	LUCADA dataset

Record details of all key investigations used to establish the lung cancer diagnosis and stage. Record the date of any procedures undertaken

3.3 Was a CT Scan performed

DDL

Record if the patient underwent a CT scan

	Data Item	Code
3.3	Was a CT scan performed	Y – Yes N – No 9 - Unknown

3.2 Record the date the CT scan was undertaken

DD/MM/YYYY

This field records the date of the CT scan

3.3 Was a PET / PET-CT scan performed

DDL

Record if the patient underwent a PET / PET-CT scan

	Data Item	Code
3.3	Was a PET / PET-CT scan performed	Y – Yes N – No 9 - Unknown

3.2 Record the date the PET / PET-CT Scan was undertaken

DD/MM/YYYY

This field records the date of the PET / PET-CT scan

L33 Was a bronchoscopy performed

DDL

Record if the patient underwent a bronchoscopy

	Data Item	Code
L33	Was a bronchoscopy performed	Y – Yes N – No 9 - Unknown

L34 Record the date the bronchoscopy was undertaken*DD/MM/YYYY*

This field records the date of the bronchoscopy

L37 Was a CT guided biopsy performed*DDL*

Record if the patient underwent a CT guided biopsy

	Data Item	Code
L37	Was a CT guided biopsy performed	Y – Yes N – No 9 – Unknown

L38 Record the date the CT guided biopsy was undertaken*DD/MM/YYYY*

This field records the date of the CT guided biopsy

L35 Was any other biopsy performed*DDL*

Record if the patient underwent any other biopsy

	Data Item	Code
L35	Was any other biopsy performed	Y – Yes N – No 9 - Unknown

L36 Record the date any other biopsy was undertaken*DD/MM/YYYY*

This field records the date any other biopsy was taken

NURSING CARE

This section is about the input of the Lung Cancer Nurse Specialist into the lung cancer patient journey and refers to any specialist nursing input that occurs between the patient being referred to the hospital to the point at which the patient receives their primary treatment. It is not intended to record follow up information after treatment.

For the purposes of the audit a Lung Cancer Nurse Specialist is defined below

'A Lung Cancer Nurse Specialist is a first level nurse, locally recognised as part of the specialist lung cancer multidisciplinary team and designated (i.e. part of the formal job description) as a specialist in lung cancer. The nurse should spend at least 50% of his or her time caring for lung cancer patients.'

Patient assessment for the purposes of the nursing care section of the audit is defined as:-

Any face to face contact with the patient or a telephone call during which the patients needs are discussed. This does not include interactions with the sole intention of introduction, providing contact details or MDT discussion.

Data Item	Dataset Ref.	Source
PATIENT ASSESSED BY LUNG CANCER NURSE SPECIALIST	L47	LUCADA dataset
DATE FIRST ASSESSMENT BY LUNG CANCER NURSE SPECIALIST	L48	LUCADA dataset
HOW WAS PATIENT FIRST ASSESSED BY LUNG CANCER NURSE SPECIALIST	L49	LUCADA dataset
AT WHAT STAGE(S) IN THE PATIENT JOURNEY WAS THE PATIENT ASSESSED BY THE LUNG CANCER NURSE SPECIALIST	L50	LUCADA dataset
LUNG CANCER NURSE SPECIALIST PRESENT WHEN THE PATIENT RECEIVED THEIR DIAGNOSIS	L51	LUCADA dataset

L47 Was the patient assessed by a Lung Cancer Nurse Specialist ? DDL

Record here if the patient was assessed by a Lung Cancer Nurse Specialist

Data Item	Code
Was the patient assessed by a Lung Cancer Nurse Specialist	Y
	N
	9 Unknown
	99 Not recorded

L48 Date of assessment by Lung Cancer Nurse Specialist? DD/MM/YYYY

If the patient was assessed by a Lung Cancer Nurse Specialist record the date of the assessment

L49 How was the patient first assessed by a Lung Cancer Nurse Specialist?**DDL**

If the patient was assessed by a Lung Cancer Nurse Specialist record how the assessment took place

Data Item	Code
How was the patient first assessed by a Lung Cancer Nurse Specialist	1 In clinic 2 Home visit 3 Ward Visit 4 Telephone 8 Other 9 Unknown 99 Not recorded

L50 At what stages in the patient journey was the patient assessed by the Lung Cancer Nurse Specialist?**DDL**

If the patient was assessed by a Lung Cancer Nurse Specialist record at what point in the patient journey this occurred. The purpose of this audit field is to identify at which point in the patient journey patients are reviewed. This field does not record how many times a patient was seen, just the timings.

Data Item	Code
At what stages in the patient journey was the patient assessed by the Lung Cancer Nurse Specialist	1 Before diagnosis 2 At diagnosis only 3 After diagnosis 4 Before and after diagnosis 9 Unknown 99 Not recorded

L51 Was the Lung Cancer Nurse Specialist present when the patient received their diagnosis?**DDL**

Record whether or not the lung cancer nurse specialist was present when the patient received their diagnosis of lung cancer. This field will automatically be set to **Y** if 'at diagnosis only' is selected in L50

Data Item	Code
Lung Cancer Nurse Specialist present when the patient received their diagnosis	Y N 9 Unknown 99 Not recorded

TREATMENT

Treatment for lung cancer can involve single modality or combination treatment. The database allows the entry of single modality treatment or combination treatment. For the online reports the patient will be allocated to a treatment group by the earliest treatment date entered.

Planned Treatment

Planned multi-modality treatment will only be recorded if it is entered using the multiple modality option. If the individual modalities are entered using the single modality option, then the earliest treatment date entry will count as the treatment the patient received. Entry of more than one single modality treatment, for example, second line treatment because of disease progression, is at the user's discretion. If combination treatment is planned but not given, the relevant outcome section fields L30 and L31 must be completed explaining why.

Clinical trial

Use this section to record whether or not the patient is eligible for entry into a clinical trial

Data Item	Dataset Ref.	Source
PATIENT TRIAL STATUS (CANCER) (Clinical Trial Status)	13.1	NCDS

13.1 PATIENT TRIAL STATUS (CANCER) (Clinical Trial Status)

RADIO

Record the status of the clinical trial entry for the patient.

Patient Trial Status	Code
Patient eligible, consented to and entered trial	Y
Patient not entered into clinical trial	N
Clinical trial status unknown	9

L28 Planned treatment type

DDL

Select whether the patient is to have single modality or multi modality treatment

	Data Item	Repeating?	Source of definition
L28	Planned treatment type	No	01 Single Modality 02 Multiple Modality 9 Unknown

L29 Treatment planned

DDL

Record the type of treatment regimen planned

	Data Item	Repeating?	Source of definition
L29	Planned treatment	No	01 Surgery 02 Teletherapy / Radiotherapy 03 Chemotherapy 04 Brachytherapy 05 Palliative care 06 Active Monitoring 07 Sequential chemotherapy and radiotherapy 08 Concurrent chemotherapy and radiotherapy 09 Induction chemotherapy to downstage before surgery 10 Neo-adjuvant chemotherapy and surgery 11 Surgery followed by adjuvant chemotherapy

The details of the planned treatments must be recorded. Specialist palliative interventions including endobronchial laser treatment, bronchial stenting, IVC stenting drainage of a pleural effusion and medical pleurodesis. (Medical pleurodesis refers to a pleurodesis performed via a chest drain on a ward post drainage of a pleural effusion). These interventions should be recorded in the interventional palliative care window (L41)

Surgery

For Lung Cancer patients (including clinical diagnoses)

Record here any surgical procedure under taken with the intention of curing the patient.

Do not record here any procedures undertaken for purely diagnostic purposes – these should be entered in the Care Plan / MDT section.

For Mesothelioma Patients

It is accepted that all surgical procedures in this group of patients are palliative. Please enter any therapeutic procedures as surgery – other (E57.8).

Do not record here any procedures undertaken for purely diagnostic purposes – these should be entered in the Care Plan / MDT section.

The information for this section should be collected as soon as possible after the procedure has taken place.

Data Item	Dataset Ref.	Source
SITE CODE (OF SURGERY) (Hospital)	7.1	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust Site
DECISION TO TREAT DATE (SURGERY) (Date of decision to operate)	7.5	
PROCEDURE DATE (Date of surgery)	7.9	
PRIMARY PROCEDURE (OPCS) (Main surgical procedure)	7.10	OPCS

7.1 SITE CODE (OF SURGERY) (Hospital)*Five character alphanumeric*

Record the organisation code of the hospital where the procedure took place.

7.5 DECISION TO TREAT DATE (SURGERY) (Date of decision to operate)*DD/MM/YYYY*

Record the date on which it was decided that this patient should receive surgery. This is the date that the consultation between the patient and the surgeon took place and a treatment plan for surgery was agreed. Very often this is the date the patient was added to the surgical waiting list.

7.9 PROCEDURE DATE (Date of surgery)*DD/MM/YYYY*

Record the date on which the procedure took place.

Please note that this definition is different from that used for Cancer Waiting Times data which requires collection of the clinical intervention date (first diagnostic test).

7.10 PRIMARY PROCEDURE (OPCS) (Main surgical procedure)*Alphanumeric*

Record the main operative procedure carried out. See below for a list of procedures (which map to OPCS-4).

OPCS/Read Codes for main Surgical Procedures

Surgical Procedure	Code
Wedge resection of lesion of lung (segment)	E54.4A
Multiple wedges resected	E54.8A
Segmental resection	E54.4B
Sleeve resection	E54.8B
Lung resection with resection of chest wall (not identifying which lobe resection)	E54.8 + T01
Carinal resection	E44.1
Lobectomy	E54.3
Pneumonectomy	E54.1
Bilobectomy	E54.2
Open operation on lung (open and close) (Incision of lung nec)	E57.4
Other open operation on lung	E57.8
Extrapleural pneumonectomy	01
Debulking pleurectomy	02
Pleurodesis	03

Post surgery pathology

Recorded here are details relating to the completeness of the surgical resection and the post operative staging based on the TNM system. Note that post-operative histology data is recorded in the histology window and not in the surgical treatment window.

Data Item	Dataset Ref	Source
EXCISION MARGIN (Excision margins – R Classification)	L15	UICC Coding
T CATEGORY (PATHOLOGICAL) (Pathological T category)	8.16	UICC Coding
N CATEGORY (PATHOLOGICAL) (Pathological N category)	8.17	UICC Coding
M CATEGORY (PATHOLOGICAL) (Pathological M category)	8.18	UICC Coding
TNM CATEGORY (PATHOLOGICAL) (Overall Pathological TNM Stage grouping)	8.19	UICC Coding

L15 EXCISION MARGIN (Excision margins – R Classification)*DDL*

Record the absence or presence of residual tumour after surgery as per the table below.

Excision Margin	Code
Presence of residual tumour cannot be assessed	RX
No residual tumour	R0
Microscopic residual tumour	R1
Macroscopic residual tumour	R2

8.16 T CATEGORY (PATHOLOGICAL) (Pathological T category)*DDL*

This field records the extent of the primary tumour after excision based on the evidence from pathological examination.

8.17 N CATEGORY (PATHOLOGICAL) (Pathological N category)

This field records the absence or presence and extent of regional lymph node involvement with the lung cancer. It is based on histological examination of lymph nodes removed at the time of surgery.

8.18 M CATEGORY (PATHOLOGICAL) (Pathological M category)

This field records the histological evidence of the absence or presence of distant metastases.

Distant metastases cannot be assessed microscopically as it is frequently impossible for pathologists to assess their presence or absence. It is recognised that data item 8.18 (M Category – Pathological) may not always be available. Because of this there are certain rules around the calculation of TNM CATEGORY (PATHOLOGICAL) (Data item 8.19). These rules are different for version 6 and version 7 of the classification.

Version 6

When calculating the TNM category (pathological) the LUCADA system assumes that MX is equivalent to M0 unless M1 is recorded for final pre-treatment M category M (Data item 6.5).

Version 7

If no value is recorded for data item 8.18, then the TNM Category (Pathological) is calculated using the value recorded for pre-treatment M Category (6.5) in combination with the pathological category values for T and N (data items 8.16 and 8.17).

8.19 TNM CATEGORY (PATHOLOGICAL) (Overall pathological TNM stage grouping) CALC

The pathological stage is populated using the calculate button. A stage is automatically assigned using the criteria in the tables below

Stage	T	N	M
Stage IA	T1	N0	M0
Stage IB	T2	N0	M0
Stage IIA	T1	N1	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T1	N2	M0
	T2	N2	M0
	T3	N1, N2	M0
Stage IIIB	Any T	N3	M0
	T4	Any N	M0
Stage IV	Any T	Any N	M1

Version 7

Stage	T	N	M
Stage IA	T1A	N0	M0
Stage IA	T1B	N0	M0
Stage IB	T2A	N0	M0
Stage IIA	T2B	N0	M0
Stage IIA	T1A	N1	M0
Stage IIA	T1B	N1	M0
Stage IIA	T2A	N1	M0
Stage IIB	T2B	N1	M0
Stage IIB	T3	N0	M0
Stage IIIA	T1A	N2	M0
Stage IIIA	T1B	N2	M0
Stage IIIA	T2A	N2	M0
Stage IIIA	T2B	N2	M0
Stage IIIA	T3	N1	M0
Stage IIIA	T3	N2	M0
Stage IIIA	T4	N0	M0
Stage IIIA	T4	N1	M0
Stage IIIB	T4	N2	M0
Stage IIIB	Any T	N3	M0
Stage IV	Any T	Any N	M1 (A or B)
Uncertain	Any T	Nx	M0
Stage IV	Any T	Nx	M1 (A or B)
Occult Carcinoma	Tx	N0	M0

Histology (Post Surgery)**LUCADA implementation note**

This section is completed for all patients undergoing surgery where the surgery was performed as a curative procedure. It should not be completed for any other patient group.

INVESTIGATION RESULT DATE (Date Specimen Reported)	8.3	
HISTOLOGY (SNOMED) (Histology)	8.10	SNOMED
POST TREATMENT: SITE-SPECIFIC STAGING CLASSIFICATION (Site-specific classification)	L23	Site-specific coding

8.3 INVESTIGATION RESULT DATE (Date specimen reported)

DD/MM/YYYY

The date of the histology report for the post-operative surgical specimen.

8.10 HISTOLOGY (SNOMED)(Histology)**For Lung Cancer patients**

Record here any histology from specimens obtained during a surgical procedure where the surgery was performed with the intention of curing the patient.

Do not record here any histology results from surgical procedures undertaken for purely diagnostic purposes – these should be entered in the Care Plan / MDT section.

For Mesothelioma Patients

It is accepted that all surgical procedures in this group of patients are palliative. Please record any histology obtained from such procedures

Do not record here any histology procedures undertaken for purely diagnostic purposes – these should be entered in the Care Plan / MDT section.

**SNOMed Codes for Histology (Pathology)
(SNOMed III (1993)/ICD-O-2 (1990) unless stated)**

		<i>LUCADA Mapping</i>
M 8010/2	Carcinoma in situ	NSCLC
M 8041/3	Small cell carcinoma	SCLC
M 8046/3	Non-small cell carcinoma (ICD-O-3) (includes adenosquamous carcinoma)	NSCLC
M 8070/3	Squamous cell carcinoma NOS	NSCLC
M 8140/3	Adenocarcinoma NOS (Adenocarcinoma without alveolar cell features)	NSCLC
M 8250/3	Bronchio-alveolar cell carcinoma (Adenocarcinoma with alveolar cell features)	NSCLC
M 8012/3	Large cell Carcinoma NOS	NSCLC
M 8020/3	Large cell – undifferentiated	NSCLC
M 8013/3	Large cell neuroendocrine (ICD-O-3)	NSCLC
M 8240/3	Carcinoid tumour NOS (includes atypical carcinoid)	Separate category
M 8980/3	Carcinosarcoma NOS	NSCLC
M 9050/3	Malignant Mesothelioma NOS	Mesothelioma
M 9052/3	Mesothelioma (epithelioid)	Mesothelioma
M 9051/3	Mesothelioma (sarcomatoid) (ICD-O-3)	Mesothelioma
M 8940/3	Mixed tumour (malignant)	NSCLC
M 9999/9	Other	NSCLC

L23 SITE-SPECIFIC STAGING CLASSIFICATION (Site-specific classification)

RADIO

As a result of the changes in the UICC staging manual version 7, TNM staging of small cell carcinoma of the lung is now the preferred method and should be recorded wherever possible. However, the old staging classification of Limited disease or Extensive disease (US Veterans Administration) is acceptable, if preferred.

Site Specific Stage	Code
Stage unknown	X
Limited	1
Extensive	2

Limited disease	Extensive disease
Disease confined to one hemithorax including involvement of ipsi-and/or contralateral hilar, mediastinal or supraclavicular lymph nodes. Patients with ipsilateral pleural effusion, regardless of pleural cytology, should be included in this group.	Any disease beyond the definition of limited stage.

Chemotherapy

Data Item	Dataset Ref.	Source
SITE CODE (OF CANCER DRUG TREATMENT) (Hospital)	9.1	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust Site
DECISION TO TREAT DATE (ANTI-CANCER DRUG REGIMEN) (Date of decision to treat)	9.4	
START DATE (ANTI-CANCER DRUG REGIMEN) (Drug treatment start date)	9.10	
CHEMOTHERAPY TREATMENT GIVEN	L27	01 Chemotherapy alone 02 Neo-adjuvant chemotherapy before surgery 03 Part of a chemotherapy / radiotherapy treatment plan 04 Adjuvant chemotherapy post surgery 05 Induction chemotherapy to down stage before surgery

9.1 SITE CODE (OF CANCER DRUG TREATMENT) (Hospital) *Five character alphanumeric*

Record the unique five figure organisation code of the Hospital where the patient is receiving their chemotherapy.

9.4 DECISION TO TREAT DATE (ANTI-CANCER DRUG REGIMEN) (Date of decision to treat) *DD/MM/YYYY*

Record the date on which it was decided that this patient should receive chemotherapy drug treatment. This is the date that the consultation between the patient and the clinician took place and a treatment plan for chemotherapy was agreed.

9.10 START DATE (ANTI-CANCER DRUG REGIMEN) (Drug treatment start date) *DD/MM/YYYY*

Record the date on which the first dose of the chemotherapy drug treatment is administered to the patient

L27 Chemotherapy treatment given

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

	Code
Chemotherapy alone	01
Neo-adjuvant chemotherapy before surgery	02
Part of a chemotherapy / radiotherapy treatment plan	03
Adjuvant chemotherapy post surgery	04
Induction chemotherapy to downstage prior to surgery	05

Teletherapy (external beam radiotherapy).

This section is used to record the initial teletherapy treatment.

Data Item	Dataset Ref.	Source
SITE CODE (OF TELETHERAPY) (Hospital)	10.1	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust Site
DECISION TO TREAT DATE (TELETHERAPY TREATMENT COURSE) (Date of decision to treat)	10.3	
RADIOTHERAPY TREATMENT GIVEN	L26	LUCADA DATASET
RADIOTHERAPY ANATOMICAL TREATMENT SITE (Anatomical treatment site)	10.7	OPCS 'Z' Codes
START DATE (TELETHERAPY TREATMENT COURSE) (Teletherapy start date)	10.8	

10.1 SITE CODE (OF TELETHERAPY) (Hospital)

Five character alphanumeric

Record the organisation code of the hospital providing the teletherapy to the patient.

**10.3 DECISION TO TREAT DATE
(TELETHERAPY TREATMENT COURSE) (Date of decision to treat)**

DD/MM/YYYY

Record the date on which it was decided that this patient should receive teletherapy. This is the date that the consultation between the patient and the clinician took place and a treatment plan for teletherapy was agreed.

L26 RADIOTHERAPY TREATMENT GIVEN

DDL

Record the reason that the teletherapy is being carried out.

Treatment Given	Code
Curative (radical) radiotherapy	01
Curative (CHART / CHARTWEL)	02
Part of a chemotherapy / radiotherapy treatment plan	03
Adjuvant following surgical treatment	04
Palliative Radiotherapy	05

10.7 RADIOTHERAPY ANATOMICAL TREATMENT SITE (Anatomical treatment site)

DDL

Record the actual site, which is the part of the body to which the prescription is administered. This is coded using OPCS4 'Z' codes from the following list. Where no other anatomical site has been mentioned, Z24.6 (lung) should be selected rather than leaving this field blank.

Anatomical Site	Code
Tissue of brain (nec)	Z01.9
Trachea	Z24.3
Lung	Z24.6
Mediastinum	Z24.7
Skin of other (nec)	Z50.9
Chest wall (nec)	Z52.9
Bone (nec)	Z87.1
Mesothelioma drain site	01
Other Region of Body (nec)	Z92.9

10.8 START DATE (TELEOTHERAPY TREATMENT COURSE) (Teletherapy start date)

DD/MM/YYYY

Record the date on which the first treatment of teletherapy is administered to the patient.

Brachytherapy

Data Item	Dataset Ref.	Source
SITE CODE (OF BRACHYTHERAPY) (Hospital)	11.1	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust Site
DECISION TO TREAT DATE (BRACHYTHERAPY TREATMENT COURSE) (Date of decision to treat)	11.3	
START DATE (BRACHYTHERAPY TREATMENT COURSE) (Brachytherapy start date)	11.9	NCDS

11.1 SITE CODE (OF BRACHYTHERAPY) (Hospital)

Five character alphanumeric

Record the five figure organisation code of the hospital providing the brachytherapy to the patient.

11.3 DECISION TO TREAT DATE (BRACHYTHERAPY TREATMENT COURSE) (Date of decision to treat)

DD/MM/YYYY

Record the date on which it was decided that this patient should receive brachytherapy. This is the date that the consultation between the patient and the clinician took place and a treatment plan for brachytherapy was agreed.

11.9 START DATE (BRACHYTHERAPY TREATMENT COURSE) (Brachytherapy start date)

DD/MM/YYYY

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

Palliative care

Data Item	Dataset Ref.	Source
SITE CODE (SPECIALIST PALLIATIVE TREATMENT COURSE)	12.n1	NHS Data Dictionary, Supporting Information, Administrative Codes, NHS Trust Site
PALLIATIVE CARE PROVIDER TYPE	L39	LUCADA dataset
PALLIATIVE CARE COMMUNITY PROVIDER TYPE	L40	LUCADA dataset
DECISION TO TREAT DATE (SPECIALIST PALLIATIVE TREATMENT COURSE) (Date of decision to treat)	12.n2	
START DATE (SPECIALIST PALLIATIVE TREATMENT COURSE) (Specialist Palliative Care Start Date)	12.n3	
PALLIATIVE CARE INTERVENTIONAL TREATMENT GIVEN	L41	LUCADA dataset
DATE INTERVENTIONAL TREATMENT GIVEN	L42	LUCADA dataset

Specialist palliative care is defined as care being administered by any member of a specialist palliative care team (e.g. Consultant in Palliative Care, Hospice Staff and Macmillan Specialist Palliative Care Nurses). It also includes specialist palliative procedures such as pleurodesis and the insertion of bronchial or superior vena caval stents. Details of such palliative procedures should be recorded under L41 and L42.

12.n1 SITE CODE (SPECIALIST PALLIATIVE TREATMENT COURSE) (Hospital)

Five character alphanumeric

Record the five figure organisation code of the Unit providing the specialist palliative care to the patient.

L39 PALLIATIVE CARE PROVIDER TYPE

Enter whether the palliative care was given in hospital or the community

	Code
L39 Palliative Care Provider Type	01 Hospital 02 Community

L40 PALLIATIVE CARE COMMUNITY PROVIDER TYPE

If the palliative care was given in the community indicate where this care was provided

	Code
L40 Palliative care community provider type	01 Hospice 02 Nursing Home 03 Home care 08 Other 09 Unknown

12.n2 DECISION TO TREAT DATE *DD/MM/YYYY*
(SPECIALIST PALLIATIVE TREATMENT COURSE) (Date of decision to treat)

Record the date on which it was decided that this patient should receive specialist palliative care. This is the date that the consultation between the patient and the clinician took place and a treatment plan for specialist palliative care was agreed.

12.n3 START DATE *DD/MM/YYYY*
(SPECIALIST PALLIATIVE TREATMENT COURSE) (Specialist Palliative Care Start Date).

Record the date of the first treatment/support from specialist palliative care.

L41 PALLIATIVE CARE INTERVENTIONAL TREATMENT GIVEN *(Radio)*
Record if the patient underwent a palliative care procedure (e.g. bronchial stenting, SVC stenting pleurodesis etc.)

L42 PALLIATIVE CARE INTERVENTIONAL TREATMENT DATE *DD/MM/YYYY*
Record the date that the palliative care procedure was undertaken

Active monitoring

	Data Item	Repeating?	Source of definition
L25	SITE CODE (ACTIVE MONITORING) (Hospital)	No	NCDS
16.9	DECISION TO TREAT DATE (ACTIVE MONITORING)	No	Date format

L25 SITE CODE (ACTIVE MONITORING) (Hospital) *Five character alphanumeric*

Record the five figure organisation code of the Unit where it was decided that the patient should be actively monitored.

16.9 DECISION TO TREAT DATE (ACTIVE MONITORING) *DD/MM/YYYY*

If the first treatment is active monitoring, record the date on which it was decided that the patient should be actively monitored.

Outcome

Death

Record here details of the patients death.

Also, complete L21 for all patients who received prophylactic cranial irradiation

	Data Item	Repeating?	Source of definition
15.1	PERSON DEATH DATE (Date of death)	No	NCDS
L20	Was Death Related to Treatment?	No	LUCADA dataset
14.7	TREATMENT TYPE (CANCER MORBIDITY) (Treatment Related Morbidity Type)	No	NCDS
L21	Did patient received PCI?)	No	LUCADA dataset
L30	Was the original treatment plan carried out	No	LUCADA dataset
L31	Reason why original treatment plan failed	No	LUCADA dataset

(Note 14.7 also cross references to NCDS 14.8, 14.10,14.11 & 14.12)

15.1 PERSON DEATH DATE (Date of death)

Record the date the patient died, in date format. Completion of this field is optional as this will be automatically updated from ONS

L 20 WAS DEATH RELATED TO TREATMENT?

Record whether or not the patient death was related to treatment.

Yes	Y
No	N
Unknown	9

14.7 TREATMENT TYPE (CANCER MORBIDITY) (Treatment Related Morbidity Type)

Record here the details of any treatment morbidity severe enough to result in death
If death was related to treatment record treatment type to which death was related using the DDL below.

Treatment Type	Code
Surgery	1
Chemotherapy	2
Radiotherapy	3
Combination	4

Prophylactic cranial irradiation**L 21 DID THE PATIENT RECEIVE PROPHYLACTIC CRANIAL IRRADIATION?**

Use the DDL to indicate whether patients received prophylactic cranial irradiation. This is particularly important for patients with limited stage small cell lung cancer

Yes	Y
No	N
Unknown	9

Treatment plan**L30 WAS THE ORIGINAL TREATMENT PLAN CARRIED OUT***RADIO*

Record here if the original treatment plan (L29) was carried out

Yes	Y
No	N
Unknown	9

L31 ORIGINAL TREATMENT PLAN FAILURE REASON*DDL*

If the treatment plan (L29) was not followed or completed, record the reason why.

		Code
L31	Reason why original treatment plan failed	01 Cancer progressed through treatment such that a new treatment plan required 02 Patient choice 03 Patient died 04 Treatment toxicity 05 Disease progression

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

The National Administrative Codes Service (NACS) is a Department of Health funded service that provides nationally agreed reference data to the NHS and other interested parties. The reference data covers not just healthcare organisations but also practitioners, postcodes and other administrative details.

The National Administrative Codes Service provides information via NHS net, via a quarterly release of data on CD-ROM and on the Internet.

To download a file containing hospital site codes

Access the National Administrative Codes Service web site:

<http://nww.connectingforhealth.nhs.uk/nacs>

On this page, use the 'Data Downloads' link

On this page, use the 'Downloads Index' link.

On this page, use the 'NHS Trust sites' link.

On this page, use the '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: nww.connectingforhealth.nhs.uk/nacs

On this page, use the 'Online enquiries' link.

On this page, use the 'Search using name, address or postcode' link.

Appendix B: 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, or an overlapping site 8 (unless specifically indexed – see below), or unspecified sub-site 9.

Example

C34 Malignant neoplasm of bronchus and lung

C34.0 Main bronchus

Carina

Hilus (of lung)

C34.1 Upper lobe, bronchus or lung

C34.2 Middle lobe, bronchus or lung

C34.3 Lower lobe, bronchus or lung

C34.8 Overlapping lesion of bronchus and lung

C34.8 Bronchus or lung, unspecified

An **in situ tumour** of the bronchus and lung would be coded D02.2, where D02 are **carcinoma in situ** of middle ear and respiratory system, sub-site .2 bronchus and lung.

A **benign tumour** of the bronchus and lung would be coded D14.3, where D14 are **benign neoplasms** of middle ear and respiratory system, with sub-site .3 for bronchus and lung.

A **tumour of uncertain or unknown behaviour** would be coded as D38.1 where D38 are neoplasms of uncertain or unknown behaviour of middle ear and respiratory and intrathoracic organs, sub-site .1 for trachea, bronchus and lung.

International Classification of Diseases for Oncology, 2nd edition (ICD-O-2) **Morphology codes**

ICD-10 includes a copy of this coding system to allow it to be used in conjunction with the above site codes, to identify histological type.

Morphology codes are prefixed by **M** to identify morphology. Four identity digits for the histological type of neoplasm, and a slash, then a one-digit behaviour code follow this as follows:

- /0** *benign*
- /1** *uncertain benign or malignant*
- /2** *carcinoma in situ*
- /3** *malignant, primary site*
- /6** *malignant metastatic, or secondary site*

Example:

M8070 describes squamous carcinoma

M8070/2 squamous cell carcinoma in-situ

M8070/3 squamous cell carcinoma (Not Otherwise Specified)

M8070/6 squamous cell carcinoma metastatic (i.e. in a node with an unknown primary)

There is also a /9 behaviour code for malignant uncertain whether primary or metastatic site, but this is not applicable for use in conjunction with the ICD 'C' site codes as all malignant neoplasms are presumed to be primary /3 or secondary /6

It should be noted that some histological types of neoplasm are specific to certain sites or types of tissue and that the 'C' and 'D' site codes are shown after these.

e.g. M8972/3 Pulmonary blastoma (C34.-) identifies that the morphology only relates to tumours occurring in the lungs.

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:

- E54 Excision of lung
- E54.1 Total pneumonectomy
- E54.2 Bibobectomy of lung
- E54.3 Lobectomy of lung
- E54.4 Excision of segment of lung
- E54.5 Partial lobectomy of lung nec
- E54.8 Other specified
- E54.9 Unspecified

UICC Coding

This refers to the International Union Against Cancer's TNM coding system (6th edition 2002, 7th edition 2009) – the global standard in cancer staging.

Copyright for Lung Cancer Data Manual

Copyright © 2010, The Information Centre, Clinical Audit Support Unit (CASU). 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.