WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2020 / 14
Date of Issue:	25th June 2020

Ministerial / Official Letter: N/A	**Subject:** National Cancer Data Standards for Wales – Site Specific - Upper Gastrointestinal (GI)[1] [1](For the purposes of COSD v9 reference, includes Pathology v4)
Sponsor: Cancer Implementation Group (CIG) Welsh Government	
Implementation Date: The Cancer Informatics Solution (CIS) MUST comply with this Standard with immediate effect. Services/data providers, however, MUST operate to **'business as usual'** in terms of the data being collected and reported (see section Actions Required in this Notice)	

DATA STANDARDS CHANGE NOTICE

A Data Standards Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on 18th June 2020

WISB Reference: ISRN 2020 / 008

Summary:

To introduce a new standard for site-specific cancer minimum reporting requirements for tumour site - Upper Gastrointestinal (GI).

Whilst this introduces a change to an existing information standard, the immediate use of this mandate will be used as a framework for the development of the CIS, therefore services/data providers should continue with **'business as usual'** in terms of the data being collected and reported (see section Actions Required in this Notice).

Data sets / returns affected:

- All Wales Oesophago-Gastric Cancer Minimum Reporting Requirements v2.0 including Core Reporting Items v5.0

Please address enquiries about this Data Standards Change Notice to the Data Standards Team in NHS Wales Informatics Service

E-mail: data.standards@wales.nhs.uk / Tel: 02920502539

The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARDS CHANGE NOTICE

Introduction

The original All Wales Cancer Minimum Reporting Requirements were mandated via Data Standards Change Notices (DSCNs) in 2011 for Core and Site Specific (http://nww.nwisinformationstandards.wales.nhs.uk/empty-5)

A revision of the existing all Wales Core Cancer Minimum Reporting Requirements together with the development of new Site-Specific Cancer Minimum Reporting Requirements is necessary to ensure Wales has effective, efficient and timely world-class healthcare information to provide intelligence and the insight to drive healthcare service improvements.

A revised standard for Core was mandated through National Cancer Data Standards for Wales – Core (DSCN 2019/09) (http://www.nwisinformationstandards.wales.nhs.uk/sitesplus/documents/299/20191210-DSCN%202019%2009-National%20Cancer%20Data%20Standards%20for%20Wales%20-%20Core-v1-0.pdf). **Core data items should be collected for all cancers**.

This Notice encompasses the site-specific cancer minimum reporting requirements for Upper Gastrointestinal (GI) i.e.:

- Oesophago-Gastric
- Liver
- Gastrointestinal Stromal Tumour (GIST)
- Neuroendocrine Tumour (NET)
- Pancreas
- High Grade Dysplasia

This should be used in conjunction with National Cancer Data Standards for Wales – Core (DSCN 2019/09).

Description of Change

This Standard covers the data items for Upper Gastrointestinal (GI), listed in NHS England Cancer Outcome and Services Data set (COSD) V9.0 (which includes Pathology V4.0) for comparability, and additional items to reflect NHS Wales reporting.

Whilst this introduces a change to an existing information standard, the immediate use of this mandate will be used as a framework for the development of the CIS, therefore services/data providers should continue with **'business as usual'** in terms of the data being collected and reported (see section Actions Required in this Notice).

Typically, within the DSCN we use a combination of 'strike through' and highlighted text to denote changes to the existing standard, however given that there have been a number of iterations of the COSD in England since the publication of the All Wales Cancer Minimum Reporting Requirements in Wales, for usability this practice has not been followed in this document.

Data Dictionary Version

Where applicable, this DSCN reflects changes introduced by DSCN and/or DDCN since the release of version 4.10 of the NHS Wales Data Dictionary.

Given that the immediate use of this mandate will be as a framework for the development of the CIS only, the changes introduced by this DSCN will not be published to the NHS Wales Data Dictionary until such time that it applies to a wider audience and fully replaces the existing Standard.

Actions Required

Actions for the NHS Wales Informatics Service:

- To apply this Standard with immediate effect in the development of the CIS
- Continue to make routine extracts available to the Welsh Cancer Intelligence and Surveillance Unit (WCISU) for the purpose of cancer registration via existing means.

Actions for Health Boards/Trusts:

There are no actions for health boards/trusts with regards to the changes in this Standard presently. However, health boards are expected to continue with '**business as usual'** as it pertains to the existing Standard, namely to collect and report data using existing national systems, i.e. CaNISC, PMS, WPAS, Cancer Tracking Module (Tracker 7) for the following:

- National Cancer Audits for Wales - a Tier 1 Welsh Government requirement
- Collection and reporting to the existing standards for cancer, the All Wales Core and Site-specific minimum reporting requirements (see http://howis.wales.nhs.uk/sites3/page.cfm?orgid=769&pid=19419)
- Collection and reporting of data required for Cancer Waiting Times and Single Cancer Pathway as per DSCNs issued.

In conjunction with the above points for Health Boards/Trusts, it is also important to note that:

Interim changes are currently in development for WPAS and Cancer Tracking Module (Tracker 7) to support the single cancer pathway data collection.

That data continues to be entered into the CWT fields within CaNISC, as many standard reports rely on the completion of those data items in report logic. Such reports continue to be used for many reporting purposes including national audit submissions.

SPECIFICATION

Information Specification

The data items required for National Cancer Data Standards for Wales – Site Specific - Upper Gastrointestinal (GI) and their equivalent labels in COSD V9.0, where there is an equivalent, are listed below.

Where the specification cites **NHS Wales Data Dictionary**, please refer to the Dictionary for the relevant guidance i.e. definition, format or code list.

For consistency, all dates listed in the Specification are standardised as ccyymmdd.

Where *D* is denoted in Status, this indicates that the information should be derived from another data item. This typically occurs with data items that are simply text representations of their code counterparts. Other Status codes are *M* (Mandatory), *R* (Required) – the data item should be recorded where applicable and *O* (Optional).

Core data items should be collected for all cancers. To reduce replication of information, Core data items have not been listed in this site-specific Standard and users should refer to National Cancer Data Standards for Wales – Core (DSCN 2019/09)(http://www.nwisinformationstandards.wales.nhs.uk/sitesplus/documents/299/20191210-DSCN%202019%2009-National%20Cancer%20Data%20Standards%20for%20Wales%20-%20Core-v1-0.pdf) for a list of Core requirements. However, in some cases, the site-specific application of Core data items may differ e.g. a particular tumour site may require additional or fewer codes to those already published in Core, or perhaps have additional business rules as to how the Core data item should be coded. Where this occurs, the Core data item will be replicated in the site-specific Standard with the respective additional site-specific detail. These are flagged in the following table with an * next to the data item name.

National Cancer Data Standards – Upper Gastrointestinal (GI): Oesophago-gastric (OG)

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Referral - Oesophago-gastric (OG). To carry referral details for OG (One occurrence of this group)						
Source of Referral for Out-patients (CWT) *	The source of referral classification used to identify the source of referral of each episode or referral **Note:** The adjacent codes are not present in Core but have been added here as a site specific requirement. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - Oesophago-gastric site-specific standard.	Code List	20	Open Access Endoscopy	R	Source of Referral for Out-patients (CWT) (CR1600)
			21	From Barrett's Surveillance		
			99	Not Known		
Diagnosis - Oesophago-gastric (OG). To carry diagnosis details for OG (One occurrence of this group)						
Pre-Treatment Tumour Site	Specify the characteristics of the OG cancer at diagnosis **Note:** Where possible this should be derived from Core data item *Primary Diagnosis (ICD)* or *Primary Diagnosis (SNOMED)*	Code List	01	Oesophagus upper third	D	N/A
			02	Oesophagus middle third		
			03	Oesophagus lower third		
			04	Siewert 1		
			05	Siewert 2		
			06	Siewert 3		
			07	Fundus		
			08	Body of stomach		
			09	Antrum		
			10	Pylorus		
Staging Procedures	Record the investigations performed to establish the stage of disease	Code List	00	None	R	N/A
			01	CT Scan		
			02	PET/PET-CT		

			03	Endoscopic US/EUS		
			04	Staging laparoscopy		
			05	EUS Fine needle aspiration		
			97	Other		
Comorbidity	Specify what other long term conditions the patient has at diagnosis. To detail the nature of any pre-existing conditions/co-morbidity which may have an effect on subsequent treatment. **Note:** Multiples can be selected, however the code *None* cannot be used with any other code	Code List	00	None	R	N/A
			01	COPD/Asthma		
			02	Chronic Renal Impairment		
			03	Liver Failure or Cirrhosis		
			04	Diabetes		
			05	Mental Illness		
			06	Barrett's Oesophagus		
			97	Significant Other		
			07	Ischemic Heart Disease		
			08	Cerebrovascular Disease		
			09	Peripheral Vascular Disease		
Dietetic Involvement Before Treatment	Specify what type of dietetic involvement (or planned involvement) the patient will receive between diagnosis and treatment.	Code List	1	Assessment and advice from a general dietitian	R	N/A
			2	Assessment and advice from a specialist OG dietitian		
			3	Assessment and advice from a dietitian not known if general or specialist		
			4	No contact with a dietitian as no dietitian available		
			5	No contact with a dietitian as assessed as not required		
			6	No contact with a dietitian		
Investigations - Oesophago-gastric (OG). To carry staging investigations details for OG (One occurrence of this group)						

Staging Procedures	Indicate the staging investigations performed in order to establish the cancer stage **Note:** Multiples can be selected, however the code None cannot be used with any other code	Code List	00	None	R	N/A
			01	CT Scan		
			02	PET/PET-CT		
			03	Endoscopic US/EUS		
			04	Staging laparoscopy		
			05	EUS Fine needle aspiration		
			97	Other		
Cancer Care Plan - Oesophago-gastric (OG). To carry details of the cancer care plan for OG (One occurrence of this group)						
Planned Cancer Treatment Type *	This is the clinically proposed treatment, usually agreed at a Multidisciplinary Team Meeting, and may not be the same as the treatment which is subsequently agreed with the patient. More than one planned treatment type may be recorded, and these may either be alternative or sequential treatments. **Note:** The codes *Endoscopic Mucosal Resection*, *Palliative surgery*, *Palliative oncology: Unspecified* and *Endoscopic palliative therapy: Unspecified* are not present in Core but have been added here as a site specific requirement. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - Oesophago-gastric site-specific standard.	Code List	01	Surgery	R	Planned Cancer Treatment Type (CR0470)
			02	Teletherapy		
			03	Chemotherapy		
			15	Endoscopic Mucosal Resection		
			14	Radiotherapy - Other		
			16	Palliative surgery		
			17	Palliative oncology: Unspecified		
			18	Endoscopic palliative therapy: Unspecified		
			07	Biological Therapy		
Surgery - General - Oesophago-gastric (OG). To carry surgery details for OG (One occurrence per Core Surgery and Other Procedure group)						
Palliative Treatment Reason (Upper GI)	Rationale for palliative treatment	Code List	1	Extensive intrahepatic disease	M	Palliative Treatment Reason (Upper GI) (UG13810)
			2	Widespread disease		

			3	Both extensive intrahepatic and widespread disease		
			4	Biliary obstruction		
			5	Gastric outlet obstruction		
			6	Pain		
Surgical Admission Date	The date of admission for the hospital stay during which the main surgical procedure took place	ccyymmdd	N/A	N/A	R	N/A
Surgical Pathway Type	Record the type of surgical pathway that the patient followed	Code List	1	A protocol enhanced recovery (ERAS) without daily documentation in medical notes	R	N/A
			2	A protocol enhanced recovery (ERAS) with daily documentation in medical notes		
			3	A standard surgical pathway		
			9	Not Known		
ERAS Pathway Completed	Did the patient complete the ERAS pathway Note: only for completion if 1 or 2 is chosen as value in Surgical Pathway Type	Code List	1	Yes	R	N/A
			2	No, but partial completion		
			3	No, non-completion		
			9	Unknown/Not documented		
Post Operative Tumour Site (Upper GI)	The main cancer site for which the patient is receiving care, as established in the resected specimen. **Note:** Cardia should no longer be used to describe adenocarcinoma located at the gastro-oesophageal junction - instead these tumours should be described by the appropriate Siewert type	Code List	01	Oesophagus upper third	R	Post Operative Tumour Site (Upper GI) (UG14230)
			02	Oesophagus middle third		
			03	Oesophagus lower third		
			04	Siewert 1		
			05	Siewert 2		
			06	Siewert 3		
			07	Fundus		
			08	Body of stomach		

			09	Antrum		
			10	Pylorus		
Main Procedure	The main surgical procedure carried out **Note:** Where possible this should be derived from Core data item *Primary Procedure (OPCS)* or *Primary Procedure (SNOMED)*	Code List	01	Left Thoraco-abdominal Oesophagectomy	D	N/A
			02	2-Phase (Ivor-Lewis) Oesophagectomy		
			03	3-Phase (McKeown) Oesophagectomy		
			04	Transhiatal Oesophagectomy		
			05	Thoracotomy (Open & Shut)		
			06	Total Gastrectomy		
			07	Extended Total Gastrectomy		
			08	Proximal Gastrectomy		
			09	Distal Gastrectomy		
			10	Completion Gastrectomy		
			11	Merendino Gastrectomy		
			12	Wedge/localised gastric resection		
			13	Bypass procedure/Jejunostomy only		
			14	Laparotomy (Open and Shut)		
Surgical Access Thoracic *	Record the approach used to perform the thoracic part of the main procedure **Note:** Of the adjacent codes, only *Open Surgery* and *Not applicable* are present in Core. The remaining codes have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - Oesophago-gastric site-specific standard.	Code List	01	Open Surgery	R	Surgical Access Type (CR6310)
			2a	Thoracoscopic with planned conversion to open surgery		
			2b	Thoracoscopic with unplanned conversion to open surgery		
			04	Thoracoscopic completed		
			5a	Robotic converted to open		

			5b	Robotic completed		
			Z	Not applicable		
Surgical Access Abdominal *	Record the approach used to perform the abdominal part of the main procedure **Note:** Of the adjacent codes, only *Open Surgery* is present in Core. The remaining codes have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - Oesophago-gastric site-specific standard.	Code List	01	Open surgery	R	Surgical Access Type (CR6310)
			03	Laparoscopic with unplanned conversion to open surgery		
			04	Laparoscopic completed		
			5a	Robotic converted to open		
			5b	Robotic completed		
Nodal Dissection	Record the extent of the lymphadenectomy performed	Code List	0	None	R	N/A
			1	1-field		
			2	2-field		
			3	3-field		
			4	DO (peri-gut resection)		
			5	D1		
			6	D2		
			7	D3		
Discharge Date	The date the patient was discharged or died in hospital	ccyymmdd	N/A	N/A	R	N/A

Death in Hospital	Indicates whether the patient died in hospital following surgical treatment. To monitor the proportion of deaths for surgically treated patients.	Code List	Y	Yes	R	N/A
			N	No		
Post Operative Nutritional Support During Admission	Record the type of nutritional support/intervention the patient receives during their admission for surgery	Code List	1	Nasojejunal tube	R	N/A
			2	Jejunostomy		
			3	Oral Nutrition		
			4	Parenteral Nutrition		
			7	Other		
			9	No Management		
Dietetic Involvement After Surgery	Record the type of dietetic involvement that the patient received after surgery	Code List	1	Assessment and advice from a general dietitian	R	N/A
			2	Assessment and advice from a specialist OG dietitian		
			3	Assessment and advice from a dietitian not known if general or specialist		
			4	No contact with a dietitian as no dietitial available		
			5	No contact with a dietitian as assessed as not required		
			6	No contact with a dietitian		
Post Operative Nutritional Support on Discharge	Record the type of ongoing nutritional support that the patient receives after surgery	Code List	1	Nasojejunal tube	R	N/A
			2	Jejunostomy		
			3	Oral Nutrition		
			4	Parenteral Nutrition		
			7	Other		
			9	No Management		

No of Surgeons Involved in Original Operation	Record the number of surgeons involved in the original surgery. **Note:** Surgeons involved in follow up surgery for complications should **not** be included here	max n1 Range 1 - 4	N/A	N/A	R	N/A
Consultant Code of Surgeon Responsible for Original Operation	Record the Consultant Code of the surgeon responsible for the original operation **Note:** Refer to NHS Wales Data Dictionary definition for *Consultant Code* for further information on the code's format	an8	N/A	N/A	R	N/A
Consultant Code of any Additional Surgeons involved	Record the Consultant Codes of any additional surgeons that were involved in the original operation **Note:** i. This is a repeating data item. Up to 3 additional surgeons may be included ii. Refer to NHS Wales Data Dictionary definition for *Consultant Code* for further information on the code's format	an8	N/A	N/A	R	N/A
Surgery - Upper Gastrointestinal (GI). To carry additional surgery details for Upper GI - Esophageal Database (ESODATA) (One occurrence per Core surgery group)						
Surgical Complications - International Esophageal Database (ESODATA)	The types of complications as defined in the International Esophageal Database (ESODATA). This list has been compiled by the Esophageal Complications Consensus Group (ECCG) **Note:** 1. The code *Haemorrhage* is not present in COSD but has been added here as a site	Code List	**0100** 0101 0102 0103	**Gastrointestinal** No post-operative complications Oesophagoentric leak from anastomosis, staple line, or localised conduit necrosis Conduit necrosis/failure requiring surgery	R	Surgical Complications - International Esophageal Database (ESODATA) (UG15010)

	specific requirement. ii. This is a repeating data item and multiple codes can be recorded		0104	Ileus defined as small bowel dysfunction preventing or delaying enteral feeding	
			0105	Small bowel obstruction	
			0106	Feeding J-tube complication	
			0107	Pyloromyotomy/Pyloroplasty complication	
			0108	Clostridium Difficile infection	
			0109	GI bleeding requiring intervention or transfusion	
			0110	Pancreatitis	
			0111	Liver dysfunction	
			0112	Delayed conduit emptying requiring intervention or delaying discharge or requiring maintenance of ng drainage >7 days post op	
			0113	Bowel ischaemia	
			0199	None	
			0200	**Pulmonary**	
			0201	Pneumonia	
			0202	Pleural effusion requiring additional drainage procedure	
			0203	Pneumothorax requiring intervention	
			0204	Atelectasis mucous plugging requiring bronchoscopy	
			0205	Respiratory failure requiring intubation	

0206	Acute respiratory distress syndrome
0207	Acute aspiration
0208	Tracheobronchial injury
0209	Chest drain requirement for air leak for >10 days post op
0299	None
0300	**Cardiac**
0301	Cardiac arrest requiring CPR
0302	Myocardial infarction
0303	Dysrhythmia atrial requiring intervention
0304	Dysrhythmia ventricular requiring intervention
0305	Congestive heart failure requiring intervention
0306	Pericarditis requiring intervention
0399	None
0400	**Thromboembolic**
0401	DVT (Deep Vein Thrombosis)
0402	PE (Pulmonary Embolus)
0403	Stroke (CVA)
0404	Peripheral thrombophlebitis
0499	None
0500	**Urologic**
0501	Acute renal insufficiency (defined as: doubling of baseline creatinine)

0502	Acute renal failure requiring dialysis
0503	Urinary tract infection
0504	Urinary retention requiring reinsertion of urinary catheter, delaying discharge, or discharge with urinary catheter
0599	None
0600	**Infection**
0601	Wound infection requiring opening wound or antibiotics
0602	Central iv line infection requiring removal or antibiotics
0603	Intrathoracic/Intra-abdominal abscess
0604	Generalised sepsis
0605	Other infections requiring antibiotics
0699	None
0700	**Neurologic/Psychiatric**
0701	Recurrent nerve injury
0702	Other neurologic injury
0703	Acute delirium
0704	Delirium tremens
0799	None
0800	**Wound/Diaphragm**
0801	Thoracic wound dehiscence
0802	Acute abdominal wall dehiscence/hernia

			0803	Acute diaphragmatic hernia		
			0899	None		
			0900	**Other**		
			0901	Chyle leak		
			0902	Chyle lead severity/type		
			0903	Reoperation for thoracic bleeding		
			0904	Reoperation for abdominal bleeding		
			0905	Reoperation for reasons other than bleeding, anastomotic leak or conduit necrosis		
			0906	Multiple organ dysfunction syndrome		
			0950	Haemorrhage		
			0999	None		
			1000	**Additional comments**		
			1001	The patient had other complications that is not in the ECCG recommended complications list above		
Leak Severity Type	Record the severity of the leak. **Note:** Only required if code *Oesophagoentric leak from anastomosis, staple line, or localised conduit necrosis* is recorded for data item *Surgical Complications - International Esophageal Database (ESODATA)*	Code List	1	Type I	R	Leak Severity Type (UG15020)
			2	Type II		
			3	Type III		
			9	Not known (not recorded)		
Conduit Necrosis/Failure Type	Record the conduit necrosis/failure type	Code List	1	Type I	R	Conduit Necrosis/Failure Type (UG15030)

	Note: Only required if code *Conduit necrosis/failure requiring surgery* is recorded for data item *Surgical Complications - International Esophageal Database (ESODATA)*		2	Type II		
			3	Type III		
			9	Not known (not recorded)		
Recurrent Laryngeal Nerve Injury Involvement Type	Record any recurrent laryngeal nerve injury involvement type **Note:** Only required if code *Recurrent nerve injury* is recorded for data item *Surgical Complications - International Esophageal Database (ESODATA)*	Code List	1	Type Ia	R	Recurrent Laryngeal Nerve Injury Involvement Type (UG15040)
			2	Type Ib		
			3	Type IIa		
			4	Type IIb		
			5	Type IIIa		
			6	Type IIIb		
			9	Not known (not recorded)		
Chyle Leak Severity Type	Record any Chyle leak severity type **Note:** Only required if code *Chyle lead severity/type* is recorded for data item *Surgical Complications - International Esophageal Database (ESODATA)*	Code List	1	Type Ia	R	Chyle Leak Severity Type (UG15050)
			2	Type Ib		
			3	Type IIa		
			4	Type IIb		
			5	Type IIIa		
			6	Type IIIb		
			9	Not known (not recorded)		
Clavien-Dindo Classification of Surgical Classifications	Record the overall grade as per the Clavien-Dindo Classification of Surgical Classifications	Code List	1	Grade I	R	Clavien-Dindo Classification of Surgical Classifications (UG15060)
			2	Grade II		
			3	Grade IIIa		
			4	Grade IIIb		
			5	Grade IVa		
			6	Grade IVb		
			7	Grade V		
			9	Not known (not recorded)		

Additional Complications	Did the patient have any complications that is not in the ECCG recommended complication list above? **Note:** i. Only required if code *the patient had other complications that is not in the ECCG recommended complications list above* is recorded for data item *Surgical Complications - International Esophageal Database (ESODATA)* ii. This is a repeating data item and multiple codes can be recorded	max an150	N/A	N/A	R	Additional Complications (UG15070)
Surgery - Upper Gastrointestinal (GI) - Outcome Measures. To carry additional surgery details for Upper GI - Eosophageal Database (ESODATA) (May be up to one occurrence per Core surgery group)						
Change in Level of Care	Record if there was any change in the level of care required for the patient?	Code List	1	No escalation in level of care required	R	Change in Level of Care (UG15110)
			2	Required escalation in level of care (ICU, ITU/HDU)		
			9	Not Known (Not recorded)		
Blood Product Utilisation	Record if there were any blood products required?	Code List	1	Intra-operative transfusions	R	Blood Product Utilisation (UG15120)
			2	Post-operative transfusions		
			3	Intra and post op transfusions		
			8	Not Applicable (None - no transfusions)		
			9	Not known (not recorded)		
Number of Units Transfused	Record the number of units of blood transfused	Code List	1	1-2 Units	R	Number of Units Transfused (UG15130)
			2	3-4 Units		
			3	5 or more Units		
			9	Not Known (Not recorded)		

Upper Gastrointestinal (GI) - Surgery - Oesophagectomy. To carry additional surgery details for - Oesophagectomy (One occurrence per Core surgery group)						
Surgical Approach Type	Record the type of surgical approach used during the Oesophagectomy	Code List	1	Open Oesophagectomy	R	Surgical Approach Type (UG15200)
			2	Minimally Invasive Oesophagectomy		
			9	Not Known (Not recorded)		
Open Approach Type	Record the type of open surgical approach used during the Oesophagectomy	Code List	1	Trans Thoracic Oesophagectomy	R	Open Approach Type (UG15210)
			2	Trans Hiatal Oesophagectomy		
Minimally Invasive Approach Type	Record the type of minimally invasive approach used during the Oesophagectomy	Code List	1	Total Minimally Invasive	R	Minimally Invasive Approach Type (UG15220)
			2	Abdominal part minimally invasive		
			3	Chest part minimally invasive		
Anastomosis Type	Record the type of anastomosis used during the Oesophagectomy	Code List	1	Neck anastomosis	R	Anastomosis Type (UG15230)
			2	Chest anastomosis		
			3	None		
			8	Other		
			9	Not known (not recorded)		
Oesophageal Conduit Type	Record the type of oesophageal conduit used during the Oesophagectomy	Code List	1	Stomach	R	Oesophageal Conduit Type (UG15240)
			2	Small bowel		
			3	Colon		
			4	None		
			5	Other		
			9	Not known (not recorded)		
Neck Dissection	Record if there was any neck dissection during the Oesophagectomy	Code List	Y	Neck dissection	R	Neck Dissection (UG15250)
			N	No neck dissection		
			9	Not known (not recorded)		
Surgery - Oesophago-gastric (OG) - Endocsopic or Radiological Procedures (One occurrence per Core Surgery)						

Planned Course of Multiple Treatments	Record if the first procedure is part of a planned course of multiple endoscopic treatments	Code List	Y	Yes	R	N/A
			N	No		
			9	Not Known		
Endoscopic Procedure Type	The main endoscopic procedures carried out. **Note:** 1. The codes *ESD - Endoscopic Submucosal Dissection* and *EMR - Endoscopic Mucosal Resection* are not present in COSD but have been added here as a site specific requirement. ii. This is a repeating data item and multiple codes can be recorded	Code List	1	Stent insertion	M	Endoscopic Procedure Type (UG14290)
			2	Laser therapy		
			3	Argon plasma coagulation		
			4	Photodynamic therapy		
			5	Gastrostomy		
			6	Brachytherapy		
			7	Dilation		
			8	Other		
			9	ESD - Endoscopic Submucosal Dissection		
			10	EMR - Endoscopic Mucosal Resection		
Stent Placement	Record the method used to place the stent **Note:** Only required if *Stent insertion* is recorded for data item *Endoscopic Procedure Type*	Code List	1	Fluroscopic control	M	N/A
			2	Endoscopic control		
			3	Fluroscopic and Endoscopic control		
			9	Not known		
Anaesthesia Used	Record the type of anaesthetic used during the procedure	Code List	1	Sedation	M	N/A
			2	Local anaesthetic spray		
			3	General anaesthetic		
			4	Sedation and local anaesthetic spray combined		
			9	Not Known		
Endoscopic or Radiological Complication Type	The types of complications that the patient experiences during the admission for the endoscopic procedure.	Code List	00	No complications	M	Endoscopic or Radiological Complication Type (UG13090)
			02	Perforation		

	Note: This is a repeating data item and multiple codes can be recorded		03	Haemorrhage		
			09	Pancreatitis		
			10	Cholangitis		
			88	Other		
Pathology - For Oesophago-gastric (OG) (in addition to core pathology) (One Occurrence per Path Report)						
Pathology Investigation Type *	The type of pathology investigation procedure carried out **Note:** 1. The codes *Fresh - Upper GI* and *Formulin Fixed - Upper GI* are not present in Core but have been added here as a site specific requirement.	Code List	CY	Cytology	R	Pathology Investigation Type (pCR0760)
			BU	Biopsy		
			EX	Excision		
			PE	Partial Excision		
			RE	Radical Excision		
			FE	Further Excision		
			CU	Curettage		
			SB	Shave Biopsy		
			PB	Punch Biopsy		
			IB	Incisional Biopsy		
			99	Uncertain/Other		
			FR	Fresh - Upper GI		
			FF	Formulin Fixed - Upper GI		
Excision Margin (Proximal)	Identify whether the proximal margin is involved. **Note:** i. Both proximal and distal are recorded in one data item in COSD, but these have been added as separate data items here as a site specific requirement ii. *Involved* = 1mm or less, *Not involved* = >than 1 mm	Code List	0	Margin not involved	R	Excision Margin (Proximal, Distal) (pUG14480)
			1	Margin involved		
			9	Not Known		

Excision Margin (Distal)	Identify whether the distal margin is involved. **Note:** i. Both distal and proximal are recorded in one data item in COSD, but these have been added as separate data items here as a site specific requirement ii. *Involved* = 1mm or less, *Not involved* = >than 1 mm	Code List	0	Margin not involved	R	Excision Margin (Proximal, Distal) (pUG14480)
			1	Margin involved		
			9	Not Known		
Excision Margin (Circumferential)	Identify whether circumferential margin is involved. **Note:** *Involved* = 1mm or less, *Not involved* = >than 1 mm	Code List	0	Margin not involved	R	Excision Margin (Circumferential) (pUG14490)
			1	Margin involved		
			9	Not Known		
Biomarkers - Oesophago-gastric (OG)						
HER2 Status (at diagnosis)	To record the HER2 Status for the patient, at diagnosis **Note:** All patients having palliative chemotherapy with diagnosis of OG should have a known HER2 Status	Code List	1	Positive	R	N/A
			2	Negative		
			3	Not done		
			9	Not known		
Dihydropyrimidine Dehydrogenase (DPD) Status	To record the DPD Status for the patient, if performed	Code List	1	DPYP variant homozygous	R	N/A
			2	DPYP variant heterozygous		
			3	No variant detected		
			9	Not known (Not Performed)		
Oncology - Radiotherapy Details - Oesophago-gastric (OG)						
Start Date of Radiotherapy	The date that the first cycle of radiotherapy was started	ccyymmdd	N/A	N/A	R	N/A
Outcome of Radiotherapy	Specify if the patient completed their treatment as prescribed	Code List	1	Treatment Completed as Prescribed	R	N/A
			2	Treatment Not completed		

			9	Not known (outcome)		
Reason for Incomplete Radiotherapy	Specify the reason if Radiotherapy was not completed	Code List	1	Patient died	R	N/A
			2	Progressive disease during radiotherapy		
			3	Toxicity		
			4	Patient choice (stopped or interrupted treatment)		
			7	Other		
			9	Not known (reason)		
Oncology - Chemotherapy Details - Oesophago-gastric (OG)						
Chemotherapy Start Date	The date that the first cycle of chemotherapy was started	ccyymmdd	N/A	N/A	R	N/A
Outcome of Chemotherapy	Specify if the patient completed their treatment as prescribed	Code List	1	Treatment Completed as Prescribed	R	N/A
			2	Treatment Not completed		
			9	Not known (outcome)		
Reason for Incomplete Chemotherapy	Specify the reason if Chemotherapy was not completed	Code List	1	Patient died	R	N/A
			2	Progressive disease during radiotherapy		
			3	Toxicity		
			4	Patient choice (stopped or interrupted treatment)		
			7	Other		
			9	Not known (reason)		
Proceeded to Planned Curative Surgery	Record if the patient proceeded to curative surgery after neoadjuvant chemotherapy **Note:** *Yes,* would be derived where SACT adjunctive therapy = neoadjuvant. *No* and *Not applicable* should be recorded manually	Code List	Y	Yes	D	N/A
			N	No		
			8	Not applicable		

Oncology - Immunotherapy - Oesophago-gastric (OG)						
Start Date of Immunotherapy	The date that the first cycle of immunotherapy was started	ccyymmdd	N/A	N/A	R	N/A
Outcome of Immunotherapy	Specify if the patient completed their treatment as prescribed	Code List	1	Treatment Completed as Prescribed	R	N/A
			2	Treatment Not completed		
			9	Not known (outcome)		
Reason for Incomplete Immunotherapy	Specify the reason if Immunotherapy was not completed	Code List	1	Patient died	R	N/A
			2	Progressive disease during radiotherapy		
			3	Toxicity		
			4	Patient choice (stopped or interrupted treatment)		
			7	Other		
			9	Not known (reason)		

National Cancer Data Standards – Upper Gastrointestinal (GI): Liver

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Diagnosis - Liver - Core. To record diagnostic details for the Liver Hepatocellular Carcinoma (HCC) & Cholangiocarcinoma (CC) (One Occurrence per core diagnosis group)						
Liver Surveillance Scans	Record if the patient was receiving liver cancer surveillance scans?	Code List	Y	Yes	R	Liver Surveillance Scans (LV16000)
			N	No		
			9	Not Known		
Liver Cirrhosis Type	Record the type of live cirrhosis	Code List	1	Compensated	R	Liver Cirrhosis Type (LV16010)
			2	Decompensated		
			8	Patient does not have cirrhosis of the liver		
			9	Not Known		
Cause of Liver Cirrhosis	Is the patient's liver cirrhosis caused by known risk factors for liver disease? **Note:** This is a repeating data item and multiple codes can be recorded	Code List	01	Alcohol excess	R	Cause of Liver Cirrhosis (LV16020)
			02	Hepatitis B virus infection		
			03	Hepatitis C virus infection		
			04	Non-alcohol related fatty liver disease		
			05	Hereditary haemochromatosis		
			06	Autoimmune hepatitis		
			07	Primary sclerosing cholangitis		
			10	Primary biliary cholangitis		
			98	Other		
			99	Not Known		
Transplantation - Liver (for all types HCC, CC, Mets). To record liver transplantation details for the patient						
Liver Transplantation	Was the patient listed for transplantation?	Code List	Y	Yes	R	Liver Transplantation (LV16200)
			N	No		

			9	Not known		
Surgery - Liver (for all types HCC, CC, Mets) To record surgery details for Liver (One occurrence per core surgery)						
Surgery Type	What type of liver surgery was performed?	Code List	1	Liver Resection	R	Surgery Type (LV16210)
			2	Liver Transplantation		
Surgery - Liver - Core. To record further surgical details for all Liver (HCC,CC,Liver Mets) (One occurrence per Core group)						
Clavien-Dindo Classification of Surgical Classifications	Record the overall grade as per the Clavien-Dindo Classification of Surgical Classifications	Code List	1	Grade I	R	Clavien-Dindo Classification of Surgical Classifications (UG15060)
			2	Grade II		
			3	Grade IIIa		
			4	Grade IIIb		
			5	Grade IVa		
			6	Grade IVb		
			7	Grade V		
			9	Not known (not recorded)		
Treatment & Prognostic Indicators - Liver - Core. To record further staging details for Liver HCC & CC (One occurrence per Core Treatment group)						
Portal Invasion	Record whether there is tumour present in the main portal vein, or if there is tumour present in a branch of the portal vein or if there is no tumour present in the portal vein.	Code List	1	Branch	R	Portal Invasion (LV16120)
			2	Main		
			3	Not Present		
			9	Not known		
Liver - Hepatocellular Carcinoma (HCC). Record additional data items for all HCC Malignancies						
Staging Details - Liver - HCC						
Number of Liver Lesions Seen	Total number of liver lesions seen on imaging	max n2	N/A	N/A	M	N/A
Size of Largest Liver Lesion	Record the size of the largest liver lesion seen on imaging	max n2	N/A	N/A	M	N/A
Vascular Invasion	Record if vascular invasion is present or absent	Code List	Y	Present	M	N/A
			N	Not present		
			9	Not Known		

Chronic Liver Disease	Record if chronic liver disease is present or absent	Code List	Y	Present	M	N/A
			N	Not present		
			9	Not Known		
Cause of Chronic Liver Disease	Is the patient's cause of chronic liver disease caused by known risk factors? **Note:** This is a repeating data item and multiple codes can be recorded	Code List	01	Alcohol excess	M	N/A
			02	Hepatitis B virus infection		
			03	Hepatitis C virus infection		
			04	Non-alcohol related fatty liver disease		
			05	Hereditary haemochromatosis		
			06	Autoimmune hepatitis		
			07	Primary sclerosing cholangitis		
			10	Primary biliary cholangitis		
			98	Other		
			99	Not Known		
Child-Pugh Score	Record the overall Child-Pugh score. This is the level of disease of the liver.	Code List	A	Child-Pugh A	M	Child-Pugh Score (LV16140)
			B	Child-Pugh B		
			C	Child-Pugh C		
Alpha Fetoprotein (Serum)	Maximum Serum level of alpha feto protein at diagnosis. AFP units recorded in kU/l (values > 100,000 are recorded)	max n6 Range 0-999999	N/A	N/A	M	Alpha Fetoprotein (Serum) (CR8920)
CT or MRI - full information recorded	Specify if patients CT or MRI report contains the specified full information required to enable the correct management decisions to be made at the MDT **Note:** This is derived data item. The derived code will be based whether all the data items in the *Staging Details - Liver - HCC* section have been recorded	Code List	Y	Yes	D	N/A
			N	No		
			9	No CT or MRI done		

Site Specific Staging - Liver - HCC. To record site specific staging details (One occurrence per Core Staging group)						
Barcelona Clinic Liver Cancer (BCLC) Stage	The Barcelona Clinic Liver Cancer (BCLC) stage, includes both anatomic and non-anatomic factors and is widely used within the UK to predict prognosis and determine treatment.	Code List	0	Very early	M	Barcelona Clinic Liver Cancer (BCLC) Stage (LV16100)
			A	Early		
			B	Intermediate		
			C	Advanced		
			D	Terminal		
Pathology - Liver. To record additional pathology details for Liver, HCC (One occurrence per pathology)						
Number of Tumours Present	Specify the number of tumours present	max n2	N/A	N/A	R	N/A
Bile Duct Invasion	An indication of whether bile duct invasion was present or absent	Code List	Y	Yes - Present	R	N/A
			N	No - Not Present		
Type of Fibrosis/Cirrhosis in background liver	Specify the type of fibrosis Fibrosis/Cirrhosis in Background Liver	Code List	1	Not Bridging	R	N/A
			2	Bridging		
			3	Bridging with nodules		
			4	Complete Cirrhosis		
			0	None present		
Treatment - Liver. To record other procedure details Liver - HCC (One occurrence per Core Treatment group)						
Ablative Therapy Type	Describe type of ablative (ie locally destructive treatment) therapy used if any.	Code List	R	Radiofrequency ablation	R	Ablative Therapy Type (LV16300)
			M	Microwave ablation		
			8	Other ablative treatment		
			9	Not Known		
Embolisation Modality	What modality of the Liver Trans Arterial Embolisation was used? This refers to the type of material injected into the hepatic artery.	Code List	1	TAE/BLAND	R	Embolisation Modality (LV16320)
			2	C-TACE		
			3	DEB-TACE		
			4	RO DEB-TACE		
			5	SIRT		
			9	Not known		

Treatment & Prognostic Indicators - Liver - HCC (One occurrence per Core Treatment group)						
Child-Pugh Score	Record the overall Child-Pugh score. This is the level of disease of the liver.	Code List	A	Child-Pugh A	R	Child-Pugh Score (LV16140)
			B	Child-Pugh B		
			C	Child-Pugh C		
UKELD Score	Record the UKELD score. The UKELD score is calculated using bilirubin, INR, creatine and sodium. It predicts the risk of mortality due to liver cirrhosis and is used to assess need for liver transplantation. **Note:** The UKELD calculator is available at: https://www.basi.org.uk/index.cfm/content/page/cid/34	max n2 Range 0-99	N/A	N/A	R	UKELD Score (LV16130)
Liver - Cholangiocarcinoma (CC). Record for all Cholangiocarcinoma (CC) Malignancies						
Diagnosis - Cholangiocarcinoma. To record diagnostic details for Cholangiocarcinoma (One occurrence per core diagnosis group)						
Cholangiocarcinoma Category	State where the Cholangiocarcinoma is present, using the designated categories. Any cholangiocarcinoma which involves the anatomical hilum of the liver must be classified as perihilar **Note:** 1. The code *Distal* is not present in COSD but has been added here as a site specific requirement.	Code List	1	Intrahepatic	M	Cholangiocarcinoma Category (LV16400)
			2	Perihilar		
			3	Extrahepatic		
			4	Distal		
Preoperative Drainage Type	Specify the pre-operative drainage type **Note:** Only required where *Perihilar* is recorded for data item *Cholangiocarcinoma Category*	Code List	1	PTC (Percutaneous Transhepatic Cholangiogram)	R	N/A
			2	ERCP (Endoscopic Retrograde Cholangiopancreatography)		
			3	No drainage required		

Treatment - Liver - CC (One occurrence per Core Treatment group)						
Date of Referral for Palliative Chemotherapy	Specify the date the referral was made for palliative chemotherapy	ccyymmdd	N/A	N/A	R	N/A
Liver - Liver Metastases. To be recorded for all types of Pathways - Primary progression/Non Primary Pathway - Progression & Recurrence. Ensure that all core items (Mets at diagnosis) and other treatment pathways flag liver Mets data collection if 03 liver Mets is chosen. To be Recorded for all Liver Mets regardless of Primary Site. Attach liver Mets data to the Original Primary Tumour Site (ICD10)						
Treatment - Liver Metastases. To record other procedure details Liver Mets (One occurrence per Core Treatment group)						
Ablative Therapy Type	Describe type of ablative (ie locally destructive treatment) therapy used if any.	Code List	R	Radiofrequency ablation	R	Ablative Therapy Type (LV16300)
			M	Microwave ablation		
			8	Other ablative treatment		
			9	Not Known		
Embolisation Modality	What modality of the Liver Trans Arterial Embolisation was used? This refers to the type of material injected into the hepatic artery.	Code List	1	TAE/BLAND	R	Embolisation Modality (LV16320)
			2	C-TACE		
			3	DEB-TACE		
			4	RO DEB-TACE		
			5	SIRT		
			9	Not known		
Pathology - Liver Metastases. To record additional pathology details for Liver Mets (One occurrence per core surgery)						
Total Number of Colorectal Metastases in Liver Code	Record the total number of colorectal metastases identified in the resected liver	max n2	N/A	N/A	R	Total Number of Colorectal Metastases in Liver Code (pUG14500)
Number of Tumours Present	Specify the number of tumours present	max n2	N/A	N/A	R	N/A
Bile Duct Invasion	An indication of whether bile duct invasion was present or absent	Code List	Y	Yes - Present	R	N/A
			N	No - Not Present		

National Cancer Data Standards – Upper Gastrointestinal (GI): Gastrointestinal Stromal Tumour (GIST)

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Surgery - GIST. To record additional surgery details for GIST tumours (One occurrence per surgery)						
Tumour Rupture	Record if the tumour ruptured at the time of surgery	Code List	Y	Yes	R	N/A
			N	No		
Pathology - GIST. To record additional pathology details for GIST tumours (One occurrence per pathology)						
Mitotic Count	Record the mitotic count per 5mm²	max n2 Range 0-50			R	N/A
Tumour Rupture (Pathology)	Record if the tumour ruptured at the time of surgery as seen within sample	Code List	Y	Yes	R	N/A
			N	No		
Molecular & Biomarkers - GIST. To record additional Molecular & Biomarker details for GIST tumours						
Date Referred for Mutational Analysis	Record the date the patient was referred for mutational analysis	ccyymmdd	N/A	N/A	R	N/A
Wild Type	Specify if the marker tested resulted in a mutation	Code List	1	Mutation detected	R	N/A
			2	No mutation detected		
			3	No Mutational Analysis Performed		
Prognostic Index - GIST. To record Prognostic details for GIST tumours						
Risk Recurrence Score	Record the associated risk recurrence score	Code List	0	No Risk	R	N/A
			1	Very Low Risk		
			2	Low Risk		
			3	Moderate Risk		
			4	High Risk		

National Cancer Data Standards – Upper Gastrointestinal (GI): Neuroendocrine Tumour (NET)

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Diagnosis						
NET Primary Site Code (SNOMED)	The NET primary site SNOMED code as defined by the Specialist Whilst Core has data items for *Primary Diagnosis Site Code*, this has been added here as a site specific requirement to give greater granularity	min n6 max n18	N/A	N/A	M	N/A
NET Primary Site Code Description (SNOMED)	The NET primary site SNOMED description of code as defined by the Specialist **Note:** This is derived data item and is the description associated with *NET Primary Site Code (SNOMED)*	max an100	N/A	N/A	D	N/A
Key Investigations						
Functioning Status (Syndrome)	A record of the functioning status for the patient (at diagnosis)	Code List	Y	Yes - Patient has 'carcinoid syndrome'/patient has a functioning tumour	R	N/A
			N	No - Patient has a non-functioning tumour		
			8	Not applicable		
			9	Not recorded		
Gut Hormone Profile	The result of gut hormone profile blood test (at diagnosis)	Code List	1	Abnormal	R	N/A
			2	Normal		
			3	Not done		
			4	Patient refused		

			8	Not applicable		
			9	Not recorded		
Gut Hormone Profile Type	Specify the type found within the gut hormone profile (at diagnosis) **Note:** i. If *Functioning Status (Syndrome)* is recorded as *Yes* or *Gut Hormone Profile* is recorded as *Abnormal* the *Gut Hormone Profile Type* should be specified ii. If *Functioning Status (Syndrome)* is recorded as *No* or *Gut Hormone Profile* is recorded as *Normal*, the *Gut Hormone Profile Type* should be recorded as *Not applicable*	Code List	1	Insulin	R	N/A
			2	Gastrin		
			3	Glucagon		
			4	VIP (Vasoactive Intestinal Peptide)		
			5	Somatostatin		
			8	Not applicable		
			9	Not recorded		
5-HIAA Test	The result of 24 hour 5 hydoxyindole acetic acid (5-HIAA) urine test **Note:** Only required for small bowel tumours	Code List	1	Abnormal (High)	R	N/A
			2	Normal		
			3	Not done		
			4	Patient refused		
			8	Not Applicable		
			9	Not recorded		
Chromogranin (CgA) Value	Specify the absolute value of the Chromogranin test (at diagnosis).	Integer n3 pmol units per litre	N/A	N/A	M	N/A
Chromogranin A (CgA) Test Result	The result of the Chromogranin A blood test (at diagnosis) **Note:** This is a derived data item. *Abnormal (High)* would be derived where the *Chromogranin (CgA) Value* is 61 and above and *Normal* would be derived where the *Chromogranin (CgA) Value* is 0-60. All other codes should be recorded manually.	Code List	1	Abnormal (High)	D	N/A
			2	Normal		
			3	Not done		
			4	Patient refused		
			8	Not Applicable		
			9	Not recorded		

Serotonin Test	The result of the Serotonin blood test (at diagnosis)	Code List	1	Abnormal (High)	R	N/A
			2	Normal		
			3	Not done		
			4	Patient refused		
			8	Not Applicable		
			9	Not recorded		
Key Imaging						
Date of Somatostatin Receptor Imaging (Octreoscan)	This date somatostatin receptor imaging (octreotide scan/octreoscan) was completed as part of NETs diagnostic work-up **Note:** This is a derived data item from Core data items *Imaging Code (NICIP)* or *Imaging Code (SNOMED CT)* PLUS *Procedure Date (Cancer Imaging)*	ccyymmdd	N/A	N/A	D	N/A
Date of MRI	The date MRI imaging was completed as part of NETs diagnostic work-up **Note:** This is a derived data item from Core data items *Imaging Code (NICIP)* or *Imaging Code (SNOMED CT)* PLUS *Procedure Date (Cancer Imaging)*	ccyymmdd	N/A	N/A	D	N/A
Date of CT	The date CT Imaging was completed as part of NETs diagnostic work-up **Note:** This is a derived data item from Core data items *Imaging Code (NICIP)* or *Imaging Code (SNOMED CT)* PLUS *Procedure Date (Cancer Imaging)*	ccyymmdd	N/A	N/A	D	N/A

Date of FDG PET CT	The date FDG PET CT imaging was completed as apart of NETs diagnostic work-up **Note:** This is a derived data item from Core data items *Imaging Code (NICIP)* or *Imaging Code (SNOMED CT)* PLUS *Procedure Date (Cancer Imaging)*	ccyymmdd	N/A	N/A	D	N/A
Date of Gallium 68 PET	The date Gallium68 PET Imaging was completed as part of NETs diagnostic work up **Note:** This is a derived data item from Core data items *Imaging Code (NICIP)* or *Imaging Code (SNOMED CT)* PLUS *Procedure Date (Cancer Imaging)*	ccyymmdd	N/A	N/A	D	N/A
Surgery						
Clavien-Dindo Classification of Surgical Classifications	Record the overall grade as per the Clavien-Dindo Classification of Surgical Classifications	Code List	1	Grade I	R	Clavien-Dindo Classification of Surgical Classifications (UG15060)
			2	Grade II		
			3	Grade IIIa		
			4	Grade IIIb		
			5	Grade IVa		
			6	Grade IVb		
			7	Grade V		
			9	Not known (not recorded)		
Pathology						
Histological Type and Grade	Specify the histological type and grade of the NET resection	Code List	01	Well-differentiated, NET G1 (M8240/3)	R	N/A
			02	Well-differentiated, NET G2		
			03	Well-differentiated, NET G3		

			04	Well-differentiated, grade cannot be assessed		
			05	Poorly differentiated NEC G3, small cell		
			06	Poorly differentiated NEC G3, large cell		
			07	Poorly differentiated NEC, NOS		
			08	Mixed NE-non NE carcinoma/MiNEN (for gastric/colorectal/duodenal/ampullary/proximal jejunal/lower jujunal/ileal NET resections)		
			09	Gangliocytic paraganglioma (for duodenal/ampullary/proximal jejunal/pancreatic NET resections)		
			97	Other		
Proliferation Index with Ki-67	Record the Proliferation Index with Ki-67	Code List	1	Low (<6%)	R	N/A
			2	Intermediate (6-10%)		
			3	High (>10%)		
Mitotic Count	Record the Mitotic count	Integer max n4/2 mm²	N/A	N/A	R	N/A
Presence of Necrosis	Record whether there is presence of necrosis	Code List	1	Present	R	N/A
			2	Not Identified		
Perineural Invasion	A record to determine whether there was perineural invasion noted after pathological reporting of tumour sample.	Code List	Y	Yes (Perineural invasion present)	R	N/A
			N	No (Perineural invasion not present)		
			8	Not applicable (Not sampled)		

			9	Not recorded (not recorded in pathology report)		
Immunohistochemistry - Chromogranin	A record to determine whether chromogranin immunohistochemistry (IHC) stain was carried out on tumour sample	Code List	1	Positive	R	N/A
			2	Negative		
			3	Equivocal		
			4	Insufficient material		
			5	Not done (No surgery/biopsy)		
			9	Not recorded (not recorded in pathology report)		
Immunohistochemistry - Synaptophysin	A record to determine whether synaptophysin Immunohistochemistry (IHC) stain was carried out on tumour sample	Code List	1	Positive	R	N/A
			2	Negative		
			3	Equivocal		
			4	Insufficient material		
			5	Not done (No surgery/biopsy)		
			9	Not recorded (not recorded in pathology report)		
Immunohistochemistry - CD56	A record to determine whether CD56 immunohistochemistry (IHC) stain was carried out on tumour sample	Code List	1	Positive	R	N/A
			2	Negative		
			3	Equivocal		
			4	Insufficient material		
			5	Not done (No surgery/biopsy)		
			9	Not recorded (not recorded in pathology report)		
Pathology - For Gastric NETs						

Gastric NET Type	Specify the type of Gastric NET	Code List	1	Type I	R	N/A
			2	Type II		
			3	Type III		
			9	Cannot Be Assessed		
MDT Details						
MDT Decision *	This denotes the decision the MDT took on the management of the patients care **Note:** i. Of the adjacent codes, only *Surgery*, *Chemotherapy*, *Biological Therapy* and *Not Recorded/Not Known* are present in Core. The remaining codes have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - NET site-specific standard. ii. This is a repeating data item. Up to 3 decisions may be included	Code List	01	Surgery	R	Planned Cancer Treatment Type (CR0470)
			03	Chemotherapy		
			07	Biological Therapy		
			19	Transartierial (Chemo)-embolisation (TACE)		
			20	Radiofrequency Ablation (RFA)		
			21	Radionuclide Treatment		
			22	Further Imaging/ Diagnostic Tests		
			23	Somatostatin Analogues (SSAs)		
			24	No further treatment/follow up required		
			25	Follow up only		
			26	Supportive Care Only		
			98	Not applicable		
			99	Not Recorded/Not Known		
Treatments						
Type of First Cancer Treatment *	This denotes the first specific treatment modality administered to a patient **Note:** Of the adjacent codes, *Transartierial (Chemo)-*	Code List	01	Surgery	R	Planned Cancer Treatment Type (CR0470)
			05	Teletherapy (Beam Radiation excluding Proton Therapy)		
			08	Active Monitoring		

	embolisation (TACE), *Radionuclide Treatment*, *Somatostatin analogues (SSA)*, *Supportive Care Only*, *Patient died before treatment* and *Not recorded* are not present in Core. These have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - NET site-specific standard.		02	Anti-Cancer Drug Regimen (Cytotoxic Chemotherapy)		
			21	Biological Therapies (excluding Immunotherapy)		
			15	Anti-Cancer Drug Regimen (Immunotherapy)		
			10	Radiofrequency ablation (RFA)		
			12	Cryotherapy		
			24	Transartierial (Chemo)-embolisation (TACE)		
			25	Radionuclide Treatment		
			26	Somatostatin analogues (SSA)		
			27	Supportive Care Only		
			97	Other Therapy/Other Treatment		
			96	Patient died before treatment		
			98	Patient refused all therapies/All treatment declined		
			99	Not Recorded		
Date of First Cancer Treatment	This denotes the date the *Type of First Cancer Treatment* was given to the patient **Note:** This is a derived data item from Core *Treatment Start Date (Cancer)* where *Cancer Treatment Event Type* is recorded as *First Definitive Treatment for a New Primary Cancer*	ccyymmdd	N/A	N/A	D	N/A
Liver Ablative Therapy	A record of whether liver ablative therapy was performed	Code List	1	Microwave ablation	R	N/A
			2	Radiofrequency ablation (RFA)		
			3	Patient died before treatment		
			4	Patient refused treatment		

			8	Not applicable		
			9	Not recorded		
Liver Ablative Therapy Date	This denotes the date on which liver ablative therapy was performed **Note:** If liver ablative therapy is not carried out, record as 10101010 (inapplicable)	ccyymmdd	N/A	N/A	R	N/A
Embolisation Therapy	This denotes if the patient had transarterial chemoembolisation (TACE), transarterial embolisation (TAE) or selective internal radiation therapy (SIRT) treatment	Code List	1	TACE (Transarterial chemoembolisation)	R	N/A
			2	TAE (Transarterial embolisation)		
			3	SIRT (Selective internal radiation therapy)		
			4	Patient died before embolisation therapy		
			5	Patient refused embolisation therapy		
			8	Not Applicable (no embolisation therapy given)		
			9	Not Recorded		
Embolisation Therapy Date (TACE/TAE/SIRT)	This denotes the date on which chemoemolisation (TACE), TAE or SIRT was performed **Note:** If TACE is not carried out, record as 10101010 (inapplicable)	ccyymmdd	N/A	N/A	R	N/A
Peptide Receptor Nuclide Therapy (PRRT) Type	This denotes the type of peptide receptor nuclide therapy (PRRT)	Code List	01	MIBG (Metaiodobenzylguanidine)	R	N/A
			02	Lutetium 177 (LU 177/Lutathera)		
			03	Yttrium 90 (YU 90)		
			04	Patient died before PRRT		

			05	Patient refused PRRT		
			98	Not applicable (no PRRT given)		
			97	Other		
			99	Not recorded		
Peptide Receptor Nuclide Therapy (PRRT) Type - Other	Where *Peptide Receptor Nuclide Therapy (PRRT) Type* is recorded as *Other*, please specify the type	max an50	N/A	N/A	R	N/A
Peptide Receptor Nuclide Therapy (PRRT) - Start Date	This denotes the date on which peptide receptor nuclide therapy (PRRT) was commenced **Note:** If PRRT is not carried out, record as 10101010 (inapplicable)	ccyymmdd	N/A	N/A	R	N/A
Peptide Receptor Nuclide Therapy (PRRT) - End Date	This denotes the date on which peptide receptor nuclide therapy (PRRT) was completed **Note:** If PRRT is not carried out, record as 10101010 (inapplicable)	ccyymmdd	N/A	N/A	R	N/A
Bassi Classification	Morbidity and mortality after pancreatic surgery as recorded using the Bassi Classification.	Code List	01	A - Any definition from the normal po-operative course without pharmacologic treatment or surgical, endoscopic and radiological interventions. Allowed therapeutic regimens are drugs such as antiemetics, antipyretics, analgesics, diuretics, electrolytes and physiotherapy. This grade also includes wound infections opened at the bed side	R	N/A

			02	B - Requiring pharmacologic treatment with drugs other than ones allowed for grade A complications. Blood transfusion and total parental nutrition are also included C-Ca-Cb		
			03	C - Requiring surgical, endoscopic or radiology intervention		
			04	C(a) - Intervention not under general anaesthesia		
			05	C(b) - Intervention under general anaesthesia		
			06	D - Life threatening complication requiring intermediate care/intensive care unit management		
			07	D(a) - Single organ dysfunction		
			08	D(b) - Multi organ dysfunction		
			09	E - Death of a patient		
			10	Suffix ‘d’- If the patient suffers from complication at the time of discharge, the suffix 'd' (for disability) is added to the respective grade of complication		
			98	Not applicable		
			99	Not recorded		

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Surgery - Pancreatic (One occurrence per Core Surgery)						
Clavien-Dindo Classification of Surgical Classifications	Record the overall grade as per the Clavien-Dindo Classification of Surgical Classifications	Code List	1	Grade I	R	Clavien-Dindo Classification of Surgical Classifications (UG15060)
			2	Grade II		
			3	Grade IIIa		
			4	Grade IIIb		
			5	Grade IVa		
			6	Grade IVb		
			7	Grade V		
			9	Not known (not recorded)		
Vascular Resection	Were vessels resected to ensure tumour margins negative? **Note:** This is a repeating data item and multiple codes may be recorded	Code List	0	No vascular resection	R	N/A
			1	Partial portal vein/SMV resection (cuff)		
			2	Circumferential portal vein/SMV resection		
			3	Arterial resection		
			4	IVC resection		
Splenic Resection	Was the spleen removed during the Procedure?	Code List	0	No Splenectomy	R	N/A
			1	Planned Splenectomy		
			2	Unplanned Splenectomy for Oncological Reasons		
			3	Unplanned Splenectomy for Non-Oncological Reasons		
Surgical Palliation Type	Type of surgical palliation performed if any e.g., Hepaticojejunostomy	Code List	0	None	R	Surgical Palliation Type (UG13240)
			1	Gastric bypass		

			2	Biliary bypass		
			3	Gastric/biliary bypass		
			4	Celiac plexus block		
			9	Not Known		
Pre-Operative Stenting	Did the patient have a biliary stent placed prior to surgery?	Code List	0	None	R	N/A
			1	Plastic		
			2	Metal covered		
			3	Metal uncovered		
Surgery - Pancreas - Endocsopic or Radiological Procedures (One occurrence per Core Surgery)						
Endoscopic Procedure Type	The main endoscopic procedures carried out. **Note:** i. Whilst the COSD data item has additional codes, only the adjacent codes are applicable to the Upper GI - Pancreas site-specific standard. ii. This is a repeating data item and multiple codes may be recorded	Code List	1	Stent insertion	R	Endoscopic Procedure Type (UG14290)
			4	Photodynamic therapy		
			8	Other		
Endoscopic or Radiological Complication Type	The types of complications that the patient experiences during the admission for the endoscopic procedure. **Note:** This is a repeating data item and multiple codes may be recorded	Code List	00	No complications	R	Endoscopic or Radiological Complication Type (UG13090)
			02	Perforation		
			03	Haemorrhage		
			09	Pancreatitis		
			10	Cholangitis		
			88	Other		
Cancer Care Plan - Pancreas. To carry details of the cancer care plan for Pancreas (One occurrence of this group)						
Resectability Based on Radiology	Record the MDT opinion of tumour resectability	Code List	1	Resectable	R	N/A
			2	Borderline		
			3	Locally Advanced		

			4	Unresectable due to Metastatic Disease		
Tumour Markers	CA19-9 and Chromogranins A + B (for pNET only)	Code List	1	Ca 19-9 Value	R	N/A
			2	Chromogranin A Value		
			3	Chromogranin B Value		
Pathology - Pancreas. To record additional pathology details for Pancreas tumours (One occurrence per pathology)						
Neurovascular Invasion	Is there evidence of neurovascular invasion in the resected specimen	Code List	1	Present	R	N/A
			2	Not Present		
Resection Margin Status	Is there evidence of margin involvement?	Code List	1	Tumour >1mm from resection margins	R	N/A
			2	Tumour <1mm from resection margin		
			3	Tumour present at resection margin		
			4	Margins grossly involved		
Margins Involved	Specify which margins are involved? **Note:** This is a repeating data item and multiple codes may be recorded	Code List	01	Anterior pancreatic surface	R	N/A
			02	SMA dissection margin		
			03	SMV dissection margin		
			04	Proximal enteric transection margin		
			05	Distal duodenal transection margin		
			06	Pancreatic transection margin		
			07	Bile duct transection margin		
			08	Posterior dissection margin		

National Cancer Data Standards – Upper Gastrointestinal (GI): High Grade Dysplasia

Reporting Data Item	Definition	Format	Code List (Code)	Code List (Text)	Status	COSD
Record HGD data collection for the following where: (i) High Grade Dysplasia within Barrett's Oesophagus - Primary Site Code K227 with Morphology 8140/2 In Situ (HGD of Glandular Tissue) or 8070/2 In situ (Squamous in-situ) (ii) High Grade Dysplasia (No Barrett's Oesophagus) - Primary Site Code D001 (Ca In-Situ Oesophagus) with Morphology 8140/2 In Situ (HGD of Glandular Tissue) or 8070/2 In situ (Squamous in-situ)						
Referral - High Grade Dysplasia (HGD). To carry referral details for OG (One occurrence of this group)						
Source of Referral for Out-patients (CWT) *	The source of referral classification used to identify the source of referral of each episode or referral **Note:** The adjacent codes are not present in Core but have been added here as a site specific requirement. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - Oesophago-gastric site-specific standard.	Code List	02	Symptomatic	M	Source of Referral for Out-patients (CWT) (CR1600)
			21	From Barrett's Surveillance		
			99	Not Known		
Diagnosis - High Grade Dysplasia (HGD). To carry additional diagnosis details for HGD Surgical Palliation Type (One occurrence of this group)						
Original Diagnosis of HGD confirmed by a second pathologist	To indicate if the original diagnosis of HGD was confirmed by a second pathologist. To determine what proportion of patients had their initial diagnosis of HGD confirmed by a second pathologist. Refer to the histology report from the initial biopsy and confirm whether two pathologists have confirmed the diagnosis.	Code List	Y	Yes	M	N/A
			N	No		
			9	Not Known		

Comorbidity	Specify what other long term conditions the patient has at diagnosis. To detail the nature of any pre-existing conditions/co-morbidity which may have an effect on subsequent treatment. **Note:** Multiples can be selected, however the code *None* cannot be used with any other code	Code List	00	None	R	N/A
			01	COPD/Asthma		
			02	Chronic Renal Impairment		
			03	Liver Failure or Cirrhosis		
			04	Diabetes		
			05	Mental Illness		
			07	Ischemic Heart Disease		
			08	Cerebrovascular Disease		
			09	Peripheral Vascular Disease		
			97	Significant Other		
Barrett's Segment Involved	To indicate if Barrett's segment is involved. To distinguish what proportion of patients have HGD in Barrett's Oesophagus and the characteristics of HGD at diagnosis	Code List	1	Present	R	N/A
			2	Absent		
			9	Not Known		
Lesion of Glandular or Squamous Mucosa	To indicate if the lesion at diagnosis is of glandular or squamous mucosa. To determine the characteristics of the HGD at diagnosis.	Code List	1	Glandular	R	N/A
			2	Squamous Mucosa		
			9	Not Known		
Appearance of HGD	Describe the HGD appearance. To determine the characteristics of the HGD at diagnosis	Code List	1	Flat mucosa	R	N/A
			2	Nodular lesion		
			3	Depressed lesion		
			4	Ulcerated		
			9	Not Known		

Length (cm)	Record the specific Barrett's segment length (cm) **Note:** i. Required for collection to determine the type of therapy required as treatment ii. For HGD within Barrett's Oesophagus only	max n2 Integer	N/A	N/A	R	N/A
Circumferential Segment	As part of the Prague Classification, record the circumferential segment - C in cm **Note:** i. Required for collection to determine the type of therapy required as treatment ii. For HGD within Barrett's Oesophagus only	max n2 Integer	N/A	N/A	R	N/A
Maximum Barrett's Extent	As part of the Prague Classification, record the maximum Barrett's extent - M in cm **Note:** i. Required for collection to determine the type of therapy required as treatment ii. For HGD within Barrett's Oesophagus only	max n2 Integer	N/A	N/A	R	N/A
Cancer Care Plan - High Grade Dysplasia (HGD). To carry additional details of the cancer care plan for HGD (One occurrence of this group)						
Planned Cancer Treatment Type *****	This is the clinically proposed treatment, usually agreed at a Multidisciplinary Team Meeting, and may not be the same as the treatment which is subsequently agreed with the patient. More than one planned treatment type may be recorded, and these may either be	Code List	01	Surgery	R	Planned Cancer Treatment Type (CR0470)

	alternative or sequential treatments. **Note:** i. The codes *Surveillance (follow up endoscopy)* and *No surveillance or endoscopy* are not present in Core but have been added here as a site specific requirement. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - HGD site-specific standard. ii. Where Surgery is recorded it is presumed that this relates to oesophagectomy		27	Surveillance (follow up endoscopy)		
			28	No surveillance or endoscopy		
			10	Other Active Treatment		
Reason for the Treatment Plan	Indicate what was the reason for the treatment plan. To determine why some patients are placed on surveillance or given no active treatment **Note:** Only required where *Surveillance (follow up endoscopy)* or *No surveillance or endoscopy* is recorded for *Planned Cancer Treatment Type*	Code List	1	Patient choice	R	N/A
			2	Patient unfit for endoscopic or surgical treatment		
			3	Lack of access to endoscopic treatment or surgery		
			9	Not Known		
If plan was Surveillance, when is next surveillance endoscopy planned	Indicate when the next surveillance endoscopy is planned for. **Note:** Only required where *Surveillance (follow up endoscopy)* is recorded for *Planned Cancer Treatment Type*	Code List	1	3 months or less	R	N/A
			2	4-6 months		
			3	7-12 months		
			4	More than 12 months		
			9	Not Known		
Treatments - High Grade Dysplasia. Treatment Summary - to record HGD treatment details (Multiple occurrences of this group can be added)						

Initial Treatment Modality *	Specify the initial treatment modality. To determine the types of treatments patients receive for HGD **Note:** *Argon plasma coagulation*, *Multipolar electrocautery*, *Laser Treatment (excluding Argon Beam therapy)* and *Endoscopic resection (including EMR and ESD)* are not in Core and have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - HGD site-specific standard.	Code List	01	Surgery	R	Cancer Treatment Modality (Registration) (CR2040)
			16	Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy		
			10	Radiofrequency ablation (RFA)		
			29	Argon plasma coagulation		
			30	Multipolar electrocautery		
			28	Laser Treatment (excluding Argon Beam therapy)		
			12	Cryotherapy		
			31	Endoscopic resection (including EMR and ESD)		
			97	Other Treatment		
Secondary Treatment Modality/Modalities *	Specify the secondary treatment modality/modalities given. To determine the types of treatments patients receive for HGD **Note:** i. *Argon plasma coagulation*, *Multipolar electrocautery*, *Laser Treatment (excluding Argon Beam therapy)* and *Endoscopic resection (including EMR and ESD)* are not in Core and have been added here to provide greater granularity. Whilst the Core data item has additional codes, only the adjacent codes are applicable to the Upper GI - HGD site-specific standard. ii. This is a repeating data item and multiple codes may be recorded	Code List	01	Surgery	R	Cancer Treatment Modality (Registration) (CR2040)
			16	Light Therapy (including Photodynamic Therapy and Psoralen and Ultra Violet A (PUVA) Therapy		
			10	Radiofrequency ablation (RFA)		
			29	Argon plasma coagulation		
			30	Multipolar electrocautery		
			28	Laser Treatment (excluding Argon Beam therapy)		
			12	Cryotherapy		
			31	Endoscopic resection (including EMR and ESD)		
			04	Chemoradiotherapy		
			97	Other Treatment		

Hospital where initial treatment was given	The Organisation Identifier of the Organisation/hospital where the initial treatment was given. To determine where patients receive treatment for HGD. **Note:** i. Only required where Initial Treatment Modality is recorded ii. Refer to NHS Wales Data Dictionary definition for *Organisation Code* for further information on the code's format	min an5 max an7	N/A	N/A	R	N/A
Hospital/s where secondary treatment modality/modalities given	The Organisation Identifier of the Organisation/hospital where the initial treatment was given. To determine where patients receive treatment for HGD. **Note:** i. Only required where *Secondary Treatment Modality/Modalities* are recorded ii. Multiple codes can be recorded but these must link to each secondary treatment modality chosen) iii. Refer to NHS Wales Data Dictionary definition for *Organisation Code* for further information on the code's format	min an5 max an7	N/A	N/A	R	N/A

Date initial treatment commenced	The date that the initial treatment commenced (was given). To determine how long after the initial diagnosis the initial treatment is given	ccyymmdd	N/A	N/A	R	N/A
Pathology - For High Grade Dysplasia (One Occurrence per Path Report)						
EMR/ESD Date	Record the date of most recent EMR	ccyymmdd	N/A	N/A	R	N/A
Involvement of Lateral Margins	State the involvement of the lateral resection margins. To determine the outcomes of endoscopic resection.	Code List	1	Clear of HGD/Cancer	R	N/A
			2	Positive		
			9	Not Known		
Involvement of Deep Margins	State the involvement of the deep resection margins. To determine the outcomes of endoscopic resection.	Code List	1	Clear of HGD/Cancer	R	N/A
			2	Positive		
			9	Not Known		
EMR Pathology	Describes the results of the EMR Pathology. To determine the outcomes of the endoscopic resection.	Code List	1	High grade dysplasia confirmed	R	N/A
			2	Intramucosal carcinoma identified		
			3	Submucosal carcinoma or worse		
			4	No dysplasia		
			5	Low grade dysplasia		
What is the ongoing plan/further treatment after endoscopic resection	Record what the ongoing plan/further treatment is required after endoscopic resection	Code List	1	Further endoscopic resection	R	N/A
			2	Further ablative endoscopic treatment		

			3	Refer for Oesophagectomy		
			4	Endoscopic surveillance only		
			5	No further surveillance or treatment		
			9	Not known		