

Appendix 5

CODING GUIDE FOR NATIONAL DATASET

The use of a common national coding guide will facilitate the pooling of data from screening programmes across the country to allow epidemiological analysis.

The Coding Guide for the National Dataset is divided into sections and is intended to be used either on its own or in conjunction with the database. It will allow a quick overview of the fields and sections the audit aims to record. The last section provides a list of fields that are essential for Audit purposes. The fields that are not mentioned are desirable and an effort should be made to collect the data. Please ensure that desirable fields are complete before submitting data.

The Electronic Database (Access) is available upon request and is provided in conjunction with an explanatory manual. Please e-mail nhscsp.audit@cancer.org.uk for a copy and/or more details.

Contents

Coding

- ◆ Personal Details
- ◆ Cytology History
- ◆ Colposcopy History
- ◆ Histology History/Review
- ◆ Cytology Review
- ◆ GP Notes

Essential Fields

Personal and Cancer Details

Postcode It is essential that postcode is recorded in full. Postcodes are available from www.royalmail.com.
The postcode will be used to obtain an Index of Multiple Deprivation for each woman.

Index of Multiple Deprivation

The index can be obtained by typing the Postcode into the appropriate space in the Access database, the database will automatically return the corresponding Index. This index is calculated by the Office of the Deputy Prime Minister, it is based on geographical areas (Super Output Areas) each of which includes approximately 1,500 residents. The index is ranked and the percentile is recorded.

Study ID Study ID is 14 characters long and is assigned automatically by AJ-CRUK (Exeter) at the same time that the controls are assigned to the case.

It has the following format TES/QT2/CCYY/NNNX, where

- TES = HA cipher
- QT2 = Q code of Case/Control as at the date of diagnosis
- CCYY = the year of the case's diagnosis
- NNN = a sequence number for the Qcode and year of diagnosis
- X = the Case/Control type identifier. If:
 - o X = 1 – indicates a Case
 - o X = 2 – indicates a GP Control
 - o X = 3 – indicates a District Control
 - o X = 4 – an Adjusted Screened Control
 - o X = 5 – an Abnormal Control
 - o X = 6 – an Unadjusted Screened Control.

Dates All dates are of the form DD MM YYYY (eg. May 7, 1992 becomes 07 05 1992)
If only the year is available then leave the day and month blank.
(Most of the dates can be obtained from Open Exeter or AJ-CRUK)

Stage Two boxes have been provided for the FIGO stage to allow a preliminary FIGO on which the AJ-CRUK job can be run. The final FIGO stage can be entered at any time after that.

Pretreatment FIGO staging should be used. 1A, 1A1, 1A2, 1B, 1B1, 1B2, 2, 2A, 2B, 3A, 3B, 4A, 4B.

Convert Roman numerals to Arabic numerals. E.g. IIIb becomes 3B. Micro-invasive (1A) should be recorded by the laboratory.

NOTE: valid stage codes for AJ-CRUK are: 1A, IN, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, X.
“X” should be used for unknown stage and “IN” if the tumour is known to be worse than micro-invasive, but the stage is not available (this can also be labeled as “1B+”)

Histology (this coding must be used in order to run Exeter AJ-CRUK and should only be used in reference to this output)

- S. Squamous
 - A. Adeno
 - B. Adeno-squamous
 - U. Undifferentiated
- (10)

CYTOLOGY HISTORY

No Cytology

1. Not on Exeter System
2. Invited but did not attend
3. Not yet called
4. Ceased
5. Unclear

Ceased

1. Age
2. Absence of cervix
3. Informed Choice
4. Other/ unknown

Result

If there is a conflict between the result recorded on Exeter and the one in the laboratory records, this should be brought to the attention of the QARC as a matter of urgency. Leave blank if the sample was only used for HPV DNA testing.

Use standard codes:

1. Inadequate
2. Negative
3. Mild dyskaryosis
4. Severe dyskaryosis
5. ?Invasive cancer
6. ?Glandular neoplasia
7. Moderate dyskaryosis
8. Borderline dyskaryosis

Action Code

- A. Routine screening/ Call/ Recall
- H. Result recorded but no change in current action code
- R. Early recall at interval specified by lab
- S. Suspend recall pending referral

Cytology Source (this field is not provided by AJ-CRUK)

1. GP
2. NHS Community Clinic
3. GUM Clinic
4. NHS Hospital
5. Private
6. Other
7. Unknown

COLPOSCOPY HISTORY

Please give details of all known relevant colposcopy appointments prior to diagnosis date.

Satisfactory Examination

Defined as able to see the squamocolumnar junction

Exam (Satisfactory Examination)

1. Satisfactory
2. Unsatisfactory
3. Not Recorded
4. DNA(Did not attend)
5. Hospital Cancellation

TZ Type (Transformation Zone)

0. Not Recorded
1. Fully Visible(completely ectocervical)
2. Fully Visible(endocervical component)
3. Not Fully Visible
4. Unsatisfactory Exam

Colposcopist

1. Consultant
2. Medical Non-Consultant
(Associate specialist/Registrar/SHO/Clinical assistant)
3. Nurse
4. Trainee

Colposcopic Impression

1. Normal
2. HPV only
3. Low Grade
4. High Grade
5. Invasive Cancer
6. Not Recorded
7. CGIN
8. Micro-invasive

Colposcopic/Surgical Procedure

0. None
1. Punch Biopsy
2. LLETZ (loop)
3. Laser excision/cone
4. Knife Cone
5. Laser Ablation
6. Cold Coagulation
7. Cryotherapy
8. Not Recorded
9. Radical Diathermy

Pregnant

Leave blank if the woman is NOT pregnant.
Write "NK" if NOT KNOWN.

Follow-up

Leave blank if unknown. Write 99 if patient was discharged

Pathological Diagnosis Codes

0. Normal (include cervicitis, infection)
- X Inadequate Biopsy
1. HPV Changes only
2. CIN - not otherwise specified
 - 2.1 CIN 1
 - 2.2 CIN 2
 - 2.3 CIN 3
3. CGIN- not otherwise specified
 - 3.1 Low grade CGIN
 - 3.2 High grade CGIN
 - 3.5 SMILE (Stratified Mucin-producing Intraepithelial Lesions)
4. Invasive Squamous Carcinoma- not otherwise specified
 - 4.1 Keratinizing
 - 4.2 Non-Keratinizing
 - 4.3 Basaloid
 - 4.4 Verrucous
 - 4.5 Warty
 - 4.6 Papillary
 - 4.7 Lymphoepithelioma-like
 - 4.8 Squamotransitional
 - 4.9 Small Cell Squamous Carcinoma
5. Adenocarcinoma of Cervix – not otherwise specified
 - 5.1 Mucinous (5.11 Endocervical, 5.12 Intestinal, 5.13 Signet-ring cell, 5.14 Minimal deviation, 5.15 Villoglandular)
 - 5.2 Endometrioid
 - 5.3 Clear cell
 - 5.4 Serous
 - 5.5 Mesonephric
6. Adenosquamous Carcinoma - not otherwise specified
 - 6.1 Glassy cell carcinoma variant
7. All other Cervical Malignancy (please specify)
 - 7.1 Small Cell Carcinoma
 - 7.2 Other Neuroendocrine
8. Benign squamous cell lesions (include condyloma, papilloma, polyp)
 - 8.1 Benign glandular lesions (include mullerian, polyp)
 - 8.2 Non-cervical Atypia
 - 8.3 BAUS (Borderline abnormalities of uncertain significance)
9. Non-cervical Malignancy (include secondary tumours)

HISTOLOGY HISTORY AND REVIEW

Reviewed at (This field provides the option of recording individual review results as well as the consensus result from histology reviews)

1. Local
2. Regional
3. Local Consensus
4. Regional Consensus

Type of Specimen

1. Punch Biopsy
2. Polyp
3. LLETZ (loop)
4. Laser excision/cone
5. Knife Cone
6. Trachelectomy
7. Hysterectomy
8. Other complete cervical excisions

Pathological Diagnosis Codes

(see under Colposcopy History)

Details (this is an optional field)

- Site for non-cervical cancer or type of other cervical cancer.
- Type of other cervical malignancy.
- Mixed diagnosis, e.g. CIN3 & HGCGIN.
- Foci of invasion.
- Any extra information not covered by the Pathological Diagnosis codes.

FIGO Stage (if you are carrying out HISTOLOGY REVIEW please use 1B+ for non micro-invasive cancers where clinical staging is necessary)

1A	1B	2	3	4
1A1	1B1	2A	3A	4A
1A2	1B2	2B	3B	4B

Difficulties in Interpretation

This is an open field. Some examples of possible difficulties encountered are:
Diathermy Artefact, Epithelial Stripping, Fragmented, Small Focus of Tumour, Tumour Necrosis / Haemorrhage, Poor Preservation or Few, Small, Pale, Obscured, Unusual or Poorly Preserved Abnormal Cells.

CYTOLOGY REVIEW

Test Type

1. Routine Screening
2. Repeat (following abnormal)
3. Surveillance (following colp)
4. Symptomatic
5. Colposcopy
6. Other

Cytology Type

(This field should be filled in by the first reviewer)

1. Conventional
2. LBC (SurePath)
3. LBC (ThinPrep)
4. LBC (other)

Type of Reviewer

1. Screener
2. Checker
3. Advanced Practitioner
4. Consultant

Reviewed at (This field provides the option of recording individual review results as well as the consensus result from histology reviews)

1. Local
2. Regional
3. Local Consensus
4. Regional Consensus

Factors that contribute to Potential False Negatives

1. Small Cell Dyskaryosis
2. Pale Cell Dyskaryosis
3. Microbiopsies
4. Small Keratinized Cell
5. Sparse Dyskaryosis (<200 abnormal cells)
6. Other (specify)

Factors that contribute to Potential False Positives

- A. Normal Endometrial Cells
 - B. Endometriosis/tubo-endo metaplasia
 - C. Lower uterine segment (LUS) Endometrial Sampling
 - D. Histiocytes
 - E. Follicular Lymphocytic cervicitis
 - F. IUCD Effect
 - G. Other (Specify)
- (14)

GP NOTES

This section has changed to a standard letter requesting details from GP notes

HPV DNA

This section applies only to women who have had an HPV test the result of which might have impacted on the clinical management. If HPV testing becomes routine this information will be recorded in section B.

Essential Fields

Study ID required for all sections

SECTION A & A1

Personal and Cancer Details

NHS Number
Date of Birth
Date of Diagnosis
Stage of Tumour (FIGO)
Histology

SECTION B

Cytology

No cytology found
Date test was taken
Result of Test

SECTION C

Colposcopy

Number of colposcopic appointments
Date of colposcopy
Satisfactory Examination or DNA
Surgical Procedure

SECTION D1

Histology Cancer Diagnosis

Date of Specimen
FIGO Stage
Pathological Diagnosis

SECTION D2

Specimen History

Date of Specimen
Type of Specimen
Pathological Diagnosis
Clear Margins

SECTION E Cytology Review

E1. Original slide

Slide ID
Date of Original Test
Cytology Type
Original Test Result

E2. Review Results

Reviewed at
Review result

SECTION F Histology Review

F1. Original Specimen

Specimen ID
Date of Original Specimen

F2. Review Results

Review Pathological Diagnosis

F3. Cancer Original Specimen

Specimen ID
Date of Original Specimen

F4. Cancer Review Results

Review Pathological Diagnosis

SECTION G

GP Notes

Although Section G is not essential, if you attempt to collect data, all fields are required

SECTION H

HPV DNA Testing

Date of Sample
Result (16)