AUDIT OF INVASIVE CERVICAL CANCER March 2013

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 the same sections as the data collection forms and will allow a quick overview of the fields and section that the Audit aims to record.

The last section provides a list of fields that are essential for Audit purposes. Items in this list are essential because without them meaningful analysis of the data cannot be conducted. Items not on this list are still important and reasonable effort should be made to collect them because they provide a complete and in depth picture of the pathway to diagnosis.

Information for Section A, Section B.1 and Section B.2 is almost entirely included in the Exeter download and entering these data onto the forms might not be required (please follow QARC guidelines regarding this).

Section G (GP Notes) is no longer part of the audit, however if contacting the GP has been found to be useful this activity should continue. The Audit database still allows for GP data to be recorded. Section H (HPV tests) has been incorporated into Section B (Cytology history).

Section C (Colposcopy) has been divided in two parts, C.1 - colposcopy history and C.2 - colposcopy review

New codes do not overlap with previous codes, so data entered so far will not be affected by this upgrade

Contents

PERSONAL AND CANCER DETAILS

AJ-CRUK download

AJ-CRUK runs on the National Health Authority Information System ('NHAIS', also known as 'the Exeter system'). It downloads details on the screening histories of both cases and controls. The output can be automatically uploaded onto the Access database used to collate all Audit produced data regionally. AJ-CRUK has been updated and now includes the following fields: surname, forename, NHS number, postcode, date of birth, date of GP registration, cytology test date, cytology result, action code, reason, laboratory number, HPV infection marker, next test repeat in months and details of any episodes where women were ceased or postponed from the programme.

Study ID

Study ID is 16 or 17 characters long and is assigned automatically by AJ-CRUK at the same time that the controls are assigned to the case.

The Study ID had the following format **TES/QT2/CCYY/NNNX**

TES = HA cipher

QT2 = Q code of Case/Controls as of the date of diagnosis

CCYY = the year of the cases' diagnosis

NNN = a sequence number for the Qcode and the year of diagnosis

X = the Case/Control type identifier, where

- X = 1 indicates a Case
- X = 2 indicates a GP control
- X = 3 indicates a District (Health Authority) control
- X = 4 indicates an Adjusted Screened control
- X = 5 indicates an Abnormal control
- X = 6 indicates an Unadjusted Screened control

Postcode

It is essential that postcode is recorded in full. Postcodes are available from the AJ-CRUK electronic download. When uploaded into the Access database the postcode is used to assign an index of multiple deprivation for each woman.

Index of Multiple Deprivation

The index is calculated by the Office of the Deputy Prime Minister, it is based on geographical areas called Super Output Areas that include approximately 1,500 residents. We have ranked the index from least deprived to most deprived and divided them into deciles (0 most deprived to 9 least deprived).

Dates

All dates should be entered in the following format DD MM YYYY (e.g. May 7, 1992 becomes 07 05 1992)

Stage

Two boxes have been provided for stage (on the paper forms) to allow a preliminary staging on which the AJ-CRUK job can be run. The final FIGO stage can be entered at any time. Valid stage codes for AJ-CRUK are: 1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, IN, 1B+, X. "X" should be used for unknown stage and "IN" or "1B+" if the tumour is known to be worse than micro invasive, but the full stage is not available.

Histology

The following histological coding must be used to run AJ-CRUK and should only be used in reference to this output

S. Squamous	U. Undifferentiated
A. Adenocarcinoma	O. Other
B. Adeno-squamous carcinoma	U. Unknown

Treatment

Only one treatment option can be recorded for each woman. Please record the most severe treatment received by the woman.

CYTOLOGY HISTORY

(all fields provided by AJ-CRUK, except where noted)

No Cytology Reason
(not provided by AJ-CRUK)
1 Not on Exeter System
2 Invited but did not attend
3 Not yet called
4 Ceased
5 Unclear

Action Code
A Routine Screening/Call/Recall
H Result recorded but no change in code
R Early recall at interval specified by lab
S Suspend recall pending referral

Source
(not provided by AJ-CRUK)
1 GP
2 NHS Community Clinic
3 GUM clinic
4 NHS Hospital (Colp)
5 Private
6 Other
7 Unknown

Result Codes

1	Inadequate
2	Negative
N	Negative (HPV)
3	Mild Dyskaryosis
M	Mild (HPV)
4	Severe Dyskaryosis
5	? invasive cancer
6	? glandular neoplasia of endocervix
7	Moderate dyskaryosis
8	Borderline changes in squamous cells
B	Borderline changes in squamous cells (HPV)
9	Borderline changes in endocervical cells
E	Borderline changes in endocervical cells (HPV)
0	?Glandular (non cervical)
G	?Glandular (non cervical) (HPV)

HPV infection code

0	HPV negative
9	HPV positive
U	HPV result unavailable/unreliable

CYTOLOGY CEASED OR POSTPONED

Postponement Reason

1 Recent Test
2 Current Pregnancy
3 Patient wish to defer
4 Under treatment relevant to screening
5 Administrative reason
10 Practice Invitation

Ceased Reason

6 Age
7 Absence of cervix
8 Informed Choice
9 Other
99 Mental Capacity Act (Best interests)

COLPOSCOPY HISTORY

Attendance Type
1 Yes
2 No
3 Not Recorded
4 DNA (Did not attend)
5 Hospital Cancellation
6 Patient Cancellation

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

Colposcopist
1 Consultant
2 Medical Non-consultant
3 Nurse
4 Trainee

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

Surgical Procedure
0 None
1 Cervix 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 (in this section, if the sample has multiple diagnosis, please enter most severe diagnosis only)

0. Normal (include, cervicitis, infection, inflammatory changes)
X. Inadequate
1. HPV Changes
2. CIN - not otherwise specified
   - 2.1 CIN1
   - 2.2 CIN2
   - 2.3 CIN3
3. CGIN - not otherwise specified
   - 3.1 Low grade CGIN
   - 3.2 High grade CGIN
   - 3.3 HGCIN and CGIN
   - 3.5 SMILE (Stratified mucin-producing intraepithelial lesions)
4. Squamous carcinoma - not otherwise specified
   - 4.1 Squamous Keratinizing
   - 4.2 Squamous non-keratinizing
   - 4.3 Squamous basaloid
   - 4.4 Squamous verrucous
   - 4.5 Squamous warty
   - 4.6 Squamous papillary
   - 4.7 Squamous lymphoepithelioma
   - 4.8 Squamous squamoustransitional
   - 4.9 Squamous small cell
5. Adenocarcinoma - not otherwise specified
   - 5.1 Adeno mucinous
     - 5.11 Adeno mucinous endo
     - 5.12 Adeno mucinous intestinal
     - 5.13 Adeno mucinous signet-ring
     - 5.14 Adeno mucinous minimal deviation
     - 5.15 Adeno mucinous villoglandular
   - 5.2 Adeno endometriod
   - 5.3 Adeno clear cell
   - 5.4 Adeno serous
   - 5.5 Adeno mesonephric
6. Adenosquamous - not otherwise specified
   - 6.1 Adenosquamous glassy cell variant
7. Carcinoma cervix other type
   - 7.1 Small cell carcinoma
   - 7.2 Other neuroendocrine carcinoma
   - 7.3 Carcinoma type unknown
   - 7.4 Undiff carcinoma of cervix
8. Benign squam cell lesions (include condyloma/papilloma/polyp)
   - 8.1 Benign glandular (include mullerian/polyp)
   - 8.2 Non-cervical atypia
   - 8.3 BAUS (Epithelial changes uncertain significance)
   - 8.4 Other benign and non-neoplastic abnormalities not listed
9. Non-cervical malignancy (including secondary tumours)
NK. Not known

HISTOLOGY HISTORY AND REVIEW

Both these sections are based on the RCPath minimum dataset. We allow for up to three pathological diagnosis to be entered to allow for all possible combinations.

Type of Specimen

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

FIGO Stage

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

Excision status

Complete
Incomplete
Not applicable

Excision margin

1. Ectocervical
2. Endocervical
3. Deep lateral/radial

Margin involved by

2. CIN
3. CGIN
4. SMILE
5. NA
6. Invasive Cancer

Additional features

This is an open field. You can make a note of the following if applicable: TEM, endometriosis, micro glandular hyperplasia, diathermy artefact, epithelial stripping, fragmented, small focus of tumour, tumour necrosis/haemorrhage.

Pathological Diagnosis (in this section, if the sample has multiple diagnosis, you can enter up to three diagnosis for each specimen)

Full coding can be found in the colposcopy section (page 3) of this document

0. Normal (include, cervicitis, infection, inflammatory changes)
X. Inadequate
1. HPV Changes
2. CIN - not otherwise specified
    2.1 CIN1
    2.2 CIN2
    2.3 CIN3
3. CGIN - not otherwise specified
    3.1 Low grade CGIN
    3.2 High grade CGIN
    3.3 HGCIN and CGIN
    3.5 SMILE (Stratified mucin-producing intraepithelial lesions)
4. Squamous carcinoma -
5. Adenocarcinoma
6. Adenosquamous
7. Carcinoma cervix other type
8. Benign squam cell lesions
9. Non-cervical malignancy (including secondary tumours)
NK. Not known

CYTOLOGY REVIEW

Test Type
1 Routine Screening
2 Repeat (following abnormal)
3 Surveillance (following Colp)
4 Symptomatic
5 Colposcopy
6 Other

Cytology Type
1 Conventional
2 LBC (SurePath)
3 LBC (ThinPrep)
4 LBC (Other)

Result Codes
1 Inadequate
2 Negative
N Negative (HPV)
3 Mild Dyskaryosis
M Mild (HPV)
4 Severe Dyskaryosis
5 ? invasive cancer
6 ? glandular neoplasia of endocervix
7 Moderate dyskaryosis
8 Borderline changes in squamous cells
B Borderline changes in squamous cells (HPV)
9 Borderline changes in endocervical cells
E Borderline changes in endocervical cells (HPV)
0 ?Glandular (non cervical)
G ?Glandular (non cervical) (HPV)

Not available for review, reasons
Not Found
Not Released
Not Suitable

Reviewed at
1 Local
2 Training Centre
3 Consensus

Reviewer Type
Consultant Pathologist
Consultant BMS
Assistant Director
Training Centre Manager
Medical Director

Potential False Positives
A Normal Endometrial Cells
B Endometriosis/tubo-endo metaplasia
C LUS Endometrial Sampling
D Histiocytes
E Follicular Lymphocytic cervicitis
F IUCD Effect
G Other (Specify)

Potential False Negatives
1 Small Cell Dysk
2 Pale Cell Dysk
3 Microbiopsies
4 Small Keratinized cells
5 Sparse Dysk (<200 cells)
6 Other (Specify)

If inadequate, details
1 Insufficient material
2 Not properly stained
3 Cytolitic
4 Obscured

Technical features
1 Fixation adequate
2 Artefact/contaminant present
3 Staining adequate

ESSENTIAL FIELDS

Study ID is required for all sections

SECTION A	Date of Birth
Personal and Cancer Details	Date of Diagnosis
	Stage of Tumour (FIGO)
	Histology
	Treatment
	Index of Multiple Deprivation
SECTION B.1 & B.2	Reason for no cytology
Cytology History	Date test was taken
	Result of the cytology test
	HPV result
SECTION C.1 & C.2	Number of colposcopic appointment
Colposcopy History	Date of colposcopy
	Attendance Type
	Colposcopist
	Surgical Procedure
Colposcopy Review	All fields should be completed
SECTION D1	Date of specimen
Histology Cancer Diagnosis	Type of specimen
	Pathological diagnosis
	FIGO stage
SECTION D2	Date of specimen
Histology Specimen History	Type of specimen
	Pathological diagnosis
	Excision status
SECTION E	Slide ID
Cytology review	Cytology Type
	Date of original cytology
	Result of original cytology
	Reviewed at
	Review result
	Original result NFR (no further review)
SECTION F	Specimen ID
Histology Review	Date of original specimen
	Pathological diagnosis of original specimen
	Evidence of TZ sampling
	Reviewed at
	Review pathological diagnosis
	Excision status