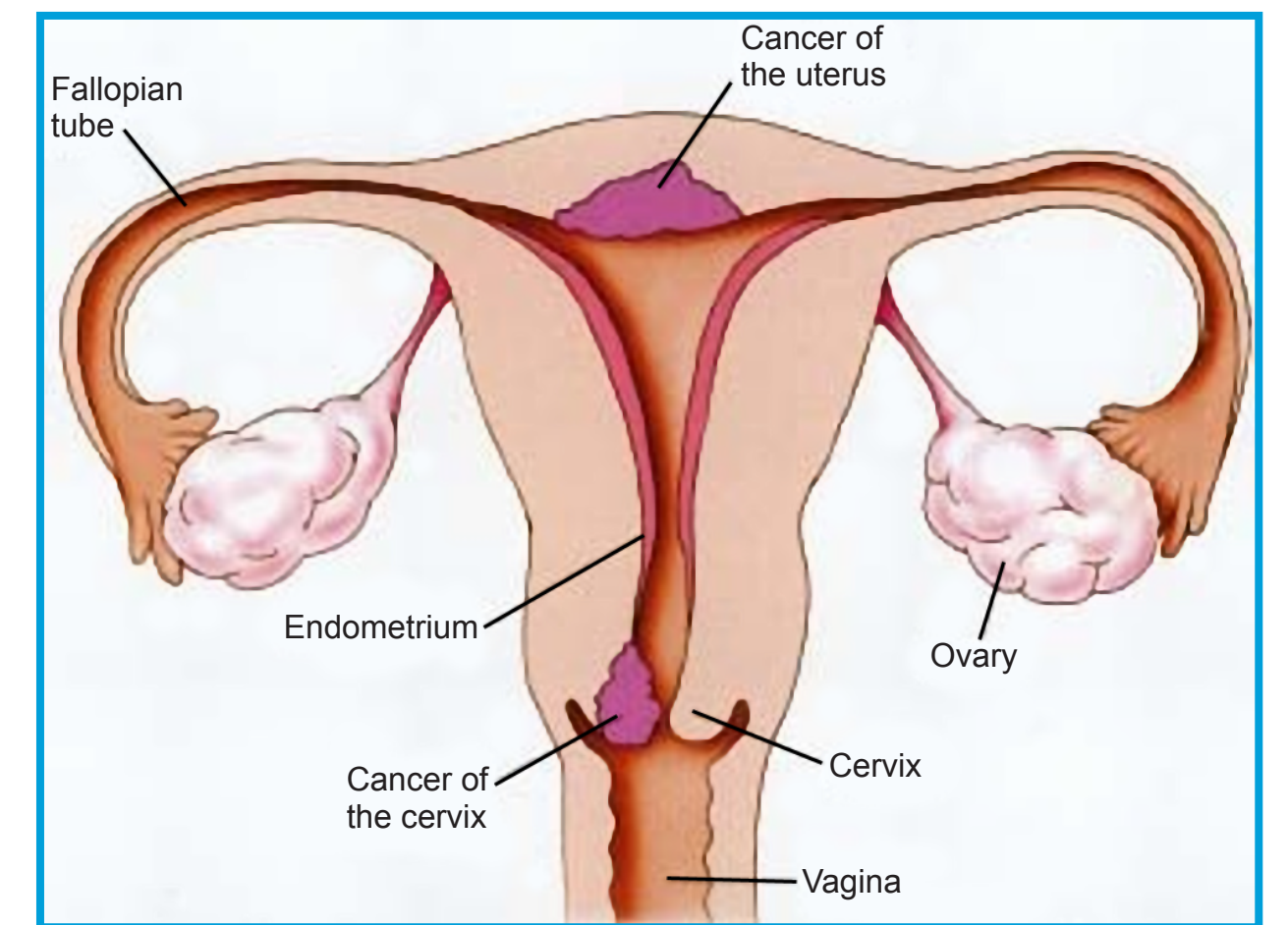


Introduction

There were around 19,800 in situ cervical cancer cases diagnosed in England during 2006, compared with 2,350 malignant cervical cancer cases. Registration is largely reliant on access to pathology and before a full national analysis can be considered it will be necessary to confirm that ascertainment levels are satisfactory.

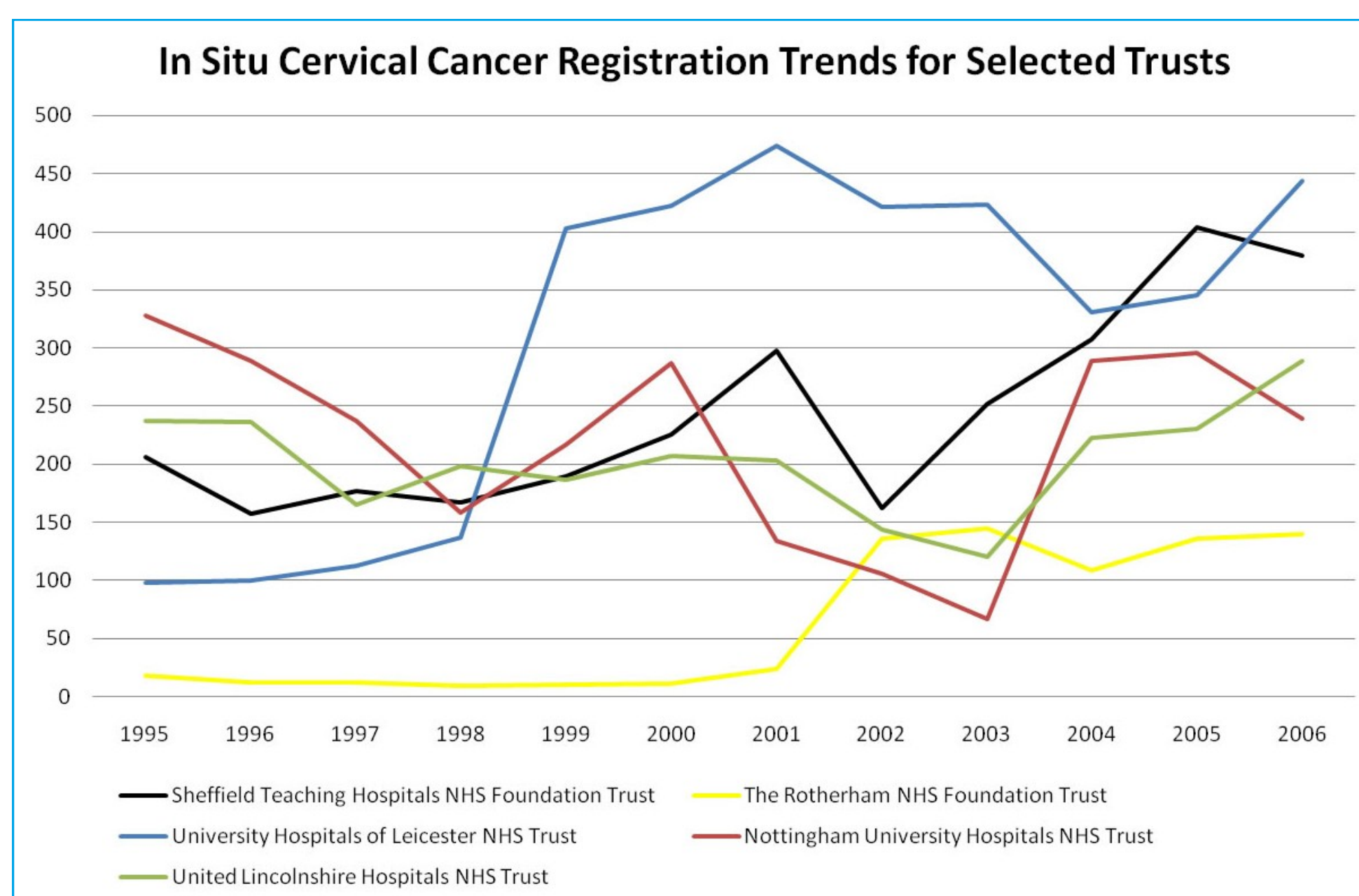
This poster summarises a data quality initiative based on an analysis of local data for Trent Cancer Registry, national lead registry for gynaecological cancers. Subsequent guidelines and recommendations will be circulated to all English cancer registries in due course.



Method

The Methods of exploration included:

- Checking clinical definitions and terminology for in situ cervical cancers (ICD10 D06). These include both CIN3 (cervical intraepithelial neoplasia), CGIN3 (cervical glandular intraepithelial neoplasia) and high grade dysplasia.
- The route by which the data is submitted to the registry, currently in laboratory pathology reports and to a smaller extent from trust PAS systems.
- Benchmarking registry figures against both (a) KC65 returns submitted quarterly by trusts to QARCs, and (b) from trust colposcopy clinic(s). From January 2009 cancer waiting time data can also be used as a comparator.
- Comparing age-standardised local authority incidence rates against those benchmarks mentioned above.



This chart highlights the importance of identifying in situ cervical cancer from pathology reports. Numbers rose by a notable amount when trusts started providing the registry with routine pathology:

- ◆ 2001 for Sheffield, but lost pathology in 2002 due to relocation
- ◆ 1999 for Leicester
- ◆ 2004 for Lincolnshire
- ◆ 2006 for Rotherham, but data back to 2002
- ◆ 2006 for Nottingham, but data back to 2004

Guidelines and Recommendations

At present we would recommend the following checks be carried out by registries to assess the quantity and quality of in situ cervical cancer in their area.

1. As pathology data is vitally important in identifying outpatients we suggest that at least 90% of women are identified using a pathology source, and that figures may only be considered 'good quality' at or above this level.
2. Where pathology has only become available in recent years, consideration should be given to the timing of the availability of good quality data.
3. Age-standardised incidence rates below 100 per 100,000 women in local areas (for example local authorities) are likely to indicate missing information.
4. Check that all CIN3 and CGIN3 morphology codes are being provided to the registry, and identified at the registry from pathology reports. This should include the high grade dysplasia morphology codes (intraepithelial neoplasms M74008 and M74009).
5. Check registration figures tally against those from KC65 forms submitted to QARCs, multiplying figures up as appropriate. Also check registration figures tally against trust colposcopy records directly. Bear in mind that the KC65 will and local systems may count the number of biopsies rather than tumours.
6. Check that CGIN3 numbers are a small subset of all in situ cervical numbers, typically in the region of 3%.

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