Public Health England

Protecting and improving the nation's health

Cancer Outcomes and Services Dataset (COSD)

Version 8.0

User Guide – Pathology Dataset

Version 3.0.4

About Public Health England

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Version Control

Version	Date	Brief Summary of Change	Editor
3.0	11-09-2017	Changes since publication of Version 7.0.2 of dataset. New version control numbering, now based on the Pathology User Guide version	Andrew Murphy
3.0.1	25-10-2017	Removal of SK12450 from user guide. This was removed from the data set under the advisement of clinical experts.	Andrew Murphy
3.0.2	19-12-2017	Added list of staging systems (Appendix D), required to be used from Jan 2018, as defined by the Royal College of Pathologists (pg84).	Andrew Murphy
3.0.3	12-03-2018	Updated list of staging systems (Appendix D), required to be used from Jan 2018, as defined by the Royal College of Pathologists (pg84). Corrected typo (Appendix B) C84.1 (pg71)	Andrew Murphy
3.0.4	02-05-2019	Updated Appendix A, with advice on recording new cases using SNOMED CT (pg50-Pg51). This includes a weblink to the pathology subset for SNOMED CT, available via TRUD	Andrew Murphy

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Status – User Guide

Cancer Outcomes and Services Data set – Version 8.0 Release (April 2018)

This User Guide is one of a suite of documents to aid Users in implementing the COSD Information Standard (DCB1521 Amd74/2016)[1]. It includes all the data items in COSD, together with definitions, formats, codes and values and additional guidance on collection and implementation.

This User Guide is aligned with, and should be read in conjunction with COSD version 8.0 (pathology v3.0) of the data set, which is available to download on the NCIN website[2]. Other guidance and supporting documents are also available on the NCIN website and we are continuing to explore an online version of the Guide.

This revised version of the User Guide incorporates some amendments to the data set, an extension of scope and a revision of the current schema specification in order to continue to meet the business objectives of the standard. It accompanies a change notice for the standard (Amd 74/2016) which has been accepted by the Data Coordination Board (DCB).

Implementation of the Standard is carried out by the National Cancer Registration and Analysis Service (NCRAS) and queries regarding implementation, should initially be raised with the Data Liaison staff at the local offices of the NCRAS.

Queries regarding the Standard itself should be addressed in the first instance to COSDenquiries@phe.gov.uk or your local NCRAS Liaison Manager (their details can be obtained from the CancerStats portal).

All Providers have access to their current monthly position via CancerStats[3] (NHS N3 connections only) which has been established by the NCRAS. This provides feedback on files submitted (Level 1) and completion for some key data items (Level 2), where the files are submitted in the prescribed XML format. It also now includes the next level of reports (Level 3), which covers data that has been processed and quality assured by the NCRAS.

In addition there are now reporting tools for the National Lung Cancer Audit (NLCA) and the National Prostate Cancer Audit (NPCA) as well as access to population level Incidence, Mortality and Survival data. In 2017 additional reporting of the National Radiotherapy data set (RTDS), Clinical Headline Indicators (CHI) was made available too.

We would like to take this opportunity to thank all those who have been involved in the development and implementation of the Standard and encourage you to continue to send us your comments which help to identify necessary amendments and improvements. A COSD Advisory Board was created in 2015 which has Trust level representation to help manage change moving forward.

Andrew Murphy

Head of Cancer Data sets
National Cancer Registration and Analysis Service (NCRAS),
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September 2017

[1] http://content.digital.nhs.uk/isce/publication/scci1521
[2] http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd
[3] https://nww.cancerstats.nhs.uk/users/sign_in

Introduction

What is the Cancer Outcomes and Services Dataset?

The Cancer Outcomes and Services Data set (COSD) is the national standard for reporting cancer in the NHS in England. It replaced the former National Cancer Data set and the former Cancer Registration Data set and includes additional site specific data items relevant to the different tumour types. It is aligned with other national cancer data sets, including Cancer Waiting Times (NCWTMDS)[4], Radiotherapy (RTDS)[5], Systemic Anti-Cancer Therapy (SACT)[6] and Diagnostic Imaging (DID)[7].

Why is it needed?

Periodically we needed to revise the Cancer Outcomes and Services Data set to ensure that we meet the current information requirements for the NHS. The Cancer Reform Strategy (2007) identified better information and stronger commissioning as two of the key drivers to achieve the goal that cancer services in this country should be amongst the best in the world. The subsequent Improving Outcomes: A Strategy for Cancer (January 2011) further supported this concept to demonstrate cancer outcomes using high quality data and intelligence for all stakeholders.

The Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020 (Taskforce Report) further strengthens the need to have strong cancer data collection and empowers both PHE and NHS England to enforce this through the mandate of data collection. These data will be the base for cancer analysis and research for the next five years.

Other guidance documentation

Technical Guidance and Implementation Guidance is provided separately and is available on the NCIN website[8].

Which diagnoses does COSD apply to?

For the purposes of COSD the term “cancer” relates to all conditions defined as registerable by the UK and Ireland Association of Cancer Registries (UKIACR) and these are listed in Appendix B & C. This covers all new diagnoses and secondary/metastatic breast cancer from 1st January 2013.

All recurrences diagnosed from 1st July 2015 must now be included. All recurrences diagnosed from 1st April to 31st June 2015 can be included if available.

[4] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp?shownav=1
[5] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/radiotherapy_data_set_fr.asp?shownav=1
[6] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/systemic_anti-cancer_therapy_data_set_fr.asp?shownav=1
[7] http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/diagnostic_imaging_data_set_fr.asp?shownav=1
[8] http://www.ncin.org.uk/home

What data items should be completed?

All registerable conditions should be reported as defined in Appendix A. This includes submitting all pathology reports for these cases.

In addition to the core dataset, most cases will also require a site specific dataset to be completed.

The CORE LINKAGE items are Mandatory and must be submitted for all records. (Please note that the core linkage for pathology differs from the main COSD linkage items).

All other applicable data in each section marked as 'required' should be submitted for each record as soon as available.

How is Pathology Recorded?

There is a separate schema for reporting pathology data items. These data should be reported by the pathologist, directly from their Laboratory Information Management Systems (LIMS), and sent monthly to the NCRAS (from the pathology department) in structured COSD XML.

It is not expected therefore that MDT Coordinators or other non-clinical staff, should attempt to read and transcribe these reports and information into COSD. The reduction in their workload by removing this duplication is estimated to be approximately up-to 30%, and this time should be used to ensure full compliance for data collection across all other data-items.

When should the data be submitted?

The deadline for first submitting a record is 25 working days after the end of each month. All available relevant data items should be included and additional information or updates not available at the time should be uploaded with ensuing monthly submissions.

It is acceptable for pathology records to be submitted quicker than 25 working days, and in some cases are submitted in real-time as the pathologist authorises each report.

The reporting dates can be found on the CancerStats website.

Feedback and Queries

This User Guide provides additional information to support the COSD Specification and should also be used in conjunction with the COSD v8.0 (Pathology v3.0) Data set. Implementation and Technical Guidance documents are also available for further information on the NCIN website.

Feedback and questions relating to the COSD are welcomed and should be emailed to COSDenquiries@phe.gov.uk

I would like to express my thanks to all those who have participated and continue to provide support and guidance in the development of this information standard. Specific thanks goes to the COSD Advisory Group and SSCRG members for helping to guide COSD and continue to ensure all data is clinically relevant and not out-of-date.

Particular thanks also has to be given the NCRAS Liaison Managers, who work tirelessly around the country supporting their local Trusts with data quality, ascertainment and cancer data set issues and queries. Together they provide a huge resource and their work often goes unnoticed, but by a few.

Thank you all for your support, it is hugely appreciated by me and the Trusts you support.

Andrew Murphy
Head of Cancer Datasets
Public Health England

Using This Guide

This COSD Pathology User Guide is a summary guide based on the complete COSD User Guide v8.0. The full document provides additional information to support the COSD Specification and should also be used in conjunction with the COSD Dataset v8.0. Implementation and Technical Guidance documents are also available for further information on the NCIN website.

Layout of the User Guide

The Guide includes a Generic chapter for Core dataset followed by individual chapters for each of the site specific datasets applicable to each Tumour Group.

Schema Specification

Mandatory

The CORE LINKAGE items are Mandatory and must be submitted for all records. It is vital that these are always available so that the correct information can be linked to the right patient and the correct tumour. ***A record will not be able to be submitted if any mandatory data item is missing***. These records should not be added to the main file otherwise the whole file will fail the schema.

Required

Most other data-items are set as 'Required'. This means that if they are applicable to the reported tumour or patient pathway, they **must** be completed and treated as a mandatory item. Not every data-item however will be applicable to every patient or tumour, by using 'Required', this allows for a more accurate and inclusive collection of data. Therefore all applicable data in each section marked as 'required' must be submitted for each record as soon as available.

Pilot

In some cases new data-items maybe piloted by a small group of Trusts. These data **do not** have to be completed by any other Trust unless you are part of the pilot. If you want to submit these data, please speak with your regional NCRAS liaison team(s). All pilot data-items are under review and may change in future version controls of COSD[9].

Optional

There are a few data-items that are optional, any Trust can submit these data, but there is no requirement to enforce this data collection at this point. All optional data-items are under review and may change in future version controls of COSD.

Items marked as "X"

In the schema specification items marked as "X" should not be submitted as part of the COSD data flow from Providers. These items will be collected from other sources such as ONS (See Appendix L) or are submitted under other standards such as Cancer Waiting Times and RTDS (See Appendix K). Items that are shared specifically with the Cancer Waiting Times data set (NCWTMDS) are marked as (CWT) in the relevant descriptions. However for COSD these items are all extended to relate to all registerable conditions. Definitions within these items for "primary cancer" are therefore also extended to cover all registerable conditions.

Meaning of "NOT KNOWN" value

"Not known" includes both "not recorded" and for example "test not done". This is usually coded 9 or 99 (depending on the data item format).

[9] There are currently no new data-items being piloted by Trusts.

Key to Data Item Tables

All data items are listed as follows:

- Data item No:
  - The reference number for the COSD data item
- Data Item Section:
  - The section in which the data item appears
- Data Item Name:
  - The name of the data item. This is followed by the *[DATA DICTIONARY ITEM NAME]* if different in purple
- Format:
  - Format required for submission of the data item

National Codes

Where there is a defined list of values for a data item, the code appears on the left of the table and the definition appears on the right, as shown in the example below.

National Code	Definition
1	1 to 3
2	4 or more
U	Number uncertain

Demographics

Demographic details are required for every record in order to ensure that the correct patient can be identified and information can be correctly linked.

The Demographics section should be completed by every Provider the first time a record is submitted.

There will only be one Demographics section completed for each record. Demographic linkage items will be required each time the record is submitted. Almost all patients should have an NHS Number and this should always be included where available. For those who do not have an NHS Number, the hospital number (LOCAL PATIENT IDENTIFIER) must be provided.

Diagnosis

Both Topography and Morphology (SNOMED and/or ICD) must be completed for all cases.

Pathology

Pathological diagnosis and grade (where applicable) are recorded on biopsies and may be amended after surgical resection (if appropriate), when pathological staging should also be available. Full text pathology reports should always be submitted.

Linkage Data Items

In order to ensure that records submitted can be linked appropriately some key data fields must be completed for each record submitted. These are shown in the Core Linkage section. For pathology records this includes both Patient Identity and Pathology details and differs from the main core linkage items identified in the full User Guide.

There will be one linkage section completed each time the record is submitted.

1. CORE

These items are Mandatory for every record in order to link patient records.

In order to ensure that records submitted can be linked appropriately some key data fields must be completed for each record submitted. These are shown in the Core Linkage section.

There will be one linkage section completed each time the record is submitted.

Note: It is important to refer to the Pathology User Guide if reporting pathology direct from the LIMS as there are different linkage items required.

1.1 CORE LINKAGE

These items are Mandatory for every record in order to link patient records.

1.1.1 CORE LINKAGE - PATIENT IDENTITY DETAILS

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0010	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER**	n10	M[10]
CR0020	CORE - PATIENT IDENTITY DETAILS	**LOCAL PATIENT IDENTIFIER** *[LOCAL PATIENT IDENTIFIER (EXTENDED)]*	max an20	M[11]
CR1350	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER STATUS INDICATOR CODE**	an2	M
CR0100	CORE - PATIENT IDENTITY DETAILS	**PERSON BIRTH DATE**	an10 ccyy-mm-dd	R
CR0030	CORE - PATIENT IDENTITY DETAILS	**ORGANISATION CODE (CODE OF PROVIDER)**	an3 or an5	M

NHS NUMBER: The NHS NUMBER is a unique identifier for a PATIENT within the NHS in England and Wales. This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

LOCAL PATIENT IDENTIFIER: For linkage purposes, NHS NUMBER and/or LOCAL PATIENT IDENTIFIER are required. This is a number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system.

Note: This has been extended to 'max an20' to help support Trusts where local numbers are now >10 and prevents data being truncated on upload.

NHS NUMBER STATUS INDICATOR CODE: The NHS NUMBER STATUS INDICATOR CODE indicates the verification status of the NHS number provided.

01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS Number or patient detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old)

[10] A combination of **NHS NUMBER** and/or **LOCAL PATIENT IDENTIFIER** is Mandatory for the schema
[11] A combination of **NHS NUMBER** and/or **LOCAL PATIENT IDENTIFIER** is Mandatory for the schema

PERSON BIRTH DATE: The date on which a PERSON was born or is officially deemed to have been born.

ORGANISATION CODE (CODE OF PROVIDER): The ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider. This is the three digit code of the organisation submitting the demographic details. This will therefore normally be either the organisation where the referral is received or the treating organisation[12].

1.1.2 CORE LINKAGE – PATHOLOGY DETAILS:

Note: ***INVESTIGATION RESULT DATE & SERVICE REPORT IDENTIFIER:*** *are no longer required as core linkage, due to the way the data set has now been re-structured*

1.2 CORE – DEMOGRAPHIC DETAILS

Demographic details are required for every record in order to ensure that the correct patient can be identified and information can be correctly linked.

The Demographics section should be completed by every Provider the first time a record is submitted.

There will only be one Demographics section completed for each record. Demographic linkage items will be required each time the record is submitted. Almost all patients should have an NHS Number and this should always be included where available. For those who do not have an NHS Number, the hospital number (LOCAL PATIENT IDENTIFIER) must be provided.

It is anticipated that some of the demographic data items listed below will be collected by every provider with which the patient has contact. Where this information is exchanged, the appropriate data item name should be used.

This section will be recorded once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0050	CORE - DEMOGRAPHICS	**PERSON FAMILY NAME**	max an35	R
CR0060	CORE - DEMOGRAPHICS	**PERSON GIVEN NAME**	max an35	R
CR0070	CORE - DEMOGRAPHICS	**PATIENT USUAL ADDRESS (AT DIAGNOSIS)**	an175 (5 lines each an35)	R
CR0080	CORE - DEMOGRAPHICS	**POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS)**	max an8	R
CR3170	CORE - DEMOGRAPHICS	**PERSON STATED GENDER CODE**	an1	R

PERSON FAMILY NAME: That part of a PERSON's name which is used to describe family, clan, tribal group, or marital association.

PERSON GIVEN NAME: The forename(s) or given name(s) of a PERSON.

PATIENT USUAL ADDRESS (AT DIAGNOSIS): The PATIENT USUAL ADDRESS of the PATIENT at the

[12] http://www.datadictionary.nhs.uk/data_dictionary/attributes/o/org/organisation_code_de.asp?query=organisation%20code&rank=1001

time of PATIENT DIAGNOSIS.

POSTCODE OF USUAL ADDRESS (AT DIAGNOSIS): The POSTCODE OF USUAL ADDRESS of the PATIENT at the time of PATIENT DIAGNOSIS.

PERSON STATED GENDER CODE: Person's gender as self-declared (or inferred by observation for those unable to declare their PERSON STATED GENDER).

1	Male
2	Female
9	Indeterminate (Unable to be classified as either male or female)
X	Not known (PERSON STATED GENDER CODE not recorded)

1.3 CORE - PATHOLOGY

As of January 2016, all pathology should be submitted to the NCRAS in structured xml. These reports will include all the data as prescribed below and would be submitted to the NCRAS directly from the pathology Laboratory Information Management Systems (LIMS). Once the pathologist has completed and signed off each report, they can be submitted either individually or as a monthly batch of data. There is a separate pathology schema for submissions which come directly from the pathology LIMS.

There is no expectation therefore for Providers to double enter these data by non-clinical MDT coordinators trying to read a pathology report and transcribe the relevant information correctly into their local cancer information system.

Pathological diagnosis and grade (where applicable) are recorded on biopsies and may be amended after surgical resection (if appropriate), when pathological staging should also be available. Full text pathology reports should be submitted to include these data items if structured coded extracts are not available. There may be more than one Pathology section completed for each record.

To carry the pathology details. The core data set includes general pathological items which are applicable to all tumour sites unless otherwise stated, and in v7.0 the site specific pathology items (relating to stage components) we moved to CORE but retained their site specific pathology sections. These core and site specific items are a subset of the RCPath cancer data sets which have been approved as Professional Standards by the College.

Where structured reporting systems are not available for pathology it is expected that many of the relevant data items will be included in the free text pathology report. Providers may also wish to submit these items from other structured systems such as MDT software, however the original pathology report should always be submitted and there is no expectation for Providers to double enter these data unless they have chosen to do so for local purposes.

A patient may have any number of pathology reports, and there may be more than one pathology report per specimen.

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CR0780	CORE - PATHOLOGY DETAILS	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	R
CR0950	CORE - PATHOLOGY DETAILS	**SERVICE REPORT IDENTIFIER**	min an1 max an36	R
CR6220	CORE - PATHOLOGY DETAILS	**PATHOLOGY OBSERVATION REPORT IDENTIFIER**	min an1 max an36	R
CR0960	CORE - PATHOLOGY DETAILS	**SERVICE REPORT STATUS**	an1	R
CR0990	CORE - PATHOLOGY DETAILS	**CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY)**	an8	R

CR0980	CORE - PATHOLOGY DETAILS	**ORGANISATION SITE IDENTIFIER (PATHOLOGY TEST REQUESTED BY)** *[ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST)]*	min an5 max an9	R
CR1010	CORE - PATHOLOGY DETAILS	**SAMPLE COLLECTION DATE**	an10 ccyy-mm-dd	R
CR0770	CORE - PATHOLOGY DETAILS	**SAMPLE RECEIPT DATE**	an10 ccyy-mm-dd	R
CR0800	CORE - PATHOLOGY DETAILS	**ORGANISATION IDENTIFIER (OF REPORTING PATHOLOGIST)** *[ORGANISATION SITE IDENTIFIER (OF REPORTING PATHOLOGIST)]*	min an3 max an5	R
CR0790	CORE - PATHOLOGY DETAILS	**CONSULTANT CODE (PATHOLOGIST)**	an8	R
CR0970	CORE - PATHOLOGY DETAILS	**SPECIMEN NATURE**	an1	R
CR6990	CORE - PATHOLOGY DETAILS	**SNOMED VERSION (PATHOLOGY)**	an2	R
Start of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
CR6410	CORE - PATHOLOGY DETAILS	**TOPOGRAPHY (SNOMED) PATHOLOGY**	an8	R
End of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
Start of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
CR6420	CORE - PATHOLOGY DETAILS	**MORPHOLOGY (SNOMED) PATHOLOGY**	min n6 max n18	P
End of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
Start of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
CR0810	CORE - PATHOLOGY DETAILS	**PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)**	min an4 max an6	R
End of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
CR0820	CORE - PATHOLOGY DETAILS	**TUMOUR LATERALITY (PATHOLOGICAL)**	an1	R
CR0760	CORE - PATHOLOGY DETAILS	**PATHOLOGY INVESTIGATION TYPE**	an2	R
CR1020	CORE - PATHOLOGY DETAILS	**PATHOLOGY REPORT TEXT**	max an270000	R
CR0830	CORE - PATHOLOGY DETAILS	**LESION SIZE (PATHOLOGICAL)**	max n3.max n2	R
CR0860	CORE - PATHOLOGY DETAILS	**GRADE OF DIFFERENTIATION (PATHOLOGICAL)**	an2	R
CR0870	CORE - PATHOLOGY DETAILS	**CANCER VASCULAR OR LYMPHATIC INVASION**	an2	R
CR0880	CORE - PATHOLOGY DETAILS	**EXCISION MARGIN** *[EXCISION MARGIN INDICATION CODE]*	an2	R
CR0840	CORE - PATHOLOGY DETAILS	**SYNCHRONOUS TUMOUR INDICATOR**	an1	R
CR0890	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES EXAMINED**	max n3	R
CR0900	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES POSITIVE**	max n3	R
CR6980	CORE - PATHOLOGY DETAILS	**TNM CODING EDITION**	an1	R
CR6820	CORE - PATHOLOGY DETAILS	**TNM VERSION NUMBER (PATHOLOGICAL)**	max an2	R
CR0910	CORE - PATHOLOGY DETAILS	**T CATEGORY (PATHOLOGICAL)**	max an15	R
CR0920	CORE - PATHOLOGY DETAILS	**N CATEGORY (PATHOLOGICAL)**	max an15	R
CR0930	CORE - PATHOLOGY DETAILS	**M CATEGORY (PATHOLOGICAL)**	max an15	R
CR0940	CORE - PATHOLOGY DETAILS	**TNM STAGE GROUPING (PATHOLOGICAL)**	max an15	R
CR1000	CORE - PATHOLOGY DETAILS	**NEOADJUVANT THERAPY INDICATOR**	an1	R

INVESTIGATION RESULT DATE: The date on which an investigation was concluded eg the date the result was authorised.

SERVICE REPORT IDENTIFIER: A unique identifier of a SERVICE REPORT.

PATHOLOGY OBSERVATION REPORT IDENTIFIER: local identifier of an OBSERVATION REPORT.

Note: ***This differs from the Service Report Identifier as it identifies the specific RC Path Form used, multiple of these could be contained within a Service Report (where there are multiple tumours are identified). This was included after discussion with a major LIMS supplier.***

SERVICE REPORT STATUS: The status of the SERVICE REPORT.

1	Final (complete)
2	Preliminary (Interim)
3	Test not available
4	Unspecified
5	Supplementary/second opinion
6	Deleted

Note: ***This field has the addition of [6 – Deleted], included after discussion with a major LIMS supplier.***

CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY): The code of the CARE PROFESSIONAL who requests the pathology test. This is not required if the request comes from a GENERAL MEDICAL PRACTITIONER.

ORGANISATION SITE IDENTIFIER (PATHOLOGY TEST REQUESTED BY: The ORGANISATION IDENTIFIER of the Organisation Site at which the CARE PROFESSIONAL, who requested the DIAGNOSTIC TEST REQUEST for suspected cancer, is based.

SAMPLE COLLECTION DATE: The date that a SAMPLE collection takes place or the start of a period for SAMPLE collection. This is the same as the date the Sample is taken.

SAMPLE RECEIPT DATE: Date of receipt of a SAMPLE by a LABORATORY.

ORGANISATION IDENTIFIER (OF REPORTING PATHOLOGIST: The ORGANISATION IDENTIFIER of the Organisation at which the authorising pathologist is based.

CONSULTANT CODE (PATHOLOGIST): The CONSULTANT CODE of the Pathologist who authorises the pathology report.

SPECIMEN NATURE: The nature of the specimen taken during a Clinical Investigation.

1	Primary tumour
2	Further excision of primary tumour
4	Regional Lymph Nodes
5	Metastatic site other than regional lymph nodes
9	Not known

Note: **Where none of the above options are applicable, 'Not known' maybe selected**.

SNOMED VERSION: The version of SNOMED used to encode MORPHOLOGY (SNOMED) PATHOLOGY and TOPOGRAPHY (SNOMED) PATHOLOGY.

Note: ***Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

01	SNOMED II
02	SNOMED 3
03	SNOMED 3.5
04	SNOMED RT
05	SNOMED CT
99	Not Known

TOPOGRAPHY (SNOMED) PATHOLOGY: This is the topographical site of the tumour as categorised by SNOMED International / SNOMED CT.

Note: ***Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

MORPHOLOGY (SNOMED) PATHOLOGY: This is the morphology of the tumour as categorised by SNOMED International / SNOMED CT.

Note: ***Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017 other than for historical content***

PRIMARY DIAGNOSIS (ICD PATHOLOGICAL): The PRIMARY DIAGNOSIS based on the evidence from a pathological examination.
Format CXX.X or DXX.X

TUMOUR LATERALITY (PATHOLOGICAL): Tumour laterality identifies the side of the body for a tumour relating to paired organs within a PATIENT based on the evidence from a pathological examination.

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

PATHOLOGY INVESTIGATION TYPE: The type of pathology investigation procedure carried out.

Note: ***Please see Skin site specific data set for further information on collecting this data item, including the site specific values to be used.***

CY	Cytology
BU	Biopsy NOS
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

PATHOLOGY REPORT TEXT: The full text from the pathology report which may be required by Registries to calculate diagnosis and staging details.

LESION SIZE (PATHOLOGICAL): The size in millimetres of the diameter of a lesion, largest if more than one, if the histology of a SAMPLE proves to be invasive.

Note: ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***
Note: ***This data item is not applicable for Haematology diagnosis.***
Note: ***Please see Skin site specific data set for further information on collecting this data item, including the site specific values to be used.***

GRADE OF DIFFERENTIATION (PATHOLOGICAL): The definitive grade of the Tumour based on the evidence from a pathological examination.

GX	Grade of differentiation is not appropriate or cannot be assessed
G1	Well differentiated

G2	Moderately differentiated
G3	Poorly differentiated
G4	Undifferentiated / anaplastic

Note: ***This data item is not applicable for CNS, Haematology and Sarcoma diagnosis.***
Note: ***Please see Skin site specific data set for further information on collecting this data item, including the site specific values to be used, although this data item is not used for Melanoma, but is for Squamous Cell Carcinoma.***
Note: ***This data item is not required for Sarcoma cancers. The 3-grade system should be used for sarcoma cancers and therefore HISTOPATHOLOGICAL TUMOUR GRADE (SA11120) should be submitted instead of this item.***

The following mapping table can be used to map other (site-specific) invasive pathological grades, into the main [Grade of Differentiation (Pathological)] field. These fields have been retired from the data set for v8.0 (Apr-18).

Grade	General Description	Invasive grade breast [BR4170]	CNS [BA3160]	Salivary tumour grade [HN9380]	Sarcoma - Histopathological tumour grade [SA11120]	Fallopian tube, ovary, peritoneal [GY7150]
GX	Grade of differentiation is not appropriate or cannot be assessed	n/a	n/a	n/a	n/a	n/a
G1	Well differentiated	Grade 1	I	Low	Low	Low
G2	Moderately differentiated	Grade 2	II	n/a	Intermediate	Intermediate
G3	Poorly differentiated	Grade 3	III	High	High	High
G4	Undifferentiated / anaplastic	n/a	IV	n/a	n/a	n/a

CANCER VASCULAR OR LYMPHATIC INVASION: An indication of the presence or absence of unequivocal tumour in lymphatic and/or vascular spaces.

NU	No - vascular/lymphatic invasion not present
YU	Yes - vascular/lymphatic invasion present
YV	Vascular invasion only present
YL	Lymphatic invasion only present
YB	Both lymphatic and vascular invasion present
UU	Uncertain whether vascular/lymphatic invasion is present or not
XX	Cannot be assessed
99	Not known

Note: ***This data item is not applicable for Haematology diagnosis.***

EXCISION MARGIN: An indication of whether the excision margin was clear of the tumour and if so, by how much. Where there is more than one measurement, record the closest or closest relevant margin. Where actual measurements are not taken use options 01, 05 or 06.

01	Excision margins are clear (distance from margin not stated)
02	Excision margins are clear (tumour >5mm from the margin)
03	Excision margins are clear (tumour >1mm but less than or equal to 5mm from the margin
04	Tumour is less than or equal to 1mm of excision margin, but does not reach margin
05	Tumour reaches tumour margin
06	Uncertain
98	Not applicable
99	Not known
07	Margin not involved (equal to or greater than 1mm)
08	Margin not involved (less than 1mm)
09	Margin not involved (1 to 5 mm)

Note: ***Codes 07, 08 and 09 are only applicable for skin cancers. They have been included to align with the RCPath data sets for skin diagnoses.***
Note: ***This data item is not applicable for Haematology diagnosis.***

SYNCHRONOUS TUMOUR INDICATOR: An indicator of the presence of multiple tumours at a tumour site.

N	No, no synchronous tumours present
Y	Yes, synchronous tumours present
9	Not Known

Note: This data item is not applicable for Haematology diagnosis.

NUMBER OF NODES EXAMINED: The number of local and regional nodes examined.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.

NUMBER OF NODES POSITIVE: The number of local and regional nodes reported as being positive for the presence of Tumour metastases.

Note: This data item is not applicable for CNS, Haematology or Lung diagnosis.
Note: The COSD Core TNM Staging data items below are not applicable for CNS, Gynaecology, Haematology, Skin and most CTYA diagnoses. Please see site specific data sets for further information on collecting applicable stage data, including the site specific values to be used for TNM where relevant.

TNM CODING EDITION: The TNM Coding edition in use.

TNM VERSION NUMBER (PATHOLOGICAL): The Pathological UICC or AJCC version number used for Tumour, Node and Metastasis (TNM) staging based on the evidence from a pathological examination.

T CATEGORY (PATHOLOGICAL): T CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) or American Joint Committee on Cancer (AJCC) code which classifies the size and extent of the primary Tumour based on the evidence from a pathological examination.

N CATEGORY (PATHOLOGICAL): N CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) or American Joint Committee on Cancer (AJCC) code which classifies the absence or presence and extent of regional lymph node metastases based on the evidence from a pathological examination.

M CATEGORY (PATHOLOGICAL): M CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) or American Joint Committee on Cancer (AJCC) code which classifies the absence or presence of distant metastases based on the evidence from a pathological examination.

TNM STAGE GROUPING (PATHOLOGICAL): TNM STAGE GROUPING (PATHOLOGICAL) is the Union for International Cancer Control (UICC) or American Joint Committee on Cancer (AJCC) code which classifies the combination of Tumour, node and metastases into stage groupings based on the evidence from a pathological examination.

NEOADJUVANT THERAPY INDICATOR: Indicator of whether the pathological stage was recorded after the patient had received neoadjuvant therapy (ie chemotherapy or radiotherapy prior to surgery).

Note: If this is "Yes" the pathology stage fields should NOT be prefixed with the letter "y".

Y	Yes
N	No
9	Not known

2. BREAST - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
BR4140	BREAST - PATHOLOGY	**MULTIFOCAL TUMOUR INDICATOR (BREAST)**	an1	R
BR4160	BREAST - PATHOLOGY	**DCIS GRADE** *[DUCTAL CARCINOMA IN SITU GRADE]*	an1	R
BR4180	BREAST - PATHOLOGY	**NON INVASIVE TUMOUR SIZE**	max n3.max n2	R
BR4190	BREAST - PATHOLOGY	**WHOLE TUMOUR SIZE**	max n3.max n2	R
BR4200	BREAST - PATHOLOGY	**METASTASIS EXTENT CODE**	an1	R
BR4210	BREAST - PATHOLOGY	**DISTANCE TO MARGIN**	max n2.max n1	R
BR4230	BREAST - PATHOLOGY	**ER ALLRED SCORE** *[ALLRED SCORE (ESTROGEN RECEPTOR)]*	an1	R
BR4220	BREAST - PATHOLOGY	**ER STATUS** *[ESTROGEN RECEPTOR STATUS]*	an1	R
BR4300	BREAST - PATHOLOGY	**PR ALLRED SCORE** *[ALLRED SCORE (PROGESTERONE RECEPTOR)]*	an1	R
BR4290	BREAST - PATHOLOGY	**PR STATUS** *[PROGESTERONE RECEPTOR STATUS]*	an1	R
BR4280	BREAST - PATHOLOGY	**HER2 STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR STATUS]*	an1	R
BR4310	BREAST - PATHOLOGY	**HER2 ISH STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR IN-SITU HYBRIDIZATION RECEPTOR STATUS]*	an1	R
BR4240	BREAST - PATHOLOGY	**CYTOLOGY (BREAST)** *[CYTOLOGY RESULT CODE (BREAST)]*	an2	R
BR4250	BREAST - PATHOLOGY	**CYTOLOGY (NODE)** *[CYTOLOGY RESULT CODE (NODE)]*	an2	R
BR4260	BREAST - PATHOLOGY	**CORE BIOPSY (BREAST)** *[CORE BIOPSY RESULT CODE (BREAST)]*	max an3	R
BR4270	BREAST - PATHOLOGY	**CORE BIOPSY (NODE)** *[CORE BIOPSY RESULT CODE (NODE)]*	an2	R

MULTIFOCAL TUMOUR INDICATOR (BREAST)*:* Is there more than one discrete tumour identified in the same breast?

Y	Yes
N	No
9	Not Known

Note: ***[BR4170 - INVASIVE GRADE (BREAST)]****: has been removed from the data set as it can now be collected using [CR0860 - GRADE OF DIFFERENTIATION (PATHOLOGICAL)].*

DCIS GRADE: If ductal carcinoma in situ is present, record the DCIS grade. This is the cytonuclear grade.

H	High
I	Intermediate
L	Low
X	Not assessable

NON INVASIVE TUMOUR SIZE: The size of the non-invasive tumour in mm. This is only required if there is no invasive component.

> ***Note:*** ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***

WHOLE TUMOUR SIZE: Whole size of tumour (invasive + surrounding DCIS, if DCIS extends >1mm beyond invasive) (mm) (For tumours without a DCIS component this will be the same as INVASIVE LESION SIZE).

> ***Note:*** ***For COSD reporting purposes, this data item is not required to be submitted to two decimal places.***

METASTASIS EXTENT CODE: For single node positivity, specify micrometastatic status as follows: Greater than 2mm = Metastases, 2mm to greater than 0.2mm = Micrometastasis, less than or equal to 0.2mm = Isolated tumour cells.

1	Metastasis
2	Micrometastasis
3	Isolated tumour cells
9	Not known

DISTANCE TO MARGIN: Distance to closest relevant margin (mm). Distance to nearest margin whether invasive or non-invasive. (For COSD measurement to the nearest mm is sufficient but may be recorded to nearest tenth of mm).

ER ALLRED SCORE: ER Allred score (range 0, 2 -8).

ER STATUS*:* Oestrogen Receptor (ER) status.
(A positive score means that oestrogen is causing the tumour to grow, and a negative score means that the tumour is not driven by oestrogen).

P	Positive
N	Negative
X	Not performed

PR ALLRED SCORE*:* Record the PR ALLRED score if known. (Range 0, 2-8).

PR STATUS*:* Progesterone Receptor Status. Record the PR status if known.

P	Positive
N	Negative
X	Not performed

HER2 STATUS: HER2 Immunohistochemical status (Human Epidermal Growth Factor Receptor 2). Where the initial result of this test is "Borderline", a further report will follow with result of the ISH test.

P	Positive
N	Negative
B	Borderline
X	Not performed

HER2 ISH STATUS*:* Record the result of the ISH (in-situ hybridization) test. This is only required if the initial HER2 status is "Borderline".

P	Positive
N	Negative

CYTOLOGY (BREAST)*:* Cytology opinion (Breast).

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CYTOLOGY (NODE)*:* Cytology opinion on axillary lymph node.

C1	Inadequate/unsatisfactory specimen
C2	Benign
C3	Uncertain
C4	Suspicious of malignancy
C5	Malignant

CORE BIOPSY (BREAST)*:* Needle core biopsy opinion.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5a	Malignant (In situ)
B5b	Malignant (Invasive)
B5c	Malignant (Not assessable)

CORE BIOPSY (NODE)*:* Needle biopsy opinion on axillary lymph node.

B1	Normal
B2	Benign
B3	Uncertain malignant potential
B4	Suspicious
B5	Malignant

3. CENTRAL NERVOUS SYSTEM - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Molecular Diagnostics Code				
BA3070	CENTRAL NERVOUS SYSTEM-PATHOLOGY	**MOLECULAR DIAGNOSTICS CODE**	an2	R
End of repeating item - Molecular Diagnostics Code				
Start of repeating item - Immunohistochemistry Hormone Expression Type				
BA3150	CENTRAL NERVOUS SYSTEM-PATHOLOGY	**IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE** *[HORMONE EXPRESSION TYPE]*	an1	R
End of repeating item - Immunohistochemistry Hormone Expression Type				

Note: ***[BA3160 - WHO TUMOUR GRADE (CNS)]****: has been removed from the data set as it can now be collected using [CR0860 - GRADE OF DIFFERENTIATION (PATHOLOGICAL)].*

MOLECULAR DIAGNOSTICS CODE: Chromosomal or genetic markers associated with the brain tumour. This may involve selection of more than one value for each tumour.
This table was extensively discussed by the Brain CNS SSCRG and has been based on the new 2016 WHO categories for Molecular Diagnostic Markers.

~~01~~	~~Evidence of IDH1 or IDH2 mutation~~
~~02~~	~~Evidence of methylation of the MGMT gene CpG island~~
~~03~~	~~Evidence of total loss of 1p and 19q~~
~~04~~	~~Evidence of KIAA 1549-BRAF fusion gene~~
~~05~~	~~Other~~
06	Evidence of *ALK* rearrangement
07	Evidence of native *ALK*
08	Evidence of *ATRX* mutation
09	Evidence of wt *ATRX*
10	Evidence of *BRAF* V600E mutation
11	Evidence of wt *BRAF*
12	Evidence of *KIAA1549-BRAF* fusion
13	Evidence of *BRAF/RAF1* mutations, or fusions involving genes other than *KIAA1549*
14	Evidence of *C11orf95-RELA* fusion
15	Evidence of native *C11orf95* and *RELA*
16	Evidence of amplification or fusion of *C19MC* locus (chr.19q13.42)
17	Evidence of unaltered *C19MC* locus (chr.19q13.42)
18	Evidence of *CDK4/6* amplification
19	Evidence of *CDK4/6* normal copy number
20	Evidence of *CDKN2A* locus homozygous deletion
21	Evidence of *CDKN2A* locus normal copy number
22	Evidence of *CCND1/2/3* amplification
23	Evidence of *CCND1/2/3* normal copy number
24	Evidence of *CTNNB1* mutation
25	Evidence of wt *CTNNB1*
26	Evidence of amplification of *EGFR*
27	Evidence of mutation / rearrangement of *EGFR*
28	Evidence of unaltered *EGFR*
29	Evidence of *EWSR1-FLI1* fusion
30	Evidence of native *EWSR1* and *FLI1*
31	Evidence of *FGFR1* mutation / rearrangement / fusion

32	Evidence of unaltered *FGFR1*
33	Evidence of *H3F3A/H3F3B* (H3.3) K27M mutation
34	Evidence of *H3F3A/H3F3B* (H3.3) wt K27
35	Evidence of *H3F3A/H3F3B* (H3.3) G34R/V mutation
36	Evidence of *H3F3A/H3F3B* (H3.3) wt G34
37	Evidence of *HIST1H3B* K27M mutation
38	Evidence of *HIST1H3B* wt K27
39	Evidence of *HIST1H3C* K27M mutation
40	Evidence of *HIST1H3C* wt K27
41	Evidence of *ID2* amplification
42	Evidence of *ID2* normal copy number
43	*IDH1* (codon 132) or *IDH2* (codon 172) mutation identified
44	*IDH1* (codon 132) and *IDH2* (codon 172) wt confirmed
45	Evidence of *KLF4* K409Q and *TRAF7* mutations
46	Evidence of wt *KLF4* and *TRAF7*
47	Evidence of *MAP2K1* mutation
48	Evidence of wt *MAP2K1*
49	Evidence of *MET* amplification
50	Evidence of *MET* normal copy number
51	Evidence of significant *MGMT* promoter methylation
52	Evidence of unmethylated *MGMT* promoter
53	Evidence of *MYC/MYCN* amplification
54	Evidence of *MYC/MYCN* normal copy number
55	Evidence of *NF1* biallelic loss / mutation
56	Evidence of unaltered *NF1*
57	Evidence of *NF2* biallelic loss / mutation
58	Evidence of unaltered *NF2*
59	Evidence of *NKTR* fusions
60	Evidence of native *NKTR*
61	Evidence of *PTEN* biallelic loss / mutation
62	Evidence of unaltered *PTEN*
63	Evidence of *SDHB* or *SDHD* mutation
64	Evidence of wt *SDHB* and *SDHD*
65	Evidence of *SHH* pathway activation
66	Evidence of normal *SHH* pathway
67	Evidence of inactivation of *SMARCB1* (INI1)
68	Evidence of wt *SMARCB1* (INI1)
69	Evidence of inactivation of *SMARCA4*
70	Evidence of wt *SMARCA4*
71	Evidence of *TERT* promotor mutation
72	Evidence of wt *TERT* promotor
73	Evidence of *TP53* mutation
74	Evidence of wt *TP53*
75	Evidence of *TSC1* or *TSC2* mutation
76	Evidence of wt *TSC1* and *TSC2*
77	Evidence of *VHL* mutation
78	Evidence of wt *VHL* gene
79	Evidence of *WNT* pathway activation
80	Evidence of normal *WNT* pathway
81	Evidence of *WWTR1-CAMTA1* fusion
82	Evidence of native *WWTR1* and *CAMTA1*
83	Evidence of codeletion of chr.1p and chr.19q
84	Evidence of total chr.1p loss but normal copy number of chr.19q
85	Evidence of normal copy number of both chr.1p and chr.19q
86	Evidence of monosomy chr.6
87	Evidence of chr.6 normal copy number

88	Evidence of polysomy chr.7
89	Evidence of chr.7 normal copy number
90	Evidence of loss of chr.10 or chr.10q
91	Evidence of chr.10 normal copy number
92	Evidence of loss of chr.22 or chr.22q
93	Evidence of chr.22 or chr.22q normal copy number
98	Other
99	Not Known (Not Recorded)

The old codes can be mapped as follows to enable a seamless transition from v6.0 to v7.0 and now to v8.0, where old reports are re-submitted as part of a clinical review.

Old Codes and Descriptions		New Codes and Descriptions	
01	Evidence of IDH1 or IDH2 mutation	**43**	IDH1 (codon 132) or IDH2 (codon 172) mutation identified
02	Evidence of methylation of the MGMT gene CpG island	**51**	Evidence of significant MGMT promoter methylation
03	Evidence of total loss of 1p and 19q	**83**	Evidence of codeletion of chr.1p and chr.19q
04	Evidence of KIAA 1549-BRAF fusion gene	**12**	Evidence of KIAA1549-BRAF fusion
05	Other	**98**	Other

IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE: Hormone expression by immunohistochemistry. FOR PITUITARY ADENOMAS ONLY. (Multiple values may be recorded).

0	Non functioning
1	ACTH
2	LH
3	FSH
4	Alpha-subunit
5	TSH
6	Prolactin
7	Growth Hormone

WHO TUMOUR GRADE (CNS) [WORLD HEALTH ORGANISATION CENTRAL NERVOUS SYSTEM TUMOUR GRADE]: The grade of the tumour using WHO classification for tumours of the central nervous system. FOR INTRA AXIAL AND EXTRA AXIAL ONLY.

1	I
2	II
3	III
4	IV

4. COLORECTAL - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CO5190	COLORECTAL - PATHOLOGY	**POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
CO5210	COLORECTAL - PATHOLOGY	**DISTANCE TO CIRCUMFERENTIAL MARGIN** *[DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN]*	max n2.max n2	R
CO5260	COLORECTAL - PATHOLOGY	**PLANE OF SURGICAL EXCISION** *[PLANE OF SURGICAL EXCISION TYPE]*	an1	R
CO5270	COLORECTAL - PATHOLOGY	**DISTANCE FROM DENTATE LINE**	max n3.max n2	R
CO5280	COLORECTAL - PATHOLOGY	**DISTANCE BEYOND MUSCULARIS PROPRIA**	max n3.max n2	R
CO5290	COLORECTAL - PATHOLOGY	**RESPONSE TO PREOPERATIVE THERAPY** *[PREOPERATIVE THERAPY RESPONSE TYPE]*	an1	R
CO5300	COLORECTAL - PATHOLOGY	**STATUS OF CIRCUMFERENTIAL EXCISION MARGIN** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R
CO5410	COLORECTAL - PATHOLOGY	**GRADE OF DIFFERENTIATION (COLORECTAL PATHOLOGICAL)**	an1	R

POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN: Record whether the proximal or distal resection margins were involved. If the minimal distance from the cut margin is less than or equal to 1 mm the margin is considered "involved".

0	Margin not involved
1	Margin involved
9	Not known

DISTANCE TO CIRCUMFERENTIAL MARGIN: Record the distance from the outer margin of the tumour to the closest non-peritonealised circumferential resection margin in mm. RECTAL CANCERS ONLY.

PLANE OF SURGICAL EXCISION: FOR RECTAL CANCERS ONLY. This is the quality of the surgical excision as seen by the pathologist. This grades the resection on its worst plane.

1	Mesorectal fascia
2	Intramesorectal
3	Muscularis propria

DISTANCE FROM DENTATE LINE: For abdominoperineal excision specimens only. Record the distance of the tumour from the dentate line in mm measured on the gross specimen.

DISTANCE BEYOND MUSCULARIS PROPRIA: Maximum distance of spread beyond muscularis propria in mm. If there is doubt about the sites of the muscularis propria estimate the distance as accurately as possible.

RESPONSE TO PREOPERATIVE THERAPY: If preoperative therapy was given what was the response.

~~1~~	~~No residual tumour cells/mucous lakes only~~
~~2~~	~~Minimal residual cancer~~
~~3~~	~~No marked regression~~
4	No viable tumour cells (fibrosis or mucus lakes only)
5	Single tumour cells or scattered small groups of cancer cells
6	Residual cancer outgrown by fibrosis
7	Minimal or no regression (extensive residual tumour)

This field has been updated in 2018, removing outdated attributes and including a four tier system, similar to that described by Ryan et al.

The following mapping table should be used by developers:

Old Attributes			New Attributes	
~~1~~	~~No residual tumour cells/mucous lakes only~~	**To**	4	No viable tumour cells (fibrosis or mucus lakes only)
~~2~~	~~Minimal residual cancer~~	**To**	5	Single tumour cells or scattered small groups of cancer cells
		To	6	Residual cancer outgrown by fibrosis
~~3~~	~~No marked regression~~	**To**	7	Minimal or no regression (extensive residual tumour)

STATUS OF CIRCUMFERENTIAL EXCISION MARGIN: Record if the edge of the tumour is 1 mm or less from the circumferential resection margin (ie margin involved) Circumferential margin refers to the completeness of the surgeon's resection margin in the opinion of the histopathologist. In parts of the colon where it is completely surrounded by peritoneum, recording of the circumferential resection margin (CRM) is not appropriate.

0	Margin not involved
1	Margin involved
9	Not known

GRADE OF DIFFERENTIATION (COLORECTAL PATHOLOGICAL): GRADE OF DIFFERENTIATION for Colorectal Pathological is the definitive grade of the Tumour based on the evidence from a pathological examination.

1	Well/Moderately differentiated
2	Poorly differentiated
9	Not Applicable

5. CTYA - RENAL PATHOLOGY (Paediatric Kidney)

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
CT6610	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR RUPTURE** *[TUMOUR RUPTURE INDICATOR]*	an1	R
CT6620	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**ANAPLASTIC NEPHROBLASTOMA** *[ANAPLASTIC NEPHROBLASTOMA TYPE]*	an1	R
CT6630	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**PERIRENAL FAT INVASION** *[TUMOUR INVASION INDICATOR (PERIRENAL FAT)]*	an1	R
CT6640	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL SINUS INVASION** *[TUMOUR INVASION INDICATOR (RENAL SINUS)]*	an1	R
CT6650	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
CT6660	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**VIABLE TUMOUR** *[VIABLE TUMOUR INDICATOR]*	an1	R
CT6670	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR LOCAL STAGE (PATHOLOGICAL)** *[TUMOUR LOCAL STAGE]*	an1	R

TUMOUR RUPTURE: Integrity of tumour margins based on pathologist's assessment.

Y	Yes
N	No
X	Not stated

ANAPLASTIC NEPHROBLASTOMA: Is there evidence of anaplasia, focal or diffused, based on established pathological classification.

F	Focal Anaplasia
D	Diffused Anaplasia
U	Uncertain

PERIRENAL FAT INVASION: Are there areas of perirenal fat suspected for tumour infiltration.

Y	Yes
N	No
U	Uncertain

RENAL SINUS INVASION: Is there evidence of invasion of renal sinus by tumour.

Y	Yes
N	No
U	Uncertain

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein.

Y	Yes
N	No
U	Uncertain

VIABLE TUMOUR: Is there evidence of viable tumour in the renal sinus.

Y	Yes
N	No
U	Uncertain

TUMOUR LOCAL STAGE (PATHOLOGICAL): Local stage of the tumour as assessed by pathologist. Classification system used is International Society of Paediatric Oncology (SIOP).

1	Stage I
2	Stage II
3	Stage III

6. GYNAECOLOGY - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7050	GYNAECOLOGY - PATHOLOGY	**FALLOPIAN TUBE INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (FALLOPIAN TUBE)]*	an1	R
GY7120	GYNAECOLOGY - PATHOLOGY	**OVARIAN INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (OVARIAN)]*	an1	R
GY7130	GYNAECOLOGY - PATHOLOGY	**SEROSAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (SEROSA)]*	an1	R
GY7100	GYNAECOLOGY - PATHOLOGY	**OMENTAL INVOLVEMENT** *[OMENTUM INVOLVEMENT INDICATION CODE]*	an1	R

FALLOPIAN TUBE INVOLVEMENT: For endometrial and epithelial/ovarian cancers, is there microscopic involvement of fallopian tubes?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

OVARIAN INVOLVEMENT: For endometrial and fallopian cancers, is there microscopic involvement of ovaries?

1	Not involved
2	Right involved
3	Left involved
4	Both involved
X	Not assessable

SEROSAL INVOLVEMENT: For endometrial, epithelial/ovarian and fallopian cancers, is there microscopic involvement of uterine serosa?

Y	Yes
N	No
X	Not assessable

OMENTAL INVOLVEMENT: For endometrium, ovary, fallopian tube and primary peritoneum cancers, is there involvement of the omentum?

1	Involved - deposit size not specified
2	Involved - deposit(s) 20mm or less
3	Involved - deposit(s) greater than 20mm
4	Not involved
X	Not assessable/not sent

6.1 GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7140	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**CAPSULE STATUS**	an1	R
GY7190	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**OVARIAN SURFACE INVOLVEMENT** *[OVARY SURFACE INVOLVEMENT INDICATOR]*	an1	R
GY7170	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL CYTOLOGY** *[PERITONEAL CYTOLOGY RESULT CODE]*	an1	R
GY7180	GYNAECOLOGY - PATHOLOGY - FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL INVOLVEMENT** *[PERITONEAL INVOLVEMENT INDICATOR]*	an1	R
GY7450	GYNAECOLOGY - PATHOLOGY	**INVASIVE THICKNESS**	max n2.max n2	R

CAPSULE STATUS: Capsule status of ovaries (record the most severe).

1	Intact
2	Disrupted
3	Involved
X	Not assessable

Note: ***[GY7150 - TUMOUR GRADE]****: has been removed from the data set as it can now be collected using [CR0860 - GRADE OF DIFFERENTIATION (PATHOLOGICAL)].*

OVARIAN SURFACE INVOLVEMENT: Is there involvement of the surface of either ovary?

Y	Yes
N	No
X	Not assessable

PERITONEAL CYTOLOGY: Result of peritoneal cytology.

1	Involved
2	Not involved
3	Equivocal
X	Not sent

PERITONEAL INVOLVEMENT: Is there peritoneal involvement?

Y	Yes
N	No
X	Not assessable / Not sent

INVASIVE THICKNESS: The thickness or depth of the invasive lesion in mm

6.2 GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7240	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**INVOLVEMENT OF CERVICAL STROMA** *[MICROSCOPIC INVOLVEMENT INDICATOR (CERVICAL STROMA)]*	an1	R
GY7260	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**MYOMETRIAL INVASION** *[MYOMETRIAL INVASION IDENTIFICATION CODE]*	an1	R
GY7270	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PARAMETRIUM INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (PARAMETRIUM)]*	an1	R
GY7280	GYNAECOLOGY - PATHOLOGY - ENDOMETRIAL	**PERITONEAL WASHINGS** *[PERITONEAL WASHINGS IDENTIFIED]*	an1	R

Note: ***DISTANCE TO SEROSA****: has been removed from the data set as it is no longer part of the RC Path core data set, and as such may not be collectable and we should not be adding data that are outside the scope of the RC Path. COSD and RC Path should be aligned (wherever possible).*

INVOLVEMENT OF CERVICAL STROMA: Is there microscopic involvement of cervical stroma?

Y	Yes
N	No
X	Not assessable

MYOMETRIAL INVASION: Is there microscopic evidence of myometrial invasion?

1	None
2	Less than 50%
3	Greater than or equal to 50%

PARAMETRIUM INVOLVEMENT: Is there microscopic involvement of parametrium?

Y	Yes
N	No
X	Not assessable

PERITONEAL WASHINGS: Were peritoneal washings submitted and if so were malignant cells seen?
These attributes have been changed after discussions with HSCIC (Data Dictionary Team).

P	Positive
N	Negative
X	Not sent/Not assessable

6.3 GYNAECOLOGY - PATHOLOGY - CERVICAL

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7290	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CGIN GRADE** *[CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7300	GYNAECOLOGY - PATHOLOGY - CERVICAL	**CIN GRADE** *[CERVICAL INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
GY7350	GYNAECOLOGY - PATHOLOGY - CERVICAL	**SMILE** *[SMILE INDICATION CODE]*	an1	R
GY7310	GYNAECOLOGY - PATHOLOGY - CERVICAL	**EXCISION MARGIN (PRE INVASIVE)** *[RESECTION MARGIN INVOLVEMENT INDICATOR]*	an1	R
GY7340	GYNAECOLOGY - PATHOLOGY - CERVICAL	**PARACERVICAL OR PARAMETRIAL INVOLVEMENT** *[PARACERVICAL OR PARAMETRIAL INVOLVEMENT INDICATOR]*	an1	R
GY7360	GYNAECOLOGY - PATHOLOGY - CERVICAL	**THICKNESS UNINVOLVED STROMA** *[UNINVOLVED CERVICAL STROMA THICKNESS]*	max n2.max n2	R
GY7370	GYNAECOLOGY - PATHOLOGY - CERVICAL	**VAGINAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (VAGINAL)]*	an1	R

CGIN GRADE: Specify presence and grade of CGIN (cervical glandular intraepithelial neoplasia).

1	Low
2	High
3	Not present
X	Not assessable

CIN GRADE: Specify presence and grade of CIN (cervical intra-epithelial neoplasia).

1	1
2	2
3	3
4	Not present
X	Not assessable

SMILE: Specify presence of SMILE (Stratified Mucin-Producing Intra-Epithelial Lesion).

1	Present
2	Absent
X	Not assessable

EXCISION MARGIN (PRE INVASIVE): Is there evidence of resection margin involvement by in situ/pre invasive disease (CIN, CGIN, and SMILE).

Y	Yes
N	No
X	Not assessable

PARACERVICAL OR PARAMETRIAL INVOLVEMENT: Is there evidence of paracervical and/or parametrial involvement?

Y	Yes
N	No
X	Not assessable

THICKNESS UNINVOLVED STROMA: Minimum thickness of uninvolved cervical stroma in millimetres (mm) (minimum tumour-free rim).

VAGINAL INVOLVEMENT: Is there evidence of microscopic vaginal involvement?

Y	Yes
N	No
X	Not assessable

6.4 GYNAECOLOGY - PATHOLOGY - NODES

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
GY7020	GYNAECOLOGY - PATHOLOGY - NODES	**NODAL STATUS CERVICAL CANCER** *[CERVICAL NODE STATUS]*	an2	R
GY7060	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PARA-AORTIC)** *[NUMBER OF NODES EXAMINED (PARA-AORTIC)]*	max n2	R
GY7080	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PARA-AORTIC)** *[NUMBER OF NODES POSITIVE (PARA-AORTIC)]*	max n2	R
GY7070	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PELVIC)** *[NUMBER OF NODES EXAMINED (PELVIC)]*	max n2	R
GY7090	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PELVIC)** *[NUMBER OF NODES POSITIVE (PELVIC)]*	max n2	R
GY7410	GYNAECOLOGY - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES EXAMINED (INGUINO-FEMORAL)]*	max n2	R
GY7420	GYNAECOLOGY - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES POSITIVE (INGUINO-FEMORAL)]*	max n2	R
GY7230	GYNAECOLOGY - PATHOLOGY - NODES	**EXTRANODAL SPREAD** *[EXTRANODAL SPREAD INDICATOR]*	an1	R

NODAL STATUS CERVICAL CANCER: FOR CERVICAL CANCERS ONLY. Only required for surgically staged early FIGO stage cancers. Histological assessment of regional lymph nodes, including surgical excision or fine needle aspiration. (FIGO staging for cervical cancer is clinical, but nodal status may be an important prognostic factor and determinant of management options including the need for adjuvant

therapy).
This could be derived from NODES EXAMINED NUMBER (PELVIC) and NODES POSITIVE NUMBER (PELVIC) but may also be entered separately.

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Regional lymph node metastases

NODES EXAMINED NUMBER (PARA-AORTIC): The number of para-aortic nodes examined. (Not applicable for vulval cancers) Use 0 if nodes not sent.

NODES POSITIVE NUMBER (PARA-AORTIC): The number of para-aortic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers).

NODES EXAMINED NUMBER (PELVIC): The number of pelvic nodes examined (Not applicable for vulval cancers). Use 0 if nodes not sent.

NODES POSITIVE NUMBER (PELVIC): The number of pelvic nodes reported as being positive for the presence of tumour metastases. (Not applicable for vulval cancers).

NODES EXAMINED NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes examined. (Only applicable to vulval cancers). Use 0 if nodes not sent.

NODES POSITIVE NUMBER (INGUINO-FEMORAL): The number of inguino-femoral nodes reported as being positive for the presence of tumour metastases. (Only applicable to vulval cancers).

EXTRANODAL SPREAD: Is there evidence of extranodal spread/extension?

Y	Yes
N	No
X	Not assessable

7. HAEMATOLOGY - PATHOLOGY

Currently, Haematology has no site-specific pathological data items to collect.

8. HEAD & NECK – PATHOLOGY - GENERAL

8.1 HEAD & NECK - PATHOLOGY - VARIOUS

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9300	HEAD & NECK - PATHOLOGY - VARIOUS	**MAXIMUM DEPTH OF INVASION**	max n3	R
HN9310	HEAD & NECK - PATHOLOGY - VARIOUS	**BONE INVASION** *[BONE INVASION INDICATION CODE]*	an1	R
HN9320	HEAD & NECK - PATHOLOGY - VARIOUS	**CARTILAGE INVASION** *[CARTILAGE INVASION INDICATION CODE]*	an1	R
HN9330	HEAD & NECK - PATHOLOGY - VARIOUS	**NECK DISSECTION LATERALITY** *[ANATOMICAL SIDE (NECK DISSECTION)]*	an1	R

MAXIMUM DEPTH OF INVASION: The maximum depth of invasion in mm. Record as 00 to indicate 'not applicable', (This is not applicable for nasopharynx, hypopharynx, nasal cavity or sinuses).

BONE INVASION [BONE INVASION INDICATION CODE]: Is there evidence of invasion into bone. This is not applicable to many sites as bone not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

CARTILAGE INVASION: Is there evidence of invasion into cartilage. This is not applicable to many sites as cartilage is not resected.

1	Present
2	Absent
3	Not assessed
4	Not applicable

NECK DISSECTION LATERALITY: Identify laterality of neck dissection if performed.

1	Left
2	Right
3	Bilateral
4	Not performed
8	Not applicable

8.2 HEAD & NECK - PATHOLOGY - SALIVARY

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9390	HEAD & NECK - PATHOLOGY - SALIVARY	**MACROSCOPIC EXTRAGLANDULAR EXTENSION** *[MACROSCOPIC EXTRAGLANDULAR EXTENSION INDICATION CODE]*	an1	R

Note: ***[HN9380 – HISTOLOGICAL GRADE (SALIVARY TUMOUR]****: has been removed from the data set as it can now be collected using [CR0860 - GRADE OF DIFFERENTIATION (PATHOLOGICAL)].*

MACROSCOPIC EXTRAGLANDULAR EXTENSION: Macroscopic extension of tumour outside the capsule of the salivary gland.

1	Present
2	Absent

8.3 HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
HN9400	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**POSITIVE NODES LATERALITY** *[ANATOMICAL SIDE (POSITIVE NODES)]*	an1	R
HN9410	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS LEFT NECK** *[LARGEST METASTASIS (LEFT NECK)]*	max n3	R
HN9420	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS RIGHT NECK** *[LARGEST METASTASIS (RIGHT NECK)]*	max n3	R
HN9430	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**EXTRACAPSULAR SPREAD** *[EXTRACAPSULAR SPREAD INDICATION CODE]*	an1	R

POSITIVE NODES LATERALITY: If nodes positive specify laterality.

1	Left
2	Right
3	Bilateral
8	Not applicable

LARGEST METASTASIS LEFT NECK: If Neck dissected on Left side, the size in mm of the largest metastasis.

LARGEST METASTASIS RIGHT NECK: If Neck dissected on Right side, the size in mm of the largest metastasis.

EXTRACAPSULAR SPREAD: Invasion of metastatic tumour outside the capsule of a lymph node.

1	Present
2	Absent
3	Not assessable

9. LUNG - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
LU10100	LUNG - PATHOLOGY	**PROXIMITY TO CARINA** *[TUMOUR PROXIMITY TO CARINA]*	an1	R
LU10110	LUNG - PATHOLOGY	**EXTENT OF ATELECTASIS**	an1	R
LU10120	LUNG - PATHOLOGY	**EXTENT OF PLEURAL INVASION**	an1	R
LU10130	LUNG - PATHOLOGY	**PERICARDIAL INVASION** *[TUMOUR INVASION INDICATOR (PERICARDIUM)]*	an1	R
LU10140	LUNG - PATHOLOGY	**DIAPHRAGM INVASION** *[TUMOUR INVASION INDICATOR (DIAPHRAGM)]*	an1	R
LU10150	LUNG - PATHOLOGY	**INVASION INTO GREAT VESSEL** *[TUMOUR INVASION INDICATOR (GREAT VESSELS)]*	an1	R
LU10160	LUNG - PATHOLOGY	**INVASION INTO HEART** *[TUMOUR INVASION INDICATOR (HEART)]*	an1	R
LU10170	LUNG - PATHOLOGY	**MALIGNANT PLEURAL EFFUSION** *[MALIGNANT PLEURAL EFFUSION INDICATOR]*	an1	R
LU10180	LUNG - PATHOLOGY	**SATELLITE TUMOUR NODULES LOCATION**	an1	R

PROXIMITY TO CARINA: Is the tumour within 20mm of carina (if known) or more than 20mm from carina.

1	< 20mm
2	>20mm

EXTENT OF ATELECTASIS: Extent of atelectasis/obstructive pneumonitis.

1	None or less than the two other categories
2	Involving hilar region but not whole lung
3	Involving whole lung

EXTENT OF PLEURAL INVASION: What is the extent of pleural invasion?

1	No pleural invasion
2	Visceral pleura only
3	Parietal pleura/chest wall
4	Mediastinal pleura

PERICARDIAL INVASION: Does the tumour invade the pericardium?

Y	Yes
N	No
9	Not known

DIAPHRAGM INVASION: Does the tumour invade the diaphragm?

Y	Yes
N	No
9	Not known

INVASION INTO GREAT VESSEL: Does the tumour invade the great vessels (aorta, central pulmonary artery or vein)?

Y	Yes
N	No
9	Not known

INVASION INTO HEART: Does the tumour invade the Atrium or Heart?

Y	Yes
N	No
9	Not known

MALIGNANT PLEURAL EFFUSION: Is there evidence of malignant pleural effusion?

Y	Yes
N	No
9	Not known

SATELLITE TUMOUR NODULES LOCATION: Record the most distant location of separate tumour nodules.

1	Separate tumour nodules in same lobe
2	Separate tumour nodules in a different ipsilateral lobe
3	Separate tumour nodules in a contralateral lobe
4	No separate tumour nodules
9	Not known

10. SARCOMA - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11170	SARCOMA - PATHOLOGY	**GENETIC CONFIRMATION INDICATOR**	an1	R
CT6420	SARCOMA - PATHOLOGY	**SARCOMA SURGICAL MARGIN ADEQUACY**	an1	R

Note: ***[SA11120 - HISTOLOGICAL TUMOUR GRADE]****: has been removed from the data set as it can now be collected using [CR0860 - GRADE OF DIFFERENTIATION (PATHOLOGICAL)].*

GENETIC CONFIRMATION INDICATOR: Are there any cytogenetic or molecular genetic data confirming the histological diagnosis?

Y	Yes, confirmed
N	No, not confirmed
X	Test not done

SARCOMA SURGICAL MARGIN ADEQUACY: Pathological assessment of completeness of resection. This is required for CTYA - Osteosarcoma patients. This item has moved from the Children, Teenage, Young Adult (CTYA) section, as it was felt it could be used for more than CTYA cases and hopefully improve ascertainment.

I	Intralesional
M	Marginal
W	Wide
C	Compartmental
O	Other
9	Not Known

10.1 SARCOMA - PATHOLOGY - BONE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11130	SARCOMA - PATHOLOGY - BONE	**EXTENT OF LOCAL SPREAD (BONE)** *[TUMOUR BREACH IDENTIFIER]*	an1	R
SA11140	SARCOMA - PATHOLOGY - BONE	**TUMOUR NECROSIS**	max n3	R

EXTENT OF LOCAL SPREAD (BONE) [TUMOUR BREACH IDENTIFIER]: FOR MEDULLARY TUMOURS ONLY. Does the tumour breach the cortex? The extent of local spread will determine whether the tumour is intracompartmental or extracompartmental.

I	Intracompartmental
E	Extracompartmental

TUMOUR NECROSIS: Approximate percentage of tumour necrosis in response to pre-operative therapy.

10.2 SARCOMA - PATHOLOGY - SOFT TISSUE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SA11100	SARCOMA - PATHOLOGY - SOFT TISSUE	**TUMOUR DEPTH**	an1	R
SA11220	SARCOMA - PATHOLOGY - SOFT TISSUE	**MITOTIC RATE (SARCOMA)**	max n3	R

TUMOUR DEPTH: Record the deepest tissue compartment where the tumour is located.

1	Intradermal/cutaneous
2	Subcutaneous
3	Fascial/subfascial
9	Not known

MITOTIC RATE (SARCOMA): Mitotic rate per 5mm squared. Also known as mitotic index and mitotic count. Component used to stage GISTs. **Only applicable to GISTS**.

11. SKIN - PATHOLOGY

11.1 SKIN - GENERAL - BASAL CELL CARCINOMA (BCC), SQUAMOUS CELL CARCINOMA (SCC) and MALIGNANT MELANOMA (MM)

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12120	SKIN - GENERAL - BCC, SCC & MM	**SKIN CANCER LESION INDICATOR** *[SKIN CANCER LESION NUMBER]*	max an3	R

SKIN CANCER LESION INDICATOR: This is the specimen number or letter used to identify the specimen within a report. Where more than one primary skin cancer is reported on the same pathology report, record the lesion number or letter as specified on the pathology report.

11.2 SKIN - PATHOLOGY - BASAL CELL CARCINOMA (BCC) and SQUAMOUS CELL CARCINOMA (SCC)

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12530	SKIN - PATHOLOGY - BCC & SCC	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR]*	an1	R
SK12537	SKIN - PATHOLOGY - BCC & SCC	**LESION DIAMETER GREATER THAN 20MM INDICATOR** *[LESION DIAMETER GREATER THAN 20MM INDICATION CODE]*	an1	R
SK12650	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT3** *[TUMOUR INVASION INDICATOR (PT3)]*	an1	R
SK12660	SKIN - PATHOLOGY - BCC & SCC	**DEEP INVASION INDICATOR FOR pT4** *[TUMOUR INVASION INDICATOR (PT4)]*	an1	R

PERINEURAL INVASION: Is there perineural invasion (invasion into perineurium of nerve bundles- PNI).

Y	Yes (Present)
N	No (Not identified)
X	Cannot be assessed
9	Not known

LESION DIAMETER GREATER THAN 20MM INDICATOR: Is the diameter of the lesion greater than 20mm?

Y	Yes (Greater than 20mm)
N	No (Less than or equal to 20mm)
U	Uncertain
X	Cannot be assessed
9	Not known

DEEP INVASION INDICATOR FOR pT3: For Stage pT3 Tumours only: Tumour with invasion of maxilla, mandible, orbit or temporal bone.

Y	Yes
N	No

U	Uncertain
X	Cannot be assessed

DEEP INVASION INDICATOR FOR pT4: For Stage pT4 Tumours only: Tumour with invasion of skeleton (axial or appendicular) or perineural invasion of skull base.

Y	Yes
N	No
U	Uncertain
X	Cannot be assessed

11.3 SKIN - PATHOLOGY - SQUAMOUS CELL CARCINOMA (SCC)

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12545	SKIN - PATHOLOGY - SCC & MM	**CLARKS LEVEL IV INDICATOR** *[CLARKS LEVEL IV INDICATION CODE]*	an1	R
SK12565	SKIN - PATHOLOGY - SCC	**LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR** *[LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATION CODE]*	an1	R

CLARKS LEVEL IV INDICATOR: Greater than or equal to Clarks level IV.

Y	Yes
N	No
U	Uncertain
X	Cannot be assessed

Note: ***Clark level IV Indicator is only required to differentiate between T1a and T1b melanomas when mitotic rate cannot be measured AND in the absence of ulceration. In these cases Clarks level IV or above categorises the melanoma as stage T1b.***

LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR: Is the vertical thickness of the lesion greater than 2mm.

Y	Yes (Greater than 2mm)
N	No (Less than or equal to 2mm)
U	Uncertain
X	Cannot be assessed
9	Not known

11.4 SKIN - PATHOLOGY - MALIGNANT MELANOMA

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
SK12580	SKIN - PATHOLOGY - MM	**ULCERATION INDICATOR** *[ULCERATION INDICATION CODE]*	an1	R
SK12590	SKIN - PATHOLOGY - MM	**MITOTIC RATE (SKIN)**	max n3	R

SK12600	SKIN - PATHOLOGY - MM	**MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR** *[MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATION CODE]*	an1	R
SK12620	SKIN - PATHOLOGY - MM	**TUMOUR REGRESSION INDICATOR** *[TUMOUR REGRESSION INDICATION CODE]*	an1	R
SK12630	SKIN - PATHOLOGY - MM	**BRESLOW THICKNESS**	max n2.max n2	R
SK12430	SKIN - PATHOLOGY - MM	**TUMOUR INFILTRATING LYMPHOCYTES (TILS)** *[TUMOUR INFILTRATING LYMPHOCYTE TYPE]*	an1	R
SK12460	SKIN - PATHOLOGY - MM	**SENTINEL NODES EXAMINED NUMBER** *[NUMBER OF SENTINEL NODES SAMPLED]*	max n2	R
SK12470	SKIN - PATHOLOGY - MM	**SENTINEL NODES POSITIVE NUMBER** *[NUMBER OF SENTINEL NODES POSITIVE]*	max n2	R
SK12480	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER** *[NUMBER OF NODES SAMPLED (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R
SK12490	SKIN - PATHOLOGY - MM	**POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER** *[NUMBER OF NODES POSITIVE (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]*	max n2	R

ULCERATION INDICATOR: Loss of full thickness of epidermis associated with reactive changes (ulceration).

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

MITOTIC RATE (SKIN): Mitotic rate per square millimetres (mm).

Note: ***May also be known as Mitotic Index or Count.***

MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR: Is there evidence of Microsatellite or in transit metastases.

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

TUMOUR REGRESSION INDICATOR: Area of loss of tumour associated with reactive changes.

Y	Yes (Present)
N	No (Not identified)
U	Uncertain
X	Cannot be assessed
9	Not known

BRESLOW THICKNESS: Breslow thickness in mm, can be recorded to nearest 0.01mm where clinically appropriate.

Note: ***Breslow thickness should be measured to a minimum of one decimal place but at times to a greater degree of precision as to allow accurate AJCC staging.... it is essential that the thickness in mm that is recorded in a database should accurately reflect the stated AJCC7 stage.'*** *(Data set for the histological reporting of primary cutaneous malignant melanoma and regional lymph nodes (2nd edition) November 2012)*

TUMOUR INFILTRATING LYMPHOCYTES (TILS): Type of TILS. Tumour infiltrating lymphocytes (TILS) are white blood cells that have left the bloodstream and migrated into a tumour.

N	Non-brisk
B	Brisk
A	Absent

SENTINEL NODES EXAMINED NUMBER: Number of sentinel nodes sampled.

SENTINEL NODES POSITIVE NUMBER: Number of sentinel nodes positive.

POST SNB COMPLETION LYMPHADENECTOMY - NODES SAMPLED NUMBER: Post SNB completion lymphadenectomy, number of nodes sampled. This procedure is not carried out in all cases.

POST SNB COMPLETION LYMPHADENECTOMY - NODES POSITIVE NUMBER: Post SNB completion lymphadenectomy, number of nodes positive. This procedure is not carried out in all cases.

12. UPPER GI - PATHOLOGY

This section can be recorded more than once.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UG14470	UPPER GI - PATHOLOGY - LIVER METS	**NUMBER OF COLORECTAL METASTASES IN LIVER CODE**	an1	R
UG14480	UPPER GI - PATHOLOGY - OESOPHAGEAL AND STOMACH	**EXCISION MARGIN (PROXIMAL, DISTAL)** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
UG14490	UPPER GI - PATHOLOGY - OESOPHAGEAL, OG JUNCTION, PANCREAS, BILE DUCT, LCC, LIVER HCC AND LIVER METS	**EXCISION MARGIN (CIRCUMFERENTIAL)** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R

NUMBER OF COLORECTAL METASTASES IN LIVER CODE: Number of colorectal metastases identified in resected liver.

0	None
1	1
2	2
3	3
4	4
5	5
M	Greater than 5

EXCISION MARGIN (PROXIMAL, DISTAL): Identify whether either proximal or distal margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved
1	Margin involved
9	Not known

EXCISION MARGIN (CIRCUMFERENTIAL): Identify whether circumferential margin is involved. (Involved equals 1mm or less, not involved equals greater than 1mm).

0	Margin not involved
1	Margin involved
9	Not known

13. UROLOGY - PATHOLOGY

13.1 UROLOGY - PATHOLOGY - BLADDER

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15120	UROLOGY - PATHOLOGY - BLADDER	**DETRUSOR MUSCLE PRESENCE INDICATOR** *[DETRUSOR MUSCLE PRESENCE INDICATION CODE]*	an1	R
UR15290	UROLOGY - PATHOLOGY - BLADDER	**TUMOUR GRADE (UROLOGY)**	an1	R

DETRUSOR MUSCLE PRESENCE INDICATOR: BLADDER ONLY. Presence or absence of detrusor muscle in the specimen.

TUMOUR GRADE (UROLOGY): BLADDER ONLY. Specify whether LOW, HIGH Grade or PUNLMP (Papillary Urothelial Neoplasm of Low Malignant Potential).

L	Low
H	High
P	PUNLMP
X	Not applicable

13.2 UROLOGY - PATHOLOGY - KIDNEY

This section will be recorded once is permitted per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15130	UROLOGY - PATHOLOGY - KIDNEY	**TUMOUR NECROSIS INDICATOR**	an1	R
UR15140	UROLOGY - PATHOLOGY - KIDNEY	**PERINEPHRIC FAT INVASION** *[TUMOUR INVASION INDICATOR (PERINEPHRIC FAT)]*	an1	R
UR15150	UROLOGY - PATHOLOGY - KIDNEY	**ADRENAL INVASION** *[TUMOUR INVASION INDICATOR (ADRENAL)]*	an1	R
UR15160	UROLOGY - PATHOLOGY - KIDNEY	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR]*	an1	R
UR15170	UROLOGY - PATHOLOGY - KIDNEY	**GEROTA'S FASCIA INVASION** *[TUMOUR INVASION INDICATOR (GEROTAS FASCIA)]*	an1	R

TUMOUR NECROSIS INDICATOR: Is there evidence of coagulative tumour necrosis?

Y	Yes
N	No

PERINEPHRIC FAT INVASION: Is there evidence of perinephric fat invasion?

Y	Yes
N	No

ADRENAL INVASION: Is there evidence of direct adrenal invasion?

Y	Yes
N	No

RENAL VEIN TUMOUR: Is there evidence of tumour thrombus in the renal vein?

Y	Yes
N	No
U	Uncertain

GEROTA'S FASCIA INVASION: Is there evidence of invasion into Gerota's fascia?

Y	Yes
N	No

13.3 UROLOGY - PATHOLOGY - PENIS

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15180	UROLOGY-PATHOLOGY - PENIS	**CORPUS SPONGIOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS SPONGIOSUM)]*	an1	R
UR15190	UROLOGY-PATHOLOGY - PENIS	**CORPUS CAVERNOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS CAVERNOSUM)]*	an1	R
UR15200	UROLOGY-PATHOLOGY - PENIS	**URETHRA OR PROSTATE INVASION** *[TUMOUR INVASION INDICATOR (URETHRA OR PROSTATE)]*	an1	R

CORPUS SPONGIOSUM INVASION: Is there evidence of invasion into corpus spongiosum?

Y	Yes
N	No

CORPUS CAVERNOSUM INVASION: Is there evidence of invasion into corpus cavernosum?

Y	Yes
N	No

URETHRA OR PROSTATE INVASION: Is there evidence of invasion into the urethra or prostate?

Y	Yes
N	No

13.4 UROLOGY - PATHOLOGY - PROSTATE

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15210	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (PRIMARY)**	an1*	R
UR15220	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (SECONDARY)**	an1*	R

UR15230	UROLOGY - PATHOLOGY - PROSTATE	**GLEASON GRADE (TERTIARY)**	an1*	R
UR15240	UROLOGY - PATHOLOGY - PROSTATE	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (UROLOGY)]*	an1	R
UR15250	UROLOGY - PATHOLOGY - PROSTATE	**ORGAN CONFINED** *[ORGAN CONFINED INDICATOR]*	an1	R
UR15260	UROLOGY - PATHOLOGY - PROSTATE	**SEMINAL VESICLES INVASION** *[TUMOUR INVASION INDICATOR (SEMINAL VESICLES)]*	an1	R
UR15270	UROLOGY - PATHOLOGY - PROSTATE	**TURP TUMOUR PERCENTAGE**	max n3	R

**Format an1 used to align with Data Dictionary rules.*

Applies to the next three data items:

The Gleason Grading System is used to help evaluate the prognosis of men with prostate cancer.

A pathologist assigns a Gleason grade to the most common tumour pattern in a biopsy specimen (Primary Grade) then the second most common (Secondary Grade). The grades are added together to give the Gleason Score. Sometimes pathologists will also give a grade to a third component of the specimen (Tertiary Grade) although this recorded separately and is not added to the score.

GLEASON GRADE (PRIMARY): What is the most extensive Gleason grade?

1 - 5	Range 1-5

GLEASON GRADE (SECONDARY): If additional grades are present, what is the highest grade (biopsy) or the second most extensive grade (TURP and radicals)? If no additional grades are present, primary and secondary grades are the same.

1 - 5	Range 1-5

GLEASON GRADE (TERTIARY): Is there a different third grade in addition the primary and secondary grades and what is its value? Note that this is only applicable to about 5% of prostate cases. ***It is important to note that the Tertiary Grade is not the added value of the Primary and Secondary Gleason***.

1 - 5	Range 1 – 5
8	Not applicable

PERINEURAL INVASION: Is there perineural invasion (invasion into perineurium of nerve bundles- PNI).

Y	Yes
N	No
X	Cannot be assessed
9	Not known

ORGAN CONFINED: If prostatectomy was performed, is the tumour confined to the prostate?

Y	Yes
N	No
X	Not applicable

SEMINAL VESICLES INVASION: If prostatectomy was performed, is there invasion into Seminal Vesicles?

Y	Yes
N	No
X	Not applicable

TURP TUMOUR PERCENTAGE: For TURP only, what percentage of tumour if clinically unsuspected tumour. Range 0 - 100.

13.5 UROLOGY - PATHOLOGY - TESTICULAR

This section will be recorded once per pathology report where applicable.

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
UR15310	UROLOGY - PATHOLOGY - TESTICULAR	**RETE TESTES INVASION** *[TUMOUR INVASION INDICATOR (RETE TESTIS)]*	an1	R

RETE TESTES INVASION: For Seminoma only, does the tumour invade the rete testis?

Y	Yes
N	No
X	Not applicable

Appendix A – SNOMED Codes for Primary Diagnoses

The following guide shows all the registerable diseases by SNOMED code.
Further guidance is available from your local National Cancer Registration and Analysis Service office.

All conditions represented by all versions of SNOMED morphology codes (prior to CT) beginning M8 and M9 are registerable if the last digit of the code is in the range 1-9.

BENIGN CANCERS

Codes ending in a zero (0=benign) are ***not*** registerable unless the corresponding SNOMED topography code is shown in table A1:

Tumour Site	SNOMED2 Topography code (First 3/4 digits)	SNOMED International Topography code (First 3/4 digits)
Pituitary Gland	T91	TB1
Pineal Body	T92	TB2
Brain and Central Nervous System	TX excluding TX05-TX07	TA0-TA8 excluding TA05-TA07

Table A1

NON M8/M9 MORPHOLOGIES

The following codes not beginning with M8 or M9 **are registerable and should also be sent**:

SNOMED Morphology code	Tumour Site	SNOMED2 Topography code	SNOMED International Topography Code
M49000	Bone Marrow	T06	TC1
M74008	All Sites excluding skin		
M74009	All Sites excluding skin		

Table A2

SNOMED CT

Versions of SNOMED prior to SNOMED CT ceased to be licenced by The International Health Terminology Standards Development Organisation (IHTSDO) after April 2017, other than for historical content.

All Trusts are therefore advised to report all SNOMED Topography and Histology from April 2017 in CT only

Unfortunately, there is no simple rule (like M8* etc) to identify registerable diseases using SNOMED CT codes. The codes used must therefore be compared to explicit lists of registerable codes.

The explicit lists are available as subset for SNOMED CT via TRUD (registration is required):
https://isd.digital.nhs.uk/trud3/user/authenticated/group/0/pack/40/subpack/469/releases

The lists of registerable code are updated when SNOMED CT is updated (usually every 6 months).

The subset contains 6 clusters:

CLUSTER 1A Malignant diagnosis
CLUSTER 1B In situ diagnosis
CLUSTER 1C Uncertain diagnosis
CLUSTER 1D CNS neoplasms diagnosis
CLUSTER 2 Benign neoplasms diagnosis
CLUSTER 3 Anatomic structures of the Central Nervous system diagnosis

Trusts should submit cases to NCRAS if the pathology report has been coded with a SNOMED CT conceptid from CLUSTER 1A, 1B, 1C or 1D. CLUSTER 1A, 1B and 1C code all malignant, in situ and uncertain behaviour tumours. Cluster 1D captures all CNS neoplasms where there is enough information in a single code to know it should be registered e.g. Benign neoplasm of cerebrum (disorder).

Trusts should also submit a case to NCRAS if the pathology report has been coded with SNOMED CT conceptids from both CLUSTER 2 and CLUSTER 3. CLUSTER 2 is benign neoplasms and CLUSTER 3 is CNS structures - NCRAS only requires benign tumours to be sent if they are associated with the CNS.

Appendix B – Cancer Waiting Times ICD10 Codes and Tumour Groups for Primary Diagnoses

(Applicable from April 2012) *These are registerable conditions for the purposes of Cancer Waiting Times and used within Cancer Registration ie NCRAS mandatory fields*

Notes:

- ***The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.***
- ***This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.***
- ***Further guidance is available from your local cancer registration service office.***

Key:
() = if applicable
* = different dataset from CWT group specified

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0	External upper lip	Head and Neck		●		
C00.1	External lower lip	Head and Neck		●		
C00.2	External lip, unspecified	Head and Neck		●		
C00.3	Upper lip, inner aspect	Head and Neck	●			
C00.4	Lower lip, inner aspect	Head and Neck	●			
C00.5	Lip, unspecified, inner aspect	Head and Neck	●			
C00.6	Commissure of lip	Head and Neck	●			
C00.8	Overlapping lesion of lip	Head and Neck	●			
C00.9	Lip, unspecified	Head and Neck	●			
C01	Malignant neoplasm of base of tongue	Head and Neck	●			
C02.0	Dorsal surface of tongue	Head and Neck	●			
C02.1	Border of tongue	Head and Neck	●			
C02.2	Ventral surface of tongue	Head and Neck	●			
C02.3	Anterior two-thirds of tongue, part unspecified	Head and Neck	●			
C02.4	Lingual tonsil	Head and Neck	●			
C02.8	Overlapping lesion of tongue	Head and Neck	●			
C02.9	Tongue, unspecified	Head and Neck	●			
C03.0	Upper gum	Head and Neck	●			
C03.1	Lower gum	Head and Neck	●			
C03.9	Gum, unspecified	Head and Neck	●			
C04.0	Anterior floor of mouth	Head and Neck	●			
C04.1	Lateral floor of mouth	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C04.8	Overlapping lesion of floor of mouth	Head and Neck	●			
C04.9	Floor of mouth, unspecified	Head and Neck	●			
C05.0	Hard palate	Head and Neck	●			
C05.1	Soft palate	Head and Neck	●			
C05.2	Uvula	Head and Neck	●			
C05.8	Overlapping lesion of palate	Head and Neck	●			
C05.9	Palate, unspecified	Head and Neck	●			
C06.0	Cheek mucosa	Head and Neck	●			
C06.1	Vestibule of mouth	Head and Neck	●			
C06.2	Retromolar area	Head and Neck	●			
C06.8	Overlapping lesion of other and unspecified parts of mouth	Head and Neck	●			
C06.9	Mouth, unspecified	Head and Neck	●			
C07	Malignant neoplasm of parotid gland	Head and Neck	●			
C08.0	Submandibular gland	Head and Neck	●			
C08.1	Sublingual gland	Head and Neck	●			
C08.8	Overlapping lesion of major salivary glands	Head and Neck	●			
C08.9	Major salivary gland, unspecified	Head and Neck	●			
C09.0	Tonsillar fossa	Head and Neck	●			
C09.1	Tonsillar pillar (anterior) (posterior)	Head and Neck	●			
C09.8	Overlapping lesion of tonsil	Head and Neck	●			
C09.9	Tonsil, unspecified	Head and Neck	●			
C10.0	Vallecula	Head and Neck	●			
C10.1	Anterior surface of epiglottis	Head and Neck	●			
C10.2	Lateral wall of oropharynx	Head and Neck	●			
C10.3	Posterior wall of oropharynx	Head and Neck	●			
C10.4	Branchial cleft	Head and Neck	●			
C10.8	Overlapping lesion of oropharynx	Head and Neck	●			
C10.9	Oropharynx, unspecified	Head and Neck	●			
C11.0	Superior wall of nasopharynx	Head and Neck	●			
C11.1	Posterior wall of nasopharynx	Head and Neck	●			
C11.2	Lateral wall of nasopharynx	Head and Neck	●			
C11.3	Anterior wall of nasopharynx	Head and Neck	●			
C11.8	Overlapping lesion of nasopharynx	Head and Neck	●			
C11.9	Nasopharynx, unspecified	Head and Neck	●			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	●			
C13.0	Postcricoid region	Head and Neck	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C13.1	Aryepiglottic fold, hypopharyngeal aspect	Head and Neck	•			
C13.2	Posterior wall of hypopharynx	Head and Neck	•			
C13.8	Overlapping lesion of hypopharynx	Head and Neck	•			
C13.9	Hypopharynx, unspecified	Head and Neck	•			
C14.0	Pharynx, unspecified	Head and Neck	•			
C14.2	Waldeyer's ring	Head and Neck	•			
C14.8	Overlapping lesion of lip, oral cavity and pharynx	Head and Neck	•			
C15.0	*Cervical part of oesophagus*	*Upper Gastrointestinal*	*			*Usually treated by Head & Neck MDT.*
C15.1	Thoracic part of oesophagus	Upper Gastrointestinal	•			
C15.2	Abdominal part of oesophagus	Upper Gastrointestinal	•			
C15.3	Upper third of oesophagus	Upper Gastrointestinal	•			
C15.4	Middle third of oesophagus	Upper Gastrointestinal	•			
C15.5	Lower third of oesophagus	Upper Gastrointestinal	•			
C15.8	Overlapping lesion of oesophagus	Upper Gastrointestinal	•			
C15.9	Oesophagus, unspecified	Upper Gastrointestinal	•			
C16.0	Cardia	Upper Gastrointestinal	•			
C16.1	Fundus of stomach	Upper Gastrointestinal	•			
C16.2	Body of stomach	Upper Gastrointestinal	•			
C16.3	Pyloric antrum	Upper Gastrointestinal	•			
C16.4	Pylorus	Upper Gastrointestinal	•			
C16.5	Lesser curvature of stomach, unspecified	Upper Gastrointestinal	•			
C16.6	Greater curvature of stomach, unspecified	Upper Gastrointestinal	•			
C16.8	Overlapping lesion of stomach	Upper Gastrointestinal	•			
C16.9	Stomach, unspecified	Upper Gastrointestinal	•			
C17.0	*Duodenum*	*Colorectal*		•		*Usually treated by Upper GI MDT*
C17.1	*Jejunum*	*Colorectal*		•		*Usually treated by Upper GI MDT*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C17.2	*Ileum*	*Colorectal*		•		*Usually treated by Upper GI MDT*
C17.3	*Meckel's diverticulum*	*Colorectal*		•		*Usually treated by Upper GI MDT*
C17.8	*Overlapping lesion of small intestine*	*Colorectal*		•		*Usually treated by Upper GI MDT*
C17.9	*Small intestine, unspecified*	*Colorectal*		•		*Usually treated by Upper GI MDT*
C18.0	Caecum	Colorectal	•			
C18.1	Appendix	Colorectal		•		
C18.2	Ascending colon	Colorectal	•			
C18.3	Hepatic flexure	Colorectal	•			
C18.4	Transverse colon	Colorectal	•			
C18.5	Splenic flexure	Colorectal	•			
C18.6	Descending colon	Colorectal	•			
C18.7	Sigmoid colon	Colorectal	•			
C18.8	Overlapping lesion of colon	Colorectal	•			
C18.9	Colon, unspecified	Colorectal	•			
C19	Malignant neoplasm of rectosigmoid junction	Colorectal	•			
C20	Malignant neoplasm of rectum	Colorectal	•			
C21.0	Anus, unspecified	Colorectal		•		
C21.1	Anal canal	Colorectal		•		
C21.2	Cloacogenic zone	Colorectal		•		
C21.8	Overlapping lesion of rectum, anus and anal canal	Colorectal		•		
C22.0	Liver cell carcinoma	Upper Gastrointestinal	•			Liver cell carcinoma is also known as HCC.
C22.1	Intrahepatic bile duct carcinoma	Upper Gastrointestinal	•			
C22.2	Hepatoblastoma	Upper Gastrointestinal	•			
C22.3	Angiosarcoma of liver	Upper Gastrointestinal	•			
C22.4	Other sarcomas of liver	Upper Gastrointestinal	•			
C22.7	Other specified carcinomas of liver	Upper Gastrointestinal	•			
C22.9	Liver, unspecified	Upper Gastrointestinal	•			
C23	Malignant neoplasm of gallbladder	Upper Gastrointestinal	•			
C24.0	Extrahepatic bile duct	Upper Gastrointestinal	•			
C24.1	Ampulla of Vater	Upper Gastrointestinal	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	•			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	•			
C25.0	Head of pancreas	Upper Gastrointestinal	•			
C25.1	Body of pancreas	Upper Gastrointestinal	•			
C25.2	Tail of pancreas	Upper Gastrointestinal	•			
C25.3	Pancreatic duct	Upper Gastrointestinal	•			
C25.4	Endocrine pancreas	Upper Gastrointestinal	•			
C25.7	Other parts of pancreas	Upper Gastrointestinal	•			
C25.8	Overlapping lesion of pancreas	Upper Gastrointestinal	•			
C25.9	Pancreas, unspecified	Upper Gastrointestinal	•			
C26.0	Intestinal tract, part unspecified	Colorectal	•			
C26.1	Spleen	Colorectal		•		
C26.8	Overlapping lesion of digestive system	Colorectal		•		
C26.9	Ill-defined sites within the digestive system	Colorectal		•		
C30.0	Nasal cavity	Head and Neck	•			
C30.1	Middle ear	Head and Neck	•			
C31.0	Maxillary sinus	Head and Neck	•			
C31.1	Ethmoidal sinus	Head and Neck	•			
C31.2	Frontal sinus	Head and Neck	•			
C31.3	Sphenoidal sinus	Head and Neck	•			
C31.8	Overlapping lesion of accessory sinuses	Head and Neck	•			
C31.9	Accessory sinus, unspecified	Head and Neck	•			
C32.0	Glottis	Head and Neck	•			
C32.1	Supraglottis	Head and Neck	•			
C32.2	Subglottis	Head and Neck	•			
C32.3	Laryngeal cartilage	Head and Neck	•			
C32.8	Overlapping lesion of larynx	Head and Neck	•			
C32.9	Larynx, unspecified	Head and Neck	•			
C33	Malignant neoplasm of trachea	Lung	•			
C34.0	Main bronchus	Lung	•			
C34.1	Upper lobe, bronchus or lung	Lung	•			
C34.2	Middle lobe, bronchus or lung	Lung	•			
C34.3	Lower lobe, bronchus or lung	Lung	•			
C34.8	Overlapping lesion of bronchus and lung	Lung	•			
C34.9	Bronchus or lung, unspecified	Lung	•			
C37	Malignant neoplasm of thymus	Lung	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C38.0	Heart	Lung		●		
C38.1	Anterior mediastinum	Lung		●		
C38.2	Posterior mediastinum	Lung		●		
C38.3	Mediastinum, part unspecified	Lung		●		
C38.4	Pleura	Lung		●		
C38.8	Overlapping lesion of heart, mediastinum and pleura	Lung		●		
C39.0	Upper respiratory tract, part unspecified	Lung		●		
C39.8	Overlapping lesion of respiratory and intrathoracic organs	Lung		●		
C39.9	Ill-defined sites within the respiratory system	Lung		●		
C40.0	Scapula and long bones of upper limb	Sarcoma	●			
C40.1	Short bones of upper limb	Sarcoma	●			
C40.2	Long bones of lower limb	Sarcoma	●			
C40.3	Short bones of lower limb	Sarcoma	●			
C40.8	Overlapping lesion of bone and articular cartilage of limbs	Sarcoma	●			
C40.9	Bone and articular cartilage of limb, unspecified	Sarcoma	●			
C41.0	Bones of skull and face	Sarcoma	●			
C41.1	Mandible	Sarcoma	●			
C41.2	Vertebral column	Sarcoma	●			
C41.3	Ribs, sternum and clavicle	Sarcoma	●			
C41.4	Pelvic bones, sacrum and coccyx	Sarcoma	●			
C41.8	Overlapping lesion of bone and articular cartilage	Sarcoma	●			
C41.9	Bone and articular cartilage, unspecified	Sarcoma	●			
C43.0	Malignant melanoma of lip	Skin	●			
C43.1	Malignant melanoma of eyelid, including canthus	Skin	●			
C43.2	Malignant melanoma of ear and external auricular canal	Skin	●			
C43.3	Malignant melanoma of other and unspecified parts of face	Skin	●			
C43.4	Malignant melanoma of scalp and neck	Skin	●			
C43.5	Malignant melanoma of trunk	Skin	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	●			
C43.7	Malignant melanoma of lower limb, including hip	Skin	●			
C43.8	Overlapping malignant melanoma of skin	Skin	●			
C43.9	Malignant melanoma of skin, unspecified	Skin	●			
C44.0	Skin of lip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.1	Skin of eyelid, including canthus	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.2	Skin of ear and external auricular canal	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.3	Skin of other and unspecified parts of face	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.4	Skin of scalp and neck	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.5	Skin of trunk	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.6	Skin of upper limb, including shoulder	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.7	Skin of lower limb, including hip	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C44.8	Overlapping lesion of skin	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C44.9	Malignant neoplasm of skin, unspecified	Skin	(●)	(●)	(●)	See the Skin chapter of the COSD User Guide (Overview Section) for further information on the collection of this Skin disease.
C45.0	Mesothelioma of pleura	Lung		●		
C45.1	Mesothelioma of peritoneum	Lung		●		
C45.2	Mesothelioma of pericardium	Lung		●		
C45.7	Mesothelioma of other sites	Lung		●		
C45.9	Mesothelioma, unspecified	Lung		●		
C46.0	Kaposi sarcoma of skin	Sarcoma		●		
C46.1	Kaposi sarcoma of soft tissue	Sarcoma		●		
C46.2	Kaposi sarcoma of palate	Sarcoma		●		
C46.3	Kaposi sarcoma of lymph nodes	Sarcoma		●		
C46.7	Kaposi sarcoma of other sites	Sarcoma		●		
C46.8	Kaposi sarcoma of multiple organs	Sarcoma		●		
C46.9	Kaposi sarcoma, unspecified	Sarcoma		●		
C47.0	*Peripheral nerves of head, face and neck*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.1	*Peripheral nerves of upper limb, including shoulder*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.2	*Peripheral nerves of lower limb, including hip*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.3	*Peripheral nerves of thorax*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.4	*Peripheral nerves of abdomen*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*
C47.5	*Peripheral nerves of pelvis*	*Brain/Central Nervous System*		●		*Usually treated by Sarcoma MDT.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C47.6	*Peripheral nerves of trunk, unspecified*	*Brain/Central Nervous System*		•		*Usually treated by Sarcoma MDT.*
C47.8	*Overlapping lesion of peripheral nerves and autonomic nervous system*	*Brain/Central Nervous System*		•		*Usually treated by Sarcoma MDT.*
C47.9	*Peripheral nerves and autonomic nervous system, unspecified*	*Brain/Central Nervous System*		•		*Usually treated by Sarcoma MDT.*
C48.0	*Retroperitoneum*	*Sarcoma*	•			*Usually treated by Sarcoma MDT.*
C48.1	*Specified parts of peritoneum*	*Sarcoma*	• *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.2	*Peritoneum, unspecified*	*Sarcoma*	• *			** Sarcoma and Gynaecology Datasets to be collected where applicable.*
C48.8	Overlapping lesion of retroperitoneum and peritoneum	Sarcoma	•			
C49.0	Connective and soft tissue of head, face and neck	Sarcoma	•			
C49.1	Connective and soft tissue of upper limb, including shoulder	Sarcoma	•			
C49.2	Connective and soft tissue of lower limb, including hip	Sarcoma	•			
C49.3	Connective and soft tissue of thorax	Sarcoma	•			
C49.4	Connective and soft tissue of abdomen	Sarcoma	•			
C49.5	Connective and soft tissue of pelvis	Sarcoma	•			
C49.6	Connective and soft tissue of trunk, unspecified	Sarcoma	•			
C49.8	Overlapping lesion of connective and soft tissue	Sarcoma	•			
C49.9	Connective and soft tissue, unspecified	Sarcoma	•			
C50.0	Nipple and areola	Breast	•			
C50.1	Central portion of breast	Breast	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C50.2	Upper-inner quadrant of breast	Breast	●			
C50.3	Lower-inner quadrant of breast	Breast	●			
C50.4	Upper-outer quadrant of breast	Breast	●			
C50.5	Lower-outer quadrant of breast	Breast	●			
C50.6	Axillary tail of breast	Breast	●			
C50.8	Overlapping lesion of breast	Breast	●			
C50.9	Breast, unspecified	Breast	●			
C51.0	*Labium majus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.1	*Labium minus*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.2	*Clitoris*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* *Gynaecology and Skin Datasets to be collected where applicable.*
C52	Malignant neoplasm of vagina	Gynaecological	●			
C53.0	Endocervix	Gynaecological	●			
C53.1	Exocervix	Gynaecological	●			
C53.8	Overlapping lesion of cervix uteri	Gynaecological	●			
C53.9	Cervix uteri, unspecified	Gynaecological	●			
C54.0	Isthmus uteri	Gynaecological	●			
C54.1	Endometrium	Gynaecological	●			
C54.2	Myometrium	Gynaecological	●			
C54.3	Fundus uteri	Gynaecological	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C54.8	Overlapping lesion of corpus uteri	Gynaecological	●			
C54.9	Corpus uteri, unspecified	Gynaecological	●			
C55	Malignant neoplasm of uterus, part unspecified	Gynaecological	●			
C56	Malignant neoplasm of ovary	Gynaecological	●			
C57.0	Fallopian tube	Gynaecological	●			
C57.1	Broad ligament	Gynaecological	●			
C57.2	Round ligament	Gynaecological	●			
C57.3	Parametrium	Gynaecological	●			
C57.4	Uterine adnexa, unspecified	Gynaecological	●			
C57.7	Other specified female genital organs	Gynaecological	●			
C57.8	Overlapping lesion of female genital organs	Gynaecological	●			
C57.9	Female genital organ, unspecified	Gynaecological	●			
C58	Malignant neoplasm of placenta	Gynaecological	●			
C60.0	*Prepuce*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.1	*Glans penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.2	*Body of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.8	*Overlapping lesion of penis*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C60.9	*Penis, unspecified*	*Urological*	● *			** Urology and Skin Datasets to be collected where applicable.*
C61	Malignant neoplasm of prostate	Urological	●			
C62.0	Undescended testis	Urological	●			
C62.1	Descended testis	Urological	●			
C62.9	Testis, unspecified	Urological	●			
C63.0	Epididymis	Urological	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C63.1	Spermatic cord	Urological	●			
C63.2	Scrotum	Urological		●		
C63.7	Other specified male genital organs	Urological	●			
C63.8	Overlapping lesion of male genital organs	Urological	●			
C63.9	Male genital organ, unspecified	Urological	●			
C64	Malignant neoplasm of kidney, except renal pelvis	Urological	●			
C65	Malignant neoplasm of renal pelvis	Urological	●			
C66	Malignant neoplasm of ureter	Urological	●			
C67.0	Trigone of bladder	Urological	●			
C67.1	Dome of bladder	Urological	●			
C67.2	Lateral wall of bladder	Urological	●			
C67.3	Anterior wall of bladder	Urological	●			
C67.4	Posterior wall of bladder	Urological	●			
C67.5	Bladder neck	Urological	●			
C67.6	Ureteric orifice	Urological	●			
C67.7	Urachus	Urological	●			
C67.8	Overlapping lesion of bladder	Urological	●			
C67.9	Bladder, unspecified	Urological	●			
C68.0	Urethra	Urological	●			
C68.1	Paraurethral glands	Urological	●			
C68.8	Overlapping lesion of urinary organs	Urological	●			
C68.9	Urinary organ, unspecified	Urological	●			
C69.0	*Conjunctiva*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.1	*Cornea*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.2	*Retina*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.3	*Choroid*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.4	*Ciliary body*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.5	*Lachrymal gland and duct*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT.*
C69.6	*Orbit*	*Brain/Central Nervous System*		●		*Not normally treated by CNS MDT. Maybe treated by Sarcoma MDT.*

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C69.8	*Overlapping lesion of eye and adnexa*	*Brain/Central Nervous System*		•		*Not normally treated by CNS MDT.*
C69.9	*Eye, unspecified*	*Brain/Central Nervous System*		•		*Not normally treated by CNS MDT.*
C70.0	Cerebral meninges	Brain/Central Nervous System	•			
C70.1	Spinal meninges	Brain/Central Nervous System	•			
C70.9	Meninges, unspecified	Brain/Central Nervous System	•			
C71.0	Cerebrum, except lobes and ventricles	Brain/Central Nervous System	•			
C71.1	Frontal lobe	Brain/Central Nervous System	•			
C71.2	Temporal lobe	Brain/Central Nervous System	•			
C71.3	Parietal lobe	Brain/Central Nervous System	•			
C71.4	Occipital lobe	Brain/Central Nervous System	•			
C71.5	Cerebral ventricle	Brain/Central Nervous System	•			
C71.6	Cerebellum	Brain/Central Nervous System	(•) (*)			CTYA dataset collected for Medulloblastoma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	•			
C71.8	Overlapping lesion of brain	Brain/Central Nervous System	•			
C71.9	Brain, unspecified	Brain/Central Nervous System	•			
C72.0	Spinal cord	Brain/Central Nervous System	•			
C72.1	Cauda equina	Brain/Central Nervous System	•			
C72.2	Olfactory nerve	Brain/Central Nervous System	•			
C72.3	Optic nerve	Brain/Central Nervous System	•			
C72.4	Acoustic nerve	Brain/Central Nervous System	•			
C72.5	Other and unspecified cranial nerves	Brain/Central Nervous System	•			
C72.8	Overlapping lesion of brain and other parts of central nervous system	Brain/Central Nervous System	•			
C72.9	Central nervous system, unspecified	Brain/Central Nervous System	•			
C73	Malignant neoplasm of thyroid gland	Head and Neck		•		
C74.0	Cortex of adrenal gland	Other		•		
C74.1	Medulla of adrenal gland	Other		•		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C74.9	Adrenal gland, unspecified	Other		•		
C75.0	Parathyroid gland	Other		•		
C75.1	*Pituitary gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.2	*Craniopharyngeal duct*	*Other*	*			*Usually treated by CNS MDT.*
C75.3	*Pineal gland*	*Other*	*			*Usually treated by CNS MDT.*
C75.4	Carotid body	Other		•		
C75.5	Aortic body and other paraganglia	Other		•		
C75.8	Pluriglandular involvement, unspecified	Other		•		
C75.9	Endocrine gland, unspecified	Other		•		
C76.0	Head, face and neck	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.1	Thorax	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.2	Abdomen	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.3	Pelvis	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.4	Upper limb	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.5	Lower limb	Other		•		Other and ill defined - use only if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C76.7	Other ill-defined sites	Other		•		Other and ill defined - use only if unable to code to specific primary site
C76.8	Overlapping lesion of other and ill-defined sites	Other		•		Other and ill defined - use only if unable to code to specific primary site
C77.0	Lymph nodes of head, face and neck	Head and Neck	•			Secondary - only use if unable to code to specific primary site
C77.1	Intrathoracic lymph nodes	Other		•		Secondary - only use if unable to code to specific primary site
C77.2	Intra-abdominal lymph nodes	Other		•		Secondary - only use if unable to code to specific primary site
C77.3	Axillary and upper limb lymph nodes	Other		•		Secondary - only use if unable to code to specific primary site
C77.4	Inguinal and lower limb lymph nodes	Other		•		Secondary - only use if unable to code to specific primary site
C77.5	Intrapelvic lymph nodes	Other		•		Secondary - only use if unable to code to specific primary site
C77.8	Lymph nodes of multiple regions	Other		•		Secondary - only use if unable to code to specific primary site
C77.9	Lymph node, unspecified	Other		•		Secondary - only use if unable to code to specific primary site

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C78.0	Secondary malignant neoplasm of lung	Lung		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.1	Secondary malignant neoplasm of mediastinum	Lung		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.2	Secondary malignant neoplasm of pleura	Lung		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.3	Secondary malignant neoplasm of other and unspecified respiratory organs	Lung		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.4	Secondary malignant neoplasm of small intestine	Colorectal		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.5	Secondary malignant neoplasm of large intestine and rectum	Colorectal		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum	Sarcoma		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct	Upper Gastrointestinal		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C78.8	Secondary malignant neoplasm of other and unspecified digestive organs	Colorectal		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.0	Secondary malignant neoplasm of kidney and renal pelvis	Urological		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.1	Secondary malignant neoplasm of bladder and other and unspecified urinary organs	Urological		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.2	Secondary malignant neoplasm of skin	Skin		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.3	Secondary malignant neoplasm of brain and cerebral meninges	Brain/Central Nervous System		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.4	Secondary malignant neoplasm of other and unspecified parts of nervous system	Brain/Central Nervous System		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.5	Secondary malignant neoplasm of bone and bone marrow	Sarcoma		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.6	Secondary malignant neoplasm of ovary	Gynaecological		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.7	Secondary malignant neoplasm of adrenal gland	Other		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C79.8	Secondary malignant neoplasm of other specified sites	Other		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C79.9	Secondary malignant neoplasm, unspecified site	Other		•		Normally treated by MDT of site of primary tumour. Only use if unable to code to specific primary site.
C80.0	Malignant neoplasm, primary site unknown, so stated	Other		•		Only use if unable to code to specific primary site.
C80.9	Malignant neoplasm, unspecified	Other		•		Only use if unable to code to specific primary site.
C81.0	Nodular lymphocyte predominant Hodgkin lymphoma	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			
C81.1	Nodular sclerosis classical Hodgkin lymphoma	Haematological				
C81.2	Mixed cellularity classical Hodgkin lymphoma	Haematological				
C81.3	Lymphocytic depleted classical Hodgkin lymphoma	Haematological				
C81.4	Lymphocyte-rich classical Hodgkin lymphoma	Haematological				
C81.7	Other classical Hodgkin lymphoma	Haematological				
C81.9	Hodgkin lymphoma, unspecified	Haematological				
C82.0	Follicular lymphoma grade i	Haematological				
C82.1	Follicular lymphoma grade ii	Haematological				
C82.2	Follicular lymphoma grade iii, unspecified	Haematological				
C82.3	Follicular lymphoma grade iiia	Haematological				
C82.4	Follicular lymphoma grade iiib	Haematological				
C82.5	Diffuse follicle centre lymphoma	Haematological				
C82.6	Cutaneous follicle centre lymphoma	Haematological				
C82.7	Other types of follicular lymphoma	Haematological				
C82.9	Follicular lymphoma, unspecified	Haematological				
C83.0	Small cell B-cell lymphoma	Haematological				
C83.1	Mantle cell lymphoma	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C83.3	Diffuse large B-cell lymphoma	Haematological				
C83.5	Lymphoblastic (diffuse) lymphoma	Haematological				
C83.7	Burkitt lymphoma	Haematological				
C83.8	Other non-follicular lymphoma	Haematological				
C83.9	Non-follicular (diffuse) lymphoma, unspecified	Haematological				
C84.0	Mycosis fungoides	Haematological				
C84.1	Sézery disease	Haematological				
C84.4	Peripheral T-cell lymphoma, not elsewhere classified	Haematological				
C84.5	Other mature T/NK-cell lymphomas	Haematological				
C84.6	Anaplastic large cell lymphoma, ALK-positive	Haematological				
C84.7	Anaplastic large cell lymphoma, ALK-negative	Haematological				
C84.8	Cutaneous T-cell lymphoma, unspecified	Haematological				
C84.9	Mature T/NK-cell lymphoma, unspecified	Haematological				
C85.1	B-cell lymphoma, unspecified	Haematological				
C85.2	Mediastinal (thymic) large B-cell lymphoma	Haematological				
C85.7	Other specified types of non-Hodgkin lymphoma	Haematological				
C85.9	Non-Hodgkin lymphoma, unspecified	Haematological				
C86.0	Extranodal NK/T-cell lymphoma, nasal type	Haematological				
C86.1	Hepatosplenic T-cell lymphoma	Haematological				
C86.2	Enteropathy-type (intestinal) T-cell lymphoma	Haematological				
C86.3	Subcutaneous panniculitis-like T-cell lymphoma	Haematological				
C86.4	Blastic N/K-cell lymphoma	Haematological				
C86.5	Angioimmunoblastic T-cell lymphoma	Haematological				
C86.6	Primary cutaneous CD30-positive T-cell proliferations	Haematological				
C88.0	Waldenström macroglobulinaemia	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C88.2	Other heavy chain disease	Haematological				
C88.3	Immunoproliferative small intestinal disease	Haematological				
C88.4	Extranodal marginal zone B-cell lymphoma of mucosa associated lymphoid tissue (MALT-lymphoma)	Haematological				
C88.7	Other malignant immunoproliferative diseases	Haematological				
C88.9	Malignant immunoproliferative disease, unspecified	Haematological				
C90.0	Multiple myeloma	Haematological				
C90.1	Plasma cell leukaemia	Haematological				
C90.2	Extramedullary plasmacytoma	Haematological				
C90.3	Solitary plasmacytoma	Haematological				
C91.0	Acute lymphoblastic leukaemia [ALL]	Haematological				
C91.1	Chronic lymphocytic leukaemia of B-cell type	Haematological				
C91.3	Prolymphocytic leukaemia of B-cell type	Haematological				
C91.4	Hairy-cell leukaemia	Haematological				
C91.5	Adult T-cell lymphoma/leukaemia (HTLV-1-associated)	Haematological				
C91.6	Prolymphocytic leukaemia of T-cell type	Haematological				
C91.7	Other lymphoid leukaemia	Haematological				
C91.8	Mature B-cell leukaemia Burkitt-type	Haematological				
C91.9	Lymphoid leukaemia, unspecified	Haematological				
C92.0	Acute myeloid leukaemia [AML]	Haematological				
C92.1	Chronic myeloid leukaemia [CML], BCR/ABL-positive	Haematological				
C92.2	Atypical chronic myeloid leukaemia, BCR/ABL-negative	Haematological				
C92.3	Myeloid sarcoma	Haematological				
C92.4	Acute promyelocytic leukaemia [PML]	Haematological				
C92.5	Acute myelomonocytic leukaemia	Haematological				
C92.6	Acute myeloid leukaemia with 11q23-abnormality	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C92.7	Other myeloid leukaemia	Haematological				
C92.8	Acute myeloid leukaemia with multilineage dysplasia	Haematological				
C92.9	Myeloid leukaemia, unspecified	Haematological				
C93.0	Acute monoblastic/monocytic leukaemia	Haematological				
C93.1	Chronic myelomonocytic leukaemia	Haematological				
C93.3	Juvenile myelomonocytic leukaemia	Haematological				
C93.7	Other monocytic leukaemia	Haematological				
C93.9	Monocytic leukaemia, unspecified	Haematological				
C94.0	Acute erythroid leukaemia	Haematological				
C94.2	Acute megakaryoblastic leukaemia	Haematological				
C94.3	Mast cell leukaemia	Haematological				
C94.4	Acute panmyelosis with myelofibrosis	Haematological				
C94.6	Myelodysplastic and myeloproliferative disease, not elsewhere classified	Haematological				
C94.7	Other specified leukaemias	Haematological				
C95.0	Acute leukaemia of unspecified cell type	Haematological				
C95.1	Chronic leukaemia of unspecified cell type	Haematological				
C95.7	Other leukaemia of unspecified cell type	Haematological				
C95.9	Leukaemia, unspecified	Haematological				
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis [Letterer-Siwe disease]	Haematological				
C96.2	Malignant mast cell tumour	Haematological				
C96.4	Sarcoma of dendritic cells (accessory cells)	Haematological				
C96.5	Multifocal and unisystemic (disseminated) Langerhans-cell histiocytosis	Haematological				
C96.6	Unifocal Langerhans-cell histiocytosis	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C96.7	Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue	Haematological				
C96.8	Histiocytic sarcoma	Haematological				
C96.9	Malignant neoplasms of lymphoid, haematopoietic and related tissue, unspecified	Haematological				
C97	Malignant neoplasms of independent (primary) multiple sites	Other		•		
D05.0	Lobular carcinoma in situ	Breast	•			
D05.1	Intraductal carcinoma in situ	Breast	•			
D05.7	Other carcinoma in situ of breast	Breast	•			
D05.9	Carcinoma in situ of breast, unspecified	Breast	•			

Appendix C – Mandatory Registerable Conditions

MANDATORY REGISTERABLE CONDITIONS

Further details to be provided regarding applicable data fields for each disease. These are additional Cancer Registration ie NCRAS mandatory registerable conditions

Notes:

- ***The following table lists all the registerable diseases by ICD10 code, together with the expected dataset to be completed and the potential stage.***
- ***This table provides general guidelines only as not all permutations can be covered and there will always be exceptions. Local clinical input is essential to identify and complete the appropriate stage.***
- ***Further guidance is available from your local cancer registration service office.***

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
C00.0 – C97	Malignant neoplasms (See Appendix B for full list)					
D00.0	Carcinoma in situ of Lip, oral cavity and pharynx	Head and Neck			•	
D00.1	Carcinoma in situ of Oesophagus	Upper Gastrointestinal			•	
D00.2	Carcinoma in situ of Stomach	Upper Gastrointestinal			•	
D01.0	Carcinoma in situ of Colon	Colorectal			•	
D01.1	Carcinoma in situ of Rectosigmoid junction	Colorectal			•	
D01.2	Carcinoma in situ of Rectum	Colorectal			•	
D01.3	Carcinoma in situ of Anus and anal canal	Colorectal			•	
D01.4	Carcinoma in situ of Anus and anal canal	Colorectal			•	
D01.5	Carcinoma in situ of Liver, gallbladder and bile ducts	Upper Gastrointestinal			•	
D01.7	Other specified digestive organs	Colorectal			•	
D01.9	Carcinoma in situ of Digestive organ, unspecified	Colorectal			•	
D02.0	Carcinoma in situ of Larynx	Head and Neck			•	
D02.1	Carcinoma in situ of Trachea	Lung			•	
D02.2	Carcinoma in situ of Bronchus and lung	Lung			•	
D02.3	Carcinoma in situ of Other parts of respiratory system	Lung			•	
D02.4	Carcinoma in situ of Respiratory system, unspecified	Lung			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D03.0	Melanoma in situ of lip	Skin		•		
D03.1	Melanoma in situ of eyelid, including canthus	Skin		•		
D03.2	Melanoma in situ, of ear and external auricular canal	Skin		•		
D03.3	Melanoma in situ of other and unspecified parts of face	Skin		•		
D03.4	Melanoma in situ of scalp and neck	Skin		•		
D03.5	Melanoma in situ of trunk	Skin		•		
D03.6	Melanoma in situ of upper limb, including shoulder	Skin		•		
D03.7	Melanoma in situ of lower limb, including hip	Skin		•		
D03.8	Melanoma in situ of other sites	Other			•	
D03.9	Melanoma in situ, unspecified	Skin		•		
D05.0	Lobular carcinoma in situ	Breast	•			
D05.1	Intraductal carcinoma in situ	Breast	•			
D05.7	Other carcinoma in situ of breast	Breast	•			
D05.9	Carcinoma in situ of breast, unspecified	Breast	•			
D06.0	carcinoma in situ of endocervix	Gynaecological			•	
D06.1	carcinoma in situ of exocervix	Gynaecological			•	
D06.7	carcinoma in situ of other parts of cervix	Gynaecological			•	
D06.9	carcinoma in situ of cervix, unspecified	Gynaecological			•	
D07.0	carcinoma in situ of endometrium	Gynaecological			•	
D07.1	carcinoma in situ of vulva	Gynaecological			•	
D07.2	carcinoma in situ of vagina	Gynaecological			•	
D07.3	carcinoma in situ of other and unspecified female genital organs	Gynaecological			•	
D07.4	carcinoma in situ of penis	Urological			•	
D07.5	carcinoma in situ of prostate	Urological			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D07.6	carcinoma in situ of other and unspecified male genital organs	Urological			•	
D09.0	Carcinoma in situ of Bladder	Urological	•			
D09.1	carcinoma in situ of other and unspecified urinary organs	Urological			•	
D09.2	carcinoma in situ of eye	Other			•	
D09.3	carcinoma in situ of thyroid and other endocrine glands	Head and Neck			•	
D09.7	carcinoma in situ of other specified sites	Other			•	
D09.9	carcinoma in situ, unspecified	Other			•	
D32.0	benign neoplasm of cerebral meninges	Brain/Central Nervous System	•			
D32.1	benign neoplasm of spinal meninges	Brain/Central Nervous System	•			
D32.9	benign neoplasm of meninges, unspecified	Brain/Central Nervous System	•			
D33.0	Benign neoplasm of brain, supratentorial	Brain/Central Nervous System	•			
D33.1	Benign neoplasm of brain, infratentorial	Brain/Central Nervous System	•			
D33.2	Benign neoplasm of brain, unspecified	Brain/Central Nervous System	•			
D33.3	Benign neoplasm of cranial nerves	Brain/Central Nervous System	•			
D33.4	Benign neoplasm of spinal cord	Brain/Central Nervous System	•			
D33.7	Benign neoplasm of other specified parts of central nervous system	Brain/Central Nervous System	•			
D33.9	Benign neoplasm of central nervous system, unspecified	Brain/Central Nervous System	•			
D35.2	Benign neoplasm of Pituitary gland	Brain/Central Nervous System	•			
D35.3	*Benign neoplasm of Craniopharyngeal duct*	*Other*	•			*Usually classified as CNS*
D35.4	Benign neoplasm of Pineal gland	Brain/Central Nervous System	•			
D37.0	Neoplasm of uncertain or unknown behaviour of lip, oral cavity and pharynx	Head and Neck			•	
D37.1	Neoplasm of uncertain or unknown behaviour of Stomach	Upper Gastrointestinal			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D37.2	Neoplasm of uncertain or unknown behaviour of Small intestine	Upper Gastrointestinal			•	
D37.3	Neoplasm of uncertain or unknown behaviour of Appendix	Colorectal			•	
D37.4	Neoplasm of uncertain or unknown behaviour of Colon	Colorectal			•	
D37.5	Neoplasm of uncertain or unknown behaviour of Rectum	Colorectal			•	
D37.6	Liver, gallbladder and bile ducts	Upper Gastrointestinal			•	
D37.7	Other digestive organs	Colorectal/Upper Gastrointestinal			•	
D37.9	Digestive organ, unspecified	Colorectal/Upper Gastrointestinal			•	
D38.0	Neoplasm of uncertain or unknown behaviour of Larynx	Head and Neck			•	
D38.1	Neoplasm of uncertain or unknown behaviour of Trachea, bronchus and lung	Lung			•	
D38.2	Neoplasm of uncertain or unknown behaviour of Pleura	Lung			•	
D38.3	Neoplasm of uncertain or unknown behaviour of Mediastinum	Lung			•	
D38.4	Neoplasm of uncertain or unknown behaviour of Thymus	Lung			•	
D38.5	Neoplasm of uncertain or unknown behaviour of Other respiratory organs	Lung			•	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			•	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D39.1	Neoplasm of uncertain or unknown behaviour of Ovary	Gynaecological			•	
D39.2	Neoplasm of uncertain or unknown behaviour of Placenta	Gynaecological			•	
D39.7	Neoplasm of uncertain or unknown behaviour of Other female genital organs	Gynaecological			•	
D39.9	Neoplasm of uncertain or unknown behaviour of Female genital organ, unspecified	Gynaecological			•	
D40.0	Neoplasm of uncertain or unknown behaviour of prostate	Urological			•	
D40.1	Neoplasm of uncertain or unknown behaviour of testis	Urological			•	
D40.7	Neoplasm of uncertain or unknown behaviour of other male genital organs	Urological			•	
D40.9	Neoplasm of uncertain or unknown behaviour of male genital organs, unspecified	Urological			•	
D41.0	Neoplasm of uncertain or unknown behaviour of kidney	Urological			•	
D41.1	Neoplasm of uncertain or unknown behaviour of renal pelvis	Urological	•			
D41.2	Neoplasm of uncertain or unknown behaviour of ureter	Urological	•			
D41.3	Neoplasm of uncertain or unknown behaviour of urethra	Urological	•			
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D41.7	Neoplasm of uncertain or unknown behaviour of other urinary organs	Urological			•	
D41.9	Neoplasm of uncertain or unknown behaviour of urinary organs, unspecified	Urological			•	
D42.0	Neoplasm of uncertain or unknown behaviour of cerebral meninges	Brain/Central Nervous System	•			
D42.1	Neoplasm of uncertain or unknown behaviour of spinal meninges	Brain/Central Nervous System	•			
D42.9	Neoplasm of uncertain or unknown behaviour of meninges, unspecified	Brain/Central Nervous System	•			
D43.0	Neoplasm of uncertain or unknown behaviour of brain, supratentorial	Brain/Central Nervous System	•			
D43.1	Neoplasm of uncertain or unknown behaviour of brain, infratentorial	Brain/Central Nervous System	•			
D43.2	Neoplasm of uncertain or unknown behaviour of brain, unspecified	Brain/Central Nervous System	•			
D43.3	Neoplasm of uncertain or unknown behaviour of cranial nerves	Brain/Central Nervous System	•			
D43.4	Neoplasm of uncertain or unknown behaviour of spinal cord	Brain/Central Nervous System	•			
D43.7	Neoplasm of uncertain or unknown behaviour of other parts of central nervous system	Brain/Central Nervous System	•			
D43.9	Neoplasm of uncertain or unknown behaviour of central nervous system, unspecified	Brain/Central Nervous System	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D44.0	Neoplasm of uncertain or unknown behaviour of thyroid gland	Head and Neck			•	
D44.1	Neoplasm of uncertain or unknown behaviour of adrenal gland	Other			•	
D44.2	Neoplasm of uncertain or unknown behaviour of parathyroid gland	Other			•	
D44.3	Neoplasm of uncertain or unknown behaviour of pituitary gland	Brain/Central Nervous System	•			
D44.4	Neoplasm of uncertain or unknown behaviour of Craniopharyngeal duct	Brain/Central Nervous System	•			
D44 .5	Neoplasm of uncertain or unknown behaviour of pineal gland	Brain/Central Nervous System	•			
D44 .6	Neoplasm of uncertain or unknown behaviour of carotid body	Other			•	
D44 .7	Neoplasm of uncertain or unknown behaviour of aortic body and other paraganglia body	Other			•	
D44 .8	Neoplasm of uncertain or unknown behaviour of pluriglandular involvement	Other			•	
D44 .9	Neoplasm of uncertain or unknown behaviour of endocrine gland, unspecified	Other			•	
D45	Polycythaemia vera	Haematological	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			
D46.0	Refractory anaemia without ringed sideroblasts, so stated	Haematological				
D46.1	Refractory anaemia with ringed sideroblasts	Haematological				
D46.2	Refractory anaemia with excess of blasts	Haematological				
D46.4	Refractory anaemia, unspecified	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D46.5	Refractory anaemia with multi-lineage dysplasia	Haematological				
D46.6	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality	Haematological				
D46.7	Other myelodysplastic syndromes	Haematological				
D46.9	Myelodysplastic syndrome, unspecified	Haematological				
D47.0	Histiocytic and mast cell tumours of uncertain and unknown behaviour	Haematological				
D47.1	Chronic myeloproliferative disease	Haematological				
D47.3	Essential (haemorrhagic) thrombocythaemia	Haematological				
D47.4	Osteomyelofibrosis	Haematological				
D47.5	Chronic eosinophilic leukaemia (hypereosinophilic syndrome)	Haematological				
D47.7	Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue	Haematological				
D47.9	Neoplasm of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue, unspecified	Haematological				
D48.0	Neoplasm of uncertain or unknown behaviour of Bone and articular cartilage	Sarcoma			•	
D48.1	Neoplasm of uncertain or unknown behaviour of Connective and other soft tissue	Sarcoma			•	Only applicable for GISTs

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Dataset to be collected			Comment
			Core and Site Specific Dataset	Core Dataset	Path Only	
D48.2	Neoplasm of uncertain or unknown behaviour of Peripheral nerves and autonomic nervous system	Other			•	
D48.3	Neoplasm of uncertain or unknown behaviour of Retroperitoneum	Other			•	
D48.4	Neoplasm of uncertain or unknown behaviour of Peritoneum	Other			•	
D48.5	Neoplasm of uncertain or unknown behaviour of Skin	Skin			•	
D48.6	Neoplasm of uncertain or unknown behaviour of Breast	Breast			•	
D48.7	Neoplasm of uncertain or unknown behaviour of Other specified sites	Other			•	
D48.9	Neoplasm of uncertain or unknown behaviour unspecified	Other			•	
E85.9[13]	Amyloidosis, unspecified	Haematology	See the Haematology chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematology diseases.			

[13] Although Primary amyloidosis (E85.9) is listed as an E ICD code in the World Health Organisation (WHO) disease classification, amongst clinicians it is widely acknowledged and subsequently treated as a cancer, receiving Chemotherapy in cases. Whilst we await the WHO disease classification being updated to reflect this fact, it's inclusion as a registerable condition requiring collection via the COSD has been agreed with the National Cancer Registration Service of Public Health England.

Appendix D - Recommended Staging to be collected by Cancer Registries

The National Staging Panel for Cancer Registration recommends that the staging systems recorded by the cancer registries follow the guidance issued by the Royal College of Pathologists and the Cancer Outcomes Services Data set.

It is also important to note that both UICC and AJCC coding systems are updating to v8.0, please refer to the either the Cancer Stats documentary library and then the appropriate staging sheet for your tumour type[14] or refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[15].

Note: The change from TNM 7 and TNM 8 take effect from 1st January 2018 unless otherwise stated.

TUMOUR TYPE	***STAGING SYSTEM (up-to 31st December 2017)***	***STAGING SYSTEM (from 1st January 2018)***
ADRENAL CORTEX TUMOURS	UICC TNM 7	UICC TNM 8
AMPULLA OF VATER - CARCINOMA	UICC TNM 7	UICC TNM 8
AMPULLA OF VATER - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
ANAL CANAL	UICC TNM 7	UICC TNM 8
APPENDIX - CARCINOMA	UICC TNM 7	UICC TNM 8
APPENDIX - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
BONE	UICC TNM 7	UICC TNM 8
BREAST	UICC TNM 7	UICC TNM 8
CERVIX	FIGO and N STAGE	FIGO (2009) and N STAGE
CHRONIC LYMPHOCYTIC LEUKAEMIA	BINET	BINET
COLON AND RECTUM - CARCINOMA	UICC TNM 5 & DUKES	UICC TNM 8
COLON AND RECTUM – GIST	UICC TNM 7	UICC TNM8
COLON AND RECTUM - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
CONJUNCTIVA - CARCINOMA	UICC TNM 7	UICC TNM 8
CONJUNCTIVA – MELANOMA	UICC TNM 7	UICC TNM 8
CUTANEOUS SQUAMOUS CELL CARCINOMA AND OTHER CUTANEOUS CARCINOMA	AJCC TNM 7	UICC TNM 8
EXTRAHEPATIC BILE DUCT - PERIHILAR	UICC TNM 7	UICC TNM 8
EXTRAHEPATIC BILE DUCTS - DISTAL	UICC TNM 7	UICC TNM 8
FALLOPIAN TUBE	FIGO	FIGO (2013)***
GALLBLADDER	UICC TNM 7	UICC TNM8
GESTATIONAL TROPHOBLASTIC DISEASE	FIGO	FIGO (2009)
GLOTTIS	UICC TNM 7	UICC TNM 7
HEPATOBLASTOMA (CTYA)	PRETEXT STAGING SYSTEM STAGE	PRETEXT STAGING SYSTEM STAGE

[14] https://nww.cancerstats.nhs.uk/cosd/staging
[15] http://www.wileyanduicc.com/

HODGKIN LYMPHOMA	ANN-ARBOR	ANN-ARBOR
HYPOPHARYNX	UICC TNM 7	UICC TNM 7
KIDNEY	UICC TNM 7*	UICC TNM 8
KIDNEY, WILMS	WILMS TUMOUR STAGE (NWTSG)	WILMS TUMOUR STAGE (NWTSG)
LACRIMAL GLAND - CARCINOMA	UICC TNM 7	UICC TNM 8
LIP	UICC TNM 7	UICC TNM 7
LIVER - INTRAHEPATIC BILE DUCTS	UICC TNM 7 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LIVER - HEPATOCELLULAR	UICC TNM 7 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LUNG	UICC TNM 7	UICC TNM 8
MAJOR SALIVARY GLANDS	UICC TNM 7	UICC TNM 7
MAXILLARY SINUS	UICC TNM 7	UICC TNM 7
MEDULLOBLASTOMA	CHANG STAGING SYSTEM	CHANG STAGING SYSTEM
MYELOMA	INTERNATIONAL STAGING SYSTEM (ISS)	INTERNATIONAL STAGING SYSTEM (ISS)
NASAL CAVITY AND PARANASAL SINUSES	UICC TNM 7	UICC TNM 7
NASOPHARYNX	UICC TNM 7	UICC TNM 7
NEUROBLASTOMA	INTERNATIONAL NEUROBLASTOMA RISK GROUP	INTERNATIONAL NEUROBLASTOMA RISK GROUP
NON-HODGKIN LYMPHOMA (ADULT)	ANN-ARBOR	ANN-ARBOR
NON-HODGKIN LYMPHOMA (CHILDREN)	MURPHY ST. JUDE STAGING SYSTEM	MURPHY ST. JUDE STAGING SYSTEM
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – CARCINOMA	UICC TNM 7	UICC TNM 8
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)
ORAL CAVITY	UICC TNM 7	UICC TNM 7
OROPHARYNX	UICC TNM 7	UICC TNM 7
OMENTUM AND MESENTERY – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)
OVARY AND PERITONEUM	FIGO	FIGO (2013)***
PANCREAS	UICC TNM 7	UICC TNM 8
PANCREAS - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
PENIS	UICC TNM 7*	UICC TNM 8
PLEURAL MESOTHELIOMA	UICC TNM 7*	UICC TNM 8
PROSTATE	UICC TNM 7	UICC TNM 8
RENAL PELVIS AND URETER	UICC TNM 7	UICC TNM 8
RETINOBLASTOMA	UICC TNM 7	UICC TNM 8
RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS (CTYA)	IRS POST SURGICAL GROUP	UICC TNM 8 & IRS POST SURGICAL GROUP
HEPATOBLASTOMA (CTYA)	PRETEXT STAGING SYSTEM STAGE	PRETEXT STAGING SYSTEM STAGE
SARCOMA OF ORBIT	UICC TNM 7	UICC TNM 8
SKIN - MALIGNANT MELANOMA	AJCC TNM 7	UICC TNM 8
SKIN - MERKEL CELL CARCINOMA**	AJCC TNM 7	UICC TNM 8
SKIN OF EYELID - CARCINOMA	UICC TNM 7	UICC TNM 8

SMALL INTESTINE - GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)
SMALL INTESTINE - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
SMALL INTESTINE - CARCINOMA	UICC TNM 7	UICC TNM 8
SOFT TISSUE	UICC TNM 7	UICC TNM 8
STOMACH - CARCINOMA	UICC TNM 7	UICC TNM 8
STOMACH – GIST	none recommended (if UICC TNM 7 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)
STOMACH - NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
SUBGLOTTIS	UICC TNM 7	UICC TNM 7
SUPRAGLOTTIS	UICC TNM 7	UICC TNM 7
TESTIS	UICC TNM 7 & ROYAL MARSDEN STAGING SYSTEM*	UICC TNM 8 & ROYAL MARSDEN STAGING SYSTEM*
THYMUS	----------	UICC TNM 8
THYROID	UICC TNM 7	UICC TNM 8
UPPER AERODIGESTIVE TRACT - MALIGNANT MELANOMA	UICC TNM 7	UICC TNM 7
URETHRA	UICC TNM 7	UICC TNM 8
URINARY BLADDER	UICC TNM 7	UICC TNM 8
UTERUS - ENDOMETRIUM	FIGO	FIGO (2009)
UTERUS - UTERINE SARCOMA	FIGO	FIGO (2009)
UVEA - MALIGNANT MELANOMA	UICC TNM 7	UICC TNM 8
VAGINA	FIGO	FIGO (2009)
VULVA	FIGO	FIGO (2009)
VULVA – MALIGNANT MELANOMA	AJCC TNM 7	UICC TNM 8

Note: The use of preferred staging systems (which should be used), is under frequent review and may change in the future:

- *** - this staging system is recognised as currently being discussed and new guidance will be available if changes are required**
- **** - see Section 1.16 Stage of COSD User Guide v8.0.3 (or later) for further advice on how to record Neuroendocrine tumours for COSD**
- ***** FIGO 2013 was implemented in January 2014**