Public Health England

Protecting and improving the nation's health

Cancer Outcome and Services Data set

Pathology user guide

Version 4.0.3

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Contents

Version control

Version	Date	Brief Summary of Change	Editors
Version 4.0 Final	28 June 2019	Updated User Guide to support the COSD Pathology data set v4.0 (DCB1521 Amd 13/2019)	Andrew Murphy
Version 4.0 Final	2 August 2019	Final amended document for publication	Andrew Murphy
Version 4.0.1 Final	10 October 2019	Corretion to 'Ki-67 RESULT' format pg19	Andrew Murphy
Version 4.0.2 Final	5 November 2019	Diagnosis (ICD Pathological) code reporting update pg23, change to web-link pg70 and Update to Appendix D pg102	Andrew Murphy
Version 4.0.3 Final	16 January 2020	Update to table 2 in Appendix A pg69	Andrew Murphy

Executive summary

Cancer outcomes and services dataset – pathology v4.0 release (April 2020)

This User Guide is one of a suite of documents to aid Users in implementing the COSD Information Standard (DCB1521 Amd 13/2019)[1]. It includes all the pathological 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 version 4.0 of the data set which is available to download on the NCIN website[2]. Other guidance and supporting documents are also available on both the NCIN and NHS Digital websites.

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.

Ongoing linkage with the Royal College of Pathologists CORE data sets is vital, and continues to be a priority to ensure clinical accuracy. This data set was reviewed by the chair of the Royal College of Pathologists Working Group on Cancer Services.

[1] http://content.digital.nhs.uk/isce/publication/scci1521
[2] http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd

Introduction

What is the cancer outcomes and services dataset?

The Cancer Outcomes and Services Data set (COSD) is a compiled data set which provides the standard for secondary uses information required to support national cancer registration and associated analysis (at local, regional, national and international level), as well as other national cancer audit programmes.

This standard consists of:

- a set of individual data items with their definitions
- the assemblage of these data items into discrete data sets
- the means of flowing the data items
- compilation of the data items into a single reconciled and verified data set

All patients diagnosed with or receiving cancer treatment in or funded by the NHS in England are covered by the standard. This includes adult and paediatric cancer patients.

Providers of cancer services have been required to provide a monthly return on all cancer patients diagnosed from 1 January 2013 using this data set. Data are collated via the National Cancer Registration and Analysis Service (NCRAS) local offices, and formal mechanisms for transmission of data from providers to NCRAS have been extended to carry the COSD data set.

More information can be found at the following websites:

- The Change Specification, Requirements Specification and Implementation Guidance are available on the NHS Digital website[3]
- Further guidance is published by Public Health England[4]

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

[3] www.content.digital.nhs.uk/isce/publication/dcb1521
[4] http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd

commissioning as 2 of the key drivers to achieve the goal that cancer services in this country should be amongst the best in the world.

The Achieving World-Class Cancer Outcomes, A Strategy for England 2015 to 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 5 years.

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[5] (NHS N3 connections only) which has been established by the NCRAS. This provides feedback on files submitted (Level 1).

Other guidance documentation

Technical Guidance and Implementation Guidance is provided separately and is available on the NCIN website[6].

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.

These are in addition to Appendix A – Cancer Waiting Times ICD10 Codes and Tumour Groups for Primary Diagnoses. COSD requires that all new diagnoses and secondary/metastatic cancer are recorded.

All recurrences diagnosed at each Trust must now also be included.

[5] https://cancerstats.ndrs.nhs.uk/
[6] 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 specific schema for reporting COSD pathology data items. These data should be reported by the pathologist, directly from their Laboratory Information Management Systems (LIMS), and sent 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. From v9 (April 2020), pathological data items have been removed from the main COSD data set (v9.0) and can only be submitted through the COSD Pathology data set and associated schema packs.

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.

Ongoing linkage with the Royal College of Pathologists CORE data sets is vital, and continues to be a priority to ensure clinical accuracy. This data set was reviewed by the chair of the Royal College of Pathologists Working Group on Cancer Services.

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 Pathology v4.0 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 to the COSD Advisory Group and experts from the Royal College of Pathologists 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.

Using this guide

This COSD Pathology User Guide document provides additional information to support the COSD Specification and should also be used in conjunction with the COSD Pathology data set v4.0. 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.

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.

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).

Key to data item tables

All data items are listed as follows:

- data item No:
- (the reference number for the COSD data item)
- (from v4 all pathology data items have a prefixed 'p', all other data items remain interoperable with the main COSD data set)
- 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 tbl-1 below.

Tbl-1

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.

There will be 1 linkage section completed each time the record is submitted.

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.

CORE – LINKAGE

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.

CORE – PATIENT IDENTITY DETAILS

One of the following Core Linkage Identifier sections must be provided per record (1..1)

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[7]
CR0020	CORE - PATIENT IDENTITY DETAILS	**LOCAL PATIENT IDENTIFIER** *[LOCAL PATIENT IDENTIFIER (EXTENDED)]*	min an1 max an20	M[8]
CR1350	CORE - PATIENT IDENTITY DETAILS	**NHS NUMBER STATUS INDICATOR CODE**	an2	M
CR0100	CORE - PATIENT IDENTITY DETAILS	**PERSON BIRTH DATE**	an10 ccyy-mm-dd	M
CR0030	CORE - PATIENT IDENTITY DETAILS	**ORGANISATION IDENTIFIER (CODE OF PROVIDER)**	min an3 max an5	M

[7] A combination of either **NHS NUMBER** and/or **LOCAL PATIENT IDENTIFIER** is Mandatory for the schema. Both can be submitted, but a record cannot be submitted without at least one of these data items.

NHS NUMBER: The NHS NUMBER is a unique identifier for a PATIENT within the NHS in England and Wales. This will not vary between any ORGANISATIONS 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 case note number and may be assigned automatically by the computer system.

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 6 weeks old)

PERSON BIRTH DATE: This is now a mandatory data item from v9.0. The date on which a PERSON was born or is officially deemed to have been born. This should be automatically linked via your local PAS system when you create a record for the first time.

ORGANISATION IDENTIFIER (CODE OF PROVIDER): The ORGANISATION IDENTIFIER of the Organisation acting as a Health Care Provider (an6 not applicable to COSD). This is the 3 or 5-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[8].

CORE – DEMOGRAPHIC DETAILS

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.

[8] https://www.datadictionary.nhs.uk/data_dictionary/attributes/o/org/organisation_code_de.asp

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.

May be up to one occurrence per record (0..1)

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 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)

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. As a result, all pathology data item have been removed from the main COSD data set and can only be reported via the pathology departments and this data set.

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 site specific pathology items (relating to stage components). 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.

In v4, the data items across the data set were aligned exactly with the RC Path – Core pathology data items. This has created additional changes to both data item names, descriptions and/or the attribute lists, where these were different in COSD. It is expected that these changes will help improve the data quality and ascertainment, whilst reducing the burden of double reporting.

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. These reports should be sent to the NCRAS through pre-agreed methods of submission. The regional Data Liaison Managers can support Trusts with this and any testing required for new reporting of data.

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

May be multiple occurrences per record (0..*)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pCR0780	CORE - PATHOLOGY DETAILS	**INVESTIGATION RESULT DATE**	an10 ccyy-mm-dd	M
pCR0950	CORE - PATHOLOGY DETAILS	**SERVICE REPORT IDENTIFIER**	min an1 max an36	M
pCR6220	CORE - PATHOLOGY DETAILS	**PATHOLOGY OBSERVATION REPORT IDENTIFIER**	min an1 max an36	R
pCR0960	CORE - PATHOLOGY DETAILS	**SERVICE REPORT STATUS**	an1	R
Start of SECTION - Consultant (PATHOLOGY TEST REQUESTED BY)				Section 0..1
pCR7100	CORE - PATHOLOGY DETAILS	**PROFESSIONAL REGISTRATION ISSUER CODE - CONSULTANT (PATHOLOGY TEST REQUESTED BY)** *[PROFESSIONAL REGISTRATION ISSUER CODE (PATHOLOGY TEST REQUESTED BY)]*	an2	M
pCR7120	CORE - PATHOLOGY DETAILS	**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER - CONSULTANT (PATHOLOGY TEST REQUESTED BY)** *[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (PATHOLOGY TEST REQUESTED BY)]*	min an1 max an32	M
End of SECTION - Consultant (PATHOLOGY TEST REQUESTED BY)				
pCR0980	CORE - PATHOLOGY DETAILS	**ORGANISATION SITE IDENTIFIER (PATHOLOGY TEST REQUESTED BY)** *[ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST)]*	min an5 max an9	R
pCR1010	CORE - PATHOLOGY DETAILS	**SAMPLE COLLECTION DATE**	an10 ccyy-mm-dd	R
pCR0770	CORE - PATHOLOGY DETAILS	**SAMPLE RECEIPT DATE**	an10 ccyy-mm-dd	R
pCR0800	CORE - PATHOLOGY DETAILS	**ORGANISATION IDENTIFIER (OF REPORTING PATHOLOGIST)** *[ORGANISATION SITE IDENTIFIER (OF REPORTING PATHOLOGIST)]*	min an3 max an5	R
Start of SECTION - Consultant (PATHOLOGIST)				Section 0..1
pCR7130	CORE - PATHOLOGY DETAILS	**PROFESSIONAL REGISTRATION ISSUER CODE - CONSULTANT (PATHOLOGIST)** *[PROFESSIONAL REGISTRATION ISSUER CODE (PATHOLOGY REPORT AUTHORISED BY)]*	an2	M
pCR7140	CORE - PATHOLOGY DETAILS	**PROFESSIONAL REGISTRATION ENTRY IDENTIFIER - CONSULTANT (PATHOLOGIST)** *[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (PATHOLOGY REPORT AUTHORISED BY)]*	min an1 max an32	M
End of SECTION - Consultant (PATHOLOGIST)				
pCR0970	CORE - PATHOLOGY DETAILS	**SPECIMEN NATURE** *[CANCER SPECIMEN NATURE]*	an1	R
Start of SECTION - Topography/Morphology SNOMED				Section 0..1
pCR6990	CORE - PATHOLOGY DETAILS	**SNOMED VERSION (PATHOLOGY)**	an2	M
TOPOGRAPHY/MORPOLOGY CHOICE				Choice 1..2
TOPOGRAPHY/MORPOLOGY CHOICE - CHOICE 1				
Start of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
pCR6410	CORE - PATHOLOGY DETAILS	**TOPOGRAPHY (SNOMED) PATHOLOGY**	min an6 max an18	M*
End of repeating item - TOPOGRAPHY (SNOMED) PATHOLOGY				
END OF TOPOGRAPHY/MORPOLOGY CHOICE - CHOICE 1				
TOPOGRAPHY/MORPOLOGY CHOICE - CHOICE 2				

Start of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
pCR6420	CORE - PATHOLOGY DETAILS	**MORPHOLOGY (SNOMED) PATHOLOGY**	min n6 max n18	M*
End of repeating item - MORPHOLOGY (SNOMED) PATHOLOGY				
END OF TOPOGRAPHY/MORPOLOGY CHOICE - CHOICE 2				
END OF TOPOGRAPHY/MORPOLOGY CHOICE				
End of SECTION - Topography/Morphology SNOMED				
Start of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
pCR0810	CORE - PATHOLOGY DETAILS	**DIAGNOSIS (ICD PATHOLOGICAL)**	min an4 max an6	R*
End of repeating item - PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)				
pCR0820	CORE - PATHOLOGY DETAILS	**TUMOUR LATERALITY (PATHOLOGICAL)**	an1	R
pCR0760	CORE - PATHOLOGY DETAILS	**PATHOLOGY INVESTIGATION TYPE**	an2	R
pCR1020	CORE - PATHOLOGY DETAILS	**PATHOLOGY REPORT TEXT**	max an270000	R
pCR0830	CORE - PATHOLOGY DETAILS	**LESION SIZE (PATHOLOGICAL)**	max n3.max n2	R
pCR0860	CORE - PATHOLOGY DETAILS	**GRADE OF DIFFERENTIATION (PATHOLOGICAL)**	an2	R
pCR0870	CORE - PATHOLOGY DETAILS	**CANCER VASCULAR OR LYMPHATIC INVASION**	an2	R
pCR0880	CORE - PATHOLOGY DETAILS	**EXCISION MARGIN** *[EXCISION MARGIN INDICATION CODE]*	an2	R
pCR0840	CORE - PATHOLOGY DETAILS	**SYNCHRONOUS TUMOUR INDICATOR**	an1	R
pCR0890	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES EXAMINED**	max n3	R
pCR0900	CORE - PATHOLOGY DETAILS	**NUMBER OF NODES POSITIVE**	max n3	R
pCR6980	CORE - PATHOLOGY DETAILS	**TNM CODING EDITION**	an1	R
pCR6820	CORE - PATHOLOGY DETAILS	**TNM VERSION NUMBER (PATHOLOGICAL)**	max an2	R
pCR0910	CORE - PATHOLOGY DETAILS	**T CATEGORY (PATHOLOGICAL)**	max an15	R
pCR0920	CORE - PATHOLOGY DETAILS	**N CATEGORY (PATHOLOGICAL)**	max an15	R
pCR0930	CORE - PATHOLOGY DETAILS	**M CATEGORY (PATHOLOGICAL)**	max an15	R
pCR0940	CORE - PATHOLOGY DETAILS	**TNM STAGE GROUPING (PATHOLOGICAL)**	max an15	R
pCR1000	CORE - PATHOLOGY DETAILS	**NEOADJUVANT THERAPY INDICATOR**	an1	R
pCR7000	CORE - PATHOLOGY DETAILS	**Ki-67 INDICATOR** *[CANCER SPECIMEN NATURE]*	an1	R
pCR7010	CORE - PATHOLOGY DETAILS	**Ki-67 RESULT** *[KI-67 PERCENTAGE RESULT]*	max n3	R
pCR7020	CORE - PATHOLOGY DETAILS	**MLH1 NUCLEAR EXPRESSION INTACT** *[MLH1 IMMUNOHISTOCHEMISTRY NUCLEAR EXPRESSION INTACT INDICATION CODE]*	an1	R
pCR7030	CORE - PATHOLOGY DETAILS	**PMS2 NUCLEAR EXPRESSION INTACT** *[PMS2 IMMUNOHISTOCHEMISTRY NUCLEAR EXPRESSION INTACT INDICATION CODE]*	an1	R
pCR7040	CORE - PATHOLOGY DETAILS	**MSH2 NUCLEAR EXPRESSION INTACT** *[MSH2 IMMUNOHISTOCHEMISTRY NUCLEAR EXPRESSION INTACT INDICATION CODE]*	an1	R
pCR7050	CORE - PATHOLOGY DETAILS	**MSH6 NUCLEAR EXPRESSION INTACT** *[MSH6 IMMUNOHISTOCHEMISTRY NUCLEAR EXPRESSION INTACT INDICATION CODE]*	an1	R

pCR7060	CORE - PATHOLOGY DETAILS	**MICROSATELLITE INSTABILITY (MSI) TESTING** *[MICROSATELLITE INSTABILITY TESTING RESULT]*	an1	R

Note: the following data item has been retired from v4.0:

- CARE PROFESSIONAL CODE (PATHOLOGY TEST REQUESTED BY)
- CONSULTANT CODE (PATHOLOGIST)

INVESTIGATION RESULT DATE: This is now a mandatory data item from v4. Record the date on which an investigation was concluded – for example the date the result was authorised.

SERVICE REPORT IDENTIFIER: This is now a mandatory data item from v4. A unique identifier of a SERVICE REPORT.

Note: it is possible that some legacy data may not have all the required mandatory fields for v9. The recommendation is for Trusts to update their data to meet the new requirements and improve/enrich their data submissions, or not upload the legacy data items in the new record (if that data is not available).

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/taken).

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: the next 2 data items are now a multiple selection group and are mandatory within the group. There may be one occurrence per CORE – Pathology Details section.

PROFESSIONAL REGISTRATION ISSUER CODE – CONSULTANT (PATHOLOGY TEST REQUESTED BY): This is a new data item in v4 replacing the 'Care Professional Code (Pathology Test Requested By)', and is a code which identifies the PROFESSIONAL REGISTRATION BODY for the Consultant or health care professional who requested the pathology test.

02	General Dental Council
03	General Medical Council
04	General Optical Council
08	Health and Care Professions Council
09	Nursing and Midwifery Council

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER – CONSULTANT (PATHOLOGY TEST REQUESTED BY): This is a new data item in v4 replacing the 'Care Professional Code (Pathology Test Requested By)', and is the registration identifier allocated by an Organisation for the Consultant or health care professional who requested the pathology test.

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.

Note: the next 2 data items are now a multiple selection group and are mandatory within the group. There may be one occurrence per CORE – Pathology Details section.

PROFESSIONAL REGISTRATION ISSUER CODE – CONSULTANT (PATHOLOGIST): This is a new data item in v4 replacing the 'Consultant Code (Pathologist)', and is a code which identifies the PROFESSIONAL REGISTRATION BODY for the Consultant or health care professional who authorises the pathology report.

02	General Dental Council
03	General Medical Council
04	General Optical Council

08	Health and Care Professions Council
09	Nursing and Midwifery Council

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER – CONSULTANT (PATHOLOGIST): This is a new data item in v4 replacing the 'Consultant Code (Pathologist)', and is the registration identifier allocated by an Organisation for the Consultant or health care professional 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

Note: the next 2 data items form a 2-choice menu and at least one of the following choices must be provided per submission (1..2)

Choice 1

TOPOGRAPHY (SNOMED) PATHOLOGY: This is the topographical site of the tumour as categorised by SNOMED International / SNOMED CT, multiple codes may be submitted.

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.

Choice 2

MORPHOLOGY (SNOMED) PATHOLOGY: This is the morphology of the tumour as categorised by SNOMED International / SNOMED CT, multiple codes may be submitted.

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.

DIAGNOSIS (ICD PATHOLOGICAL): The ICD DIAGNOSIS based on the evidence from a pathological examination, multiple codes may be submitted.

Note: Where the ICD10 code only has 3 characters, for example C01, please add “X” as a ‘packing digit’ to meet the validation rules (such as C01.X, C07.X, C73.X). In addition, the reporting format excludes the decimal CXX.X or DXX.X, all xml reports must be recorded as CXXX or DXXX.

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.

Notes:

- for COSD reporting purposes, this data item can be submitted to 2 decimal places
- this data item is not applicable for Haematology diagnosis
- 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

The following mapping table can be used to map other (site-specific) invasive pathological grades, into the main [Grade of Differentiation (Pathological)] field.

Grade	**GX**	**G1**	**G2**	**G3**	**G4**
General Description	Grade of differentiation is not appropriate or cannot be assessed	Well differentiated	Moderately differentiated	Poorly differentiated	Undifferentiated / anaplastic
Invasive Grade Breast	n/a	Grade 1	Grade 2	Grade 3	n/a
Colorectal	n/a	Well / Moderately differentiated	n/a	Poorly differentiated	n/a
CNS	n/a	I	II	III	IV
Salivary Tumour Grade	n/a	Low	n/a	High	n/a
Sarcoma - Histological Tumour Grade	n/a	Low	Intermediate	High	n/a
Fallopian Tube, Ovary, Peritoneal	n/a	Low	Intermediate	High	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
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)
98	Not applicable
99	Not Known

Notes:

- 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
- 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.

Notes:
- this data item is not applicable for CNS, Haematology or Lung diagnosis
- the COSD Core TNM Staging data items below are not applicable for CNS, Gynaecology, Haematology, Skin and most CTYA diagnoses
- 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.

1	UICC (Union for International Cancer Control)
2	AJCC (American Joint Committee on Cancer)
3	ENETS (European Neuroendocrine Tumour Society)

Note: for v4 the addition of European Neuroendocrine Tumour Society (ENTS) has been added to this list of TNM coding editions reportable through COSD, to improve data quality.

TNM VERSION NUMBER (PATHOLOGICAL): The AJCC, UICC or ENETS version number used for Tumour, Node and Metastasis (TNM) staging for cancer diagnosis.

T CATEGORY (PATHOLOGICAL): T CATEGORY (PATHOLOGICAL) is the 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 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 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 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 (i.e. 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

Ki-67 INDICATOR: This is a new data item in v4. Indicate if a Ki-67 staining was done on the sample.

1	Done and available
2	Done but not available
3	Not done
9	Not Known

Ki-67 RESULT: This is a new data item in v4. Record the percentage of tumour cells that are positive for Ki-67, on a scale of 0 to 100.

MLH1 NUCLEAR EXPRESSION INTACT: This is a new data item in v4. Is MLH1 immunohistochemistry nuclear expression intact?

Y	Yes
N	No
E	Equivocal
F	Test failed
X	Not performed

PMS2 NUCLEAR EXPRESSION INTACT: This is a new data item in v4. Is PMS2 immunohistochemistry nuclear expression intact?

Y	Yes
N	No
E	Equivocal
F	Test failed
X	Not performed

MSH2 NUCLEAR EXPRESSION INTACT: This is a new data item in v4. Is MSH2 immunohistochemistry nuclear expression intact?

Y	Yes
N	No
E	Equivocal
F	Test failed
X	Not performed

MSH6 NUCLEAR EXPRESSION INTACT: This is a new data item in v4. Is MSH6 immunohistochemistry nuclear expression intact?

Y	Yes
N	No
E	Equivocal
F	Test failed
X	Not performed

MICROSATELLITE INSTABILITY (MSI) TESTING: This is a new data item in v4.
Result of microsatellite instability (MSI) testing.

H	MSI-high
L	MSI-low
S	MSI-stable
F	Test failed
X	Not performed

BREAST – PATHOLOGY

This is the site specific section for additional breast cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pBR4140	BREAST - PATHOLOGY	**MULTIFOCAL TUMOUR INDICATOR (BREAST)**	an1	R
pBR4160	BREAST - PATHOLOGY	**DCIS GRADE** *[DUCTAL CARCINOMA IN SITU GRADE]*	an1	R
pBR4180	BREAST - PATHOLOGY	**DCIS/PLEOMORPHIC OR DCIS LIKE LCIS SIZE** *[NON INVASIVE TUMOUR SIZE]*	max n3.max n2	R
pBR4190	BREAST - PATHOLOGY	**WHOLE TUMOUR (INVASIVE + DCIS) SIZE** *[WHOLE TUMOUR SIZE]*	max n3.max n2	R
pBR4200	BREAST - PATHOLOGY	**METASTASIS EXTENT CODE**	an1	R
pBR4210	BREAST - PATHOLOGY	**DISTANCE TO MARGIN**	max n2.max n1	R
pBR4230	BREAST - PATHOLOGY	**ER ALLRED SCORE** *[ALLRED SCORE (ESTROGEN RECEPTOR)]*	an1	O
pBR4220	BREAST - PATHOLOGY	**ER STATUS** *[ESTROGEN RECEPTOR STATUS]*	an1	R
pBR4300	BREAST - PATHOLOGY	**PR ALLRED SCORE** *[ALLRED SCORE (PROGESTERONE RECEPTOR)]*	an1	O
pBR4290	BREAST - PATHOLOGY	**PR STATUS** *[BREAST PROGESTERONE RECEPTOR STATUS]*	an1	O
pBR4280	BREAST - PATHOLOGY	**HER2 STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR STATUS (BREAST)]*	an1	R
pBR4310	BREAST - PATHOLOGY	**HER2 ISH STATUS** *[HUMAN EPIDERMAL GROWTH FACTOR IN SITU HYBRIDISATION RECEPTOR STATUS (BREAST)]*	an1	R
pBR4240	BREAST - PATHOLOGY	**CYTOLOGY (BREAST)** *[CYTOLOGY RESULT CODE (BREAST)]*	an2	R
pBR4250	BREAST - PATHOLOGY	**CYTOLOGY (NODE)** *[CYTOLOGY RESULT CODE (NODE)]*	an2	R
pBR4260	BREAST - PATHOLOGY	**CORE BIOPSY (BREAST)** *[NEEDLE CORE BIOPSY RESULT CODE (BREAST)]*	min an2 - max an3	R
pBR4270	BREAST - PATHOLOGY	**CORE BIOPSY (NODE)** *[NEEEDLE CORE BIOPSY RESULT CODE (AXILLARY LYMPH NODE)]*	an3	R

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

Y	YES (Multiple invasive foci)
N	NO (Localised)
9	Not Known (Cannot be assessed)

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 (Cannot be assessed)

DCIS/PLEOMORPHIC OR DCIS LIKE LCIS SIZE: This data item name has been updated in v4 to match the RC Path Core Data set. Record 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 can be submitted to 2 decimal places.

WHOLE TUMOUR (INVASIVE + DCIS) SIZE: This data item name has been updated in v4 to match the RC Path Core Data set. Record the whole size of the 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 can be submitted to 2 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 (ITCs)
4	Macrometastasis
9	Not known

DISTANCE TO MARGIN: Distance to closest relevant margin (mm). Distance to nearest radial 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). This is now an optional data item from v4 as it is not in the RC Path Core data set.

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 (> or = 1%)

N	Negative (<1%)
X	Not performed

PR ALLRED SCORE: Record the PR ALLRED score if known. (Range 0, 2-8). This is now an optional data item from v4 as it is not in the RC Path Core data set.

PR STATUS: Progesterone Receptor Status. Record the PR status if known. This is now an optional data item from v4 as it is not in the RC Path Core data set.

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.

~~N~~	~~Negative~~
N1	Negative (0)
N2	Negative (1+)
B	Borderline (2+)
P	Positive (3+)
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 (Amplified)
N	Negative (Non-amplified)
B	Borderline
X	Not performed

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	Unsatisfactory/normal tissue only
B2	Benign
~~B3~~	~~Uncertain malignant potential~~
B3a	Uncertain malignant potential without epithelial atypia
B3b	Uncertain malignant potential with epithelial atypia
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~~
LB1	Inadequate/unsatisfactory
LB2	Normal/Benign
LB3	Uncertain
LB4	Suspicious
LB5	Malignant

CENTRAL NERVOUS SYSTEM – PATHOLOGY

This is the site specific section for additional central nervous system cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
Start of repeating item - Molecular Diagnostics Code				
pBA3070	CENTRAL NERVOUS SYSTEM-PATHOLOGY	**MOLECULAR DIAGNOSTICS CODE**	an2	R*
End of repeating item - Molecular Diagnostics Code				
Start of repeating item - Immunohistochemistry Hormone Expression Type				
pBA3150	CENTRAL NERVOUS SYSTEM-PATHOLOGY	**IMMUNOHISTOCHEMISTRY HORMONE EXPRESSION TYPE** *[HORMONE EXPRESSION TYPE]*	an1	R*
End of repeating item - Immunohistochemistry Hormone Expression Type				

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.

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

COLORECTAL – PATHOLOGY

This is the site specific section for additional colorectal cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pCO5190	COLORECTAL - PATHOLOGY	**POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN** *[MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]*	an1	R
pCO5210	COLORECTAL - PATHOLOGY	**DISTANCE TO CIRCUMFERENTIAL MARGIN** *[DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN]*	max n2.max n2	R
pCO5260	COLORECTAL - PATHOLOGY	**PLANE OF SURGICAL EXCISION** *[PLANE OF SURGICAL EXCISION TYPE]*	an1	R
pCO5270	COLORECTAL - PATHOLOGY	**DISTANCE FROM DENTATE LINE**	max n3.max n2	R
pCO5280	COLORECTAL - PATHOLOGY	**DISTANCE BEYOND MUSCULARIS PROPRIA**	max n3.max n2	R
pCO5290	COLORECTAL - PATHOLOGY	**RESPONSE TO PREOPERATIVE THERAPY** *[PREOPERATIVE THERAPY RESPONSE TYPE]*	an2	R
pCO5300	COLORECTAL - PATHOLOGY	**STATUS OF CIRCUMFERENTIAL EXCISION MARGIN** *[MARGIN INVOLVED INDICATION CODE (CIRCUMFERENTIAL MARGIN)]*	an1	R

Note: the following data item has been retired from v4.0

- GRADE OF DIFFERENTIATION (COLORECTAL PATHOLOGICAL)

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
8	Not submitted by pathologist
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.

~~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)~~
08	No viable cancer cells (TRS 0)
09	Single cells or rare small groups of cancer cells (TRS 1)
10	Residual cancer with evident tumour regression (TRS 2)
11	No evident tumour regression (TRS 3)
97	Not Applicable

STATUS OF CIRCUMFERENTIAL EXCISION MARGIN: Record if the edge of the tumour is 1 mm or less from the circumferential resection margin (i.e. 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

CHILDREN TEENAGERS AND YOUNG ADULTS – RENAL PATHOLOGY (paediatric kidney)

This is the site specific section for additional children teenagers and young adult cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pCT6610	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR RUPTURE** *[TUMOUR RUPTURE INDICATOR (PATHOLOGICAL)]*	an1	R
pCT6620	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**ANAPLASTIC NEPHROBLASTOMA** *[ANAPLASTIC NEPHROBLASTOMA TYPE]*	an1	R
pCT6630	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**PERIRENAL FAT INVASION** *[TUMOUR INVASION INDICATOR (PERIRENAL FAT)]*	an1	R
pCT6640	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL SINUS INVASION** *[TUMOUR INVASION INDICATOR (RENAL SINUS)]*	an1	R
pCT6650	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR INDICATOR (PAEDIATRIC KIDNEY)]*	an1	R
pCT6680	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**VIABLE TUMOUR AT RESECTION MARGIN** *[VIABLE TUMOUR EVIDENCE AT RESECTION MARGIN]*	an1	R
pCT6670	CTYA - RENAL PATHOLOGY (Paediatric Kidney)	**TUMOUR LOCAL STAGE (PATHOLOGICAL)** *[INTERNATIONAL SOCIETY OF PAEDIATRIC ONCOLOGY TUMOUR LOCAL STAGE]*	an1	R

Note: the following data item has been retired from v4.0

- VIABLE TUMOUR

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 AT RESECTION MARGIN: This is a new data item for v4, and replaces CT6660. Is there evidence of viable tumour in the renal sinus.

V	Viable
N	Non-viable
X	Not applicable

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

GYNAECOLOGICAL – PATHOLOGY

This is the site specific section for additional gynaecological cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pGY7050	GYNAECOLOGICIAL - PATHOLOGY	**FALLOPIAN TUBE INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (FALLOPIAN TUBE)]*	an1	R
pGY7120	GYNAECOLOGICIAL - PATHOLOGY	**OVARIAN INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (OVARIAN)]*	an1	R
pGY7130	GYNAECOLOGICIAL - PATHOLOGY	**SEROSAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATION CODE (UTERINE SEROSA)]*	an1	R
pGY7100	GYNAECOLOGICIAL - 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
I	Invasive carcinoma
B	Borderline changes (non-invasive implants)
N	Not involved

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

FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pGY7140	GYNAECOLOGICIAL - PATHOLOGY -FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**CAPSULE STATUS** *[GYNAECOLOGICIAL CAPSULE STATUS]*	an1	R
pGY7190	GYNAECOLOGICIAL - PATHOLOGY -FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**OVARIAN SURFACE INVOLVEMENT** *[OVARY SURFACE INVOLVEMENT INDICATOR]*	an1	R
pGY7170	GYNAECOLOGICIAL - PATHOLOGY -FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL CYTOLOGY** *[PERITONEAL CYTOLOGY RESULT CODE]*	an1	R
pGY7180	GYNAECOLOGICIAL - PATHOLOGY -FALLOPIAN TUBE, OVARIAN EPITHELIAL and PRIMARY PERITONEAL	**PERITONEAL INVOLVEMENT** *[PERITONEAL INVOLVEMENT INDICATION CODE]*	an1	R

Note: the following data item has been moved to the cervical table in v4.0

- INVASIVE THICKNESS

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

1	Intact
2	Disrupted
3	Involved
X	Not assessable

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 (Not Involved)
X	Not assessable / Not sent
I	Invasive carcinoma/ invasive implants
B	Non-invasive borderline implants

ENDOMETRIAL

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pGY7240	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**INVOLVEMENT OF CERVICAL STROMA** *[MICROSCOPIC INVOLVEMENT INDICATOR (CERVICAL STROMA)]*	an1	R
pGY7260	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**MYOMETRIAL INVASION** *[MYOMETRIAL INVASION IDENTIFICATION CODE]*	an1	R
pGY7270	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**PARAMETRIUM INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (PARAMETRIUM)]*	an1	R
pGY7280	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**PERITONEAL WASHINGS** *[PERITONEAL WASHINGS IDENTIFIED]*	an1	R
pGY7500	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**PERITONEAL INVOLVEMENT (ENDOMETRIAL)** *[PERITONEAL INVOLVEMENT INDICATOR (ENDOMETRIAL CANCER)]*	an1	R
pGY7510	GYNAECOLOGICIAL - PATHOLOGY - ENDOMETRIAL	**SITE OF PERITONEAL INVOLVEMENT** *[GYNAECOLOGICIAL CANCER SITE OF PERITONEAL INVOLVEMENT]*	an1	R

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

Y	Yes (Involved)
N	No (Not involved)
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%
4	None or less than 50%

PARAMETRIUM INVOLVEMENT: Is there microscopic involvement of parametrium?

Y	Yes (Involved)
N	No (Not involved)
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

PERITONEAL INVOLVEMENT (ENDOMETRIAL): This is a new data item in v4. Is there involvement of peritoneum?

Y	Involved
N	Not involved
X	Not assessable

SITE OF PERITONEAL INVOLVEMENT: This is a new data item in v4. If there is peritoneal involvement, which site(s) is involved?

P	Pelvic
A	Abdominal
X	Not assessable

CERVICAL

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pGY7290	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**CGIN GRADE** *[CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
pGY7300	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**CIN GRADE** *[CERVICAL INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE]*	an1	R
pGY7350	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**SMILE** *[SMILE INDICATION CODE]*	an1	R
pGY7310	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**EXCISION MARGIN (PRE INVASIVE)** *[RESECTION MARGIN INVOLVEMENT INDICATOR]*	an1	R
pGY7340	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**PARACERVICAL OR PARAMETRIAL INVOLVEMENT** *[PARACERVICAL OR PARAMETRIAL INVOLVEMENT INDICATOR]*	an1	R
pGY7360	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**THICKNESS UNINVOLVED STROMA** *[UNINVOLVED CERVICAL STROMA THICKNESS]*	max n2.max n2	R
pGY7370	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**VAGINAL INVOLVEMENT** *[MICROSCOPIC INVOLVEMENT INDICATOR (VAGINAL)]*	an1	R
pGY7450	GYNAECOLOGICIAL - PATHOLOGY - CERVICAL	**INVASIVE THICKNESS**	max n2.max n2	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	Grade 1
2	Grade 2
3	Grade 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

INVASIVE THICKNESS: This data item has moved in v4 to its correct section. Record the thickness or depth of the invasive lesion in mm.

PATHOLOGY – NODES

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pGY7060	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PARA-AORTIC)** *[NUMBER OF NODES EXAMINED (PARA-AORTIC)]*	max n2	R
pGY7080	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PARA-AORTIC)** *[NUMBER OF NODES POSITIVE (PARA-AORTIC)]*	max n2	R

pGY7070	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (PELVIC)** *[NUMBER OF NODES EXAMINED (PELVIC)]*	max n2	R
pGY7090	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (PELVIC)** *[NUMBER OF NODES POSITIVE (PELVIC)]*	max n2	R
pGY7410	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES EXAMINED NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES EXAMINED (INGUINO-FEMORAL)]*	max n2	R
pGY7420	GYNAECOLOGICIAL - PATHOLOGY - NODES	**NODES POSITIVE NUMBER (INGUINO-FEMORAL)** *[NUMBER OF NODES POSITIVE (INGUINO-FEMORAL)]*	max n2	R
pGY7230	GYNAECOLOGICIAL - PATHOLOGY - NODES	**EXTRANODAL SPREAD** *[EXTRANODAL SPREAD INDICATOR]*	an1	R

Note: the following data item has been retired from v4.0

- NODAL STATUS CERVICAL CANCER

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

HAEMATOLOGY – PATHOLOGY

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

HEAD and NECK – PATHOLOGY

This is the site specific section for additional head and neck cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

HEAD & NECK – PATHOLOGY – VARIOUS

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pHN9300	HEAD & NECK - PATHOLOGY - VARIOUS	**MAXIMUM DEPTH OF INVASION**	max n3	R
pHN9310	HEAD & NECK - PATHOLOGY - VARIOUS	**BONE INVASION** *[BONE INVASION INDICATION CODE]*	an1	R
pHN9320	HEAD & NECK - PATHOLOGY - VARIOUS	**CARTILAGE INVASION** *[CARTILAGE INVASION INDICATION CODE]*	an1	R
pHN9330	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

HEAD & NECK – PATHOLOGY – SALIVARY

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pHN9390	HEAD & NECK – PATHOLOGY – SALIVARY	**MACROSCOPIC EXTRAGLANDULAR EXTENSION** *[MACROSCOPIC EXTRAGLANDULAR EXTENSION INDICATION CODE]*	an1	M

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

1	Present (Yes)
2	Absent (No)

HEAD & NECK – PATHOLOGY – GENERAL and SALIVARY

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pHN9400	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**POSITIVE NODES LATERALITY** *[ANATOMICAL SIDE (POSITIVE NODES)]*	an1	R
pHN9410	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS LEFT NECK** *[LARGEST METASTASIS (LEFT NECK)]*	max n3	R
pHN9420	HEAD & NECK - PATHOLOGY - GENERAL and SALIVARY	**LARGEST METASTASIS RIGHT NECK** *[LARGEST METASTASIS (RIGHT NECK)]*	max n3	R
pHN9430	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

HEAD & NECK – PATHOLOGY – HUMAN PAPIlLOMAVIRUS (HPV)

This is a new section in v4 to accurately record HPV testing for head and neck cancers.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pHN9500	HEAD & NECK – PATHOLOGY – HUMAN PAPILLOMAVIRUS (HPV)	**p16 TESTING INDICATOR** *[P16 IMMUNOHISTOCHEMISTRY TEST RESULT]*	an1	R
pHN9510	HEAD & NECK – PATHOLOGY – HUMAN PAPILLOMAVIRUS (HPV)	**HPV-ISH TESTING** *[HUMAN PAPILLOMAVIRUS IN SITU HYBRIDISATION TEST RESULT]*	an1	R

p16 TESTING INDICATOR: This is a new data item in v4. Indicate the result of p16 immunohistochemistry.

P	Positive
N	Negative
X	Not Performed/Not Known

HPV-ISH TESTING: This is a new data item in v4. Indicate the result of HPV-ISH testing (Human Papillomavirus – In Situ Hybridisation).

P	Positive
N	Negative
X	Not Performed/Not Known

LUNG – PATHOLOGY

This is the site specific section for additional lung cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pLU10110	LUNG – PATHOLOGY	**EXTENT OF ATELECTASIS**	an1	R
pLU10120	LUNG – PATHOLOGY	**EXTENT OF PLEURAL INVASION**	an1	R
pLU10130	LUNG – PATHOLOGY	**PERICARDIAL INVASION** *[TUMOUR INVASION INDICATOR (PERICARDIUM)]*	an1	R
pLU10140	LUNG – PATHOLOGY	**DIAPHRAGM INVASION** *[TUMOUR INVASION INDICATOR (DIAPHRAGM)]*	an1	R
pLU10150	LUNG – PATHOLOGY	**INVASION INTO GREAT VESSEL** *[TUMOUR INVASION INDICATOR (GREAT VESSELS)]*	an1	R
pLU10160	LUNG – PATHOLOGY	**INVASION INTO HEART** *[TUMOUR INVASION INDICATOR (HEART)]*	an1	R
pLU10170	LUNG – PATHOLOGY	**MALIGNANT PLEURAL EFFUSION** *[MALIGNANT PLEURAL EFFUSION INDICATOR]*	an1	R
pLU10190	LUNG – PATHOLOGY	**INVASION INTO MEDIASTINUM** *[TUMOUR INVASION INDICATOR (MEDIASTINUM)]*	an1	R
pLU10180	LUNG – PATHOLOGY	**SATELLITE TUMOUR NODULES LOCATION**	an1	R

Note: the following data item has been retired from v4.0

- PROXIMITY TO CARINA

EXTENT OF ATELECTASIS: Extent of atelectasis/obstructive pneumonitis.

~~1~~	~~None or less than the 2 other categories~~
~~2~~	~~Involving hilar region but not whole lung~~
~~3~~	~~Involving whole lung~~
4	Extends to the hilar region, either involving part of the lung or the whole lung
5	None/less than the other category

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 (Cannot be assessed)

DIAPHRAGM INVASION: Does the tumour invade the diaphragm?

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

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

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

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

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

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

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

INVASION INTO MEDIASTINUM: This is a new data item in v4. Is there evidence of malignant pleural effusion?

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

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

SARCOMA – PATHOLOGY

This is the site specific section for additional gynaecological cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSA11170	SARCOMA - PATHOLOGY - BONE AND SOFT TISSUE	**GENETIC CONFIRMATION INDICATOR**	an1	R

Note: the following data item has been retired from v4.0:

- SARCOMA SURGICAL MARGIN ADEQUACY

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 – PATHOLOGY – BONE

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSA11130	SARCOMA - PATHOLOGY - BONE	**EXTENT OF LOCAL SPREAD (BONE)** *[SARCOMA TUMOUR BREACH IDENTIFIER]*	an1	R
pSA11140	SARCOMA - PATHOLOGY - BONE	**TUMOUR NECROSIS** *[TUMOUR NECROSIS PERCENTAGE]*	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. Range 0 to 100

SARCOMA – PATHOLOGY – SOFT TISSUE

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSA11100	SARCOMA - PATHOLOGY - SOFT TISSUE	**TUMOUR DEPTH** *[SARCOMA TUMOUR DEPTH]*	an1	R
pSA11220	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.

SKIN – PATHOLOGY

This is the site specific section for additional skin cancer specific data items to be recorded. These will be aligned within the schema to form a single report. Data items within the following groups have been re-ordered to improve data collection and prevent errors, in some cases the same data item may be collected within more than one section.

SKIN – PATHOLOGY – BASAL CELL CARCINOMA (BCC)

This is a new section for v4 and allows for only Basal Cell Carcinoma (BCC) data to be recorded.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSK12120	SKIN - PATHOLOGY - BCC	**SKIN CANCER LESION INDICATOR** *[SKIN CANCER LESION SPECIMEN IDENTIFIER]*	max an3	R
pSK12530	SKIN - PATHOLOGY - BCC	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (SKIN)]*	an1	R
pSK12537	SKIN - PATHOLOGY - BCC	**LESION DIAMETER GREATER THAN 20MM INDICATOR** *[LESION DIAMETER GREATER THAN 20MM INDICATION CODE]*	an1	R

Note: the following data items has been retired from v4.0:

- DEEP INVASION INDICATOR FOR pT3
- DEEP INVASION INDICATOR FOR pT4

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.

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

SKIN – PATHOLOGY – SQUAMOUS CELL CARCINOMA (SCC)

This is a new section for v4 and allows for only Squamous Cell Carcinoma (SCC) data to be recorded.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSK12120	SKIN - PATHOLOGY - SCC	**SKIN CANCER LESION INDICATOR** *[SKIN CANCER LESION SPECIMEN IDENTIFIER]*	max an3	R
pSK12530	SKIN - PATHOLOGY - SCC	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (SKIN)]*	an1	R
pSK12537	SKIN - PATHOLOGY - SCC	**LESION DIAMETER GREATER THAN 20MM INDICATOR** *[LESION DIAMETER GREATER THAN 20MM INDICATION CODE]*	an1	R
pSK12545	SKIN - PATHOLOGY - SCC	**CLARKS LEVEL IV INDICATOR** *[CLARKS LEVEL IV INDICATION CODE]*	an1	R
pSK12565	SKIN - PATHOLOGY - SCC	**LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATOR** *[LESION VERTICAL THICKNESS GREATER THAN 2MM INDICATION CODE]*	an1	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.

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

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

SKIN – PATHOLOGY – MALIGNANT MELANOMA (MM)

This section allows for only Malignant Melanoma (MM) data to be recorded.

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pSK12120	SKIN – PATHOLOGY – MM	**SKIN CANCER LESION INDICATOR** [SKIN CANCER LESION SPECIMEN IDENTIFIER]	max an3	R
pSK12580	SKIN – PATHOLOGY – MM	**ULCERATION INDICATOR** [SKIN ULCERATION INDICATION CODE]	an1	R
pSK12590	SKIN – PATHOLOGY – MM	**MITOTIC RATE (SKIN)**	max n3	R
pSK12600	SKIN – PATHOLOGY – MM	**MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATOR** [MICROSATELLITE OR IN-TRANSIT METASTASIS INDICATION CODE]	an1	R
pSK12620	SKIN – PATHOLOGY – MM	**TUMOUR REGRESSION INDICATOR** [TUMOUR REGRESSION INDICATION CODE (SKIN)]	an1	R
pSK12630	SKIN – PATHOLOGY – MM	**BRESLOW THICKNESS**	max n2.max n2	R

pSK12430	SKIN – PATHOLOGY – MM	**TUMOUR INFILTRATING LYMPHOCYTES (TILS)** [TUMOUR INFILTRATING LYMPHOCYTE TYPE]	an1	R
pSK12460	SKIN – PATHOLOGY – MM	**SENTINEL NODES EXAMINED NUMBER** [NUMBER OF SENTINEL NODES SAMPLED]	max n2	R
pSK12470	SKIN – PATHOLOGY – MM	**SENTINEL NODES POSITIVE NUMBER** [NUMBER OF SENTINEL NODES POSITIVE]	max n2	R
pSK12480	SKIN – PATHOLOGY – MM	**POST SNB COMPLETION LYMPHADENECTOMY – NODES SAMPLED NUMBER** [NUMBER OF NODES SAMPLED (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]	max n2	R
pSK12490	SKIN – PATHOLOGY – MM	**POST SNB COMPLETION LYMPHADENECTOMY – NODES POSITIVE NUMBER** [NUMBER OF NODES POSITIVE (POST SENTINEL NODE COMPLETION LYMPHADENECTOMY]	max n2	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.

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.

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.

UPPER GI – PATHOLOGY

This is the site specific section for additional Upper GI cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

May be up to one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUG14500	UPPER GI – PATHOLOGY – LIVER METS	**TOTAL NUMBER OF COLORECTAL METASTASES IN LIVER CODE** [NUMBER OF COLORECTAL METASTASES IN LIVER]	Max n2	R
pUG14480	UPPER GI – PATHOLOGY – OESOPHAGEAL AND STOMACH	**EXCISION MARGIN (PROXIMAL, DISTAL)** [MARGIN INVOLVED INDICATION CODE (POSITIVE PROXIMAL OR DISTAL RESECTION MARGIN)]	an1	R
pUG14490	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

Note: the following data item has been retired from v4.0

- NUMBER OF COLORECTAL METASTASES IN LIVER CODE

TOTAL NUMBER OF COLORECTAL METASTASES IN LIVER CODE: Record the total number of colorectal metastases identified in the resected liver.

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

UROLOGICAL – PATHOLOGY

This is the site specific section for additional urological cancer specific data items to be recorded. These will be aligned within the schema to form a single report.

UROLOGY – PATHOLOGY – BLADDER

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUR15120	UROLOGICAL - PATHOLOGY - BLADDER	**DETRUSOR MUSCLE PRESENCE INDICATOR** *[DETRUSOR MUSCLE PRESENCE INDICATION CODE]*	an1	R
pUR15290	UROLOGICAL - PATHOLOGY - BLADDER	**TUMOUR GRADE (UROLOGY)**	an1	R

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

1	Present (Yes)
2	Absent (No)
~~9~~	~~Not known~~
I	Indeterminate
X	Not applicable

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

UROLOGY – PATHOLOGY – KIDNEY

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUR15130	UROLOGICAL - PATHOLOGY - KIDNEY	**TUMOUR NECROSIS INDICATOR** *[TUMOUR NECROSIS INDICATION CODE]*	an1	R
pUR15140	UROLOGICAL - PATHOLOGY - KIDNEY	**PERINEPHRIC FAT INVASION** *[TUMOUR INVASION INDICATOR (PERINEPHRIC FAT)]*	an1	R
pUR15150	UROLOGICAL - PATHOLOGY - KIDNEY	**ADRENAL INVASION** *[TUMOUR INVASION INDICATION CODE (DIRECT ADRENAL)]*	an1	R

pUR15160	UROLOGICAL - PATHOLOGY - KIDNEY	**RENAL VEIN TUMOUR** *[RENAL VEIN TUMOUR THROMBUS INDICATION CODE (UROLOGICAL)]*	an1	R
pUR15170	UROLOGICAL - 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~~
1	Macroscopic (confluent)
2	Microscopic (coagulative)
3	Not identified
8	Cannot be assessed (for example, post embolisation)

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

Y	Yes (Present)
N	No (Not Identified)
9	Cannot be assessed/Not applicable

ADRENAL INVASION: Is there evidence of direct adrenal invasion?

~~Y~~	~~Yes~~
~~N~~	~~No~~
1	Present, direct extension
2	Present, metastasis
3	Not identified
8	Cannot be assessed/Not applicable

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

~~Y~~	~~Yes~~
~~N~~	~~No~~
~~U~~	~~Uncertain~~
1	Microscopic involvement only
2	Gross involvement confirmed microscopically
3	Not identified
8	Cannot be assessed/Not applicable

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

Y	Yes (Present)
N	No (Not Identified)
9	Cannot be assessed/Not applicable

UROLOGY – PATHOLOGY – PENIS

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUR15180	UROLOGICAL-PATHOLOGY - PENIS	**CORPUS SPONGIOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS SPONGIOSUM)]*	an1	R
pUR15190	UROLOGICAL-PATHOLOGY - PENIS	**CORPUS CAVERNOSUM INVASION** *[TUMOUR INVASION INDICATOR (CORPUS CAVERNOSUM)]*	an1	R
pUR15200	UROLOGICAL-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

UROLOGY – PATHOLOGY – PROSTATE

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUR15210	UROLOGICAL - PATHOLOGY - PROSTATE	**GLEASON GRADE (PRIMARY)**	an1*	R
pUR15220	UROLOGICAL - PATHOLOGY - PROSTATE	**GLEASON GRADE (SECONDARY)**	an1*	R
pUR15230	UROLOGICAL - PATHOLOGY - PROSTATE	**GLEASON GRADE (TERTIARY)**	an1*	R
pUR15240	UROLOGICAL - PATHOLOGY - PROSTATE	**PERINEURAL INVASION** *[PERINEURAL INVASION INDICATOR (UROLOGY)]*	an1	R
pUR15270	UROLOGICAL - PATHOLOGY - PROSTATE	**TURP TUMOUR PERCENTAGE**	max n3	R

Note: the following data item has been retired from v4.0

- ORGAN CONFINED
- SEMINAL VESICLES INVASION

*Format an1 used to align with Data Dictionary rules.

Applies to the next 3 data items.

1. The Gleason Grading System is used to help evaluate the prognosis of men with prostate cancer.
2. 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).
3. 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?

2 to 5	Range 2 to 5 (IN CATEGORIES)

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.

2 to 5	Range 2 to 5 (IN CATEGORIES)

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.

3 to 5 8 to Not applicable	Range 3 to 5 and Not applicable (IN CATEGORIES)

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

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

UROLOGY – PATHOLOGY – TESTICULAR

May be one occurrence per Pathology Report (0..1)

Data item No.	Data Item Section	Data Item Name	Format	Schema specification (M/R/O/X)
pUR15310	UROLOGICAL - 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 (Present)
N	No (Not identified)
X	Not applicable (Cannot be assessed)

What's changed since user guide 3.0.3

This updated version of the User Guide includes new data-items, re-alignment of data structure, amendments and contains corrections – for example, where there were errors in previous versions and updates where clinical coding or staging values changed from COSD Pathology Data set v3.0, and should be used to help data collection.

COSD v4.0, has further aligned all data items with those in the Royal College of Pathologists 'Core' data sets. This has meant some data item name, description and/or list of attribute changes.

In addition, all pathological data item numbers have been prefixed with a 'p' and all others are interoperable with the main COSD v9 data set. This allows for updates and corrections to be made without having 2 data items in different data sets with the same data item number.

Throughout the data set there are now a choices which will make collecting and reporting data easier to understand, and will be supported by the new schemas.

There are some key new sections within the CORE section, as below.

Linkage:

- either a NHS Number or a Local Patient Identifier must be provided with every record submitted
- date of birth is now mandatory

Core pathology:

- all records will have to has both an 'Investigation Result Date' and a 'Service Report Identifier' as mandatory fields from v9
- there are new ways for recording consultant data
- a choice has been created for topography and morphology
- Ki-67 has been added to the data set
- new data items have been added to record mismatch repair

Site specific sections:

- many data items have been updated to meet the RC Path data set variables – this will improve ascertainment and reduce the burden of data collection (through duplication)

It is possible that some legacy data may not have all the required mandatory fields for v9. The recommendation is for Trusts to update their data to meet the

new requirements and improve/enrich their data submissions, or not upload the legacy data items in the new record (if that data is not available).

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 to 9.

BENIGN CANCERS

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

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

NON M8/M9 MORPHOLOGIES

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

Table A2

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		
M72860	All Sites including skin		

The WHO classification of tumours now considers keratoacanthoma a sub-type of squamous cell carcinoma, so the morphology code for keratoacanthoma (M72680) has been added to the list of morphologies to be included in the submission.

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/279/releases

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

The subset contains 6 clusters:

1. CLUSTER 1A Malignant diagnosis
2. CLUSTER 1B In situ diagnosis
3. CLUSTER 1C Uncertain diagnosis
4. CLUSTER 1D CNS neoplasms diagnosis
5. CLUSTER 2 Benign neoplasms diagnosis
6. 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 – for example, 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 i.e. NCRAS mandatory fields.

Notes:

- the following table lists all the registerable diseases by ICD10 code, together with the expected data set 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 data set from CWT group specified

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	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	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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	●			
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	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
C11.9	Nasopharynx, unspecified	Head and Neck	•			
C12	Malignant neoplasm of pyriform sinus	Head and Neck	•			
C13.0	Postcricoid region	Head and Neck	•			
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 Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	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	•			
C24.8	Overlapping lesion of biliary tract	Upper Gastrointestinal	•			
C24.9	Biliary tract, unspecified	Upper Gastrointestinal	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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	•			
C38.0	Heart	Lung		•		
C38.1	Anterior mediastinum	Lung		•		
C38.2	Posterior mediastinum	Lung		•		
C38.3	Mediastinum, part unspecified	Lung		•		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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	•			
C43.6	Malignant melanoma of upper limb, including shoulder	Skin	•			
C43.7	Malignant melanoma of lower limb, including hip	Skin	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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.
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.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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.
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		●		

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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.
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 Gynaecological Data sets to be collected where applicable.
C48.2	Peritoneum, unspecified	Sarcoma	• *			* Sarcoma and Gynaecological Data sets to be collected where applicable.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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	●			
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*	● *			* Gynaecological and Skin Data sets to be collected where applicable.
C51.1	*Labium minus*	*Gynaecological*	● *			* Gynaecological and Skin Data sets to be collected where applicable.
C51.2	*Clitoris*	*Gynaecological*	● *			* Gynaecological and Skin Data sets to be collected where applicable.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
C51.8	*Overlapping lesion of vulva*	*Gynaecological*	● *			* Gynaecological and Skin Data sets to be collected where applicable.
C51.9	*Vulva, unspecified*	*Gynaecological*	● *			* Gynaecological and Skin Data sets 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	●			
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	● *			* Urological and Skin Data sets to be collected where applicable.
C60.1	Glans penis	Urological	● *			* Urological and Skin Data sets to be collected where applicable.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
C60.2	Body of penis	Urological	● *			* Urological and Skin Data sets to be collected where applicable.
C60.8	Overlapping lesion of penis	Urological	● *			* Urological and Skin Data sets to be collected where applicable.
C60.9	Penis, unspecified	Urological	● *			* Urological and Skin Data sets 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	●			
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.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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.
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 data set collected for Medulloblastoma patients under 25.
C71.7	Brain stem	Brain/Central Nervous System	●			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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		●		
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

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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
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

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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
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 Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	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.
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.

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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.
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 Haematological chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematological 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				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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				
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				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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				
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				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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				
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				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	Core Data set	Path Only	
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				
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 i.e. NCRAS mandatory registerable conditions

Notes:

- the following table lists all the registerable diseases by ICD10 code, together with the expected data set 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 Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
C00.0 – C97	Malignant neoplasms (See Appendix A 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			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
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			•	
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			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
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			•	
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	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
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			•	
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			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
D38.6	Neoplasm of uncertain or unknown behaviour of Respiratory organ, unspecified	Lung			•	
D39.0	Neoplasm of uncertain or unknown behaviour of Uterus	Gynaecological			•	
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	•			

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
D41.4	Neoplasm of uncertain or unknown behaviour of bladder	Urological	•			
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 Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**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 Haematological chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematological 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				
D46.5	Refractory anaemia with multi-lineage dysplasia	Haematological				

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
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
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			•	

ICD-10 4th Edition All C Codes are Malignant Neoplasms	Description	Cancer Waiting Times Site specific group	Expected Data set to be collected			Comment
			Core and Site Specific Data set	**Core Data set**	**Path Only**	
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[9]	Amyloidosis, unspecified	Haematology	See the Haematological chapter of COSD User Guide (Section 7.2) for information regarding what is required to be submitted for these Haematological diseases.			

9 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. While 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 have updated to v8.0, please refer directly to the TNM Staging Books, for the most recent and accurate stage groupings/combination[1].

Note: The change from TNM 7 and TNM 8 took effect from 1 January 2018 apart from for head & neck sites which took effect from 1 January 2019. FIGO 2018 for cervical cancer takes effect from 1 January 2020.

TUMOUR TYPE	STAGING SYSTEM (from 1 January 2019)	STAGING SYSTEM (from 1 January 2020)
ADRENAL CORTEX TUMOURS	UICC TNM 8	UICC TNM 8
AMPULLA OF VATER – CARCINOMA	UICC TNM 8	UICC TNM 8
AMPULLA OF VATER – NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM	ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM
ANAL CANAL	UICC TNM 8	UICC TNM 8
APPENDIX – CARCINOMA	UICC TNM 8	UICC TNM 8
APPENDIX – NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM**
BONE	UICC TNM 8	UICC TNM 8
BREAST	UICC TNM 8	UICC TNM 8
CERVIX	FIGO (2009) and N STAGE	FIGO (2018)
CHRONIC LYMPHOCYTIC LEUKAEMIA	BINET	BINET
COLON AND RECTUM – CARCINOMA	UICC TNM 8	UICC TNM 8
COLON AND RECTUM – GIST	UICC TNM 8	UICC TNM 8
COLON AND RECTUM – NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM	ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM
CONJUNCTIVA – CARCINOMA	UICC TNM 8	UICC TNM 8
CONJUNCTIVA – MELANOMA	UICC TNM 8	UICC TNM 8
CUTANEOUS SQUAMOUS CELL CARCINOMA AND OTHER CUTANEOUS CARCINOMA	UICC TNM 8	UICC TNM 8
EXTRAHEPATIC BILE DUCT – PERIHILAR	UICC TNM 8	UICC TNM 8
EXTRAHEPATIC BILE DUCTS – DISTAL	UICC TNM 8	UICC TNM 8

[1] http://www.wileyanduicc.com/

FALLOPIAN TUBE	FIGO (2013)	FIGO (2013)
GALLBLADDER	UICC TNM8	UICC TNM8
GESTATIONAL TROPHOBLASTIC DISEASE	FIGO (2009)	FIGO (2009)
GLOTTIS	UICC TNM 8	UICC TNM 8
HEPATOBLASTOMA (CTYA)	PRETEXT STAGING SYSTEM STAGE	PRETEXT STAGING SYSTEM STAGE
HODGKIN LYMPHOMA	ANN-ARBOR	ANN ARBOR STAGE
HYPOPHARYNX	UICC TNM 8	UICC TNM 8
KIDNEY	UICC TNM 8	UICC TNM 8
KIDNEY, WILMS	WILMS TUMOUR STAGE (NWTSG)	WILMS TUMOUR STAGE (NWTSG)
LACRIMAL GLAND – CARCINOMA	UICC TNM 8	UICC TNM 8
LIP	UICC TNM 8	UICC TNM 8
LIVER – INTRAHEPATIC BILE DUCTS	UICC TNM 8 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LIVER – HEPATOCELLULAR	UICC TNM 8 & BARCELONA STAGE	UICC TNM 8 & BARCELONA STAGE
LUNG	UICC TNM 8	UICC TNM 8
MAJOR SALIVARY GLANDS	UICC TNM 8	UICC TNM 8
MAXILLARY SINUS	UICC TNM 8	UICC TNM 8
MEDULLOBLASTOMA	CHANG STAGING SYSTEM	CHANG STAGING SYSTEM
MYELOMA	INTERNATIONAL STAGING SYSTEM (ISS)	REVISED INTERNATIONAL STAGING SYSTEM (R-ISS)
NASAL CAVITY AND PARANASAL SINUSES	UICC TNM 8	UICC TNM 8
NASOPHARYNX	UICC TNM 8	UICC TNM 8
NEUROBLASTOMA	INTERNATIONAL NEUROBLASTOMA RISK GROUP	INTERNATIONAL NEUROBLASTOMA RISK GROUP (INRG) STAGING SYSTEM
NON-HODGKIN LYMPHOMA (ADULT)	ANN-ARBOR	ANN ARBOR STAGE
NON-HODGKIN LYMPHOMA (CHILDREN)	MURPHY ST. JUDE STAGING SYSTEM	MURPHY ST. JUDE STAGING SYSTEM
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – CARCINOMA	UICC TNM 8	UICC TNM 8
OESOPHAGUS INCLUDING OESOPHAGOGASTRIC JUNCTION – GIST	UICC 8	UICC 8
ORAL CAVITY	UICC TNM 8	UICC TNM 8
OROPHARYNX	UICC TNM 8	UICC TNM 8
OMENTUM AND MESENTERY – GIST	none recommended (if UICC TNM 8 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 (2013)	FIGO (2013)
PANCREAS	UICC TNM 8	UICC TNM 8
PANCREAS – NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM	ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM
PENIS	UICC TNM 8	UICC TNM 8
PLEURAL MESOTHELIOMA	UICC TNM 8	UICC TNM 8
PROSTATE	UICC TNM 8	UICC TNM 8
RENAL PELVIS AND URETER	UICC TNM 8	UICC TNM 8
RETINOBLASTOMA	UICC TNM 8	UICC TNM 8 and INTERNATIONAL STAGING SYSTEM FOR RETINOBLASTOMA

RHABDOMYOSARCOMA and OTHER SOFT TISSUE SARCOMAS (CTYA)	UICC TNM 8 & 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 8	UICC TNM 8
SKIN – MALIGNANT MELANOMA	UICC TNM 8	UICC TNM 8
SKIN – MERKEL CELL CARCINOMA**	UICC TNM 8	UICC TNM 8
SKIN OF EYELID – CARCINOMA	UICC TNM 8	UICC TNM 8
SMALL INTESTINE – GIST	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)	none recommended (if UICC TNM 8 is submitted this will be recorded by the NCRAS)
SMALL INTESTINE – NEUROENDOCRINE TUMOURS	EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM	ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM
SMALL INTESTINE – CARCINOMA	UICC TNM 8	UICC TNM 8
SOFT TISSUE	UICC TNM 8	UICC TNM 8
STOMACH – CARCINOMA	UICC TNM 8	UICC TNM 8
STOMACH – GIST	none recommended (if UICC TNM 8 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	ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM
SUBGLOTTIS	UICC TNM 8	UICC TNM 8
SUPRAGLOTTIS	UICC TNM 8	UICC TNM 8
TESTIS	UICC TNM 8	UICC TNM 8
THYMUS	UICC TNM 8	UICC TNM 8
THYROID	UICC TNM 8	UICC TNM 8
UPPER AERODIGESTIVE TRACT – MALIGNANT MELANOMA	UICC TNM 8	UICC TNM 8
URETHRA	UICC TNM 8	UICC TNM 8
URINARY BLADDER	UICC TNM 8	UICC TNM 8
UTERUS – ENDOMETRIUM	FIGO (2009)	FIGO (2009)
UTERUS – UTERINE SARCOMA	FIGO (2009)	FIGO (2009)
UVEA – MALIGNANT MELANOMA	UICC TNM 8	UICC TNM 8
VAGINA	FIGO (2009)	FIGO (2009)
VULVA	FIGO (2009)	FIGO (2009)
VULVA – MALIGNANT MELANOMA	UICC TNM 8	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 list was accurate at the time of publication.

ENETS - EUROPEAN NEUROENDOCRINE TUMOUR SOCIETY TNM, can now be recorded in the CORE – STAGING section, along with all other TNM stage (where applicable).

Following discussions with NCRAS, the British Association of Gynaecological Pathologists (BAGP) and BGCS Council, we have agreed that we should implement the transition for the purposes of cancer registration data from the

2009 to the 2018 FIGO staging systems for cervical cancer for all cases diagnosed on and beyond 1 January 2020.

This provides adequate time to implement changes to IT system capturing staging data including Infoflex and Somerset, as certain disease stages did not previously exist in the old staging system (such as, cervical cancer IIIC1 and IIIC2).