NHS Cervical Screening Programme

NHS Cancer Screening Programmes

Coding guide for the audit of invasive cancers (April 2013 protocol)

Addendum 3 to NHSCSP PUBLICATION No 28

MARCH 2013

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Document Information Protocol changes to the audit of invasive cervical cancers to be implemented April 2013: Coding Guide	
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Authors	Alejandra Castanon
Comments	Comments may be sent to Alejandra Castanon, a.castanon@qmul.ac.uk, in readiness for review
Document objective	To provide a guide to coding for the audit of invasive cervical cancers.
Clinical/healthcare/social questions covered	Which data items are required for the audit? What are the different result codes?
Population affected	Women screened as part of the NHSCSP.
Target audience	Health professionals.
Archived	Current document

CONTENTS

INTRODUCTION

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

The coding guide for the national dataset is divided into the same sections as the data collection forms and will allow a quick overview of the fields and sections that the audit aims to record.

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

Information for Section A, Section B.1, and Section B.2 is almost entirely included in the National Health Applications & Infrastructure Services (NHAIS) system download. Entering these data onto the forms might not be necessary (please follow local QARC guidelines regarding this).

Section G (GP notes) is no longer part of the audit. However if contacting the GP has been found to be useful, this activity should continue. The audit database still allows for GP data to be recorded.

Section H (HPV tests) has been incorporated into Section B, Cytology history.

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

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

SECTION A: PERSONAL AND CANCER DETAILS

AJ-CRUK download

AJ-CRUK runs on the NHAIS system (also known as 'the Exeter system'). It downloads details on the screening histories of both cases and controls. The output can be automatically uploaded onto the Access database used to collate all audit produced data regionally.

AJ-CRUK has been updated and now includes the following fields: surname, forename, NHS number, postcode, date of birth, date of GP registration, cytology test date, cytology result, action code, reason, laboratory number, HPV infection marker, next test repeat in months and details of any episodes where women were ceased or postponed from the programme.

Study ID

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

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

TES = HA cipher

QT2 = Q code of case/controls as of the date of diagnosis

CCYY = the year of the case's diagnosis

NNN = a sequence number for the Q code and the year of diagnosis

X = the case/control type identifier, where

X = 1 indicates a case

X = 2 indicates a GP control

X = 3 indicates a district (health authority) control

X = 4 indicates an adjusted screened control

X = 5 indicates an abnormal control

X = 6 indicates an unadjusted screened control

Postcode

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

Index of multiple deprivation

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

Dates

All dates should be entered in the format DD/MM/YYYY. For example, May 7 1992 becomes 07 05 1992.

Stage

Two boxes have been provided for stage (on the paper forms) to allow a preliminary staging on which the AJ-CRUK job can be run. The final FIGO stage can be entered at any time.

Valid stage codes for AJ-CRUK are: **1A, 1B, 2, 2A, 2B, 3, 3A, 3B, 4, 4A, 4B, IN, 1B+, X**.

X should be used for unknown stage and "IN" or "1B+" if the tumour is known to be worse than micro invasive, but the full stage is not available.

Histology

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

S Squamous
U Undifferentiated
A Adenocarcinoma
O Other
B Adenosquamous carcinoma
U Unknown

Treatment

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

SECTION B.1 CYTOLOGY HISTORY

All fields are provided by AJ-CRUK, except where noted.

No cytology reason (not provided by AJ-CRUK)

1 Not on NHAIS system
2 Invited but did not attend
3 Not yet called
4 Ceased
5 Unclear

Action code

A Routine recall at interval appropriate to age, or cease due to age (dependent on screening history)
H No action
R Repeat at interval specified by laboratory.
S Suspend due to referral

Result codes

1 Inadequate
2 Negative
N Negative (HPV)
3 Low-grade dyskaryosis
M Low-grade dyskaryosis (HPV)
4 High-grade dyskaryosis (severe)
5 High-grade dyskaryosis/?invasive squamous carcinoma
6 ?Glandular neoplasia of endocervical type
7 High-grade dyskaryosis (moderate)
8 Borderline change in squamous cells
B Borderline change in squamous cells (HPV)
9 Borderline change in endocervical cells
E Borderline change in endocervical cells (HPV)
0 ?Glandular (non-cervical)
G ?Glandular (non-cervical) (HPV)

HPV infection code

0 No HR-HPV DNA detected (i.e. negative)
9 HR-HPV DNA detected (i.e. positive)
U HPV result unavailable or unreliable

Source (not provided by AJ-CRUK)

1 GP
2 NHS community clinic
3 GUM clinic
4 NHS hospital (Colp)
5 Private
6 Other
7 Unknown

SECTION B.2 CYTOLOGY CEASED OR POSTPONED

Postponement reason

1 Recent test
2 Current pregnancy
3 Patient wish to defer
4 Under treatment relevant to screening
5 Administrative reason
10 Practice invitation

Ceased reason

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

SECTION C: COLPOSCOPY

Attendance type

1 Yes
2 No
3 Not recorded
4 DNA (did not attend)
5 Hospital cancellation
6 Patient cancellation

TZ Type

0 Not recorded
1 Fully visible (ectocervical)
2 Fully visible (endocervical)
3 Not fully visible
4 Unsatisfactory exam

Colposcopist

1 Consultant
2 Medical non-consultant
3 Nurse
4 Trainee

Colposcopic impression

1 Normal
2 HPV only
3 Low-grade
4 High-grade
5 Invasive cancer
6 Not Recorded
7 CGIN
8 Microinvasive

Surgical procedure

0 None
1 Cervix biopsy
2 LLETZ (loop)
3 Laser excision/cone
4 Knife cone
5 Laser ablation
6 Cold coagulation
7 Cryotherapy
8 Not recorded
9 Radical diathermy

Pregnant: leave blank if the woman is **not** pregnant. Write ‘NK’ if not known.

Follow up: Leave blank if unknown. Write ‘99’ if patient was discharged

Pathological diagnosis

In this section, if the sample has multiple diagnosis, please enter most severe diagnosis only.

0 Normal (includes: cervicitis, infection, inflammatory changes)
X Inadequate
1 HPV Changes
2 CIN - not otherwise specified
- 2.1 CIN1
- 2.2 CIN2
- 2.3 CIN3

3 CGIN - not otherwise specified
- 3.1 Low-grade CGIN
- 3.2 High-grade CGIN
- 3.3 HGCIN and CGIN
- 3.5 SMILE (stratified mucin-producing intraepithelial lesions)

4 Squamous carcinoma - not otherwise specified
- 4.1 Squamous keratinizing
- 4.2 Squamous non-keratinizing
- 4.3 Squamous basaloid
- 4.4 Squamous verrucous
- 4.5 Squamous warty
- 4.6 Squamous papillary
- 4.7 Squamous lymphoepithelioma
- 4.8 Squamous squamoustransitional
- 4.9 Squamous small cell

5 Adenocarcinoma - not otherwise specified
- 5.1 Adeno mucinous
  - 5.11 Adeno mucinous endo
  - 5.12 Adeno mucinous intestinal
  - 5.13 Adeno mucinous signet-ring
  - 5.14 Adeno mucinous minimal deviation
  - 5.15 Adeno mucinous villoglandular
- 5.2 Adeno endometriod
- 5.3 Adeno clear cell
- 5.4 Adeno serous
- 5.5 Adeno mesonephric

6 Adenosquamous - not otherwise specified
- 6.1 Adenosquamous glassy cell variant

7 Carcinoma cervix other type
- 7.1 Small cell carcinoma
- 7.2 Other neuroendocrine carcinoma
- 7.3 Carcinoma type unknown
- 7.4 Undiff carcinoma of cervix

8 Benign squam cell lesions (include condyloma/papilloma/polyp)
- 8.1 Benign glandular (include mullerian/polyp)
- 8.2 Non-cervical atypia
- 8.3 BAUS (epithelial changes uncertain significance)
- 8.4 Other benign and non-neoplastic abnormalities not listed

9 Non-cervical malignancy (including secondary tumours)
NK Not known

SECTIONS D AND F: HISTOLOGY HISTORY AND REVIEW

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

Type of specimen

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

FIGO stage

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

Excision status

Complete
Incomplete
Not applicable

Excision margin

1 Ectocervical
2 Endocervical
3 Deep lateral/radial

Margin involved by

2 CIN
3 CGIN
4 SMILE
5 NA
6 Invasive cancer

Additional features

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

Pathological diagnosis

In this section, if the sample has multiple diagnosis, you can enter up to three diagnosis for each specimen.

Full coding can be found in the colposcopy section of this document

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

SECTION E: CYTOLOGY REVIEW

Test type

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

Cytology type

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

Result codes

1 Inadequate
2 Negative
N Negative (HPV)
3 Low-grade dyskaryosis
M Low-grade dyskaryosis (HPV)
4 High-grade dyskaryosis (severe)
5 High-grade dyskaryosis/?invasive squamous carcinoma
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B Borderline change in squamous cells (HPV)
9 Borderline change in endocervical cells
E Borderline change in endocervical cells (HPV)
0 ?Glandular (non-cervical)
G ?Glandular (non-cervical) (HPV)

Not available for review, reasons

Not found
Not released
Not suitable

Reviewed at

1 Local
2 Training centre
3 Consensus

Reviewer type

Consultant pathologist
Consultant BMS
Assistant director
Training centre manager
Medical director

Potential false positives

A Normal endometrial cells
B Endometriosis/tubo-endo metaplasia
C LUS endometrial sampling
D Histiocytes
E Follicular lymphocytic cervicitis
F IUCD effect
G Other (specify)

Potential false negatives

1 Small cell dyskaryosis
2 Pale cell dyskaryosis
3 Microbiopsies
4 Small keratinized cells
5 Sparse dyskaryosis (<200 cells)
6 Other (specify)

If inadequate, details

1 Insufficient material
2 Not properly stained
3 Cytolitic
4 Obscured

Technical features

1 Fixation adequate
2 Artefact/contaminant present
3 Staining adequate

ESSENTIAL FIELDS

SECTION A : Personal and cancer details

Date of birth
Date of diagnosis
Stage of tumour (FIGO)
Histology
Treatment
Index of Multiple Deprivation

SECTION B.1 & B.2: Cytology history

Reason for no cytology
Date test was taken
Result of the cytology test
HPV result

SECTION C.1: Colposcopy history

Number of colposcopic appointments
Date of colposcopy
Attendance type
Colposcopist
Surgical procedure

SECTION C2: Colposcopy review

All fields under 'Colposcopy review' should be completed.

SECTION D1: Histology cancer diagnosis

Date of specimen
Type of specimen
Pathological diagnosis
FIGO stage

SECTION D2: Histology specimen history

Date of specimen
Type of specimen
Pathological diagnosis
Excision status

SECTION E: Cytology review

Slide ID
Cytology type
Date of original cytology
Result of original cytology
Reviewed at
Review result
Original result NFR (no further review)

SECTION F: Histology review

Specimen ID
Date of original specimen
Pathological diagnosis of original specimen
Evidence of TZ sampling
Reviewed at
Review pathological diagnosis
Excision status

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