

## Cancer initial treatment — completion date

### Identifying and definitional attributes

**Knowledgebase ID:** 001055      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The date on which the initial non-surgical treatment for cancer was completed.
<b>Context:</b>	This item is collected for the analysis of outcome by treatment type. Collected for radiation therapy and systemic therapy. Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

<b>Data domain:</b>	Valid date.
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#### Guide for use:

**Verification rules:** This field must:

- be greater than or equal to Date of diagnosis of cancer
- be greater than or equal to Cancer initial treatment — starting date

#### Collection methods:

**Related metadata:** Relates to the data element concept Initial treatment episode for cancer, version 1.  
 Relates to the data element Radiotherapy treatment given, version 1.  
 Relates to the data element Systemic therapy agent name, version 1.  
 Relates to the data element Cancer initial treatment — starting date, version 1.

**Information model link:** NHIM      Exit/leave from service event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004  
**Source organisation:** Commission on Cancer, American College of Surgeons.

**Source document:** Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Cancer initial treatment — starting date

### Identifying and definitional attributes

**Knowledgebase ID:** 001056      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The start date of the initial course of non-surgical treatment for cancer.
<b>Context:</b>	This item is collected for the analysis of outcome by treatment type. Collected for radiation therapy and systemic therapy. Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death. Date of surgical treatment is collected as a separate item.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

<b>Data domain:</b>	Valid date.
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**Guide for use:** The start date of the treatment is recorded regardless of whether it is completed as intended or not. Treatment subsequent to a recurrence will not be recorded.

**Verification rules:** This field must:

- be greater than or equal to Date of diagnosis of cancer
- be less than or equal to Cancer initial treatment — completion date

**Collection methods:**

**Related metadata:** Relates to the data element Radiotherapy treatment given, version 1.  
 Relates to the data element Systemic therapy agent name, version 1.  
 Relates to the data element Date of diagnosis of cancer, version 1.  
 Relates to the data element Cancer initial treatment — completion date, version 1.

**Information model link:** NHIM      Request for/entry into service event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004  
**Source organisation:** Commission on Cancer, American College of Surgeons.

**Source document:** Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Cancer staging — M stage code

### Identifying and definitional attributes

**Knowledgebase ID:** 001057      **Version number:** 1  
**Metadata type:** Data element

**Definition:** M stage is the coding system used to record the absence or presence of distant metastases at the time of diagnosis of the primary cancer. It is part of the TNM cancer staging system.

**Context:** For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 3  
**Representational class:** Code      **Format:** AAA

**Data domain:** Valid M codes from the current edition of the *UICC TNM Classification of Malignant Tumours*.  
 88 Not applicable

**Guide for use:** Refer to the UICC reference manual, *TNM Classification of Malignant Tumours* for coding rules.

Choose the lower (less advanced) M category when there is any uncertainty.

#### Verification rules:

**Collection methods:** From information provided by the treating doctor and recorded on the patient's medical record.

#### Related metadata:

Relates to the data element Cancer staging — T stage code, version 1.  
 Relates to the data element Cancer staging — N stage code, version 1.  
 Relates to the data element Staging basis, version 1.  
 Relates to the data element Cancer staging — TNM stage grouping code, version 1.  
 Relates to the data element Staging scheme source, version 1.  
 Relates to the data element Staging scheme edition number, version 1.

**Information model link:** NHIM      Physical wellbeing

**Data set specifications:**      **Start date**      **End date**  
 DSS — Cancer (clinical)      04/06/2004

## Administrative attributes

<b>Admin. status:</b>	CURRENT	<b>Effective Date:</b>	04/06/2004
<b>Source organisation:</b>	International Union Against Cancer (UICC). Commission on Cancer, American College of Surgeons.		
<b>Source document:</b>	UICC <i>TNM Classification of Malignant Tumours</i> (5th Edition) (1997). Commission on Cancer, <i>Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II</i> (1998).		
<b>Registration authority:</b>	National Health Information Group.		
<b>Steward:</b>			
<b>Comments:</b>	<p>Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.</p> <p>TNM staging applies to solid tumours excluding brain tumours.</p>		

## Cancer staging — N stage code

### Identifying and definitional attributes

**Knowledgebase ID:** 001058      **Version number:** 1  
**Metadata type:** Data element

**Definition:** N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases at the time of diagnosis of the primary cancer. It is a part of the TNM cancer staging system.

**Context:** For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 3  
**Representational class:** Code      **Format:** AAA

**Data domain:** Valid N codes from the current edition of the *UICC TNM Classification of Malignant Tumours*.  
 88 Not applicable

**Guide for use:** Refer to the UICC reference manual, *TNM Classification of Malignant Tumours* for coding rules.  
 Choose the lower (less advanced) N category when there is any uncertainty.

#### Verification rules:

**Collection methods:** From information provided by the treating doctor and recorded on the patient's medical record.

**Related metadata:** Relates to the data element Cancer staging — T stage code, version 1.  
 Relates to the data element Cancer staging — M stage code, version 1.  
 Relates to the data element Staging basis, version 1.  
 Relates to the data element Cancer staging — TNM stage grouping code, version 1.  
 Relates to the data element Staging scheme source, version 1.  
 Relates to the data element Staging scheme edition number, version 1.

**Information model link:** NHIM      Physical wellbeing

**Data set specifications:**      **Start date**      **End date**  
 DSS — Cancer (clinical)      04/06/2004

## Administrative attributes

<b>Admin. status:</b>	CURRENT	<b>Effective Date:</b>	04/06/2004
<b>Source organisation:</b>	International Union Against Cancer (UICC). Commission on Cancer, American College of Surgeons.		
<b>Source document:</b>	UICC <i>TNM Classification of Malignant Tumours</i> (5th Edition) (1997). Commission on Cancer, <i>Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II</i> (1998).		
<b>Registration authority:</b>	National Health Information Group.		
<b>Steward:</b>			
<b>Comments:</b>	<p>Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.</p> <p>TNM staging applies to solid tumours excluding brain tumours.</p>		

## Cancer staging — T stage code

### Identifying and definitional attributes

**Knowledgebase ID:** 001059      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	T stage is the coding system used to identify the presence the primary tumour. It reflects the tumour size and extent of the primary cancer at the time of diagnosis. It is a part of the TNM cancer staging system.
<b>Context:</b>	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 3  
**Representational class:** Code      **Format:** AAA

<b>Data domain:</b>	Valid T codes from the current edition of the <i>UICC TNM Classification of Malignant Tumours</i> . 88      Not applicable
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**Guide for use:** Refer to the UICC reference manual, *TNM Classification of Malignant Tumours* for coding rules.  
Choose the lower (less advanced) T category when there is any uncertainty.

**Verification rules:**

**Collection methods:** From information provided by the treating doctor and recorded on the patient's medical record.

**Related metadata:** Relates to the data element Cancer staging — N stage code, version 1.  
Relates to the data element Cancer staging — M stage code, version 1.  
Relates to the data element Staging basis, version 1.  
Relates to the data element Cancer staging — TNM stage grouping code, version 1.  
Relates to the data element Staging scheme source, version 1.  
Relates to the data element Staging scheme edition number, version 1.

**Information model link:** NHIM      Physical wellbeing

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Cancer (clinical)	04/06/2004	

## Administrative attributes

<b>Admin. status:</b>	CURRENT	<b>Effective Date:</b>	04/06/2004
<b>Source organisation:</b>	International Union Against Cancer (UICC). Commission on Cancer, American College of Surgeons.		
<b>Source document:</b>	UICC TNM Classification of Malignant Tumours (5th Edition) (1997). Commission on Cancer. <i>Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II</i> (1998).		
<b>Registration authority:</b>	National Health Information Group.		
<b>Steward:</b>			
<b>Comments:</b>	<p>Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.</p> <p>TNM staging applies to solid tumours excluding brain tumours.</p>		

## Cancer staging — TNM stage grouping code

### Identifying and definitional attributes

**Knowledgebase ID:** 001060      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The stage grouping defines the anatomical extent of disease at diagnosis based on the previously coded T, N and M stage categories.
<b>Context:</b>	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 4  
**Representational class:** Code      **Format:** AN(4)

<b>Data domain:</b>	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.
	8888 Not applicable
	9999 Unknown, Stage X

**Guide for use:** Refer to the UICC reference manual *TNM Classification of Malignant Tumours* for coding rules.  
Choose the lower (less advanced) stage grouping when there is any uncertainty.

#### Verification rules:

**Collection methods:** From information provided by the treating doctor and recorded on the patient's medical record.

**Related metadata:** Relates to the data element Cancer staging — T stage code, version 1.  
Relates to the data element Cancer staging — N stage code, version 1.  
Relates to the data element Cancer staging — M stage code, version 1.  
Relates to the data element Staging basis, version 1.  
Relates to the data element Staging scheme source, version 1.  
Relates to the data element Staging scheme edition number, version 1.

**Information model link:** NHIM      Physical wellbeing

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Cancer (clinical)	04/06/2004	

**Administrative attributes**

**Admin. status:** CURRENT **Effective Date:** 04/06/2004

**Source organisation:** International Union Against Cancer (UICC).  
Commission on Cancer, American College of Surgeons.

**Source document:** UICC *TNM Classification of Malignant Tumours* (5<sup>th</sup> Edition) (1997).  
Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Cancer treatment type

### Identifying and definitional attributes

**Knowledgebase ID:** 001061      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The type of treatment for cancer given as initial treatment for the particular patient.
<b>Context:</b>	This item is collected for surgical treatment, radiation therapy and systemic therapy. It is used for correlating outcome with original intent of the treatment.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 1  
**Representational class:** Code      **Format:** N

<b>Data domain:</b>	0	No treatment
	1	Surgical treatment
	2	Radiation therapy
	3	Systemic agent therapy
	4	Surgical and radiation treatment
	5	Surgical treatment and systemic agent treatment
	6	Radiation and systemic agent treatment
	7	All three treatment types

#### Guide for use:

#### Verification rules:

#### Collection methods:

**Related metadata:**

- Relates to the data element concept Initial treatment episode for cancer, version 1.
- Relates to the data element Intention of treatment for cancer, version 1.
- Relates to the data element Surgical treatment procedure for cancer, version 1.
- Relates to the data element Date of surgical treatment for cancer, version 1.
- Relates to the data element Radiotherapy treatment given, version 1.
- Relates to the data element Systemic therapy agent name, version 1.
- Relates to the data element Cancer initial treatment – starting date, version 1.
- Relates to the data element Cancer initial treatment – completion date, version 1.

**Information model link:** NHIM      Exit/leave from service event

<i>Data set specifications:</i>	<i>Start date</i>	<i>End date</i>
DSS – Cancer (clinical)	04/06/2004	

## **Administrative attributes**

<i>Admin. status:</i>	CURRENT	<i>Effective Date:</i>	04/06/2004
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*Source organisation:* Commission on Cancer, American College of Surgeons.  
New South Wales Health Department.

*Source document:* Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).  
Public Health Division NSW *Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1* Sydney NSW Health Dept (2001).

*Registration authority:* National Health Information Group.

*Steward:*

*Comments:*

## Cancer treatment — target site

### Identifying and definitional attributes

**Knowledgebase ID:** 001062      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The site or region of cancer which is the target of a particular surgical or radiotherapy treatment.

**Context:** This information is collected for surgical and radiotherapy treatments.

### Relational and representational attributes

**Data type:** Alphanumeric      **Maximum field size:** 3  
**Representational class:** Code      **Format:** ANN

**Data domain:** Current edition of ICD-O topography codes (Major organ only — first 3 characters).  
 Current edition of ICD-10-AM.

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:** Relates to the data element concept Initial treatment episode for cancer, version 1.

**Information model link:** NHIM      Physical wellbeing

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** World Health Organization

**Source document:** Current edition of *International Classification of Diseases for Oncology (ICD-O)*, World Health Organization.  
 Current edition of *International Classification of Diseases (ICD-10-AM)*, Australian Modification, National Centre for Classification in Health, Sydney.

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Chest pain pattern category

### Identifying and definitional attributes

**Knowledgebase ID:** 001025      **Version number:** 1  
**Metadata type:** Date element

**Definition:** Describes the person's chest pain pattern.

**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 1  
**Representational class:** Code      **Format:** N

<b>Data domain:</b>	1	Atypical chest pain
	2	Stable chest pain pattern
	3	Unstable chest pain pattern: rest &/or prolonged
	4	Unstable chest pain pattern: new & severe
	5	Unstable chest pain pattern: accelerated & severe
	8	No chest pain/discomfort
	9	Not stated/inadequately described

**Guide for use:** For Acute coronary syndrome (ACS) reporting, identifies the chest pain pattern described on presentation.

Code 1 Atypical chest pain. Pain, pressure, or discomfort in the chest, neck, or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

Code 2 Chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

Code 3 Unstable chest pain pattern: rest &/or prolonged. Chest pain that occurred at rest and was prolonged, usually lasting more than 10 minutes.

Code 4 Unstable chest pain pattern: new & severe. New-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification III severity.

Code 5 Unstable chest pain pattern: accelerated & severe. Recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III

Code 8 No chest pain/discomfort.

Code 9 Not stated/ inadequately described.

Chest pain or discomfort of myocardial ischaemic origin is usually described as chest pain, discomfort or pressure, jaw pain, arm pain or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

**Verification rules:****Collection methods:**

**Related metadata:** Is used in conjunction with Time patient presents, version 2.  
 Is used in conjunction with Date patient presents, version 2.  
 Is a qualifier of Acute coronary syndrome stratum, version 1.

**Information model link:** NHIM Physical wellbeing

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

**Administrative attributes**

**Admin. status:** CURRENT **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
 The Cardiac Society of Australia and New Zealand.

**Comments:** The Canadian Cardiovascular Society classes of angina can be used to support categorisation of chest pain patterns. Canadian Cardiovascular Society (CCS) classes of angina (Campeau L. *Grading of angina pectoris*. *Circulation* 1976; 54:522.)

1. Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation
2. Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions)
3. Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace)
4. Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

## Clinical evidence status

### Identifying and definitional attributes

*Knowledgebase ID:* 001026      *Version number:* 1  
*Metadata type:* Data element

<i>Definition:</i>	Indicator of the status of evidence for a pre-existing clinical condition.
<i>Context:</i>	Acute coronary treatment settings.

### Relational and representational attributes

*Data type:* Numeric      *Maximum field size:* 1  
*Representational class:* Code      *Format:* N

<i>Data domain:</i>	1	objective evidence
	2	no objective evidence

#### *Guide for use:*

#### **Acute coronary syndrome – DSS specific**

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

#### **For chronic lung disease**

Objective evidence is coded where the diagnosis is supported by current use of chronic lung disease pharmacological therapy, or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/FVC less than 0.7 (post bronchodilator). Respiratory failure PaO<sub>2</sub> less than 60 mmHg (8kPa), or PaCO<sub>2</sub> greater than 50 mmHg (6.7 kPa).

#### **For heart failure**

Objective evidence is coded where a patient has current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.

#### **For stroke**

For ischaemic: non-haemorrhagic cerebral infarction, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI), or

For haemorrhagic: intracerebral haemorrhage, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI).

#### **For peripheral arterial disease**

For Peripheral artery disease, objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation for a patient with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

For aortic aneurysm, objective evidence is coded when the diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) is supported and substantiated by appropriate documentation of objective testing.

For renal artery stenosis, objective evidence is coded when the diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

#### **Sleep apnoea syndrome**

Objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

#### **Verification rules:**

**Collection methods:** For each concurrent clinical condition – on presentation, the data element Clinical evidence status must also be recorded.

**Related metadata:** Is used in conjunction with the data element Concurrent clinical condition – on presentation, version 1.

**Information model link:** NHIM Acute event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

## **Administrative attributes**

**Admin. status:** CURRENT **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

#### **Chronic lung disease**

- current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids) and/or
- Note: the diagnosis rests on the airflow limitation which is not fully reversible. Consider treating as asthma if airflow limitation is substantially reversible. (The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, *Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook*. Version 1, November 2002.)

#### **Heart failure**

The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE).

Other modalities include:

- transoesophageal echocardiography (TOE)
- radionuclide ventriculography (RVG)

- left ventriculogram (LVgram)
- magnetic resonance imaging (MRI).

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- third heart sound (S3)
- cardiomegaly
- elevated jugular venous pressure (JVP)
- chest X-ray evidence of pulmonary congestion.

## Clinical procedure timing status

### Identifying and definitional attributes

**Knowledgebase ID:** 001027      **Version number:** 1  
**Metadata type:** Data element

**Definition:** An indicator of the timing of the provision of a clinical procedure.

**Context:** Acute coronary treatment settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 1  
**Representational class:** Code      **Format:** N

**Data domain:**

1	procedure performed prior to an episode of admitted patient care
2	procedure performed during an episode of admitted patient care

**Guide for use:** Record only for those procedure codes that apply.

**Verification rules:**

**Collection methods:** This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

**Related metadata:** Is used in conjunction with Acute coronary syndrome procedure type, version 1.  
 Is used in conjunction with Acute coronary syndrome stratum, version 1.

**Information model link:** NHIM      Acute event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Clopidogrel therapy status

### Identifying and definitional attributes

**Knowledgebase ID:** 001028 **Version number:** 1  
**Metadata type:** Data element

**Definition:** Identifies the person's clopidogrel therapy status.  
**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric **Maximum field size:** 2  
**Representational class:** Code **Format:** NN

<b>Data domain:</b>	10	Given
	21	Not given – therapy not indicated
	22	Not given – patient refusal
	23	Not given – true allergy to clopidogrel
	24	Not given – active bleeding
	25	Not given – bleeding risk
	26	Not given – thrombocytopenia
	27	Not given – severe hepatic dysfunction
	29	Not given – other
	90	Not stated/inadequately described

**Guide for use:** If recording 'Not given', record the principal reason if more than one code applies.

**Collection methods:** For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

**Related metadata:**

**Information model:** NHIM Physical wellbeing

**Data set specifications:** **Start date** **End date**  
DSS – Acute coronary syndrome (clinical) 04/06/2004

### Administrative attributes

**Admin. status:** CURRENT **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

## Concurrent clinical condition — on presentation

### Identifying and definitional attributes

**Knowledgebase ID:** 001029      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The concurrent medical conditions, which are pertinent to the risk stratification and treatment of acute coronary syndrome that a person has or has undergone prior to presentation.

**Context:** Acute coronary syndrome clinical reporting only.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 2  
**Representational class:** Code      **Format:** NN

**Data domain:**

- Angina**
  - 11 Angina for more than last two weeks
  - 12 Angina only in the last two weeks
- Chronic lung disease**
  - 21 Chronic lung disease
- Heart failure**
  - 31 Heart failure
- Hypertension**
  - 41 Hypertension
- Stroke**
  - 51 Ischaemic: non-haemorrhagic cerebral infarction
  - 52 Haemorrhagic: intracerebral haemorrhage
- Peripheral arterial disease**
  - 61 Peripheral artery disease
  - 62 Aortic aneurysm
  - 63 Renal artery stenosis
- Sleep Apnoea syndrome**
  - 71 Sleep apnoea
- 99 not stated/inadequately described

**Guide for use:** More than one medical condition may be recorded.  
Record only those codes that apply.  
Record all codes that apply.  
Codes 21, 31, 51, 52, 61, 62, 63, and 71 must be accompanied by a Clinical evidence status code.

**Acute coronary syndrome – DSS specific****Angina**

Code 11 – This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, for more than the last two weeks.

Code 12 – This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, only in the last two weeks.

**Chronic lung disease**

Code 21 – This code is used where there is a history or symptoms suggestive of chronic lung disease.

**Heart failure**

Code 31 – This code is used where a patient has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

**Hypertension**

Code 41 – This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

**Stroke**

Code 51 – This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Code 52 – This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

**Peripheral arterial disease**

Code 61 – This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

Code 62 – This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

Code 63 – This code is used where there is history of functional stenosis of one or both renal arteries.

**Sleep apnoea syndrome**

Code 71 – This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

**Verification rules:**

**Collection methods:**

**Related metadata:** Is qualified by the data element Clinical evidence status, version 1.  
Is used in conjunction with the data element Fibrinolytic therapy status, version 1.

**Information model link:** NHIM Health and wellbeing

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

**Administrative attributes**

**Admin. status:** CURRENT **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

## Creatine kinase MB isoenzyme (CK-MB) — measured

### Identifying and definitional attributes

**Knowledgebase ID:** 001030      **Version number:** 1  
**Metadata type:** Date element

**Definition:** A person's measured creatine kinase MB isoenzyme (CK-MB).  
**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 5  
**Representational class:** Code      **Format:** NNNNN

**Data domain:** Measured value,  
88888 Not measured  
99999 Not stated/inadequately described

**Guide for use:** Code 8888 if test for CK-MB was not done on this admission.  
Measured in different units dependent upon laboratory methodology.  
When only one CK-MB level is recorded, this should be the peak level during the admission.  
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

#### Verification rules:

#### Collection methods:

**Related metadata:** Is a qualifier of Acute coronary syndrome stratum, version 1  
Is qualified by Creatine kinase MB isoenzyme (CK-MB) — units, version 1  
Is qualified by Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range, version 1  
Is used in conjunction with Date Creatine kinase MB isoenzyme (CK-MB) measured, version 1  
Is used in conjunction with Time Creatine kinase MB isoenzyme (CK-MB) measured, version 1

**Information model link:** NHIM      Service provision event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS — Acute coronary syndrome (clinical)	04/06/2004	

**Administrative attributes**

<i>Admin. status:</i>	CURRENT	<i>Effective Date:</i>	04/06/2004
<i>Source organisation:</i>	Acute Coronary Syndrome Data Working Group.		
<i>Source document:</i>			
<i>Registration authority:</i>	National Health Information Group.		
<i>Steward:</i>	The National Heart Foundation of Australia. The Cardiac Society of Australia and New Zealand.		
<i>Comments:</i>			

## Creatine kinase MB isoenzyme (CK-MB) — units

### Identifying and definitional attributes

**Knowledgebase ID:** 001031      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The units used to measure the CK-MB.

**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 1  
**Representational class:** Code      **Format:** N

<b>Data domain:</b>	1	µg/L (micrograms per litre) (immunoassay)
	2	IU
	3	%
	4	index
	5	ng/dl
	6	kCat/l
	9	Not stated/inadequately described

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:** Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) – measured, version 1  
 Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) – upper limit of normal range, version 1  
 Is used in conjunction with Date creatine kinase MB isoenzyme (CK-MB) measured, version 1

**Information model link:** NHIM      Service provision event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

## Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range

### Identifying and definitional attributes

*Knowledgebase ID:* 001032 *Version number:* 1

*Metadata type:* Data element

*Definition:* Laboratory standard for the value of creatine kinase MB isoenzyme (CK-MB) that is the upper boundary of the normal reference range.

*Context:* Health care and clinical settings.

### Relational and representational attributes

*Data type:* Numeric *Maximum field size:* 4

*Representational class:* Quantitative value *Format:* NNNN

*Data domain:* CK-MB value, or  
9999 Not stated/Inadequately described

*Guide for use:* Record the upper limit of the CK-MB normal reference range for the testing laboratory.

*Verification rules:*

*Collection methods:*

*Related metadata:* Is qualified by Creatine kinase MB isoenzyme (CK-MB) — units, version 1.  
Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) — measured, version 1.  
Is used in conjunction with Date creatine kinase MB isoenzyme (CK-MB) measured, version 1.

*Information model link:* NHIM Service provision event

<i>Data set specifications:</i>	<i>Start date</i>	<i>End date</i>
DSS — Acute coronary syndrome (clinical)	04/06/2004	

### Administrative attributes

*Admin. status:* CURRENT *Effective Date:* 04/06/2004

*Source organisation:* Acute Coronary Syndrome Data Working Group.

*Source document:*

*Registration authority:* National Health Information Group.

*Steward:* The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

*Comments:*

## Date creatine kinase MB isoenzyme (CK-MB) measured

### Identifying and definitional attributes

**Knowledgebase ID:** 001033      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The date a creatine kinase MB isoenzyme (CK-MB) is measured.

**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

**Data domain:** Valid date.

**Guide for use:** This data element pertains to the measuring of CK-MB isoenzyme at any time point during this current event.

**Verification rules:**

**Collection methods:**

**Related metadata:**

- is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) – measured, version 1
- is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) – units, version 1
- is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) – upper limit of normal range, version 1
- is used in conjunction with Time Creatine kinase Mb isoenzyme (CK-MB) measured, version 1

**Information model link:** NHIM      Service provision event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

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## Date of death

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### Identifying and definitional attributes

**Knowledgebase ID:** 001063      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The date of death of the person.
<b>Context:</b>	Required for statistical survival analysis for derivation of the length of time between diagnosis with primary cancer and death.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

<b>Data domain:</b>	Valid date.
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**Guide for use:** Recorded for patients who have died.

**Verification rules:** This field must be greater than or equal to Date of diagnosis of primary cancer.

**Collection methods:** It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.

#### Related metadata:

**Information model link:** NHIM      Demographic characteristic

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Health Data Standards Committee.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

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## Date of diagnosis of first recurrence

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### Identifying and definitional attributes

**Knowledgebase ID:** 001064      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
<b>Context:</b>	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

<b>Data domain:</b>	Valid date.
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**Guide for use:** The term 'recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.

**Verification rules:** This field must:

- be greater than Date of diagnosis of cancer
- be greater than Cancer initial treatment – completion date (if less than Cancer initial treatment – completion date, the patient was never disease-free)

**Collection methods:**

**Related metadata:** Relates to the data element Region of first recurrence, version 1.

**Information model link:** NHIM      Request for/entry into service event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Commission on Cancer, American College of Surgeons.

**Source document:** Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Date of first angioplasty balloon inflation or stenting

### Identifying and definitional attributes

**Knowledgebase ID:** 001034      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The date of the first angioplasty balloon inflation or stent placement.  
**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** DDMMYYYY  
**Representational class:** Date      **Format:** 8

**Data domain:** Valid date.

**Guide for use:** For Acute coronary syndrome (ACS) reporting, refers to the Date of first angioplasty balloon inflation or coronary stenting for this admission.

**Verification rules:** For Acute coronary syndrome (ACS) reporting, must be the same as, or later than the Date of triage.

#### Collection methods:

**Related metadata:** Is used in conjunction with Acute coronary syndrome procedure type, version 1  
 Is used in conjunction with Time of first angioplasty balloon inflation or stenting, version 1  
 Is used in conjunction with Date of triage, version 1  
 Is used in conjunction with Time of triage, version 1

**Information model link:** NHIM      Service provision event

**Data set specifications:**      **Start date**      **End date**  
 DSS – Acute coronary syndrome (clinical)      04/06/2004

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

#### Source document:

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

## Date of intravenous fibrinolytic therapy

### Identifying and definitional attributes

**Knowledgebase ID:** 001035      **Version number:** 1  
**Metadata type:** Data element

**Definition:** The date intravenous (IV) fibrinolytic therapy was administered or initiated.

**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

**Data domain:** Valid date.

**Guide for use:** For Acute coronary syndrome (ACS) reporting, refers to coronary arteries. If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be reported.

**Verification rules:**

**Collection methods:**

**Related metadata:** Is used in conjunction with Acute coronary syndrome procedure type, version 1.  
 Is used in conjunction with Date of triage, version 1.  
 Is used in conjunction with Time of triage, version 1.  
 Is used in conjunction with Fibrinolytic drug used, version 1.  
 Is used in conjunction with Time of intravenous fibrinolytic therapy, version 1.

**Information model link:** NHIM      Service provision event

**Data set specifications:**      **Start date**      **End date**  
 DSS – Acute coronary syndrome (clinical)      04/06/2004

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
The Cardiac Society of Australia and New Zealand.

**Comments:**

## Date of surgical treatment for cancer

### Identifying and definitional attributes

**Knowledgebase ID:** 001065      **Version number:** 1  
**Metadata type:** Data element

<b>Definition:</b>	The date on which the cancer-directed surgical treatment was performed.
<b>Context:</b>	This item is collected for analyses of outcome by treatment type.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

<b>Data domain:</b>	Valid date.
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**Guide for use:** The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.

**Verification rules:** This field must be greater than or equal to Date of diagnosis of cancer.

**Collection methods:**

**Related metadata:** Relates to the data element concept Initial treatment episode for cancer, version 1.  
 Relates to data element Surgical treatment procedure for cancer, version 1.

**Information model link:** NHIM      Service provision event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Cancer (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Commission on Cancer, American College of Surgeons.

**Source document:** Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**

## Date troponin measured

### Identifying and definitional attributes

**Knowledgebase ID:** 001036      **Version number:** 1  
**Metadata type:** Data element

**Definition:** Date the troponin assay is measured.

**Context:** Health care and clinical settings.

### Relational and representational attributes

**Data type:** Numeric      **Maximum field size:** 8  
**Representational class:** Date      **Format:** DDMMYYYY

**Data domain:** Valid date.

**Guide for use:** This data element pertains to the measuring of troponin at any time point during this current event.

**Verification rules:**

**Collection methods:**

**Related metadata:** Is used in conjunction with Time troponin measured, version 1.  
 Is used in conjunction with Troponin measured, version 1.  
 Is used in conjunction with Troponin assay type, version 1.  
 Is used in conjunction with Troponin assay – upper limit of normal, version 1.

**Information model link:** NHIM      Service provision event

<b>Data set specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

### Administrative attributes

**Admin. status:** CURRENT      **Effective Date:** 04/06/2004

**Source organisation:** Acute Coronary Syndrome Data Working Group.

**Source document:**

**Registration authority:** National Health Information Group.

**Steward:** The National Heart Foundation of Australia.  
 The Cardiac Society of Australia and New Zealand.

**Comments:**

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## Degree of spread of cancer

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### Identifying and definitional attributes

*Knowledgebase ID:* 000862      *Version number:* 1  
*Metadata type:* Data element

<b>Definition:</b>	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time.
<b>Context:</b>	<p>This information is collected for the purpose of:</p> <ul style="list-style-type: none"> <li>– determining what proportion of cancers are localised to the site of the primary cancer at the time of diagnosis.</li> <li>– indicating the extent of disease at the time of diagnosis.</li> <li>– for previously diagnosed cancers, the degree of spread may be measured at each patient episode to track the progression of the cancer.</li> <li>– assessing how early in its course the cancer was diagnosed (used to assess impact of early diagnosis measure).</li> </ul> <p>Estimating severity by degree of spread (used for comparing survival after adjusting for degree of spread).</p>

### Relational and representational attributes

*Data type:* Numeric      *Maximum field size:* 1  
*Representational class:* Code      *Format:* N

<b>Data domain:</b>	<p>Degree of spread of cancer:</p> <table> <tr><td>1</td><td>Localised to the tissue of origin</td></tr> <tr><td>2</td><td>Invasion of adjacent tissue or organs</td></tr> <tr><td>3</td><td>Regional lymph nodes</td></tr> <tr><td>4</td><td>Distant metastases</td></tr> <tr><td>5</td><td>Not applicable</td></tr> <tr><td>9</td><td>Unknown</td></tr> </table>	1	Localised to the tissue of origin	2	Invasion of adjacent tissue or organs	3	Regional lymph nodes	4	Distant metastases	5	Not applicable	9	Unknown
1	Localised to the tissue of origin												
2	Invasion of adjacent tissue or organs												
3	Regional lymph nodes												
4	Distant metastases												
5	Not applicable												
9	Unknown												

**Guide for use:**

The valid values for the variable are listed below.

**Code 1** Localised to the tissue of origin: Includes a primary cancer where the spread is contained within the organ of origin.

Note: this includes in situ breast (D05.0–D05.9) and in situ melanoma (D03.0–D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

**Code 2** Invasion of adjacent tissue or organs: A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

**Code 3** Regional lymph nodes: The primary cancer has metastasised to the nearby draining lymph nodes.

The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck – Cervical nodes

Larynx – Cervical nodes

Thyroid – Cervical and upper mediastinal nodes

Stomach – Perigastric nodes along the lesser and greater curvatures

Colon and rectum – Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal – Perirectal, internal iliac, and inguinal lymph nodes

Liver – Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas – Peripancreatic nodes

Lung – Intrathoracic, scalene and supraclavicular

Breast – Axillary, interpectoral, internal mammary

Cervix – Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary – Hypogastric (obturator), common iliac, external iliac, lateral, sacral, paraortic and inguinal

Prostate and bladder – Pelvic nodes below the bifurcation of the common iliac arteries

Testes – Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney – Hilar, abdominal, para-aortic or paracaval

Code 4 Distant metastases: The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

Code 5 Not Applicable: This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0-C96.9) only.

Code 9 Unknown: No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories

**Verification rules:**

**Collection methods:**

**Related metadata:**

**Information model link:** NHIM Assessment event

## Administrative attributes

**Admin. status:** CURRENT **Effective Date:** 25/02/04

**Source organisation:** World Health Organization.  
NSW Health Department.

**Source document:** Full International Classification of Diseases for Oncology, Second Edition (ICD-O-2).  
NSW Inpatient Statistics Collection Manual-2000/2001.

**Registration authority:** National Health Information Group.

**Steward:**

**Comments:**