

Errata

National Health Data Dictionary, Version 12 Supplement

(AIHW Cat. No HWI 72)

Page 183 – Most valid basis of diagnosis of cancer

The data domain in this data element was incorrectly printed in the National Health Data Dictionary Version 12 Supplement. The correct code set should be 0, 1, 2, 4, 5, 6, 7, 8 and 9 and is correctly represented in the following pages.

Most valid basis of diagnosis of cancer

Identifying and Definitional attributes

Knowledgebase ID: 000861 **Version number:** 1

Metadata type: Data element

Definition: The basis of diagnosis of a cancer is the microscopic or non-microscopic or death certificate source of the diagnosis. The most valid basis of diagnosis is that accepted by the cancer registry as the most reliable diagnostic source of the death certificate, non-microscopic, and microscopic sources available.

Context: Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1

Representational class: Code **Format:** N

Data domain:	0	Death Certificate Only: Information provided is from a death certificate.
		Non-microscopic
	1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
	2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis.
	4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site.
		Microscopic
	5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.
	6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens.
	7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour.
	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified.
		Other
	9	Unknown.

Guide for use: The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this item should

be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

- (a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);
- (b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the Histology codes should be recorded instead);
- (c) the autopsy findings are not supported by any histological diagnosis.

Verification rules:

Collection methods:

Related metadata:

Information model link: NHIM Physical wellbeing

Data Set Specifications:	Start date	End date
DSS – Cancer (clinical)	04/06/2004	

Administrative attributes

Admin status: CURRENT **Effective Date:** 25/02/2004

Source organisation: International Agency for Research on Cancer and International Association of Cancer Registries.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

In a hospital setting this item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnostic technique is used during an admission, select the higher code from 1 to 8.