Person with cancer—most valid basis of diagnosis of the first recurrence, code N

Exported from METEOR (AIHW's Metadata Online Registry)

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Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Most valid basis of diagnosis of recurrence
METEOR identifier:	394047
Registration status:	Health!, Standard 07/12/2011
Definition:	The most valid basis of diagnosis of the first recurrence of locoregional cancer or distant metastasis in a person with cancer, as represented by a code.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Person with cancer—most valid basis of diagnosis of a cancer
METEOR identifier:	269649
Registration status:	Health!, Standard 01/03/2005
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.
Object class:	Person with cancer
Property:	Most valid basis of diagnosis of a cancer

Value domain attributes

Identifying and definitional attributes

Value domain:	Basis of diagnosis of cancer code N
METEOR identifier:	270758
Registration status:	Health!, Standard 01/03/2005
Definition:	A code set representing sources of cancer diagnosis.

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	0	Death certificate only: Information provided is from a death certificate
	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
	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
Supplementary values:	9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

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

Data element attributes

Collection and usage attributes

Guide for use:

Record the most valid basis of diagnosis that identifies the first recurrence of locoregional cancer or a distant metastasis.

The term recurrence refers to the return, reappearance or metastasis of cancer of the same histology after a disease-free period. It may be locoregional or a distant metastasis.

The information is collected for the first recurrence of cancer at any site.

The coding system is based on that recommended by the International Agency for Research on Cancer (IARC) and the International Association of Cancer Registries (IACR). The value "3" is not represented.

If more than one investigation identifying the recurrence is conducted at the same time, select the higher number code from 1 to 8 reflecting the most definitive method of diagnosis. For example, if the patient has both imaging (Code 2) and histology of a primary tumour (Code 7) to verify the cancer, record Code 7 as the most valid basis of diagnosis.

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 feasibility of making a morphological (histological) diagnosis is dependent upon a variety of factors, such as the health and age of the patient, accessibility of the tumour, availability of medical services, and the beliefs and decisions of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, for example, 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 to determine whether the site of the biopsy is primary or metastatic, Code 8. Cytological and histological diagnoses should also be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. When using endoscopic procedures such as bronchoscopy, gastroscopy or laparoscopy, 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.

Collection methods:

The information should be obtained from the patient's medical record.

Comments:

Information regarding the basis of diagnosis is important for determining how definitively the malignancy was confirmed and subsequently the reliability of cancer statistics.

Source and reference attributes

Submitting organisation:

Cancer Australia

Origin:

International Agency for Research on Cancer (IARC)

International Association of Cancer Registries (IACR)

Relational attributes

Related metadata references:

See also Patient—diagnosis date of first recurrence as distant metastasis, DDMMYYYY
Health!, Standard 07/12/2011

See also Patient—diagnosis date of first recurrence as locoregional cancer, DDMMYYYY
Health!, Standard 07/12/2011

See also Person with cancer—region of first recurrence as distant metastasis, topography code (ICD-O-3) ANN.N
Health!, Standard 07/12/2011

See also Person with cancer—region of first recurrence as locoregional cancer, topography code (ICD-O-3) ANN.N
Health!, Standard 07/12/2011

Implementation in Data Set Specifications:

Cancer (clinical) DSS
Health!, Superseded 08/05/2014
Conditional obligation: Conditional on the return, reappearance or metastasis of cancer of the same histology after a disease-free intermission or remission.

Cancer (clinical) DSS
Health!, Superseded 14/05/2015
Conditional obligation: Conditional on the return, reappearance or metastasis of cancer of the same histology after a disease-free intermission or remission.

Cancer (clinical) NBPDS
Health!, Standard 14/05/2015
Conditional obligation:

Conditional on the return, reappearance or metastasis of cancer of the same histology after a disease-free intermission or remission.