Person with cancer—most valid basis of diagnosis of a cancer, 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 cancer
METEOR identifier:	422772
Registration status:	Health!, Standard 07/12/2011
Definition:	The most valid basis of diagnosis 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:

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 metadata 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 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, 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.

Comments:

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

Source and reference attributes

Origin:

International Agency for Research on Cancer

International Association of Cancer Registries

Relational attributes

Related metadata references:

Supersedes Person with cancer—most valid basis of diagnosis of a cancer, code N
Health!, Superseded 07/12/2011

Implementation in Data Set Specifications:

Breast cancer (cancer registries) NBPDS
Health!, Standard 01/09/2012

Cancer (clinical) DSS
Health!, Superseded 08/05/2014

Cancer (clinical) DSS
Health!, Superseded 14/05/2015

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