NSW Outpatient Radiation Oncology Data Set (EROD)

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NSW GOVERNMENT

cancer institute NSW

Contents

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Introduction

The purpose of this document is to describe the content, process and timing of extracting and transferring the Radiotherapy data (Source Data) from health institutions to the NSW Cancer Registry database (Target Database). Radiotherapy data is hosted and maintained in a number of systems (source systems) run by private and public institutions. Radiotherapy data is extracted from the source systems report through predefined data extract and upload processes. The mandatory cancer notifications, authorized under the Public Health Act 2012, are included in this radiotherapy extract.

The scope of this document is to:

- Describe the Radiotherapy Report Standard extract format
- Specify naming conventions used
- Describe methods to transfer (source data) into the destination database

Reporting Schedule

Due to the nature and duration of treatment for various protocols, notifying institutions are required to send their reports every 6 weeks. The report should include details of all patients who have:

- Completed a Radiotherapy course, or
- Assigned a consultation date.

Guide for Use

The following section describes report rules to clarify any points of ambiguity in what should be reported when.

- Identifier
    - All reports should contain identifier information for the person irrelevant of whether it has been reported previously. This would be data items such as medical record number (MRN) and patient unique identifier (UID).
    - Demographic reports should contain demographic information for the person irrelevant of whether it has been reported previously.
    - The address reported should be the address at the time of the episode.
- Cancer Staging Items
    - Staging should be the stage at the time of the episode.
    - Rules articulated in the AJCC staging manual should be used to determine the TNM staging basis.

- If the EROD contains a clinical and pathological stage at the time of the episode, both the clinical and pathological staging can be reported as specified in the section Multiple Rows for a Report.

- Cancer Treatment Items

- Quality of Care Indicators
  - Performance status should be at the time of the episode.

Naming Conventions

All source data files submitted must conform to a standard naming convention. The naming convention will provide information about the file type, and the date the file was created and which institution loaded the file. The file should be named in the following way:

[Notification Type Name]_[Notification Institution]_[Date Time].[Extension]

The naming convention for the file name is as follows:

[String]_[String]_[ddMMyyyyhhmm].[String]

Where:

Notification Type Name: a valid predefined notification type such as (PATH - Pathology, RADIO - Radiotherapy, OUPT - OutPatient, INP - InPatient, D - Death, and CHEMO – OMIS Long Format, and MEDONC – OMIS Short Format)

Report Institution: a valid predefined notifying institution code such as (C208 – Prince of Wales Hospital)

Data Time: Date and Time the file was created (DD: Day, MM:Month, yyyy:Year, hh:Hour, mm:Minute)

Extension: Extracted file extension. For this extract all the files should be CSV files

An example of correctly named file using the above convention is:

Radio_C208_150620110700.CSV

Acquiring Source Data

Radiotherapy data is received as reports extracted from a Radiotherapy Information System located in a health service institution, either Public or Private, as a CSV format flat file.

Submitting Source Data

Radiotherapy data should be submitted utilising CSV upload capability in the New South Wales Cancer Registry. All csv files uploaded will be passed through validation routines and an error report generated and returned to the submitting user.

Report Format

The table below describes the Radiotherapy Standard Report format that is required for extracted Radiotherapy CSV files. All **Mandatory** fields should be extracted and populated in the order specified, **Optional** fields could be populated with their data (default value, blank, or empty string).

Note:

Letters in **Format** column means:

A – Alphanumeric

N – Numeric

X – Text or String values

Letters in **M/O** column means:

M – Mandatory

O – Optional*

C – Conditional*

X – N/A

* Any items that are Optional or Conditional are to remain blank in the extract if these are unable to be reported

Rules for data items:

- Patient Demographics:
  - It is mandatory to report the Usual Residential Address at the time of the episode using items 10-13.
- AMO Identifiers:
  - It is mandatory to report the AMO Registration Number of the treating clinician for each report.
- Cancer Diagnostic items:
  - It is mandatory to report either Primary Site of Cancer Code ICD10AM or Primary Site of Cancer Code ICDO3.

Values in the **Type** column means:

Varchar	– Field accepts alphanumeric data
Numeric	– Field accepts numeric data
Date	– Field accepts dates
Datetime	– Field accept Date and Time data

Multiple Rows for a Report

The GroupID allows the system to identify multiple rows to be allocated to the same record, for those items where multiple items are to be notified in the same report (for example additional treatment sites or multiple staging records).

Matching will be completed with all other fields in the row to ensure the same record, with differences in the field values on each row creating an error in the system.

The following fields will be the exceptions to the matching rule, and each of these sets of data will be able to be added multiple times to the report, with additional records being provided in subsequent rows – the GroupID indicating it is all part of one record (fields marked in light blue in the below section):

Cancer Staging Items – TNM

- T Stage
- N Stage
- M Stage
- TNM Stage Group
- TNM Staging Group Basis

Cancer Treatment – Radiotherapy Treatment Sites

- Radiotherapy Information System Site Name
- Site Start Date
- Site End Date
- Prescribed Dose
- Actual Dose
- Prescribed fractions
- Actual fractions

Record Validation Rules

When the file is uploaded into the NSWCRs, each record will be validated according to a set of validation rules specified below. If the record fails the validation rules, the record will be rejected and returned to the user with an error message. The validation rules applied are:

1. **Mandatory fields** – Each field specified as mandatory must be populated.

2. **Valid field values** – Each field populated must meet the format requirements (as an example field length or numeric only).

3. **Valid data** – Each field populated where the accepted values are defined must be populated by a valid value.

4. **Cross field date validations** – The following cross field date validations apply when both the fields have been populated with dates (if the default date of 01/01/9999 has been populated for a date field, the field is excluded from the validation)

Cross field date validation rule	Description
Date of birth <= Site Start Date	Date of birth must be before or equal to the Site Start Date
Date of birth <= Site End Date	Date of birth must be before or equal to the Site End Date
Date of birth <= Date of Primary Diagnosis	Date of birth must be before or equal to the Date of Primary Diagnosis
Date of birth <= Date of Referral to cancer specialist	Date of birth must be before or equal to the Date of Referral to cancer specialist
Date of birth <= Date of first consultation with cancer specialist	Date of birth must be before or equal to the Date of first consultation with cancer specialist
Date of birth <= Read for Care Date	Date of birth must be before or equal to the Ready for Care Date
Date of birth <= Multidisciplinary team consultation	Date of birth must be before or equal to the Date of Multidisciplinary team consultation
Date of birth <= Date of Performance Status	Date of birth must be before or equal to the Performance Status Date
Date of birth <= Date of referral to Palliative care	Date of birth must be before or equal to the Date of referral to Palliative care
Date of birth <= Today's Date	Date of birth must be before or equal to Today's Date
Date of Primary Diagnosis <= Site End Date	Date of Primary Diagnosis must be before or equal to the Site End Date
Date of Primary Diagnosis <= Read for Care Date	Date of Primary Diagnosis must be before or equal to the Ready for Care Date
Date of Primary Diagnosis <= Today's Date	Date of Primary Diagnosis must be before or equal to Today's Date
Site Start Date <= Today's Date	Site Start Date must be before or equal to Today's Date
Site Start Date <= Site End Date	Site Start Date must be before or equal to the Site End Date
Site End Date <= Today's Date	Site End Date must be before or equal to Today's

	Date
Ready for Care Date <= Site Start Date	Ready for Care Date must be before or equal to the Site Start Date
Date of Referral to cancer specialist <= Date of first consultation with cancer specialist	Date of Referral to cancer specialist must be before or equal to the Date of first consultation with cancer specialist

Header Record

Each extract file must have a header record written by the extract process, which must have the format as defined below. This describes and identifies the content of the file. It must precede the first data record.

Notification Table Field Name (ID)	Field Description	Format	Comments
HospitalFacilityID	Hospital Facility Identifier	ANNN	The treating facility hospital code that the Department or Unit belongs to.
Notificationperiodfrom	Report period from	DDMMYYYY	
Notificationperiodto	Report period to	DDMMYYYY	
Fileproductiondate	File production date	DDMMYYYY	
Fileproductiontime	File production Time (in 24 hour format)	HHMM	
Numberofrecords	Number of records (including header record)	N	
NotificationTypeID	Report Type Identifier	A	Populated from the CSV file Name (Notification Type) P - Pathology O - Outpatient I - Inpatient D - Death R - Radiotherapy C - Chemotherapy
CancerFacilityCodeID	Cancer Service Unit Identifier	ANNN	Department or Unit submitting the report.

Detail Records

NSWCRs Data Dictionary ID	Field Name	Field Order	Type	Format	M/O	Accepted Values / Format	Description	Table / Field Name (ID)
	Source CSV File						**Destination NSWCR Database**	
N/A	GroupID	1	Numeric	N (11)	M	Positive numeric value	An identifier that allows multiple rows to be grouped into one report. Data items in this document that can be reported multiple times in one Report are marked in purple. All other items should be duplicated on subsequent rows for the same report.	Staging.GroupID
Patient Identifiers								
NOT021	Medicare Number	2	Numeric	N (12)	O		Medicare (Card) Number	MedicareNumber
NOT211	MRN	3	Varchar	A (20)	O		Medical Record Number	MRN
NOT210	Patient Area Unique Identifier	4	Numeric	A(20)	O	Numeric value (0-9)	Person Area Unique Identifier	UniqueIdentifier
Patient Demographic Items								
NOT005	First Given Name	5	Varchar	X (40)	M		Patient's First Given Name	GivenName1
NOT006	Second Given Name	6	Varchar	X (40)	O		Patient's Second Given Name	GivenName2
NOT001	Surname	7	Varchar	X (40)	M		Patient's Family Name	Surname

NOT010	Sex	8	Numeric	N(1)	M	1,2,3, 9	The biological distinction between male and female, as represented by a code. 1 – Male 2 – Female 3 – Indeterminate 9 – Not Stated	Sex
NOT011	Date of birth	9	Date	N(8)	M	DDMMYYYY	Date of Birth	DateOfBirth
NOT016	Usual Residential Address (URA)	10	Varchar	A(180)	M	Unit 1/ 50 George Street	Address of usual residence at the time of the episode Composite of unit, street number, name	WayfareAddress
NOT017	URA Suburb	11	Varchar	A (40)	C	Valid Suburb Name (Redfern)	Usual Residential Address suburb name as defined in Australia Post's Postcode Database at the time of the episode	Locality
NOT018	URA Postcode	12	Varchar	A (4)	M	Valid postcode as defined in Australia Post's Postcode Database	URA postcode at the time of the episode 9990 overseas 9998 NFA 9999 Unknown	Postcode
NOT019	URA State	13	Varchar	N(2)	M	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 98, 99	URA State Number at the time of the episode 0 - Overseas not known or stated 1 - New South Wales 2 - Victoria 3 - Queensland 4 - South Australia 5 - Western Australia	WayfareStateID

							6 - Tasmania 7 - Northern Territory 8 - Australian Capital Territory 9 - Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory) 98 - Australia not known NFA 99 Unknown or not stated	
NOT014	Indigenous status	14	Numeric	N(1)	O	1 , 2, 3, 4, 8, 9	Aboriginal and Torres Strait Islander Status (TSI): 1 – Aboriginal but not TSI origin 2 – TSI but not Aboriginal origin 3 – Both Aboriginal & TSI origin 4 - Neither Aboriginal nor TSI origin 8 - Declined to respond 9 – Not stated / inadequately described	IndigenousStatusID
Provider Details								
NOT205	AMO/AHPRA Registration Number of the Treating Doctor	15	Varchar	A(20)	M	AAANNNNNNN	The AHPRA Registration Number of the treating oncologist/haematologist or the Medical Board of Australia Registration Number of the treating oncologist/haematologist.	AmoRegReferringNumber
NOT206	Treating Doctor's name	16	Varchar	A(120)	M		The full name of the doctor in charge of the case. Eg. Dr Peter Bloggs	DoctorName
Provider Details								

TBA	Hospital Facility Identifier	17	Varchar	A(4)	O	ANNN	Department of Health Unique Hospital Facility Code in which the episode occurred Example: C208 Prince of Wales Hospital	TreatingFacilityCode
NOT025	Cancer Department Identifier	18	Varchar	A(4)	M	ANNN	Department of Health Unique Cancer Department Code in which the episode occurred Example: C926 Prince of Wales Department of Radiation Oncology	FacilityCode
Cancer Diagnostic Items								
NOT100	Date of Primary Diagnosis	19	Date	N(8)	M	DDMMYYYY	Date of diagnosis of primary cancer Default Diagnosis Date 01/01/9999	DateOfDiagnosis
NOT101	Primary Site of Cancer Code	20	Varchar	A(7)	M		Valid ICD-10-AM or ICD-O-3 cancer codes. The latest version will be applied to the reported Primary Site of Cancer Code.	CancerSiteCodeID
NOT104	Best Basis of Diagnosis	21	Numeric	N(1)	O	1, 2, 4, 5, 6, 7, 8	Most valid basis of diagnosis of cancer: 1 – Clinical: Prior to death 2 – Clinical: Diagnostic techniques 4 – Specific tumour markers 5 – Cytology	BestBasisOfDiagnosisID

							6 – Histology of metastasis 7 – Histology of a primary tumour 8 – Histology: either unknown whether of primary or metastatic site, or not otherwise specified	
NOT103	Laterality of primary cancer	22	Varchar	N(1)	O	1, 2, 3, 9	Laterality describes which side of a paired organ is involved with the tumour. 1 – Left 2 – Right 3 – Not Applicable 9 – Unknown	Laterality
NOT107	Histopathological grade	23	Numeric	N(2)	O	1, 2, 3, 4, 8, 9	The histopathological grade describes how much the tumour resembles the normal tissue from which it arose: 1 – Grade 1: low grade 2 – Grade 2: Intermediate 3 – Grade 3: High 4 – Grade 4: Undifferentiated 8 – Grade not applicable 9 – Grade or differentiation not determined, not stated	HistopathologicalGradeID
NOT102	Morphology of cancer code	24	Varchar	A(10)	O	The morphology code can be reported in the following formats ANNNN/N	Morphology refers to the histological classification of the cancer tissue (Histopathological Type) and a description of the course of development that a tumour is likely to take: benign or malignant, as represented by a code.	MorphologyCodeID

						NNNN/N NNNNN	The latest version will be applied to the reported Morphology of Cancer Code.	
Cancer Staging Items								
NOT116	T Stage	25	Varchar	A(50)	O	Valid T Stage codes from the AJCC TNM Code set **Refer to Appendix B**	T stage is the coding system used to identify the extent of the tumour at the primary site. It commonly refers to the tumour size and extent at the time of diagnosis. It is part of the AJCC TNM cancer staging system: Unstaged Not applicable Unknown	TStageID
NOT118	N Stage	26	Varchar	A(50)	O	Valid N Stage codes from the AJCC TNM Code set **Refer to Appendix C**	N stage is the coding system used to denote the absence or presence of regional lymph node metastases, and the extent of nodal involvement, at the time of diagnosis of the primary cancer. It is part of the AJCC TNM cancer staging system: Unstaged Not applicable Unknown	NstageID
NOT120	M Stage	27	Varchar	A(50)	O	Valid M Stage codes from the AJCC TNM Code set	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 AJCC TNM cancer staging	MStageID

						Refer to Appendix D	system: Unstaged Not applicable Unknown	
NOT122	TNM Stage Group	28	Varchar	A(50)	O	Valid TNM Stage codes from the AJCC TNM Code set **Refer to Appendix A**	TNM stage grouping code that defines the anatomical extent to disease at diagnosis based on previously coded T, N and M stage categories. It is part of the AJCC TNM cancer staging system: Unstaged Not applicable Unknown	TNMStagingGroupingID
NOT123	TNM Staging Group Basis	29	Varchar	A(1)	C	C, P	The evidence basis for the TNM stage value for a cancer, as represented by a code. C – Clinical P – Pathological Conditional mandatory: if T Stage, N Stage M Stage or TNM Stage Group are populated then TNM Staging Group Basis must be populated.	TNMStagingBasisID
Cancer Treatment – Items								
NOTP001	PSA Score	30	Numeric	N(6)	O		The PSA score at time of treatment should be reported.	PSAID
NOT201	Intention of treatment	31	Numeric	N(2)	O	0, 1, 2, 21, 22, 23, 3, 4, 9	The intention of the treatment. 0 – Did not have treatment 1 – Prophylactic 2 – Curative	EpisodeIntentID

							21 – Curative - adjuvant 22 – Curative - Neoadjuvant 23 – Curative - Recurrent 3 – Palliative 4 – Diagnostic/staging 9 – Not Stated	
NOT352	Radiotherapy Type	32	Numeric	N(2)	O	0, 1, 2, 3, 4, 5, 6, 9, 10, 11	The type of radiation therapy used in the primary treatment of the cancer, as represented by a code. 0-Active surveillance 1-External Beam Radiation 2-Brachytherapy (Radioactive implants) 3-Unsealed Radioisotopes 4 Intensity modulated radiation therapy (IMRT) 5-Seed Brachytherapy 6-HDR Brachytherapy 9-Radiotherapy was administered but method was not stated 10-Orthovoltage 11-Stereotactic Radiotherapy	RadiotherapyTypeId
Cancer Treatment – Radiotherapy Course								
NOT357	Course Name	33	Varchar	A(512)	M		The radiotherapy course name as recorded by the source system.	RadiotherapyCourse
NOT358	Priority Code	34	Numeric	N(2)	O	1, 2, 3, 4	The priority code of the Radiotherapy Course: 1-Emergency - treat within 24hrs 2-Treat within 2-21 days 3-Standard patient (after 21	RadiotherapyPriorityId

							days) 4-Advance (after 30 days)	
Cancer Treatment – Radiotherapy – Treatment Sites								
NOT366	Radiotherapy Information System Site Name	35	Varchar	A(512)	C	**Refer to Appendix E**	The radiotherapy site name as recorded by the source system. Mandatory if reporting treatment sites. Example: Breast Chest Pelvis Free text source Site Name can be added to Reference data through an update to NSWCR	RISSiteName
NOT359	Site Start Date	36	Date	N(8)	C	DDMMYYYY	The start date of the radiotherapy administered to the radiotherapy site during the initial course of treatment for cancer, expressed as DDMMYYYY. Mandatory if reporting treatment sites.	SiteStartDate
NOT360	Site End Date	37	Date	N(8)	O	DDMMYYYY	The completion date of the radiotherapy administered to the radiotherapy site during the initial course of treatment for cancer, expressed as DDMMYYYY.	SiteEndDate
NOT361	Prescribed	38	Numeric	N(4)	O		The prescribed dose of	PrescribedDose

	Dose						radiation that was to be delivered to the Radiotherapy Site measured in cGy.	
NOT362	Actual Dose	39	Numeric	N(4)	O		The received dose of radiation delivered to the Radiotherapy Site measured in the cGy.	ActualDose
NOT364	Prescribed fractions	40	Numeric	N(2)	O		Number of radiotherapy fractions that were prescribed to be delivered to the Radiotherapy Site.	PrescribedFractions
NOT365	Actual fractions	41	Numeric	N(2)	O		Number of radiotherapy fractions delivered to the Radiotherapy Site.	ActualFractions
Cancer Treatment – Quality of Care Indicators								
NOT207	Date of Referral to cancer specialist	42	Date	N(8)	O	DDMMYYYY	Date of referral to Radiation Oncologist valid to the date of consultation with Oncologist for this course of treatment.	ReferralDate
NOT213	Ready for Care Date	43	Date	N(8)	O	DDMMYYYY	The date on which a Radiation Oncologists indicated when a person is ready for care for a course of radiotherapy to commence	DecisionDate
NOT208	Date of first consultation with cancer specialist	44	Date	N(8)	M	DDMMYYYY	Date of consultation with Oncologist for this course of treatment.	ConsultationDate
NOT135	Date of Multidisciplinary team consultation	45	Date	N(8)	O	DDMMYYYY	The date when the (MDT) first consulted about the patient. Indicates whether an MDT consulted about the patient.	MDTDate

NOT138	Date of referral to Palliative care	46	Date	N(8)	O	DDMMYYYY	The date when the patient referred to Palliative care as recorded by the treating doctor.	ReferralToPalliativeCareDate
NOT136	Performance Status Date	47	Date	N(8)	O	DDMMYYYY	The date on which the appraisal of the individual's ability to manage activities of daily living was conducted.	PerformanceStatusDate
NOT137	Performance status	48	Numeric	N(1)	O	0, 1, 2, 3, 4, 9	The result of the appraisal of the individual's ability to manage activities of daily living. The performance status at time of treatment should be reported. Scaled by USA East Coast Oncology Group (ECOG), as follows: 0 – ECOG 0 (Asymptomatic, normal activity) 1 – ECOG 1 (Symptomatic, but ambulatory) 2 – ECOG 2 (Symptomatic, in bed less than 50% of day, needs minimal assistance) 3 – ECOG 3 (Symptomatic, in bed more than 50% of day, requires considerable assistance) 4 – ECOG 4 (100% bedridden, severely disabled) 9 – Not stated	

Appendix A – Staging values - See NSWCR Reference Data Log (E16/08312)

Field Label	Values
TNM Classification of Malignant Tumours (AJCC) – TNM Staging Group values	1. 0 2. 0a 3. 0is 4. I 5. IS 6. IA1 7. IA2 8. IB 9. IB1 10. IB2 11. IC 12. II 13. IIA 14. IIA1 15. IIA2 16. IIB 17. IIC 18. III 19. IIIA 20. IIIB 21. IIIC 22. IV 23. IVA 24. IVA1 25. IVA2 26. IVB 27. IVC 28. Occult Carcinoma

Appendix B – T Stage

Field Label	Values
TNM Classification of Malignant Tumours (AJCC) – TNM Staging Group values	1. 0 2. 1 3. 2 4. 3 5. 4 6. 1a 7. 1a1 8. 1a2 9. 1b 10. 1b1 11. 1b2 12. 1c 13. 1d 14. 1mi 15. 2a 16. 2a1 17. 2a2 18. 2b 19. 2c 20. 2d 21. 3a 22. 3b 23. 3c 24. 3d 25. 4a 26. 4b 27. 4c 28. 4d 29. 4e 30. a 31. is 32. ISD 33. ISL 34. ISP 35. ISPD 36. ISPU 37. Not Applicable 38. REVIEW 39. Unknown 40. Unstaged 41. X

Appendix C – N Stage

Field Label	Values
TNM Classification of Malignant Tumours (AJCC) – TNM Staging Group values	1. 0 2. 1 3. 2 4. 3 5. 4 6. 0(i-) 7. 0(i+) 8. 0(mol-) 9. 0(mol+) 10. 0a (biopsy) 11. 0b (no biopsy) 12. 1a 13. 1b 14. 1c 15. 1mi 16. 2a 17. 2b 18. 2c 19. 3a 20. 3b 21. 3c 22. 3d 23. Not Applicable 24. REVIEW 25. Unknown 26. Unstaged 27. X

Appendix D – M Stage

Field Label	Values
TNM Classification of Malignant Tumours (AJCC) – TNM Staging Group values	1. 0 2. 1 3. 0(i+) 4. 1A 5. 1B 6. 1C 7. 1D 8. 1E 9. Not Applicable 10. REVIEW 11. Unknown 12. Unstaged 13. X

Appendix E – RIS Site Name

Field Label	Values
The radiotherapy site name as mapped to these values recorded in the source system	1. Abdo/pelvis 2. Abdomen 3. Ankle/foot 4. Arm 5. Boost 6. Brain 7. Breast 8. Cerebrospinal irradiation 9. Chest 10. Chest wall 11. Eye/Orbit 12. Hand/wrist 13. Head and Neck 14. Hip 15. Ill-defined site 16. Leg 17. Lymph nodes 18. Neck/Chest 19. Pelvis 20. Penis 21. Rib 22. Sacrum 23. Scrotum 24. Shoulder 25. Skin of external ear 26. Skin of eyelid 27. Skin of head and neck 28. Skin of lower extremity 29. Skin of trunk 30. Skin of upper extremity 31. Skin, multiple sites 32. Skin, NOS 33. Skull 34. Spine, cervical 35. Spine, lumbar 36. Spine, Multi-Level 37. Spine, NOS 38. Spine, thoracic 39. Testis 40. Total body irradiation 41. Unknown radiation site

sBulleted lists