National Oesophago-Gastric Cancer Audit

Frequently Asked Questions

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Participation

How do I submit data to the audit?	To submit data to the audit you will need access to the Clinical Audit Platform (CAP). The User Registration Form and a CAP User Guide are available on our audit website: www.nogca.org.uk/resources

Inclusion criteria

Which patients will be included in the audit annual reports?	Each annual report includes patients diagnosed with invasive epithelial cancer of the oesophagus or stomach (ICD10 codes C15 and C16) diagnosed during the last two audit years, and patients diagnosed with oesophageal High Grade glandular Dysplasia (HGD) between 1 April 2012 and the last audit year. For example, the 2021 annual report will include oesophago-gastric (OG) patients diagnosed between 1 April 2018 and 31 March 2020 and HGD patients diagnosed between 1 April 2012 and 31 March 2020. The annual reports include all diagnoses within the relevant audit years and any associated treatment and pathology data submitted prior to the final submission deadline.
What patients are excluded from the audit?	There are some specific exclusions: • Patients who are diagnosed with OG cancer abroad • Patients without a confirmed histology of OG cancer • Patients who die before MDT discussion • Gastro-intestinal stromal tumours (GISTs) • Neuroendocrine tumours • Malignant melanoma • Sarcomas (these very rare cancers originate from connective tissue and often behave differently from epithelial cancers) • Recurrences or progressions of cancer

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Are intramucosal cancers included in the audit?	Yes. Intramucosal cancers should be entered as cancers and have an OG Tumour record.
Are private patients included?	NHS England fund the audit for the participation of NHS patients only. NHS patients receiving their care within the private sector are included. If you wish to discuss private provider participation in NOGCA, contact Sarah Walker (Project Manager) at HQIP: Sarah.Walker@hqip.org.uk
How would we record patients who die before treatment (would we just fill in the registration datasheet)?	Only fill in the registration datasheet (the Patient and OG Tumour records) for patients who have a management plan decided but die before treatment starts. Patients who die before MDT discussion should be excluded from the audit.
Do I enter data on a patient who has a diagnosis and progression within the same audit year?	Yes. Submit data on the primary diagnosis of OG cancer.

Dataset

Does the NOGCA dataset map to the COSD v9 dataset?	Where possible we have mapped to the COSD dataset. Mappings can be found against the data items in the Dataset Validation Workbook, which is available on the audit website: www.nogca.org.uk
Which data items are mandatory?	The Dataset Validation Workbook provides the full dataset for each type of record (for example, Patient Demographics, OG Tumour and Surgery records) and there is a column to show which data items are mandatory. The Excel workbook is available on the audit website: www.nogca.org.uk

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Which responses are valid?	The Dataset Validation Workbook includes: a Rules tab which provides information about general dataset rules; a column of validation rules against every data item within each record tab; and a tab at the end which details all the valid reference data.

Data collection

Our patients move across a number of organisations throughout the patient pathway – how will NOGCA cope with this?	Registered users from different trusts can submit different parts of a patient's pathway to the Clinical Audit Platform (CAP). Trusts should decide between them how to manage the submission process. If different trusts are responsible for the same part of the patient's pathway, for example the HGD record, they will have to work together to submit that record. All mandatory data items within each record must be completed for the record to be submitted successfully. If a record already exists in the system with the same NHS number and date of birth, the existing record can be viewed and updated by another user. If the NHS number is entered with a different date of birth, then the record will still be displayed but CAP will ask if you want to amend the date of birth that has already been entered. **Please be aware that it is possible to overwrite data already submitted by another trust. The system prevents valid data being overwritten by a null value. However, it does not prevent valid responses being overwritten by another (but different) valid response.**
For some of my patients I won't have all data available at the time of the submission deadline. How long do I have to upload treatment records?	There is usually around 10 months following 31 March before the final submission deadline for that audit year. We pool at least two years of data in our annual reports in order to include complete patient pathways that may not have been included in the previous year's report. So, it is still worth submitting data after the deadline for inclusion in future reports.

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Is there a way of protecting any data that has already been keyed in directly so that our electronic upload does not over-write it?	No. If you upload records for a patient who has already been entered manually, the new upload will take priority in the same way you can overwrite manually with updated data. Each type of record is separate. If a chemotherapy record were added or amended, it would only affect the patient's oncology record; it would not affect their other records.

Problems submitting to the Clinical Audit Platform (CAP)

When a notification is corrected in CAP, why does the notification not update to read successful in the 'File Submission Details Screen'?	The notification that is displayed on the file submission screen is a static message representing the record that was entered at the time. A user can correct the record in a fresh upload and a new set of notifications will be created relating to that file upload. Alternatively, the user can correct it manually via the data input screen and no new notifications will be created. Neither method will affect the original notification.
On the 'File Submission Details' screen, does Unsuccessful mean that the whole record will not be included as uploaded or just the incorrect parts?	Unsuccessful means that that the entire record has not been uploaded into the system.
On the 'File Submission Details' screen, why aren't all my unsuccessful records listed in the notifications?	The notification grid defaults to showing 10 records per page. You can click 'next' at the bottom right hand of the screen to show the next set of 10 records. If you want to see more records per page, click the dropdown in the top left corner to display 25, 50, or 100 records per page.
Why does the following error message come up when I try to upload a surgical record: 'The record cannot be uploaded because an OG Tumour or HGD record does not currently exist for this patient'?	The OG Tumour record or HGD record needs to be submitted before a surgical record can be submitted. The Record Tree tab in the Dataset Validation Workbook gives a visual representation of this dependency.

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Oesophageal High-Grade Dysplasia (HGD)

For which patients should I submit an HGD record?	We only include patients diagnosed with oesophageal glandular highgrade dysplasia (HGD). Patients with HGD of the stomach should not be included in the audit.
Do I need to enter a tumour record or HGD record for patients who have a diagnosis of both made within the same audit year?	If initial endoscopy and biopsy shows: • HGD **AND** cancer - submit OG Tumour record. • HGD only, but subsequent repeat biopsy reports a diagnosis of cancer - submit OG Tumour record. • HGD only and patient referred directly for treatment EMR for HGD where a cancer is subsequently diagnosed - submit HGD record and OG Tumour record. On the HGD record select EMR as planned treatment and then in the EMR histology section select that intramucosal or submucosal cancer was found on EMR histology. If the patient goes on to require surgery as result of new cancer diagnosis then select 'EMR incomplete, follow up oesophagectomy' and proceed to enter the relevant surgery and pathology record. • HGD only and patient referred directly for oesophagectomy - submit HGD record. On the HGD record select oesophagectomy as planned treatment, and then proceed to enter the relevant surgery and pathology record.

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Should I enter an OG Tumour record for patients who are initially diagnosed with HGD and subsequently develop OG cancer?	From spring 2019, users can submit an HGD record and an OG Tumour record for a patient who has a diagnosis of HGD then goes on to develop cancer. Historical cases can also be updated.
I have entered “9-Not known” for the item about Barrett’s Segment. However I am unable to submit the HGD record without entering information for the two items about length of columnar lining.	NOGCA will be updating the validation rules so that the items about length of lining are not required for patients if the presence of Barrett’s Segment is not known. In the meantime, please enter “60” for both items and the NOGCA team will treat this as dummy data.

Initial referral and diagnosis (OG cancer)

What date should we enter for the ‘Date of referral’ item in the OG Tumour record?	This should be (in order of preference): • Date on the letter/fax/proforma/e-mail from referring GP or other hospital department • Date of telephone call from referring GP or other hospital department • Date of cross-referral, where patient is already in hospital • Date of admission to hospital, in the case of patients coming in as emergencies • Date on the recall letter for patients recalled following a routine screening appointment
As a treatment centre receiving patients from other hospitals, how should we enter the ‘Date of referral’ item in the OG Tumour record?	The ‘Date of Referral’ refers to the date on which the initial referral for investigation and treatment of suspected cancer was made, i.e. the initial referral to the local OG cancer team for investigation and management of suspected cancer. It does not relate to the referral from the local OG cancer unit to the tertiary cancer centre (if applicable).

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How should I enter records where the 'Diagnosis date' precedes 'Date of referral'?	In this situation you should set 'Date of referral' as the 'Diagnosis Date'. Validation rules in the dataset and data collection system allow 'Diagnosis date' to be greater or equal to the Date of referral', so you can set them both as the same date.

Diagnosis – Site (OG cancer)

How should I enter 'Pretreatment Tumour Site' for a patient whose tumour covers more than one area of the stomach or oesophagus?	Select the area which contains the bulk of the tumour. You may need to seek the opinion of the endoscopist /pathologist. Only one option for site may be selected.
How do the audit's diagnosis codes map to ICD-10 codes?	Oesophageal upper third - C153 Oesophageal middle third - C154 Oesophageal lower third (Non-adenocarcinoma) - C155 Siewert 1- C155 (Adenocarcinoma only) Siewert 2 - C155 (Adenocarcinoma only) Siewert 3 - C160 (Adenocarcinoma only) Fundus - C161 Body - C162 Antrum - C163 Pylorus - C164 The mapping of audit diagnosis codes is one-way only. In other words, the audit's diagnosis codes can be mapped to ICD-10 codes, but ICD-10 codes cannot be mapped to the audit's diagnosis codes. This is because ICD-10 does not code tumours of the gastro-oesophageal junction in as much clinical detail as the Siewart classification.

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Regarding 'Pretreatment Tumour Site', a trust confirmed a diagnosis of C16.9 with the morphology of M81403 – Adenocarcinoma. As the morphology is Adenocarcinoma should the Siewerts classification override the ICD-10 code?	If the trust has given a Siewert classification and the ICD10 code given is C16.9 or C15.9 (malignant neoplasm of stomach or oesophagus unspecified), then the Siewert classification should override the ICD-10 code as it is more precise in providing pretreatment site.
Does the audit require the use of the Siewert classification for patients diagnosed with lower third oesophageal cancer?	The audit will continue to use the Siewert classification for the foreseeable future. Tumours should be classified as below: • Adenocarcinomas of the distal third of the oesophagus can be classified as just that (distal third) or Siewert type I gastro-oesophageal junction (GOJ) tumours (an adenocarcinoma of the distal oesophagus with its epicentre within five cm of the GOJ). For analysis we pool these two together. • We realise that classification of Siewert type II & III remains controversial, so we pool these two groups together for analysis.
What should the 'Pretreatment Tumour Site' be for the following diagnosis codes? • C165 Malignant neoplasm of lesser curvature of stomach, unspecified • C166 Malignant neoplasm of greater curvature of stomach, unspecified • C168 Malignant neoplasm overlapping lesion of stomach • C169 Malignant neoplasm of stomach, unspecified	Select 'Body' for all of them, although it is less clear for C168 and C169.

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Diagnosis – Histology (OG cancer)

How should I enter data for patients without a histology confirming diagnosis of cancer?	Only patients with a confirmed OG cancer on histology should be submitted to the audit. Patients with no pretreatment histology are not included in the audit.
How should I enter data for a patient with a histology reported as (T7) Leiomyosarcoma (M8890/3) as it is not available in the dataset?	The audit only includes invasive cancers of epithelial origin (i.e. carcinomas). Sarcomas originate from connective tissue (and are very rare) and often behave differently from epithelial cancers so they are not included in the audit.
How should I enter data for a patient with a histology reported as 'Carcinoma of the stomach has mixed features of both neuroendocrine type and adenocarcinoma as a minor component'?	If the pathologists think that this is mainly a neuroendocrine tumour then it should be excluded. If it is an adenocarcinoma with some neuro-endocrine differentiation then it is included.

Diagnosis – Staging (OG cancer)

How should I enter pre-treatment stage where this changes during the planning process?	Enter the final pre-treatment stage after all staging investigations: • If patient has initial stage given based on CT but goes on to have a EUS or staging laparoscopy, then enter the stage after these investigations but before any treatment was given. • If a patient has neo-adjuvant oncology treatment prior to surgery, with the aim of down-staging the tumour prior to surgery, the pre-treatment stage should be entered as the stage prior to administration of chemotherapy.

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Our trust is a diagnosing trust whose patients are treated at a different tertiary trust. I am not able to submit an OG tumour record because the tertiary trust will submit the TNM staging information.	If 0-None is entered for Staging Procedures, TNM data does not need to be submitted. The treating trust can subsequently update the staging data fields.
What pre-treatment stage should I enter for patients who have a tissue diagnosis of OG cancer, but are deemed unfit for CT and further investigation?	Enter ‘None’ for the staging investigation.
What pre-treatment stage should I enter for a patient who died before staging investigations could be carried out?	This patient would not be included in the audit (see exclusions on page 3).
What pre-treatment stage should I enter for a patient who does not undergo staging investigations before endoscopic treatment such as endoscopic mucosal resection (EMR)?	Endoscopic resection is suitable only for patients who have a small tumour which has not spread, therefore you should enter: TX N0 M0

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Treatment Plan (HGD and OG cancer)

If a patient receives more than one type of treatment does this need to be recorded?	The audit is primarily concerned with patients' outcomes rather than purely the process of their treatment. Therefore, we need information on ALL of the **primary treatments** they receive.
For 'Date final care plan agreed (MDT Decision date)', should we use the first or most recent date recorded as the date the care plan was agreed?	Record the date on which it was decided to manage the patient's treatment with the corresponding management modalities. This is usually the MDT decision date.
If a patient is admitted as an emergency and has surgery before the MDT meeting, how should we enter the following dates? 1. Date of referral 2. Diagnosis date (cancer) 3. Date final care plan agreed (MDT Decision date)	1. Enter the 'Date of referral' as date referred to OG surgeon who did operation. 2. Enter the 'Diagnosis date' based on whether it was made on CT or endoscopy. 3. Enter the 'Date final care plan agreed (MDT Decision date)' as date the decision was made to operate.
There is no option in the drop down menu for Brachytherapy, where the treatment intent is curative. How should I enter the treatment plan for such patients?	Brachytherapy is a form of internal radiotherapy. If the Cancer Care Plan Intent is curative, select '02-radiotherapy'. If the treatment intent is non-curative, select '22-palliative oncology'.
How should I enter data for a patient receiving radiotherapy as their palliative treatment?	You should select Cancer Care Plan Intent as 'Non-curative (palliative)' and then Planned Cancer Treatment Type as '22-palliative oncology'.

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How should I enter data for a patient who received EMR as a treatment for: 1. OG cancer? 2. HGD?	1. The details of planned treatment in the OG Tumour record are used to determine patterns of primary treatment and to enable analysis of discrete groups of patients, particularly where several modalities are used. So, enter EMR for 'Planned cancer treatment type' in the OG Tumour record. 2. Enter EMR for 'Initial treatment modality' in the HGD record, and in addition submit the EMR pathology.
If a patient receives active monitoring is this classed as treatment?	Active monitoring is NOT classified as a treatment. If this is the case, please select 'No active treatment'.

Surgery (OG cancer)

Does 'Main Procedure' in the Surgery record map to OPCS codes?	No. The main procedure codes cannot be mapped to OPCS because extra levels of detail (such as the choice of conduit) would be required.
How should I enter data for a patient who moved from our hospital, to a community hospital and then back to our hospital?	Only one Postoperative Datasheet within the proforma (the Surgery record in the dataset) should be completed per patient. If a patient has an unplanned return to theatre then this should be entered in the 'postoperative complications' part of the Datasheet (the 'Complications' section of the Surgery record).

Pathology (OG cancer)

Which pathology record should I submit?	We are only interested in the histology record from the first pathology reported after surgery.

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Chemotherapy / Radiotherapy / Immunotherapy (OG cancer)

How many oncology records should I enter?	Enter only one oncology record for: • Patients who received any combination of chemotherapy, radiotherapy and/or immunotherapy preoperatively only. All preoperative treatments should be recorded on the same oncology record. • Patients who had definitive chemo-radiotherapy. Both chemotherapy and radiotherapy should be recorded on the same oncology record. • Patients who received two separate courses of therapy either as neo-adjuvant therapy or definitive treatment. Please only record details of the initial therapy. Enter two separate oncology records for: • Surgical patients who received neo-adjuvant therapy AND adjuvant therapy.
Our system collects chemotherapy and radiotherapy as individual records, does this mean I need to work out how to upload as a single treatment?	Yes, if it is relevant. Please refer to information above about when to upload one or two oncology records.
For 'Modality of Oncological therapy' there is a 'Chemo-radiotherapy' option. Is this where chemotherapy and radiotherapy is given at the same time or one after the other?	This could be given at the same time or sequentially.

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How should I respond to the data item 'Proceeded to planned curative surgery?' for a patient who completes neo-adjuvant chemotherapy and the MDT agrees curative surgery, but the surgeon then discovers the disease is inoperable and the surgery has to be abandoned?	Select 'No'.
In Adjunctive Therapy, when should I use 03 Not applicable (primary or palliative)?	01 Adjuvant and 02 Neoadjuvant are relevant for patients having surgery. 03 Not applicable (primary or palliative) is for patients who are not having surgery so oncology is their primary treatment (curative or non-curative).
How should I record changes to chemotherapy regimens during treatment?	For ‘Outcome of Chemotherapy’ select ‘08-treatment not completed’. Select the appropriate reason for the change in regimen from the options listed under ‘Reason if Chemotherapy Not Completed’. If a patient’s chemotherapy regimen was changed due to the COVID-19 pandemic, select ’10-other’.

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Endoscopic / Radiological Palliative Therapy (OG cancer)

If a patient has multiple procedures as part of a treatment package, do we submit an Endo-Rad-Palliative therapy record for each procedure within the treatment package, for example, brachytherapy?	Only submit data on the first therapeutic procedure. We are not asking for data on subsequent procedures for several reasons: • It increases the data burden on local units, and this is something that throughout the design of the dataset we have made great efforts to minimise. • From a methodological point of view it makes the data extremely difficult to analyse. • Details of subsequent stenting procedures etc. can be identifed using HES data.
Does 'insertion of oesophageal stents' need to be recorded as treatment?	Oesophageal stents do need to be recorded as treatment. The details should be entered into the 'Endoscopy Radiology Palliative Therapy' record.
In the endoscopic palliative file under procedure there is an option for 'Stent Insertion', does this cover any type of stent or just oesophageal stent?	The option covers any stent inserted for oesophageal or gastric cancer. In practice the vast majority of these will be oesophageal stents. There will be a few duodenal stents inserted for stenosing pyloric tumours, but the vast majority will be oesophageal. Pancreatic and biliary stents are only ever used for carcinomas of the head of the pancreas or cholangiocarcinomas causing pancreatic or biliary obstruction. These problems don't occur in oesophageal or gastric cancer.
Are duodenal stents included as Endo-Palliative Care?	No.

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Private Patients

How should I enter records where the patient was diagnosed at a private hospital?	Patients diagnosed in a private hospital and treated in a NHS hospital should have all the same data items completed as an NHS patient. Any treatment received privately should be entered as normal. Select the hospital where the decision was made to treat the patient and where the consultant giving the treatment is based. Patients who are diagnosed and treated entirely in the private sector are currently not included in the audit because private hospitals do not currently participate in the audit. We expect this to be a minor issue in this audit. Due to the scale of the surgery and the urgency of treatment, most patients will receive their treatment on the NHS.
How should I complete the mandatory field 'Date of referral' for private patients who have been investigated elsewhere, and have then been referred to us as a tertiary provider?	Private patients should be entered as '11-Referral from Another Hospital Consultant', with the 'Date of referral' as date of the referral letter to your hospital.

Reporting

If more than one trust is involved in the patient pathway, to which trust will the patient be attributed?	The patient will be attributed to the hospital (and trust) where diagnosis or treatment takes place. For example, case ascertainment for OG patients will be reported at diagnosing trust level and performance indicators at treating trust level. HGD patients have so far been attributed to the hospital (trust) where the biopsy was taken (as identified on the HGD record).

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