SCOTTISH HOSPITAL SERVICE

Organisation of Scottish Cancer Services
Registration of Neoplasms

1. The Standing Cancer Committee have again revised and brought up to date the booklet on cancer records and the case abstract card, a copy of which is incorporated in the booklet. The previous revised version of the booklet was issued in March 1958 under cover of S.H.M. 58/24.

2. Copies of the latest version entitled "Registration of Neoplasms: Scotland", are being sent to Regional Hospital Boards under separate cover. They should be distributed to all members of hospital staffs who are concerned with the registration of cancer patients. Further copies are available on request.

3. At the beginning of each calendar year the Department will issue supplies of registration cards and of case abstract cards to Regional Hospital Boards for distribution to the hospitals in their Region. At the end of each month the completed registration cards, each stamped with its appropriate serial number, should be sent to the Regional Board, duplicate copies being retained by the hospital or department as a record of the cases registered. One year later the Regional Board should issue a case abstract card for every registration card received. (See paragraphs 10-12 of booklet).

5. The abstract cards pertaining to each year should be sent to the Department of Health on the 1st May of the year following the completion of first, third, fifth, seventh and tenth anniversaries (See paragraph 14 of booklet).

6. In accordance with the recommendations of the Standing Cancer Committee, copies of the revised booklet will be sent to Medical Officers of Health and to Executive Councils for issue to general practitioners.

Department of Health for Scotland,
Edinburgh, 1. 23rd October, 1961.

HSC/20/2/3

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Registration of Neoplasms: Scotland

DEPARTMENT OF HEALTH FOR SCOTLAND,
ST. ANDREW'S HOUSE,
EDINBURGH, 1

August, 1961
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PART I

General and Explanatory

Value of accurate records

1. In cancer, perhaps more than any other disease, successful treatment and advances in methods depend upon accurate clinical and pathological records concerning the individual patient. In the majority of acute and subacute illnesses the end results of treatment are known within a few weeks or months, and the absence of certain signs and symptoms proclaims that the patient is cured; the practitioner can complete his case history with all the relevant details still in mind. With cancer, however, there is no end point at which the patient can be said with certainty to be cured, and results cannot even be estimated until 5 years from the date on which treatment commenced. After such a lapse of time many important details are bound to have been forgotten. It is essential, therefore, that full and accurate records be made at the time of treatment and careful notes kept thereafter of the patient's condition at follow-up examinations or, as follow-up examinations will not always be possible, by obtaining reports from general practitioners, whose co-operation is thus most necessary. It is only in this way that real progress can be hoped for in cancer therapy, the work of the Registrar being as important as that of other members of the team. Provision should be made for sufficient numbers of properly trained secretarial staff, and expenditure under this head is properly to be regarded as part cost of treatment.

Research

2. In addition to maintaining the general system of registration and follow-up by means of cards, as described below, it is hoped that some hospitals will be able to undertake more detailed studies of the problems of cancer and to carry out special research into the development and evaluation of new methods of treatment.

Information required

3. Precision and uniformity in records are essential if an analysis based upon them is to prove informative rather than misleading. The data to be recorded on the cards...
described below have been reduced to the simplest practical form for obtaining, on a national scale, information on the following matters:
(a) Incidence of cancer in relation to site, age, sex and area of residence.
(b) Interval between first sign or symptom and the patient coming under observation and treatment.
(c) Extent of the disease when first diagnosed.
(d) Method of treatment employed.
(e) Proportion of patients treated radically.
(f) Survival rates by different methods of treatment and where no treatment is given.
(g) Survival rates as affected by the extent of the disease when first diagnosed.
(h) Comparisons between survival rates in histologically proven and not proven cases.
(i) Incidence of two or more primary malignant growths.
(j) Interval between first sign or symptom and death.
Central analysis will be carried out by the Department of Health for Scotland, St. Andrew's House, Edinburgh.

Definitions

4. For the purpose of records kept under this scheme the term “Cancer” comprises:
All carcinomas, all sarcomas, all tumours with the suffix “blastoma” and all tumours qualified by the term “malignant” (e.g. malignant papilloma, malignant giant cell tumour, etc.). It also includes the leukaemias, the lymphadenopathies (lymphadenoma (Hodgkin’s disease), lymphosarcoma, reticulum cell sarcoma, reticulosis and giant follicular lymphoma (Brill-Symmer’s disease)), the gliomas (astrocytoma, oligodendroglioma ependymoma, papilloma of the choroid, etc.), rodent ulcer, Bowen’s disease, dysgerminoma, teratoma of the testicle (teratomas of other sites should not be included unless they are stated to be malignant), epithelioma, endothelioma, chondoma, pinesoma, choroma, Wilm’s tumour, Ewing’s tumour, mycosis fungoides, plasmacytoma and multiple myeloma.

So that registration will be consistent in all centres the following debatable tumours should be regarded as malignant and should therefore be registered:
Mixed tumours of salivary glands (salivary adenomas), adenomas of the trachea and bronchus, Rathke pouch tumours (suprasellar cysts), adamantinomas and synoviomas.

It will be appreciated that this list of registrable tumours is not exhaustive. In fact, all other border-line or debatable tumours should be registered in the first instance and their subsequent inclusion or exclusion one year later should be individually determined after consultation with the pathologist if a histological examination of the lesion has been made.

Clinical records required

5. The clinical records required in respect of cases of cancer are of two complementary types, viz., Case Papers and Record Cards.
(a) Case Papers. Each hospital acting as a diagnostic centre will keep its own clinical records. It is recommended that the hospital clinical record should be so arranged that the information for the Registration and Abstract Cards can be abstracted from the Case Paper by a properly trained clerk. The personal and clinical data required for analysis are tabulated in the Case Abstract Card. (Appendix A.)
(b) Record Cards. Two forms of cards must be completed for each patient:
(i) Registration Card.
(ii) Abstract Card.
PART II

Registration Cards

Object of registration

6. The object of registration is to ensure that no case of cancer will be overlooked in any of the hospitals in the Region to which the scheme applies. A Registration Card should be made out as soon as there are reasonable grounds for a provisional diagnosis of cancer or of any of the non-cancerous tumours specified in paragraph 4 (other non-malignant cases may be registered and some malignant cases may be registered twice, but these can easily be deducted later). The important point is that the Registration Cards will provide an index of every case record that needs to be examined when the Case Abstract Cards (see Part III) are completed before despatch to the Department of Health.

Cases will occur in which a hitherto unsuspected cancer is discovered during treatment for some other condition or on post-mortem examination; these cases should be registered as soon as the diagnosis of malignant disease is made.

Types to be registered

7. Except where a new primary tumour develops (see paragraph 8) the following patients should not be registered:

(a) Patients who received treatment in respect of the present tumour before registration was commenced on 1st July, 1968.

(b) Patients transferred from another Region and known to have been registered by that Region. (Where doubt exists the patient should be registered.)

(c) Patients previously treated in private and not previously registered but later referred to hospital for treatment of a recurrence.

If, on the other hand, a patient has surgical treatment in private and is immediately referred to one of the hospitals in the region for complementary radiotherapy such a patient should be registered and the date of the first treatment should then be the date of the operation and not the date of commencing radiotherapy. The clinical findings before operation should be ascertained.

8. As part of the investigation is to determine the frequency of more than one primary tumour in the same patient (see paragraph 3(o)) a new Registration Card should be made for each primary and appropriately cross-referenced, preferably by providing the original registration number in the appropriate space.

Accordingly whenever a new tumour is judged histologically (after reference back to the pathologist so as to exclude a metastatic deposit) to be a new primary, a new card should be made out except in the case of the following tumours:

(a) Multiple basal cell carcinomas (rodent ulcers) should be regarded as an expression of a single neoplastic process and registered only once. If multiple tumours are present at the time of registration, register only the largest tumour and place the word "multiple" in brackets after the entry "Provisional Diagnosis." If further tumours develop subsequently they should be ignored for registration purposes.

(b) Malignant papillomas of the bladder are often multicentric in origin but again patients should be registered only once. In the case of the bladder, however, any tumour developing subsequently should be regarded as a recurrence and any subsequent treatment to the bladder should therefore be recorded. (See paragraph 32.)

Data required for Registration Card

9. The information recorded on the Registration Card will be required later for the Abstract Card and should be accurately obtained. It will be transferred without delay to punch cards so that the patient’s identity will subsequently be concealed.

(a) Hospital. Give the name of the hospital at which registration took place.

(b) Region. Give the hospital region in which the centre is geographically situated.

(c) Surname and Christian Names. The completeness and accuracy of this entry are particularly important in the case of common surnames. If a patient’s name is changed by marriage or otherwise the new name should be bracketed with the preceding one.

(d) Date of Birth. If the patient’s date of birth at registration is not known, insert "N.K." This will save further enquiry.

(e) Sex. Insert “M” or “F.” If female: Single: Married: or Other. In relation to marital status of women “other” includes "unknown.”

(f) Home Address.

*Note. The medical profession has endorsed the provision of this information, in order to ensure accuracy of the registration of cancer but, if for ethical or other reasons, it is considered desirable to withhold detailed information, the following data should be given, namely: initials, exact date of birth and geographical district of residence, e.g. city, county.
(g) **Date of Registration.** This is the date on which the Registration Card is made out.

(h) **Hospital Number.** This is for the hospital's own convenience in identification and is of no importance for central analysis.

(i) **Provisional diagnosis.** It is, of course, recognised that the entry under this heading must often be indefinite. Immediate registration is essential to avoid cases being overlooked and at this stage only a tentative diagnosis may be possible, e.g.:

- Pharynx — ? Carcinoma
- Oesophagus — ? Carcinoma
- Bone — ? Sarcoma
- Abdomen — ? New growth

### Issue of Registration Cards

10. At the beginning of each calendar year, Registration Cards will be issued by the Department of Health to the Central Records Office of each Region. These cards must be completed in duplicate and each stamped with its appropriate serial number (not the hospital number).

In some regions Registration Cards may be distributed to each hospital in the region or even to the larger departments of a single hospital. In that event, the decision to issue, or not to issue, block series of registration numbers would rest with the Regional Records Office.

It is recommended that the Registration Card and the corresponding Abstract Card should have a distinctive matching colour band.

### Submission of Registration Cards

11. At the beginning of each month, subsidiary places of registration, as indicated in paragraph 10, must send to their Regional Records Office the Registration Cards of the patients registered during the previous month, retaining the duplicate copies as an index of the cases registered. It is important that none of these cards be mislaid and all unused cards should be returned to the Regional Records Office at the end of each year.

### Issue of Abstract Cards

12. Case Abstract Cards (see Part III) will be issued along with the Registration Cards. They must be completed as soon as possible in every detail from the case papers of each patient in accordance with instructions to be issued by each Regional Records Office.

### PART III

#### Abstract Cards

**Data required for Abstract Card**

13. The Case Abstract Card (see Appendix A) details the minimum information which must be recorded in the clinical notes. This card is used for all cases of cancer as defined in paragraph 4.

**Submission of Abstract Cards**

14. The Abstract Cards pertaining to each year should be sent to the Department of Health on 1st May of the year following the completion of first, third, fifth, seventh and tenth anniversaries, e.g. 1959 Abstract Cards should be sent to the Department of Health as follows:

- On 1st May, 1961, with the first anniversary completed.
- On 1st May, 1963, with the second and third anniversaries completed.
- On 1st May, 1965, with the fourth and fifth anniversaries completed.
- On 1st May, 1967, with the seventh anniversary completed.
- On 1st May, 1970, with the tenth anniversary completed.

15. When the Abstract Cards are sent to the Department of Health, the cards should be complete in respect of all patients seen or treated for the year to which they relate. The Abstract Cards for any one year will, therefore, differ in the following manner from the Registration Cards made during the same year, e.g.:

(a) Patients registered at the beginning of 1960 may have been treated in 1959 and these cases, therefore, require 1959 Abstract Cards which should be sent to the Department of Health on 1st May, 1961.

(b) Patients registered in 1959 may not be treated until January or February, 1960. Such patients will require 1960 Abstract Cards which should be sent to the Department of Health on 1st May, 1962.

**Return of Abstract Cards**

16. The Abstract Cards will be returned by the Department of Health as soon as the information has been transferred to punch cards except in the following cases:

(a) where the patient is dead;
(b) where subsequent information has resulted in change of diagnosis to some non-malignant condition;
(c) where the patient has not been traced on three consecutive anniversaries;
(d) where in the case of a rodent ulcer there has been no recurrence for a period of five years.

Instructions for Completion of Abstract Cards

17. Clearly an analysis based upon differently interpreted terms would be of small value, if indeed not misleading. The following notes explain the sense in which the various terms are used, and while it is fully recognised that all of them may not meet with universal acceptance, it is requested that for the purpose of a central analysis the guidance given be closely observed. The headings are dealt with here in the order in which they appear on the card.

18. Wherever information is to be recorded by the ringing of numbers, it is requested that such places are never left completely blank. In the past, unnecessary enquiries have had to be made because the entry for "NONE" was omitted.

Details of Identification

19. The entries for Surname, Christian Name(s), Date of Birth, Home Address, Sex, Hospital, Region, Hospital Number and Present Registration Card Serial Number should be exact copies of the corresponding entries on the Registration Card. Provision is made for "previous" and "future" Registration Card serial numbers for cross-reference in cases of more than one primary malignant growth (see paragraph 8). If the name is changed, e.g. by marriage, after registration the change should be superscribed both in the Registration Card and in the Case Abstract Card in order to facilitate the follow-up.

Obstetric History

20. The sub-division of "Total Number of pregnancies" (to be entered in figures) into "Completed" and "Interrupted" (i.e. miscarriages and abortions) is designed to elucidate the important question whether cancer of the cervix uteri might be correlated with the hormonal disturbance associated with any pregnancy rather than with the traumatic laceration of the cervix resulting from the delivery of a viable infant. The same information regarding total number of pregnancies is also desired in cases of cancer of the breast but not in other cancers.

Time Lag

21. Date of first sign or symptom should be entered to nearest month. Where a tumour is first noted at post-mortem examination the letters "P.M." should be placed in this space. The next two entries should be left blank.

Date first sought medical advice. The actual date should be stated but if this is not available the entry should be to the nearest month. If the tumour was first noted in the course of investigation of some other disease, the date of this examination should be entered.

Date first attended hospital. The actual date should be entered.

Non-Malignant

22. If a case is found to be non-malignant this section should be completed and no further entries need be made.

Diagnosis

23. In the Registration Card only a provisional diagnosis is required. In the Abstract Card every effort should be made to ascertain the diagnosis as accurately as possible. In difficult cases the diagnosis usually becomes evident by the end of the first year. The "diagnosis" should therefore be checked before the Abstract Card is sent to the Department of Health. By checking the diagnosis at the end of the year the amendments to the original diagnosis (see paragraph 35) will be reduced to the minimum.

Enter the site followed by the nature of the growth. No other clinical details should be given, e.g.

- L. Breast / carcinoma
- R. Femur / sarcoma

If the site of the primary tumour is not known, the main site involved by the secondary deposit should be given and the nature of the tumour stated as accurately as possible, e.g.

- Cervical node / carcinoma
- Rib / tumour

The fact that these are secondary deposits will be made clear in the next section, by ringing 1 to denote that the primary site is unknown.

Registrable lesions must be classified by the Regional Records Office in strict accordance with the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death 1957, Vol 1, pp. 75—104 in order to facilitate the comparison of Scottish with other national data and results of treatment.
Clinical Findings

24. In order to achieve comparability between treated and untreated cases the entries in the whole of this section must be based on clinical and radiographic examination and not on operative or histological findings. If the tumour was detected only at post-mortem this section should be left blank.

Tumours have been divided broadly into "neoplasms other than those of lymphatic and haemopoietic tissues" and "neoplasms of lymphatic and haemopoietic tissues." It is important that only one of these sections should be completed. In cases of doubt the entry should be made in "neoplasms other than those of lymphatic and haemopoietic tissues."

25. Primary Growth

(a) If the site of the primary tumour is unknown, ring 1.

(b) If the site of the primary tumour is known and the lesion is not measurable, (see below), ring 2.

(c) If measurable, ring 3 and insert maximum diameter in centimetres.

Objective measurements of primary tumours when they can be made are of greater value than the less precise terms "early" and "late" (see Appendix B). It is particularly requested that the size of the primary tumour should be recorded in the following sites—breast, skin, mouth, eye, oesophagus, larynx, lung, pharynx, bone and urinary bladder. The most convenient single measurement of the primary tumour is its maximum length or maximum diameter in centimetres. In some of the above sites, the size may require to be determined from radiographs with due regard to complicating factors occasioned for example in the lung by atelectasis and inflammation. When the measurement is made at the time of the clinical examination as, for example, in the breast, the size of the tumour will be over-estimated if the tumour is gripped between the fingers or pair of calipers. The size should be determined by identifying the margin of the tumour by direct backward pressure, gently applied. Ink marks may be placed on the skin to facilitate measurement. Measurements made in this way correspond very closely to the size of the tumour as determined by the pathologist.

Regional lymph nodes

26. The regional lymph nodes cannot be accurately defined. They should be accepted as the nodes usually first involved.

Where the site of the primary is known and if there are no palpable regional nodes, ring "none"; if the regional lymph nodes are palpable, (whether mobile or fixed) ring "present."

Where the site of the primary is not known do not ring "none" or "present."

Other Metastases

27. This section refers to metastatic involvement of liver, lung, bone, skin, etc., and of any lymph nodes other than the regional lymph nodes.

If there is none, ring "none"; if present, ring "present."

Neoplasms of lymphatic and haemopoietic tissues

28. As a rule, a definitive diagnosis of these neoplasms can be attained only by haematological or histological examination.

Primary lymphadenopathy. The term is broadly intended to cover all neoplastic processes originating in the reticulo-endothelial system which manifest themselves by enlargement of lymph nodes. If the lymph node enlargement is confined to one group of lymph nodes, e.g. cervical, axillary or inguinal, ring "localised." If more than one group of lymph nodes is enlarged, ring "generalised." If leukaemia is present this section should be left blank and the next section completed.

Leukaemia. The type will have been entered under diagnosis. The nature of the disease should be specified as acute or chronic by ringing 3 or 4.

29. International Staging of Cervix Uteri and of the Breast

Cancer of Cervix Uteri. (Staging adopted in 1951.)

Stage 0. Carcinoma in situ—also known as pre-invasive carcinoma, intraepithelial carcinoma—and similar conditions.

Stage I. The carcinoma is strictly confined to the cervix.

Stage II. The carcinoma extends beyond the cervix but has not reached the pelvic wall. The carcinoma involves the vagina but not the lower third.

Stage III. The carcinoma has reached the pelvic wall. (On rectal examination no "cancer-free" space is found between the tumour and the pelvic wall.)

The carcinoma involves the lower third of the vagina.

Stage IV. The carcinoma involves the bladder or the rectum, or both, or has extended beyond the limits previously described.

Cancer of the Breast. (Staging adopted in 1960)

On the suggestion of the International Union against Cancer, the following classification of malignant tumours of the breast, to facilitate the comparison of information...
between treatment centres, has been adopted for a trial period of five years from

Clinical Stages

Stage I: Tumour of 5 cm. or less
  Skin fixation absent or incomplete
  Nipple may be retracted or Paget's disease may be present
  Pectoral muscle fixation absent
  Chest wall fixation absent
  No homolateral axillary nodes palpable
  No distant metastases

Stage II: Primary tumour as in Stage I
  Homolateral axillary nodes palpable but moveable
  No distant metastases

Stage III: Tumour of more than 5 cm. in diameter
  or skin fixation complete or skin involvement wide of tumour
  or peau d'orange present in tumour area or wide of tumour
  or pectoral muscle fixation incomplete or complete
  or chest wall fixation present
  or homolateral axillary nodes fixed
  or oedema of the arm
  or homolateral supraclavicular or infraclavicular nodes moveable
  or fixed
  No distant metastases

Stage IV: Distant metastases present regardless of the condition of the primary
tumour and regional lymph nodes.

The size of the primary breast tumour should also be recorded (see paragraph 25).

Histology up to the first anniversary date

30. Ring the appropriate figure according to the information obtained up to the
date of the first anniversary. When the histological finding is entered as either "non-
malignant" or "indeterminate" but the clinical findings of malignancy are accepted
the case should still be regarded as one of malignant disease. The decision rests
with the hospital and it is, therefore, appropriate to make out a card for a case believed
to be a malignant tumour even where the histological report denotes the condition is
non-malignant or where the histological report is indeterminate or uncertain.

Once the Abstract Card has been sent to the Department of Health this section
must not be altered. Where revision is required this should be made in the appropriate
space at the end of the card (see paragraph 35).

Initial planned treatment

31. Enter the particulars required but note that all the information requested is
confined to the initial planned treatment. Any treatment given subsequently should
not be entered in this section but in the space provided below. (See paragraph 32.)

Date of Commencement. In most scientific publications the survival rate is calculated
from the commencement of treatment or, in the untreated cases, from the time
the decision was taken not to treat the patient. This procedure has now been adopted
in connection with this investigation. In the majority of treated patients the date of
commencement of treatment is immediately obvious but in others the examples given
on pages 19 to 21 should be studied so as to ensure that the correct date is entered.

Note that if radical treatment was given any surgical intervention prior to the
radical treatment should be ignored in determining the date of commencement. See
examples (b), (d), (f), (h), (o) and (r).

Methods

Before any entry is made it is important to decide whether the treatment as a whole
is to be regarded as "radical" or "palliative" or "exploratory" or if the patient is
to be classified as "not treated." The treatment given should then be entered in the
appropriate section: only one section is to be completed.

Radical. Treatment should be described as "radical" if, because of its nature and
scope, it was undertaken to eliminate the disease and provided that this treatment
was completed.

Palliative. Treatment should be described as "palliative" if it was known to be
insufficient to eliminate the disease entirely or if it was undertaken for the relief of
symptoms only (e.g. colostomy for an inoperable carcinoma of the colon or
radiotherapy for metastases in the spine). Treatment which was planned as "radical"
treatment but which was not completed should be described as "palliative." Occa-
sionally it may happen that treatment regarded as "palliative" may effect a cure.
Even when this occurs the description of the treatment must remain "palliative"
because at the time when it was given it was regarded as palliative.

The terms "radical" and "palliative" qualify the treatment as a whole. Thus a
patient treated by surgery and radiotherapy may have had incomplete surgery or
incomplete radiotherapy, but if the treatment as a whole was regarded as sufficient
for the elimination of the disease, the treatment should be entered under the "radical"
section.

16
Exploratory covers all forms of exploratory surgery undertaken for the establishment of a diagnosis and all forms of surgery limited to the determination of the extent of disease, e.g., exploratory laparotomy or thoracotomy.

Not Treated. If for any reason the decision is taken not to treat the patient, this fact should be recorded. It is important to appreciate that, if, at a later date, on account of pain or discharge, palliative treatment be given, this palliative treatment must be entered as subsequent treatment and the "Not Treated" should remain unaltered.

Surgery. The term "surgery" denotes partial or complete removal of the primary growth, partial or complete removal of the regional lymph nodes, palliative operations and exploratory operations (see definition of "palliative" and "exploratory" above). Biopsy and surgery of access (e.g., cystotomy for the insertion of radium into a bladder tumour) should not be regarded as "surgery" and no account should be taken of these procedures (see example (g)).

Note that incomplete surgery, which would otherwise be regarded as "palliative," when combined with radical radiotherapy should be entered in the "radical" section (see example (a)).

"Radiotherapy" covers any form of treatment by radium or radon, whether by implant, mould, intracavitary application or radium-beam. It covers all types of X-ray therapy at all voltages and all forms of radioactive isotopes.

It is eminently desirable to try to evaluate the comparative efficacy of the several available radiotherapeutic techniques and, for this purpose, the appropriate code list number should be inserted by the recording officer in the bracket(s) according to the following schedule:

Sub-division of "Radiotherapy"

<table>
<thead>
<tr>
<th>Code List No.</th>
<th>Radiotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Less than 150 KV</td>
</tr>
<tr>
<td>2</td>
<td>150 KV to under 1 MeV</td>
</tr>
<tr>
<td>3</td>
<td>1 MeV and over</td>
</tr>
<tr>
<td>4</td>
<td>Beam Therapy (Radium, Cobalt, Caesium, Iridium) up to 100 curies</td>
</tr>
<tr>
<td>5</td>
<td>Beam Therapy (Radium, Cobalt, Caesium, Iridium) over 100 curies</td>
</tr>
<tr>
<td>6</td>
<td>Small Gamma Ray Sources (Implants, Moulds or Intracavitary)</td>
</tr>
<tr>
<td>7</td>
<td>Beta ray plaques</td>
</tr>
<tr>
<td>8</td>
<td>Isotopes—oral or parenteral</td>
</tr>
</tbody>
</table>

Sub-division of "Other methods"

<table>
<thead>
<tr>
<th>Code List No.</th>
<th>Other methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>2</td>
<td>Hormones</td>
</tr>
<tr>
<td>3</td>
<td>Removal or irradiation of ovaries, adrenals and pituitary</td>
</tr>
</tbody>
</table>

Examples

(a) 1.1.60 Partial removal of parotid tumour 8.2.60 Radical radium implant of parotid gland Ring 1 & 2(6) Date 1.1.60

(b) 2.2.60 Colostomy for intestinal obstruction 16.2.60 Resection of carcinoma descending colon Ring 1 Date 16.2.60

(c) 2.2.60 Colostomy for intestinal obstruction Tumour inoperable or patient died before resection could be undertaken Ring 5 Date 2.2.60

(d) 3.3.60 Biopsy of carcinoma lip 10.3.60 Radical radium mould to lip 10.4.60 Block dissection of neck Ring 2(6) & 3 Date 10.3.60

(e) 3.3.60 Radical excision of L. Breast 18.3.60 250 KV X-ray therapy to L. chest wall and L. axilla to 18.4.60 Ring 1, 2(2), 3 & 4(2) Date 3.3.60

(f) 3.3.60 Simple mastectomy L. Breast 13.3.60 Radical 250 KV X-ray therapy to L. chest wall and L. axilla Ring 1, 2(2) & 4(2) Date 3.3.60
(g) 3.3.60 Excision of L. Breast for fungating tumour
13.3.60 Oestrogen therapy commenced for metastases in skeleton

(h) 3.3.60 Palliative 250 KV X-ray therapy to spine for metastases
Ring 5 & 7(2) Date 3.3.60

(i) 3.3.60 Ovarian irradiation for acute lactation breast cancer
Ring 6(2) Date 3.3.60

(j) 4.4.60 Tracheotomy for carcinoma pharynx
6.4.60 Radical Cobalt 2,000 Curie therapy to primary
6.5.60 tumour and to cervical lymph nodes
Ring 2(5) & 4(5) Date 6.4.60

(k) 4.4.60 Tracheotomy for carcinoma pharynx
6.4.60 Palliative Cobalt 25 Curie therapy to tumour
13.4.60 Ring 5 & 6(4) Date 4.4.60

(l) 5.5.60 Exploratory operation for abdominal tumour and biopsy
20.5.60 Radical 4 MeV therapy to abdomen
20.6.60 Ring 2(3) Date 20.5.60

(m) 5.5.60 Exploratory operation for abdominal tumour and biopsy
Ring 8 Date 5.5.60

(n) 6.6.60 Cystotomy for bladder carcinoma
Radical radon seed implant to whole tumour
Ring 2(6) Date 6.6.60

(o) 6.6.60 Cystotomy for bladder carcinoma
Tumour too extensive for resection or implant
20.6.60 Radical 4 MeV X-ray therapy to bladder
20.7.60 Ring 2(3) Date 20.6.60

(p) 6.6.60 Cystotomy for bladder carcinoma
Tumour too extensive for resection or implant
Permanent suprapubic drainage established
Ring 5 Date 6.6.60

(q) 6.6.60 Cystotomy for bladder carcinoma
Tumour too extensive for resection or implant
Bladder closed
Ring 8 Date 6.6.60

(r) 6.6.60 Cystotomy for bladder carcinoma
Bilateral transplantation of ureters
27.6.60 Resection of bladder
Ring 1 Date 27.6.60

(e) 6.6.60 Nitrogen Mustard therapy commenced for lymphadenoma
Ring 7(1) Date 6.6.60

Subsequent Treatment
32. Any treatment of the tumour subsequent to the initial planned treatment is rarely curative and is difficult to analyse. However the fact that subsequent treatment was necessary is worth recording. Only the year or years in which this treatment was given should be entered.

See paragraph 8 and note that only one basal cell carcinoma is to be registered. Accordingly, treatment given to any other basal cell carcinoma should not be recorded as subsequent treatment.

Note however that in the case of malignant papilloma of the bladder all subsequent treatment must be recorded in this section.

Follow-up
33. ALIVE. "Years after first treatment" means completed years from the date of commencement of treatment, for the definition of which see paragraph 31.

"Date of examination or report." Enter the date when the examination was made or the report received. This date should be on or as soon as possible after the anniversary of the date of the initial planned treatment. It must not precede the anniversary.
"Subsequent histological verification of malignancy after first anniversary date." If further histological examination during life, or at post mortem, confirms that the tumour was in fact malignant put "X" in the appropriate space in the column according to the year of verification. Do not modify the "histology" section on the front of the card (see paragraph 30).

"Not traced." If it has proved impossible to ascertain whether, at the anniversary concerned, a patient is alive or dead, enter a plus sign in the column headed "not traced." Every effort should be made to keep the number of untraced cases as small as possible. Please see Appendix C for details of the facilities available to assist hospitals in tracing patients.

34. Dead. Enter date of death.

"Growth present," "No evidence of growth," "Indeterminate." Ring appropriate number. "Indeterminate" indicates that there was no accurate information as to whether growth was present or not.

"Post-Mortem." If a post-mortem examination was carried out, ring 5. The information given above regarding the presence or absence of growth will be more accurate if a post-mortem was carried out.

Amendment to Original Diagnosis (after the first treatment date)

35. If the original diagnosis stated on the front of the card requires alteration after the card has been sent to the Department of Health at the end of the first year, any alteration required should be made in this section. A punch card will have been prepared by the Department of Health according to the diagnosis originally supplied. If an entry is made in this section a new punch card will be prepared. It is important to note that no alterations must be made on the front of the card once the card has been sent to the Department of Health.

It will be noted that provision has been made for an alteration in diagnosis even when the case remains malignant, e.g. at the end of the first anniversary a diagnosis may have been recorded as a brain tumour but subsequent information revealing that the patient had in fact a metastases in the brain from a primary lung cancer. The amended diagnosis of "Lung-carcinoma" should be entered in this section.

If, after the first anniversary, the condition is found to be non-malignant the appropriate entry should also be made in this section. In this event the card will be retained by the Department of Health.
# APPENDIX A

## CASE ABSTRACT CARD

Details for completion are contained in Registration of Neoplasms (Scotland) Booklet.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Site</th>
<th>Nature of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Int. List No.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Neoplasms other than those of lymphatic and haemopoietic tissues

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site unknown</td>
<td>Not measurable</td>
<td>Maximum diameter in cms.</td>
</tr>
</tbody>
</table>

Regional

<table>
<thead>
<tr>
<th>Lymph Nodes</th>
<th>Other Metastases</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Present</td>
</tr>
</tbody>
</table>

Neoplasms of lymphatic and haemopoietic tissues

<table>
<thead>
<tr>
<th>Lymphadenopathy</th>
<th>Site of Leukaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localised</td>
<td>Acute</td>
</tr>
<tr>
<td>Generalised</td>
<td>Chronic</td>
</tr>
</tbody>
</table>

International Staging (only cervix uteri and breast)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I</td>
</tr>
<tr>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td>III</td>
<td>IV</td>
</tr>
</tbody>
</table>

Histology: (up to the first anniversary date)

<table>
<thead>
<tr>
<th>Histology</th>
<th>Site of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant</td>
<td>Non-malignant</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>No histological examination made</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Initial Planned Treatment:

<table>
<thead>
<tr>
<th>Methods</th>
<th>Radical Growth</th>
<th>Radical Nodes</th>
<th>Palliative</th>
<th>Exploratory</th>
<th>Not Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Surgery</td>
<td>Radiotherapy</td>
<td>1</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Growth</td>
<td>Radiotherapy</td>
<td>2</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Follow-up:

<table>
<thead>
<tr>
<th>Years after first treatment</th>
<th>Alive</th>
<th>Subsequent histological verification of malignancy (after 1st anniversary date)</th>
<th>Dead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 yrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If treatment was palliative or exploratory or if not treated, state reason(s):
- Disease too far advanced
- Distant metastases
- Age
- Concomitant disease
- Treatment refused
- Patient referred elsewhere
- First discovered at P.M.

Subsequent treatment (year)

Date of Commencement

Date of examination or report

Date of Death

Growth present
- No evidence of growth
- Indeterminate
- Post-Mortem
- None
- Yes

Amendment to original diagnosis: (after the first anniversary date)
- Malignant: Site
- Nature of growth

- Non-Malignant: Site
- Nature of growth

Int. List No.
APPENDIX B

BREAST CANCER

Two factors determine the size of a tumour—its duration and its rate of growth. It follows, therefore, that a large tumour has either been present for a long period of time or is rapidly growing. Long duration and rapid growth are also important factors in determining the extent of metastatic spread and therefore the patient’s prognosis. Consequently a correlation is to be expected between the size of the primary tumour and the prognosis. Analysis of a large number of case records shows that this is so. In the following table the findings obtained in breast carcinoma are presented by the courtesy of Professor R. McWhirter.

<table>
<thead>
<tr>
<th>Size of Primary Tumour</th>
<th>-1cm</th>
<th>-2cm</th>
<th>-3cm</th>
<th>-4cm</th>
<th>-5cm</th>
<th>-6cm</th>
<th>-7cm</th>
<th>&gt;7cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I. No. of Cases</td>
<td>71</td>
<td>159</td>
<td>220</td>
<td>185</td>
<td>150</td>
<td>62</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>% Alive</td>
<td>85%</td>
<td>75%</td>
<td>61%</td>
<td>63%</td>
<td>59%</td>
<td>48%</td>
<td>56%</td>
<td>41%</td>
</tr>
<tr>
<td>Stage II. No. of Cases</td>
<td>32</td>
<td>97</td>
<td>150</td>
<td>143</td>
<td>149</td>
<td>64</td>
<td>49</td>
<td>33</td>
</tr>
<tr>
<td>% Alive</td>
<td>81%</td>
<td>66%</td>
<td>60%</td>
<td>58%</td>
<td>41%</td>
<td>38%</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td>Locally Advanced</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Cases</td>
<td>11</td>
<td>31</td>
<td>83</td>
<td>130</td>
<td>124</td>
<td>109</td>
<td>77</td>
<td>147</td>
</tr>
<tr>
<td>% Alive</td>
<td>45%</td>
<td>68%</td>
<td>40%</td>
<td>37%</td>
<td>26%</td>
<td>26%</td>
<td>13%</td>
<td>18%</td>
</tr>
<tr>
<td>Distant Metastases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Cases</td>
<td>1</td>
<td>9</td>
<td>26</td>
<td>34</td>
<td>49</td>
<td>48</td>
<td>50</td>
<td>135</td>
</tr>
<tr>
<td>% Alive</td>
<td>0%</td>
<td>33%</td>
<td>4%</td>
<td>3%</td>
<td>10%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Total: No. of Cases</td>
<td>115</td>
<td>296</td>
<td>479</td>
<td>492</td>
<td>472</td>
<td>283</td>
<td>203</td>
<td>342</td>
</tr>
<tr>
<td>% Alive</td>
<td>79%</td>
<td>69%</td>
<td>54%</td>
<td>50%</td>
<td>40%</td>
<td>29%</td>
<td>21%</td>
<td>14%</td>
</tr>
</tbody>
</table>

It will be noted that the large tumours are more commonly associated with clinical evidence of metastatic spread and that the prognosis becomes poorer as the size of the primary tumour increases.

25
APPENDIX C

SUPPLY OF INFORMATION

Regional Records Offices in Scotland, having difficulty in tracing patients, should send a list of the patients concerned giving full particulars of name, National Health Service number, date of birth and last known address, to the National Health Service Central Register, Department of Health for Scotland, Government Buildings, Broomhouse Drive, Saughton, Edinburgh, 11. The list will be returned as soon as possible with a note of the address of the National Health Service Executive Council in whose area the patient is shown to have last chosen a doctor. The Records Office can then ascertain from the Executive Council concerned the latest address, according to their records, and (if this information is desired) the name of the doctor on whose list the patient is included for general medical services under the National Health Service.

Local Registrars are prepared to supply information to the Regional Records Offices in Scotland about deaths, etc., on payment of a fee of 1s. 6d., if approach is by direct contact, and of a fee of 5s. 6d. if indirect approach is made (i.e. requiring the provision of an extract).