Intermediate Adenoma Coding Application SOP

(Ann Thomson, Jill Waddingham 3/12/2012)

Contents

1. Database Overview

There are 5 tabs at the top of the coding application when you come to the first screen; these allow access to all the areas of the database. Below is a guide to what is in each section. These sections are:

1. **Coding**
2. **Hospital Overview**
3. **Bugs & Suggestions**
4. **Help**
5. **Review**

- **Patient List screen:**
  This screen shows a list of patients that still need to be coded. Patients have been anonymised and are identified only by a unique study number. Each patient can be selected by clicking on the individual study number or by typing the study number you want to recall into the search bar. On this screen there is a function that allows the user to filter, sort and highlight records. The flashback feature also allows the user to return to the data as it existed at a previous point in time. On the right hand side of the screen is a helpful 'Patient Lists' navigation panel, which allows coders to access records that they have already analysed or categorised. It also shows the last record analysed.

- **Patient Details screen:**
  This screen shows a list of all endoscopy records, polyps found and all pathology records that are linked to the patient. From here you can enter each individual endoscopy record by clicking on the individual endoscopy ID number; the same is true for each polyp and pathology record. The polyp numbering screen can also be accessed from this page to enable the coder to complete polyp numbering if necessary. This is the screen that you can use to exclude patients that meet the exclusion criteria. Data cleaning tasks will be shown at the bottom of this screen.

- **Endoscopy Overview screen:**
  This screen shows the endoscopy record and a list of polyps found at that endoscopy. The endoscopy record contains details of the type of exam, extent of the exam and any potential limitations and observations that occurred at endoscopy. The polyp list contains details on the endoscopic and pathological appearance of the polyp. From this screen you can navigate to four other screens which enable further details to be added to the Endoscopy Overview screen and polyp list.
  - **Endoscopy Indications Details screen:**
    This screen shows a list of clinical indications that precluded endoscopy. Additional indications can be added from here if they are present elsewhere on the report.
  - **Endoscopy Diagnosis Details screen:**
    This screen shows a list of diagnoses for the patient. Additional diagnoses can be added from here if they are present elsewhere on the report.
  - **Endoscopy Polyp Coding screen:**
    This screen is accessed from the Endoscopy Overview screen by clicking on the 'Add/edit polyp' button above the Polyp List and it shows the polyp list in a form which can be edited using a series of drop down menus. The endoscopy report is summarised above for the coder's reference.
  - **Pathology Polyp Coding screen:**
    This screen is accessed from the Endoscopy Overview screen by clicking on the 'Edit Polyp Pathology' button below the polyp list and it shows the polyp list in a form which can be edited

using a series of drop down menus. The pathology report is summarised above for the coder's reference.

- **Polyp Numbering Screen:**
This screen is accessed from the patient details screen. It displays the polyp row(s) for each exam, with exams shown in date order. The coder is able to review all polyp details in order to match any polyps thought to be the same and apply a percentage certainty to each match.

This screen shows a drop down menu which enables the selection of the centre of interest and on the right hand side the navigation panel is also present which enables the coder to look at the records they have already analysed or select those that have been flagged for query. This screen also shows a pie chart detailing the coding progress.

This screen enables the user to note down any problems or suggestions found so that they can be viewed and monitored by database administrators.

This screen enables the user to view any reference documents which have been written to help the coding process.

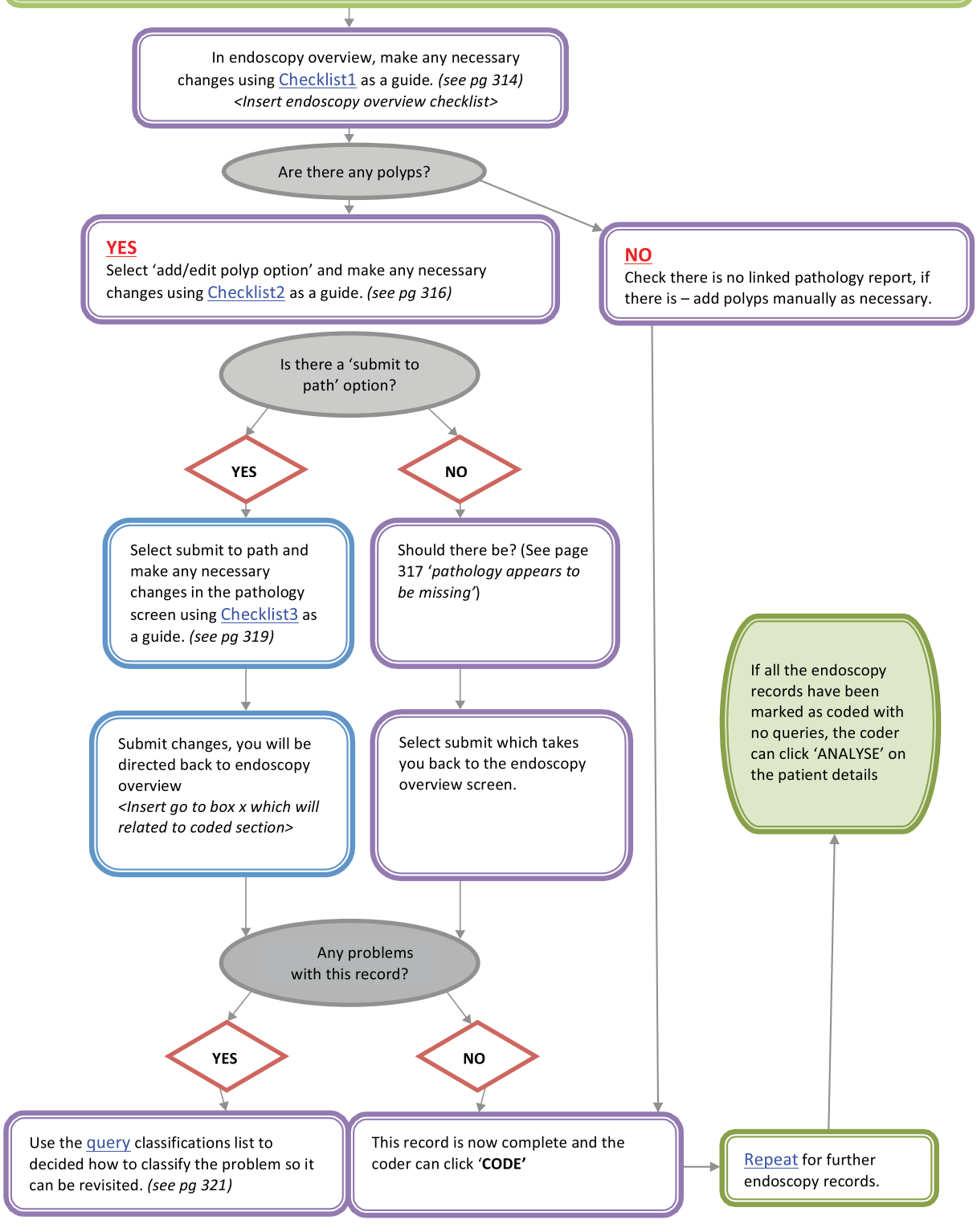
This section is for coders to review sections of the coding to check for systematic errors and make comments for correction.

The default list dropdown lets you choose which patient list (e.g All Patients, Query Patients) you would prefer the application to switch back to when you press Analyse, Cancel or Apply Changes in the main Patient page.

Each time you login the default value is set back to the coding list (the first page you come to when you login).

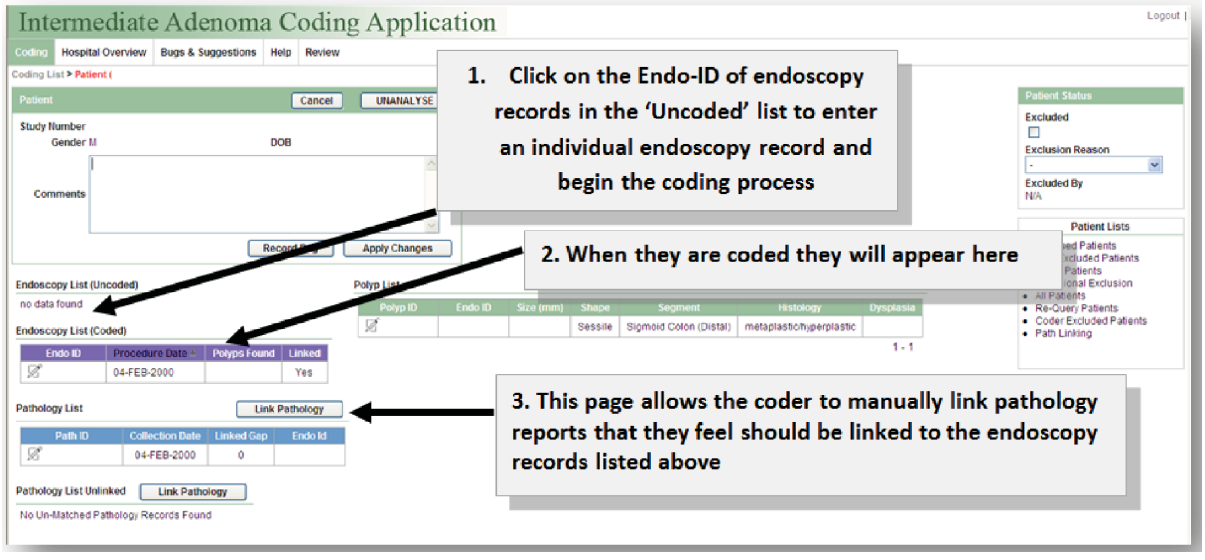
2. How to code records

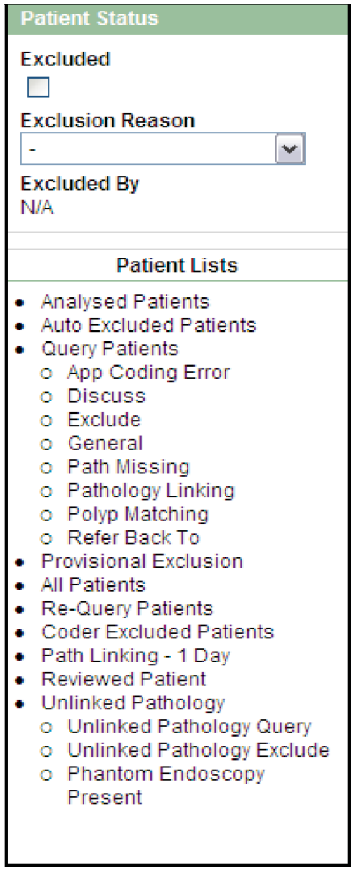
First select a hospital dataset on the coding list screen using the hospital drop down menu and then select a patient from the list below to display a list of their endoscopy records. In the Patient Details screen, select one of these records *(see pg 313).*



3. The Patient Details Screen

This screen summarises patient information and is where the coding process begins. It lists all the endoscopy records, pathology records and polyps that relate to an individual patient.



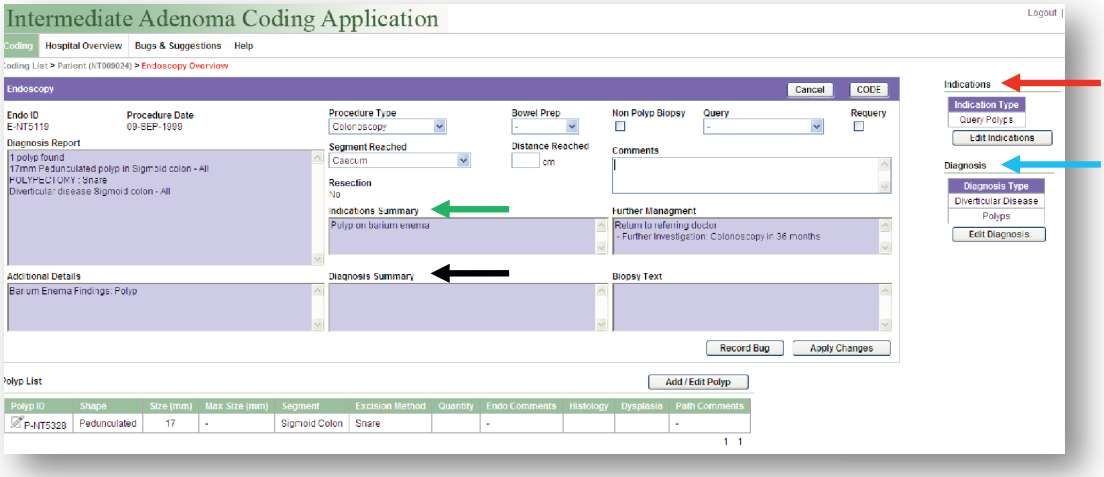


The **Patient Status** box in this screen allows the coder to exclude a patient based on the details provided in the endoscopy and pathology reports listed. Come back to this box when you have finished coding.

<u>This screen also displays:</u>

- A list of total polyps found in that patient at all the endoscopy exams (Polyp List)
- A list of pathology records which are related to the findings at the endoscopy exams listed (Pathology List)
- A list of other pathology records related to the patient but unrelated to the endoscopy exams listed (Pathology Unlinked).
- Link to the polyp numbering screen, if appropriate.
- Data cleaning task(s), if appropriate

4. Checklist 1: Endoscopy Overview Screen



✓ Check that any information from the 'Diagnosis Report' and 'Endoscopist Comments/Additional Details' boxs (if present) (see **purple** arrows) have been correctly entered into the following fields:

Procedure Type – Type of endoscopic procedure used to investigate the colon

Segment Reached – the segment of the large bowel which was reached by the endoscope

Distance Reached – the distance reached by the endoscope in cm.

Bowel Prep – quality of bowel cleansing prior to the exam

✓ Check that any indications in the 'Indications Summary' box (**green** arrow) have been coded in the far right hand box labelled 'Indications' (see **red** arrow)
If indications need to be added/amended:

Click on **'Edit Indications' →'Add Row'** → choose from drop-down menu → click on **'Submit'**

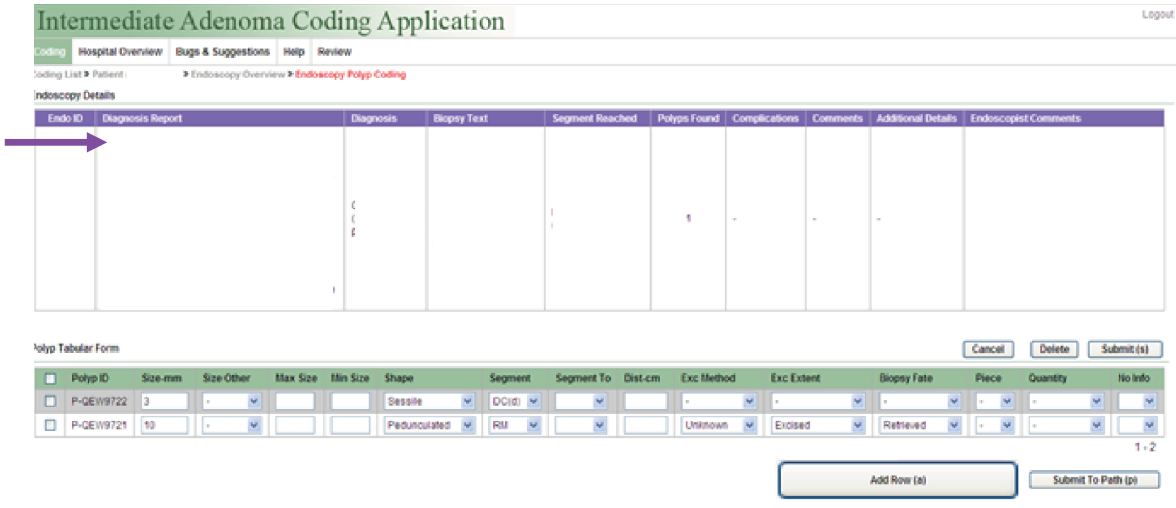
✓ Check that any Diagnoses in the 'Diagnosis Summary' box (**black** arrow) have been coded by looking at the right hand column under 'Diagnosis' (see **blue** arrow)
If diagnoses need to be added/amended:

Click on **'Edit Diagnosis' →'Add Row'** → choose from drop-down menu → click on **'Submit'**

Scenarios you may encounter whilst in this screen

Scenario	Possible Solutions
Contradictory information between fields	When the diagnosis report shows evidence that contradicts an entered field, ***coders must always go with the report***. E.g. Bowel prep marked as 'Excellent' in the field but report notes poor bowel prep; change field to 'Poor'.
Contradictory Information in the Diagnosis Report	In some cases the Diagnosis Report contains two contradictory statements about the Bowel Preparation. This may be due to automatically generated sentences at the top of the report. Coders should use the latter sentence or any free text description in the additional details field to code bowel prep. If in doubt flag records up for group discussion.
Growth/polyp/tumour does not appear on polyp list	Any polyps mentioned in the endoscopy report that do not appear in the polyp list below will need to be added manually by coders. The endoscopy may also mention tumours, polypoidal growths or lesions – these must also be added as polyps. However, this does not include: strictures, Angiodysplasia or ulcers. These can be added to the diagnosis field instead. *To add a polyp manually:* Click on **'add/edit polyp' →'Add Row'** → Use the drop-down menus to fill in all the details you have available for the polyp → **click on** Don't forget to go through the coding process as usual once it has been added.
Possible polyps not listed in polyp list	If an endoscopist sees a polyp but cannot find it again (i.e. it was not visible on retraction) – ***Add a polyp row using the method above*** If an endoscopist sees a possible polyp or is in any way unsure about the polyps presence and there is no linked pathology – ***DO NOT add a polyp row***
Pathology report attached to an endoscopy with no polyp	In this case, check the pathology for polyps. If polyps are identified in the pathology coders must add each polyp manually following the instructions in the scenario above. Remember to carefully check that the pathology is correctly linked to the endoscopy in question by looking at the date of pathology and endoscopy and any previous exams on the patient's records.
Blank Diagnosis Report	In some cases the Diagnosis Report will be missing, in which case, fill in any information available and move onto the next stage.
Indication/Diagnosis not present on drop down menu	Double check the indication does not suggest something that warrants exclusion. If you cannot find a description on the list that adequately describes the indication, it should be left blank.
Family History as an Indication	Coders should only us the Indication options 'Family History of Colorectal Cancer' and 'Family History of Cancer' when specified. When the Endoscopist only states 'Family History' no indication should be coded.

5. Checklist 2: Add/Edit Polyp Screen



✓ Check that any polyp information from the 'Diagnosis Report' (**purple** arrow) has been entered correctly into the following fields:

Size-mm – *This refers to the size of the polyp in mm*

Size Other – *This can be used when as specific size of a polyp is not stated*

Max Size – *This refers to the maximum size of a polyp if there are a number of polyps and only the largest polyp's size is stated or there is a size range*

Min Size – *This refers to the minimum size of a polyp if there is a size range stated rather than a specific size*

Shape – *This refers to the shape of the polyp in the bowel*

Segment – *This refers to the segment of the large bowel the polyp was found in*

Segment to – This is used if there is a range of segments. The most proximal segment in which a polyp is added here and the most distal in the 'Segment' field

Dist-cm – *This refers to the distance at which the scope was inserted when the polyp was found*

Exc Method – *This refers to the method used to biopsy or excise the polyp*

Exc Extent – *This refers to whether or not the polyp was excised or not. If biopsied, this should be left blank as the excision cannot be assumed.*

Biopsy Fate – *This refers to what happened to the polyp after biopsy/excision*

Piece – *This refers to whether a lesion has been removed piecemeal or not.*

Quantity – *Used when polyps are present and a specific number is not stated*

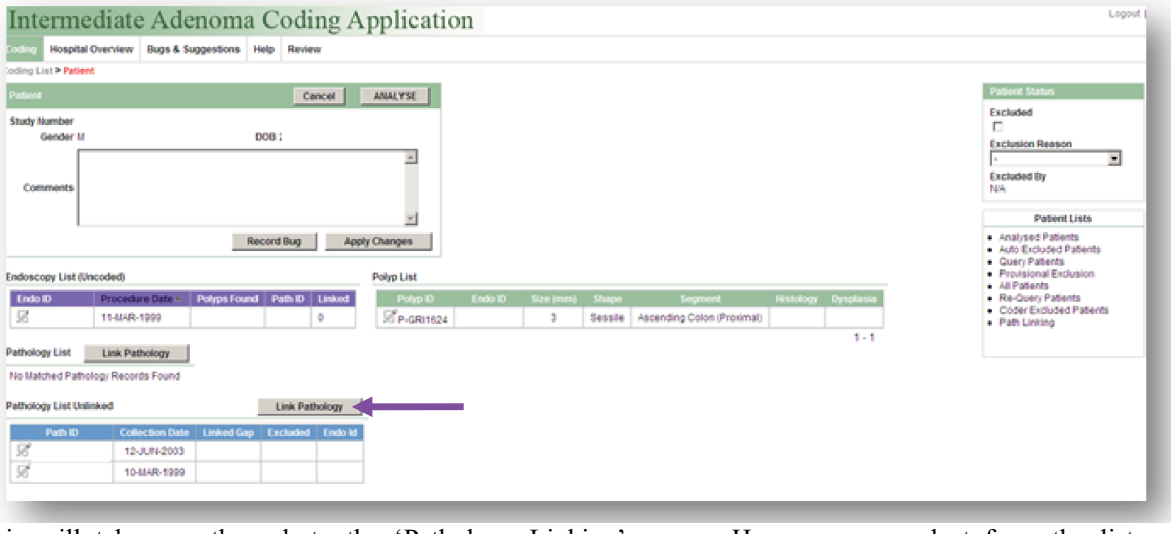
No Info – *This refers to whether or not a polyp mentioned has any information given about it*

Scenarios you may encounter whilst in this screen

Scenario	Possible Solutions
Size of polyp not specified	In the event that there is no indication of polyp size stated in the report, the box must be left blank (remove any zeros) If there is a range of sizes or a maximum size, these should be added as an alternative if a specific size is not available.
Excision/ biopsy method not specified	• It is worth checking the 'Biopsy Text' field which may contain further information on method. • If not, the coder must select 'Unknown Method' in the excision method menu. Try not to leave this blank, unless there was no excision.
Blank Diagnosis Report	In some cases the Diagnosis Report will be missing, in which case, fill in any information available and move onto the next stage.
Pathology appears to be missing	• The text in the report suggests the polyp has been excised or biopsied but a pathology report has not been linked to the endoscopist. • Only flag records with polyps as 'Pathology Missing' There are two ways to deal with this problem: 1) Refer to the patient overview screen and look at the list of unlinked pathology reports. Check the contents and the dates to check any of these reports should be attached to the endoscopy record. If they do, you can manually link the records together – *see manual pathology linking below* 2) If the unlinked pathologies do not appear to match the endoscopy, this record can be queried as **'Pathology missing'**. For information on how to query see the query page of this document page 15.

6. Manual Pathology Linking

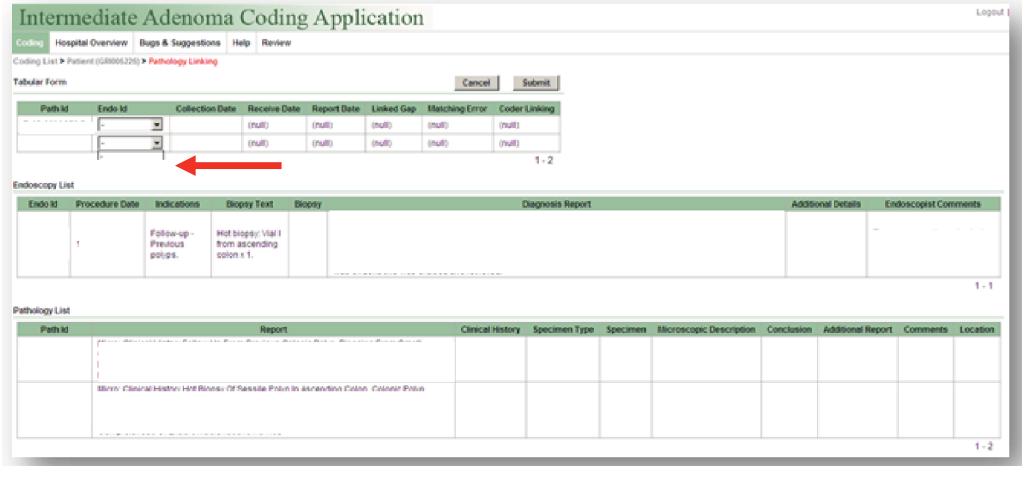
Coders can manually link pathology records to endoscopy records in the list if they feel they are certain they should be linked. This can be done in the Patient screen. To link pathology, select the 'Link Pathology' button (**Purple** arrow)



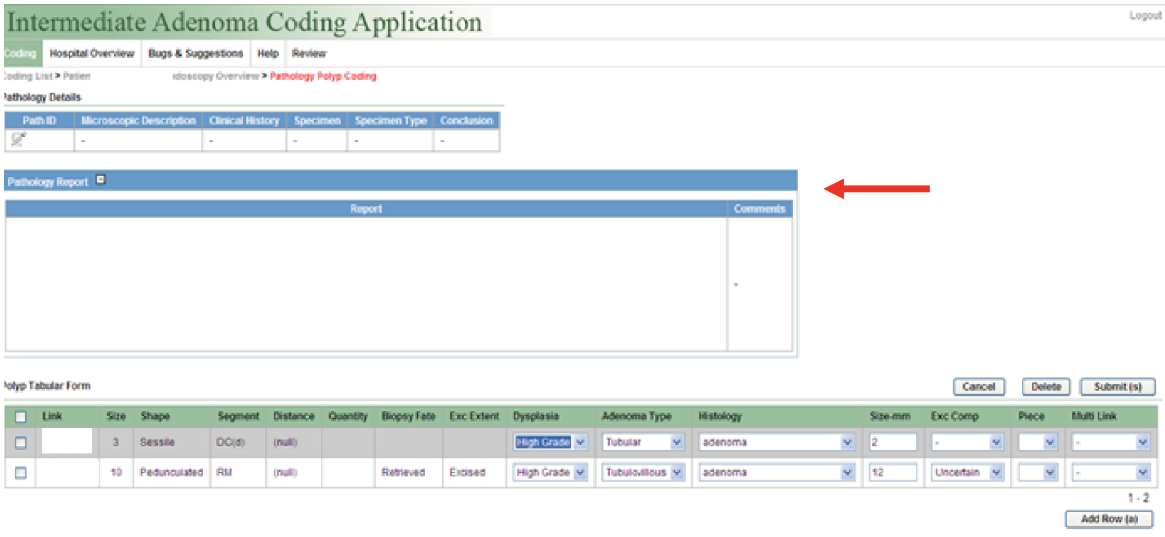
This will take you through to the 'Pathology Linking' screen. Here you can select from the list on endoscopies (**Red** arrow) that you think should be linked to each of the pathology records listed in the table at the top of the screen. When you do this, consider the date of the report on both the endoscopy and pathology reports carefully.

When you have finished linking, go back into the endoscopy record and match the histology as normal.

If any information indicates that the unlinked pathology belongs to another, missing endoscopy report, then coders must NOT link the data, even if the data relates to the same polyp. Instead, coders should create a **phantom endoscopy** (see Phantom SOP and Coders reference document – phantoms).



7. Checklist 3: Edit Polyp Pathology Screen



✓ Use a combination of the information from the sections in the pathology report (**red** arrow) to match up each polyp with the pathological description and fill in as many details as possible about the polyp into the following fields:

Dysplasia – *This refers to the level of dysplasia/atypia exhibited by the polyp*

Adenoma Type – *This refers to the extent of the tubular or villous features exhibited by any adenomas*

Histology – *This refers to the type of lesion as seen under the microscope*

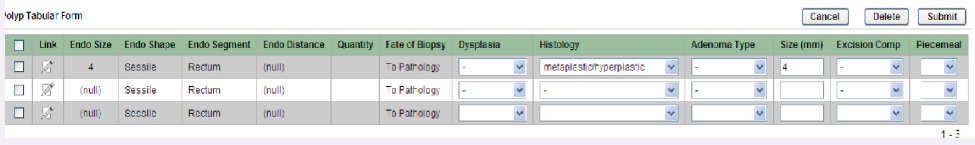
Size-mm – *This refers to the size of the specimen that the pathologist has received for analysis. Coders should always record the maximum diameter stated in mm. In cases where it is difficult to match the size to the polyp then follow the guidelines for 'polyp matching' outlined below and in cases where it is simply not possible to assign the correct size to the corresponding polyp then leave it blank.*

Exc Comp – *Refers to the completion of excision as concluded by the pathologist*

Piece - *This refers to whether a lesion has been removed piecemeal or not.*

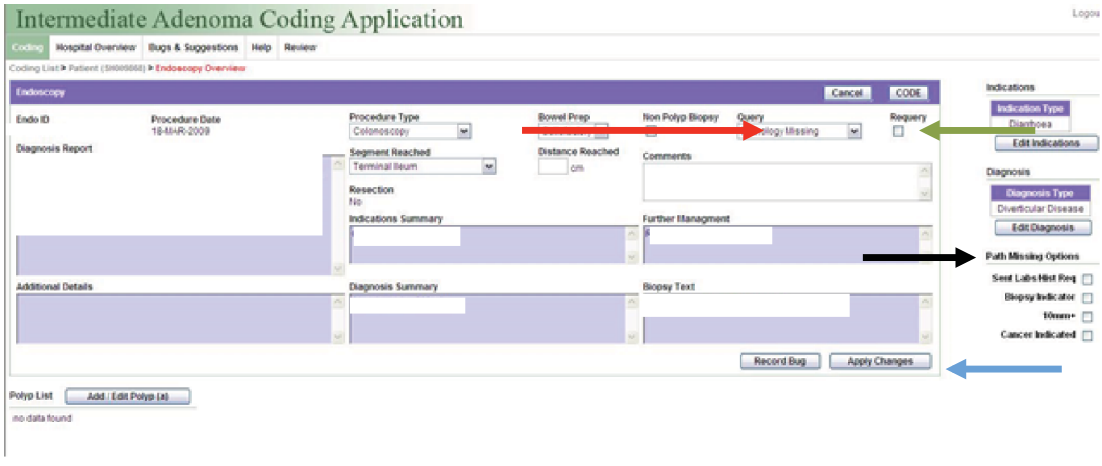
Multi Link – *This is used to link polyps created at pathology with relate to 'multiple' polyps added at endoscopy*

Scenarios you may encounter whilst in this screen

Scenario	Possible Solutions
Cannot match polyp with pathology details	• If the polyps are of a similar size and from the same segment, the coder should choose to allocate the worst pathology to the largest polyp (only if both of the polyps are under 10mm in size) • Similarly, if 2 polyps have been identified at endoscopy but only one pathology is provided and it is unclear which polyp this relates to, then, provided that the polyps are of similar size and were found in the same section of the bowel, the coder can assume that the pathology relates to the larger polyp. This rule only applies when both/all polyps involved are less than 10mm *(see below)*. • If there are two polyps of similar size in different locations that you cannot match. Use the segment range fields in the add/edit polyp screen to adapt each polyp so it covers the sections of both polyps and then apply the histology details. The same can be done with size if absolutely necessary as long as both polyps are above 10mm or below 10mm. This can be done using the min and max size fields in the add/edit polyp screen.  Polyp Tabular Form Cancel Delete Submit Link | Endo Size | Endo Shape | Endo Segment | Endo Distance | Quantity | Fate of Biopsy | Dysplasia | Histology | Adenoma Type | Size (mm) | Excision Comp | Piecemeal 4 | Sessile | Rectum | (null) | To Pathology | - | metaplastic/hyperplastic | - | 4 | - | (null) | Sessile | Rectum | (null) | To Pathology | - | - | - | | - | (null) | Sessile | Rectum | (null) | To Pathology | | | | | | 1 - 3 If you still have a problem matching the polyps, record this endoscopy record as a query in the endoscopy overview screen. The query for this case would be: **'Polyp Matching'**. For information on how to query see the query page of this document *(pg 10)*.
Individual pathologies provided for Multiple Polyps	• Pathology reports sometimes give individual diagnoses for 'multiple polyps'. In this case, manually add a row for each polyp pathology mentioned, leaving the row for 'multiple polyps' blank. e.g. 2 adenomas and 2 metaplastic *OR* 6 metaplastic *OR* one adenoma (add an extra polyp row for each of these) • To indicate that these polyps relate to the row labelled 'multiple' by selecting the polyp ID of the 'Multiple' row in **Multi Link** field. • If a single collective diagnosis is given at pathology for 'multiple polyps', then code accordingly in the 'multiple polyp' row. e.g. the polyps in the sigmoid are all Metaplastic. • When there are 'multiple' adenomas and an individual dysplasia grade is not allocated the following rules apply: o A number of adenomas ranging from mild to moderate → code as 'low grade' o A number of adenomas ranging from moderate to severe → code as a general query and mark it as "dysplasia range problem" in the comments field.
Description could be one of two mutually exclusive options on drop down	When a pathology report describes the histology of a polyp always choose the worst diagnosis. e.g. 'Tubular adenoma with moderate to severe dysplasia' – this would be recorded as a tubular adenoma with severe dysplasia. e.g. 'either a mildly dysplastic adenoma or a metastatic polyp' – this would be recorded as an adenoma.

No definite diagnosis	• If the pathologist has reported a probable histology, the coder should assume that this is a diagnosis. For example a 'Probable Adenoma' or a 'Probable Metaplastic' would be coded as Adenoma and Metaplastic. • If the sample is too small or damaged to be diagnosed then this should be marked under the histology field as 'Not possible to diagnose'.
Excision cannot be assessed	This should be marked under the complete excision field as 'Uncertain'
Endoscopy and Pathology give conflicting information	There will be occasions where the endoscopy report states something that is then contradicted by the pathology report. In this case we always give preference to endoscopy information. e.g. Endoscopy refers to a polyp as 'sessile' but the pathology report refers to it as 'pedunculated'. In this case we would code the polyp as sessile.

8. How to Query a Record



In the event of a query, do not code the record but instead go to the 'Endoscopy Overview' page and use the 'Query' drop-down menu (**red** arrow) to categorise the query. This will then open a 'Query Options' check list in the bottom right corner of the screen from which you may select the reason for the query (**Black** arrow). If there is no corresponding tick box category or you wish to further clarify or comment on the reason for the query then use the comments box to describe it. Once you have queried a record, you can click to 'Apply Changes' (**Blue** arrow), return to the previous screen using the breadcrumbs and remember to not code the record as this makes it easier to pick out when returning to in the future.

These are the query categories with their associated tick box options explained. You will be given the following options to choose from:

Application Coding Error – To be used when indicating that options or drop-down menus will be changed at a later date by the database administrator and you will return at a later date to finish coding.

- **Blank pathology** – when a pathology is attached but has no text
- **Truncated path report** – when the text is clearly cut off before the end of the

pathology report

- **Irrelevant endoscopy** – when endoscopy report is from an unrelated region i.e. gynaecological exam, upper GI exam
- **Duplicate endoscopy** – when there are two of the same endoscopy report
- **Truncated endoscopy** – when the text is clearly cut off before the end of the endoscopy report
- **Blank endoscopy** - when endoscopy has no text

Discuss – To be used when coders wish to discuss the record with other members of the team.

- **IBD** - use when you are uncertain whether exclusion for colitis/crohn's is required due to terminology or ambiguous wording
- **How best to code** - use when you have been unable to record data effectively or feel the need to discuss with the other coders how best to proceed.
- **HNPCC -** use when HNPCC is suspected

Exclude – To be used when a patient's endoscopy or pathology report may indicate something worthy of exclusion but requires further clarification. If you wish to exclude something based on the procedures set out for exclusion, use the Patient Status box when you return to the main patient details screen.

- **Cancer first exam -** use when you have query excluded because a cancer was seen on first endoscopy/confirmed by pathology
- **Resection first exam -** use when you have query excluded because in the first procedure, terminology indicates that the patient has had surgery shortening the bowel
- **HNPCC -** use when you have query excluded because HNPCC family cancer syndrome has been indicated in any report
- **Polyposis -** use when the colon has a very large number of polyps (20+) lining a large proportion of the colons surface. It may be acceptable to exclude for less than 20 polyps if there is a number of exams with multiple polyps and information indicating family history of polyps
- **Colitis -** use when you have query excluded because colitis or any of the inflammatory bowel diseases have been indicated at endoscopy or pathology in any report

General – To be used for any queries other than those already listed. These may include :

- **Sup Report Missing** – when an report indicates that there should be a further exam and there is no such record shown*
- **Possible Cancer** – when the endoscopist is uncertain if he sees a cancer or not, and there is no pathology or other reports to confirm or deny cancer
- **When Cancer** – when it is not possible to identify when a cancer occurred (usually when it has been referred to in the indications)**
- **When Resection -** when it is not possible to identify when a resection occurred (usually when it has been referred to in the indications)**
- **Polyp Numbers** – when it is not clear how many polyp rows should be added
- **Unsure Terminology** – when terminology is used that cannot be defined

using the Glossary of Terms or Google.

* be sure to check that the date of the intended, missing report does fall outside of the dates for which we have collected data for each hospital (see the Dataset Date Range document)

** if a previous cancer/resection is referred to in the indications for the 1st exam, then this should be excluded for 'Cancer at 1st Exam'/'Resection at 1st Exam'

Pathology linking - Pathology linking queries are to be used when the coder is unsure if a pathology report should be linked to an endoscopy.

Pathology Missing – To be used when there has clearly been a biopsy/excision of a polyp that is awaiting histology and does not appear to have a linked pathology report. If you are unsure you can use the following criteria:

1. The endoscopy report specifically refers to sending the polyp sample to pathology/histology/labs
2. Polyps that have been biopsied or if there is biopsy text relating to the section of the bowel that polyps were found.
3. Polyps ≥10mm or Tumours/Cancers, even they haven't been biopsied (unless the exam specifically states that they have not been removed or biopsied for some reason)

Only exams with polyps should be marked as pathology missing.

- **Sent to lab/await pathology stated** - Use when it says "Sent to labs" or "Await pathology/histology" in any of the text fields
- **Large polyp of >=10mm** - use when polyp size of >= 10mm or described as large.
- **Biopsy Indicator** - use when there is some indication of pathology requested in the biopsy text box
- **Cancer/tumour indicated** - use when a cancer is seen or suspected. Clarification of the presence of cancer is important for the study

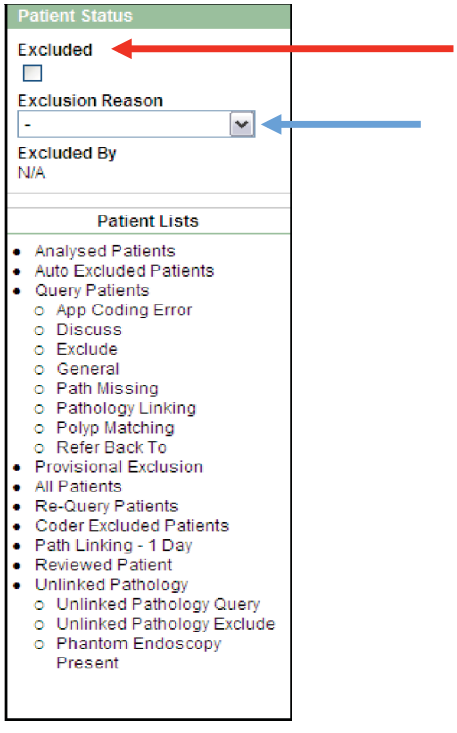
Polyp Matching – To be used when coder is unable to match pathological information to the polyps in the list due to lack of detail or clarity.

Refer Back To - To be used for personal reference when you need to come back to a record.

Once all queries have been followed up through additional data collection, if you do not feel you can resolve them then tick the re-query box (**Green** arrow). This will send the record to a new list where they can be reviewed at a later date.

9. How to Exclude a Patient

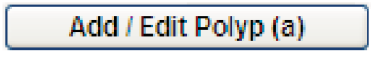
The exclusion SOP sets out the criteria for exclusion of patients, this should be carefully observed. Excluded patients do not need to be coded but any records for these patients that have already been coded can be left and do not need to be deleted. If you find a patient to be worthy of exclusion you should do this immediately in the patient details screen. Using the **Patient Status** box on the right hand side of the screen you can select exclude (**Red** arrow) and then use the drop down menu to select an **Exclusion Reason** (**Blue** arrow). If you select 'Other' do not forget to put your reasons in the comments box at the top of the screen and **Apply Changes.**



10. Top Tips!

- Try coding the pathology of a polyp faster by using the keyboard instead of your mouse. Simply use the letters of the category you wish to select to avoid going through the whole list, then press tab to go onto the next column. For example to code a moderately dysplastic tubular adenoma with a specimen size of 2mm, start in the dysplasia box and type; M M TAB T TAB A TAB 2.

- The keyboard can also be used to navigate through all of the polyp coding screens using the Alt key plus the letter that is in brackets on each of the submit buttons. E.g. to add/edit a polyp you can click on the add/edit polyp button or use the keyboard and press 'Alt+a'



- Navigation back to previous screens should be done using breadcrumbs, links or tabs. Avoid using the internet browser navigation buttons.

- In some cases the endoscopist will mention polyps in their summary that have already been referred to in the report. Coders must be aware of this, taking care not to add the same polyp twice, and if unsure, flag up reports for group discussion.

- Anal Cancer and Colorectal Cancer are distinct. Anal cancer occurs via a completely separate and unrelated pathways so do not treat anal cancers and colorectal cancer. If in doubt, query the record for discussion.

Coding Reference Document

(3/12/2012)

Contents

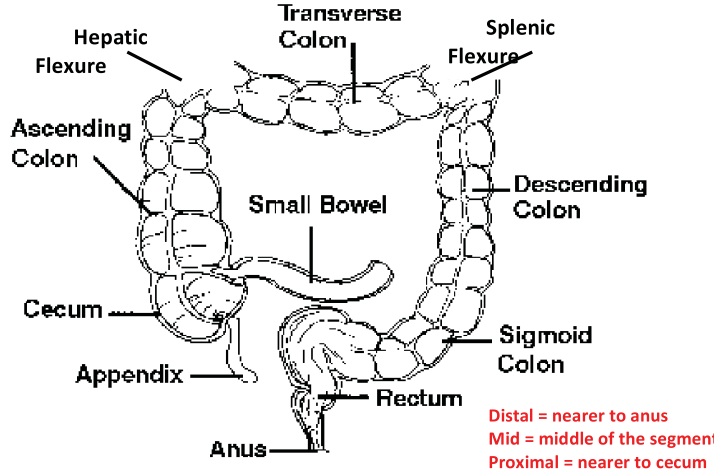
1. **Patient Details Screen (patient status box):**

For further details on exclusions – see Exclusion SOP

Field Name	Option	Definition
Excluded		*Tick box option. Select if you wish to exclude a patient, then choose a reason from the list below.*
Exclusion Reason	**Cancer 1st Exam**	*It is indicated there has been a cancer prior to the earliest dated exam or the pathologist diagnoses a Cancer (Adenocarcinoma) during the first exam on record. Cancers arising from adenomas or disputed cancers should NOT be excluded.*
	Colitis	*The endoscopist or pathologist notes a history/previous diagnosis of colitis or the pathologist confirms colitis at any of the exams.*
	Crohn's Disease	*The endoscopist or pathologist notes a history/previous diagnosis of crohn's or the pathologist confirms crohn's at any of the exams.*
	FAP	*The endoscopist reports or the pathologist identifies Familial Adenomatous Polyposis.*
	Family Hx FAP	*The exam indicates that close family members of the patient have had FAP or there is a genetic indication (see SOP for details).*
	HNPCC	*The exam reports/identifies the patient as having Hereditary non-polyposis colorectal cancer, or, a family history or genetic predisposition for HNPCC.*
	IBD	*The endoscopist notes a history/previous diagnosis of IBD or the pathologist confirms IBD at any of the exams.*
	Other – See Comments	*There is a reason to exclude the patient that does not fit with any of the reasons on the list. The reason should be detailed in the comments box on the patients details screen and should be justified using the Exclusion SOP.*
	P-J Polyposis	*The exam indicates presence of Peutz-Jeghers polyposis.*
	Polyposis	*The exam indicates presence of another type of polyposis.*
	Resection 1st Exam	*The exam indicates there has been a resection prior to the first dated exam on the list.*
	Ulcerative Colitis	*The endoscopist notes a history/previous diagnosis of Ulcerative Colitis, or, the pathologist confirms Ulcerative Colitis at any of the exams.*

2. **Endoscopy Overview Screen:**

Field Name	Option	Definition
Procedure Type	**Colonoscopy**	*The endoscopic examination of the* ***whole of the large colon*** *and the distal part of the small bowel with a camera on a tube passed through the anus.*
	Flexible Sigmoidoscopy	*The endoscopic examination of the large intestine* ***from the rectum to the distal descending,*** *using a flexible scope.*
	Proctoscopy	*Short ridged metal tube is inserted into the rectum, anal cavity or sigmoid to enable direct visualisation of the area.*
	Rigid	*The endoscopic examination of the large intestine* ***from the rectum to***

	Sigmoidoscopy	***the distal sigmoid,*** *using a rigid scope.*
	Sigmoidoscopy	*Examination of the large colon* ***up to the distal descending****.*
Segment Reached	*Note: Complete or Total Colonoscopy can be assumed to have reached the Cecum. A complete or total ileo-colonoscopy can be assumed to have reached the Terminal ileum.*	
Bowel Prep	**Excellent** **Good** **Poor** **Satisfactory**	*These should just be inserted as stated in the report*
Distance Reached		*This is a number field. Type in the distance reached by the endoscope from the anus if it is specified by the endoscopist.*
Query	**Application Coding Error**	*To be used when indicating that options or drop-down menus will be changed at a later date by the database administrator and you will return at a later date to finish coding.* *Coders can further categorise this query by selecting one or more of the following:* • ***Blank pathology*** *– when a pathology is attached but has no text* • ***Truncated path report*** *– when the text is clearly cut off before the end of the pathology report* • ***Irrelevant endoscopy*** *– when endoscopy report is from an unrelated region i.e. gynaecological exam, upper GI exam* • ***Duplicate endoscopy*** *– when there are two of the same endoscopy report* • ***Truncated endoscopy*** *– when the text is clearly cut off before the end of the endoscopy report* • ***Blank endoscopy*** *- when endoscopy has no text*
	Discuss	*To be used when coders wish to discuss the record with other members of the team.* *Coders can further categorise this query by selecting one or more of the following:* • ***Colitis*** *– when the query is regarding Colitis* • ***How to code*** *– when unclear about how to code any part of the record*

	• ***HNPCC*** *– when the query is regarding HNPCC*
Exclude	*To be used when a patient's endoscopy or pathology report indicates, but does not confirm the presence of study exclusion criteria. For details on the exclusion criteria see the 'Exclusion SOP'.* *Coders can further categorise this query by selecting one or more of the following:* • ***Cancer 1st exam*** • ***Resection 1st exam*** • ***HNPCC*** • ***Polyposis*** • ***Colitis*** *When it is unclear if you should exclude for...*
General	*To be used for any other query, particularly if you feel it warrants discussion with other members of the team. When using a general query, you should describe the nature of the query in the comments box below the query field.* *Coders can further categorise this query by selecting one or more of the following:* • ***Sup Report Missing*** *– when an report indicates that there should be a further exam and there is no such record shown** • ***Possible Cancer*** *– when the endoscopist is uncertain if he sees a cancer or not, and there is no pathology or other reports to confirm or deny cancer* • ***When Cancer*** *– when it is not possible to identify when a cancer occurred (usually when it has been referred to in the indications)*** • ***When Resection -*** *when it is not possible to identify when a resection occurred (usually when it has been referred to in the indications)*** • ***Polyp Numbers*** *– when it is not clear how many polyp rows should be added* • ***Unsure Terminology*** *– when terminology is used that cannot be defined using the Glossary of Terms or Google.* * be sure to check that the date of the intended, missing report does fall outside of the dates for which we have collected data for each hospital (see the Dataset Date Range document) ** if a previous cancer/resection is referred to in the indications for the 1st exam, then this should be excluded for 'Cancer at 1st Exam'/'Resection at 1st Exam'
Pathology Linking	*To be used when a pathology report appears to be linked/unlinked incorrectly to an endoscopy record, but it is not certain.* *If the pathology is clearly linked/unlinked incorrectly, it can be manually linked/unlinked using the Link Pathology button on the patient details screen. Once the linking has been corrected there is no need to query the record.*
Pathology Missing	*To be used when there has clearly been a biopsy/excision that is awaiting histology and does not appear to have a linked pathology report. If you are unsure you can use any of the following criteria:*

		4. *The endoscopy report specifically refers to sending a sample of a polyp to pathology/histology/labs* 5. *The endoscopy report specifically refers to awaiting histology for a polyp* 6. *Large polyps (10mm+) with no pathology that have been biopsied* 7. *Cancer is indicated* 8. *The biopsy text relates to a polyp segment or refers to a polypectomy* *Coders can further categorise their queries by selecting one or more of the following:* • ***Sent Labs/Hist Req*** *– when the report specifically refers to sending a sample of a polyp to pathology/histology/labs* • ***Biopsy Indicator*** *– when the Biopsy Text field refers to a biopsy from the same segment as a polyp or a polypectomy* • ***10mm+*** *- when one or more polyps are 10mm or above* • ***Cancer Indicated*** *– when a polyp is referred to as highly suspicious/tumour/cancer* ***In all these cases the pathology is NOT missing if the endoscopist states that the polyps in question have not been biopsied.*** **Note**: Polyps that have not been excised may have been biopsied. If unsure – query the record as Pathology Missing.
	Polyp Matching	*To be used when coder is unable to match pathological information to the polyps in the list due to lack of detail or clarity.*
	Refer Back To	*To be used for personal reference when you need to come back to a record.*
Comments		*This is a free text field. This should be used to enter any comments that relate to the record or the query.*

3. Endoscopy Indications Screen:

Field Name	Option	Definition
Indication	**Abdominal Mass**	Swelling or mass in the abdomen.
	Abdominal Pain	Generalised pain in the abdominal region. LIF and RIF pain can also be classified as abdominal pain.
	Abnormal Barium Enema	Abnormal findings on a Barium Enema prior to exam in question (sometimes referred to as an 'equivocal BA/Barium Enema').
	Abnormal CT	Abnormal findings on a CT scan prior to exam in question.
	Abnormal Sigmoidoscopy	Abnormal findings on a Sigmoidoscopy prior to exam in question.
	Anaemia	Deficiency of haemoglobin in the blood.
	Bowel Cancer Screening Programme	The patient is having an endoscopy examination as part of the national Bowel Cancer Screening Programme (BCSP).
	Cancer	The patient has had a colorectal cancer prior to the exam

	in question.
Carcinoma	The patient has had a carcinoma prior to the exam in question.
Change in Bowel Habits	The patient is experiencing a change in the frequency of bowel movements compared to normal.
Colitis	The endoscopist has specified the presence of colitis prior to the procedure. Colitis is a chronic digestive disease characterized by inflammation of the colon. Inflammation alone does not warrant a classification of colitis. (It is a member of the IBD family but is defined separately here for clarity)
Colonic Obstruction	Presence of a blockage in the large bowel prior to the exam.
Constipation	Hard faeces that are difficult to expel, often accompanied by a reduction in the frequency of bowel movements.
Crohn's	Chronic inflammatory disease which can affect any part of the gastrointestinal tract. (It is a member of the IBD family but is defined separately here for clarity)
Diarrhoea	Frequent loose or liquid bowel movements.
Diverticular Disease	Presence of uncomplicated diverticula in the colon (Diverticulosis) or inflamed diverticular (Diverticulitis).
Family History of Cancer*	Patient has relatives who have or have had cancer (unknown type).
Family History of Colorectal Cancer*	Patient has relatives who have had colorectal cancer.
Fissure	Natural crack or tear in skin tissue, which can cause bleeding. Present in the past or prior to the exam.
Haemorrhoids	Swelling and inflammation of the veins in the rectum and anus. This is the same as piles.
Hereditary Non-Polyposis Colorectal Cancer	An inherited condition where there is a very high chance of getting colorectal cancer.
IBD	Inflammatory Bowel Disease. This encompasses a number of conditions such as colitis and Crohn's disease. Use only if the endoscopist says 'IBD'. If they specify colitis or Crohn's then use these options.
Incontinence	Involuntary leakage of faeces.
Melena/Melana	Stools stained black by a dark blood pigment.
Mucus Discharge	Mucous that passes out of the rectum from a source in the bowel.
Polyposis	A condition where a person suffers with a large number of polyps coating a large surface area throughout the colon.
Polyps	The patient has had known previous polyps.
Positive Faecal Occult Blood Test	Also FOBT or FOB. Positive result in screening test for 'unseen' blood.
Query Cancer	It has been indicated that the reason for the exam is that the patient is suspected to have colorectal cancer.
Query Colitis	It has been indicated that the reason for the exam is that the patient is suspected to have colitis. This may be indicated as ?IBD, in which case both query colitis and query Crohn's should be added to the indications.
Query Crohns	It has been indicated that the reason for the exam is that the patient is suspected to have Crohns. This may be

		indicated as ?IBD, in which case both query colitis and query Crohns should be added to the indications.
	Query polyps	It has been indicated that the reason for the exam is that the patient is suspected to have polyps. This is usually depicted by 'polyps seen on barium enema/CT'.
	Rectal Bleeding	Bleeding appearing to come from the rectum.
	Rectal Pain	Pain in the rectum.
	Rectal Mass	Palpable mass in the area of the rectum.
	Tenesmus	Feeling or urge to defecate but without needing to pass stool.
	Ulcers	Known presence of ulcers prior to the exam or presence of ulcers in the past.
	Volvulus	Life threatening bowel obstruction where the bowel twists on itself.
	Weight Loss	Uncharacteristic loss of body mass.

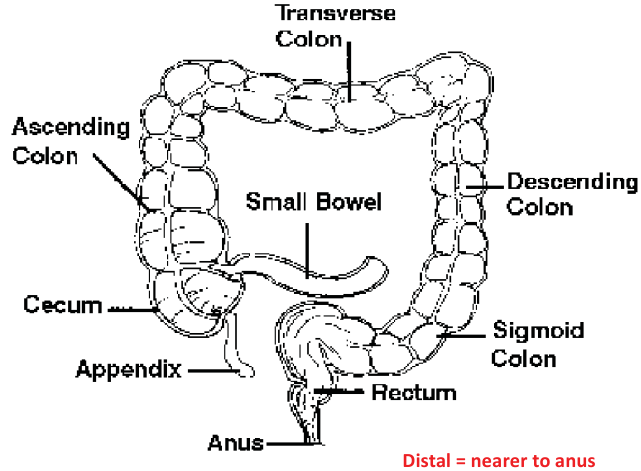
***Coders should only us the Indication options 'Family History of Colorectal Cancer' and 'Family History of Cancer' when specified. When the Endoscopist only states 'Family History' no indication should be coded.**

4. <u>Endoscopy Diagnosis Screen:</u>

Field Name	Option	Definition
Diagnosis	**Anastomosis**	*Endoscopist has observed an Anastomosis which is the surgical reconnection of two parts of the colon post resection.*
	Angiodysplasia/Telangectasia	*Endoscopist has observed areas of vascular malformation in the gut. Can be a common cause of unexplained bleeding in the colon. Sometimes referred to as AVMs/AVCMs.*
	Benign Tumour	*Endoscopist has observed an abnormal growth/neoplasm that they feel lacks the malignant qualities of cancer.*
	Cancer	*Malignant neoplasm.*
	Colitis	*The endoscopist has specified the presence of colitis from the observations made during the exam.*
	Colonic Obstruction	*Endoscopist comes across an obstruction of unspecified nature in the colon upon examination – this does not include cancers or large polyps.*
	Crohn's	*The endoscopist strongly suspects the patient has crohn's disease or is known to already have crohn's disese.*
	Diverticular disease	*Endoscopist has observed uncomplicated diverticula in the colon (Diverticulosis) or inflamed diverticular (Diverticulitis).*

FAP	*The endoscopist or the pathologist suspect the presence of Familial Adenomatous Polyposis due to the number of polyps in the colon.*
Fissure	*Endoscopist visualised a fissue during the course of the exam, this is a natural crack or tear in skin tissue. Can cause bleeding.*
Haemorrhoids	*Endoscopist has observed Haemorrhoids/piles.*
IBD	*Inflammatory Bowel Disease. This encompasses a number of conditions such as colitis and Crohn's disease. Use only if the endoscopist says 'IBD'. If they specify colitis or Crohn's then use these options.*
Incomplete exam	*A record should be coded as Incomplete Exam when the max segment is not reached AND a reason is given (other than 'planned limited procedure' or 'pathology encountered').* *Possible reasons include;* - *Looping (of the bowel or scope)* - *Patient consent withdrawn* - *Unsuccessful intubation* - *A technical problem* - *Poor Bowel Prep* - *An abandoned procedure* - *Patient intolerance/discomfort*
Melena/Melana	*Stools stained black by a dark blood pigment.*
Piles	*See haemorrhoids*
Polyposis	*Endoscopist suspects the presence of polyposis due to the number of polyps observed in the bowel.*
Polyps	*Endoscopist has found polyps in the bowel during the exam.*
Proctitis	*Endoscopist has observed Inflammation of the lining of the rectum and anus.*
Prolapse	*Endoscopist has observed a part of the bowel prolapsing (falling or slipping out of place). Or the endoscopist has observed mucosal prolapse.*
Suspected IBD	*Endoscopist has reason to suspect Colitis or Crohns disease and has taken biopsies to confirm but the pathology is not present. (Apthous Ulcers can also be recognised as Suspected IBD)* **Note**: Remember to check if pathology confirms or refutes a suspicion of IBD. If it is explicitly ruled out, remove 'Suspected IBD' from the Diagnosis. If it is confirmed, refer to page 3 – Exclusion Reasons.
Strictures	*Endoscopist visualises a stricture during the exam. This is an abnormal narrowing of a bodily passage. This can be due to cancer, diverticulosis or inflammation.*
Ulcers	*Endoscopist visualises ulcers in the colon.*
Volvulus	*Endoscopist has observed a life threatening bowel obstruction where the bowel twists on itself.*

5. Add/Edit Polyp Screen:

Field Name	Option	Definition
Size-mm		This is a number field. The size of the polyp stated by the endoscopist should be noted here. Convert to mm if necessary. Only to be used if an exact number is specified.
Size Other	**5-9mm**	Polyp is between 5 and 9mm. Exact size is not specified.
	<10mm	The polyp is smaller than 10mm/sub centimetre. Exact size is not specified.
	<5mm	The polyp is smaller than 5mm. Exact size is not specified.
	>10mm	The polyp is larger than 10mm. Exact size is not specified.
	Large	The polyp(s) are described as large. Exact size is not specified.
	Small	The polyp(s) are described as small. Exact size is not specified.
	Tiny	The polyp(s) are described as tiny. Exact size is not specified.
Max Size		This is a number field. If multiple polyps are noted and maximum size is given, this can be entered here. This field can also be used to add a size where a size range is given to a single polyp.
Min Size		This is a number field. This field can also be used to add a size where a size range is given to a single polyp.
Shape	**Pedunculated**	The polyp observed was on a stalk.
	Sessile	Polyp with no stalk.
	Flat	Polyp that is flat on the surface of the bowel.
	Pseudo Polyp	A mass that has the appearance of a polyp but is not.
	Sub Pendunc	Avoid using this option.
Segment	The segment of the colon in which a polyp is found. (If a range of segments is stated the most distal is entered here) **Note:** Right colon can be assumed to be Ascending colon unless otherwise specified in pathology. Proximal colon cannot.	
Segment to	If a range of segments is stated the most proximal is entered here.	See diagram above.
Dist-cm		This is a number field. Sometimes the distance in which the polyp was found from the anus is stated. This should be entered in cm.
Exc Method	**APC**	The endoscopist or pathologist specifies the primary use of

		Argon Plasma Coagulation.
	Cold Biopsy	Also Cold Bx/B'x. Insert if specified by endoscopist or pathologist.
	Hot Biopsy	Also Hot Bx/B'x. Insert if specified by endoscopist or pathologist.
	Snare	A wire loop device designed to slip over a polyp and, upon closure, result in removal of the polyp.
	Cold Snare	Insert if specified by endoscopist or pathologist.
	Hot Snare	Insert if specified by endoscopist or pathologist.
	EMR	Endoscopic mucosal resection. Insert if specified by endoscopist or pathologist.
	Unknown Method	Used when you know removal or biopsy has taken place but the method is unspecified or they used the term 'diathermised'.
Exc Extent	**Excised**	Endoscopist has specified that they have removed the polyp.
	Partially Excised	Endoscopist has specified that they have only removed part of the polyp. Use this option when it is stated in the diagnosis report.
	Not Excised	Endoscopist has specified that they have not removed the polyp. They may still have biopsied the polyp for pathology.
Biopsy Fate	**Retrieved**	The polyp has been collected by the endoscopist from the colon after excision, and not left inside the colon. (This may or may not have been sent to pathology.) Only use when specifically stated by the endoscopist.
	Burnt Off	Method of removal that destroys the polyp in situ.
	Not Retrieved	The specimen was lost after removal either inside the patient or outside the patient upon collection. A specimen/biopsy may still have been sent to pathology.
Piece	**Yes**	The polyp has been removed piecemeal
	No	The polyp has not been removed piecemeal. If this is the case, this can be left blank if preferred.
Quantity	**A number of**	The endoscopist describes the presence of "A number of" polyps. Exact number not specified.
	Few	The endoscopist describes the presence of "A few" polyps. Exact number not specified.
	Many	The endoscopist describes the presence of "Many" polyps. Exact number not specified.
	Multiple	The endoscopist describes the presence of "Multiple" polyps. Exact number not specified.
	Several	The endoscopist describes the presence of "Several" polyps. Exact number not specified.
	Some	The endoscopist describes the presence of "Some" polyps. The exact number not specified.
No Info	**Yes**	There is a polyp mentioned but there is no information that can be entered into the polyp row.

6. Edit Polyp Pathology Screen

Field Name	Option	Definition
Dysplasia	**High Grade**	*The pathologist describes high grade dysplasia/atypia. This is synonymous with severe dysplasia. Use only when*

		specified.
	IM Cancer	*The pathologist describes presence of Intra-mucosal cancer.*
	IM Cancer in dispute	*The pathologist cannot confidently confirm IM cancer.*
	Low Grade	*The pathologist describes low grade dysplasia/atypia. This is synonymous with either mild or moderate dysplasia.* *If the pathologist describes 'mild to moderate' or 'mild and moderate' dysplasia, use this option.*
	Mild	*The pathologist describes Mild dysplasia/atypia.*
	Moderate	*The pathologist describes Moderate or focally moderate dysplasia/atypia.*
	Severe	*The pathologist describes Severe or focally severe dysplasia/atypia*
Adenoma Type	**Tubular**	*The pathologist describes the morphology of the Adenomatous tissue as tubular.*
	Tubulovillous	*The pathologist describes the morphology of the Adenomatous tissue as tubulovillous. A polyp with both tubular and villous morphology is considered tubulovillous.*
	Villous	*The pathologist describes the morphology of the Adenomatous tissue as villous.* *Not to be confused with villiform mucosa.*
Histology	**Adenoma**	*Pathologist specifies adenoma / Adenomatous polyp. Benign dysplastic colonic tumour. Can progress to become malignant.*
	Amyloid	*Insoluble fibrous protein aggregates.*
	Angiodysplasia	*Vascular malformation in the gut which can often cause bleeding into the colon.*
	Ca+adenoma	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from an adenoma or when a cancer diagnosis also includes adenomatous material.*
	Ca+mixed	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a mixed polyp or adenoma*
	Ca+serrated	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a serrated polyp or adenoma*
	Ca in dispute	*If a pathologist cannot confidently confirm cancer / malignancy / level of invasion* ***in an adenoma*** *or cannot decide between an adenoma or cancer.*
	Cancer query	*If a pathologist mention or suspects but is not able to confirm a diagnosis of cancer / malignancy*
	Cancer	*Malignant neoplasm / adenocarcinoma / carcinoma/ malignancy / invasion* ***Note*** *– if Cancer is diagnosed at the 1st exam – see page 3 – Exclusion Reasons*
	Cap polyp	*Inflammatory polyp with a 'cap' of debris or granulation tissue.*
	Carcinoid/neuroendocrine tumour	*Tumour originating from the neuroendocrine system.*
	Colitis	*Chronic bowel disease characterised by inflammation of the colon. Only to be used if colitis is specified, there is a separate option for generalised inflammation.*

	Note *– if Crohns is diagnosed – see page 3 – Exclusion Reasons*
Congestion	*Mucosal cells appear congested.*
Crohn's disease	*An autoimmune inflammatory disease that can affect any part of the gastrointestinal tract* ***Note*** *– if Crohns is diagnosed – see page 3 – Exclusion Reasons*
Fibroepithelial polyp	*Benign cutaneous lesion / skin tag. 'Polypiod fibrous nodules' can also be coded as this.*
Ganglioneuromatosis	*Tumours arising from the nervous system.*
Gastric heterotopia	*Normal gastric mucosa seen elsewhere in the body.*
GIST	*Gastro Intestinal Stromal Tumour*
Granulation tissue	*Tissue that replaces fibrin clots during the healing of tissue.*
Haemangioma	*Benign noncancerous tumour composed of rapidly proliferating blood vessels.*
Hamartomatous polyp	*Benign mucosal polyps usually found in the jejunum and ileum (small bowel).*
Inflammation	*Generalised inflammation of mucosa.*
Inflammatory	*Inflammatory polyp.*
Ischaemia	*Restriction of blood supply.*
Juvenile polyp	*Rare form of large bowel polyp. AKA retention polyp.*
Leiomyoma	*Benign neoplasm of smooth muscle.*
Lipoma	*Benign tumour composed of fatty tissue.*
Lymphangiectasia	*Intestinal disease characterised by lymphatic dilation.*
Lymphoid polyp	*Benign polyps occurring where lymphoid follicles are present in the colon.*
Melanosis coli	*Pigmentation of the wall of the colon, not associated with any disease pathway.*
Metaplastic/Hyperplastic	*Benign non-dysplastic polyps with lengthening and cystic dilation of mucosal glands. Hyperplastic and Metaplastic are synonymous with each other.* *"Hyperplastic areas" may also be coded this way.*
Metastases from another site	*Malignant material that is not from a primary bowel cancer and originates from a cancer somewhere else in the body.*
Mets/tumour infiltrating	*Malignant material that is infiltrating into the colon from a tumour outside the colon (if unsure use 'Mets from another site')*
Mixed adenoma/metaplastic	*Polyp displaying characteristics of an adenoma and those of a metaplastic polyp. This is rare.*
Mucosal prolapse	*Slippage of mucosa.*
Neurofibromatosis	*Genetically inherited disease where nerve fibres grow tumours.*
Non-Hodgkins Lymphoma	*(NHL) A diverse group of blood cancers that include any kind of lymphoma except Hodgkin's lymphomas.*
Normal mucosa	*Specimen shows no signs of a polyp and levels of dysplasia/atypia are within normal limits.*
Not possible to diagnose	*The polyp sample is too small or too damaged on removal to reliably diagnose the specimen.*
Oedema	*Swelling due to accumulation of fluids.*

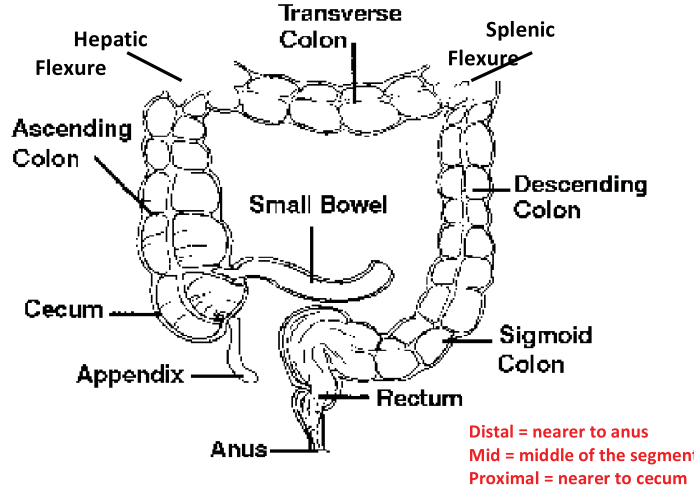
	Previous polypectomy site	*Appears to be tissue from the site where a previous polyp was removed.*
	Proctitis	*Inflammation of the lining of the anus and rectum.*
	Pseudolipomatus	*Artifactual microscopic change in tissues that resembles fatty infiltration.*
	Regenerative polyp	*Hyperplastic polyp of the gastric mucosa.*
	Sarcoma	*Cancerous tumour of soft tissue*
	Serrated adenoma	*Benign dysplastic colonic tumour which has a serrated appearance under the microscope.*
	Specimen not seen	*No evidence of a specimen in the pot received at pathology.*
	Spirochaetosis	*A type of bacterial infection of the colon.*
	Squamous cell carcinoma	*Skin Cancer normally found in the anus, but may be reported as rectal. Code as squamous cell carcinoma.*
	Submucosal haematoma	*Result of bleeding outside of the blood vessels.*
	Ulcer	*A break in the lining of the digestive tract that fails to heal naturally.*
	Unicryptal adenoma	*Very early beginning of adenoma growth.*
	Xanthoma	*Fatty deposits under the skin or mucosa causing yellow bumps.*
Size-mm		*This is a number field. The size of the sample received for histological examination should be written here. Coders should always record the maximum diameter stated.*
Exc Complete	**Complete**	*Pathologist has specified that the polyp appears completely excised.*
	Incomplete	*Pathologist has specified that the polyp appears to be incompletely excised.*
	Uncertain	*The pathologist is unsure about the completeness of excision or the extent of excision cannot be accessed.*
Piece	**Yes**	*The pathologist has indicated the polyp appears to have undergone piecemeal removal.*
	No	*This does not need to be used and can be left blank.*
Multi Link		*This drop down menu will give a list of the polyp ID's found at the exam. These can be selected if two rows are linked (see SOP for more details on when to link polyps).*

7. Unlinked Pathology Page:

Field Name	Option	Definition
Excluded	**General**	*Use this option for any general queries about the report.*
	Not Relevant Path	*Use this option when a report describes a biopsy from any site other than the Large Bowel.*
	Duplicate	*Use this option when the pathology report is a duplicate and needs to be deleted.*
Query	**Blank Pathology**	*Use this option when the pathology report is blank.*
	Possible Link	*Use this option when the details of the pathology (in terms of date, polyp numbers and segments) indicate that it may belong to an endoscopy report in the Patient Page.*
	Truncated Pathology Report	*Use this option when the pathology report is truncated.*
	Unclear Specimen	*Use this option when it is unclear if the specimen is from the*

	Origin	*large bowel or not.*
Normal Mucosa		*This is a tick box option. Use this option when the report does not describe any polyp attributes.* **Note**: A phantom report must still be created even if there is no endoscopic information to fill in.

8. Unlinked Pathology Endo Coding Page:

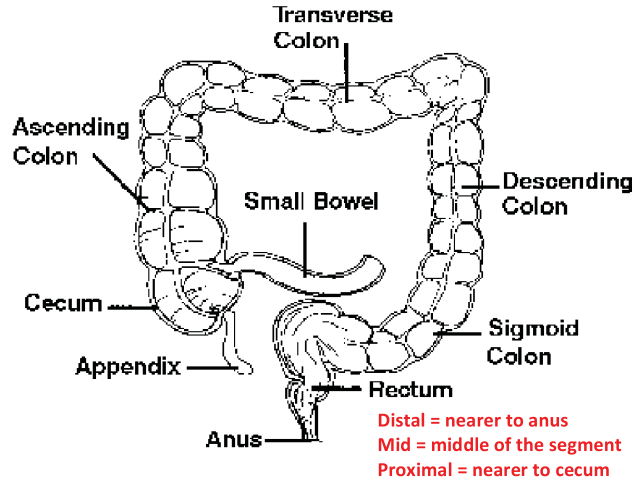
Field Name	Option	Definition
Procedure Type	**Colonoscopy**	*The endoscopic examination of the **whole of the large colon** and the distal part of the small bowel with a camera on a tube passed through the anus.*
	Flexible Sigmoidoscopy	*The endoscopic examination of the large intestine **from the rectum to the distal descending,** using a flexible scope.*
	Proctoscopy	*Short ridged metal tube is inserted into the rectum, anal cavity or sigmoid to enable direct visualisation of the area.*
	Rigid Sigmoidoscopy	*The endoscopic examination of the large intestine **from the rectum to the distal sigmoid,** using a rigid scope.*
	Sigmoidoscopy	*Examination of the large colon **up to the distal descending**.*
Bowel Prep	**Excellent** **Good** **Poor** **Satisfactory**	*These should just be inserted as stated in the report*
Segment Reached	***Note:** Complete or Total Colonoscopy can be assumed to have reached the Cecum. A complete or total ileo-colonoscopy can be assumed to have reached the Terminal ileum.*	
Distance Reached (cm)		*This is a text field. Type in the distance (in cm's) reached by the endoscope from the anus if it is specified.*
Query	**Application Coding Error**	*To be used when indicating that options or drop-down menus will be changed at a later date by the database administrator and you will return at a later date to finish coding.*
	Discuss	*To be used when coders wish to discuss the record with other members of the team.*
	Exclude	*To be used when a patient's endoscopy or pathology report indicates,*

		but does not confirm the presence of study exclusion criteria. For details on the exclusion criteria see the 'Exclusion SOP'.
	General	*To be used for any other query, particularly if you feel it warrants discussion with other members of the team. When using a general query, you should describe the nature of the query in the comments box below the query field.*
	Pathology Linking	*To be used when a pathology report appears to be linked/unlinked incorrectly to an endoscopy record, but it is not certain.* **Note**: If the pathology is clearly linked/unlinked incorrectly, it can be manually linked/unlinked using the Link Pathology button on the patient details screen. Once the linking has been corrected there is no need to query the record.
	Pathology Missing	*This option is not relevant, do not use.*
	Polyp Matching	*This option is not relevant, do not use.*
	Refer Back To	*To be used for personal reference when you need to come back to a record.*
Comments		*This is a free text field. This should be used to enter any comments that relate to the record or the query.*

For Indications and Diagnosis Screen please see sections; 3 & 4

9. Phantom Polyp Coding:

Field Name	Option	Definition
E Size		This is a number field. The size of the polyp stated by the endoscopist should be noted here. Convert to mm if necessary. Only to be used if an exact number is specified.
Size Other	**5-9mm**	Polyp is between 5 and 9mm. Exact size is not specified.
	<10mm	The polyp is smaller than 10mm/sub centimetre. Exact size is not specified.
	<5mm	The polyp is smaller than 5mm. Exact size is not specified.
	>10mm	The polyp is larger than 10mm. Exact size is not specified.
	Large	The polyp(s) are described as large. Exact size is not specified.
	Small	The polyp(s) are described as small. Exact size is not specified.
	Tiny	The polyp(s) are described as tiny. Exact size is not specified.
Shape	**Pedunculated**	The polyp observed was on a stalk.
	Sessile	Polyp with no stalk.
	Flat	Polyp that is flat on the surface of the bowel.
	Pseudo Polyp	A mass that has the appearance of a polyp but is not.
	Sub Pendunc	Avoid using this option.

Segment	The segment of the colon in which a polyp is found. (If a range of segments is stated the most distal is entered here) **Note:** Right colon can be assumed to be Ascending colon unless otherwise specified in pathology. Proximal colon cannot.	
Segment to	If a range of segments is stated the most proximal is entered here.	See diagram above.
Dist-cm		This is a number field. Sometimes the distance in which the polyp was found from the anus is stated. This should be entered in cm.
Exc Method	**APC**	The endoscopist or pathologist specifies the primary use of Argon Plasma Coagulation.
	Cold Biopsy	Also Cold Bx/B'x. Insert if specified by endoscopist or pathologist.
	Hot Biopsy	Also Hot Bx/B'x. Insert if specified by endoscopist or pathologist.
	Snare	A wire loop device designed to slip over a polyp and, upon closure, result in removal of the polyp.
	Cold Snare	Insert if specified by endoscopist or pathologist.
	Hot Snare	Insert if specified by endoscopist or pathologist.
	EMR	Endoscopic mucosal resection. Insert if specified by endoscopist or pathologist.
	Unknown Method	Used when you know removal or biopsy has taken place but the method is unspecified or they used the term 'diathermised'.
Piece	**Yes**	The polyp has been removed piecemeal
	No	The polyp has not been removed piecemeal. If this is the case, this can be left blank if preferred.
P Size		This is a number field. The size of the sample (in mm) received for histological examination should be written here. Coders should always record the maximum diameter stated.
Dysplasia	**High Grade**	The pathologist describes high grade dysplasia/atypia. This is synonymous with severe dysplasia. Use only when specified.
	IM Cancer	The pathologist describes presence of Intra-mucosal cancer.
	IM Cancer in dispute	The pathologist cannot confidently confirm IM cancer.
	Low Grade	The pathologist describes low grade dysplasia/atypia. This is synonymous with either mild or moderate dysplasia. If the pathologist describes 'mild to moderate' or 'mild and moderate' dysplasia, use this option.
	Mild	The pathologist describes Mild dysplasia/atypia.

	Moderate	The pathologist describes Moderate or focally moderate dysplasia/atypia.
	Severe	The pathologist describes Severe or focally severe dysplasia/atypia
Adenoma Type	**Tubular**	The pathologist describes the morphology of the Adenomatous tissue as tubular.
	Tubulovillous	The pathologist describes the morphology of the Adenomatous tissue as tubulovillous. A polyp with both tubular and villous morphology is considered tubulovillous.
	Villous	The pathologist describes the morphology of the Adenomatous tissue as villous. Not to be confused with villiform mucosa.
Histology	**Adenoma**	Pathologist specifies adenoma / Adenomatous polyp. Benign dysplastic colonic tumour. Can progress to become malignant.
	Amyloid	Insoluble fibrous protein aggregates.
	Angiodysplasia	Vascular malformation in the gut which can often cause bleeding into the colon.
	Ca+adenoma	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from an adenoma or when a cancer diagnosis also includes adenomatous material.
	Ca+mixed	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a mixed polyp or adenoma
	Ca+serrated	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a serrated polyp or adenoma
	Ca in dispute	If a pathologist cannot confidently confirm cancer / malignancy / level of invasion **in an adenoma** or cannot decide between an adenoma or cancer.
	Cancer query	If a pathologist mention or suspects but is not able to confirm a diagnosis of cancer / malignancy
	Cancer	Malignant neoplasm / adenocarcinoma / carcinoma/ malignancy / invasion **Note** – if Cancer is diagnosed at the 1st exam – see page 3 – Exclusion Reasons
	Cap polyp	Inflammatory polyp with a 'cap' of debris or granulation tissue.
	Carcinoid tumour	Tumour originating from the neuroendocrine system.
	Colitis	Chronic bowel disease characterised by inflammation of the colon. Only to be used if colitis is specified, there is a separate option for generalised inflammation. **Note** – if Crohns is diagnosed – see page 3 – Exclusion Reasons
	Congestion	Mucosal cells appear congested.
	Crohn's disease	An autoimmune inflammatory disease that can affect any part of the gastrointestinal tract **Note** – if Crohns is diagnosed – see page 3 – Exclusion Reasons
	Fibroepithelial polyp	Benign cutaneous lesion / skin tag. 'Polypiod fibrous nodules' can also be coded as this.
	Ganglioneuromatosis	Tumours arising from the nervous system.
	Gastric heterotopia	Normal gastric mucosa seen elsewhere in the body.
	GIST	Gastro Intestinal Stromal Tumour
	Granulation tissue	Tissue that replaces fibrin clots during the healing of tissue.

Haemangioma	Benign noncancerous tumour composed of rapidly proliferating blood vessels.
Hamartomatous polyp	Benign mucosal polyps usually found in the jejunum and ileum (small bowel).
Inflammation	Generalised inflammation of mucosa.
Inflammatory	Inflammatory polyp.
Ischaemia	Restriction of blood supply.
Juvenile polyp	Rare form of large bowel polyp. AKA retention polyp.
Leiomyoma	Benign neoplasm of smooth muscle.
Lipoma	Benign tumour composed of fatty tissue.
Lymphangiectasia	Intestinal disease characterised by lymphatic dilation.
Lymphoid polyp	Benign polyps occurring where lymphoid follicles are present in the colon.
Melanosis coli	Pigmentation of the wall of the colon, not associated with any disease pathway.
Metaplastic/Hyperplastic	Benign non-dysplastic polyps with lengthening and cystic dilation of mucosal glands. Hyperplastic and Metaplastic are synonymous with each other. "Hyperplastic areas" may also be coded this way.
Metastases from another site	Malignant material that is not from a primary bowel cancer and originates from a cancer somewhere else in the body.
Mets/tumour infiltrating	Malignant material that is infiltrating into the colon from a tumour outside the colon (if unsure use 'Mets from another site')
Mixed adenoma/metaplastic	Polyp displaying characteristics of an adenoma and those of a metaplastic polyp. This is rare.
Mucosal prolapsed	Slippage of mucosa.
Neurofibromatosis	Genetically inherited disease where nerve fibres grow tumours.
Non-Hodgkins Lymphoma	(NHL) A diverse group of blood cancers that include any kind of lymphoma except Hodgkin's lymphomas.
Normal mucosa	Specimen shows no signs of a polyp and levels of dysplasia/atypia are within normal limits.
Not possible to diagnose	The polyp sample is too small or too damaged on removal to reliably diagnose the specimen.
Oedema	Swelling due to accumulation of fluids.
Previous polypectomy site	Appears to be tissue from the site where a previous polyp was removed.
Proctitis	Inflammation of the lining of the anus and rectum.
Pseudolipomatus	Artifactual microscopic change in tissues that resembles fatty infiltration.
Regenerative polyp	Hyperplastic polyp of the gastric mucosa.
Sarcoma	Cancerous tumour of soft tissue
Serrated adenoma	Benign dysplastic colonic tumour which has a serrated appearance under the microscope.
Specimen not seen	No evidence of a specimen in the pot received at pathology.
Spirochaetosis	A type of bacterial infection of the colon.
Squamous cell carcinoma	Skin Cancer normally found in the anus, but may be reported as rectal. Code as squamous cell carcinoma.
Submucosal haematoma	Result of bleeding outside of the blood vessels.
Ulcer	A break in the lining of the digestive tract that fails to heal

		naturally.
	Unicryptal adenoma	Very early beginning of adenoma growth.
	Xanthoma	Fatty deposits under the skin or mucosa causing yellow bumps.
Exc Complete	**Complete**	Pathologist has specified that the polyp appears completely excised.
	Incomplete	Pathologist has specified that the polyp appears to be incompletely excised.
	Uncertain	The pathologist is unsure about the completeness of excision or the extent of excision cannot be accessed.

Updated with new histology terms that were added for cancer review. These included cancer types - GIST, Sarcoma, squamous cell carcinoma. A 'cancer query' added to compliment 'cancer in dispute'. 'Mets/tumour infiltrating' added to compliment 'mets from another site'.

Exclusion SOP

(Sajith Perera 3/12/2012)

Exclusion if found at **ANY EXAM**

If the following conditions are presented as either a diagnosis or an indication in any of the patient's endoscopy or pathology records then that patient is excluded.

Criteria:	***Definition:***	**Mention of the following terms in any of the fields may indicate the presence of the exclusion criteria:**
Hereditary Non-Polyposis Colorectal Cancer OR Family History of HNPCC	*"Familial predisposition indicates elevated risk for polyp and/or bowel cancer development by genetic influence"*	HNPCC Lynch Syndrome MSH1/2 mutation MLH1/2 mutation HNPCC Pedigree HMSH2
Colitis (any type)	*"Colitis is a chronic digestive disease characterised by inflammation of the colon"* *Only exclude if it is specified as being present by the endoscopist or strongly suspected by the pathologist after looking at the histology.* *Colitis is a chronic disease, if a patient has 'healed colitis' it is only non-active. Therefore still exclude.* *Diverticular colitis is NOT an exclusion criteria as this is Diverticulitis.* *Some (short-term) colitis should NOT be excluded for. Non-exclusion colitis types are:* - *Diversion colitis* - *Infective colitis (such as that caused by Clostridium difficile or another infectious agent)* - *Pseudomembranous colitis* - *Reactive colitis* - *Procedural/enema related colitis*	Ulcerative colitis Microscopic colitis Lymphocytic colitis Collagenous colitis Healed colitis History of Colitis Ischemic Colitis Ulcerative proctitis Indeterminate colitis

	- *Drug-induced colitis* - *Antibiotic-associated colitis* - *Radiation colitis* - *Chemical colitis* - *Ischemic colitis*	
Crohn's Disease	*"Chronic inflammatory disease which can affect any part of the intestinal tract"*	Healed crohn's History of crohn's
Inflammatory Bowel Disease (IBD)	*"An umbrella term that encompasses conditions such as Crohn's and colitis"* *DO NOT GET CONFUSED WITH IBS (irritable bowel syndrome)*	Chronic Inflammation Ulcerative Proctitis
Polyposis (any type)	*"Colon has a very large number of polyps (20+) lining a large proportion of the colons surface. It may be acceptable to exclude for less than 20 polyps if there is a number of exams with multiple polyps and information indicating family history of polyps "*- rule no longer used as of March 2012. NB - March 2012, polyposis patients reviewed. Only those with reports where the endoscopist or pathologist explicitly states presence of polyposis will be coded as polyposis. Numbers of polyps will be used to classify polyposis patients at analysis.	Familial Adenomatous Polyposis (FAP) Multiple Adenomatous Polyposis (MAP) Juvenile Polyposis Adenomatous Polyposis Coli (APC) Peutz-Jegher's syndrome Hyperplastic polyposis Serrated polyposis Lymphoid polyposis Cap polyposis Polyposis MYH
Family History of FAP	*"History of family members who have suffered with FAP"*	FH FAP FH Familial Adenomatous Polyposis FAPC

Exclusion if found at **FIRST EXAM**

The following conditions will exclude the patient if they are identified within the first endoscopy exam (chronologically) for that patient. The conditions can be identified either within the diagnosis or indication

fields for this exam. If the conditions are found on any other endoscopy exams (not the patient's first exam) then the patient is not excluded and is coded as normal.

Criteria:	***Definition:***	**Mention of the following terms in any of the fields may indicate the presence of the exclusion criteria:**
Stoma	*"Surgically created opening of the colon through the abdominal wall"*	Reversal Colostomy bag
Resection	*"Partial or complete removal of the colon"*	Hartman's procedure *OR* HAR Neo-terminal ileum Ileostomy Colostomy Pouch (however not pouch of douglas) Pouchitis Pouchoscopy Rectal Stump Suture AP Resection (abdominal perineal) *OR* APR Colectomy / Hemicolectomy Rectal Sponge
Anastomosis	*"The connection of two parts of the bowel post-resection"*	
Cancer	*"Malignant findings in the colon that have been confirmed by pathological assessment or the patient has had cancer prior to the first examination listed as is undertaking cancer follow-up"* *Cancers that is seen but unconfirmed/suspected at first exam but confirmed at a second procedure should also be excluded.*	Adenocarcinoma Moderately differentiated adenocarcinoma Carcinoma Malignant tumour Signet cell carcinoma

	*Cancers in dispute that are not resolved should **NOT** be excluded.* *Any other cancers that exist outside the bowel should **NOT** be excluded* *Cancers occurring within an adenoma (Ca+adenoma) should **NOT** be excluded.*	

The patient can be excluded by using a custom perl program (exclude.pl) that will automatically go through all the patient endoscopy records in a dataset and exclude the relevant patients.

Provisional Exclusion

- Patient has no polyps plus no linked pathology
- Patient may have multiple endoscopy records
- Done automatically
- Only used if we can reliably tell if polyps were found during an endoscopy exam.
    - Endoscribe date, this classification is not used because of this reason.

A custom Perl program (exclude.pl) carries out these types of exclusions automatically.

Checking Coder Excluded Records SOP

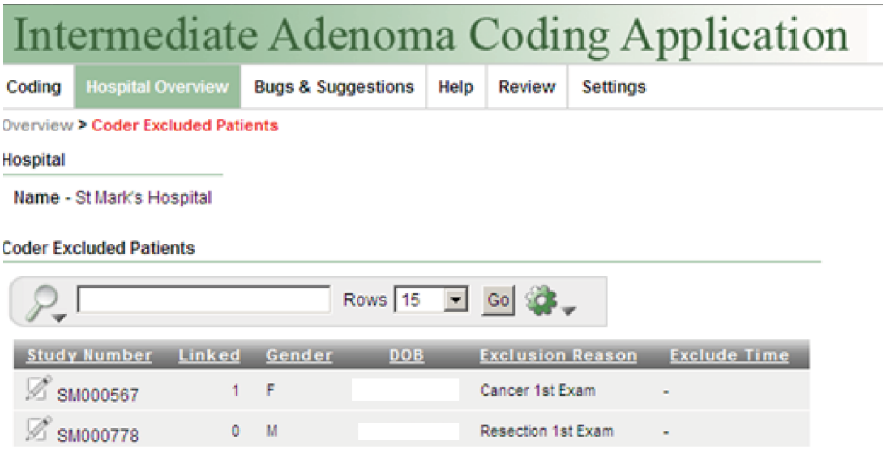
(Amy Brenner 3/29/2011)

Coder Excluded Records

A number of patients were excluded based on exclusion criteria. As a result, in some cases these patient records were not fully coded. Due to developments, they need to be properly coded in the same way as all other records. There are a number of issues that coders should be aware of when going through coder excluded records.

Identifying Coder Excluded Records

After selecting a hospital you should change the settings to 'Coder Excluded Patients'.



The exclusion criteria are:

- *Resection 1st exam*
- *Cancer 1st exam*
- *Colitis*
- *Crohns*
- *IBD*
- *HNPCC/family history of HNPCC*
- *Family history of FAP*
- *Polyposis*

Checklist

When checking coder excluded records you should confirm the following:

1) **Are all the endoscopy reports coded?**

2) **Has all the endoscopy and pathology information been entered?**

   Sometimes information may have been left out despite the report having been coded. You will need to go into both the endoscopy and pathology screens for each individual report to check this.

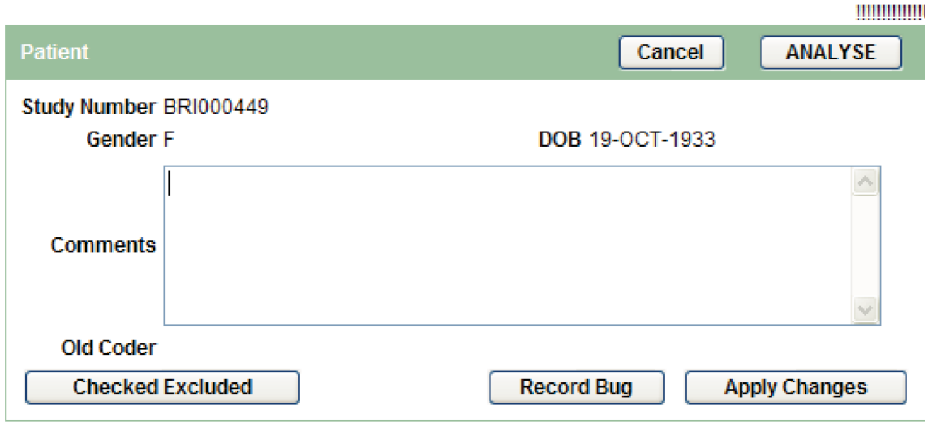
3) **Have phantom endoscopy reports been created for all unlinked pathology reports?**

4) **Should the patient be excluded?**

   It is important to ensure that the patient has been excluded correctly. Please take note that a number of records have been excluded as 'Cancer 1st exam', however the patient only had 'ca + adenoma' at their first exam, not cancer. Bear this in mind and be sure to uncheck the exclusion box if the patient has been inappropriately excluded. Analyse the record if there are no queries.

5) **Once all reports are fully coded, the patient should be marked as 'Checked Excluded'**.

   This will result in the patient being moved from 'Coder Excluded' in the Patient List to 'Checked (Coder Excluded)'. The 'Checked Excluded' button is shown below.



Creating New Queries

In some cases, checking coder excluded records will result in the creation of new queries. A query should be used if the patient cannot be confidently coded, however unnecessary queries should be avoided as it is unlikely that they will be resolved.

A new missing pathology query should only be created if:

- Cancer is suspected
- Histology requested/sent to labs
- Biopsy text indicator

NB – You should only begin checking coder excluded patients at centres for which missing pathology has already been uploaded. Any queries should be marked as a re-query.

Exclusion Reference Document

	Definition:	**Mention of the following terms in any of the fields may indicate the presence of the exclusion criteria**
Exclusion if found at ANY EXAM		
Hereditary Non-Polyposis Colorectal Cancer OR Family History of HNPCC	"Familial predisposition indicates elevated risk for polyp and/or bowel cancer development by genetic influence"	HNPCC Lynch Syndrome MSH1/2 mutation MLH1/2 mutation HNPCC Pedigree
Colitis (any type)	"Colitis is a chronic digestive disease characterised by inflammation of the colon" Only exclude if it is specified as being present by the endoscopist or strongly suspected by the pathologist after looking at the histology. Colitis is a chronic disease, if a patient has 'healed colitis' it is only non-active. Therefore still exclude. Diverticular colitis is NOT an exclusion criteria as this is Diverticulitis. Some (short-term) colitis should not be excluded for. Non-exclusion colitis types are: - Diversion colitis - Infectious colitis (such as that caused by Clostridium difficile or another infectious agent) - Pseudomembranous colitis - Reactive colitis - Procedural colitis - Drug-induced colitis - Antibiotic-associated colitis - Radiation colitis - Chemical colitis - Ischemic colitis	Ulcerative colitis Microscopic colitis Lymphocytic colitis Collagenous colitis Healed colitis History of colitis Ulcerative Proctitis Indeterminate colitis
Crohn's Disease	"Chronic inflammatory disease which can affect any part of the intestinal tract"	Healed crohn's History of crohn's
Inflammatory Bowel Disease (IBD)	"An umbrella term that encompasses conditions such as Crohn's and colitis" DO NOT GET CONFUSED WITH IBS (irritable bowel syndrome)	Chronic Inflammation Ulcerative Proctitis
Polyposis (any type)	"Colon has a very large number of polyps (20+) lining a large proportion of the colons surface. It may be acceptable to exclude for less than 20 polyps if there is a number of	Familial Adenomatous Polyposis (FAP) Multiple Adenomatous Polyposis (MAP)

	exams with multiple polyps and information indicating family history of polyps "- rule no longer used as of March 2012. NB - March 2012, polyposis patients reviewed. Only those with reports where the endoscopist or pathologist explicitly states presence of polyposis will be coded as polyposis. Numbers of polyps will be used to classify polyposis patients at analysis.	Juvenile Polyposis Adenomatous Polyposis Coli (APC) Peutz-Jegher's syndrome Hyperplastic polyposis Serrated polyposis Lymphoid polyposis Cap polyposis Polyposis MYH
Family History of FAP	"History of family members who have suffered with FAP"	FH FAP FH Familial Adenomatous Polyposis FAPC
Exclusion if found at FIRST EXAM		
Stoma	"Surgically created opening of the colon through the abdominal wall"	Reversal Colostomy bag
Resection	"Partial or complete removal of the colon"	Hartman's procedure OR HAR Neo-terminal ileum Ileostomy Colostomy Pouch (however not pouch of douglas) Pouchitis Pouchoscopy Rectal Stump AP Resection (abdominal perineal) OR APR Colectomy / Hemicolectomy Rectal Sponge
Anastomosis	"The connection of two parts of the bowel post-resection"	
Cancer	"Malignant findings in the colon that have been confirmed by pathological assessment or the patient has had cancer prior to the first examination listed as is undertaking cancer follow-up" Cancers that is seen but unconfirmed/suspected at first exam but confirmed at a second procedure should also be excluded. Cancers in dispute that are not resolved should **NOT** be excluded. Any other cancers that exist outside the bowel should **NOT** be excluded Cancers occurring within an adenoma (Ca+adenoma) should **NOT** be excluded.	Adenocarcinoma Moderately differentiated adenocarcinoma Carcinoma Malignant tumour Signet cell carcinoma

Coders Reference Document – Phantom Reports

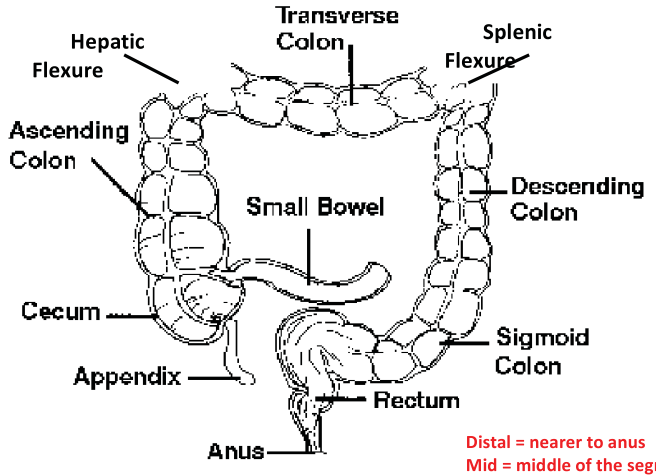
(Ann Thomson 3/12/2012)

1. Patient Page:

Field Name	Option	Definition
Excluded	**General**	*Use this option for any general queries about the report.*
	Not Relevant Path	*Use this option when a report describes a biopsy from any site other than the Large Bowel.*
	Duplicate	*Use this option when the a number of the same reports have been uploaded*
Query	**Blank Pathology**	*Use this option when the pathology report is blank.*
	Possible Link	*Use this option when the details of the pathology (in terms of date, polyp numbers and segments) indicate that it may belong to an endoscopy report in the Patient Page.*
	Truncated Pathology Report	*Use this option when the pathology report is truncated.*
	Unclear Specimen Origin	*Use this option when it is unclear if the specimen is from the large bowel or not.*
Normal Mucosa		*This is a tick box option. Use this option when the report does not describe any polyp attributes.* **Note**: A phantom report must still be created even if there is no endoscopic information to fill in.

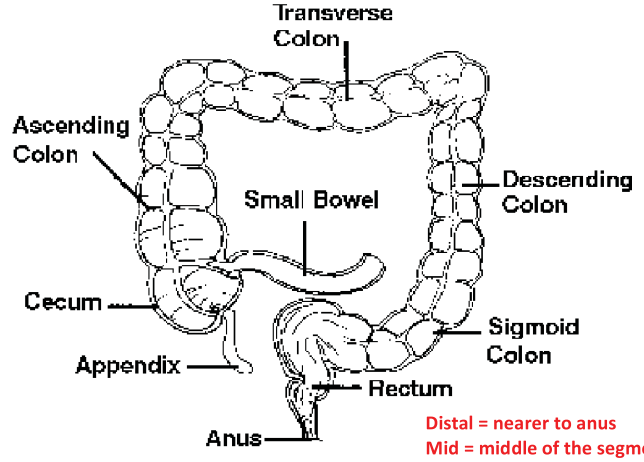
2. Unlinked Pathology Endo Coding Page:

Field Name	Option	Definition
Procedure Type	**Colonoscopy**	*The endoscopic examination of the **whole of the large colon** and the distal part of the small bowel with a camera on a tube passed through the anus.*
	Flexible Sigmoidoscopy	*The endoscopic examination of the large intestine **from the rectum to the distal descending,** using a flexible scope.*
	Proctoscopy	*Short ridged metal tube is inserted into the rectum, anal cavity or sigmoid to enable direct visualisation of the area.*
	Rigid Sigmoidoscopy	*The endoscopic examination of the large intestine **from the rectum to the distal sigmoid,** using a rigid scope.*
	Sigmoidoscopy	*Examination of the large colon **up to the distal descending**.*
Bowel Prep	**Excellent** **Good** **Poor** **Satisfactory**	*These should just be inserted as stated in the report*

Segment Reached	*Note: Complete or Total Colonoscopy can be assumed to have reached the Cecum. A complete or total ileo-colonoscopy can be assumed to have reached the Terminal ileum.*	
Distance Reached (cm)		*This is a text field. Type in the distance (in cm's) reached by the endoscope from the anus if it is specified.*
Query	**Application Coding Error**	*To be used when indicating that options or drop-down menus will be changed at a later date by the database administrator and you will return at a later date to finish coding.*
	Discuss	*To be used when coders wish to discuss the record with other members of the team.*
	Exclude	*To be used when a patient's endoscopy or pathology report indicates, but does not confirm the presence of study exclusion criteria. For details on the exclusion criteria see the 'Exclusion SOP'.*
	General	*To be used for any other query, particularly if you feel it warrants discussion with other members of the team. When using a general query, you should describe the nature of the query in the comments box below the query field.*
	Pathology Linking	*To be used when a pathology report appears to be linked/unlinked incorrectly to an endoscopy record, but it is not certain.* **Note**: If the pathology is clearly linked/unlinked incorrectly, it can be manually linked/unlinked using the Link Pathology button on the patient details screen. Once the linking has been corrected there is no need to query the record.
	Pathology Missing	*This option is not relevant, do not use.*
	Polyp Matching	*This option is not relevant, do not use.*
	Refer Back To	*To be used for personal reference when you need to come back to a record.*
Comments		*This is a free text field. This should be used to enter any comments that relate to the record or the query.*

For Indications and Diagnosis Screen please see sections; 3 & 4 of Main Coders Reference Document

3. Phantom Polyp Coding:

Field Name	Option	Definition
E Size		This is a number field. The size of the polyp stated by the endoscopist should be noted here. Convert to mm if necessary. Only to be used if an exact number is specified.
Size Other	**5-9mm**	Polyp is between 5 and 9mm. Exact size is not specified.
	<10mm	The polyp is smaller than 10mm/sub centimetre. Exact size is not specified.
	<5mm	The polyp is smaller than 5mm. Exact size is not specified.
	>10mm	The polyp is larger than 10mm. Exact size is not specified.
	Large	The polyp(s) are described as large. Exact size is not specified.
	Small	The polyp(s) are described as small. Exact size is not specified.
	Tiny	The polyp(s) are described as tiny. Exact size is not specified.
Shape	**Pedunculated**	The polyp observed was on a stalk.
	Sessile	Polyp with no stalk.
	Flat	Polyp that is flat on the surface of the bowel.
	Pseudo Polyp	A mass that has the appearance of a polyp but is not.
	Sub Pendunc	Avoid using this option.
Segment	The segment of the colon in which a polyp is found. (If a range of segments is stated the most distal is entered here) **Note:** Right colon can be assumed to be Ascending colon unless otherwise specified in pathology. Proximal colon cannot.	
Segment to	If a range of segments is stated the most proximal is entered here.	See diagram above.
Dist-cm		This is a number field. Sometimes the distance in which the polyp was found from the anus is stated. This should be entered in cm.
Exc Method	**APC**	The endoscopist or pathologist specifies the primary use of Argon Plasma Coagulation.
	Cold Biopsy	Also Cold Bx/B'x. Insert if specified by endoscopist or pathologist.

	Hot Biopsy	Also Hot Bx/B'x. Insert if specified by endoscopist or pathologist.
	Snare	A wire loop device designed to slip over a polyp and, upon closure, result in removal of the polyp.
	Cold Snare	Insert if specified by endoscopist or pathologist.
	Hot Snare	Insert if specified by endoscopist or pathologist.
	EMR	Endoscopic mucosal resection. Insert if specified by endoscopist or pathologist.
	Unknown Method	Used when you know removal or biopsy has taken place but the method is unspecified or they used the term 'diathermised'.
Piece	**Yes**	The polyp has been removed piecemeal
	No	The polyp has not been removed piecemeal. If this is the case, this can be left blank if preferred.
P Size		This is a number field. The size of the sample (in mm) received for histological examination should be written here. Coders should always record the maximum diameter stated.
Dysplasia	**High Grade**	The pathologist describes high grade dysplasia/atypia. This is synonymous with severe dysplasia. Use only when specified.
	IM Cancer	The pathologist describes presence of Intra-mucosal cancer.
	IM Cancer in dispute	The pathologist cannot confidently confirm IM cancer.
	Low Grade	The pathologist describes low grade dysplasia/atypia. This is synonymous with either mild or moderate dysplasia. If the pathologist describes 'mild to moderate' or 'mild and moderate' dysplasia, use this option.
	Mild	The pathologist describes Mild dysplasia/atypia.
	Moderate	The pathologist describes Moderate or focally moderate dysplasia/atypia.
	Severe	The pathologist describes Severe or focally severe dysplasia/atypia
Adenoma Type	**Tubular**	The pathologist describes the morphology of the Adenomatous tissue as tubular.
	Tubulovillous	The pathologist describes the morphology of the Adenomatous tissue as tubulovillous. A polyp with both tubular and villous morphology is considered tubulovillous.
	Villous	The pathologist describes the morphology of the Adenomatous tissue as villous. Not to be confused with villiform mucosa.
Histology	**Adenoma**	Pathologist specifies adenoma / Adenomatous polyp. Benign dysplastic colonic tumour. Can progress to become malignant.
	Amyloid	Insoluble fibrous protein aggregates.
	Angiodysplasia	Vascular malformation in the gut which can often cause bleeding into the colon.
	Ca+adenoma	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from an adenoma or when a cancer diagnosis also includes adenomatous material.
	Ca+mixed	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a mixed polyp or adenoma
	Ca+serrated	Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a serrated polyp or adenoma
	Ca in dispute	If a pathologist cannot confidently confirm cancer /

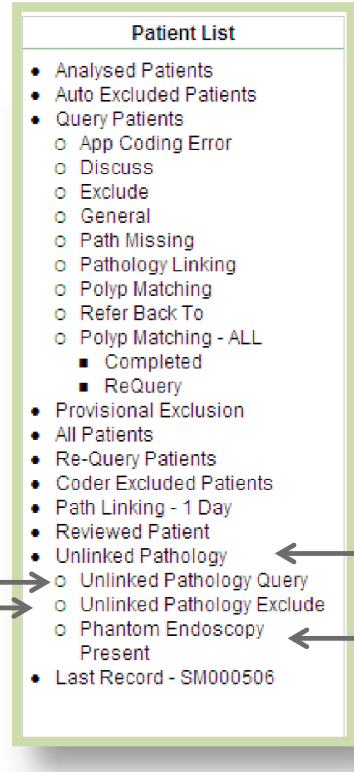
	malignancy / level of invasion **in an adenoma** or cannot decide between an adenoma or cancer.
Cancer query	If a pathologist mention or suspects but is not able to confirm a diagnosis of cancer / malignancy
Cancer	Malignant neoplasm / adenocarcinoma / carcinoma/ malignancy / invasion **Note** – if Cancer is diagnosed at the 1st exam – see page 3 – Exclusion Reasons
Cap polyp	Inflammatory polyp with a 'cap' of debris or granulation tissue.
Carcinoid/neuroendocrine tumour	Tumour originating from the neuroendocrine system.
Colitis	Chronic bowel disease characterised by inflammation of the colon. Only to be used if colitis is specified, there is a separate option for generalised inflammation. **Note** – if Crohns is diagnosed – see page 3 – Exclusion Reasons
Congestion	Mucosal cells appear congested.
Crohn's disease	An autoimmune inflammatory disease that can affect any part of the gastrointestinal tract **Note** – if Crohns is diagnosed – see page 3 – Exclusion Reasons
Fibroepithelial polyp	Benign cutaneous lesion / skin tag. 'Polypiod fibrous nodules' can also be coded as this.
Ganglioneuromatosis	Tumours arising from the nervous system.
Gastric heterotopia	Normal gastric mucosa seen elsewhere in the body.
GIST	Gastro Intestinal Stromal Tumour
Granulation tissue	Tissue that replaces fibrin clots during the healing of tissue.
Haemangioma	Benign noncancerous tumour composed of rapidly proliferating blood vessels.
Hamartomatous polyp	Benign mucosal polyps usually found in the jejunum and ileum (small bowel).
Inflammation	Generalised inflammation of mucosa.
Inflammatory	Inflammatory polyp.
Ischaemia	Restriction of blood supply.
Juvenile polyp	Rare form of large bowel polyp. AKA retention polyp.
Leiomyoma	Benign neoplasm of smooth muscle.
Lipoma	Benign tumour composed of fatty tissue.
Lymphangiectasia	Intestinal disease characterised by lymphatic dilation.
Lymphoid polyp	Benign polyps occurring where lymphoid follicles are present in the colon.
Melanosis coli	Pigmentation of the wall of the colon, not associated with any disease pathway.
Metaplastic/Hyperplastic	Benign non-dysplastic polyps with lengthening and cystic dilation of mucosal glands. Hyperplastic and Metaplastic are synonymous with each other. "Hyperplastic areas" may also be coded this way.
Metastases from another site	Malignant material that is not from a primary bowel cancer and originates from a cancer somewhere else in the body.
Mets/tumour infiltrating	Malignant material that is infiltrating into the colon from a tumour outside the colon (if unsure use 'Mets from another

		site')
	Mixed adenoma/metaplastic	Polyp displaying characteristics of an adenoma and those of a metaplastic polyp. This is rare.
	Mucosal prolapsed	Slippage of mucosa.
	Neurofibromatosis	Genetically inherited disease where nerve fibres grow tumours.
	Non-Hodgkins Lymphoma	(NHL) A diverse group of blood cancers that include any kind of lymphoma except Hodgkin's lymphomas.
	Normal mucosa	Specimen shows no signs of a polyp and levels of dysplasia/atypia are within normal limits.
	Not possible to diagnose	The polyp sample is too small or too damaged on removal to reliably diagnose the specimen.
	Oedema	Swelling due to accumulation of fluids.
	Previous polypectomy site	Appears to be tissue from the site where a previous polyp was removed.
	Proctitis	Inflammation of the lining of the anus and rectum.
	Pseudolipomatus	Artifactual microscopic change in tissues that resembles fatty infiltration.
	Regenerative polyp	Hyperplastic polyp of the gastric mucosa.
	Sarcoma	Cancerous tumour of soft tissue
	Serrated adenoma	Benign dysplastic colonic tumour which has a serrated appearance under the microscope.
	Specimen not seen	No evidence of a specimen in the pot received at pathology.
	Spirochaetosis	A type of bacterial infection of the colon.
	Squamous cell carcinoma	Skin Cancer normally found in the anus, but may be reported as rectal. Code as squamous cell carcinoma.
	Submucosal haematoma	Result of bleeding outside of the blood vessels.
	Ulcer	A break in the lining of the digestive tract that fails to heal naturally.
	Unicryptal adenoma	Very early beginning of adenoma growth.
	Xanthoma	Fatty deposits under the skin or mucosa causing yellow bumps.
Exc Complete	**Complete**	Pathologist has specified that the polyp appears completely excised.
	Incomplete	Pathologist has specified that the polyp appears to be incompletely excised.
	Uncertain	The pathologist is unsure about the completeness of excision or the extent of excision cannot be accessed.

Phantom Endoscopy SOP

(Ann Thomson 8/9/2010)

Overview



Unlinked Path Query
Shows all the Unlinked Pathology Patients that you have queried

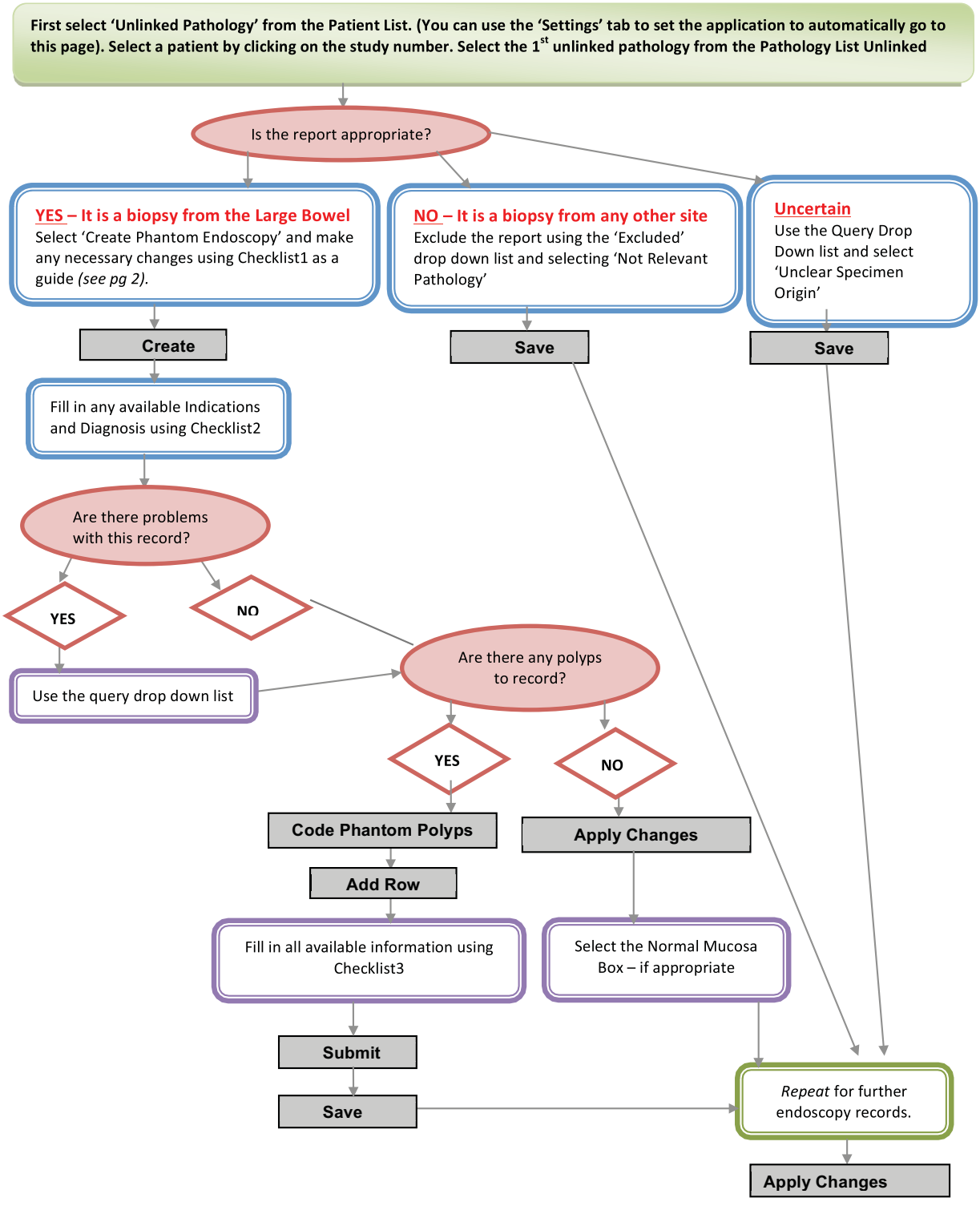
Unlinked Path Exclude
Shows all the Unlinked Pathology Patients for which you have excluded unlinked pathology reports

Unlinked Pathology
Shows a list of patients with unlinked pathology. In most cases these patients will have already been analysed

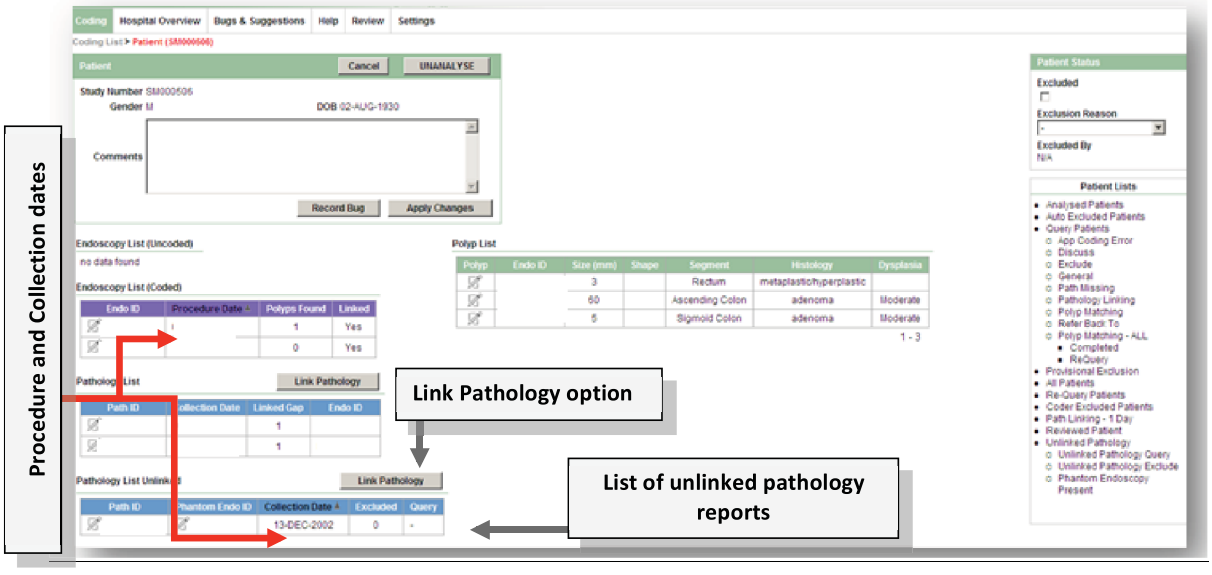
Phantom Endoscopy Present
Shows a list of patients for whom you have created phantom endoscopies. A patient will only appear here once you have created phantom endoscopies for *all* of the unlinked pathology. If you leave any unlinked pathologies un-queried, un-excluded and without a phantom endoscopy, it will remain in the *Unlinked Pathology* list

Note
Patients may appear more than once across different lists. For example, if you query a patient and create phantom endoscopies for all the available unlinked pathology, the patient will appear in both the *Unlinked Pathology Query* list and the *Phantom Endoscopy Present* list

Flow Chart


First select 'Unlinked Pathology' from the Patient List. (You can use the 'Settings' tab to set the application to automatically go to this page). Select a patient by clicking on the study number. Select the 1st unlinked pathology from the Pathology List Unlinked
Is the report appropriate?
YES – It is a biopsy from the Large Bowel
Select 'Create Phantom Endoscopy' and make any necessary changes using Checklist1 as a guide (see pg 2).
NO – It is a biopsy from any other site
Exclude the report using the 'Excluded' drop down list and selecting 'Not Relevant Pathology'
Uncertain
Use the Query Drop Down list and select 'Unclear Specimen Origin'
Create
Save
Save
Fill in any available Indications and Diagnosis using Checklist2
Are there problems with this record?
YES
NO
Use the query drop down list
Are there any polyps to record?
YES
NO
Code Phantom Polyps
Add Row
Apply Changes
Fill in all available information using Checklist3
Select the Normal Mucosa Box – if appropriate
Submit
Save
Repeat for further endoscopy records.
Apply Changes

Patient Screen



- After adding phantom reports for all of the *Pathology List Unlinked* records be sure to check if any resections or cancers coded have occurred at first exam.
- Make sure that the unlinked pathology is not supposed to be linked to any of the present endoscopy exams. Link the reports if both of the following criteria are predominantly fulfilled;
  - The collection dates from the *Pathology List Unlinked* correspond to the procedure date from the *Endoscopy List (uncoded or coded)*, (see **red** arrows)*
  - Endoscopy fields – Polyp Segment, Size and Shape –correspond with the Segment, Size and Shape in Pathology.

  If uncertain go into the unlinked pathology report and select '*Possible Link*' from the Query drop down option.

* The dates can sometimes be up to 2 weeks apart. To be safe – if the dates are within a month of each other, always check for other indicators that the reports should be linked.

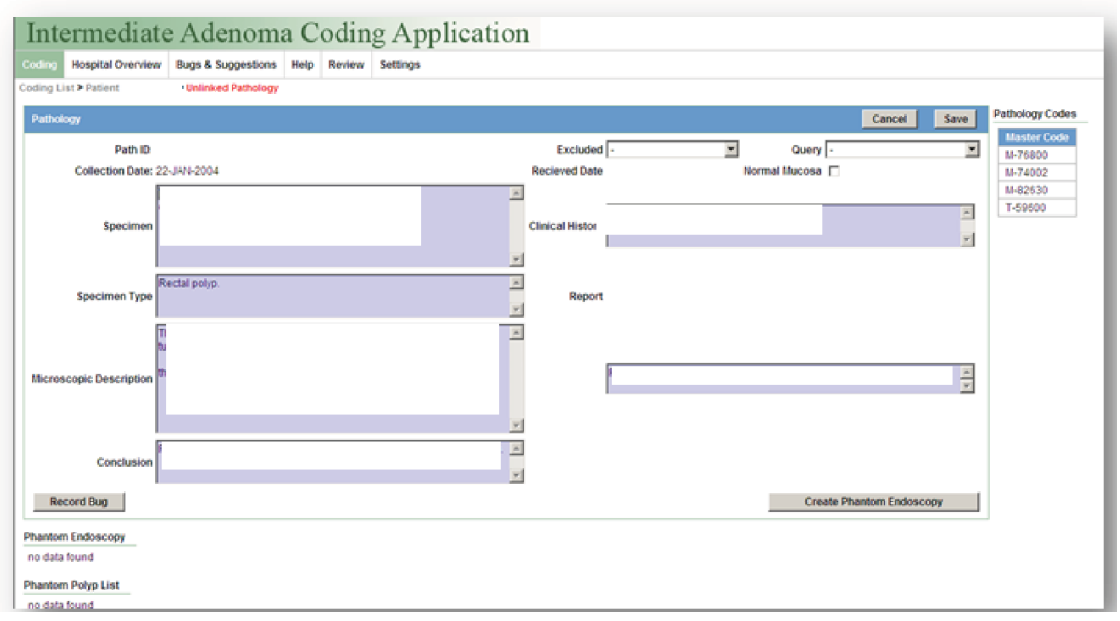
To Link Reports

Click on **'Link Pathology'** → choose the correct **Endo ID** from drop-down menu → click on **'Submit'**

Once you have submitted, go into the report via the endoscopy exam and code as normal. For more information on Polyp Linking see the Coding Application SOP (page 11).

Note: If you have linked an unlinked report, a phantom report does not need to be created.

Unlinked Pathology Screen

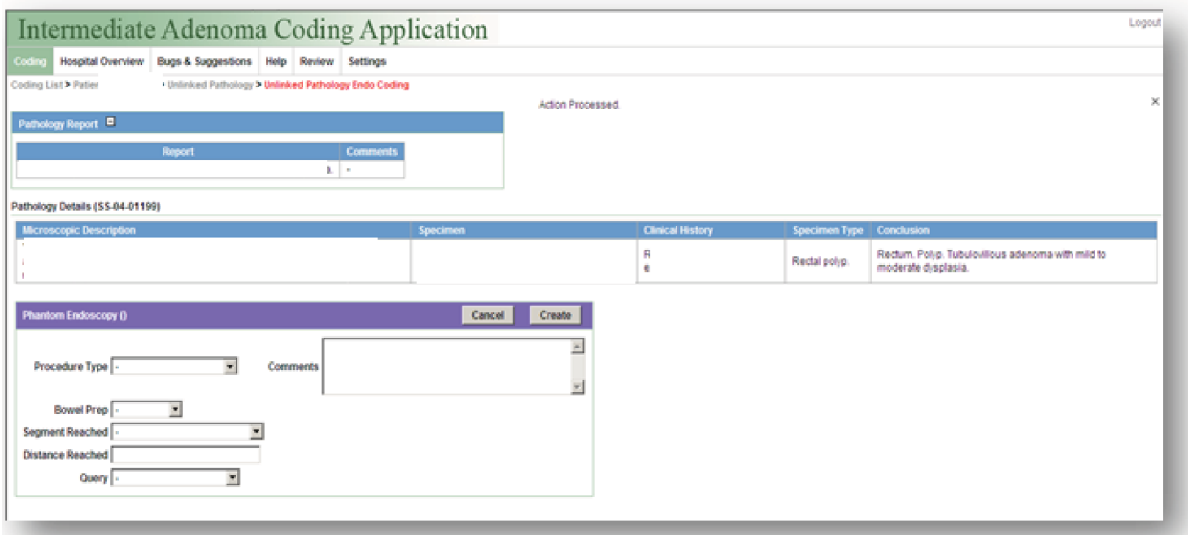


Possible Issues in this screen

Issue	Ways of Identifying the Issue	Solution
Pathology is from outside of the Large Bowel	Use the information from the all the fields on the screen to check that the report refers to a biopsy from the large bowel, if uncertain see issue below	If the report only refers to a biopsy from outside of the large bowel then select *Not Relevant Pathology* from the *Excluded* drop down option and save*
Uncertain Biopsy Origin	The report does not specify location but it may have come from the large bowel (if it contains 'tubular' or 'villous' adenoma's or metaplastic/hyperplastic polyps then code as if from general bowel, segment unknown)	Select *Uncertain Biopsy Origin* from the *Query* drop down option and save*
The Report is Blank	All of the fields will be completely empty	Select *Blank Pathology* from the *Query* drop down option and save
Truncated Text	If the report is truncated it will often stop abruptly in the middle of a sentence. It may sometimes be clear	Code any relevant information available. Select Truncated Report from the *Query* drop down option and save
Report Describes Normal Mucosa		Tick the 'normal mucosa' box then create a phantom endoscopy but leave it blank (do not add a polyp row)

** Remember to check the whole report as sometimes biopsies from the large bowel are included in reports for biopsies from the duodenum, in this case, code the information from the large bowel biopsies and ignore the biopsies from elsewhere.*

Checklist 1: Unlinked Pathology Endo Coding Screen



✓ Fill in any relevant information from the *Report*, *Comments*, *Microscopic Description*, *Specimen, Clinical History, Specimen Type* and *Conclusion* text boxes into the following fields:

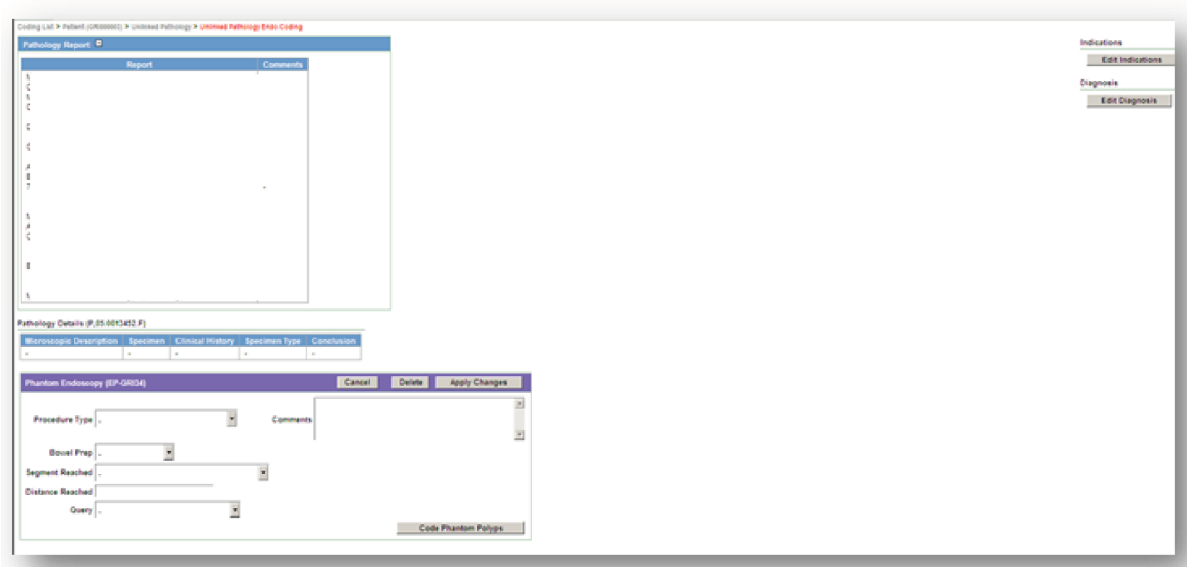
Procedure Type – Type of procedure used to investigate the colon

Segment Reached – the segment of the large bowel which was reached by the endoscope

Distance Reached – the distance reached by the endoscope in cm.

Bowel Prep – quality of bowel cleansing prior to the exam

Checklist 2: Unlinked Pathology Endo Coding Screen



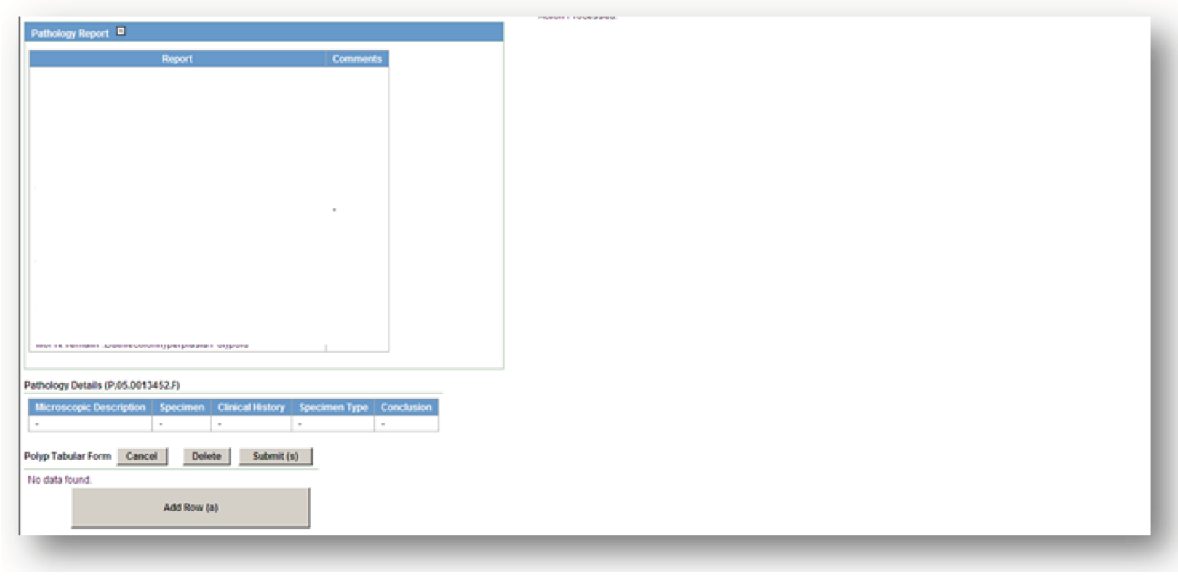
✓ Check that any indications in the report have been coded in the far right hand box labelled 'Indications'
If indications need to be added/amended:

Click on **'Edit Indications'** →**'Add Row'** → choose from drop-down menu → click on **'Submit'**

✓ Check that any Diagnoses in the report have been coded by looking at the right hand column under 'Diagnosis'
If diagnoses need to be added/amended:

Click on **'Edit Diagnosis'** →**'Add Row'** → choose from drop-down menu → click on **'Submit'**

Checklist 3: Phantom Polyp Coding Screen



How to add a Polyp Row

Click on **'add/edit polyp' →'Add Row'** → Use the drop-down menus to fill in all the details you have available for the polyp → **click on 'Submit'**

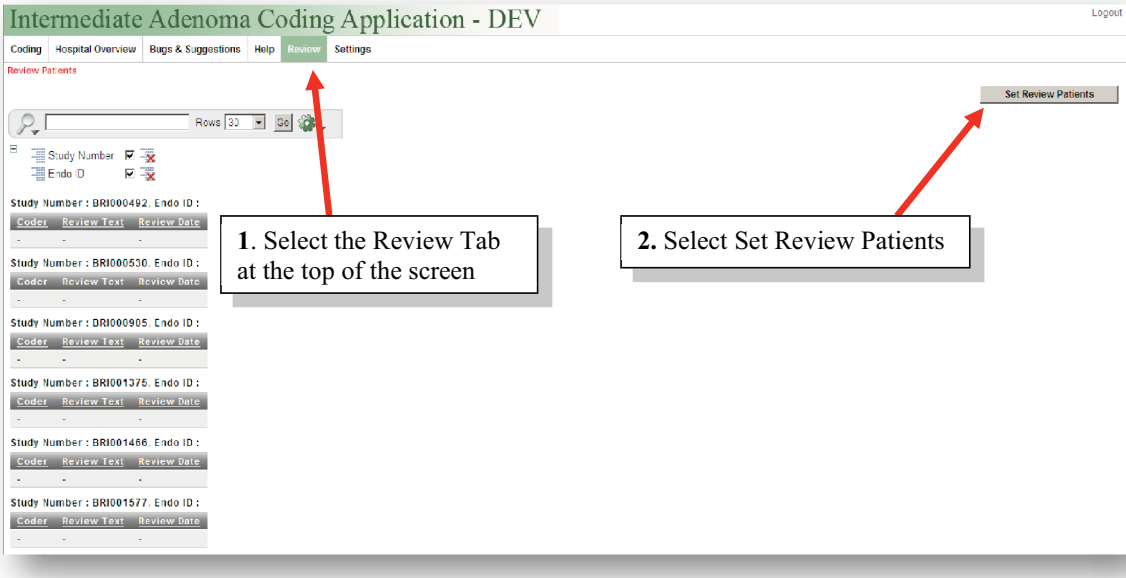
The polyp row will show both **endoscopy fields** and **pathology fields**, separated by colour.

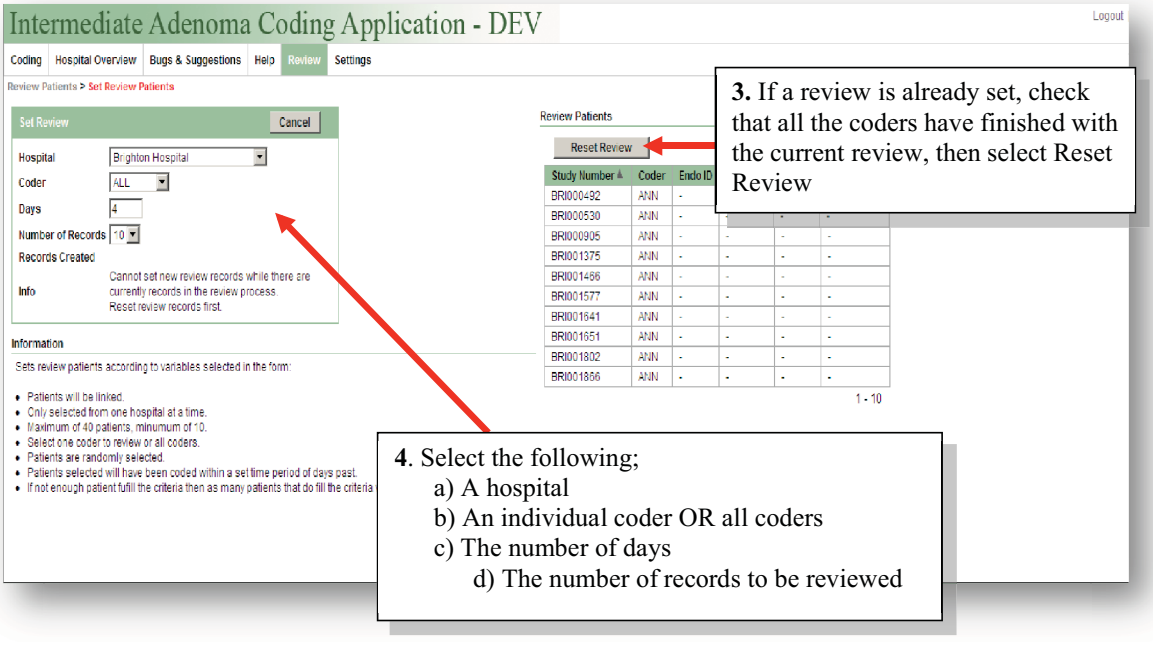
Note that Polyp rows should only be added if the histology is for a cancer, polyp, adenoma or mentions dysplasia. Any other histology should just have a blank phantom endoscopy created without a polyp row.

Review SOP

(Ann Thomson)

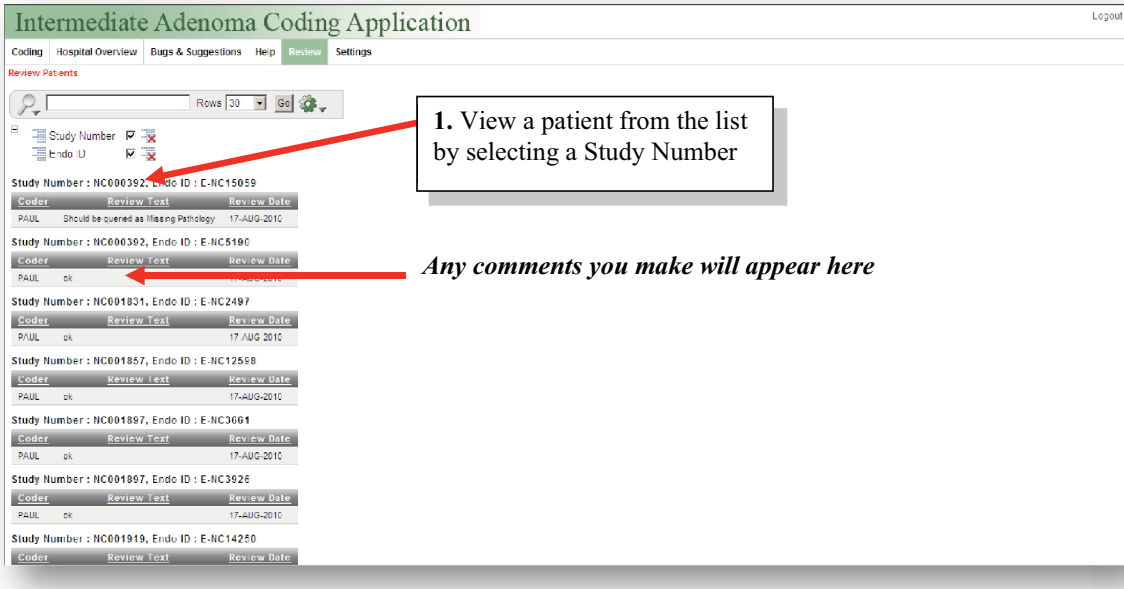
1. How to set up a review



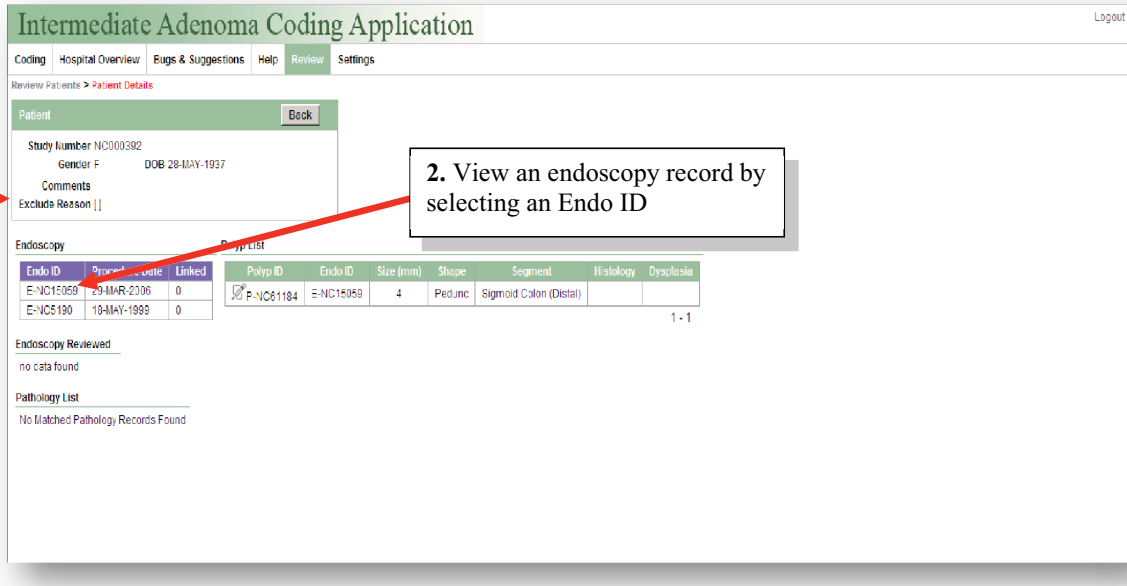


2. Review Application

In the Review tab of the coding application you will find a list of records to be reviewed.



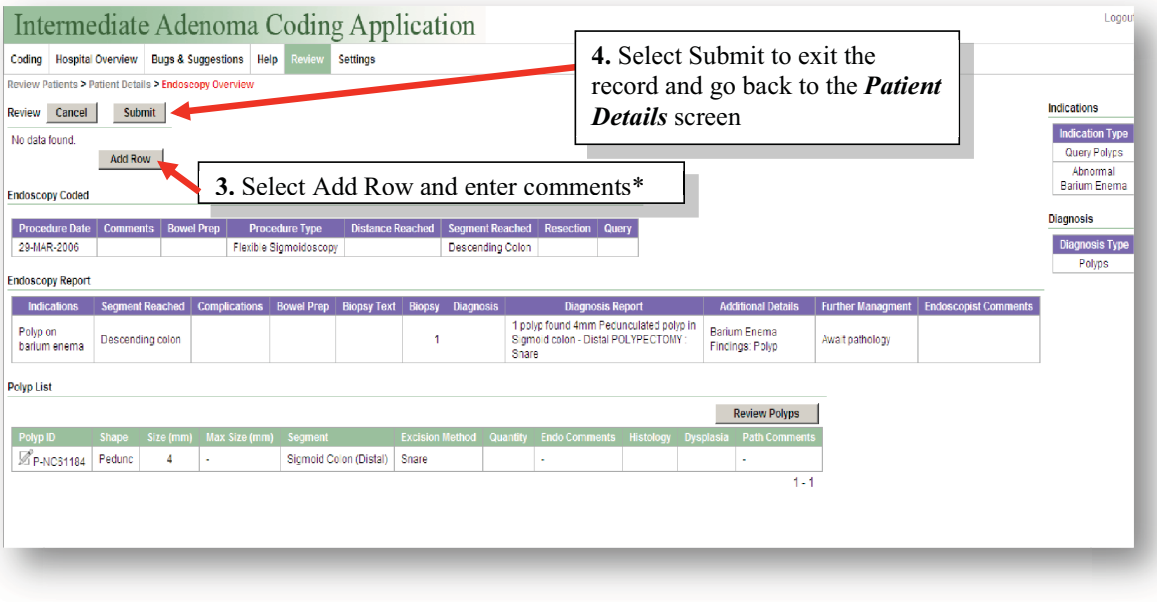
Once you have selected the record you will be able to view all the pathology, endoscopy and polyp details in the ***Patient Details*** screen.



You can see if a patient has been excluded. If they have been excluded, check that the exclusion reason is valid.

Note; if a patient is excluded, the coder may not have coded all available information. As long as the exclusion reason is valid, this is acceptable.

In the ***Endoscopy Overview*** screen you can view the endoscopy report and all coded information from endoscopy.



Things to check in this screen;

- Has the record been queried? If so, is the query appropriate?
- Has all the appropriate endoscopy and pathology polyp information been added?
- Have all the appropriate Indications and Diagnosis been entered?
- Has the Bowel Prep been entered correctly?

* Every record that has been reviewed needs a comment. Select **ADD ROW** and add any relevant comments, making sure that the coder will understand what needs to be amended. If the record is completely correct then write ‘ok’.

3. Categorising the Errors

Using the document ***Review Errors – Definitions and Examples*** *(Appendix A)* reviewers are able to categorise any errors found into Minor, Moderate and Major Errors. This may not be necessary for every review.

Review Errors –Definitions and Examples

Minor Errors

(Should be no more than 5/40 per review)

These are errors which inevitably occur in the data due to human error; this cannot be avoided, but should be kept to a minimum.

- Missed Specimen Sizes – individually this is minor (less than 3 per review)
- Missed polyp Distance
- Missing/Incorrect Excision Extent/Retrieval information – individually this is minor (less than 3 per review)
- Indication/Diagnosis Missed – where the information buried in the text of additional fields, or is unclear/not obvious
- Individual (1 per review) Keyboard/Mouse errors – where the coder has hit the wrong button accidentally. This will be hard to identify, however, in some instances it is obvious, i.e. when *Metaplastic* has been coded as *Metastases from another Site.*

Moderate Errors

(Should be no more than 3/40 per review)

These are errors due to carelessness and inaccuracy. They will occur, but must be flagged and corrected. Once they have been pointed out, the coder should try and ensure they do not repeat the same type of error.

- Indication/Diagnosis Missed – where the information is within the main report field or is clear and obvious
- Missing/Incorrect polyp Segment coded
- Consistent (1 or more per review) Keyboard/Mouse errors
- Missing/Incorrect Excision Extent/Retrieval information – consistently (3 or more per review)
- Incorrect Polyp Matching – where pathology has been assigned to the wrong polyp row - when it is not definitively clear, (in cases where it is very unclear see Interpretation Issues)
- Missed Specimen Sizes – consistently (3 or more per review)
- Incorrect/Missing histopathology assigned to a polyp row – when the information is unclear

Major Errors

(Should be no more than 1/40 per review)

These are errors due to inattention, misinterpretation and misunderstanding. Once they have been discussed and re-explained, they should not occur again.

- Missed Lesions(no polyp row added when required) – either at Endoscopy or Pathology
- Incorrect/Missing histopathology assigned to a polyp row – when the information is evidently clear
- Exam not excluded when required
- Exam not queried when required
- Pathology assigned to the wrong polyp row - when it is evidently clear

Interpretation Issues

There will also be some errors which are hard to interpret. For example, the histology of an adenoma may be ambiguously described, where one coder might interpret the information differently from another. Unless there are rules or a protocol for these instances, we cannot necessarily identify these as genuine errors. They should be counted as Interpretation Issues and be discussed with the coder to ensure the issue is not one of miss-understanding.

Polyposis and Colitis Reclassification Review SOP

(Amy Brenner 5/14/2012)

Contents

Incident 196 – Polyposis Review

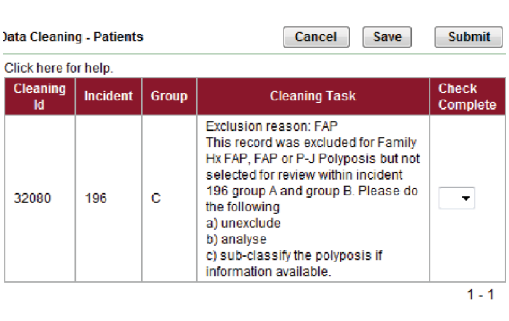
It was decided that a new method should be used to code polyposis. Firstly, polyposis should ONLY be coded as a diagnosis if the presence of polyposis is explicitly stated by the endoscopist or pathologist. Secondly, polyposis should be reclassified into more specific definitions. Consequently, a new section has been developed for coding a diagnosis of polyposis so that the coders can select sub-options for this diagnosis type. The following new polyposis sub-type options have been added:

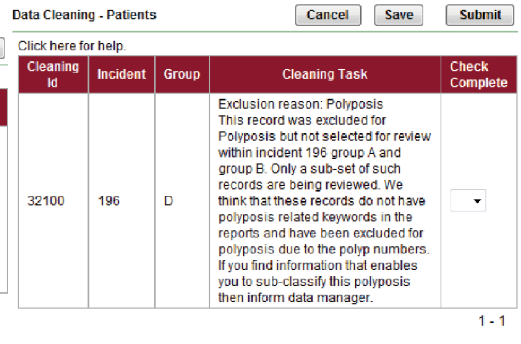
- Confirmed Polyposis – Definite polyposis
- Rule out Polyposis – Endoscopist/pathologist suggests that polyposis should be ruled out
- FAP - Presence of multiple adenomas
- Juvenile Polyposis - Presence of juvenile polyps
- PJ Polyposis - Presence of PJ-type (hamartomatous) polyps. Peutz-Jeghers syndrome (PJS)
- Hyperplastic Polyposis - Presence of multiple hyperplastic polyps
- Possible polyposis - Possible polyposis (of a certain type(s))
- Serrated polyposis - Presence of multiple serrated polyps
- Lymphoid polyposis - Presence of multiple lymphoid polyps
- Cap polyposis - Presence of multiple cap polyps
- Other Polyposis 1 - Spare1
- Other Polyposis 2 - Spare2

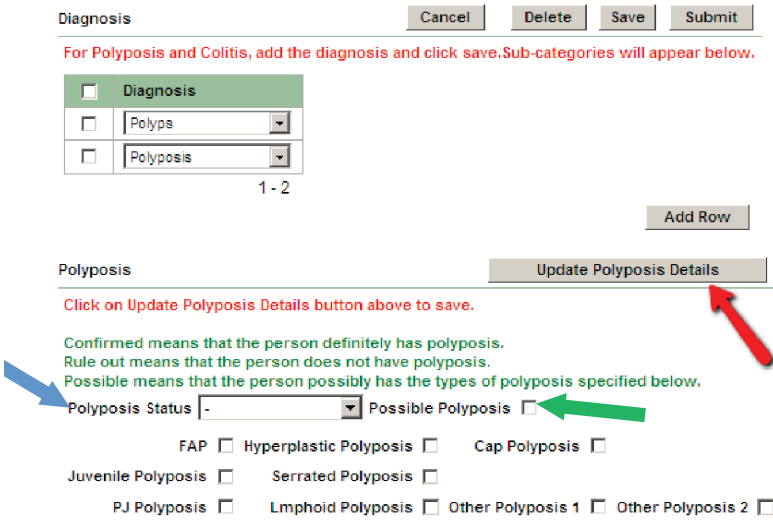
The indications field has also been updated to allow coders to add a specific subtype. All subtype options aside from ‘confirmed’, ‘rule out’ and ‘possible’ have been included.

If the endoscopist/pathologist clearly states that a patient has polyposis then the coder should add a row for ‘Polyposis’ in the diagnosis field and click save. As soon as this happens the relevant sub-options will appear. The drop-down menu ‘Polyposis Status’ enables the coder to add either ‘Confirmed polyposis’ or ‘Rule our polyposis’ (blue arrow), while a ‘Possible polyposis’ tick box allows the coder to show that polyposis is uncertain (green arrow). The other tick boxes let the coder to define what type(s) of polyposis was diagnosed or indicated. There are 2 spare checkboxes - Other Polyposis 1 and Other Polyposis 2. These will be used if the database administrator is not available. Coders will decide what the checkbox will be and the database administrator should be informed and will change the name when possible.

Records not selected for review within incident 196 group A and B (either excluded for Family Hx FAP, FAP or P-J Polyposis or Polyposis) were put in groups C and D respectively to be reviewed.







On the Diagnosis section above a ‘Save’ button was created. This will do exactly as the ‘Submit’ button does but the user will remain on this screen instead of going back to the Endoscopy screen.

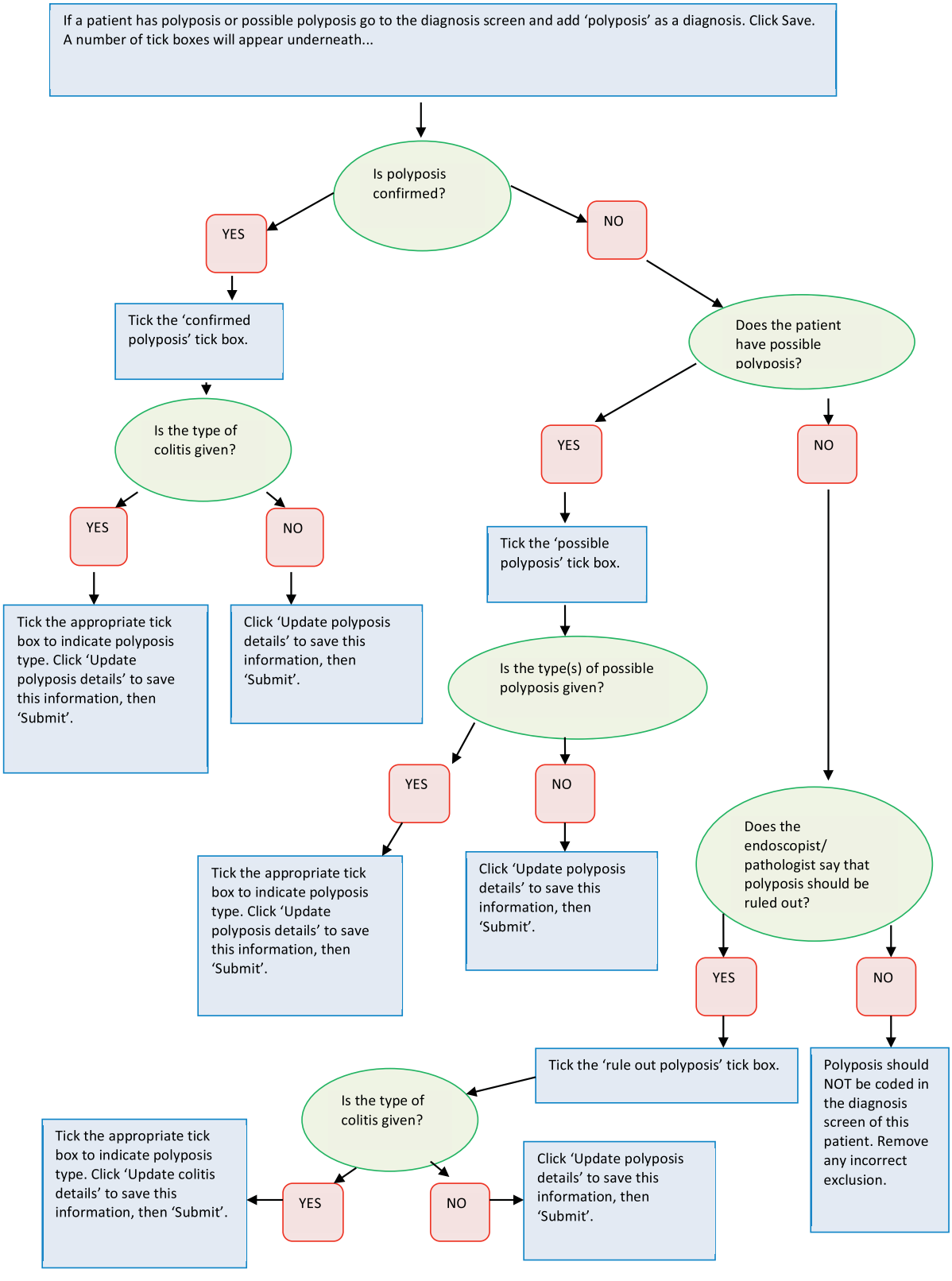
Please note:

- If polyposis has been added as a diagnosis based on the previous rule using polyp numbers, then polyposis should be removed as well as any polyposis exclusions.

- The sub-options must be saved using the ‘Update polyposis details’ button (red arrow). If you use the main ‘Save’ or ‘Submit’ buttons against the Diagnosis it will not save the sub-options (see notes in red as reminders). If you select ‘Polyposis’ in the Diagnosis and click delete, it will automatically delete all the sub-options.

- The diagnosis ‘FAP’ should not be used anymore. Polyposis should be added as a diagnosis and then the sub-type ‘FAP’ should be selected. The ‘FAP’ diagnosis will be removed once cleaning is complete.

- If polyposis is diagnosed at multiple exams, the coder should only review and add ‘confirmed’ and the polyposis subtype for the first exam encountered where a subtype of the condition is confirmed. This will then be used as a marker for the patient. If the polyposis is not confirmed and only ‘possible’ or no subtype is mentioned then coders will still review and code all records until a specific subtype is confirmed.


If a patient has polyposis or possible polyposis go to the diagnosis screen and add 'polyposis' as a diagnosis. Click Save. A number of tick boxes will appear underneath...
Is polyposis confirmed?
YES
NO
Tick the 'confirmed polyposis' tick box.
Is the type of colitis given?
YES
NO
Tick the appropriate tick box to indicate polyposis type. Click 'Update polyposis details' to save this information, then 'Submit'.
Click 'Update polyposis details' to save this information, then 'Submit'.
Does the patient have possible polyposis?
YES
NO
Tick the 'possible polyposis' tick box.
Is the type(s) of possible polyposis given?
YES
NO
Tick the appropriate tick box to indicate polyposis type. Click 'Update polyposis details' to save this information, then 'Submit'.
Click 'Update polyposis details' to save this information, then 'Submit'.
Does the endoscopist/ pathologist say that polyposis should be ruled out?
YES
NO
Tick the 'rule out polyposis' tick box.
Polyposis should NOT be coded in the diagnosis screen of this patient. Remove any incorrect exclusion.
Is the type of colitis given?
YES
NO
Tick the appropriate tick box to indicate polyposis type. Click 'Update colitis details' to save this information, then 'Submit'.
Click 'Update polyposis details' to save this information, then 'Submit'.

Incident 197 – Colitis Review

It was decided that colitis should be reclassified into more specific definitions. Similarly, a section has been developed for coding a diagnosis of colitis so that the coders can select sub-options for this diagnosis type. The following new colitis sub-type options have been added:

- Confirmed Colitis - Inflammation of the colon
- Rule out Colitis – Endoscopist/pathologist suggests that colitis should be ruled out
- Ulcerative Colitis - Chronic form of IBD characterized by ulceration of the colon and rectum
- Ulcerative Proctitis – Ulcerative colitis confined to the rectum
- Microscopic Colitis - Refers to both collagenous colitis and lymphocytic colitis, characterized by increase in inflammatory cells
- Lymphocytic Colitis - Subtype of microscopic colitis, characterized by chronic non-bloody watery diarrhea and an accumulation of lymphocytes in the colonic mucosa and lamina propria
- Collagenous Colitis - Subtype of microscopic colitis, characterized by chronic watery diarrhea, rectal bleeding and deposition of collagen in the lamina propria
- Ischemic Colitis - Inflammation and injury of the colon as a result of inadequate blood supply
- Diversion Colitis - Inflammation in a nonfunctioning colonic pouch occuring as a complication of ileostomy or colostomy, often within the year following the surgery
- Infective Colitis - Inflammation of the colon caused by bacterial or viral infection, commonly due to Clostridium difficile
- Chemical Colitis - Inflammation of the colon caused by the introduction of harsh chemicals by an enema or other procedure
- Pseudomembranous Colitis - Subtype of infectious colitis, characterized by the formation of pseudomembranes
- Drug-Induced Colitis - Inflammation of the colon as a result of treatment with various types of drug e.g. NSAIDs, anticoagulants, SSRIs
- Radiation Colitis - Inflammation and damage of the colon as a result of exposue to x-rays or radiation, commonly occurs after radiation therapy for cancer
- Procedural/Enema related - Inflammation of the colon as a result of the endoscopic procedure
- Possible Colitis - Possible colitis (of a certain type(s))
- Other Colitis 1
- Other Colitis 2

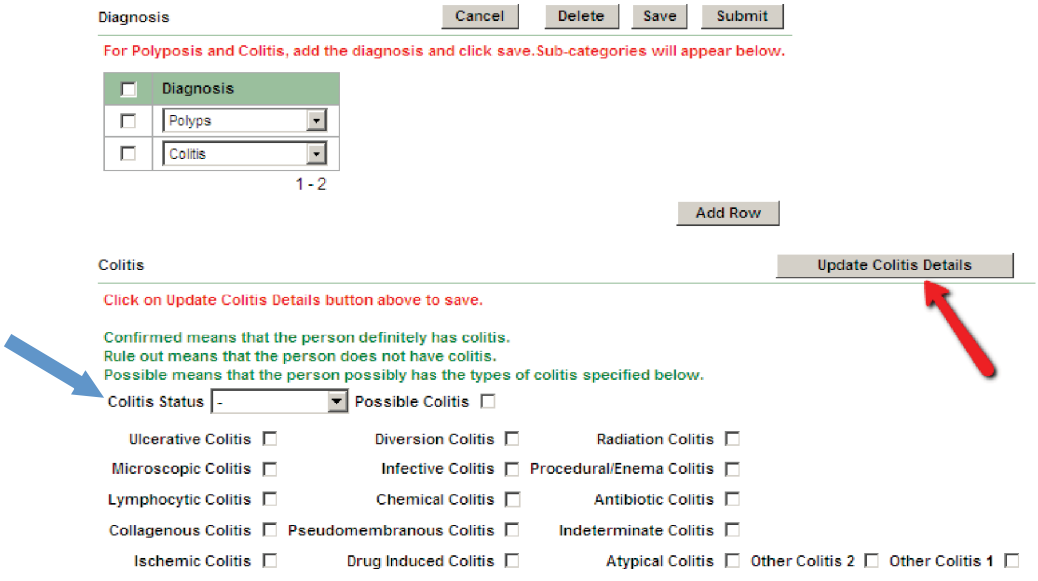
The indications field has also been updated to allow coders to add a specific subtype. All subtype options aside from ‘confirmed’, ‘rule out’ and ‘possible’ have been included.

If a patient has colitis then the coder should add a row for ‘Colitis’ in the diagnosis field and click save. As soon as this happens the relevant sub-options will appear. The drop-down menu ‘Colitis Status’ enables the coder to add either ‘Confirmed colitis or ‘Rule out colitis (blue arrow). The tick boxes allow the coder to define what type(s) of colitis was diagnosed or indicated.

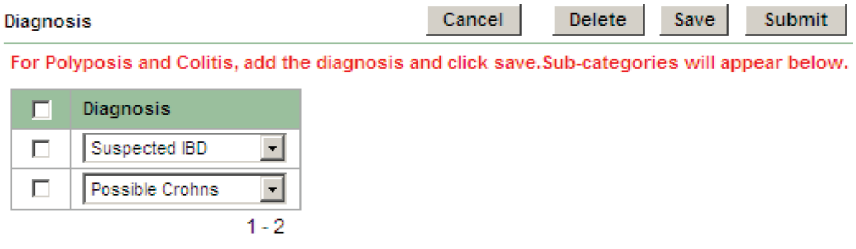
There are 2 spare checkboxes - Other Colitis 1 and Other Colitis 2. These will be used if the database administrator is not available. Coders will decide what the checkbox will be and the database administrator should be informed and will change the name when possible.

NB: The sub-options must be saved using the ‘Update colitis details’ button (red arrow). If you use the main ‘Save’ or ‘Submit’ buttons against the Diagnosis it will not save the sub-options (see notes in red as

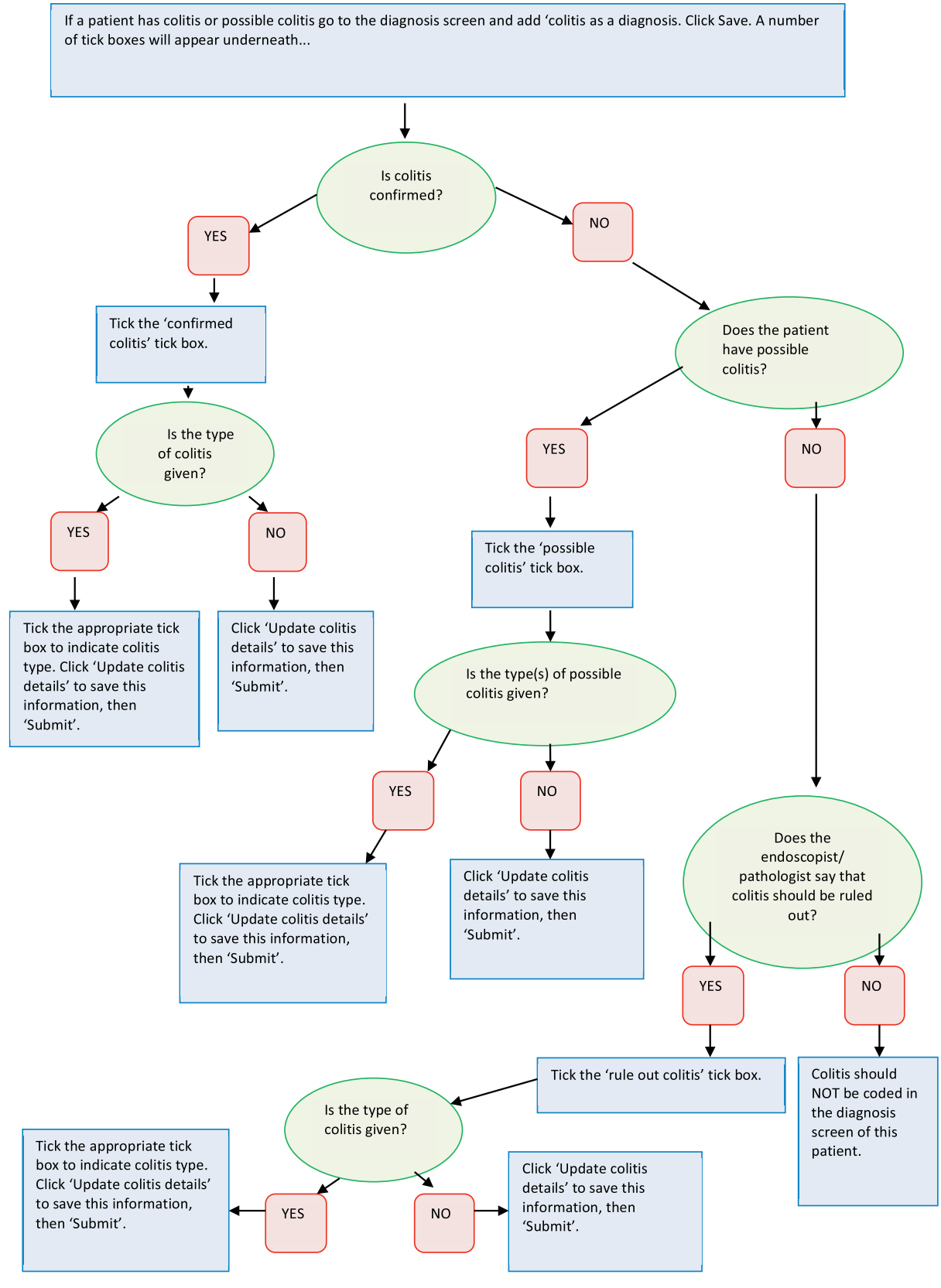
reminders). If you select ‘colitis in the Diagnosis and click delete, it will automatically delete all the sub-options.



A new option called ‘Possible Crohns’ has also been added to the Diagnosis drop down to cover all possible eventualities for IBD. Suspected IBD will be used as an umbrella term for cases in which IBD cannot be confirmed.



NB - If colitis is diagnosed at multiple exams, the coder should only review and add ‘confirmed’ and the colitis subtype for the first exam encountered where a subtype of the condition is confirmed. This will then be used as a marker for the patient. If colitis is not confirmed and only ‘possible’ or no subtype is mentioned then coders will still review and code all records until a specific subtype is confirmed.


If a patient has colitis or possible colitis go to the diagnosis screen and add 'colitis as a diagnosis. Click Save. A number of tick boxes will appear underneath...
Is colitis confirmed?
YES
NO
Tick the 'confirmed colitis' tick box.
Is the type of colitis given?
YES
NO
Tick the appropriate tick box to indicate colitis type. Click 'Update colitis details' to save this information, then 'Submit'.
Click 'Update colitis details' to save this information, then 'Submit'.
Does the patient have possible colitis?
YES
NO
Tick the 'possible colitis' tick box.
Is the type(s) of possible colitis given?
YES
NO
Tick the appropriate tick box to indicate colitis type. Click 'Update colitis details' to save this information, then 'Submit'.
Click 'Update colitis details' to save this information, then 'Submit'.
Does the endoscopist/ pathologist say that colitis should be ruled out?
YES
NO
Tick the 'rule out colitis' tick box.
Colitis should NOT be coded in the diagnosis screen of this patient.
Is the type of colitis given?
YES
NO
Tick the appropriate tick box to indicate colitis type. Click 'Update colitis details' to save this information, then 'Submit'.
Click 'Update colitis details' to save this information, then 'Submit'.

RULES FOR BOTH POLYPOSIS AND COLITIS:

1) In some cases colitis/polyposis may be confirmed but the subtype may be unclear (a number of possibilities might be suggested). The coded should make sure the patient has two or more appropriate diagnosis subtypes coded and they should also have BOTH 'confirmed' and 'possible' checked.

2) If coders select one or more subtypes then the coder MUST also select either 'confirmed', 'rule out' or 'possible'.

Exam Numbering and Multiple Row Review SOP

(Amy Brenner)

Contents

Incident 154 – Exam Numbering

In two instances exam numbering is needed to clarify the order in which exams took place:

- Group A - Ranking endoscopies without a date (use' exam ranking' field)
- Group B - Ranking multiple exams on the same date (use 'exam number' field)

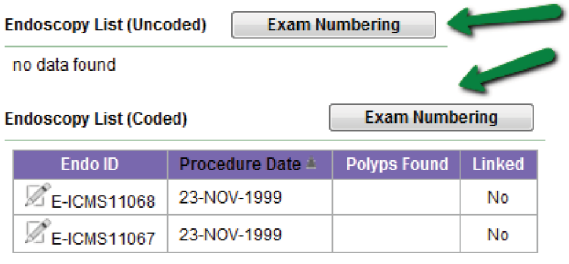
10747	154	A	Patient has an exam without procedure date. This group may have procedures that happened on the same day where one or both procedures are blank. Please click on exam numbering button and rank all the procedures for this patient in the order in which they happened. If you think one or more of the blank procedures happened on the same day as another procedure then record the reason why.	

1 - 2

10962	154	B	Patient has multiple exams on the same day. Please rank all the procedures for this patient in the order in which they happened. For procedures that happened on the same day, record the reason why they happened on the same day.	

1 - 1

On the patient details page an 'Exam Numbering button' is displayed above un-coded and coded endoscopies. These buttons will only appear where the patient is part of Incident 154.

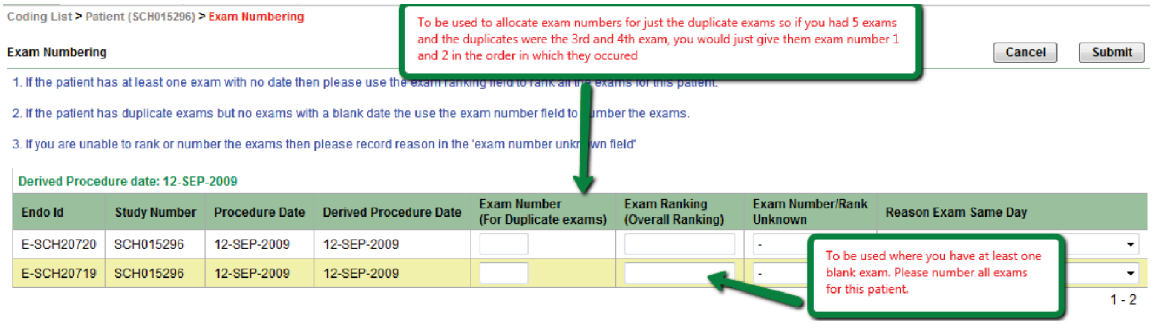


When you click the exam numbering button it takes you to the exam numbering screen. This screen will display all the procedures for the patient with the additional fields 'exam number', 'exam ranking', 'exam number/rank unknown' and 'reason exam same day'.

The 'reason exam on the same day' is a drop down menu and includes these options:

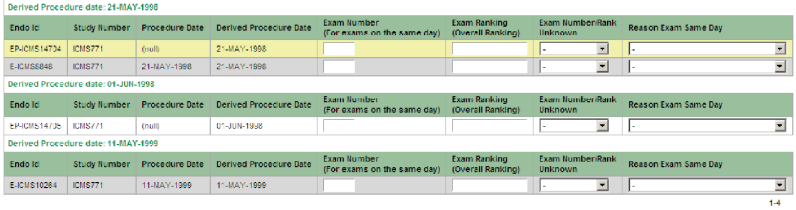
- Emergency Surgery
- 1st Procedure Abandoned
- 1st Procedure Incomplete
- This exam may not belong to this patient
- Follow-on exam
- Same procedure

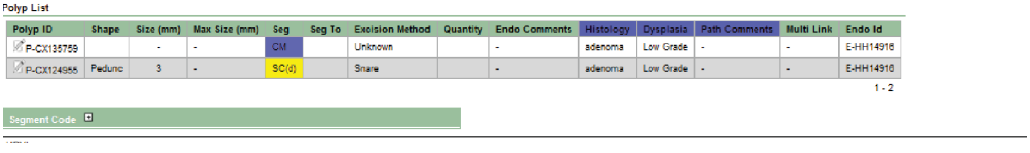
The 'exam number/rank unknown' is a drop down menu with one option of 'Could not rank', which should be used when you are unable to number/rank an exam.



The exams are broken down by derived procedure date so that you can clearly see exams that happened on the same day. The derived procedure date displays the endoscopy procedure date. When that is not available it derives the date from the various dates recorded against pathology, such as collection date, report date, received date etc. These individual dates can still be seen in the related pathology report.

When you click on an endoscopy, that record will be highlighted and the endoscopy, pathology and polyp details for the selected record will be displayed below. This information should be used to determine the order in which the exams took place.





NB - When ranking exams with no date use the ‘Exam ranking’ field, whilst exams on the same day should be numbered using the ‘Exam number’ field.

- For Group A (exam with no date) ALL of the exams should be ranked using the ‘Exam ranking’ field.
- For Group B (multiple exams on same date) only the exams with the same date should be numbered using the ‘Exam number’ field.
- For Group B, in cases where it is not possible to ascertain the order of all exams the coder should try to give an indication of where an exam with no date goes by ranking whichever exams you can.
- No exams should be given the same number.

- The ‘reason exam on the same day’ field should be applied to the subsequent exam EXCEPT for the reason ‘This exam may not belong to this patient’ which should be applied to the exam that appears to be incorrect.
- For exams that cannot be numbered the ‘exam number unknown’ field should be applied.

If exams on the same day are found to be duplicates that have been missed previously, coders should mark the appropriate record with an application coding error – duplicate endoscopy query and tick the re-query box.

Once all exams have been numbered click the ‘Submit’ button to save this information and then mark the incident as complete on the patient details screen.

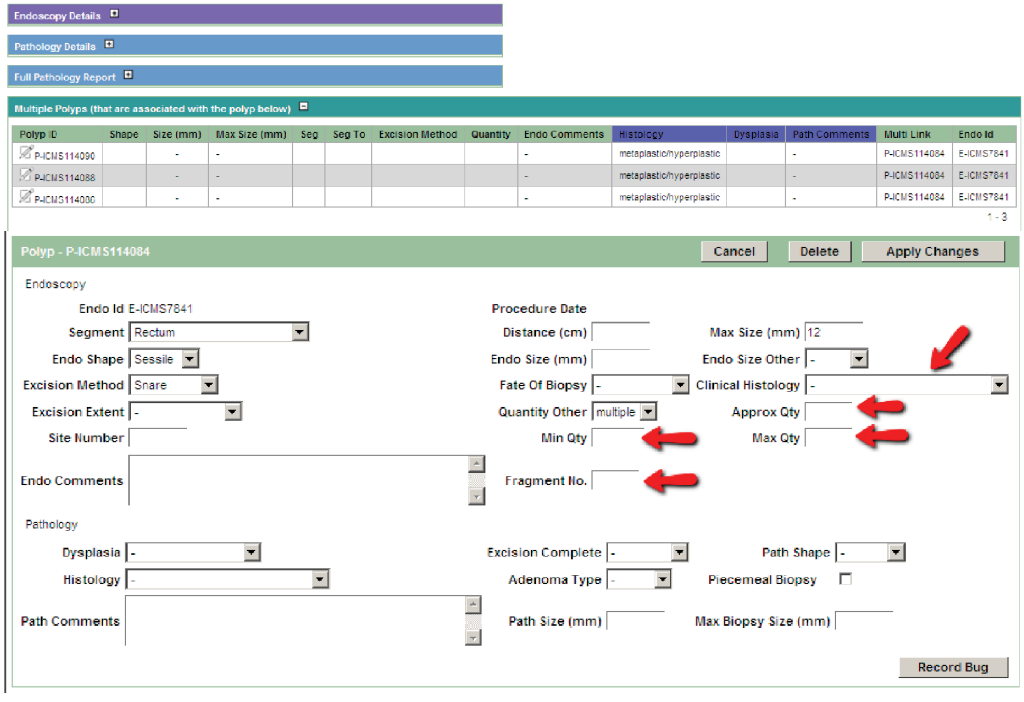
Incident 138 – Multiple Polyp Rows

Previously it was not possible to code specific quantities or clinical histology (seen at endoscopy) details for multiple rows (polyp rows with the 'quantity other' field coded). All records with multiple rows are being reviewed to insure that no important information has been overlooked. There are 2 groups here as shown below:

- Group A - No multi-linked polyps
- Group B - Multi-linked polyps

Cleaning Id	Incident	Cleaning Task	Group	Endo Id	Polyp Id	Check Complete
20305	138	This is a record where Quantity Other has been recorded for the polyp. However no polyps have been linked to this polyp. Click on the polyp_id to go directly to the polyp screen or click on the endo_id.	A	EP-CI6014	PP-CI119352	N
23472	138	This is a record where Quantity Other has been recorded for the polyp and other polyps have been linked to this polyp. Click on the polyp_id to go directly to the polyp screen or click on the endo_id.	B	E-CI976	P-CI20709	

On the patient details screen in the data cleaning section, columns called 'polyp id' and 'endo id' will appear against all 'Data Cleaning – Endoscopies' tasks and will be populated with a polyp_id/endo_id that coders may use to directly access certain screens. If you click on the endo_id, it takes you to the endoscopy. If you click on the polyp_id, it takes you to the polyp details screen.
To review multiple row details coders should go to the polyp details screen where endoscopy, pathology and other polyp rows will be shown above and below the multiple row polyp information. The details of any multi-linked polyps will also be shown (group B).



All Polyps from the exam E-ICMS7841

Polyp ID	Shape	Size (mm)	Max Size (mm)	Segment	Excision Method	Quantity	Endo Comments	Histology	Dysplasia	Path Comments	Multi Link
P-ICMS2417	Sessile	12	-	Transverse Colon (Proximal)	Snare		-	metaplastic/hyperplastic		-	-
P-ICMS114090		-	-				-	metaplastic/hyperplastic		-	P-ICMS114084
P-ICMS114088		-	-				-	metaplastic/hyperplastic		-	P-ICMS114084
P-ICMS114086		-	-				-	metaplastic/hyperplastic		-	P-ICMS114084
P-ICMS114084	Sessile	-	12	Rectum	Snare	multiple	-			-	-

1 - 5

Coders should browse the endoscopy and pathology details for anything that may provide information for the following fields:

- clinical histology – histology described at endoscopy i.e. ‘appears to have multiple adenomas’
- approximate quantity – the approximate number of polyps
- maximum quantity – the maximum possible number of polyps
- minimum quantity – the minimum possible number of polyps
- no. fragments – the number of relevant fragments of adenoma or polyp seen at pathology

If any of this information is available it should be coded into the new fields provided in the polyp details screen (see red arrows).

What information to look for:

- Information from previous and subsequent exams may be used if appropriate
  e.g. previous exam states ‘ 3 polyps not excised’, current exam says ‘multiple polyps’ at endoscopy then goes on to describe 3 polyps at pathology, assume that the ‘approximate number’ of polyps is 3.

- If present at pathology, biopsy sample indicators can be used for ‘approx quantity’
  e.g. ‘’….presence of several tubular adenomas with low grade dysplasia (A16, A17, A18, A20)’’ = 4
  ‘’… multiple hyperplastic polyps in the rectum (A1, A2 and A5)’’ = 3

- If pathology describes individual polyps count them and use this as the ‘minimum number’

Dealing with fragments:
If pathology describes a specific number of tissue fragments...

- and all of them are found to be adenomas or polyps, give the original fragment number in the ‘no. fragments’ field

- and a particular number of them are found to be adenomas or polyps, give this number in the ‘no. fragments’ field

- and it only specifies that some/a number of/a few etc. are found to be adenomas or polyps, assume that at least 2 fragments must be normal mucosa. Subtract 2 from the original fragment number and put this in the ‘no. fragments’ field

NB - Multiple rows coded in unlinked pathologies do NOT have a ‘multi-link’ field so any related polyps will not be displayed as multi-linked polyps. Thus these should not be included in the ‘approx. quantity’.

Any changes should be saved using the ‘Apply changes’ button, then the incident should be marked as completed on the patient screen.

Summary of Changes to Coding Documents

(Aug 2009)

Listed below is a summary of each of the major documents the coders use and the changes that have been made since the last published (major) version. Please make yourselves aware of these changes in the SOP.

List of changes to SOP:

Summary of change	Section	Page
Added a section about what to do if the endoscopist describes "possible polyps"	Endoscopy overview scenarios	7
Updated screen shot **Changed the field 'piecemeal' to 'piece'** **Added a description of the new 'No Info' field**	Checklist 2	8
Updated screen shot **Changed the field 'piecemeal' to 'piece'** **Added a description of the new 'Multi Link' field**	Checklist 3	10
In the second scenario down, more information has been added about use of the Multi Link menu and what to do when you have an unspecified number of polyps with a range of dysplasia levels	Edit polyp pathology scenarios	11
Updated screen shot **Explanation of the 'Requery' option**	How to query a record	13 & 14
Explanation about Anal cancer added	Top Tips	14

List of changes to Coders reference document:

Summary of change	Section	Page
Change of name to 'Coders reference document' this was due to the fact I have now incorporated all fields with an explanation of how to use them. This is no longer just drop down menus	Title Page	
Added definitions of distal, mid and proximal to the segment reached field information **Added 'distance reached' and 'comments' fields with information on how to fill these in**	Endoscopy overview screen	3 & 4
Definitions and appropriate use of: **Colonic obstruction**	Endoscopy indications screen	5 & 6

Family history of cancer **Fissure** **IBD** **Ulcers have been added to the list**		
Definitions and appropriate use of: **Colonic obstruction** **FAP** **Fissure** **IBD** **Polyposis** **Suspected IBD** **Strictures** **Ulcers have been added to the list**	Endoscopy diagnosis screen	7 & 8
Added 'size (mm)', 'Piece' and 'no info' fields with information on how to fill these in **Added definitions of distal, mid and proximal to the segment reached field information**	Add/Edit polyp screen	9 & 10
Added definition of 'metastases from another site' to the histology drop down menu. **Added 'size (mm)', 'Piece' and 'Multi Link' fields with information on how to fill these in**	Edit polyp pathology screen	12

List of changes to Exclusion SOP:

Summary of change	Section	Page
2 additional terms were added to aid the identification of possible HNPCC **Inflammatory Bowel disease (IBD) and its definition was added to the exclusion criteria**	Exclusion if found at ANY EXAM	1
Additional term added to aid the identification of possible resection **Definition of cancer was extended and clarified in further detail.**	Exclusion if found at FIRST EXAM	2
Cancers that do not originate from the colon should NOT be excluded at first exam	Exclusion if found at FIRST EXAM	2

Summary of Changes to Coding Documents

(Sept 2009)

Listed below is a summary of each of the major documents the coders use and the changes that have been made since the last published (major) version. Please make yourselves aware of these changes in the SOP.

List of changes to SOP:

Summary of change	Section	Page
Updated.	Contents	2
Included the exclude function in the description of the patient details screen.	Database Overview	3
Updated the screen shot and description of the screens content to include the exclude function.	Patient Details Screen	5
Added clarification criteria to the pathology missing query.	How to Query a Record	13
Re-defined when to use query exclude vs. excluding patient.	How to Query a Record	13
Added a new section to explain the exclusion process for a patient using the patient status box.	How to Exclude a Patient	14

List of changes to Coders reference document:

Summary of change	Section	Page
I have added this new section which explains the data entry features for the patient status box which allows coders to exclude patients.	Patient Details Screen (patient status box)	3
In the section referring to segment I have clarified when you can make the assumption that the endoscopist is talking about the ascending colon.	Add/Edit Polyp Screen	10
In the section referring to excision method I have clarified when to code this as APC.	Add/Edit Polyp Screen	10
In the section referring to size of polyp and max size of polyp I have clarified which to use when you get an exact size and a size range for a polyp and which numbers to insert.	Add/Edit Polyp Screen	10

In the section about queries I have added some helpful criteria to help you decided if it should be flagged up as pathology missing – e.g. if it is a large polyp etc.	Endoscopy Overview Screen	4-5

List of changes to Exclusion SOP:

Summary of change	Section	Page
Clarified when and when not to exclude different types of cancers: - **Cancers elsewhere in the body** - **Ca+adenomas**	Exclusion if found at **FIRST EXAM**	2
Clarified when to exclude due to colitis and the differences between where you see it at endoscopy and pathology	Exclusion if found at **ANY EXAM**	1

Summary of Changes to Coding Documents

(Oct 2009)

Listed below is a summary of each of the major documents the coders use and the changes that have been made since the last published (major) version. Please make yourselves aware of these changes in the SOP.

List of changes to SOP:

Summary of change	Section	Page
NONE.		

List of changes to Coders reference document:

Summary of change	Section	Page
Clarification of the Segment reached option. Complete/ Total ileo-colonoscopy and colonoscopy can assume to have reached terminal ileum and cecum respectively.	Endoscopy Overview Screen	4
It has been clarified under 'Query Crohn's' and 'Query Colitis' that both should be added when ?IBD is listed in the indications summary.	Endoscopy Indications Screen	7
Clarified the guidance for when to enter suspected IBD to the diagnosis or not.	Endoscopy Diagnosis Screen	9

List of changes to Exclusion SOP:

Summary of change	Section	Page
NONE.		

Missing Pathology Collection SOP

(Ann Thomson, 8/26/2010)

Introduction

When returning to hospitals to collect missing data, the following queries are used as criteria as to which records to search for. These queries will generate some false negatives, i.e. records where pathology was, in fact, not missing, but never existed.

Missing Pathology Queries - ALL

Endoscopy exams are queried as *'Missing Pathology'* by a coder when there has clearly been a biopsy/excision of a polyp that is awaiting histology and does not appear to have a linked pathology report. Coders use following criteria to identify missing pathology:

1. The endoscopy report specifically refers to sending the polyp sample to pathology/histology/labs
2. Polyps that have been biopsied or if there is biopsy text relating to the section of the bowel that polyps were found.
3. Polyps ≥10mm or Tumours/Cancers, even they haven't been biopsied (unless the exam specifically states that they have not been removed or biopsied for some reason)

Missing Pathology can be further categorised using one or more of the following fields;

- Sent to lab/await pathology stated
- Large polyp of >=10mm
- Biopsy Indicator
- Cancer/tumour indicated

Application Coding Error Queries - ALL

Coders use this option to indicate the following;

- **Blank pathology fields -** when a pathology report has fields that contain no information
- **Truncated report -** when either endoscopy or pathology reports seem to cut off mid sentence

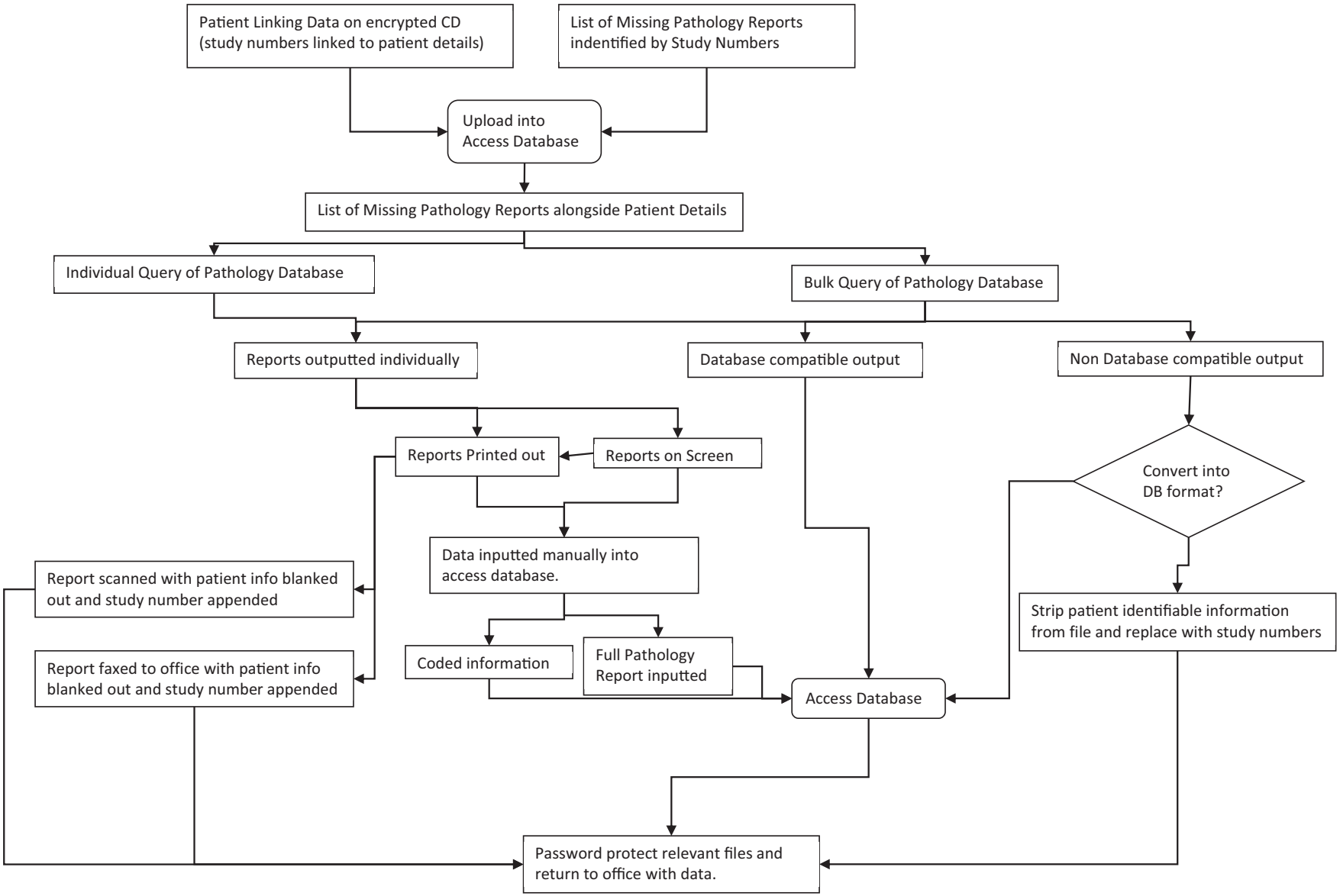
Coders also sometimes use this option when indicating that fields or drop-down menus will be changed at a later date by the database administrator and you will return at a later date to finish coding.

General Queries – Supplemental Report Missing, When Cancer, When Resection

There are a number of different categories of general query, when collecting missing data we are only concerned with three categories;

- **Supplemental endoscopy report(s) missing** –when there is an indication that the patient has been referred for endoscopy in the near future e.g. when flexi-sig indicates that endoscopy would be appropriate or when procedure has been abandoned and a follow up colonoscopy is mentioned.
- **When cancer? –**when it is not possible to work out when a mentioned cancer arose
- **When resection? –**when an anastomosis or any of the terminology indicating resection e.g. neo-terminal ileum is suddenly used

For Instructions on how to produce a list of missing pathology study numbers go to G:\IA\Missing Pathology – *Setting up a Missing Pathology Access Data*base


Patient Linking Data on encrypted CD (study numbers linked to patient details)
List of Missing Pathology Reports indentified by Study Numbers
Upload into Access Database
List of Missing Pathology Reports alongside Patient Details
Individual Query of Pathology Database
Bulk Query of Pathology Database
Reports outputted individually
Database compatible output
Non Database compatible output
Reports Printed out
Reports on Screen
Convert into DB format?
Data inputted manually into access database.
Report scanned with patient info blanked out and study number appended
Strip patient identifiable information from file and replace with study numbers
Report faxed to office with patient info blanked out and study number appended
Coded information
Full Pathology Report inputted
Access Database
Password protect relevant files and return to office with data.

Why do we need to link the data?

The data is pseudo anonymised. In other words, the study numbers (which coders can see in the database) are created specifically for the Intermediate Adenoma study. These study numbers are linked to real patient and hospital information on a CD.
To search for records on a pathology system you will need to use patient information. This means that the list of study numbers with missing pathology must be *linked* with the corresponding study numbers on the CD containing patient information.

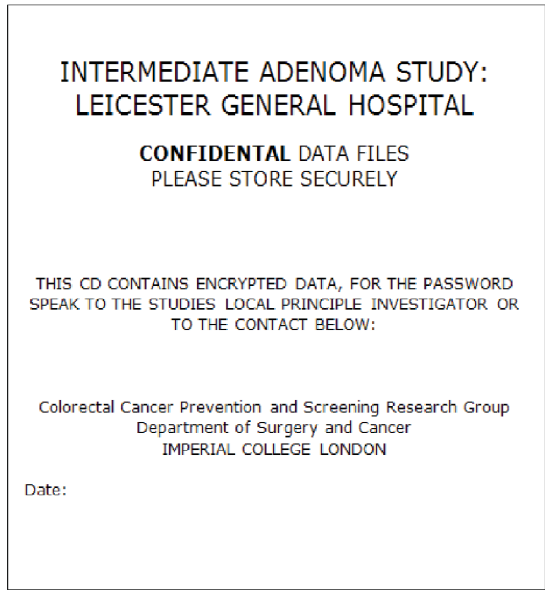
The CD

IMPORTANT: The CD contains confidential patient information and must NOT be lost, destroyed or taken outside of the hospital.

The CD is kept at the hospital and is password protected. Before you visit the hospital you must check the Data CD Storage document (SharePoint →Hospitals) and contact the person responsible for the CD. Organise for the CD to be available for collection the morning that you are due to visit the hospital, you will also need to return the CD at the end of the day. Make sure that you have the password for the CD on your visit.

Note: There are 2 CD's at each hospital, they are duplicates, it does not matter which CD you choose to collect.

The Data CD Cover


INTERMEDIATE ADENOMA STUDY:
LEICESTER GENERAL HOSPITAL

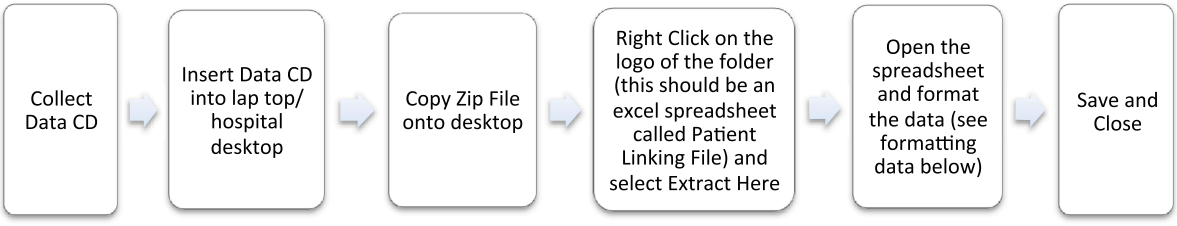
CONFIDENTAL DATA FILES
PLEASE STORE SECURELY

THIS CD CONTAINS ENCRYPTED DATA, FOR THE PASSWORD SPEAK TO THE STUDIES LOCAL PRINCIPLE INVESTIGATOR OR TO THE CONTACT BELOW:

Colorectal Cancer Prevention and Screening Research Group
Department of Surgery and Cancer
IMPERIAL COLLEGE LONDON

Date:

CD Process Summary



Formatting Data

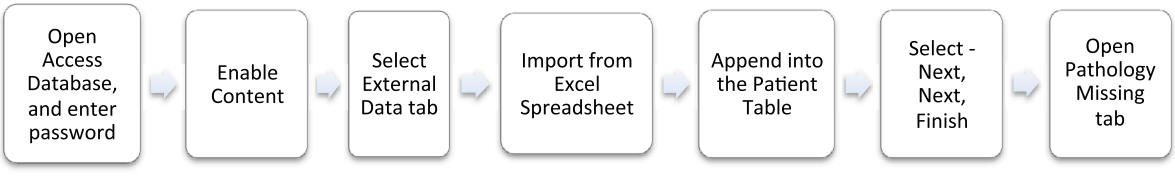
Once you have opened the Patient Linking file, you will be able to view an excel spreadsheet. This data needs to be in the same format as it is in the access database. Use the checklist below.

	A	B	C	D	E	F	G
1	Study_Number	Hospital_Number	Surname	Forename	DOB	NHS	Gender
2	SM015648	M00001	Smith	Tom	01/02/1973	324714771	Male
3	SM012079	M00002	Jones	Paul	02/02/1973	324714771	Male
4	SM027494	M00003	Fletcher	Bryn	03/02/1973	324714771	Male
5	SM023676	M00004	Simpson	Mark	04/02/1973	324714771	Male
6	SM005046	M00005	Smith	David	05/02/1973	324714771	Male
7	SM043198	M00006	Jones	John	06/02/1973	324714771	Male
8	SM043191	M00007	Fletcher	Tom	07/02/1973	324714771	Male

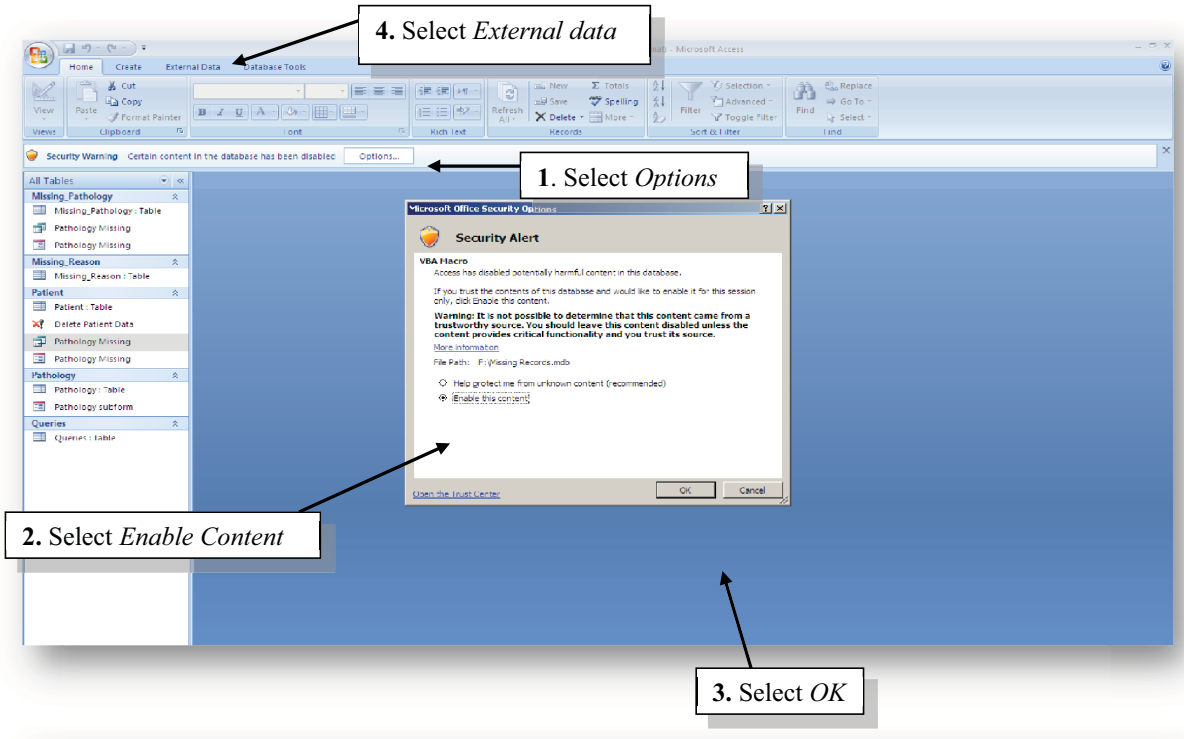
- ✓ The field names are on Row 1 of the spreadsheet (in some cases there may be rows above the field names, delete these)
- ✓ The field names are in the right order (as above)
- ✓ The field names are named correctly (as above), for example *Date of Birth* will need to be changed to *DOB*

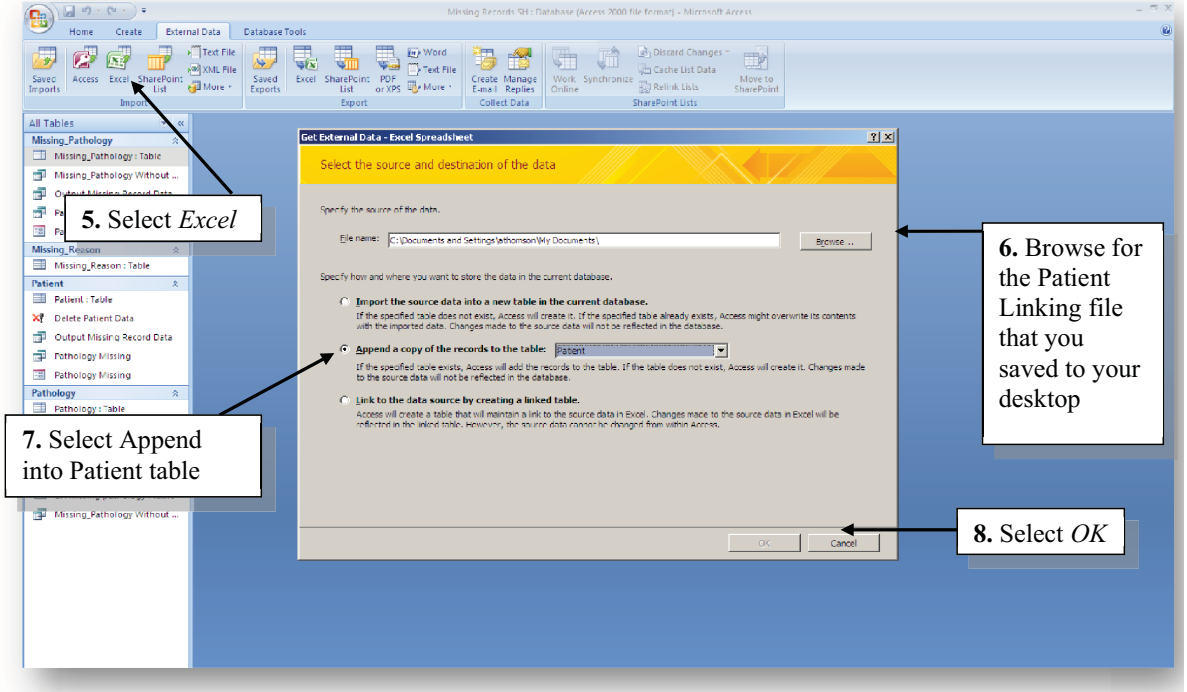
Once you have formatted the spreadsheet, save and close it.

Linking Data Summary



Follow these steps in order

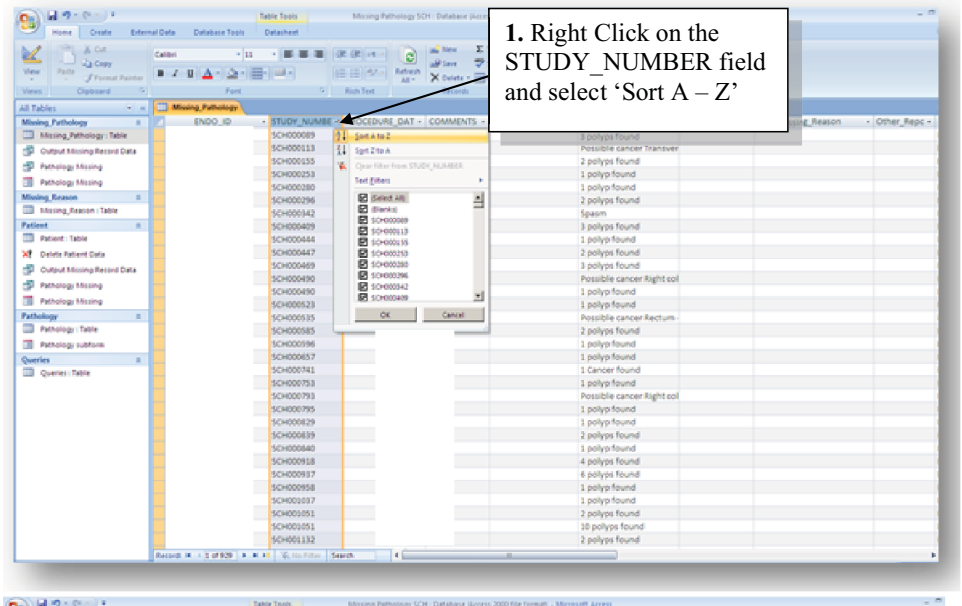


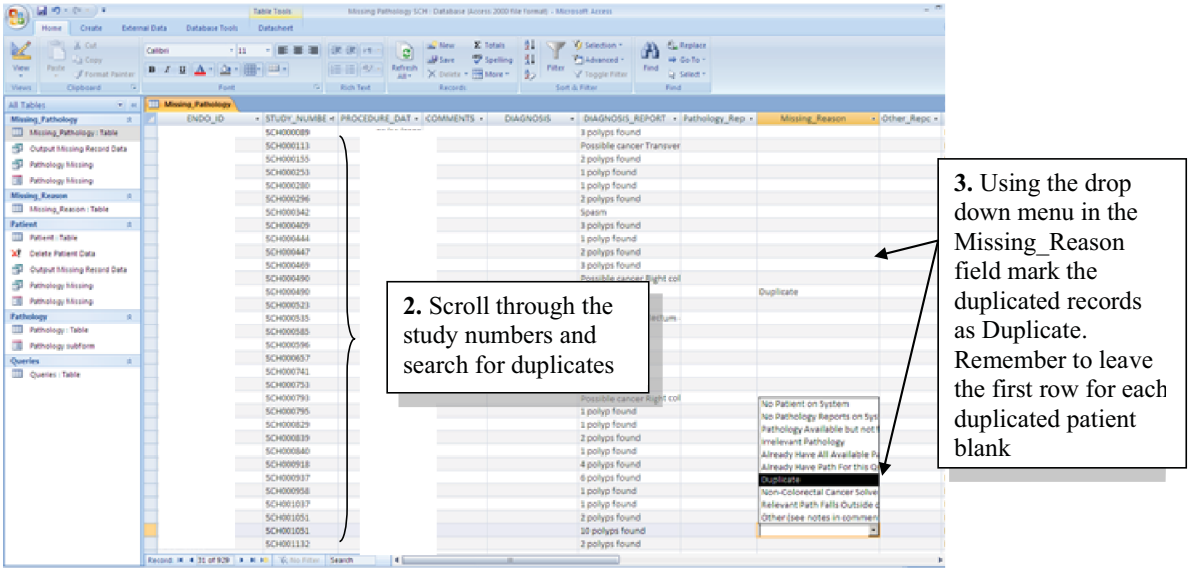


9. Over the next 2 screens – select Next, Next, Finish

The Database

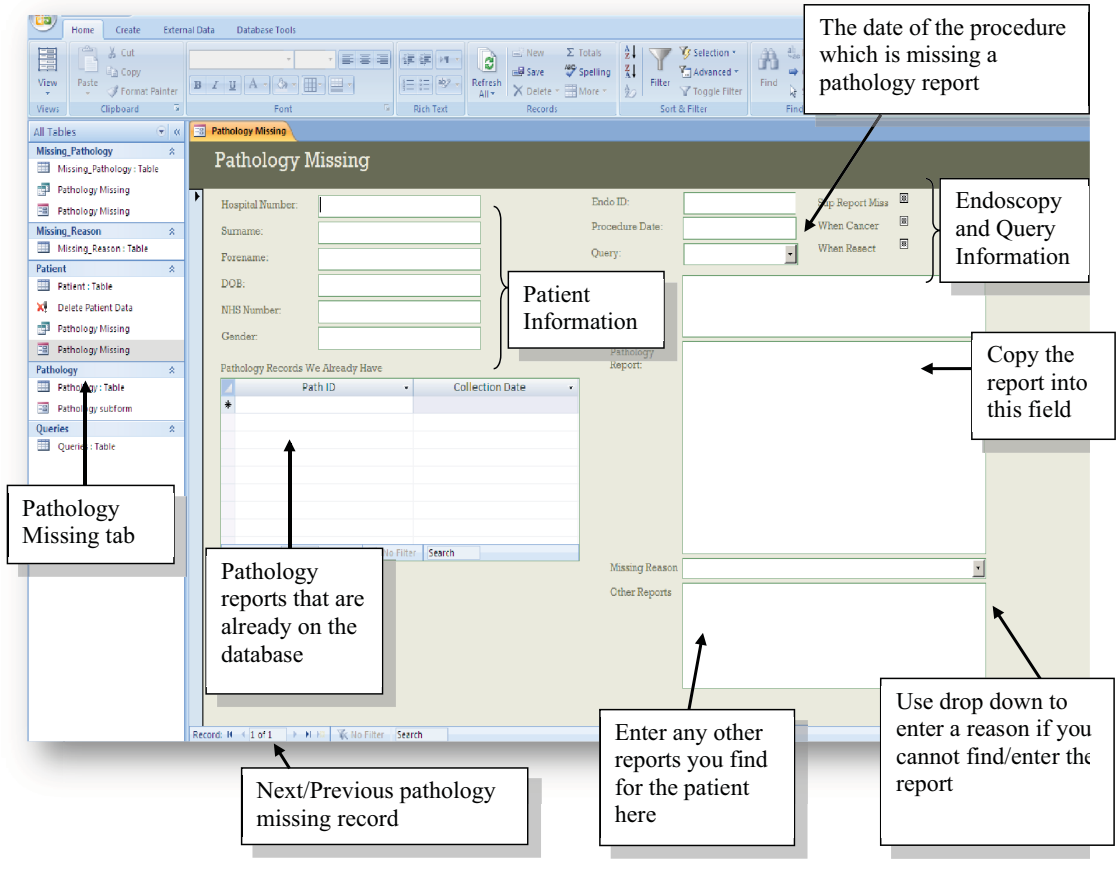
Now that you have created a list of patient's with missing pathology that is linked to patient information, Access will automatically create a database for you to enter the reports into.
Before you open the database, it is helpful to mark the duplicate patients in the system. These are patients that have more than one query. Follow the steps in the Missing_Pathology table below to mark the duplicates.





You are now ready to copy and paste records into the database Select the Pathology Missing Form in the patient table and the screen (see below) will appear.

- ! Remember that you have ordered the patients and marked the duplicates. Before you do anything in the database you should re-order the patients by name. To do this right click on the field 'Surname' and select 'Sort A-Z'.



- **Patient Information**
  The patient demographics for each endoscopy missing a pathology report will be displayed in these fields. You can use this information to search the hospital system for the patient's records.

- **Endoscopy and Query Information**
  These fields display information about the endoscopy report that has been queried as having a missing pathology, including the type of query and date of the procedure.

- **Pathology Report**
  Copy and paste the appropriate pathology report into this field. Check the following;

  - ✓ The pathology collection/report date corresponds with the date of the procedure (i.e. they are roughly within one month of each other)

- ✓ We do not already have the report (see the Pathology Reports We Already Have field)
- ✓ The report is of a specimen from the Large Bowel (if in doubt and there are no other appropriate reports, then copy the report in anyway)
- ✓ The report is from within the range of dates that we are collecting reports for. The only time we are interested in pathology outside of these dates is when it helps to solve a general query such as 'when cancer' or 'suspected ibd'. In these cases if you find relevant information, do not copy the report but answer the query in the pathology box.

➢ **Missing Reason**

If you cannot find any appropriate report for this queried endoscopy, use the following options on this drop down field to give a reason;

- **No Patient on system –** the patient could not be found on the system
- **No Pathology Reports on System –** the patient was found but there was no available pathology
- **Pathology Available but not for that date –** other pathology from the large bowel was found
- **Irrelevant Pathology –** the only available report is for a specimen from a site other than the large bowel
- **Already Have all Available Path –** we already have all the relevant reports
- **Already Have Path For This Query –** we already have the specific pathology
- **Duplicate –** we have already coded all of this patients data in a previous record
- **Non-Colorectal Cancer Solves Query –** use when non-relevant path solves query, write in notes box.
- **Relevant Path Falls Outside of Catchment Dates –** as above, write in notes box (but do not copy report)
- **Other –** see notes comment.

➢ **Other Reports**

A patient will most likely have more than one report. These 'other reports' may be useful and you should copy them into this field. Do this even when you have been unable to find the pathology that was originally queried as missing. Check that;

- ✓ We do not already have the report (see the Pathology Reports We Already Have field)
- ✓ The report is of a specimen from the Large Bowel (if in doubt and there are no other appropriate reports, then copy the report in anyway)

In some cases there will be multiple 'other reports'. You can add all of these to the Other Report field. Between each report you should leave a space and enter the text – '*NEW REPORT'*.

<u>Issues you might encounter</u>

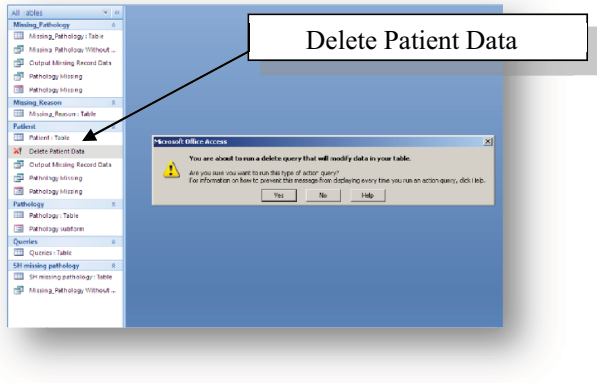
❖ You may find that a 'when cancer' or 'when resection' query cannot be solved by any pathologies within the catchment years, but that a report outside of these dates provides a date at which cancer was confirmed or negated. In this case you should type in the relevant information (date of report, what was found i.e. cancer/no cancer, if it was removed) in the comments box. You may simply write "no exams in or out of the catchment years show a diagnosis of cancer".

- When one patient has more than one query, they will appear more than once in the database. To avoid extra, unnecessary work, you should copy and paste all the pathology for one patient into one record. Subsequent records for that patient can then be left blank. You should mark these subsequent records as 'Duplicate' in the missing reason drop down. It is possible to automatically mark duplicate patient records (see page 6), so that when you come across them it is obvious. REMEMBER – you must pay attention to the type of query in each duplicate record, the pathology report needed to solve a 'when cancer' or 'when resection' query may fall outside of the catchment years
- You may come across pathology for normal mucosa. Provided you are sure that this pathology is from the large bowel copy and paste it into the database as normal.
- If the sample is clearly from another hospital write in CAPS at the top of the report 'FROM ANOTHER HOSP'.

End of Visit Checklist

It is **VERY** important that you complete the following checklist before leaving the hospital;

- ✓ Run the *Delete Patient Data* query in the database. **ONLY** do this when you have completed your visit and processed all the missing pathology queries. A window will pop up to ensure you want to delete the patient information.



- ✓ Copy the database file to the usb drive (if pass worded this is same as laptop)
- ✓ Delete the *Patient Linking File* from your desktop
- ✓ Delete ANY files with patient information on them
- ✓ If you have been using the laptop be sure to delete any files with patient information on
- ✓ Once you have deleted these files, make sure that you clear the recycling bin
- ✓ Return the CD to the person you originally retrieved it from and ensure that they will put it into the same place as before (you may wish to do this before the end of the visit, after you have linked the data)
- ✓ Delete/Destroy your note of the CD password

Passwords

CD		You will be given this before you make a visit. Keep the password safe and destroy it at the end of your visit. You may want to store the password on your phone as this will be harder to lose
SafeStick		
Laptop		
Zip-File		
Access Database		

Visit Checklist

Things to check before confirming the visit:

- ❖ Access – you will need access to the hospital server and the pathology system
- ❖ Some centres will have past pathology systems. Check if the data we require (i.e. data from the catchment years for the original data extract[*]) is all on one system. If it is not, check that you can gain access to the current AND older system(s)
- ❖ Check with the hospital staff which version of Microsoft Office is used – 2000, 2003 or 2007. If it is 2000, inform Ann asap.

Before you go on each hospital visit please check the following lists to ensure that you have everything you need:

- ✓ **Memory Stick**, containing;
  - o **Access database** (specific to the hospital you are visiting)
- ✓ **Missing Pathology SOP**
- ✓ **Contact details** of the person you will be meeting
- ✓ **Map of the hospital** or instructions on how to find Pathology
- ✓ **Mobile phone**
- ✓ **Catchment years for original data extract**
- ✓ **CD Password**
- ✓ **Arranged to have a user name and login for the hospital server**

ESSENTIAL

- ✓ Honorary Contract
- ✓ Lap Top

CD Drive for the Lap Top

[*] Catchment years for the original data extract; the data that was originally collected from the hospital will have a from and to date e.g. data for Brighton hospital ranges from 2001 – 2008 (inclusive). This is important to note, as we do not want to collect pathology from outside of these dates. Ask Ann for these dates.

Missing Pathology Coding SOP

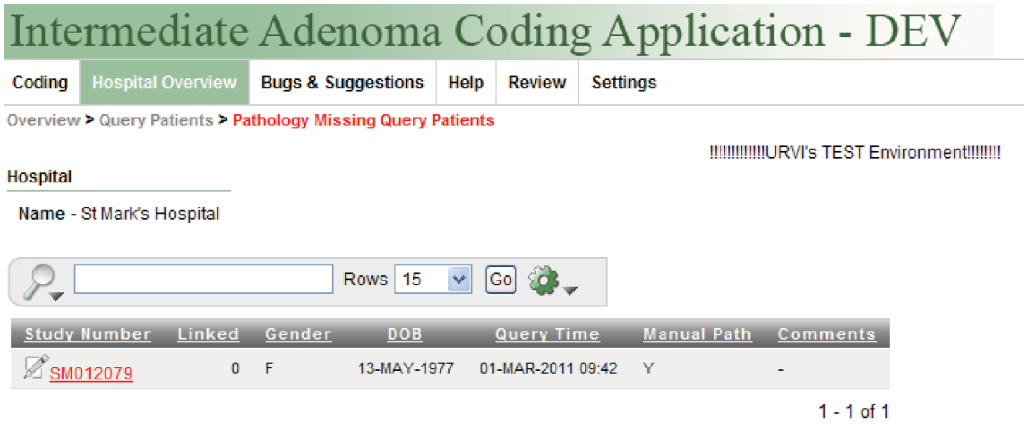
(Amy Brenner, 8/15/2011)

Coding Missing Pathology Reports

A number of new pathology reports were collected during hospital visits that were undertaken to resolve coding queries (missing pathology, exclude, application coding error and general queries). As a result, some patient records have new, previously missing pathology reports that need to be coded. The following method should be used when dealing with these records.

Identifying Records with New Pathology

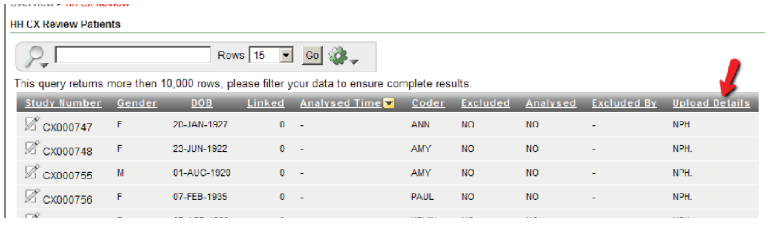
Patients with new pathology reports will be flagged with a 'Y' in the Manual Path column as shown below.



For each centre, the following queries should be checked in order to find new pathology reports:

- *Pathology Missing*
- *Application Coding Error*
- *Exclude* (except for Brighton)
- *General (Possible Cancer, When Cancer, When Resection, Supplemental Report Missing)*
- It is probably easier to go over all General queries rather than try and find specific ones.

In cases where new pathology was automatically collected from hospital databases as opposed to being manually collected, you can identify the records with new pathology by looking at the 'Upload Details' on the centre screen, which will show NPH (see red arrow).



Using New Pathology to Solve Queries

The majority of the queries listed above will be solved by the new pathology so pay attention to the specific query type. Bear the query in mind when reading the new pathology report and aim to solve it. However, in some cases there will be no new pathology...

When a report is queried as *pathology missing* but no relevant pathology was retrieved:

1) **Re-query** the report as *pathology missing* if:

   - The polyp was sent to labs
   - The endoscopist mentions awaiting histology
   - There are relevant details in the biopsy indicator box
   - Cancer/resection is indicated after the first exam (if these are indicated at first exam then exclude the patient)

2) **Clear the query and code** as normal if:

   - The reason for the original query was the polyp was 10mm +
   - You are unclear why the record was queried in the first place

Irrelevant or Duplicated Linked Pathology

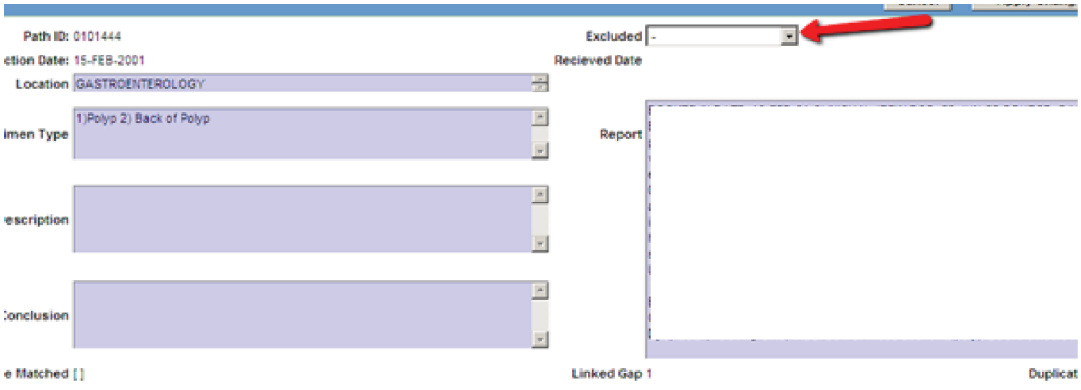
In some cases multiple or inappropriate pathology reports may be attached to an endoscopy report.

Reasons for this:

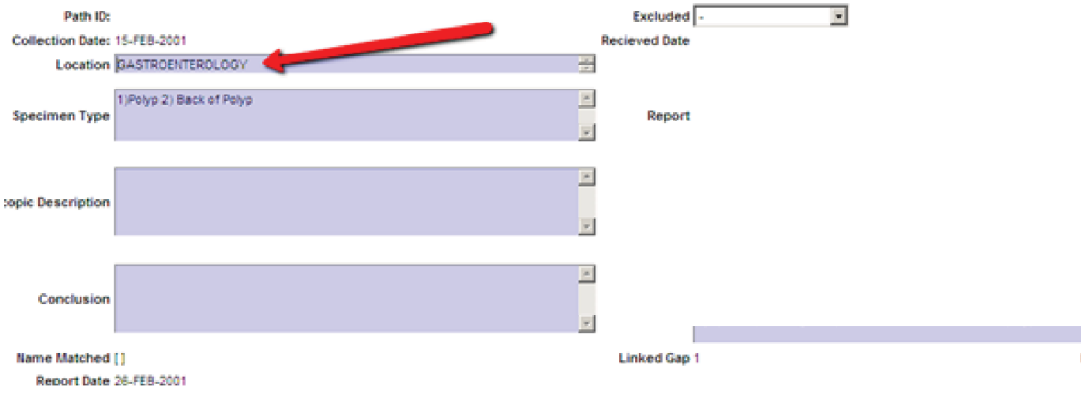
1) When an 'Application Coding Error – Truncated Pathology' query has been applied to the record the old and new pathology will be linked.
2) When a 'Pathology Missing' query has been accidentally applied to a record (due to human error – these will be rare).
3) When another type of examination took place on the same date, i.e. upper GI exam
4) When the same report has been uploaded twice.

How to deal with linked duplicates or irrelevant pathology reports:

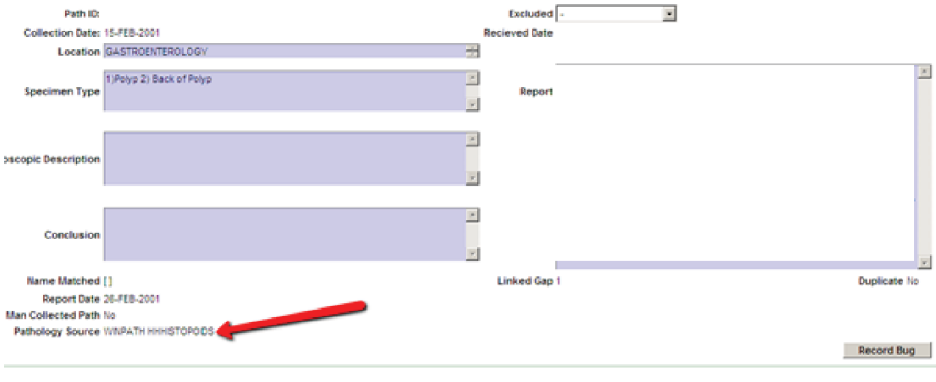
- In these cases coders can mark the inappropriate pathology reports that need to be deleted from the database.
- To do this the coder should access the pathology report by going into the pathology record directly from the patient screen.
- Then, using the 'Excluded' drop-down menu the coder can mark the record as either a duplicate, irrelevant pathology or general (see red arrow).
- **NB** - Any polyp rows must be deleted before leaving the pathology screen.
- If not already linked, the coder must then link the appropriate pathology report to the endoscopy report.
- The coder can then code the patient information and polyp details normally from the appropriate pathology report.



There is a location field in the linked pathology reports so that you can see the source of the data in order to make it easier to identify irrelevant pathology.



In cases where data was automatically collected from hospital databases the pathology data source is shown at the bottom of the pathology screen. This may be useful as you may find the same pathology from different sources.



New Unlinked Pathology & 'Other' Reports

Some of the new pathology will be in the form of unlinked pathology reports, which will either require a phantom endoscopy to be created or may need to be linked manually depending on their contents and collection/ received date (see Phantom SOP for more detail).

Some of the unlinked pathology reports will not contain any relevant pathology. These will be classed as 'other' reports, and should be marked as 'Excluded' – 'Irrelevant pathology'. Alternatively some unlinked pathology reports may be duplicates and should be marked as 'Excluded' – 'Duplicate'.

When an unlinked pathology report has biopsies that are NOT;

- Polyps (Inflammatory, Juvenile, Fibro-epithelial, etc. – see Phantom SOP for more detail)
- Adenomas
- Cancer

Create a blank phantom endoscopy, tick the normal mucosa box, save and exit the report.

! Remember to take note of any new cancers/resections that are added to a patient's record through the new pathology report(s). Be sure to check if this creates the need to exclude a patient based on the order of the exams.

Polyp Matching Re-queries – Coding Rules

(16th August 2012)

1) Size - Assign the worst histology to the largest polyp.

2) In general, hyperplastic polyp pathology should be assigned to the most distal lesion but ONLY if this lesion is 5mm or less in size.

3) Excision extent – if size is not available, assume that polyps which were snared are larger than those that were hot biopsied.

4) When the rules above cannot be used then it can be assumed that specimen labels i.e. 1-10/A-E, go from the most proximal to most distal site.

5) If none of the above rules can be applied then use size and segment ranges to code pathology.

NB - All polyp matching re-queries will be assigned a 'polyp matching best guess' label on the appropriate endoscopy record so they can be identified at analysis and the polyp matching re-query will be removed.

Polyp Numbering SOP

(Amy Brenner, 6/1/2011)

Polyp Numbering

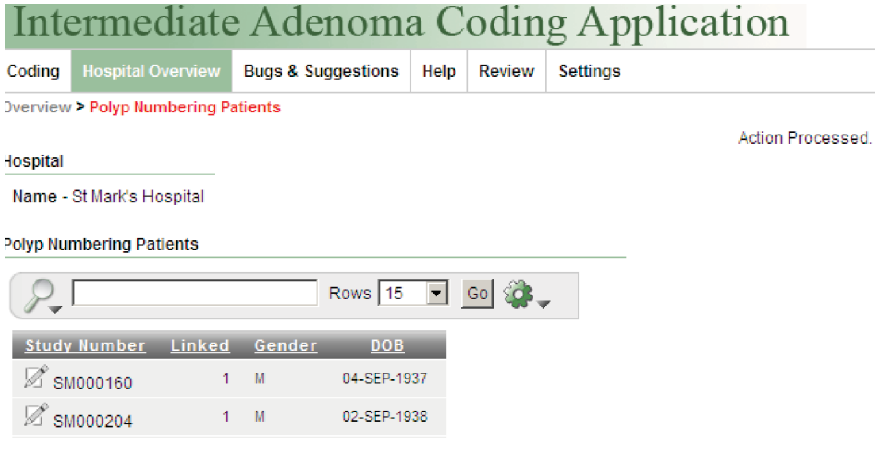
Introduction

Sometimes a polyp found at one endoscopy may be seen again at a later endoscopy. This is because the polyp was not removed or was only partially removed, i.e. de-bulked or biopsied. Alternatively, some residual polyp may have been left intact accidentally or there may have been re-growth after the polyp was thought to have been completely excised.

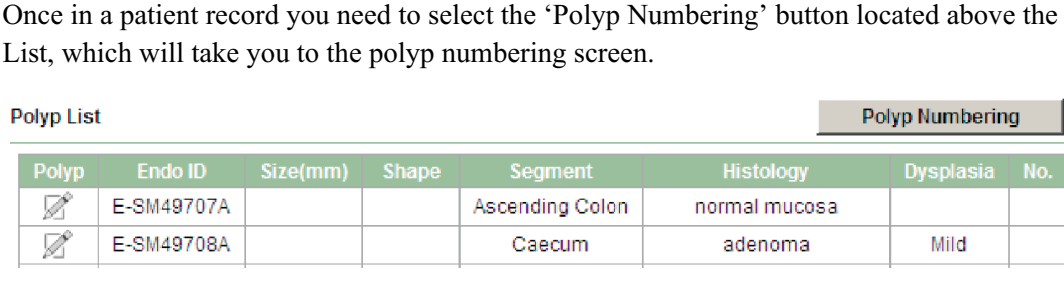
A number of patients (c.20000) were identified as requiring manual polyp numbering. These are patients who have two or more exams with polyps found on at least two occasions. The polyps found in these patients need to be numbered in order to ensure that the same polyp is not counted as a number of different polyps.

Polyp Numbering Records

After selecting a hospital you should change the settings to 'Polyp Numbering Patients'.

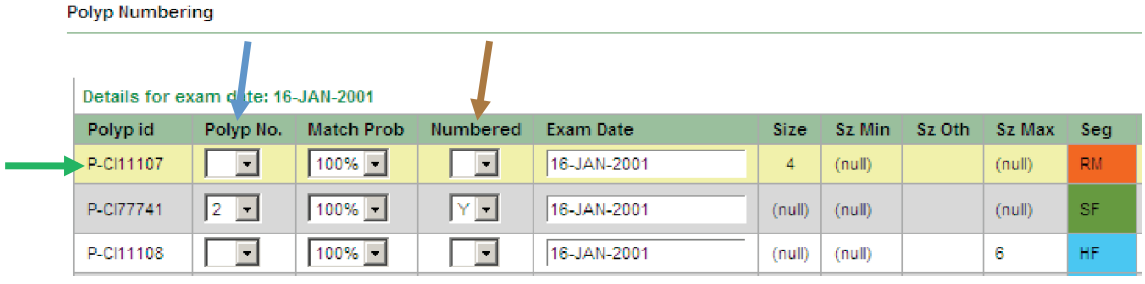


Once in a patient record you need to select the 'Polyp Numbering' button located above the Polyp List, which will take you to the polyp numbering screen.



Polyp Numbering Screen

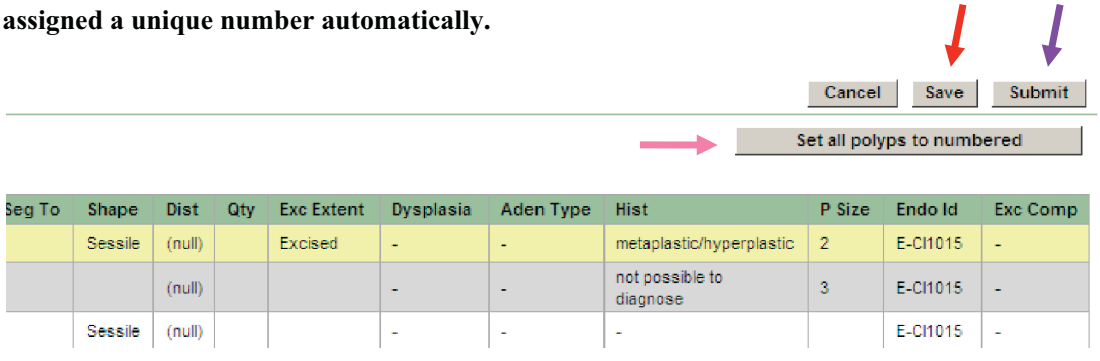
The polyp numbering screen contains an individual row for each polyp found at every exam, with various details given (as show below). It also shows endoscopy and pathology details for the polyp row that is selected, as well as a polyp numbering query field.



The polyps can be numbered by using the Polyp No. drop-down menu (blue arrow). Polyps that need matching (i.e. the same polyp seen at different exams) should be given the same polyp number.

The polyp row that is selected is highlighted in yellow. The endoscopy and pathology details and summary of each exam can be seen below the polyp table by clicking on the relevant Polyp ID (green arrow). If one or more polyps have been numbered, then the coder should click Save (red arrow) before selecting a new polyp row in order to prevent this information from being lost.

NB – Only polyps that match need to be assigned a polyp number. All other polyps will be assigned a unique number automatically.

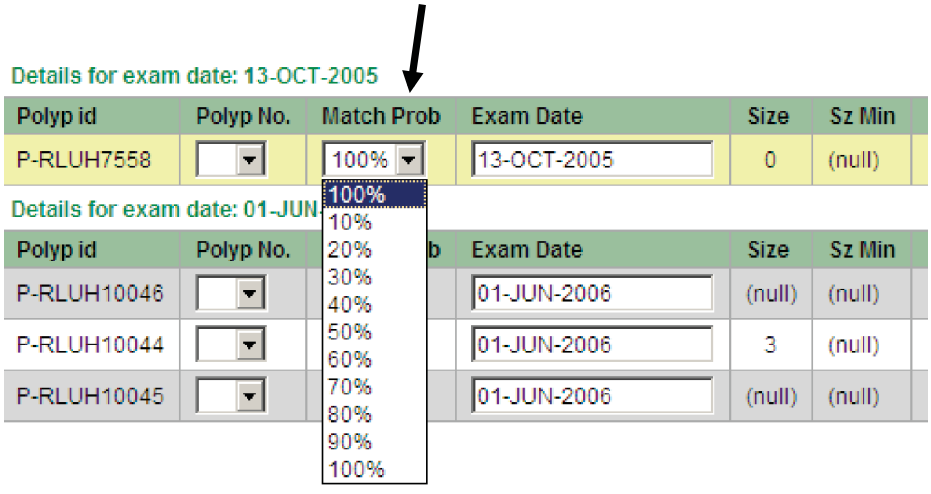


Once all matching polyps have been numbered then the coder must set all polyps to numbered (pink arrow). The record can then be submitted using the Submit button (purple arrow), which will save the polyp numbering details and return the coder to the patient screen. Finally, click 'Apply Changes' to leave the record. The record will then move into the Polyp Numbering Completed category in the Patient List, or to the Polyp Numbering Query category if a polyp numbering query has been created.

The Polyp Numbered field (brown arrow) enables coders to differentiate between non-matching, checked polyps and newly added polyps. When first entering the polyp numbering screen the Numbered field is blank. The polyp being numbered will be set 'Y' if you click on 'Save'. Before you leave the record you 'set all polyps to numbered' so that it is clear you have looked at all the

polyps. You can also manually set a polyp to ‘Y’ or ‘N’. If you return to the record at a later date any newly added polyps will show Polyp Numbered ‘N’.

Polyp Match Probability



The Match Probability drop-down menu (black arrow) is used to indicate the percentage certainty that polyps match. It is important to match as many polyps with as high a probability as possible for analytical purposes.

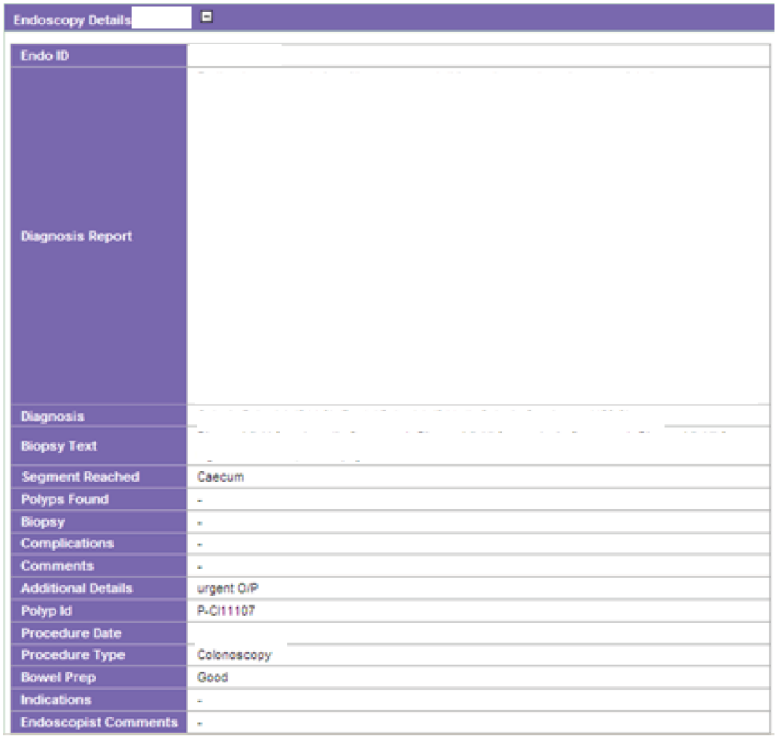
A single polyp should be used as a point of reference from which all other possible matches are based. This shall be termed the ‘**reference polyp**’. The coder should select a polyp that can be matched to the greatest number of polyps with the most certainty. The reference polyp should always be given 100% Match Probability. All possible matching polyps should then be given a match probability in relation to the reference polyp.

For example, say a patient has 5 examinations with a rectal polyp found at each. The first exam takes place in 1999, whilst the other 4 all occur in 2002 in close proximity. You are certain that the rectal polyps found at the 4 later exams are a definite match, as it is a large polyp that is undergoing de-bulking. It seems likely that the first polyp is also a match but the histology varies slightly and the timescale raises some doubt. The reference polyp should be the second polyp found as you can then set the Match Probability of the subsequent 3 polyps to 100% and set that of the first polyp to 70%. If you were to use the first polyp as the reference polyp then the 4 later polyps would all be given a lower Match probability of 70% despite them being a clear match with each other, making the polyp matching less accurate.

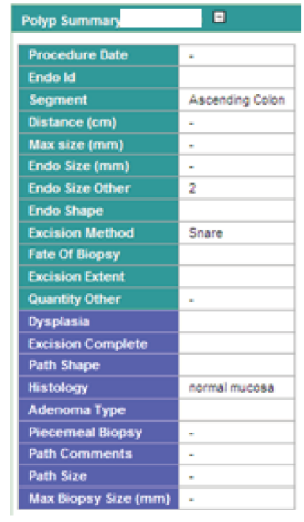
- 100% - absolutely certain polyps match
- 50% - equally likely to be the same polyps or different polyps
- 20% - unlikely to be the same polyps but a small possibility

Polyp Summary, Endoscopy and Pathology Fields

In order to match polyps appropriately the coder should use all the information provided in the Polyp Summary, Endoscopy Details and Pathology Report for each polyp, being sure to follow the polyp numbering guidelines.



Endoscopy Details	
Endo ID	
Diagnosis Report	
Diagnosis	
Biopsy Text	
Segment Reached	Caecum
Polyps Found	-
Biopsy	-
Complications	-
Comments	-
Additional Details	urgent O/P
Polyp Id	P-CI11107
Procedure Date	
Procedure Type	Colonoscopy
Bowel Prep	Good
Indications	-
Endoscopist Comments	-



Polyp Summary	
Procedure Date	-
Endo Id	
Segment	Ascending Colon
Distance (cm)	-
Max size (mm)	-
Endo Size (mm)	-
Endo Size Other	2
Endo Shape	
Excision Method	Snare
Fate Of Biopsy	
Excision Extent	
Quantity Other	-
Dysplasia	
Excision Complete	
Path Shape	
Histology	normal mucosa
Adenoma Type	
Piecemeal Biopsy	-
Path Comments	-
Path Size	-
Max Biopsy Size (mm)	-

Pathology Report	
Report	Macro: Clinical History: Multiple Colorectal Neoplasia Hepatic Flexure, 8mm Polyp. Splenic Flexure Probable Carcinoma. Sigmoid Large Polypoid Tumour. Rectum Small Polyp. Macroscopy: A: Hepatic Flexure: One Piece Of Light Tan Tissue (3mm). B: Splenic Flexure: One Piece Of Light Tan Tissue (3mm). C: Sigmoid: Two Pieces Of Light Tan Tissue (Each 2mm). D: Rectum: One Piece Of Grey Tissue (2mm). Micro: Microscopy: A: This Hepatic Flexure Biopsy Consists Of A Portion Of Normal And Abnormal Colonic Mucosa. Abnormal Colonic Mucosa Shows Low Grade Epithelial Dysplasia Consistent With A Low Grade Tubular Adenoma. B: This Splenic Flexure Biopsy Contains Essentially Normal Colonic Mucosa. In View Of Clinical Findings A Repeat Biopsy Would Seem Appropriate. C: This Sigmoid Biopsy Contains Part Of A Low Grade Tubular Adenoma. D: This Rectal Biopsy Shows Features Suggestive Of A Metaplastic Polyp. Conclusion: Colonic Biopsies - Normal Splenic Flexure Mucosa, Inconsistent With The Clinical Impression.Colonpapillary Adenoma Rectumhyperplasia Polypoid
Comments	-
Path Id	H,01.0000470.R
Endo Id	E-CI1015
Collection Date	16-JAN-2001
Specimen Type	-
Microscopic Description	A: This Hepatic Flexure Biopsy Consists Of A Portion Of Normal And Abnormal Colonic Mucosa. Abnormal Colonic Mucosa Shows Low Grade Epithelial Dysplasia Consistent With A Low Grade Tubular Adenoma. B: This Splenic Flexure Biopsy Contains Essentially Normal Colonic Mucosa. In View Of Clinical Findings A Repeat Biopsy Would Seem Appropriate. C: This Sigmoid Biopsy Contains Part Of A Low Grade Tubular Adenoma. D: This Rectal Biopsy Shows Features Suggestive Of A Metaplastic Polyp.

Polyp Numbering Guidelines

In order to match polyps you should pay particular attention to the following factors, which are listed in order of importance:

1) segment
2) length of time passed between exams
3) indication that polyp was not removed or was partially removed i.e. debulking, discomfort
4) excision extent/excision complete
5) bowel prep
6) method of excision
7) size
8) dysplasia
9) adenoma type
10) histology

You will have to take all these factors into account and use your judgement to decide whether or not any polyps need to be matched.

With regards to segment, the segment matching guide below can be used, where one should consider matching polyps found in the same segment group or the group either side, if other factors listed above indicate that polyps may match. For example a polyp in group 2 could be matched with a polyp in group 1, 2 or 3.

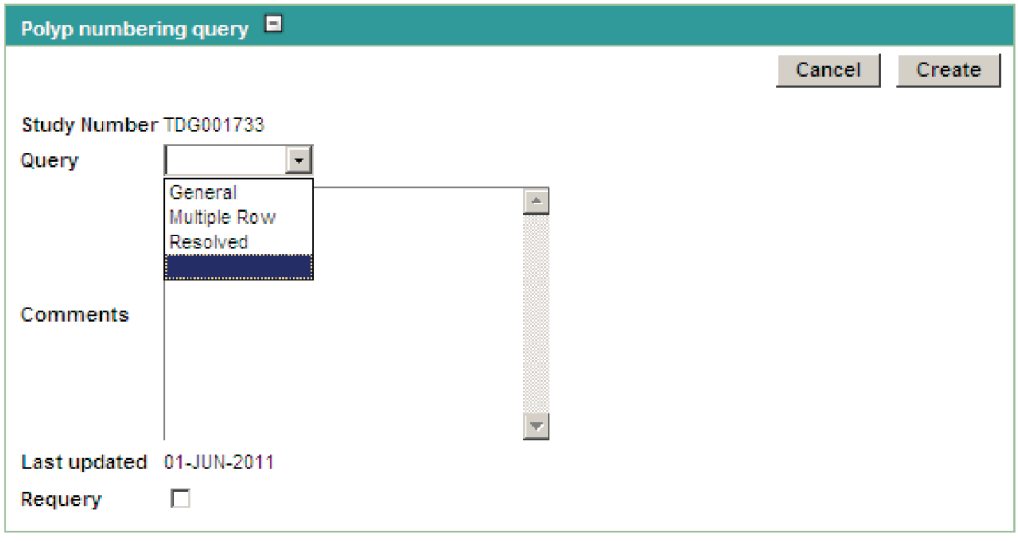
Segment Matching Guide

Segment Group Number	1	2	3	4	5	6	7
Segment Name	Anus	Sigmoid Colon	Descending Colon	Transverse Colon	Hepatic Flexure	Ileocecal Valve	Anastomosis
	Rectum	Sigmoid Colon (Distal)	Descending Colon (Distal)	Transverse Colon (Distal)	Ascending Colon (Distal)	Terminal Ileum	
	Rectum (Distal)	Sigmoid Colon (Mid)	Descending Colon (Mid)	Transverse Colon (Mid)	Ascending Colon (Mid)	Pre Pouch Ileum	
	Rectum (Mid)	Sigmoid Colon (Proximal)	Descending Colon (Proximal)	Transverse Colon (Proximal)	Ascending Colon (Proximal)	Ileal Pouch	Colostomy

	Rectum (Proximal) / Rectosigmoid		Splenic Flexure		Caecum	Neo-Terminal Ileum	

Polyp Numbering Query

If it is unclear whether or not two or more polyps should be matched then the coder can query the record using the Polyp numbering query field. The drop-down Query box should be used to select the General option and then the coder should write the reason for querying the record in the comments box. If the query is later resolved then the query option should be changed to Resolved. The record can be re-queried if the issue cannot be resolved.



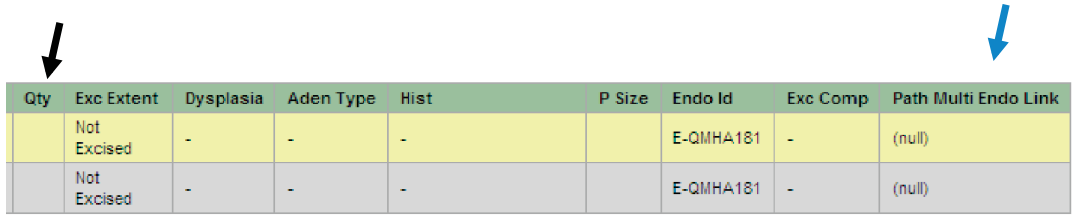
Situations when you may want to create a query...

- Exam(s) with no date
- Polyposis (too many polyps)
- Polyp matching query on record
- Exams with numerous polyp rows with quantities – ‘multiple row’
- When the case is too complicated to match polyps

Other Cases to be Aware of...

- **Quantity Field and Multi-link**

  Coders should look out for polyps with information in the Quantity field (black arrow). This may indicate that some of the polyps found at this exam are multi-linked. Any multi-linked polyps can be identified by the 'Path Multi Endo Link' row on the polyp numbering page (blue arrow).



Qty	Exc Extent	Dysplasia	Aden Type	Hist	P Size	Endo Id	Exc Comp	Path Multi Endo Link
	Not Excised	-	-	-		E-QMHA181	-	(null)
	Not Excised	-	-	-		E-QMHA181	-	(null)

  In complex cases where numerous quantity rows appear, a polyp numbering 'Multiple Row' query can be applied if it is not possible to confidently match them.

  When appropriate an individual polyp(s) should be matched to a polyp row with a quantity, e.g.

Exam 1	Polyp Number
Several 2mm Rectal Polyps Not Excised	1
Exam 2	
2mm Polyp in the Rectum Excised	1
2mm Polyp in the Rectum Excised	1
2mm Polyp in the Rectum Excised	1

  An individual polyp row can also be matched to a multiple polyp row in cases where a large polyp is later referred to as a carpet/cluster of polyps etc.

  Finally, in some cases it may be necessary to link two or more multiple rows together, however multilinked rows should not be matched as they are already linked to the polyp group in question.

- **Non-polyp Histology and 'Not Possible to Diagnose'**

  Some records will have histology such as normal mucosa, mucosal prolapse or inflammation. In general, these 'polyps' should NOT be matched. However, in some cases it may be necessary to match such 'polyps'.

  - For example, if in subsequent examinations it seems likely that the polyp was misdiagnosed then this should be matched, i.e. the first biopsy was inadequate and relevant histology is found later.

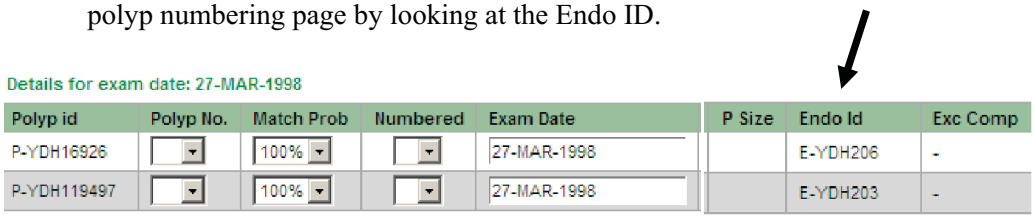
  - Polyps with irrelevant histology should also be matched if a specimen is clearly stated as being a biopsy from a previous polypectomy/excision site.

As a rule, only polyps, adenomas or cancers should be matched. Any other histology should be dealt with as discussed above.

Extra consideration may be needed for polyp rows with the histology 'not possible to diagnose'. In this case the coder should again use their initiative to determine whether or not this should be matched.

- **Multiple Exams on Same Date**

  Be aware that some exams may have the same date, resulting in polyps that were in fact found at separate exams being listed under the same exam date. This can be identified on the polyp numbering page by looking at the Endo ID.



Details for exam date: 27-MAR-1998

Polyp id	Polyp No.	Match Prob	Numbered	Exam Date	P Size	Endo Id	Exc Comp
P-YDH16926		100%		27-MAR-1998		E-YDH206	-
P-YDH119497		100%		27-MAR-1998		E-YDH203	-

- **Matching Polyps Found at Same Exam**

  In some cases polyps found at the same exam may need to be matched. For example, a number of polyps seen may be re-growths/remnants of previous single large polyp or tumour.

- **Metaplastic Polyps**

  When small (<5mm) metaplastic polyps are seen at a number of exams it is fair to assume that these are different polyps that are new or were previously missed, unless the report contains information to indicate otherwise.
  Coders should also be aware that in some cases it may be appropriate to match serrated adenomas and metaplastic polyps as a result of common misdiagnosis.

- **Which polyp?**

  Cases may arise where it is possible to match a number of polyps at one exam to a polyp(s) at another exam, and no particular polyp row contains information to make it any more likely a match than the others.
  Choose a polyp and match it. The match probability should not be affected by the fact that you are unsure about which polyp to match. It should be based solely on the probability of the polyps being the same.

March 2012 – SOP Updates and Amendments

1. Coders Reference Document

Cancer Review:
New histology terms were added for the cancer review/cleaning task (reviewing ca+adenoma, cancers, mets from another site).

- New cancer types added - GIST, Sarcoma, squamous cell carcinoma
- 'Cancer query' added to compliment 'cancer in dispute'
- 'Mets/tumour infiltrating' added to compliment 'metastasis from another site'
- 'Ca+mixed/serrated' separated into 'ca+mixed' and ca+serrated'
- 'Carcinoid tumour' changed to 'carcinoid/neuroendocrine tumour'
- 'IM cancer in dispute' added to compliment 'IM Cancer' which is now being used to reclassify cancers coded previously.

General:
Application coding error options updated to include new options (truncated endoscopy, truncated pathology, blank endoscopy, blank pathology, duplicate endoscopy, irrelevant endoscopy).

2. Coders Reference Document – Phantoms

Cancer Review:
New histology terms were added for the cancer review/cleaning task (reviewing ca+adenoma, cancers, mets from another site).

- New cancer types added - GIST, Sarcoma, squamous cell carcinoma
- 'Cancer query' added to compliment 'cancer in dispute'
- 'Mets/tumour infiltrating' added to compliment 'metastasis from another site'
- 'Ca+mixed/serrated' separated into 'ca+mixed' and ca+serrated'
- 'Carcinoid tumour' changed to 'carcinoid/neuroendocrine tumour'

3. Coding Application SOP

Patient details screen – information edited to describe details of access to polyp numbering screen and data cleaning tasks.

Query – Application coding error options updated to include new options (truncated endoscopy, truncated pathology, blank endoscopy, blank pathology, duplicate endoscopy, irrelevant endoscopy).

Re-query – defined new use (i.e. once query followed up with data collection but cannot be solved)

4. Exclusion SOP Reference Document

Colitis – non-exclusion types listed.

Polyposis – new terms added. New coding rule mentioned (i.e. patients will only be classified as having polyposis if the endoscopist or pathologist explicitly states that they have the disease.

Numbers of polyps will no longer be used by coders. Instead polyp numbers will be used to classify patients as having polyposis at analysis).

5. Exclusion SOP

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6. Missing Pathology Coding SOP

None

7. Missing Pathology Collection SOP

None

8. Phantom SOP

Minor amendments

9. Polyp Numbering SOP

Minor amendments

10. Review SOP

None

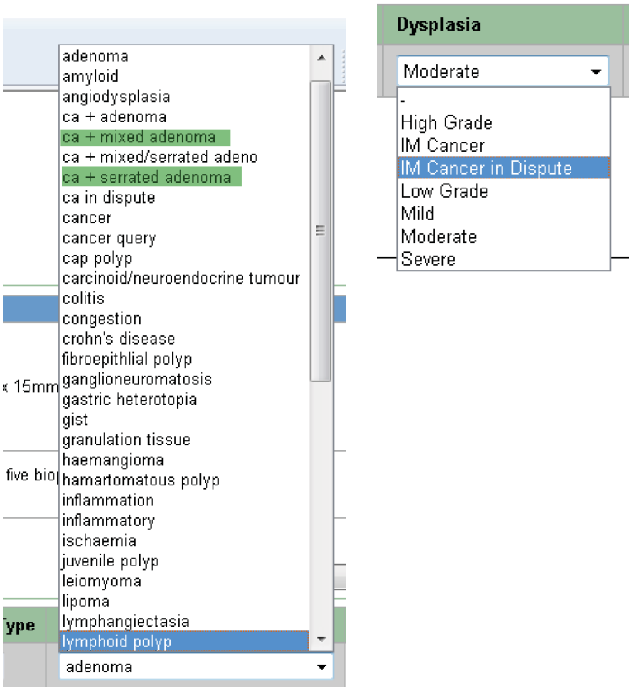
Cancer Reclassification Review SOP

(Amy Brenner, 5/14/2012)

Incident 195 – Cancer Review

It was decided that all cancers in the database needed to reviewed and reclassified into more specific categories. More detailed pathology coding options have been added to the database to enable this. There are 4 different groups to be reviewed.

Ca+adenoma (Group A) - Firstly all records with 'ca+adenoma' coded in a polyp row are to be reviewed and, if necessary, recoded to fit the new cancer definitions taken from the EU 2010 guidelines. A number of new histology options have been added for this, including 'Ca + mixed adenoma' and 'Ca + serrated adenoma', as well as dysplasia options of 'IM cancer in dispute'.



Cancer in dispute (Group B) – Records coded as 'ca in dispute' are being reviewed to allow them to be reclassified into a further category of 'query cancer' so that it is possible to differentiate between a suspicion of cancer and an inability to determine the precise level of invasion in cancerous tissue i.e. high grade dysplasia in an adenoma or invasive cancer in an adenoma.

Metastases (Group C) – Records which have been coded at 'metastases – another site' are being reviewed so that they can be reclassified into a further category of 'mets/tumour – infiltrating' so that it is possible to differentiate between a cancer that has grown into the bowel from a nearby site and cancer that has developed in the bowel through metastasis from a non-adjacent organ.

Cancer (Group D - G) – Any cancers that are NOT adenocarcinomas have been identified so they can be reclassified as more specific types of cancer i.e. squamous cell carcinoma, sarcoma, GIST, lymphoma. A word search was used to extract relevant records for this review and new terms were added to the histology drop-down menu to allow such records to be recoded.

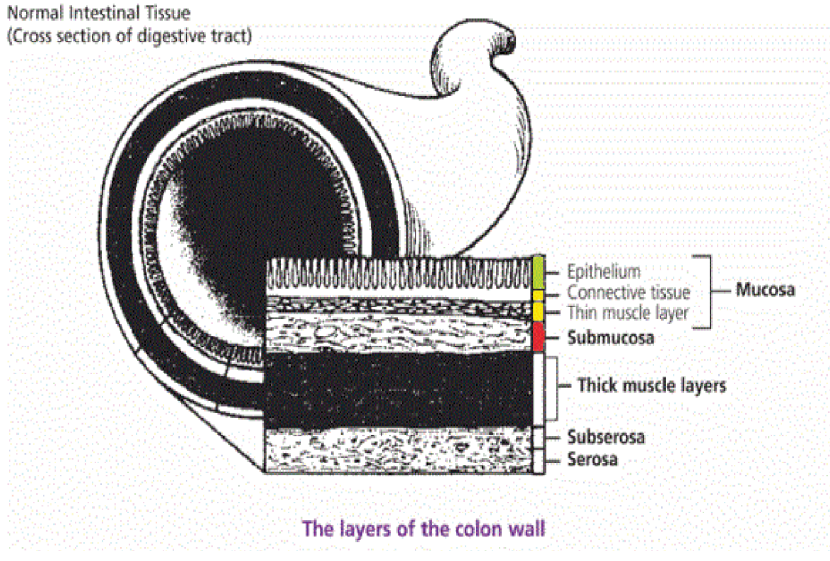
A number of new histology options were added to the histology drop-down menu, whilst some of the current options definitions were amended, as shown below. New options are shown in blue, old options in red and options with new definitions are in black.

HISTOLOGY	DESCRIPTION
Ca+adenoma	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from an adenoma or when a cancer diagnosis also includes adenomatous material.*
Ca+mixed **(Ca+mixed/serrated adeno)**	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a mixed polyp or adenoma*
Ca+serrated **(Ca+mixed/serrated adeno)**	*Carcinoma / cancer / malignant / invasive cell types, seen to be arising from a serrated polyp or adenoma*
Cancer Query	*If a pathologist mention or suspects but is not able to confirm a diagnosis of cancer / malignancy*
Ca in dispute	*If a pathologist cannot confidently confirm cancer / malignancy / level of invasion **in an adenoma** or cannot decide between an adenoma or cancer.*
Cancer	*Malignant neoplasm / adenocarcinoma / carcinoma/ malignancy / invasion*
Carcinoid/Neuroendocrine tumour **(Carcinoid tumour)**	*Tumour originating from the neuroendocrine system.*
Metastases - another site	*Malignant material found in the colon that is not from a primary bowel cancer and originates elsewhere in the body.*
Mets/tumour - infiltrating	*Malignant material that is infiltrating into the colon from a tumour outside the colon (if unsure use 'Mets from another site')*
Unknown Primary	*Malignant material found in the colon that has an unclear or unknown primary*
Non-Hodgkin's Lymphoma	*(NHL) A diverse group of blood cancers that include any kind of lymphoma except Hodgkin's lymphomas.*

Squamous Cell Carcinoma	*Skin Cancer normally found in the anus, but may be reported as rectal. Code as squamous cell carcinoma.*
G.I.S.T	*Gastro Intestinal Stromal Tumour*
Sarcoma	*Cancerous tumour of soft tissue*
Basaloid/cloacogenic cancer	*Subclass of squamous cell cancers that develop in the transitional zone, also called the cloaca. These cancers look slightly different under the microscope but they behave and are treated like other squamous cell carcinomas of the anal canal.*
Anaplastic/undifferentiated cancer	*A rare type of cancer often diagnosed at advanced stage, usually found in the small intestine*

To review an incident, access the appropriate record from the patient screen and go over the pathology report to determine whether or not the polyp row needs to be recoded in line with these new definitions. The cancer staging diagram below can be used as a guide for when to classify histology as severe dysplasia, IM cancer or ca + adenoma.

Cancer Staging Diagram:



NB: -
- Connective tissue = lamina propria
- Thin muscle layer = muscularis mucosa
- Thick muscle layer = muscularis propria

Green = Severe Dysplasia (involving the epithelium)
Yellow = IM Cancer (invading the lamina propria and/or muscularis mucosa)
Red = Cancer (penetration of the muscularis mucosa and invasion of the submucosa)

Please note:

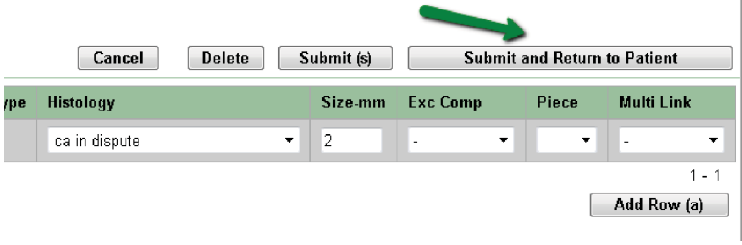
- The ‘Ca + mixed/serrated adenoma’ option will be removed once coders have reclassified these – NO records should have ‘Ca + mixed/serrated adenoma’ once reviewed.
- If a supplementary report is present this information should take precedence over the original pathology report.
- Ca in situ = high grade dysplasia + adenoma, NOT cancer
- Mention of AIN3 indicates squamous cell carcinoma
- Mention of Dukes staging indicates invasive carcinoma
- When cancers are described as arising from a dysplastic area, only the dysplasia type and cancer should be coded, NOT Ca + adenoma.
- Sometimes a polyp is resected at endoscopy then the patient has a colectomy and no residual malignancy/cancer is found (sometimes there may be some lymph nodes but no trace of the polyp). A Dukes stage may still be given in the report despite no further cancer being present. Be careful not to code as a cancer, and if there is any residual adenoma then just code as adenoma. Ensure it is 100% numbering matched to the cancer.

Example:

‘An irregular polypoid lesion 2 cms diameter. Sections show the lesion to be a tubulovillous adenomatous polyp showing severe dysplastic change. In addition, in one area near the tip there is a focus of traumatic ulceration/haemorrhage, presumably related to the previous biopsies. In this area there is evidence of
intramucosal carcinoma with small fragments of malignant looking epithelium, some of which appear buried in the muscularis mucosae. Some small islands of epithelium are also seen in a nearby mucosal vessel, but it is unclear whether this represents true invasion or simply traumatic artefact. There is no evidence of invasion of the central connective tissue core of the polyp or of the vessels in the core. The base of the lesion is well seen and it appears completely excised. The focus of intramucosal malignant change being well clear of the base by 1 cm +. There is no evidence of amyloid in this specimen.’

In the above example the polyp was coded as a ca + adenoma under the old rules but should now be coded as IM cancer, Ca in dispute.

Once the record has been reviewed use the ‘Submit and Return to Patient’ button to take you back to the patient screen where you should ensure that any cancer exclusion has been applied correctly and mark the incident as checked.



ONS Encryption SOP

Prior to the visit;

- ✓ Contact the person in charge of the Data CD (find their contact details in 'Data CD Storage' spreadsheet on SharePoint).
  - Arrange a time and place to meet with them and collect the CD.
  - Inform them that you will only need the data for a few hours and then you will need to hand it back to them.
- ✓ Be aware that the CD may have some missing data (usually missing NHS numbers).
- ✓ Find out the name and contact details of someone who can help to fill in the missing NHS numbers (usually PAS manager or information systems staff) using the information we already have (Name, DOB, Hospital Number).
- ✓ Ensure that you have a fully charged lap top with the encryption software and a CD drive.
- ✓ Ensure that you have the Data CD password (ask Ann).
- ✓ Ensure that you know the encryption password (ask Ann).
- ✓ Print off and take all the relevant R&D approvals for the hospital (on SharePoint).
- ✓ Print off and take your honorary contract and research passport (on SharePoint).

Encryption;

1. Insert the CD into the lap top
2. Locate the patient data spreadsheet (often called 'patient linking data')
3. Export/Unzip onto the desktop
4. Open
5. Key in the password
6. Format the fields as below;

Study_Number	Hospital_Number	Surname	Forename	DOB	NHS	Gender	Postcode	Address

   - If there are any missing fields make sure there is still a column and header for the field but leave it blank.
   - If there are any extra fields, add them as columns to the right of address and make a note of them.
   - If there are missing NHS numbers you will need to contact the PAS manager/information systems

7. Save the spreadsheet to your desktop under the file name 'Intermediate Adenoma Study – '*insert hospital name'* – ONS'.

8. Right click on the logo of the spreadsheet and select the option to encrypt the data with the SafeGuard PrivateCrypto (Sophos) software and key in the password.
9. Save the encrypted version to a memory stick.
10. Delete ALL other versions of the data (except the original on the CD) ensuring that the recycling bin is also cleared.