

Person with cancer—reason(s) treatment not administered, code N

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Person with cancer—reason(s) treatment not administered, code N

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Reason(s) treatment not administered (cancer)
METEOR identifier:	428257
Registration status:	Health , Standard 08/05/2014
Definition:	The reason(s) a person with cancer was not administered treatment for cancer, as represented by a code.
Data Element Concept:	Person with cancer—reason(s) treatment not administered
Value Domain:	Reason(s) treatment not administered code N

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

	Value	Meaning
Permissible values:	1	Advanced age
	2	Comorbid conditions
	3	Poor performance status
	4	Patient died prior to planned or recommended treatment
	5	Patient or family declined treatment
Supplementary values:	88	Other
	97	Not applicable-treatment administered to patient
	98	Unknown whether treatment administered to patient
	99	Treatment not administered to patient but reasons not stated/inadequately described

Collection and usage attributes

Guide for use:	Record all the reasons why treatment was not administered. Codes 1-3 should be recorded when it is a clinician's decision to not administer treatment. Code 5 should be recorded when it is a patient or family's decision to decline treatment.
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Source and reference attributes

Submitting organisation:	Cancer Australia
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Data element attributes

Collection and usage attributes

- Guide for use:** Record the reason that a person with an initial diagnosis of cancer was not administered treatment.
- Treatment refers to any surgery, radiotherapy or systemic therapy agent that removes or modifies either primary or secondary malignant tissue. It may be curative or palliative in intent.
- For this item the use of supportive therapy such as the administration of analgesia or anti-emetics is not classed as treatment.
- Collection methods:** This information should be sought from the patient's medical record.
- Comments:** This information is used to evaluate the quality of care by distinguishing between contraindications to treatment due to patient risk factors, patient or family refusing treatment, and treatment not being offered for reasons unknown.

Source and reference attributes

- Submitting organisation:** Cancer Australia
- Reference documents:** American College of Surgeons 2002. Facility Oncology Registry Data Standards (FORDS), 2009 revision. Commission on Cancer

Relational attributes

- Implementation in Data Set Specifications:** [Lung cancer \(clinical\) DSS](#)
[Health](#), Superseded 14/05/2015
- [Lung cancer \(clinical\) NBPDS](#)
[Health](#), Standard 14/05/2015