LETTERS

The reliability of cancer registry records

In their recent paper, which compared information obtained from the cancer registry with data abstracted from medical records, Pollock and Vickers concluded that “disagreements over date of diagnosis will bias survival data, disagreements over site will affect incidence data and trends, and disagreements over treatment undermine the case for using registry data to evaluate care.” To what extent are these conclusions supported by data included in their paper?

For cases with data available both from the cancer registry and from case notes, dates of diagnosis agreed to within 30 days or less for 305 of 385 cases (79%). For date of death, there was exact agreement between the two data sets for 245 of 270 cases (91%). These findings show some lack of precision in recording date of diagnosis, particularly in cases for which registration was initiated from the death certificate. This paper has not presented data which show systematic bias from misclassification of date of diagnosis or date of death, either for the sample as a whole or for subgroups. In our own study of bladder cancer we found that there was exact agreement between data in the cancer registry and case notes for date of first operation in 83% of cases. For discordant cases the median difference was -1 day (interquartile range = 10 to 3 days). Similarly for date of death there was exact agreement in 93% of cases and for discordant cases the median difference was 1-3 days. These data showed a high level of agreement between case notes and cancer registry data. In a small proportion of cases the date of first operation or date of death were recorded imprecisely but there was no evidence of a systematic bias that might influence survival estimates.

Turning to data presented for tumour site, the rate of discordance is similar to that reported for other registries.6 After excluding cases which the reviewers were unable to classify topographically (which is difficult to interpret as the authors do not give the codes used to sample from the cancer registry), data given in their table 4 are consistent with a kappa statistic of 0.86 (95% confidence interval 0.70 to 0.96). According to criteria conventionally used to evaluate the quality of epidemiological data, this is consistent with excellent agreement between the two data sources.4 No data were presented to show that the method of recording of death changed over time in a manner that might influence the assessment of secular trends; in fact, the rate of discordance was the same in both years studied.

It is clear that cancer registries are not currently in a position to document cancer treatment in a comprehensive way, this does not underestimate the case for using cancer registries as a sampling frame for evaluative research. Cancer registry data have been shown repeatedly to be of value in comparing the outcome of cancer at international, national, and local levels.7 Recognition of a central role for population based diagnostic cancer registry data in public health research has led to the increasing use of registers in the study of other conditions.

Several other points require qualification. The authors seem to regard their own data as the reference material when they have not evaluated the reliability of their own data abstraction and it is possible that an experienced cancer registry clerk may perform better than a less experienced researcher.” Because the authors only retrieved case notes for 62% of cases provided by the cancer registry, reliability was studied for 416 cases and not the 673 cases mentioned in the title of the paper. The term “death certificate only registration” is used inconsistently and the term is used in the abstract to include cases for which details of diagnosis and treatment were available from the registry.

Cancer registrations, in common with other sources of routinely collected information, are not free from error and every effort should be made to allow cancer registries to improve the quality of their work. To observe that errors exist is remarkable, it is more important to estimate the impact of such errors on subsequent data analyses. Evaluation of cancer registry data should be performed with care. The conclusion of this paper received only limited support from the data presented.

MARTIN GULLIFORD
Department of Public Health Medicine, UMDS, Guy’s and St Thomas’ Medical and Dental Schools, St Thomas’ Hospital, London SE1 7EH


AUTHORS’ REPLY — We thank Gulliford for his comments. We shall answer each in turn.

He is right to say that our paper presents no evidence of systematic bias in the recording of dates of diagnosis and dates of death. Our objectives (as stated in the abstract and introduction to our paper) were “to measure the reliability of data collected by the Thames cancer registry and to identify factors in the registration process which could undermine the quality of the data.”

The whole differences between his study and ours on absolute rates of agreement for date of diagnosis and date of treatment are in part due to our inclusion of “death certificate only” registrations (DCOs).2 We consider it essential to have included these cases and compare them to themselves to 1982 data, found that DCOs accounted for only 12% (2%) cases and they excluded them from their sample. Historically, DCO registrations were based only on those cases that remained unregistered after intensive and extended searches for information on tumour site and date of diagnosis. Since 1983, a rapid increase has taken place in Thames DCO rates. In a study of DCO registrations in the Thames Regions registration it was found that 24% of all malignant neoplasms were registered by DCO.1 This compares with a national figure of less than 4%. The registry has explained this rise to be a result of the decision taken in 1983 (for financial reasons) not to follow up cases who died at home.3 We thought it unlikely that all of the 150 (22%) DCO cases in our sample had no contact with hospital services and for this reason we requested notes on DCO cases. We retrieved notes on 66 (44%) cases recorded for the registry as DCO cases, 12% of which had a date of diagnosis preceding the date of death by more than a year.

We found 49 disagreements over ICD code (12% of our sample). This fell to 33 (8%) of our sample once DCO registrations were excluded. Although we were unable to consult the paper by Brussewsky et al cited by Gulliford (it was published in the same month that our paper was accepted for publication), we did cite other papers which report similar findings: West found error and omission rates of 7.5% for ICD coding in their study.4 We also found in our study that Waugh reported disagreements for 4% when measuring the accuracy of Scottish cancer registry data against pathology reports.5 To find that the proportion of disagreements reported is comparable with those of other studies is remarkable. Our concern lies with the fact that that proportion may be high enough to obscure changes in incidence and survival over time. This seems to us more relevant than a kappa statistic showing excellent agreement. The rise in DCO cases over time may also have affected the quality of tumour data; several studies have cast doubt on the accuracy of tumour site as recorded on death certificates.2 Cases were requested from the Thames cancer registry with an ICD code of 153 or 154.

Like Gulliford we are strong supporters of the cancer registration system. However, we have two concerns about using the Thames registry as a sampling frame. Firstly, the exclusion of DCO cases from the sample can lead to bias. We have...
shown elsewhere that old age, poor survival, DHA of residence, and place of death were all positively associated with DCO registration.1 All the studies Guillford cites have used directly the Thames cancer registry as the sampling frame for studies of case notes and all exclude DCO cases from their sample. Our second concern relates to the use of cancer registry data for health services research. National Health Service (NHS) purchasers are now funding registries directly; we consider it essential that the reliability and the validity of registry data be confirmed before they are used as a basis for needs assessment, service outcomes, and provision. Registry data cannot be used when they are inaccurate or incomplete. In a previous paper we have shown that part of the problem lies with the incompleteness of clinical notes,2 and in that paper we chose to focus on quality control within the registry.

Guillford asks how we assessed the reliability of our own data abstraction. Before beginning work, the two doctors who carried out the abstraction liaised with registry staff to confirm the criteria used when coding date of diagnosis, stage, and treatment. Data were abstracted on each chart by both doctors and separately and checked for interobserver bias. Further checks took place at clinical audit meetings with surgeons and pathologists when cases with absent or discordant information was audited. All of this is described in a previous work cited in our paper.8 We regret the ambiguity in the abstract which could be taken to mean that the registry had data on treatment for DCO cases. However, the background and methods sections make clear that the registry definition of DCO cases was the one followed in this study. References to disagreements involving DCO cases in the abstract would be better described as disagreements involving DCO cases for which we subsequently retrieved clinical data. DCO cases are important because their exclusion from the sample can bias measurements of treatment and survival. In other papers we have attempted to measure the impact of DCO cases on national survival and the effect of losing them.3

In conclusion may we identify what we take to be the strengths of our paper? Our objective was to identify factors in the registration process affecting reliability. We showed error in three areas in which the registry has explicit written policies: the date of discharge, follow-up of DCO cases, six-month active follow-up of cases, and the coding criteria for date of diagnosis. The registry has responded positively to this audit and to our recommendations for improving the internal quality of registry data.


Medication errors during hospital drug rounds

In their paper Ridge et al set out to find the nature and rate of drugs given in error in one National Health Service (NHS) hospital. It is important to distinguish between the authors’ focus, which was errors that occurred at the time of the nurse giving the drug, and prescription errors that originate with the doctor and already exist on the prescription. Prescribing errors were not examined by the authors as their survey recorded only those errors that could be classed as deviations from the doctor’s medication order as written on the patient’s chart.2 Although it is important that hospitals do review the effectiveness of their current drug supply and administration systems (as the authors suggest), it is incorrect to support the seriousness of this argument with reference to the incidence of coroner’s records which concluded that about a fifth of deaths relating to prescribing and giving drugs were due to errors.3

In this review, a total of 3277 deaths came to inquest (3.8% of all deaths in the years 1986–91) and the review of coroner’s cases actually identified 46 relevant deaths (due to adverse drug reactions or errors in prescribing or giving drugs). Of these 46, death was attributed to errors in medication in 10 cases, with an even mix of primary and secondary care cases, but of these 10 most were due to prescribing errors with possibly only one death due to a nurse giving a drug in error (and that involved oxygen).

The overall risk of death due to errors or adverse drug reactions was judged to be very small – about one in 2000 of all deaths during the study period, and of course, unlike in the paper by Ridge et al, there was no baseline for the number of total events that were potentially adverse – that is, the number of doses of medicines prescribed and given during the six year period.


Preprinted assessment sheet

Goodyear and Lloyd pointed out the advantages of a preprinted assessment sheet,1 but I would like to point out the danger of implementing this method in the hospital setup, specially for junior doctors in training.

Good history taking in medicine has for generations been the main method of educating medical students and junior doctors. Full evaluation of the history of a patient’s complaints is crucial to making a correct diagnosis, and helps in planning the management. Every doctor spends the rest of his or her professional life relearning the lesson. The doctor’s first task is to listen and observe, not only to obtain information about the current problem but also to understand the patient as a whole and to learn about their life situation.2

Symptoms identified by taking a history provide some of the most important items of information used in the process of diagnosing a disease. When patients describe the symptoms for which they are seeking professional attention, they are also reporting the story of an illness as they have lived, and remembered it, and so it can vary. To some extent, symptoms are universal human experience. Virtually everyone experiences some discomfort for which he or she has no immediate help.

Talking with a patient has a third function: it helps that person to feel that he or she is understood, and it thereby helps to establish a therapeutic relation. A style of questioning narrowly shaped for the sole purpose of diagnosing a disease ignores much of what patients have experienced and many of their concerns and questions. It therefore often prevents the development of a trusting relation, and diminishes the chances of helping the patient. Talking with a patient about the experience of being ill, on the other hand, can have great value even when nothing can be done about the disease.3

Collecting information with a preprinted assessment sheet, or computer may be good for nurse or other staff, but is not advisable for young doctors in training. It is the duty of the senior experienced doctors to identify deficiencies in history taking by a junior doctor, and help him or her to rectify the deficiencies and to become a good clinician.

The disadvantage of a preprinted assessment sheet is that you forget to