The European Commission's science and knowledge service

Joint Research Centre

Introduction to ENCR and IACR recommendations

EXERCISE

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European Commission

Case 1 Multiple malignant tumours

- Sex: female (2)
- Date of birth: 15/9/1935

- Date of incidence: 15/10/2000
- Topography: breast (C50.9)
- Laterality: right (1)
- Morphology: lobular carcinoma (8520/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 15/2/2010
- Topography: upper-outer quadrant of breast (C50.4)
- Laterality: left (2)
- Morphology: infiltrating duct adenocarcinoma (8500/3)
- Basis of diagnosis: histology (7)

According to the ENCR/IACR recommendations:

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

Table 2. Groups of malignant neoplasms considered to be histologically 'different' for the purpose of defining multiple tumours (adapted from Berg JW. Morphologic classification of human cancer. In: Schottenfeld D & Fraumeni JF Jr. *Cancer Epidemiology and Prevention*, 2nd edition, Chapter 3 of Section 1: Basic Concepts. Oxford, New York, Oxford University Press, pp. 28-44, 1996).

Group	
Carcinomas	
1. Squamous and transitional cell carcinoma	8051-8084, 8120-8131
2. Basal cell carcinomas	8090-8110
3. Adenocarcinomas	8140-8149, 8160-8162, 8190-8221, 8260-8337, 8350-8551, 8570-8576, 8940-8941
4. Other specific carcinomas	8030-8046, 8150-8157, 8170-8180, 8230-8255, 8340-8347, 8560-8562, 8580-8671
(5) Unspecified carcinomas (NOS)	8010-8015, 8020-8022, 8050
6. *Sarcomas* and soft tissue tumours	8680-8713, 8800-8921, 8990-8991, 9040-9044, 9120-9125, 9130-9136, 9141-9252, 9370-9373, 9540-9582
7. ***Mesothelioma***	9050-9055

RECOMMENDATIONS FOR RECORDING

1. Two tumours of different laterality, but of the same morphology, diagnosed in paired organs (e.g. breast) should be registered separately unless stated to have originated from a single primary.

   Exceptions to this rule are:

   a) Tumours of the ovary (of the same morphology)
   b) Wilm's tumour (nephroblastoma) of the kidney.
   c) Retinoblastoma

   which should be recorded as a single bilateral registration when they occur on both sides.

   Reminder: tumours in paired organs of completely different histology should be registered separately.

2. Cancers which occur in any 4th character subcategory of colon (C18) and skin (C44) should be registered as multiple primary cancers.

Case 2 Multiple malignant tumours

- Sex: male (1)
- Date of birth: 15/03/1930

- Date of incidence: 15/04/2001
- Topography: bladder (C67.9)
- Morphology: urothelial carcinoma (8120/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 15/10/2004
- Topography: urethra (C68.0)
- Morphology: urothelial carcinoma (8120/3)
- Basis of diagnosis: histology (7)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

Table 1. Groups of topography codes considered a single site in the definition of multiple cancers

ICD-O-2/3 site code	Label	If diagnosed at different times, code first diagnosis. If diagnosed at the same time use codes given below.
C01	Base of tongue	
C02	Other and unspecified parts of tongue	C02.9
C00	Lip	
C03	Gum	
C04	Floor of mouth	
C05	Palate	
C06	Other and unspecified parts of mouth	C06.9
C09	Tonsil	
C10	Oropharynx	
C12	Pyriform sinus	
C13	Hypopharynx	
C14	Other and ill-defined sites in lip, oral cavity and pharynx	C14.0
C19	Rectosigmoid junction	
C20	Rectum	C20.9
C23	Gallbladder	
C24	Other and unspecified parts of biliary tract	C24.9
C33	Trachea	
C34	Bronchus and lung	C34.9
C40	Bones, joints and articular cartilage of limbs	
C41	Bones, joints and articular cartilage of other and unspecified sites	C41.9
C65	Renal pelvis	
C66	Ureter	
C67	Bladder	
C68	Other and unspecified urinary organs	C68.9

Case 3 Multiple malignant tumours

- Sex: male (1)
- Date of birth: 15/01/1933

- Date of incidence: 15/09/2007
- Topography: bladder (C67.9)
- Morphology: urothelial carcinoma (8120/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 15/10/2007
- Topography: unknown primary site (C80.9)
- Morphology: malignant tumour (8000/3)
- Basis of diagnosis: clinical investigation (2)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

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(5) Unspecified carcinomas (NOS)	8010-8015, 8020-8022, 8050
6. *Sarcomas* and soft tissue tumours	8680-8713, 8800-8921, 8990-8991, 9040-9044, 9120-9125, 9130-9136, 9141-9252, 9370-9373, 9540-9582
7. ***Mesothelioma***	9050-9055

Case 4 Multiple malignant tumours

- Sex: female (2)
- Date of birth: 27/11/1938

- Date of incidence: 5/5/2004
- Topography: rectum (C20.9)
- Morphology: adenocarcinoma (8140/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 17/6/2005
- Topography: intestinal tract (C26.0)
- Morphology: adenocarcinoma (8140/3)
- Basis of diagnosis: histology (7)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

Case 4 Multiple malignant tumours

- Sex: female (2)
- Date of birth: 27/11/1938

- Date of incidence: 5/5/2004
- Topography: rectum (C20.9)
- Morphology: adenocarcinoma (8140/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 17/6/2005
- Topography: intestinal tract (C26.0)
- Morphology: adenocarcinoma (8140/3)
- Basis of diagnosis: histology (7)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

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C02	Other and unspecified parts of tongue	C02.9
C00	Lip	
C03	Gum	
C04	Floor of mouth	
C05	Palate	
C06	Other and unspecified parts of mouth	C06.9
C09	Tonsil	
C10	Oropharynx	
C12	Pyriform sinus	
C13	Hypopharynx	
C14	Other and ill-defined sites in lip, oral cavity and pharynx	C14.0
C19	Rectosigmoid junction	
C20	Rectum	C20.9
C23	Gallbladder	
C24	Other and unspecified parts of biliary tract	C24.9
C33	Trachea	
C34	Bronchus and lung	C34.9
C40	Bones, joints and articular cartilage of limbs	
C41	Bones, joints and articular cartilage of other and unspecified sites	C41.9
C65	Renal pelvis	
C66	Ureter	
C67	Bladder	
C68	Other and unspecified urinary organs	C68.9

Case 6 Multiple malignant tumours / Haematological malignancies

- Sex: male (1)
- Date of birth: 27/12/1942

- Date of incidence: 5/3/2007
- Topography: bone marrow (C42.1)
- Morphology: hairy cell leukaemia (9940/3)
- Basis of diagnosis: cytology (5)

- Date of incidence: 17/9/2012
- Topography: bone marrow (C42.1)
- Morphology: Chronic lymphocytic leukaemia, B-cell type (9823/3)
- Basis of diagnosis: cytology (5)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

Tumours of haematopoietic and lymphoid tissues	
8. Myeloid	9840, 9861-9931, 9945-9946, 9950, 9961-9964, 9980-9987
9. B-cell neoplasms	9670-9699, 9728, 9731-9734, 9761-9767, 9769, 9823-9826, 9833, 9836, 9940
10. T-cell and NK-cell neoplasms	9700-9719, 9729, 9768, 9827-9831, 9834, 9837, 9948
11. Hodgkin lymphoma	9650-9667
12. Mast-cell Tumours	9740-9742
13. Histiocytes and Accessory Lymphoid cells	9750-9758
(14) Unspecified types	9590-9591, 9596, 9727, 9760, 9800-9801, 9805, 9820, 9832, 9835, 9860, 9960, 9970, 9975, 9989
15. ***Kaposi sarcoma***	9140
16. ***Other specified*** types of cancer	8720-8790, 8930-8936, 8950-8983, 9000-9030, 9060-9110, 9260-9365, 9380- 9539
(17) ***Unspecified*** types of cancer	8000-8005

Appendix *(continued)*

Major subgroups according to the World Health Organisation (WHO) Classification	Initial diagnosis	Morphology code of the first HM	Major WHO subgroups and morphology codes probably referring to the same tumour as the first HM (see note 3)	Major WHO subgroups and morphology codes referring to potential transformation of the first HM (see note 3)
	Follicular lymphoma, grade 1	9695/3	9590/3, 9591/3, 9597/3, 9670/3, 9690/3, 9691/3, 9698/3	9680/3, 9687/3, 9826/3, 9836/3, 9728/3, 9811/3-9818/3
	Marginal zone lymphoma	9699/3	9590/3, 9591/3, 9670/3, 9689/3	9680/3,
	Heavy chain disease	9762/3	9590/3, 9591/3, 9670/3, 9671/3, 9760/3, 9761/3, PCN	9680/3,
	Immunoproliferative small intestinal disease	9764/3	9590/3, 9591/3,9760/3	9680/3
	Hairy cell leukaemia	9940/3	9590/3, 9591/3, 9670/3, 9800/3, 9820/3, 9823/3	9680/3
Mature B-cell neoplasms (MBCN), aggressive	Mantle cell lymphoma	9673/3	9590/3, 9591/3, 9596/3, 9675/3, 9680/3, 9800/3, 9820/3	
	Primary effusion lymphoma	9678/3	9590/3, 9591/3, 9596/3, 9675/3, 9679/3, 9680/3, 9684/3, 9687/3, 9688/3, 9698/3, 9712/3, 9735/3, 9737/3, 9738/3	

Case 7 Multiple malignant tumours / Haematological malignancies

- Sex: male (1)
- Date of birth: 27/7/1924

- Date of incidence: 5/10/2005
- Topography: Lymph nodes of head (C77.0)
- Morphology: classical Hodgkin lymphoma, mixed cellularity (9652/3)
- Basis of diagnosis: histology (7)

- Date of incidence: 17/10/2006
- Topography: Lymph nodes of multiple regions (C77.8)
- Morphology: peripheral T-cell lymphoma (9702/3)
- Basis of diagnosis: histology (7)

- How many cases would you register? If you would register only one tumour, please specify topography and morphology.
- How many cases would you include for incidence analysis? If you would include only one tumour, please specify topography and morphology.

Tumours of haematopoietic and lymphoid tissues	
8. Myeloid	9840, 9861-9931, 9945-9946, 9950, 9961-9964, 9980-9987
9. B-cell neoplasms	9670-9699, 9728, 9731-9734, 9761-9767, 9769, 9823-9826, 9833, 9836, 9940
10. T-cell and NK-cell neoplasms	9700-9719, 9729, 9768, 9827-9831, 9834, 9837, 9948
11. Hodgkin lymphoma	9650-9667
12. Mast-cell Tumours	9740-9742
13. Histiocytes and Accessory Lymphoid cells	9750-9758
(14) Unspecified types	9590-9591, 9596, 9727, 9760, 9800-9801, 9805, 9820, 9832, 9835, 9860, 9960, 9970, 9975, 9989
15. ***Kaposi sarcoma***	9140
16. ***Other specified*** types of cancer	8720-8790, 8930-8936, 8950-8983, 9000-9030, 9060-9110, 9260-9365, 9380- 9539
(17) ***Unspecified*** types of cancer	8000-8005

Appendix *(continued)*

Major subgroups according to the World Health Organisation (WHO) Classification	Initial diagnosis	Morphology code of the first HM	Major WHO subgroups and morphology codes probably referring to the same tumour as the first HM (see note 3)	Major WHO subgroups and morphology codes referring to potential transformation of the first HM (see note 3)
	T-cell large granular lymphocytic leukaemia	9831/3	Other MTCN, 9590/3, 9591/3, 9800/3, 9820/3, 9832/3	
	T-cell prolymphocytic leukaemia	9834/3	Other MTCN, 9590/3, 9591/3, 9800/3, 9820/3, 9832/3	
	Aggressive NK-cell leukaemia	9948/3	Other MTCN, 9800/3, 9801/3, 9805/3-8909/3, 9820/3	
Hodgkin lymphoma (HL)	Hodgkin lymphoma, NOS	9650/3	Other HL, 9590/3, 9596/3	
	Lymphocyte-rich classical Hodgkin lymphoma	9651/3	Other HL, 9590/3, 9596/3	
	Mixed cellularity classical Hodgkin lymphoma	9652/3	Other HL, 9590/3, 9596/3	
	Lymphocyte-depleted classical	9653/3	Other HL, 9590/3, 9596/3	

Case 8 Method of Detection in Relation to Screening

- Sex: female (2)
- Date of birth: 15/9/1955

- 15/10/2005. Invited to attend a mammography within the local organised breast cancer screening programme: Not attended
- 15/11/2005. Remind invitation to screening : Not attended
- 15/04/2008. Invited to attend a mammography within the local organised screening programme. Attended, asymptomatic. Mammography: highly suspect for cancer.
- 22/04/2008. Invited for urgent second level tests by the screening programme. Not attended
- 16/05/2008. Pathology report from a private Pathology lab. Breast biopsy: Ductal adenocarcinoma

According to the ENCR recommendations for coding Method of Detection in Relation to Screening how should the method of detection in relation to screening be coded?

1) Screen detected
2) Interval cancer
3) Other
4) Unknown or not applicable

ENCR recommendations for coding Method of Detection in Relation to Screening

The old codes for 'method of first detection' in 'Cancer Registration: Principles and Methods' (p. 56) are no longer considered relevant due to the difficulty in differentiating between a true 'incidental finding' and 'clinical presentation (with symptoms)', and to the currently low proportion of deaths with autopsy ('incidental finding at autopsy').

With respect to screening, evaluation and monitoring of a programme ideally require that the records of the screening programme, and cancer registries, are linked. This allows, e.g, separation of cancers in non-respondents or non-invited individuals.

1. Where feasible, cancer registries should collect a data item called '**Method of Detection in Relation to Screening**'.

    - The item has utility only in the evaluation and monitoring of organised cancer screening programmes. It is not useful to record cancer cases detected by unorganised screening programmes, or by opportunistic screening.

    - Each registry should define the sites, the screening tests and the populations concerned.

    - An 'organised screening programme' is defined as 'men and/or women in an identified population, invited to participate in a screening programme'.

    - Each registry should define 'screening', i.e., early detection of disease by a screening test (e.g. for breast it would be mammography, for cervix pap smear, etc.).

    - 'Early detection of disease by a screening test' should be defined as the initiation of the diagnostic process by a positive result in the screening test.

2. Where possible, registries should code the **Method of Detection in Relation to Screening** using the following codes:

    1) Screen detected
    2) Interval cancer (according to local definition)*
    8) Other
    9) Unknown or not applicable

    - Whatever codes are used, they should be exclusive (no overlap).

* The time interval between a negative screen and diagnosis should be recorded.

Case 9 Method of Detection in Relation to Screening

- Sex: female (2)
- Date of birth: 15/9/1955

- 15/10/2005. Invited to attend a mammography within the local organised breast cancer screening programme. Attended, asymptomatic. Mammography: negative
- 15/10/2007. Invited to attend a mammography within the local organised breast cancer screening programme. Attended, asymptomatic. Mammography: negative
- 15/10/2009. Invited to attend a mammography within the local organised breast cancer screening programme. Attended, asymptomatic. Mammography: negative
- 15/02/2010. Pathology report from a private Pathology lab. Breast biopsy: Ductal adenocarcinoma

- According to the ENCR recommendations for coding Method of Detection in Relation to Screening how should the method of detection in relation to screening be coded?

- 1) Screen detected
- 2) Interval cancer
- 3) Other
- 4) Unknown or not applicable

ENCR recommendations for coding Method of Detection in Relation to Screening

The old codes for 'method of first detection' in 'Cancer Registration: Principles and Methods' (p. 56) are no longer considered relevant due to the difficulty in differentiating between a true 'incidental finding' and 'clinical presentation (with symptoms)', and to the currently low proportion of deaths with autopsy ('incidental finding at autopsy').

With respect to screening, evaluation and monitoring of a programme ideally require that the records of the screening programme, and cancer registries, are linked. This allows, e.g, separation of cancers in non-respondents or non-invited individuals.

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    - An 'organised screening programme' is defined as 'men and/or women in an identified population, invited to participate in a screening programme'.

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2. Where possible, registries should code the **Method of Detection in Relation to Screening** using the following codes:

    1) Screen detected
    2) Interval cancer (according to local definition)*
    8) Other
    9) Unknown or not applicable

    - Whatever codes are used, they should be exclusive (no overlap).

* The time interval between a negative screen and diagnosis should be recorded.

Case 10 Current Recommendations on Date of Incidence

- Sex: man (1)
- Date of birth: 15/9/1955

- Heavy smoker since 30 years
- In July 2005 after a long period of lasting cough visit to his MP
- In July 2005. X ray thorax examination: nodule suspect for cancer in the upper right lobe.
- In August. Lung CT Scan: three nodules (4.5 mm, 1.5mm, 0.9mm) suspect for cancer in the upper right lobe.
- 15/09/2005 Day hospital for lung nodule biopsy for suspected lung cancer. Pneumothorax
- 15/09/2005 hospital admission for Pneumothorax in suspected lung cancer
- 03/10/2005 Death due to Respiratory failure in Lung Cancer
- According to the ENCR recommendations for coding Incidence Date which is the right DoI?

- 1) July 2005
- 2) August 2005
- 3) 15.09.2015
- 4) 03/10/2005

European Network of Cancer Registries (ENCR)

Recommendations for coding Incidence Date

The date of the first event (of the six listed below) to occur chronologically should be chosen as incidence date. If an event of higher priority occurs within three months of the date initially chosen, the date of the higher priority event should take precedence.

Order of declining priority:

1. Date of first histological or cytological confirmation of this malignancy (with the exception of histology or cytology at autopsy). This date should be, in the following order:

   a) date when the specimen was taken (biopsy)
   b) date of receipt by the pathologist
   c) date of the pathology report.

2. Date of admission to the hospital because of this malignancy.

3. When evaluated at an outpatient clinic only: date of first consultation at the outpatient clinic because of this malignancy.

4. Date of diagnosis, other than 1, 2 or 3.

5. Date of death, if no information is available other than the fact that the patient has died because of a malignancy.

6. Date of death, if the malignancy is discovered at autopsy.

Whichever date is selected, the date of incidence should not be later than the date of the start of the treatment, or decision not to treat, or date of death.

The choice of the date of incidence does not determine the coding of the item "basis of diagnosis".

Working Group Members:

Dr Derek Pheby (Chairman), University of West of England, Bristol, UK
Dr Carmen Martínez, Granada Cancer Registry, Granada, Spain
Dr Martine Roumagnac, Tarn Cancer Registry, Albi, France
Dr Leo Schouten, Maastricht Cancer Registry, Maastricht, The Netherlands

Case 11 Current Recommendations on Date of Incidence

- Sex: man (1)
- Date of birth: 15/9/1955

- Heavy smoker since 30 years
- In July 2005 after a long period of lasting cough visit to his MP
- In July 2005. X ray thorax examination: nodule suspect for cancer in the upper right lobe.
- In August. Lung CT Scan: three nodules (4.5 mm, 1.5mm, 0.9mm) suspect for cancer in the upper right lobe.
- 03/10/2005 Pathology report: Squamous cell carcinoma
- 12/11/2005 Hospital admission for lung lobectomy
- 25/11/2005 Pathology report: No further evidence of cancer
- 03/04/2006 Death for myocardial infarction

- According to the ENCR recommendations for coding Incidence Date which is the right DoI?

- 1) July 2005
- 2) August 2005
- 3) 03/10/2005
- 4) 12/11/2005
- 5) 25/11/2005
- 6) 03/04/2006

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   c) date of the pathology report.

2. Date of admission to the hospital because of this malignancy.

3. When evaluated at an outpatient clinic only: date of first consultation at the outpatient clinic because of this malignancy.

4. Date of diagnosis, other than 1, 2 or 3.

5. Date of death, if no information is available other than the fact that the patient has died because of a malignancy.

6. Date of death, if the malignancy is discovered at autopsy.

Whichever date is selected, the date of incidence should not be later than the date of the start of the treatment, or decision not to treat, or date of death.

The choice of the date of incidence does not determine the coding of the item "basis of diagnosis".

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Dr Leo Schouten, Maastricht Cancer Registry, Maastricht, The Netherlands

Case 12 Recommendations for coding Bladder Tumours

- Sex: man (1), Date of birth: 15/9/1955, Heavy smoker since 30 years
- In July 2005 haematuria
- In July 2005. ECO abdomen: polyp in the urinary bladder
- In August 2005. Cystoscopy: Biopsy of the polyp (1) and other random biopsies (2,3,4). It is a University Hospitals and different trainee Pathologists examined the samples and wrote the report.
- 15/09/2005 Pathology report: (1) papillary urothelial tumours, (2) grade I (WHO) carcinoma without signs of invasion (3) low grade papillary urothelial tumour (4) well-differenciated not invasive papillary
- According to the ENCR recommendations for coding Bladder Tumours how many tumours is correct to register?
- 1) 0
- 2) 1
- 3) 2
- 4) 3
- 5) 4

How many of them are /1?

- 1) 0
- 2) 1
- 3) 2
- 4) 3
- 5) 4

How many of them are /2?

- 1) 0
- 2) 1
- 3) 2
- 4) 3
- 5) 4

How many of them are /3?

- 1) 0
- 2) 1
- 3) 2
- 4) 3
- 5) 4

Recommendations for coding Bladder Tumours

Distributed in 1995

All bladder tumours should be registered, whatever the histological type and level of invasion.

Principles

The coding of tumour behaviour (/1, /2, /3) takes into account both the anatomopathological definition and the extent of invasion. It is, therefore, essential to have access to reports of any pathological examinations.

Rules

Tumour behaviour code: /1

Normal or slightly abnormal histology: low grade papillary urothelial tumours, not invasive.
In the various anatomopathological classifications these tumours are called:

. benign or simple papillomas,
. papillary urothelial tumours,
. stage I carcinoma (BRODERS' classification),
. well-differentiated papillary carcinoma (JEWETT's classification),
. grade I carcinoma (in the WHO classification), or
. classes I and lls (CHOME's classification).

Extent of invasion - none.

Case 13 Current Recommendations on Basis of Diagnosis

- Sex: man (1)
- Date of birth: 15/9/1955

- Heavy smoker since 30 years
- In July 2005 after a long period of lasting cough visit to his MP
- In July 2005. X ray thorax examination: nodule suspect for cancer in the upper right lobe.
- In August. Lung CT Scan: three nodules (4.5 mm, 1.5mm, 0.9mm) suspect for cancer in the upper right lobe.
- 15/09/2005 Day hospital for lung nodule biopsy for suspected lung cancer.
- 15/09/2005 Biopsy was taken
- 03/10/2005 Biopsy Pathology report: Squamous cell carcinoma
- 18/10/2005 Hospital admission for Lobectomy
- 20/10/2005 Date of surgery
- 02/11/2005 Lobectomy Pathology report: Squamous cell carcinoma
- 07/01/2006 start of an out-patient chemotherapy
- 03/10/2007 Death due to Respiratory failure in Lung Cancer
- According to the ENCR recommendations for coding Basis of Diagnosis which is the most valid one?

- 1) July 2005 Clinical
- 1) July 2005 Clinical investigation (X ray)
- 2) August 2005 Clinical Investigation (Scan)
- 2) 15/09/2005 Day Hospital
- 7) 15/09/2005 Date when the specimen was taken
- 1) 18/10/2005 Clinical Hospital
- 1) 20/10/2005 Clinical date of surgery
- 7) 20/10/2005 Date when the specimen was taken
- 7) 02/11/2005 Date of the pathology report
- 1) 07/01/2006 Clinical
- 0) 03/10/2007 Death certificate only

Recommendations for coding Basis of Diagnosis

Distributed in 1999

Registries may choose to record all of the notifications which they receive for a given cancer case (including date, source, and basis of diagnosis). This permits calculations of the number of notifications per case, number of sources per case, and the number of death certificate notifications (DCN).

However, for comparison between registries, and as a measure of Validity, only the "most valid basis of diagnosis" is required.

The suggested codes are hierarchical, so that the higher number represents the more valid basis, and should thus be used for this purpose.

If there is no information on how the diagnosis had been made (information obtained from an automated source, for example) the code 9 (Unknown) should be used. Such cases are excluded from calculations of the percentage of cases diagnosed clinically, microscopically, by death certificate alone, etc.

Table 1

CODE	DESCRIPTION	CRITERIA
0	**Death Certificate Only**	The only information to the registry is from a death certificate.
Non Microscopic		
1	**Clinical**	Diagnosis made before death, but without the benefit of any of the following (2-7)
2	**Clinical investigation**	To include all diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g., laparotomy) and autopsy, without a tissue diagnosis.
4	**Specific tumour markers**	To include biochemical and/or immunological markers which are specific for a tumour site (Table 2).
Microscopic		
5	Cytology	Examination of cells whether from a primary or secondary site, including fluids aspirated using endoscopes or needles. Also to include the microscopic examination of peripheral blood films and trephine bone marrow aspirates.
6	Histology of a metastasis	Histological examination of tissue from a metastasis, including autopsy specimens.
7	Histology of a primary tumour	Histological examination of tissue from the primary tumour, however obtained, including all cutting techniques and bone marrow biopsies. Also to include autopsy specimens of a primary tumour.
9	Unknown	