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Joint Research Centre

Introduction to ENCR and IACR recommendations

E Crocetti, C Martos

European Commission, Directorate General Joint Research Centre, Directorate F – Health, Consumers and Reference Materials, Health in Society Unit

European Commission

Recommendations for CRs

1. Why do we need recommendations?
2. How many recommendations are there? For what?

   Which ones do CRs have to follow?
3. What's the effect of different recommendations?
4. Why do we need to update current recom.?
5. Where are they available?
6. What is ENCR-SC doing?

Conventions used to improve comparability

Bray F, Parkin DM.
Evaluation of data quality in the cancer registry: principles and methods. Part I: comparability, validity and timeliness.
Eur J Cancer. 2009;45(5):747-55.

Parkin DM, Bray F.
Evaluation of data quality in the cancer registry: principles and methods. Part II. Completeness.
Eur J Cancer. 2009;45(5):756-64.

More extensive rules

More restrictive rules

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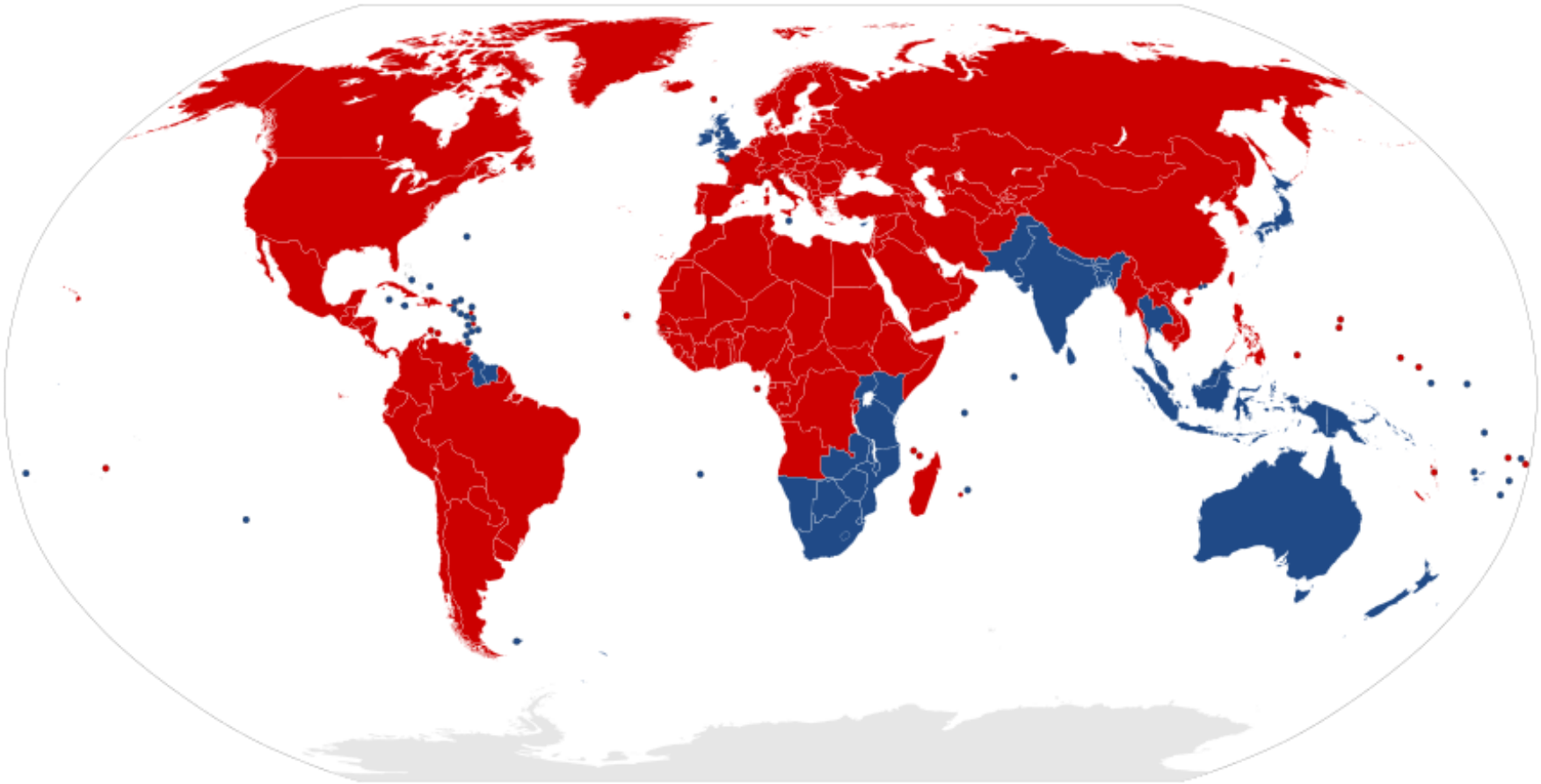
Wikipedia: Countries by handedness of traffic, c. 2016 Right-hand traffic Left-hand traffic



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‘Average’ and unfrequent cases

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RECORDING

VS

REPORTING

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.

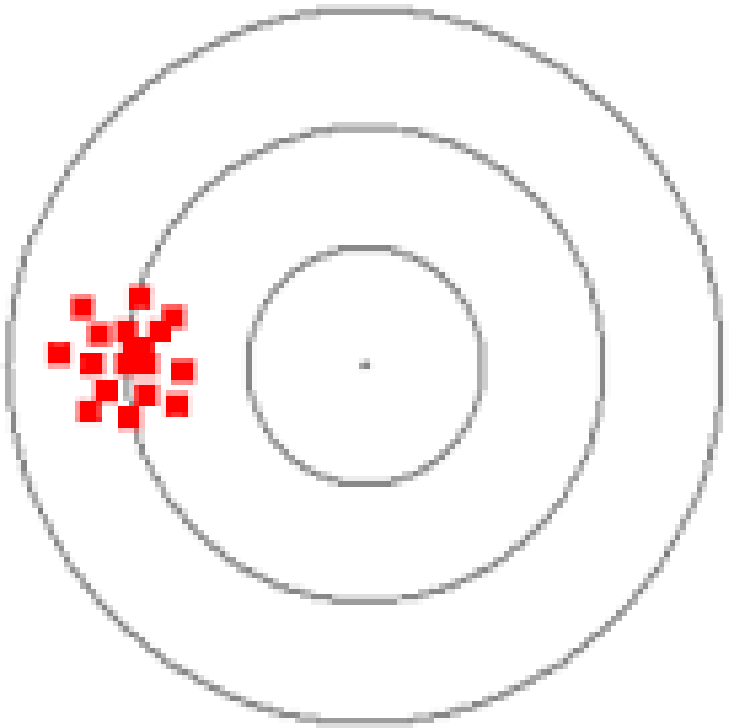
   Reminder: tumours in paired organs of completely different histology should be registered separately.

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

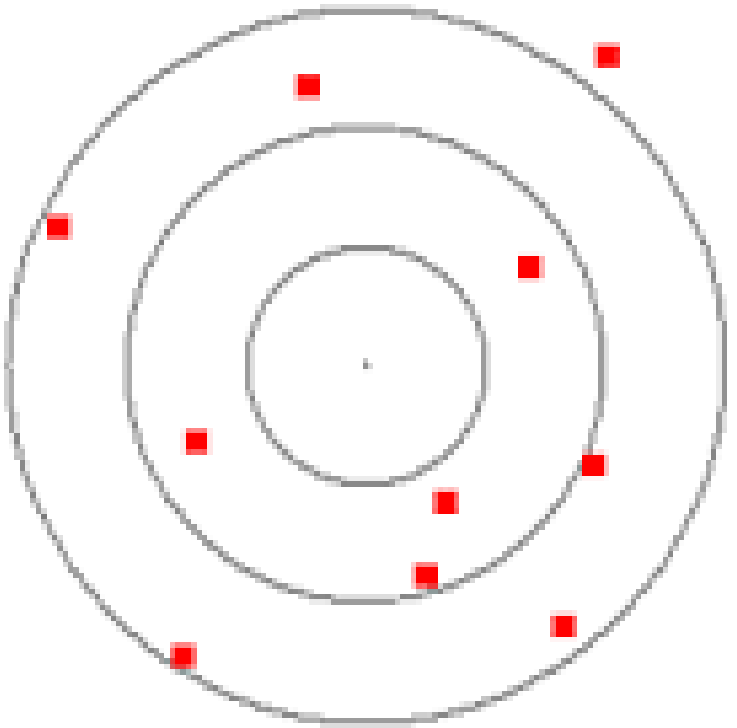
Table 5.1. The percentage difference in crude and age-standardized incidence rates (at selected body sites) within the SEER (9 registries) 2003–2007 dataset when determined using the SEER rules for multiple primary tumours versus the IARC/IACR rules (2004)

Body site	Difference in incidence rates using the SEER rules vs the IARC/IACR rules (%)			
	Males		Females	
	Crude	Age-standardized	Crude	Age-standardized
Colon	4.5	4.2	4.5	3.7
Lung	1.7	1.7	1.9	1.9
Skin (melanoma only)	9.0	8.4	5.4	4.9
Breast	–	–	8.7	8.0
Testis	2.1	2.0	–	–
Kidney	2.8	2.9	2.1	2.2
All sites except skin	1.6	1.4	3.0	2.8

Cancer Incidence in Five Continents, Vol. X.



Systematic Error



Random Error

Comparability

Requires consideration of:

Registry's procedures:

- standards and definitions used:
  - system for classifying and coding
  - cases to be included
  - date of incidence
  - multiple primaries
  - incidental diagnosis (cancers detected in asymptomatic subjects)
    - screen-detected cancers
    - autopsy diagnosis
  - bases of diagnosis

http://publications.iarc.fr/Book-And-Report-Series/Iarc-Scientific-Publications/Cancer-Incidence-In-Five-Continents-Volume-X-2014

Bray F, Parkin MD. 2009

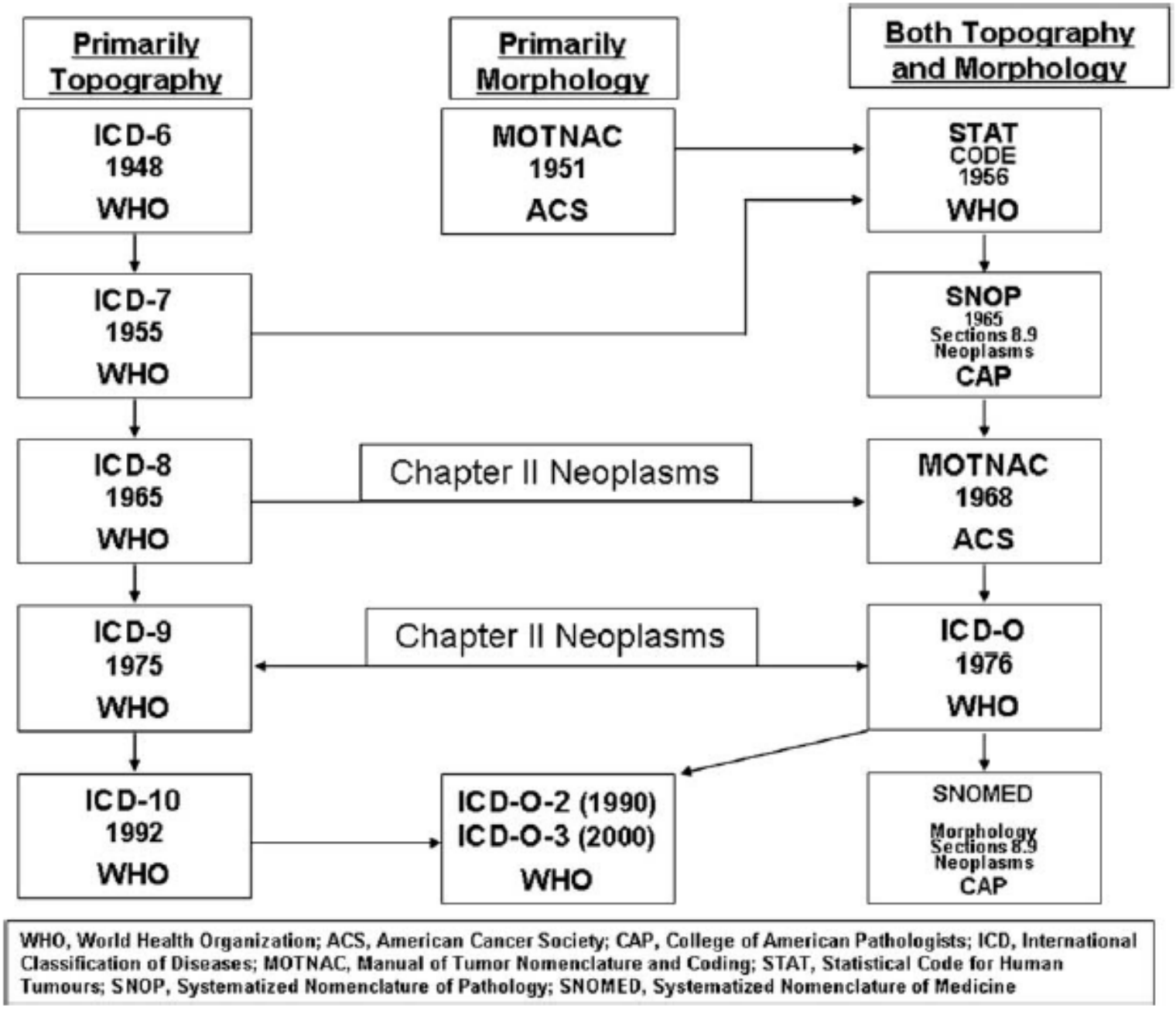


Fig. 1 – Evolution of the international classification of system for cancers (site and morphology).

THE ROLE OF INTERPRETATION

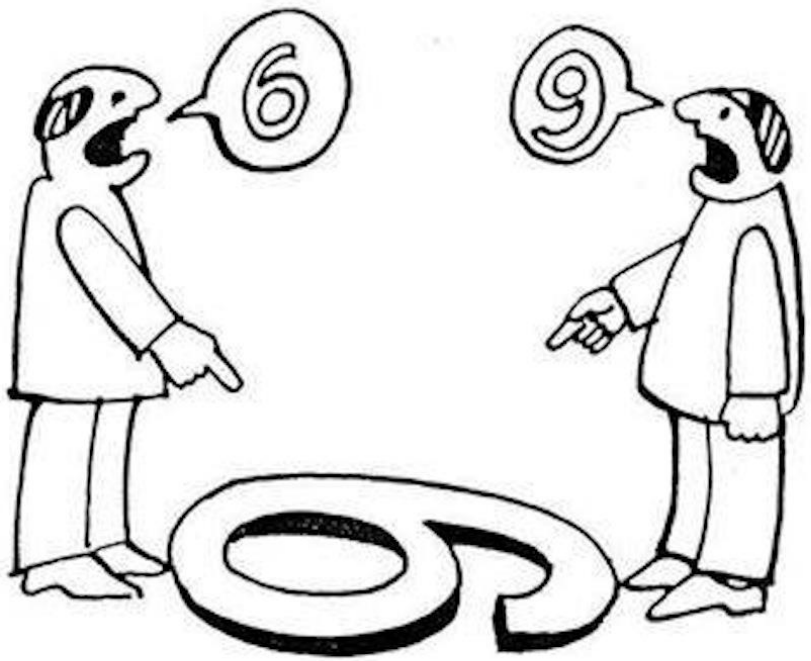


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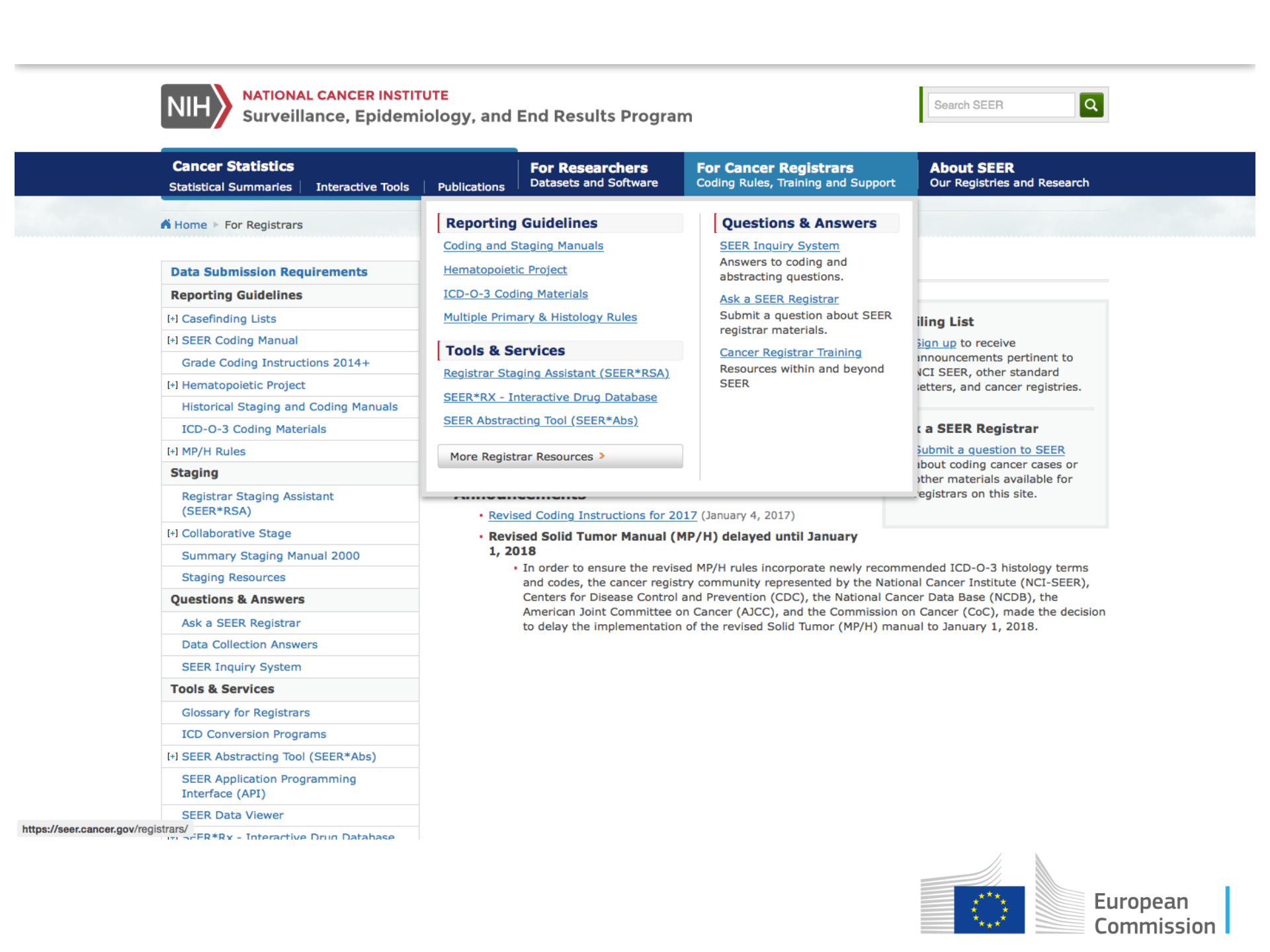
Table 3.2. (Contd) Coding practices of the registries included in CI5 Volume X

Registry	Behaviour codes							
	Benign tumours of brain and nervous system	Carcinoma of bladder, in situ	Carcinoma of bladder, not otherwise specified	Ovarian cystadenoma of borderline malignancy	Borderline tumour of ovary	Ductal carcinoma of breast, in situ	Intraductal carcinoma of breast, not otherwise specified	Lobular carcinoma of breast, in situ
Malaysia, Penang	0	3	1	3	3	3	3	3
Philippines, Manila	1	2	3	1	1	2	2	2
Philippines, Rizal	1	2	3	1	1	2	2	2
Qatar: Qatari	0	2	3	1	1	2	2	2
Saudi Arabia, Riyadh: Saudi	0	2	3	1	1	2	2	2
Singapore	0	2	1	1	1	2	2	2
Thailand, Bangkok	0	2	3	1	1	2	2	2
Thailand, Chiang Mai	0	2	3	1	3	2	3	2
Thailand, Chonburi	0	2	3	1	1	2	2	2
Thailand, Khon Kaen	0	2	3	1	1	2	2	2
Thailand, Lampang	0	2	3	1	1	2	3	2
Thailand, Songkhla	0	2	3	1	1	2	2	2
Turkey, Antalya	0	2	3	1	1	2	2	2
Turkey, Edirne	0	2	3	1	1	2	2	2
Turkey, İzmir	0	2	3	1	1	2	3	2
Turkey, Trabzon	0	2	3	1	1	2	2	2
Europe								
Austria	0	2	1	1	1	2	3	2
Austria, Tyrol	0	2	3	1	1	2	2	2
Austria, Vorarlberg	0	2	3	1	1	2	3	2
Belarus	0	2	3	3	1	2	3	2
Belgium	1	2	3	1	1	2	2	2
Bulgaria	0	2	3	3	1	2	3	2
Croatia	0	2	3	1	1	2	2	2
Cyprus	0	2	3	1	1	2	2	2
Czech Republic	0	2	3	3	3	2	3	2
Denmark	0	2	3	3	1	2	2	2
Estonia	0	2	3	3	1	2	3	2
Finland	0	2	3	1	1	2	2	2
France, Bas-Rhin	0	2	3	1	1	2	2	2
France, Calvados	1	2	3	1	1	2	2	2
France, Doubs	0	2	3	1	1	2	2	2
France, Haut-Rhin	0	2	3	1	1	2	2	2
France, Hérault	0	2	1	1	1	2	2	2
France, Isère	0	2	3	1	1	2	2	2
France, Loire-Atlantique	1	2	3	1	1	2	2	2
France, Manche	0	2	3	1	2	2	2	2
France, Somme	0	2	1	1	1	2	2	2
France, Tarn	0	2	1	1	1	2	2	2
France, Vendée	1	2	3	1	1	2	2	2
Germany, Brandenburg	0	2	3	1	1	2	2	2
Germany, Bremen	0	2	3	1	1	2	2	2
Germany, Free State of Saxony	0	2	3	1	1	2	2	2
Germany, Hamburg	0	2	3	1	1	2	3	2
Germany, Mecklenburg-Western Pomerania	0	2	3	1	1	2	2	2
Germany, Munich	0	2	3	1	1	2	2	2
Germany, North Rhine-Westphalia	0	2	3	1	1	2	3	2
Germany, Saarland	0	2	3	3	3	2	3	2
Germany, Schleswig-Holstein	0	2	3	1	1	2	2	2
Iceland	1	2	3	1	1	2	2	2

THE ROLE OF INTERPRETATION

Theoretically, the use of a standard, well-designed coding system such as ICD should make the analysis and tabulation of comparable results a simple matter. But in practice, it has been a continual exercise in detection for the editors of CI5 to establish exactly how registries code various cancers. For the present volume, registries were asked whether any malignant diagnoses were excluded from their data, and how they coded intraductal carcinoma of breast, NOS; ductal and lobular carcinoma in situ of breast; ovarian cystadenoma of borderline malignancy; borderline tumour of ovary; benign tumours of brain and nervous system; and in situ and unspecified carcinoma of bladder (see Table 3.2).

Cancer Incidence in Five Continents, Vol. X.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ICD-O-3 Coding Materials
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Staging
Registrar Staging Assistant (SEER*RSA)
[+] Collaborative Stage
Summary Staging Manual 2000
Staging Resources
Questions & Answers
Ask a SEER Registrar
Data Collection Answers
SEER Inquiry System
Tools & Services
Glossary for Registrars
ICD Conversion Programs
[+] SEER Abstracting Tool (SEER*Abs)
SEER Application Programming Interface (API)
SEER Data Viewer
Revised Coding Instructions for 2017 (January 4, 2017)
Revised Solid Tumor Manual (MP/H) delayed until January 1, 2018
In order to ensure the revised MP/H rules incorporate newly recommended ICD-O-3 histology terms and codes, the cancer registry community represented by the National Cancer Institute (NCI-SEER), Centers for Disease Control and Prevention (CDC), the National Cancer Data Base (NCDB), the American Joint Committee on Cancer (AJCC), and the Commission on Cancer (CoC), made the decision to delay the implementation of the revised Solid Tumor (MP/H) manual to January 1, 2018.
https://seer.cancer.gov/registrars/
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IACR
International Association of Cancer Registries

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Home > Support for registries > Standards

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- Software for cancer registries
- Training
- Fellowships program
- ICD-O-3
- Registries portal
- **Standards**

IACR Standards

The information generated by cancer registries has a wide variety of uses, in epidemiological research, in planning and evaluation of cancer control measures, and in monitoring some standards of clinical care. So that comparisons between different registries, countries, and over time can be made with confidence, it is essential that certain definitions, for collecitng, coding and presenting data, are comparable between registries.

The encouragement of such comparative studies is one of the objectives of IACR. Thus, to aid this process, the IACR has developed classifications (the successive editions of the International Classification of Diseases for Oncology, published by WHO), guidelines for registry practices and standard definitions.

As the guidelines available are produced or revised, they will be made available on this site.

INTERNATIONAL RULES FOR MULTIPLE PRIMARY CANCERS (ICD-O Third Edition)

BASIS OF DIAGNOSIS

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International Association of Cancer Registries
c/o International Agency for Research on Cancer

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- Email: iacr@iarc.fr

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International Agency for Research on Cancer
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ENCR

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http://www.encr.eu/

Standard dataset			10 February 2005
Incidence Date	Dr Derek Pheby, UK Dr Carmen Martínez, Spain Dr Martine Roumagnac, France Dr Leo Schouten, The Netherlands		Distributed in 1995 Revised in 1997
Multiple Primaries	from ENCR: Dr Paule-Marie Carli, France Dr Isabel Izarzugaza, Spain Dr Beata Koscianska, Poland		Distributed in 1995 Revised in 2000 Revised in 2004
Bladder Tumours	Dr Derek Pheby, UK Dr Martine Sauvage, France Dr Carmen Martínez, Spain Dr Leo Schouten, The Netherlands		Distributed in 1995
Tumours of the Brain and Central Nervous System	Dr Derek Pheby, UK Dr M. Sant, Italy Dr J. Ironside, UK Prof. W.M. Molenaar, The Netherlands		Distributed in 1998
Leukaemias and Lymphomas	Dr R. Otter, The Netherlands Dr A. Astudillo, Spain Professor P.M. Carli, France Dr A. Jack, UK Dr H. van Krieken, The Netherlands		
Basis of Diagnosis	Dr J. Smith, UK Dr R. Frost, UK Dr L. Teppo, Finland Dr O. Visser, The Netherlands		Distributed in 1999
Non-Melanoma Skin Cancers	Dr T. Davies, UK Mrs M. Page, UK Dr J.W. Coebergh, The Netherlands		Distributed in 2000
Method of Detection in Relation to Screening	Dr Leo Schouten, The Netherlands Dr Hannes Botha, UK Dr Eugenio Paci, Italy		Distributed in 2001
Confidentiality in Cancer registration	Dr Hans Storm, Denmark Dr Eva Buiatti, Italy Dr Timo Hakulinen, Finland Dr Hartwig Ziegler, Germany		Distributed in 2002
Condensed TNM for Coding the Extent of Disease	Dr F. Berrino, Italy Dr C. Brown, UK Dr T. Möller, Sweden Dr L. Sobin, USA With: Dr J. Faivre, France		Distributed in 2002
Structured Registry Review	Dr David Brewster, UK Dr Willi Oberaigner, Austria Dr Eero Pukkala, Finland		

Comparability Which recommendations face these topics?

Requires consideration of:

Registry's procedures:

- standards and definitions used:
  - system for classifying and coding
  - cases to be included
  - date of incidence
  - multiple primaries
  - incidental diagnosis (cancers detected in asymptomatic subjects)
    - screen-detected cancers
    - autopsy diagnosis
  - bases of diagnosis

Cases to be included

THE TUMOUR	
Incidence date	This date should be given priority as outlined by the ENCR recommendations as indicated here A-D. *(Optional: In order to have comparability more dates should be collected, preferably all included in the definition)*
A: Date of first histological/cytological confirmation of the tumour	Date of biopsy or date of pathology or date of pathology report (dd/mm/yyyy)
B: Date of first hospital admission or contact	May be the date of first out-patient visit for the disease (dd/mm/yyyy)
C: Other date of diagnosis	e.g. GP visit (dd/mm/yyyy)
D: Date of death	For cases discovered at death/autopsy or unknown (dd/mm/yyyy)
Primary tumour site	This should as a minimum be according to the ICD-O
Laterality	This should be recorded for all paired organs, but as a minimum for breast, eye, ovary, testis and kidney (but observe the multiple primary rules)
Primary tumour histology	This should as a minimum be according to the ICD-O

				6 → Histology of a metastasis 7 → Histology of a primary tumour 9 → Unknown Warning for value = 9
ICD-O-3 topography (topography of the metastasis is not admitted)	A4	Y	Not allowed	Valid code in ICD-O-3. Warning for undefined topography when BoD is 5 or 7 C809; C76 (C760, C761, C762, C763, C764, C765, C767 and C768); C14 (C140, C148); C26 (C260, C268, C269); C39 (C390, C398, C399); C559; C579; C639; C689; C729; C759

F: Numeric variable A: Alphanumeric variable Y=yes N=not
* If complete date of birth and/or date of incidence are missing or unknown.

Table 1. (cont.)

Variable description	Format	Mandatory	Missing/unknown values	Allowed values	
ICD-O-3 morphology	F4	Y	Not allowed	Valid code in ICD-O-3 and updated in 2011	Valid code in ICD-O-3 and updated in 2011 Warning for undefined morphology taking into account BoD (See *Figure 2*, p. 30)
ICD-O-3 behaviour	F1	Y	Not allowed	Accepted value: 0-3	
Incidental finding of cancer at the autopsy	F1	Y	9	Allowed values: 0, 1, 9 0 → No 1 → Yes 9 → Unknown Warning for value = 9	
ICD-O-3 grade	F1	Y	9	Allowed values: 1-9 1 → Well differentiated; 2 → Moderately differentiated 3 → Poorly differentiated 4 → Undifferentiated, anaplastic 5 → T-cell; T-precursor 6 → B-Cell; Pre-B; B-precursor 7 → Null cell; Non T-non B 8 → NK cell (natural killer cell) 9 → Unknown	

From: Quality check harmonization, 2014

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2. Case definition and variable format quality checks

The cancer data quality check list included in this report is based on the following case definition for CRs and European projects.

2.1. Case definition

- All primary malignant tumours (behaviour = 3), including basal cell and squamous cell carcinomas of skin.
- Benign tumours of the central nervous system (CNS).
- Uncertain behaviour tumours of CNS and urinary bladder.
- In situ tumours: breast, cervix, colon, rectum, urinary bladder and melanoma of the skin.

An extent of this case definition could be considered according to the European CRs needs in the future.

2.2

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From: Quality check harmonization, 2014

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ENCR RECOMMENDATIONS

Non-Melanoma Skin Cancers

1. Non-melanoma skin cancers to be recorded

Non-melanoma skin cancers are extremely common in some European populations. Each registry must decide whether it has the necessary resources to record all such cancers, and whether the costs involved are reasonable, with respect to the utility of the resulting statistics. In general terms, these are

- to quantify the workload imposed by treatment of these tumours
- to indicate exposure to carcinogens (including sunlight, occupation)
- for studies of associations with other cancers
- to document trends in occurrence

There are three options:

(a) Record all skin cancers
(b) Record all skin cancers, excluding basal cell carcinomas (M809-811)
(c) Record all skin cancers, excluding basal and squamous cell carcinomas (M805-811)

Members of the Working Group:

Dr T. Davies, East Anglian Cancer Registry, Cambridge, UK
Mrs M. Page, East Anglian Cancer Registry, Cambridge, UK
Dr J.W. Coebergh, Eindhoven Cancer Registry, Eindhoven, NL

November 2000

European Commission

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  - bases of diagnosis

Incidence Date	Dr Derek Pheby, UK Dr Carmen Martínez, Spain Dr Martine Roumagnac, France Dr Leo Schouten, The Netherlands		Distributed in 1995 Revised in 1997

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  - bases of diagnosis

Multiple Primaries	from ENCR: Dr Paule-Marie Carli, France Dr Isabel Izarzugaza, Spain Dr Beata Koscianska, Poland		Distributed in 1995 Revised in 2000 Revised in 2004

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    - screen-detected cancers
    - autopsy diagnosis
  - bases of diagnosis

EUROPEAN NETWORK OF CANCER REGISTRIES (ENCR)

ENCR RECOMMENDATIONS

Method of Detection in Relation to Screening

Members of the Working Group:

Dr Leo Schouten, Maastricht University, Maastricht, the Netherlands (Chairman)
Dr Hannes Botha, Trent Cancer Registry, Sheffield, UK
Dr Eugenio Paci, Tuscany Cancer Registry, Florence, Italy

March 2001

European Commission

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  - bases of diagnosis

ENCR

Working Groups

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	

IACR

BASIS OF DIAGNOSIS

In the first edition of ICD-O a set of code numbers, M-9990/_, was provided for recording diagnoses of neoplasms for which no microscopic confirmation was available. However, most registries did not use these numbers and so they have been removed. It is possible to be reasonably certain of the morphology of several tumors without histological examination (retinoblastoma, or Kaposi sarcoma, for example). It is therefore recommended that a variable distinct from the morphology code be used to distinguish how the diagnosis was made.

There are many "basis of diagnosis" codes in general use. The IARC and International Association of Cancer Registries (IACR) recommend the following codes for recording the "most valid basis of diagnosis" (Table 1).

Table 1. IARC-IACR Basis of Diagnosis Codes

Code	Description	Criteria
0	Death Certificate Only	Information provided is from a death certificate.
Non-microscopic		
1	Clinical	Diagnosis made before death, but without any of the following (codes 2-7).
2	Clinical investigation	All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g., laparotomy), and autopsy, without a tissue diagnosis.
4	Specific tumor markers	Including biochemical and/or immunological markers that are specific for a tumor site.
Microscopic		
5	Cytology	Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.
6	Histology of a metastasis	Histologic examination of tissue from a metastasis, including autopsy specimens.
7	Histology of a primary tumor	Histologic examination of tissue from primary tumor, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumor.
9	Unknown	

This coding scheme also permits the distinction between tumors diagnosed on the basis of histology of a metastasis, or from the primary site, making the use of behavior code /6 (and /9) unnecessary in the cancer registry.

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- Upcoming 2017 ENCR Steering Committee Elections
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- Corsican Summer School on Modern Methods in Biostatistics and Epidemiology 2017
- 2017 Summer School on Modern Methods in Biostatistics and Epidemiology
- EC Proposal to Protect Workers against Cancer-Causing Chemicals

Vacancies

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Recommendations issued by ENCR

Marked differences in practice exist between cancer registries, for example, with respect to data sources, definitions and processing methods.To make cancer registry data comparable, which is one of the main aims of the Network, it is important that common rules and definitions are used.

Working Groups have been established to examine specific topics, identified as potentially problematic. These expert working groups are constituted of 3-4 people, selected by the ENCR Steering Committee. Their task is to study the problem and make recommendations for the cancer registries.

The following topics and the corresponding recommendations have already been addressed:

Select the language of your choice by clicking on the corresponding flag

Topics	Authors	PDF link	Date
Quality check harmonisation	ENCR, EUROCARE, IARC, CONCORD and selected experts		1st meeting: 2 July 2013 2nd meeting: 15 October 2013 3rd meeting: 4 June 2014
New recommendations on haematological cancers	ENCR Haematology Working Group: Dr Anna Gavin, Ireland Dr Rafael Marcos-Gragera, Spain Dr Richard Middleton, Ireland Dr Brian Rous, UK Dr Otto Visser, The Netherlands Dr Roberto Zanetti, Italy		26 Feb 2014
Data protection	EUROCOURSE-ENCR		3 May 2011 September 2012

To be revised?

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The ENCR membership

Please find here all the information on the ENCR Membership

http://www.encr.eu/

Standard dataset	Outdated?		10 February 2005
Incidence Date	Dr Derek Pheby, UK Dr Carmen Martínez, Spain Dr Mar… …ance Dr Leo… …erlands		Distributed in 1995 Revised in 1997
Multiple Primaries	from EI… Dr Paul… Dr Isabe… Dr Beat…		Distributed in 1995 Revised in 2000 Revised in 2004
Bladder Tumours	Dr Derek Pheby, UK Dr Martine Sauvage, France Dr Carmen Martínez, Spain Dr Leo Schouten, The Netherlands		Distributed in 1995
Tumours of the Brain and Central Nervous System	Dr Derek Pheby, UK Dr M. Sant, Italy Dr J. Ironside, UK Prof. W… …Netherlands		Distributed in 1998
Leukaemias and Lymphomas	Dr R. Otter, The Netherlands Dr A. Astudillo, Spain Professor P.M. Carli, France Dr A. Jakucs Dr H. van Krieken, The Netherlands		
Basis of Diagnosis	Dr J. Smith, UK Dr R. Frost, UK Dr L. Teppo, Finland Dr O. Visser, The Netherlands		Distributed in 1999
Non-Melanoma Skin Cancers	Dr T. Davies, UK Ms M. Page, UK Dr J.W. Coebergh, The Netherlands		Distributed in 2000
Method of Detection in Relation to Screening	Dr Leo Schouten, The Netherlands Dr Hannes Botha, UK Dr Eugenio Paci, Italy		Distributed in 2001
Confidentiality in Cancer registration	Dr Hans Storm, Denmark Dr Eva Buiatti, Italy Dr Timo Hakulinen, Finland Dr Hartwig Ziegler, Germany		Distributed in 2002
Condensed TNM for Coding the Extent of Disease	Dr F. Berrino, Italy Dr C. Brown, UK Dr T. Möller, Sweden Dr L. Sobin, USA With: Dr J. Faivre, France		Distributed in 2002
Structured Registry Review	Dr David Brewster, UK Dr Willi Oberaigner, Austria Dr Esa Pukkala, Finland		

Outdated?

Outdated?

To be harmonised?

To be revised?

OUTDATED?

OUTDATED?

Possible recommendations for future actions

- for the ENCR-SC and current WGs:
  revise what is available in the web-site
  complete the update of 'multiple cancers'
  complete the update of 'date of incidence'
  revise the One common procedure
  produce a Standard Operating Procedure
  harmonization with national rules (Airtum, Nicer, ACRN, UK, Gekind, Redecan, etc.)

- for CRs:
  use what is available
  use own rules provided they can be recoded according to the ENCR ones
  ask for what else is (absolutely) necessary
  ask for translation

Recommendations - take home messages

- The concern is not about recommendations but about comparability.

- Recommendations are not the Ten Commandments.

    - They are not perfect but good enough for the average CR.

    - They are not compulsory. In case you use other rules they must be more extensive than the official ones.

    - Expect from recommendations what they can provide but nothing more. They address the 'standard' case.

- Difference between recording and reporting.

- Recommendations shouldn't be interpreted but just applied. (In case recommendations have to be interpreted: exception?).

- Current recommendations can be updated and new ones drown up (for all the points we need to compare, but especially for relevant points of general interest).

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