Cancer Council Victoria

Reportable Cancers Guide for Hospitals

Victorian Cancer Registry

Guide to the identification of cancers reportable to the Victorian Cancer Registry

VICTORIA State Government

Purpose

The intention of this document is to:

1) Provide an overview of hospital reporting requirements to the Victorian Cancer Registry (VCR) including which cancers are notifiable;
2) Provide further information to hospitals to assist in determining if a cancer is notifiable or not.

For the purposes of this document, the term 'notifiers' will collectively refer to all organisations required to report to the Victorian Cancer Registry i.e. hospitals, pathology and radiotherapy services. The term 'hospital' will include public and private hospitals and day procedure centres.

A companion document, *Cancer Registration – Hospital Information Kit* is also available to assist hospitals with reporting to the VCR. It can be requested via email **vcr@cancervic.org.au** or by calling (03) 9514 6236.

A generic *Reportable Cancers – Guide to identification of cancers reportable to the Victorian Cancer Registry* exists that provides a general overview on which cancers are to be reported. Hospitals do not need to review this document as there is no additional information encompassed within it. This document can be located on the CCV internet site (www.cancervic.org.au)

The VCR is committed to providing ongoing support to all notifiers to facilitate accurate and timely reporting of the required information.

Assistance

Please do not hesitate to contact the VCR for advice if you are unsure whether to report a particular case at any time.

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Victorian Cancer Registry

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1. Overview of the Victorian Cancer Registry

The Victorian Cancer Registry (VCR) is a population-based registry that is responsible for accurate and timely reporting of cancer incidence, mortality and survival in Victoria. The Registry is located at Cancer Council Victoria and collects cancer data on behalf of the Secretary, Department of Health and Human Services who is the custodian of the cancer registry data.

The cancer data collected by the VCR is used to monitor cancer trends, in order to assist in the planning, management and assessment of Victorian cancer control activities. The data also contributes to the national Australian Cancer Database and international cohorts.

The success of the VCR in supporting improved outcomes for people with cancer is reliant on accurate and complete ascertainment of cancer information for all cancers diagnosed in Victoria. The current Victorian legislation, Improving Cancer Outcomes Act 2014 (and related regulations), requires all Victorian hospitals, pathology and radiotherapy services to report to the VCR, the details of all patients diagnosed with cancer, including the diagnosis of a recurrence of a cancer, or a precursor of a prescribed cancer type.

Section 12 of the Improving Cancer Outcomes Act protects all reporting services from an action for breach of confidentiality where the release of information is in compliance with the Act.

Extracts from the relevant sections of the Improving Cancer Outcomes Act 2014 (Vic) (Appendix 1) and the Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic) (Appendix 2), are included for your information.

All cancer data held by the VCR is subject to rigorous quality assurance to ensure that the data is complete, consistent and conforms to the highest standards.

1.1 Data sources

Data is collected from all hospitals, pathology laboratories and radiotherapy services located within Victoria. Mortality data is obtained from the Registrar of Births, Deaths and Marriages Victoria.

1.2 Data collected

The information collected by the VCR is listed in Appendix 3 . Notifiers responsible for reporting each data element are listed in the right hand column. Further specification can be provided to new notifiers as required.

1.3 Submission of data

Submission of electronic data from hospitals and radiotherapy services is performed via the Victorian Cancer Registry Internet Portal (VCRIP). Electronic pathology data is submitted via the E-Path Reporter software. Some very small pathology laboratories submit paper copies of reports.

1.4 Changes to reporting

Any changes to cancer reporting are primarily governed by legislative changes, such as the Improving Cancer Outcomes Act 2014 and its associated regulations (Improving Cancer Outcomes [Diagnosis Reporting] Regulations 2015). However, on occasions, the way the stated information within the regulations is collected may change. Generally, changes are kept to a minimum and only implemented every 2-3 years, as the VCR recognises the impact these changes have on notifiers and software vendors. Every effort is made to communicate changes at least 6 months prior to the expected implementation date.

Any major changes in legislation will be communicated by the Secretary, Department of Health and Human Services.

1.5 Data access

Cancer statistics and trends are published annually in the 'Cancer in Victoria' report which includes information on Victorian incidence and mortality. Periodical publications are released on specific cancer sites or types or on cancer-related topics.

Data can be made available for:

- Record linkage and/or to identify deceased persons
- Case recruitment for research studies
- Ad hoc requests for aggregated statistical information
- Surveillance and evaluation
- Policy and planning

The VCR has guidelines regarding the use and release of data to protect against potential breaches of privacy as well as ensuring the ethical integrity and scientific merit of proposals seeking access. Data access information can be found at
www.cancervic.org.au/research/registry-statistics/accessing-registry

Interactive reports are available on the Cancer Council Victoria website at
www.cancervic.org.au/research/registry-statistics/statistics-data

2. Timelines for cancer reporting

The timelines for reporting a diagnosis of cancer are specified in Section 6 of the Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic) (Appendix 2).

Reportable cancer cases are to be notified by hospitals within 60 days from the date of diagnosis, or from the date the person in charge of the service becomes aware that a person has cancer.

A Reporting Schedule which indicates the 'within 60 days' reporting expectation for the current year is available on the VCRIP log-in page.

3. Reportable cancers

Cancers to be reported to the Victorian Cancer Registry are listed in Table 1: Reportable Cancers, over page.

The Registry collects data on:

- Malignant tumours
- In situ tumours
- Uncertain or unknown behaviour (borderline) tumours
- Benign tumours

Each of these tumour groups has exceptions or inclusions which are listed in the table.

Table 1: Reportable Cancers

Malignant tumours

All sites *excluding some skin* (see SKIN CANCER EXCEPTIONS)

In situ tumours

All sites *excluding some skin* (see SKIN CANCER EXCEPTIONS)

Uncertain or unknown behaviour (borderline) tumours

Only tumours of the:

- central nervous system and nearby endocrine glands (refer to Appendix 4 for a list of sites)
- ovary
- urinary tract
- haematological & lymphoid tumours

Benign tumours

Only tumours of the:

- central nervous system and nearby endocrine glands (refer to Appendix 4 for a list of sites)

Skin cancers

All skin cancers are required with **some exceptions** (see SKIN CANCER EXCEPTIONS)

For squamous cell carcinoma (SCC) of the skin, only the following sites are to be reported:

- lip – vermilion border (the coloured portion of the lip)
- labia majora
- labia minora
- vulva
- prepuce
- penis
- scrotum
- perianal skin including anal margin

All other skin cancers (e.g. Merkel cell carcinoma, Kaposi sarcoma) of any site must be reported.

SKIN CANCER EXCEPTIONS

For skin sites:

- **Registration is NEVER required for Basal Cell Carcinomas (BCC) (morphology codes M8090-M8110)**
- **Registration is ONLY required for sites C44.5/D04.5 referring to perianal skin/anal margin for Squamous Cell Carcinoma (SCC) (morphology codes M8050-M8084)**

Refer to Diagram 1 - Reportable Skin Cancers to assist with determining if you should report a skin cancer.

4. Reporting requirements

ICD-10-AM[1] codes, which are used by hospitals to report morbidity and other data, are also used to identify reportable cancers.

Hospitals reporting cancers should provide as much information as possible including specific site and morphology, laterality, behaviour, grade and stage of cancer at diagnosis as VCR staff do not have access to patients' medical records. VCR is required to classify these reported primary and secondary site tumours using ICD-O3[2] so providing accurate information to us is vital.

There are several hospital coding guidelines derived from the ICD-10-AM (current edition) Australian Coding Standards[3] that are relevant to the accurate coding of neoplasms by Health Information Managers and Clinical Coders. These include the following standards:

- Section 2 Neoplasms
- 0044 Chemotherapy
- 0051 Same-day endoscopy – diagnostic
- 0052 Same-day endoscopy – surveillance
- 2112 Personal History

ICD-10-AM codes for tumours that are reportable to the Victorian Cancer Registry are listed in Table 2.

For further information on how to report to VCR please refer to:

Cancer Registration - Hospital Information Kit

[1]Australian Consortium for Classification Development. The international statistical classification of diseases and health related problems, 10th revision, Australian Modification (ICD-10-AM), 9th Edition. Independent Hospital Pricing Authority, Darlinghurst, 2015.

[2]Fritz A, et al. eds. International classification of diseases for oncology (ICD-O) 3rd edition, 2000, and 1st revision 2013. World Health Organization, Geneva,

[3] Australian Consortium for Classification Development. ACS Australian Coding Standards, 9th edition. Independent Hospital Pricing Authority, Darlinghurst, 2015.

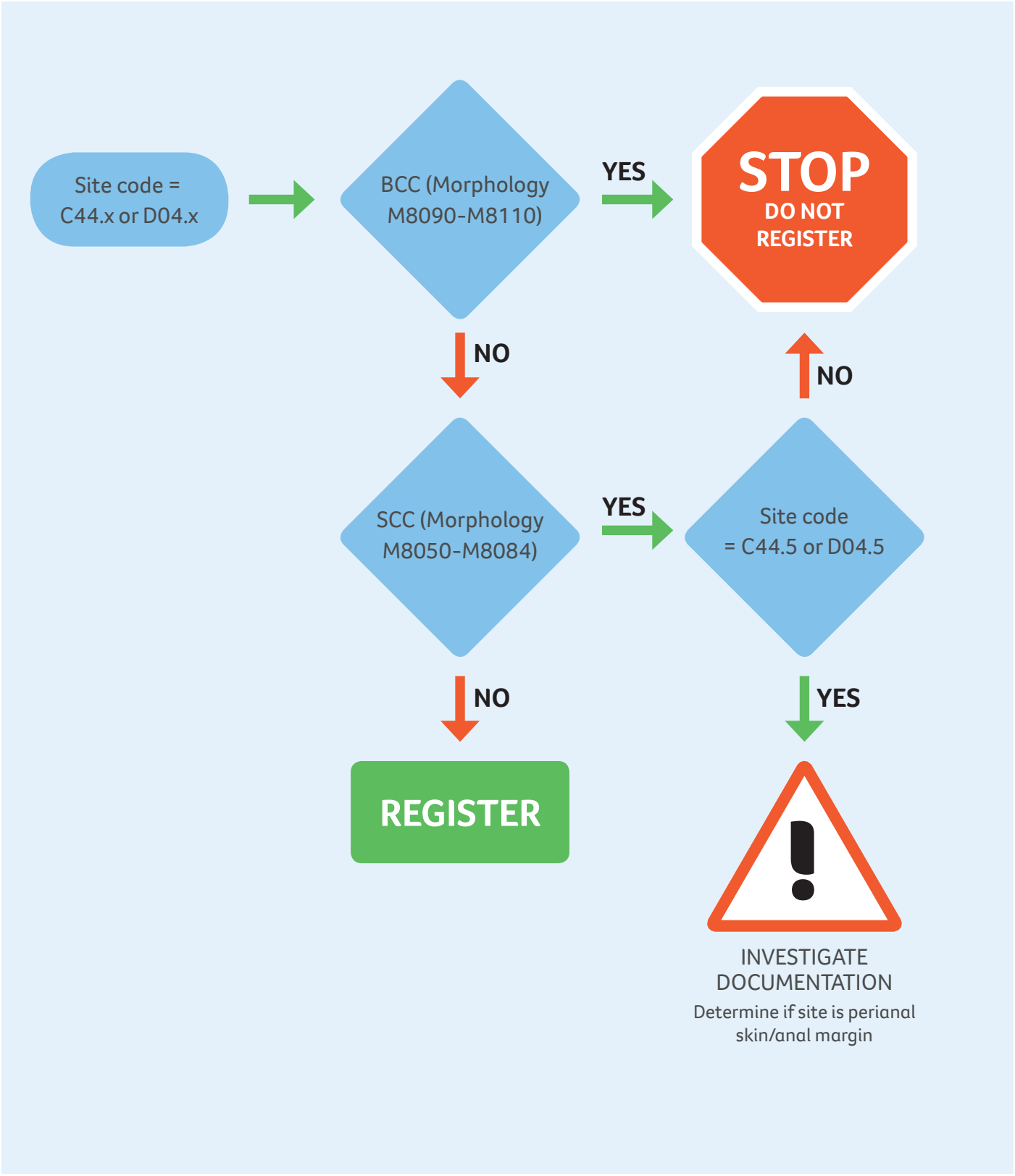
Table 2: ICD-10-AM (current edition) site codes to be reported to the Victorian Cancer Registry

Site Code	Description
Malignant	
C00-C75	Malignant neoplasms
C76-C80	Malignant neoplasms of ill-defined, secondary and unspecified sites
C81-C96	Malignant neoplasms of lymphoid, haematopoietic and related tissue
C44.5	Other malignant neoplasms of skin – trunk (refer Diagram 1 - Reportable Skin Cancers)
In situ	
D00	Carcinoma in situ of oral cavity, oesophagus and stomach
D01	Carcinoma in situ of other and unspecified digestive organs
D02	Carcinoma in situ of middle ear and respiratory system
D03	Melanoma in situ
D04.5	Carcinoma in situ of skin of trunk (refer Diagram 1 - Reportable Skin Cancers)
D05	Carcinoma in situ of breast
D06	Carcinoma in situ of cervix uteri
D07	Carcinoma in situ of other and unspecified genital organs
D09	Carcinoma in situ of other and unspecified sites
Benign	
D32	Benign neoplasm of meninges
D33	Benign neoplasm of brain and other parts of central nervous system
D35.2-D35.4	Benign neoplasm of other and unspecified endocrine glands - *New from 1 July 2018*
Uncertain or unknown behaviour	
D39.1	Neoplasm of uncertain or unknown behaviour of female genital organs - ovary
D41	Neoplasm of uncertain or unknown behaviour of urinary organs
D42	Neoplasm of uncertain or unknown behaviour of meninges
D43	Neoplasm of uncertain or unknown behaviour of brain and central nervous system
D44.3-D44.5	Neoplasm of uncertain or unknown behaviour of endocrine glands - *New from 1 July 2018*
D45	Polycythaemia vera
D46	Myelodysplastic syndromes
D47	Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue

Diagram 1: Reportable Skin Cancers

Reportable skin cancers should be coded to the specific site code rather than the C44/D04 codes for skin. For example, vermilion border of lip codes to C00.0 (reportable cancer), while dermis/skin of lip codes to C44.0 (not reportable cancer).

The exception is perianal skin/anal margin which codes to C44.5/D04.5. Codes C44.5/D04.5 require further investigation to confirm that the tumour arises in the perianal skin/anal margin. If upon review, the cancer arises in another site on the trunk (e.g. buttock, back), it is non-reportable and should not be registered.



4.1 When is a cancer registration required?

No.	A cancer registration is required when a person:
1	**Presents to your healthcare service and cancer is diagnosed during the stay**
2	**Presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility. Cancer is treated during the stay.**
3	**Presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility. Cancer is not treated during the stay.**
	Even if a cancer is not diagnosed or specifically treated during the hospital stay, it is still required to be registered.
4	**Re-presents to your healthcare service with a change in the cancer disease status ***
	A patient with a previously registered cancer and the disease status has changed (i.e. disease progression/relapse, recurrence or metastatic disease)*
5	**Presents to your healthcare service and is diagnosed with multiple primary cancers**
	A separate cancer registration is required for each primary cancer. If there is also metastatic disease you will need to add this to the related primary. Clinician clarification may be required.
6	**Dies at your healthcare service and has cancer**
	On occasions, a patient may be first diagnosed just prior to death or at autopsy or the cancer is the underlying cause of death.

* **Changed disease status** can be:

- **Recurrence** - Recurrence refers to the return or reappearance of cancer at the primary site, or appearance of a secondary (metastatic) cancer, of the same morphology, after a disease-free period (which can be months or years). Any new secondary sites relating to the recurrent primary should also be included in the registration.
- **Metastatic disease -** The anatomical location(s) of secondary, or metastatic, cancer which has spread from the primary tumour site. Metastases may be localised or distant.
- **Disease progression/relapse -** Disease progression/relapse/transformation is often indicated by a change in morphology. If the morphology of a previously reported cancer changes, then a new registration is required.

Refer to Appendix 5 for example scenarios of when a cancer registration is required.

4.2 Cancer Registration Tips

Tips	Examples
1. Presence of cancer to be registered	
Any presence of cancer in a patient that presents to your health service for the first time should be registered. Even if the cancer is not monitored or treated (i.e. not coded), a cancer registration is still required. If your cancer registration module does not have the ability to register a cancer without coding it as part of the inpatient episode you will need to complete an Eform on the Victorian Cancer Registry Internet Portal (VCRIP).	Patient admitted for pneumonia. It was noted that 3 months previously the patient had been diagnosed with prostate adenocarcinoma. This was not monitored or treated during the current inpatient stay. It is important to register these cases as we may not receive information on such cases from any other source, especially if they have been diagnosed clinically or via imaging only.
2. Multiple campus sites	
If a healthcare service has multiple campus sites that are using the one patient administration system, one unit record number system and a single medical record (paper or electronic), then a separate cancer registration is not required from each campus. If there is a change in the disease status, the same rules apply as outlined in **4.1 When is a cancer registration required?** – point 4; only one campus need report change.	Patient admitted for internal fixation of fractured humerus due to bone metastases from a breast primary. Patient is sent from the acute campus to a rehabilitation campus of a multi-site health service. A registration is completed at the acute campus (breast primary & bone metastases) but no registration is required from the rehabilitation campus.
3. Multiple admissions with no change in disease status	
When a cancer has been registered, every subsequent presentation is not required to be registered unless there is a change in the disease status.	Patient is admitted for chemotherapy. There is no need to register this case every admission after the initial registration.
4. Further information on an already registered cancer	
If further or more specific information is discovered (either via coding audit or subsequent admission), an updated registration can be sent or a new registration created. You need to ensure that any updates to a cancer registration will be re-extracted if the original registration has already been extracted and sent to the VCR. Your system administrator or person responsible for the cancer registration extracts should be able to advise if updates to registrations can be performed. If your cancer registration module does not re-extract updated/modified information, a new registration will need to be created either via your module or an Eform.	Colorectal malignancy detected on CT scan. Case is registered. Patient is admitted at a later date for a resection where adenocarcinoma of descending colon with lymph node metastases is diagnosed. As more specific information is now available, it is helpful to provide this to the VCR by either updating a previous cancer registration or completing an Eform.

(4.2 Cancer Registration Tips continued)

Tips	Examples
5. Cytology versus histology	
If malignant cells are found on cytology which results in an excision/excisional biopsy, the date of diagnosis on the cancer registration should be the date of excision/excisional biopsy. Malignant cells on cytology are not considered a definitive diagnosis. In the event that no definitive histological diagnosis was subsequently made (i.e. no excision due to age or comorbidities), then the date of cytology should be recorded as the date of diagnosis.	Patient admitted due to malignant cells being found on cytology (pap smear) 1 week previously. After further investigation and excisional biopsy, a diagnosis of high grade squamous intraepithelial lesion is made. The cancer registration would include a date of diagnosis of the excisional biopsy.

Tips
6. Patient dies at your healthcare service
If a patient dies at your healthcare service, you do not need to send a registration if you have sent one previously for the cancer in question and there was no change in disease status during this admission. Refer Appendix 5 – Example 6 VCR obtains death information from the Registrar of Births, Deaths and Marriages.
7. Registration sent in error
If a cancer registration is sent in error please email vcr@cancervic.org.au indicating: • the hospital site registered from, • unit record number, • date of birth, • admission and discharge date, • cancer site and morphology codes. Most cancer registration modules do not have the ability to send deletions, and as there should be very few scenarios like this, emailing is a quick and easy way to inform the Registry that the registration has been sent in error.

Appendix 1: Extract from Improving Cancer Outcomes Act 2014 (Vic)

The *Improving Cancer Outcomes Act 2014 and Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (VIC)* provide legislative support for the reporting of cancer cases to the VCR. The following are extracts from the Act and Regulations, outlining the reporting requirements applicable to hospitals.

For further reference: www.legislation.vic.gov.au

PART 3—COLLECTION, USE AND DISCLOSURE OF INFORMATION

Division 1—Collection of information

7 Secretary may collect health information

For the purpose of performing the Secretary's functions under this Act, the Secretary may, in accordance with this Part, collect health information about an individual.

9 Mandatory reporting of diagnosis of cancer of a prescribed type

(1) If an individual is diagnosed with cancer of a prescribed type, the prescribed person or organisation must report the diagnosis to the Secretary.

(2) For the purposes of subsection (1), a diagnosis of cancer includes a diagnosis of a recurrence of a cancer or a precursor of a prescribed type.

(3) The report of a diagnosis of cancer or a precursor must—

(a) be in the prescribed form; and

(b) be made within the prescribed time; and

(c) include the prescribed information.

10 Direction to provide further information

(1) The Secretary may direct a person or organisation to provide further information in relation to an individual who—

(a) has undergone cancer screening of a type prescribed for the purposes of section 8; or

(b) has been diagnosed with cancer or a precursor of a type prescribed for the purposes of section 9.

(2) The Secretary may give a direction under subsection (1)—

(a) to resolve any uncertainties, inconsistencies or ambiguities associated with; or

(b) to ensure the accuracy, integrity and completeness of—

information provided to the Secretary under section 8 in relation to cancer screening or under section 9 in relation to a cancer diagnosis.

(3) The Secretary may give a direction under subsection (1) to a person or organisation other than the person who reported the cancer screening or the cancer diagnosis.

12 Protection of persons from whom information is collected

(1) This section applies to a person or organisation that, in accordance with this Act, provides information that is authorised or required to be provided under this Act.

(2) The providing of the information—

(a) does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person or organisation; and

(b) does not make the person or organisation subject to any liability in respect of it; and

(c) does not constitute a contravention of any other Act or law (including common law).

Division 3—Use and disclosure of information

14 Circumstances in which Secretary may use and disclose health information

(1) The Secretary may use and disclose health information about an individual collected under this Act for the purpose of performing the Secretary's functions under this Act.

(2) The Secretary may use and disclose health information collected under this Act about an individual for any other purpose —

(a) with the consent of —

(i) the individual; or

(ii) if the individual is deceased—the individual's legal representative; or

(b) if the information is used or disclosed in accordance with HPP 2.2.

(3) Nothing in this Act prevents the Secretary from using and disclosing information about an individual collected under this Act if the identity of the individual is not apparent, and cannot reasonably be ascertained, from the information.

15 Disclosure of information

(1) Without limiting section 14(1), the Secretary may disclose information collected under this Act in any of the following circumstances—

(a) where the purpose of the disclosure is to enable the recipient of the information—

(i) to determine whether a person who has been screened for cancer has cancer, a precursor to cancer, a genetic marker to cancer or cell abnormalities which may lead to the development of cancer; or

(ii) to provide appropriate follow-up and clinical management of a person who has been screened for cancer;

(b) where the information relates to a person who has been screened for cancer in Victoria and the disclosure is to a person or organisation responsible for maintaining or managing a cancer screening register in another jurisdiction;

(c) where the information relates to a person who has been diagnosed with cancer in Victoria and the disclosure is to a person or organisation responsible for maintaining or managing a cancer register in another jurisdiction;

(d) where the disclosure is to the Australian Institute of Health and Welfare or to a successor in law to that body.

(2) The disclosure of information by the Secretary under this Division is at the discretion of the Secretary.

Appendix 2: Extract from Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)

4 Types of cancer or precursor diagnosis required to be reported

For the purposes of section 9(1) of the Improving Cancer Outcomes Act 2014, the prescribed types of cancer or precursors to cancer are those specified in Schedule 1 of "Reportable Cancers - Guide to identification of cancers reportable to the Secretary", as published by the Department of Health and Human Services from time to time.

5 Entities required to report cancer or precursor

For the purposes of section 9(1) of the Improving Cancer Outcomes Act 2014, the following persons and organisations are prescribed—

(a) any of the following as defined by section 3(1) of the **Health Services Act 1988**—

  (i) a day procedure centre;

  (ii) a denominational hospital;

  (iii) a private hospital;

  (iv) a privately-operated hospital;

  (v) a public health service;

  (vi) a public hospital;

(b) any radiotherapy service that provides a service for treating cancer patients involving the use of ionising radiation, including external beam, superficial and orthovoltage radiotherapy, particle beam therapy and brachytherapy;

(c) any pathology service that provides a service for testing for cancer, or a precursor to cancer, of a type prescribed by regulation 4.

6 Diagnosis reports

For the purposes of section 9(3) of the Improving Cancer Outcomes Act 2014—

(a) a report of a diagnosis of cancer or a precursor to cancer is in the prescribed form if it contains the prescribed information; and

(b) the prescribed time within which a report must be made is—

  (i) for a centre, hospital or service referred to in regulation 5(a) or (b), 60 days from the date the person in charge of the centre, hospital or service becomes aware that a person has cancer, or a precursor to cancer, of a type prescribed by regulation 4; and

  (ii) for a pathology service referred to in regulation 5(c), 30 days from the date the person in charge of the place where the testing is done becomes aware that a test indicates that a person has cancer,
  or a precursor to cancer, of a type prescribed by regulation 4; and

(c) the prescribed information to be included in a report is—

  (i) for a centre, hospital or service referred to in regulation 5(a) or (b), the information set out in Schedule 1; and

  (ii) for a pathology service referred to in regulation 5(c), the information set out in Schedule 2.

Schedule 1 – Prescribed information for centre, hospital or service

Regulation 6(c)(i)
Name of centre, hospital or service
Hospital identification number
Hospital unit record number
Patient details:
- Medicare number (*if known*)
- Individual Health Identifier (*if known*)
- Family name
- Given name(s)
- Maiden name (*if applicable*)
- Address
- Postcode
- Date of birth
- Sex
- Country of birth
- Aboriginal or Torres Strait Islander status
- Language spoken at home (*if known—please specify*)

Details of doctor in charge of case:
- Medicare provider number (*if known*)
- Name
- Address
- Telephone number

Details of general practitioner:
- Medicare provider number (*if known*)
- Name
- Address
- Telephone number

Date of first admission for this cancer
Date of diagnosis of this cancer
Eastern Cooperative Oncology Group (ECOG) performance status at time of diagnosis (*if known*)
Vital status
Date of discharge from centre/hospital/organisation
Investigations relevant to diagnosis of cancer
Primary site of cancer
Laterality of primary site of cancer
Morphology of primary cancer
Grade/differentiation of primary cancer
Stage of cancer at diagnosis
Cancer staging system *(to be reported in accordance with the "Victorian Cancer Staging Reporting Guidelines" as published by the Department of Health and Human Services from time to time*)
Treatment details for each primary tumour:
- Details of initial treatment
- Details of treatment of recurrence(s) (*if any*)

Cancer recurrence information:
- Date of cancer recurrence
- Site(s) of cancer recurrence

Name of person completing form
Date of completing form

Appendix 3: Information collected from hospitals by the VCR

Data Element	Definition
Patient Surname	The name a person has in common with some other members of their family.
Patient First Given Name	The person's identifying name(s) within the family group or by which the person is socially identified.
Patient Second Given Name	The person's identifying name(s) within the family group or by which the person is socially identified.
Date of Birth	The day, month and year of birth of the person.
Sex	The distinction between male, female and others who do not have biological characteristics typically associated with either the male or female sex.
Medicare Number	Person identifier, as allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Individual Healthcare Identifier	The numerical identifier that uniquely identifies each individual in the Australian healthcare system.
Previous/Maiden/Other Names	Any previous surnames, maiden name, or any other names the patient may be known by.
Indigenous Status	An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.
Building/Property Name	The full name used to identify the physical building, address site or property where the patient usually resides.
Street Address	The usual residential street address where a person lives under normal circumstances.
Suburb	The usual residential suburb/locality where a person lives under normal circumstances.
Postcode	The Australian numeric descriptor for a postal delivery area for an address.
Country of Birth	The country in which the person was born, as represented by a code.
Language Spoken at Home	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors.
Treating Doctor Surname	The surname of the patient's treating doctor.
Treating Doctor First Given Name	The first given name of the patient's treating doctor.
Treating Doctor Second Given Name	The second given name of the patient's treating doctor.
Treating Doctor Address	The business address of the patient's treating doctor.

(Appendix 3: Information collected from hospitals by the VCR continued)

Data Element	Definition
Treating Doctor Medicare Provider Number	The Medicare Provider Number is the provider number as issued by Medicare which uniquely identifies the treating doctor and the location from which the service is delivered.
Hospital Name	The name of the reporting hospital or hospital campus.
Hospital Campus Code	Indicates the hospital campus where the episode of care was provided.
Unit Record Number	The unique patient identifier, hospital-generated by the hospital or campus.
Date of Admission	The date of the patient's attendance at your facility for this episode of care.
Date of Diagnosis of Primary Cancer	The date when the cancer was first diagnosed. This may not necessarily be a date during the current episode.
Estimated Date Flag	Flag to indicate if date of diagnosis is an estimated date.
Cancer Diagnosed Prior to Admission Flag	Indicator as to whether the cancer has been previously diagnosed.
Where Previously Diagnosed	Information regarding where cancer diagnosis was made if made prior to this episode.
Date of Discharge	The most recent date of discharge or separation from your facility.
Primary Site	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Laterality of Primary Tumour	The side of a paired organ that is the origin of the primary cancer in a person with cancer.
Metastatic Site	The metastatic site is the anatomical position (topography) of the secondary cancer (can be localised or distant) which has spread from the primary tumour, as represented by an ICD-10-AM code.
Morphology	The histological classification of the cancer tissue (histopathological type) in a person with cancer, and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Grade	The histopathological grade or differentiation in a person with cancer. Grading/differentiation describes how little the tumour resembles the normal tissue from which it arose.
Investigations	All investigations relevant to the diagnosis of this cancer both at your facility and elsewhere.
ECOG Performance Status	Eastern Cooperative Oncology Group (ECOG) score given at the time of diagnosis outlining the extent to which a person with cancer's disease affects their daily living abilities.
Additional Information	Any additional or other information relating to the cancer diagnosis.

(Appendix 3: Information collected from hospitals by the VCR continued)

Data Element	Definition
Stage	The summary stage documented at the time of diagnosis or shortly thereafter before any treatment is initiated, as represented by a code, to indicate how far a cancer has spread from the point of origin. The higher the number the greater the extent of disease.
Staging System	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
TNM Stage – T code	The size and extent of the primary tumour in a person with cancer, as represented by a code.
TNM Stage – N code	The absence or presence and extent of regional lymph node metastasis in a person with cancer, as represented by a code.
TNM Stage – M code	The absence or presence of distant metastasis in a person with cancer, as represented by a code.
General Practitioner Surname	The surname of the patient's general practitioner/local doctor/local medical officer.
General Practitioner First Given Name	The first given name of the patient's general practitioner/local doctor/local medical officer.
General Practitioner Second Given Name	The second given name or second initial of the patient's general practitioner/local doctor/local medical officer.
General Practitioner Address	The address of the patient's general practitioner/local doctor/local medical officer.
General Practitioner Medicare Provider Number	The Medicare Provider Number is the provider number as issued by Medicare which uniquely identifies the doctor and the location from which the service is delivered.
Name of Person Completing the Registration	The full name of the person completing the cancer registration.
Date of Registration	The date the cancer registration is completed.

Note: Further information on the specific data elements is provided in the ***Cancer Registration – Hospital Information Kit.***

Appendix 4: Central Nervous System Sites

Cancer registration is required for all central nervous system (including brain) cancers (malignant, in situ, borderline/uncertain behaviour and benign).

The following lists some of the sites that are classified as central nervous system including some nearby endocrine glands.

MENINGES

Cerebral meninges

Cranial dura mater
Cranial meninges
Cranial pia mater
Falx cerebelli
Falx cerebri

Spinal meninges

Spinal arachnoid
Spinal dura mater
Spinal pia mater

Meninges, NOS

Arachnoid, NOS
Dura, NOS
Dura mater, NOS
Pia mater, NOS

Falx, NOS
Intracranial meninges
Intracranial arachnoid
Tentorium cerebelli
Tentorium, NOS

BRAIN

Cerebrum

Basal ganglia
Central white matter
Cerebral cortex
Cerebral hemisphere
Cerebral white matter
Corpus striatum
Globus pallidus
Hypothalamus

Insula
Internal capsule
Island of Reil
Operculum
Pallium
Putamen
Rhinencephalon
Supratentorial brain, NOS
Thalamus

Frontal lobe

Frontal pole

Temporal lobe

Hippocampus
Uncus

Parietal lobe

Occipital lobe

Occipital pole

Ventricle, NOS

Cerebral ventricle
Choroid plexus, NOS
Choroid plexus of lateral ventricle
Choroid plexus of third ventricle
Ependyma
Lateral ventricle, NOS
Third ventricle, NOS

Cerebellum, NOS

Cerebellopontine angle
Vermis of cerebellum

Brain stem

Cerebral peduncle
Basis pedunculi
Choroid plexus of fourth ventricle
Fourth ventricle, NOS
Infratentorial brain, NOS
Medulla oblongata
Midbrain
Olive
Pons
Pyramid

Overlapping lesion of brain

Corpus callosum
Tapetum

Brain, NOS

Intracranial site
Cranial fossa, NOS
Anterior cranial fossa
Middle cranial fossa
Posterior cranial fossa
Suprasellar

SPINAL CORD

Cervical cord
Conus medullaris
Filum terminale
Lumbar cord
Sacral cord
Thoracic cord

Cauda equina

Cranial nerve (CN), NOS

Olfactory nerve (CN I)
Optic nerve (CN II)
  Optic chiasm
  Optic tract
Oculomotor nerve (CN III)
Trochlear nerve (CN IV)
Trigeminal nerve (CN V)
Abducens nerve (CN VI)
Facial nerve (CN VII)
Vestibulocochlear (CN VIII)
  Acoustic nerve
  Cochlear nerve
Glossopharyngeal (CN IX)
Vagus nerve (CN X)
Spinal accessory nerve (CN XI)
Hypoglossal nerve (CN XII)

Nervous system, NOS

Central nervous system
Epidural
Extradural
Parasellar

ENDOCRINE GLANDS

Pituitary Gland
Pituitary, NOS
Hypophysis
Rathke pouch
Sella turcica
Pituitary fossa

Craniopharyngeal duct

Pineal gland

Reference:

Fritz A, Percy C, Jack A, Shanmugaratnam K, Sobin L, Parkin D and Whelan S, eds. International classification of diseases for oncology (ICD-O), 3rd edition, 2000 and 1st revision 2011, World Health Organization, Geneva.

Appendix 5: When is a cancer registration required? – Example scenarios

No.	Example scenario	Explanation
1	**Presents to your healthcare service and cancer is diagnosed during the stay**	
	Patient admitted for colonoscopy with biopsy with resulting diagnosis of adenocarcinoma of sigmoid colon.	A cancer registration is required with a diagnosis date of the stated pathology date.
2	**Presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility. Cancer is <u>treated</u> during the stay.**	
	Patient diagnosed with adenocarcinoma of colon at an endoscopy centre, now admitted for resection at a hospital.	A cancer registration is required from the hospital using the diagnosis date of the colonoscopy pathology.
	Admitted with acute tonsillitis in a patient with known lung cancer. An oncologist also reviews the patient and adjusts cancer medication during the stay.	When registering the case, check correspondence and clinical admission notes for an indication of when the cancer was diagnosed. Check *Cancer Registration – Hospital Information Kit* for further information on reporting date of diagnosis.
3	**Presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility. Cancer is <u>not treated</u> during the stay.**	
	Patient is treated for a decubitus ulcer on heel. Patient also has Chronic Myeloid Leukaemia which is not monitored or treated during the hospital stay.	A cancer registration is required for the Chronic Myeloid Leukaemia if it has not previously been registered at your hospital. Check *Cancer Registration – Hospital Information Kit* for further information on reporting date of diagnosis.
	Admitted to hospital for respiratory infection. Notes mention prostate carcinoma 5 years but nothing is monitored or checked during the hospital stay.	Register prostate carcinoma C61.9 M8010/3 and date of diagnosis as 5 years prior to current date and use the 'estimated date of diagnosis' flag. It is important to try and locate the earliest date of diagnosis, particularly for prostate cancer. Often, depending on the morphology, prostate cancers can be managed for several years with active surveillance rather than resection at diagnosis.

No.	Example scenario	Explanation
4	**Re-presents to your health service with a change in the cancer disease status.** **For example:** • Recurrence at primary site • Recurrence as metastatic disease • Disease progression/relapse	
	Patient diagnosed with a recurrent breast cancer (same site and morphology) that was resected 7 years previously. *(Recurrence)*	Even if this case was registered 7 years ago by your or another health service, it will need to be registered again indicating this is a recurrence. Enter 'Recurrence' in the Additional Information field.
	Patient has a past history of breast cancer with diagnosed bone metastases. The breast cancer was excised at the time. 3 years later, the patient presents with breast primary (same site and morphology) but now also has newly diagnosed liver metastases. *(Recurrence)*	If this case was registered 3 years ago by your or another health service, it will need to be registered again and include only the new liver metastases. The bone metastases previously reported in the original registration does not need to be reported again. If the case was not previously registered, register as normal. For both scenarios, enter 'Recurrence' in the Additional Information field.
	Patient diagnosed with recurrent colon cancer (same site and morphology) at anastomotic site 14 months post resection. *(Recurrence)*	If this case was originally registered at your hospital, it will need to be registered again indicating this is a recurrence. Enter 'Recurrence' in the Additional Information field.
	Patient diagnosed 4 months prior with prostate cancer returns to hospital with fractured vertebrae indicating bone metastases. *(Metastatic disease)*	If this case was previously registered by your health service for the prostate cancer, a further registration is required indicating that the patient now has bone metastases.
	Patient diagnosed with Plasmacytoma 5 years prior and has now presented with Multiple Myeloma. *(Disease progression/relapse)*	The Plasmacytoma should have been registered at the time of diagnosis 5 years prior. The disease has now progressed to Multiple Myeloma so this should also be registered.
	Patient had a past history of Essential Thrombocytopaenia and now has been diagnosed with Acute Myeloid Leukaemia (AML) *(Disease progression/relapse)*	If the patient had not previously attended your hospital and now presents with AML this should be registered. It is not necessary to register the Essential Thrombocytopaenia as the AML has now progressed from this. Register AML only.
	Patient presented with Fibrous Meningioma (9532/0) which 3 years later has become a Malignant Meningioma (9530/3). *(Disease progression/relapse)*	The Fibrous Meningioma should have been registered at the time of diagnosis 3 years prior. The disease has now progressed to Malignant Meningioma so this should also be registered.

(Appendix 5: When is a cancer registration required? – Example scenarios continued)

No.	Example scenario	Explanation
5	**Presents to your health service and is diagnosed with multiple primary cancers**	
	Patient has a malignant melanoma on upper back and right lower arm.	When a pathology report identifies multiple reportable cancers in different sites or subsites of a body part, a cancer registration is to be generated for each tumour. Two separate cancer registrations are required: a) Upper back b) Lower arm.
	Patient has a bowel resection and is diagnosed with mucinous carcinoma of the ascending colon and adenocarcinoma of the rectum.	Two separate cancer registrations are required: a) Ascending colon (M8480/3) b) Rectum (M8140/3)
6	**Dies at your health service and has cancer.**	
	A patient with lung cancer is admitted and dies in hospital.	If patient was previously known to the health service and lung cancer had been previously registered, a further registration is not required. If patient was new to the health service, a cancer registration is required. Review the death certificate, autopsy report if done or clinical notes for information.

Document Amendment History

Date	Section	Description
Oct 2009	2.3.2 ICD-10 AM codes to be notified	Inclusion of site code L41.2 and Q85.0
Feb 2010	2.3.2 ICD-10 AM codes to be notified	Deletion of codes D36.1 and D76
Aug 2011	2.3.2 ICD-10 AM codes to be notified	Deletion of site code Z85 Addition of line in uncertain behaviour to clarify notification of MDS/MPD with behaviour /3 but Site D45-D47
Oct 2011	Appendix 1	Moved Appendix from Hospital Information Kit to Guide to Reportable Cancers
	2.1 Introduction	Changed ICD10-AM edition information
Dec 2011	2 New	Added Section 2 to detail when hospitals are required to submit cancer notifications
	3 Identification of notifiable cancers	Modified codes and list of notifiable cancers to reflect changes to the reportable malignant, in situ, borderline/uncertain behavior and benign tumours. ICD-10-AM Uncertain behavior site codes removed including D37 – D38 (except D37.1), D40, D44 & Q85.0.
	Appendix 1	Modified scenarios to reflect changes to when hospitals need to submit registrations
Oct 2012	3.2 List of terms to be used as a guide to identifying notifiable cancers	Removed the term Craniopharyngioma from the *List of terms to be used as a guide to identifying reportable cases*. Associated site codes considered non-reportable.
	Cancer Act 1958	Moved extract from Cancer Act, Cancer (Reporting) Regulations and Trap Word list for Pathology Laboratories to Appendices. VCR Word Trap List expanded. Included are VCR Data Definitions in Appendix 3.
	4 New	Date of first diagnosis, & two new sections General revision of document.
	Guide amendment history p2	*Guide amendment history* added as Appendix 6.
Oct 2013		General revision of document
Jan 2014		New address and contact details updated

(Document Amendment History continued)

Date	Section	Description
Dec 2015	2. Timelines for cancer notification	Hospital notifiers to report cancer diagnoses within 60 days of diagnosis
	Table 1 List of VCR reportable cancers	Minor revision to include Appendix for central nervous system sites Removal of female genital organs
	4.1 Hospital notifiers	Revision of this section
	4.1.2 Degree of spread	Removal of section
	4.1.3 New reportable fields (Hospital)	Addition of Medicare provider number, stage of cancer at diagnosis and cancer staging system
	Table 2 ICD-10-AM Codes to be notified to the VCR	Malignant C81-C96 Lymphatic and Haematopoietic tissue – Morphology code changed from M956x/3 to M959X/3 L41.2 Lymphomatoid papulosis removed Uncertain Behaviour D39 revised. Only D39.1 Ovary is now required D45-D47 Site of tumour – Morphology code changed from M9989/3 to M9992/3
	Hospital Notifiers	Removal of this section
	Appendix 1 Extract from Cancer Act 1958	Replaced with extract from Improving Cancer Outcomes Act 2014 (Vic)
	Appendix 2 Extract from Cancer (Reporting) Regulations 2012	Replaced with extract from Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015 (Vic)
	Appendix 3 VCR Data Definitions	Inclusion of: Building/Property Name Treating Doctor Medicare Provider Number Stage of Cancer Flag Stage of Cancer at Diagnosis Cancer Staging System General Practitioner Medicare Provider Number TNM Stage – TNM code Staging Scheme Edition Number Radiotherapy Start Date Radiotherapy End Date Target Site 1-3 Dose 1-3 Referring Doctor Medicare Provider Number Reporting Pathologist Medicare Provider Number

(Document Amendment History continued)

Date	Section	Description
Dec 2015	Appendix 4 Central nervous system	Inclusion of central nervous system sites
	Appendix 5 When to notify VCR – hospital notifier	Update of dates
July 2018	Whole document	General revision of document and creation of a hospital specific Reportable Cancers.
	3.1	Removal of Section – List of terms to be used as a guide to identifying reportable cancers.
	4.2	Removal of Section – Data elements
	Table 2	Inclusion of D35.2 - D34.4 Inclusion of D44.3 - D44.5
	Appendix 3 – Information collected from hospitals by the VCR	Updated heading from VCR Data Definitions to information collected from hospitals by the VCR New fields TNM Stage – T code, N-code and M-code Relabelling of some data elements Redefining some data elements
	Appendix 5	Removal of scenarios 'When to notify VCR – Healthcare Service Notifier'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