Local logo	*AFCRN* CANCER REGISTRY CANCER NOTIFICATION FORM	

Cancer registry Number ☐☐☐☐ ☐☐☐☐

1. PATIENT

I.D. Number: __

Given name (First name(s) .....

Surname (Family name).....

Date of birth ☐☐☐☐☐☐☐☐ Age: ☐☐ Sex: ☐ (1=male, 2=female, 9=NK)

Usual residence address: ..... ☐☐☐

.....

.....

Telephone number: .....

Ethnic group: ..... ☐☐

2. TUMOUR

Date of incidence: ☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)

Basis of diagnosis: ☐

0. Death certificate only
1. Clinical only
2. Clinical investigations (X ray etc)
4. Specific tumour markers
5. Cytology / Haematology)
6. Histology of metastasis
7. Histology of primary
9. Unknown

Primary site of the tumour ..... C☐☐.☐

Morphology: ..... M☐☐☐☐/☐

Stage: ..... ☐☐ T: ☐ N: ☐ M: ☐

3. TREATMENT:

Surgery ☐ Radiotherapy ☐ Chemotherapy/ Hormone therapy ☐ Other (specify) ☐ .....

[1=Yes, 2=No, 9=Unknown]

4. SOURCE OF INFORMATION

Institution/ward: _____ ☐☐☐

Case number _____

Laboratory _____ ☐☐ Lab. Number _____

5. FOLLOW UP

Date of last contact (dd/mm/yyyy): _____ ☐☐☐☐☐☐☐☐

Status at last contact (1=alive, 2=dead, 9=NK) _____ ☐

Cause of death (1= this cancer, 2= 0ther cause, 9= NK) ☐

Form filled by: _____ Date _____ Signed. _____

Data entered by: _____ Date _____ Signed. _____

AFCRN CANCER REGISTRY

CODING SHEET - CANCER NOTIFICATION FORM

Cancer registry number ☐☐☐☐ ☐☐☐☐

4 numbers for the year (YYYY) and 4 figures for the patient number

Age:

00 = children < 1 year old

From 01 to 98 = children or adult from 1 year to 98 years old

99 = not known (NK)

Date of incidence

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

Basis of diagnosis:

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	

Primary site of the tumour: Enter site of PRIMARY, not metastatic sites. If unknown, state so.

Topography coding = ICD–O– 3 coding reference book[1]

Morphology: ..... M □□□□

Morphology coding = ICD–O– 3 coding reference book[1]

Behaviour: ..... □

Behaviour coding = ICD–O-3 coding reference book[1]

Stage:

AJCC codes as recorded (1,2A, 2B, 3A, 3B, 4)

TNM

When the stage/extent of the cancer is recorded in the clinical and/or pathological records according to the TNM system, these codes should be registered.

Record stage from pathology - pT (rather than cT) and pN (rather than cN), if they are available.

If there is any evidence (clinical or pathological) of metastatic disease, M is coded as **1.** If there is none, code as **M0**; if MX has been recorded, replace with **M0**.

Extent of disease as TNM is based upon all examinations carried out to plan treatment, plus surgery and pathological examination of respected specimen(s).

Examinations carried out post-surgery, but during the same hospital stay, are included.

In the absence of surgery, staging is based upon examinations carried out prior to medical treatment, or radiotherapy, or during the hospital stay when these treatments were started, or a decision made to withhold them.

The detection of metastatic disease **after** the first course of treatment (including during adjuvant treatment or hormonal therapy) does **NOT** change coding of extent of disease at diagnosis.

RECOMMENDATIONS FOR ESSENTIAL TNM

When T, and/or N, and/or M have not been explicitly recorded in the clinical/pathological records, the cancer registrar should attempt to score extent of disease according to the Essential TNM scheme:

M:	**M+**	**M- (no mention of metastases, clinically or pathologically)**	
N:	**R+ (R2/R1)**	**R- (no mention of regional nodes clinically or pathologically)**	
T:	**Advanced (A2/A1)**	**Localised** (**L2/L1)**	**X (cannot be assessed; primary is not described)**

M is based on the best available information, whether clinical, instrumental or pathological. For M, clinical signs and findings are enough to justify M**+** in the absence of pathological confirmation of metastatic deposits. If no mention of metastases, record as M-. M+ includes involvement of non-regional lymph nodes.

[1] IDC-O = International Classification of Disease for Oncology (Fritz A, Percy C, Jack A, Shanmugaratnam K, Sobin L, Parkin DM and S. Whelan S. International Classification of Diseases for Oncology. Third Edition. World Health Organization, Geneva, Switzerland, 2000).

T and **N** are extracted, if possible, from the pathology report, or, in its absence, from the clinical record (endoscopy, X-ray etc.).

The conventional values of T, N and M will be provided on a site-specific basis.

R+ refers to spread to regional lymph nodes. The definition of 'regional nodes' for each site is provided on a site-specific basis (see Appendix 2).

Absence of Specific Information on Metastases, Nodes, Tumour Size/Extent
For **M** and **N**, if there is no information on their presence, assume absent (M-, R-).

For **T**, X should be recorded if there is known to be a primary tumour, but there is no description of its size or extent. Refer to the specific sites for assessing localised or advanced status.

SOURCE CODES
Local codes: hierarchical, eg Hospital, service, ward