QUEENSLAND CANCER REGISTRY

INSTRUCTION MANUAL

FOR NOTIFYING CANCER

PRIVATE HOSPITALS

JUNE 2009

Queensland Cancer Registry
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Version 1.9

CONTENTS

Superseded Details:Amendments to previous versions:

Version 1.1 June 2004 – amendment to Mode of Separation codes Page 28
Version 1.1 June 2004 – the list of site codes required have been included and the ranges included at the back of the document. (Page 36 to Page 49 inclusive)
Version 1.2 July 2004 – amendment to Mode of Separation Page 28, Sex (inclusion of Intersex) Page 27 and amendment to Marital Status Page 27. (Removal of single in single/never married) – These have been amended as per the comparison to the QHAPDC 2004 to 2005 manual.
Version 1.3 September 2004 – Text amendments to the following descriptions:
- CAD file: Medicare number and Location.
- CAN file: Multiple Primary Site Number; Location; Laterality and Comments.
- CDX file: Reasons for Clinical Diagnosis code.

Version 1.4 Oct 2004 – addition to Appendix B at end – Page 36. How the files are linked together.
Version 1.5 April 2005 – E-mail change to Page 5. File formats from Page 26 onwards have been updated to include whether the data item is mandatory or not (under Requested Format)
Version 1.6 February 2006 – amended any reference to the 'old' act and included reference to the new Public Health Act 2005. Highlighted the sections within the file to make it more user friendly.
Version 1.8 April 2007 – Updated laboratory facility and specimen number details.
Version 1.9 June 2009 – Updated CCQ & fax number. CAN file – Text for morphology code field changed from 9 to 7 characters.

1 INTRODUCTION

1.1 Establishment of the Cancer Registry

The Queensland Cancer Registry (QCR) operates under the *Public Health Act 2005*, to receive information on cancer in Queensland. The Cancer Registry is a population-based registry and maintains a Register of all cases of cancer diagnosed in Queensland since the beginning of 1982. It was established in response to the need for Statewide information on cancer expressed by community and state organisations such as the Queensland Institute of Medical Research and the Queensland Cancer Fund. Cancer is a notifiable disease in all States and Territories and is the only major disease category from which an almost complete coverage of incidence data is available. It is also the only major cause of death in Australia that is continuing to increase. Through the National Cancer Statistics Clearing House - a collaborative enterprise of the Australian Association of Cancer Registries and the Australian Institute of Health and Welfare, Queensland data is used in the compilation of Australia-wide figures and can be compared with cancer statistics from other States.

1.2 Aims of the Registry

The main aim of the Registry is to collect data to describe the nature and extent of cancer in Queensland. This can be combined with related data to assist in the control and prevention of cancer. To this end, Queensland Cancer Registry data is available for use:

- in research projects on the causes, treatment and prevention of cancer,
- in the planning and assessment of cancer treatment and prevention services,
- in monitoring survival times of cancer patients, and
- for the education of health professionals and members of the general public.

1.3 Notification and Sources of Data

Notification of cancer is a statutory requirement for all public and private hospitals, nursing homes and pathology services. Notifications are received for all persons with cancer separated from public and private hospitals and nursing homes. Queensland pathology laboratories provide copies of pathology reports for cancer specimens. Data on all persons who die of cancer or cancer patients who die of other diseases are abstracted from the mortality files of the Registrar of Births, Deaths and Marriages and linked to hospital and pathology data.

The Registry has obtained the approval of the Registrar General of Births, Deaths and Marriages to provide hospitals with details of patient deaths where the patient has been treated at that hospital and died elsewhere. This report will be provided annually to assist with patient survival follow-up and record culling.

1.4 The Act and Regulations

The *Public Health Act 2005*, Division 3 – Notifications about cancer 234 and 235 that the ‘person in charge of a hospital’ is responsible for furnishing returns on patients known to be suffering from cancer to the chief executive of Queensland Health, or under the direction of the chief executive to the Queensland Cancer Fund (‘the contractor’), within one month.

The legislation may be viewed on the following website:

http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2005/05AC048.pdf

1.5 Confidentiality of Data

All unit record information collected by the Queensland Cancer Registry is treated as strictly confidential. All information collected is used for statistical or research purposes only.

1.6 Enquiries

If you would like more information about the Queensland Cancer Registry or you wish to obtain any publications you may contact the:

Registrar
Queensland Cancer Registry
Queensland Cancer Fund

553 Gregory Terrace
Fortitude Valley Q 4006

Locked Bag No 1450
Spring Hill Q 4004

PH (07) 3258 2333
FAX (07) 3258 2345
Email Marilla_Fraser@health.qld.gov.au

Further information about cancer may also be obtained from the following web sites:

www.health.gov.au/hic	(Queensland Health site, QCR data)
www.qldcancer.com.au	(Queensland Cancer Fund site, general cancer information)
www.aihw.gov.au/cancer/index.html	(AIHW site, national data)

2 GOING ELECTRONIC

2.1 Background

One of the major problems faced by the Registry has been the lack of quality of the data supplied, and more particularly, missing information.

Since early 2002, the Registry has been receiving data electronically on a monthly basis from all public hospitals in Queensland. This has been of immense benefit to both parties and monthly automatic reporting has made us more confident that we are receiving all notifications.

Not only is the data being received electronically from hospitals; it is also being processed electronically by the Registry.

Together this means:

* a reduction in workload for the hospital staff as there will not be such a large number of edits requiring resolution.

* a reduction in processing workload for the QCR which will allow a greater focus on quality assurance exercises and data analysis to promote the use of the information;

* an improvement in the quality and timely availability of cancer data.

* better measures are in place to ensure the confidentiality of patient data.

3 BUSINESS RULES

3.1 What Hospitals Should Notify?

All private hospitals in Queensland are required to report cancer details to the Queensland Cancer Registry.

3.2 What Cancers Should Be Notified?

All cancers as defined in Part 2 Division 1, Section 229 of the *Public Health Act* 2005 are to be notified. The Act defines cancer as:

". . . a neoplasm of human tissue-

a) in which cell multiplication is uncontrolled and progressive; and
b) that, if unchecked, may invade adjacent tissues or extend beyond its site of origin; and
c) that has the propensity to recur, either locally or remotely in the body
d) skin cancer and non-invasive carcinoma, other than skin cancer and non-invasive carcinoma of a type prescribed under a regulation".

Therefore, all invasive cancers are to be reported (excluding Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin where the ICD-10-AM site code range is C44.0 to C44.9 and morphology is M805 to M811). Merkel cell tumours of the skin and Kaposi's Sarcoma are also to be reported.

Please report any cancer with uncertain behaviour.

Please notify **all** in-situ conditions as well. The Registry collects for example, in-situ cancers of the cervix (CIN III - cervical intra-epithelial neoplasm), vagina (VAIN III - vaginal intra-epithelial neoplasm), vulva (VIN III - vulval intra-epithelial neoplasm), prostate (PIN - prostatic intra-epithelial neoplasm) bladder, breast and in-situ melanomas.

Benign central nervous system and brain tumours are also of interest to the Registry and must be reported.

Non-malignant conditions, such as CIN I or II, VAIN I or II, VIN I or II, solar keratosis or keratoacanthoma, are outside the scope of the collection.

3.3 When A Notification Should Be Completed

A notification should be completed and sent **within 30 days** for each of the following events:

(i) at discharge or transfer of a patient being **first** diagnosed with cancer, or when a **new site** is diagnosed, or the same site but a **different histological type** of cancer is diagnosed.

(ii) a patient's **first** date of attendance in each calendar year for chemotherapy or radiotherapy. (Note that as per the Queensland Health admission policy patients should be admitted for chemotherapy.)

(iii) at the **death** of a patient suffering from or with a **history** of cancer, where the patient died within the hospital.

(iv) at discharge or transfer from the **first** admission for each calendar year for all other patients suffering from or with a history of cancer. This includes patients who may be being treated for their cancer at that admission or where the cancer is incidental to that admission. It is a requirement to follow current coding standards and to only code history of cancer in the ICD-10-AM diagnosis codes where it is relevant to the admission. It is desirable for the cancer registry to still receive a notification through separately 'filing' a cancer registration notification.

A **separate notification** is required for each primary site.

3.4 Deletions

If you have sent a notification it will be reported through to the Registry. If you would like to delete it after it has been sent electronically, a manual notification is then required if the record is to be deleted from the QCR. This can be done by printing the notification

prior to deleting or photocopying the relevant notification and crossing it with DELETED. If possible, a reason should be added, eg duplicate patient, not cancer, etc.

3.5 Further Information Required

After processing a cancer notification the Registry may identify a need for further information. A response to the request for further information is required within 30 days and should be addressed as follows:

CONFIDENTIAL
The Queensland Cancer Registry
Locked Bag No 1450
Spring Hill Q 4004

It is recommended that hospitals maintain a record of the completion and dispatch of the responses to the requests for further information.

3.6 When and How A Notification Should Be Sent

Ideally, notifications should be sent on a monthly basis, with an extract sent on a certain day of the month eg. the 10th day of each month. The extract should include all notifications completed in the previous month.

The dates for sending the notifications and the format of how these will be sent eg. on a CD, password protected can be discussed.

Each set of cancer registration extract files will contain a header (HDR) details file. The HDR file will provide counts of the total number of records for that facility (including nil returns).

4 FACILITY DETAILS

4.1 Facility Number

The facility number is a numerical code that uniquely identifies each health care facility. This manual covers the facilities listed in Appendix A, recognised private hospitals. All these hospitals are able to admit patients, although not all wish to do so.

Patients moving between these hospitals are counted as separate admissions and separations and are therefore reported by both facilities.

5 PATIENT DETAILS

5.1 Patient Number (UR number)

A unique number allocated to each patient by the hospital. Allocation might be done manually or automatically by the computer. The number is used for each admission to identify the patient within the facility.

5.2 Patient Surname/Family Name

The current surname of the patient or resident.

5.3 Given Names

5.3.1 First name

The current given name of the patient or resident.

5.3.2 Second name

Second names or initials where known.

5.4 Former Names/Alias

Record any previous surname or other names that the patient or resident is now or has previously been known as. Record the complete name (first name, second name and surname).

5.5 Sex

Record the sex of the patient using the following:

M= Male
F= Female
I= Indeterminate / Intersex

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at the time of the hospital admission recorded.

Note that indeterminate will generally only be used for neonatal patients where the sex has not been determined.

5.6 Date of Birth

Record the date of birth of patient using the full date (i.e. ddmmmyyyy).

- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients) use 15-JUN-1900.

If estimated or unknown, specify in the comments in the CAN file.

5.7 Address of Usual Residence

5.7.1 Number and street of usual residence

Record the building number and street name of the usual residential address of the patient. The usual residence is where the patient lives. For example, it is not the address where the patient might be staying temporarily before or after the period of hospitalisation.

Post Office box numbers or Mail Service Numbers should not be recorded. Use a building number and street name whenever possible. Even country properties have access roads that have names.
You may use standard abbreviations, for example:

- Alley - AL
- Approach – APP
- Arcade - ARC
- Avenue – AV
- Bend - BND
- Boulevard – BVD
- Break/Brook – BR
- Broadway – BWY
- Brow – BRW
- Bypass – BPS
- Centre – CTR
- Chase – CH
- Circle – CIR
- Circuit – CCT
- Circus - CRC
- Close – CL
- Concourse – CNC
- Copse – CPS
- Corner – CNR
- Corso - CSO
- Court – CT
- Courtyard – CYD
- Cove - COV
- Crescent – CR

- Crest – CST
- Cross – CS
- Crossing – CSG
- Dale – DLE
- Downs – DN
- Drive – DR
- Edge – EDG
- Elbow – ELB
- Entrance – ENT
- Esplanade – ESP
- Expressway – EXP
- Freeway – FWY
- Frontage – FR
- Garden/s – GDN
- Gate/s – GTE
- Glade – GLD
- Glen – GLN
- Grange – GRA
- Green – GRN
- Grove - GR
- Heights - HTS
- Highway – HWY
- Junction – JNC
- Lane – LA
- Link – LK
- Loop – LP
- Mall – ML
- Meander – MDR
- Mews – MW
- Motorway – MWY
- Nook – NK
- Outlook - OUT
- Parade – PDE
- Park – PK
- Parkway – PKY
- Pass – PS
- Pathway – PWY
- Place – PL
- Plaza – PLZ
- Pocket – PKT
- Port/Point – PT
- Promenade – PRM
- Quadrant – QD
- Quay – QY
- Ramble – RA
- Reach – RCH
- Reserve – RES
- Rest – RST
- Retreat – RT

- Ridge – RDG
- Rise - RI
- Road – RD
- Roadway – RDY
- Route – RTE
- Square – SQ
- Street – ST
- Tarn – TN
- Terrace – TCE
- Tollway – TWY
- Track – TR
- Trail – TRI
- Underpass – UPS
- Vale – VA
- View – VW
- Vista – VST
- Walk – WK
- Walkway – WKY
- Way – WY
- Wynd – WYN

5.7.2 Suburb/Town of usual residence

Record the location of the usual residence of the patient as the suburb or town in which the patient usually lives. Do not record the location of temporary accommodation, or a (farm) property name in this field.

Interstate and overseas patients

If the patient lives interstate, the actual suburb or town of usual residence should be recorded.
If the patient is from overseas, also record the country in which he/she normally resides.

Patients diagnosed outside Queensland, while not reported by the Registry, are recorded on the Register. This assists with identifying duplicate registrations, notifying interstate cases, and assists matching for subsequent treatment notifications.

5.7.3 Postcode of usual residence

Record the postcode of the usual residential address of the patient.

If the patient is not an Australian resident or has no fixed address, use one of the supplementary codes:

0989 = not stated/unknown
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea

9899 = Australian External Territories
9989 = no fixed address

5.8 Medicare Number

If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card.

If the person does not have an Australian Medicare Number or if it is not available, leave this blank.

5.9 Marital Status

Use the following to record the current marital status of the patient:

NM= Never married
M= Married
F=De facto
W= Widowed
D= Divorced
A= Separated
N= Unknown

Separated means those people who are legally separated or socially separated, not persons who are temporarily living apart (e.g. construction workers living in hotels or camps).

5.10 Country of Birth

Record the country of birth of the patient using the appropriate numerical codes (as found in the Australian Standard Classification of Countries for Social Statistics ASCCSS)) eg:

- If the patient was born in Australia, use code 1101;

- If the patient was born in New Zealand, use code 1201.

5.11 Indigenous Status

The improvement of the health of Indigenous Australians has been identified as one of the priorities in the Queensland Health Corporate Plan (1998 – 2003) Key Performance Objectives. The accurate identification of Aboriginal and Torres Strait Islander patients in Queensland Health data collections is crucial to measuring their health status and the effectiveness of intervention programs.

All persons admitted to hospital should be asked "Are you of Aboriginal or Torres Strait Islander origin?". Persons who reply "Yes" to this question should be asked to specify which origin they are of, either Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. This question must be asked of all admitted patients. Where the patient is unable to provide this information, for example, when a baby or child is admitted to hospital, the parent or guardian should be asked whether the child is of Aboriginal or Torres Strait Islander origin.

Data providers should be aware that:

(1) Patients born outside Australia are unlikely to be of Australian indigenous status; and
(2) A person's Indigenous status can not be determined by observation.

For data accuracy, the patient, their carer, or next of kin must be asked the question directly.

Use the following to record indigenous status:

11= Indigenous-Aboriginal but not Torres Strait Islander origin.
12= Indigenous-Torres Strait Islander but not Aboriginal origin.
13= Indigenous-Aboriginal and Torres Strait Islander origin.
14= Not indigenous-not Aboriginal or Torres Strait Islander origin.
19= Not Stated

5.12 Occupation

Record the patient's occupation. Use the codes from the Australian Standard Classification of Occupations (ASCO). Ideally the Registry would like principal lifetime occupation. Only use pensioner/ housewife/retired if lifetime occupation is unable to be ascertained.

6 ADMISSION DETAILS

6.1 Admission Number (Episode Number)

The admission number denotes a specific admission at the facility. Admission number is important as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission.

6.2 Admission Date

Record the full date (that is, ddmmmyyyy) of admission to hospital.

6.3 Separation Date

At separation, record the full date (that is, ddmmmyyyy). This is the date that the patient was discharged, transferred or died.

6.4 Mode of Separation (Discharge Status)

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital or indicates whether this is a statistical separation due to a change in the type of episode of care.

If the patient died in hospital, please record the appropriate details for whether an autopsy was held and cause of death details.

6.5 Transferring to Facility

Record the facility number (extended source code) for the hospital, nursing home or correctional facility to which the patient is referred as an admitted patient.

6.6 Treating Doctor

To assist in improving the quality of this data, all fields should be completed.

Record the individual doctor chiefly responsible for treating the patient e.g. the Senior Treating Medical Officer, Specialist or Consultant in charge of the care. This is not the registrar or resident medical officer.

6.7 Cause of Death

If the patient died in the hospital, the description for the principal diagnosis code, for this admission, should be displayed in this field. Check and update the text details as required.

The cause of death should be determined as per the World Health Organisation (W.H.O.) definition as:

(a) "the disease or injury which initiated the train of morbid events leading directly to death, or"

(b) " the circumstances of the accident or violence which produced the fatal injury"

Ref: International Classification of Disease - 9 (Vol. 1, p. 700)

Please only complete the cause of death if the patient dies in the hospital

6.8 Autopsy Flag

Record whether an autopsy or coroners inquiry is to be/has been undertaken with an Y or N.

Please only complete the autopsy held item if the patient dies in the hospital.

6.9 Diagnosis at Separation

The principle diagnosis ICD 10 AM code for this admission.

7 CANCER DETAILS

7.1 Multiple Primary Site

This is a two digit item field, indicating multiple primary sites of cancer for any single patient.

7.2 Primary Site of Cancer

A primary site is defined as the site at which a neoplasm originated. Thus, a cancer CASE includes each primary site in a cancer patient, and a patient with two primary sites is considered as being two different cases of cancer. A patient with one primary site and one or more secondary sites is one case of cancer only.

See Section 3.2 for the cancers in the scope of the collection.

Where possible be specific when coding the primary site, for example, if known, code site as "upper lobe of lung" or "upper-inner quadrant of breast".

If the initial diagnosis is a secondary tumour, report the primary tumour site if possible. This may be indicated by the morphology or clinical notes. If it is not possible to identify the primary tumour, then code the cancer as an unknown primary site.

Details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the cancer than can be coded in ICD-10-AM. This may include more precise topography for melanomas, connective and soft tissue sites, meninges and brain, insitu cancers, etc. The Registry codes in ICD-O and has to convert or recode the ICD-10-AM codes. Any information that can assist this process would be useful.

7.3 Morphology

See Section 3.2 for the cancers in the scope of the collection.

The behaviour code (5^{th} digit) should relate to the primary cancer. While the Registry does not collect information on secondary sites, details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the type of cancer than can be coded in ICD-10-AM. This may include more precise details for lymphomas and leukaemias, etc. The Registry codes in ICD-O and records details down to the descriptor level. ICD-10-AM codes have to be converted or recoded to ICD-O. Any information that can assist this process would be useful.

7.4 Date of First Diagnosis

Try to accurately identify the full date of original diagnosis for this cancer where possible. Where unknown, please provide best estimate and enter Y in the Estimated

field. If you are unable to provide an estimate, enter 15 JUN 1900 and enter Y in the Estimated field.

7.5 Date of First Diagnosis Flag

Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.

7.6 Suburb/Locality at First Diagnosis

Name of suburb or town of usual residence at the time of first diagnosis of this cancer. If precise details of the suburb are not known but the State is, then include 'Not stated/unknown' as the suburb descriptor and the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

Supplementary suburb/postcodes:

0989 = not stated/unknown
1989 = New South Wales
2989 = Victoria
3989 = Queensland
4989 = South Australia
5989 = Western Australia
6989 = Tasmania
7989 = Northern Territory
8989 = Australian Capital Territory
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

7.7 Postcode at First Diagnosis

Australian postcode corresponding to address of usual residence at the time of first diagnosis of cancer. Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the postcode are not known but the State is, then use the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

Supplementary suburb/postcodes:

0989 = not stated/unknown
1989 = New South Wales
2989 = Victoria
3989 = Queensland
4989 = South Australia
5989 = Western Australia
6989 = Tasmania

7989 = Northern Territory
8989 = Australian Capital Territory
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

7.8 Laterality of Cancer

Where possible, for cancers of paired organs, such as Breast (C50), Lung (C34), Kidney (C64), Ovary (56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62) indicate the side affected by the tumour.

The valid inputs are:

R	Right
L	Left
B	Bilateral
N	Not Applicable
U	Unknown

Bilateral cancers are extremely rare. Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)).

Not applicable is the default value. This should be recorded for all non-paired organ sites.

Unknown: It is unknown whether, for a paired organ, the origin of the cancer was on the left or right side of the body.

7.9 Basis of Diagnosis

Refers to the most valid basis of diagnosis AT THIS ADMISSION. The following notes may assist.

Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number.

1. **Unknown**

Usually refers to a tumour which was diagnosed and treated elsewhere and the current hospital has no information regarding that treatment. This code would only apply if the current admission is unrelated to the cancer (ie a history of cancer only admission). Please provide details explaining unknown codes in the comments field. Any indication of where the person was diagnosed would avoid further follow-up.

2. **Clinical only**

When a tumour has been diagnosed by clinical examination (eg palpation) only at this admission or where the tumour has been diagnosed at a previous admission or different hospital and the diagnosis is supported only by clinical evidence at this admission.

3. **Clinical investigations**
When a tumour is diagnosed at this admission without invasive surgical procedures but may include diagnostic radioscopy and endoscopy.

4. **Exploratory surgery**
When a tumour is diagnosed at this admission by exploratory surgery without biopsy and histology. Include here an incidental autopsy finding of cancer without biopsy and histology.

5. **Specific biochemical or immunological testing**
Tumour diagnosed using particular laboratory techniques only, eg. Prostate specific antigen (PSA) for prostate.

6. **Cytology or haematology**
Tumour diagnosed using particular laboratory techniques only, eg. Fine needle aspiration without biopsy.

7. **Histology of metastasis**
When a histology is performed on a tissue sample of secondary tumour. Please identify the primary tumour if possible.

8. **Histology of primary**
When histology is performed on a tissue sample of primary tumour.

9. **Autopsy and histology**
When histology is performed on a tissue sample taken during an autopsy.

7.10 Reasons for Clinical Diagnosis

Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. This item has been designed to reduce the number of queries back to hospitals. Multiple reasons may be completed. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows:

01 Palliative Care Admission
02 Doctor's Notes/Referral (Provide doctor details)
03 Pathology (Provide laboratory details)
04 Radiological Investigation (Specify investigation details)
05 Other Non-invasive Investigation (Specify investigation details)
06 Invasive Investigation (Specify investigation details)
07 Non Cancer Admission (Specify details)
09 Other / Chemo / RT (Specify details)

Patients with a clinical admission for chemotherapy should be recorded with a code 09 and chemotherapy specified.

7.11 Details for Clinical Diagnosis

This free text field allows the user to provide the relevant details as outlined above in Reasons for Clinical Diagnosis.

7.12 Comments

This free text field allows the user to provide any other relevant details regarding the cancer that may assist the registry staff or reduce queries for the hospital.

This may include a more precise description of the cancer than is able to be coded in ICD-10-AM. Also include any indication as to whether the cancer has metastasised and to which site.

Where possible, specify grading or differentiation - that is:

1 Grade I (Well) differentiated
2 Grade II Moderately (well) differentiated
3 Grade III Poorly differentiated
4 Grade IV Undifferentiated, anaplastic

7.13 Laboratory Facility Number *

This field becomes mandatory when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis).

The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows:

01 Auslab
02 S & N
03 QML
04 Private Laboratory
05 Other

7.14 Laboratory Specimen Number *

The lab specimen number will record the specimen lab number (e.g. report number) and any other comments required (e.g. if Other lab is recorded, then the user can record the actual lab name along with the Laboratory specimen number). This is a non-mandatory free text field, and only becomes enabled when the codes of 06, 07 08 or 09 is entered into field 13.

Appendix A – Facility Numbers for Private hospitals

Code	Facility Name
302	Belmont Private Hospital
304	Canossa Hospital
307	Brisbane Private Hospital
308	Mater Misericordiae Private Hospital
309	Mater Misericordiae Mothers
310	Mount Olivet Private Hospital
311	New Farm Clinic Private Hospital
312	St Andrew's War Memorial Hospital
313	St Andrew's-IpswichPrivate Hospital
314	Toowong Private Hospital
316	Wesley Hospital (Auchenflower)
317	Sunnybank Private Hospital
318	Mater Childrens' Private Hospital
319	Peninsula Private Hospital
320	North West Brisbane Private Hospital
327	Mater Misericordiae Hospital (Gladstone)
331	Pindarra Gold Coast Private Hospital
332	Nambour/Selangor Private Hospital
333	Allamanda Private Hospital
334	Sunshine Coast Private Hospital
337	Caloundra Private Hospital
340	Friendly Society Private Hospital
341	Cooloola Community Private Hospital
342	MaterMisericordiaeHospital (Bundaberg)
345	St Stephen's Private Hospital
346	Noosa Hospital
347	Logan Private Hospital
349	Pacific Private Hospital
360	Allora District Co-Operative Hospital
361	Clifton Co-Operative Hospital Ltd
362	Crows Nest & District Co-Operative Hospital
363	Killarney & District Memorial Hospital
364	Pittsworth & District Hospital
365	St Andrew's Toowoomba Hospital
366	St Vincent's Toowoomba Hospital
368	Holy Spirit Northside
369	Spendelove House Private Hospital
370	Mater Private Hospital Redland
371	Eden Private Heathcare Centre
380	(Rockhampton)Mater Misericordiae Hospital
381	Hillcrest-Rockhampton Private Hospital
383	Mater Hospital (Yeppoon)
390	Frontier Services Hospital
391	Greenslopes Private Hospital
401	Mater Misericordiae Hospital (Mackay)
402	Pioneer Valley Private Hospital
410	MaterMisericordiae (Hospital(Townsville)
411	Wesley Hospital Townsville
Code	**Facility Name**

420	Cairns Private Hospital
441	John Flynn Gold Coast Private Hospital
442	Pine Rivers Private Hospital
482	Caboolture Private Hospital
486	Sunshine Coast Haematology
488	Mater Private Centre for Haematology & Oncology
494	The Wesley Clinic For Haematology
1166	South Burnett Community Private Hospital

Appendix B – File Formats

All fields are to be provided in the extract in the format specified in the Requested Format column, unless otherwise stated in the Source/Description column. The files will be supplied in ascii comma delimited format with double quotes as a text delimiter. Field which are reported with double quotes as text delimiters will have any embedded double quotes replaced by single quotes. Other punctuation, including commas, will not be stripped from the data.

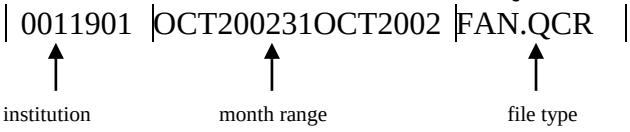
Header Details (HDR) File

Data Item	Requested Format	Source/Description
Facility number	5 num Right adjusted and zero filled from left	The facility code for the set of files being reported.
Number of CAD records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer admission records for that facility.
Number of CAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer primary site records for that facility.
Number of FAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of former/alias name records for that facility.
Number of CDX records	5 num Right adjusted and zero filled from left; zero if null	Total number of reasons for clinical diagnosis records for that facility.

File Names

The following file names are used when sending the data to the registry.
- the first five digits denote the Institution number
- the range of the month will change as per which month you are sending
- please ensure the file names are in CAPITALS.

0011901OCT200231OCT2002HDR.QCR
0011901OCT200231OCT2002CAD.QCR
0011901OCT200231OCT2002CAN.QCR
0011901OCT200231OCT2002CDX.QCR



Example of data in the HDR file

00000,00008,00009,00007,00003

Cancer Admission Details (CAD) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR Number)	8 char Right adjusted and zero filled from left. Mandatory data item.	The unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the registry.
Multiple Primary Site Count	2 num Right adjusted and zero filled from left. Mandatory data item.	The total number of primary sites for the cancer registration (ie. for the patient) will be reported. Only a single CAD file will be reported for the cancer registration, even if there are multiple primary sites.
Medicare Number	11 num Blank if not available or if null. Desirable - if available.	The Medicare number of patient. The field will not be zero or space filled. This comprises the 10 digit Medicare number and then the 1 digit Reference number together.
Patient Surname	24 char Mandatory data item.	The current surname of the patient or resident. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First name	15 char If Unknown put 'Unknown' Mandatory data item.	The current given names of the patient or resident. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second name	15 char Blank if null. Desirable – if applicable.	Second names or initials where known. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Address of Usual Residence	50 char Mandatory data item. If Unknown type "Unknown"	Number and street of usual residential address of patient. Note: this is NOT a Post Office box or Mail Service No. - identify street name where possible. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Use Street Directory abbreviations (eg. St- street, Av- Avenue etc. see section 5.7.1)
Location (suburb/ town) of Usual Residence	40 char Mandatory data item.	Name of suburb, town or locality of usual residence. Note: this item is mandatory even if patient has a Property Name or mail service number. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.
Postcode of	4 num	Australian postcode corresponding to address

Data Item	Requested Format	Source/Description
Usual Residence	Mandatory data item.	of usual residence. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.
Date of Birth	9 date ddmmmyyyy Mandatory data item.	Full date of birth of patient. If year is unknown, estimate the year. If the DOB is unknown, specify 15-JUN-1900. In addition, specify in the comments in the CAN file that the DOB is estimated.
Occupation (before retirement) Description	50 char Left adjusted, blank if null. Desirable – if known.	Means principal lifetime occupation. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Sex	1 char Mandatory data item.	The sex of the person. Only use the following: M= Male F= Female I= Indeterminate / Intersex
Country of Birth Code	4 num Right adjusted and zero filled from left. Mandatory data item.	The country in which the person is born. 4 digit code from the Australian Standard Classification of Countries for Social Statistics (ASCCSS).
Marital Status	2 char Mandatory data item.	The patients current marital status. Only use the following: NM= never married M= married F= Defacto W= widowed D= divorced A= separated N= not stated/unknown The field will not be zero or space filled.
Indigenous Status	2 num Mandatory data item	This item must be asked of the patient to collect the category to which the patient considers himself/herself to belong. 11=Indigenous-Aboriginal but not Torres Strait Islander origin. 12=Indigenous-Torres Strait Islander but not Aboriginal origin. 13=Indigenous-Aboriginal and Torres Strait Islander origin. 14=Not indigenous-not Aboriginal or Torres Strait Islander origin. 19=Not Stated The field will not be zero or space filled.

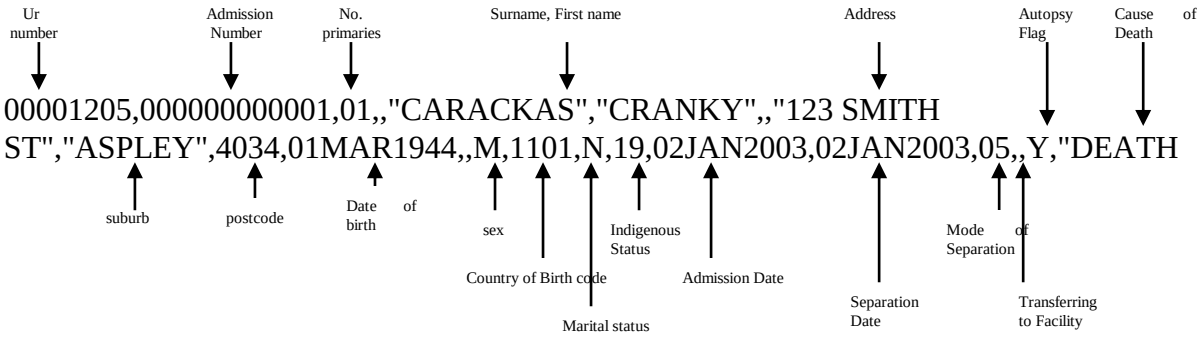
Data Item	Requested Format	Source/Description
Admission Date	9 date ddmmmyyyy Mandatory data item.	This is the date on which an admitted patient commences an episode of care. Enter the full date of admission. DDMMMYYYY.
Separation Date	9 date ddmmmyyyy Mandatory data item.	This is the date that the patient was discharged, transferred or died. DDMMMYYYY.
Mode of Separation	2 char Mandatory data item.	Code which indicates the place to which a patient is referred immediately following separation from hospital. 01=Home/usual residence 04=Other health care establishment 05=Died in hospital 06=Care Type change 07=Discharge at own risk 09=Non return from leave 12=Correctional facility 13=Organ procurement 14=Boarder 15=Residential aged care service 16=Transferred to another hospital 19=Other 99=Unknown The field will not be zero or space filled.
Transferring to Facility	5 char Mandatory - If Transferred (Mode 16)	If the patient was transferred please complete facility number of the receiving facility. The field will not be zero or space filled.
Autopsy Flag	1 char Blank if null. Mandatory – If Died (Mode 05)	Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.
Cause of Death	50 char Left adjusted, blank if null. Mandatory – If Died (Mode 05)	Please only complete the cause of death if the patient dies in the hospital or nursing home. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Title	4 char Left adjusted, blank if null. Mandatory data item.	Refers to the Tile of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Initials	9 char Left adjusted, blank if null.	Refers to the Initials of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or

Data Item	Requested Format	Source/Description
	Mandatory data item.	resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Given Names	55 char Left adjusted, blank if null. Mandatory data item.	Refers to the Given Names of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Surname	29 char Left adjusted. Mandatory data item.	Refers to the Surname of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Diagnosis at Separation	9 char Left adjusted. Mandatory data item.	The principle diagnosis ICD 10-AM code for this admission. The field will not be zero or space filled.

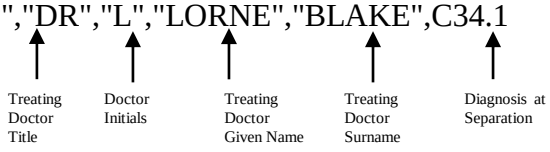
Example of data in a CAD file

00000695,000000000002,01,,"LION","LARRY",,"15 DEN ROAD","JINDALEE",4074,23JUN1940,,M,1101,D,14,20MAY1999,20JUL1999,01,,,,"DR","J","JOHN","FROGLE",J46

00001204,000000000001,01,,"NOODLEMAN","HERMAN",,"123 EAGLE PDE","ASPLEY",4034,01APR1955,,M,1101,M,14,01JAN2003,10JAN2003,01,,,,"DR","LORNE","LORNE","BLAKE",C91.01



POSTOP","DR","L","LORNE","BLAKE",C34.1



Cancer Details (CAN) File

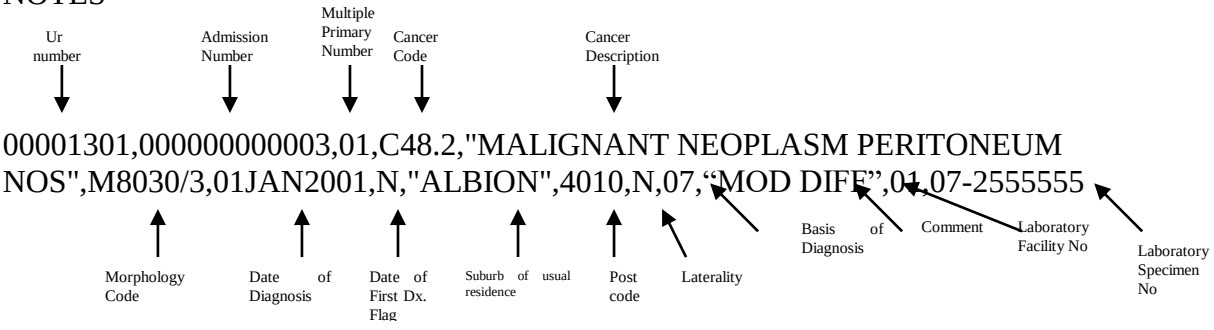
Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the registry.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each primary site for the cancer registration for that admission (for the patient) will be reported in a separate CAN record. Therefore, the patient, for that admission, may have one or many CAN records.
Primary Site of Cancer Code	9 char Left adjusted Mandatory data item.	Indicates the site where the neoplasm originated. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Primary Site of Cancer Description	40 char Left adjusted. Mandatory data item.	Where possible, be specific when describing the primary site, for example, if known, state site as "upper or lower lobe of lung" or "upper-inner quadrant of breast". The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Morphology Code	7 char Mandatory data item.	4 digit Morphology code from ICD 10 AM and 5th digit indicting the behaviour of the tumour, for example invasive or insitu etc. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Date of First Diagnosis	9 date ddmmmyyyy Mandatory data item.	Try to accurately identify the full date of original diagnosis for this cancer where possible. If the date is unknown, the users will be required to enter 15 JUN 1900 in this field.
Date of First Diagnosis Flag	1 char Blank if null. Mandatory data item.	Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.
Location (suburb/ town) of usual residence at diagnosis	40 char Mandatory data item.	Name of suburb or town of usual residence at the time of first diagnosis of this cancer. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.

Data Item	Requested Format	Source/Description
Postcode of Usual Residence at Diagnosis	4 num Mandatory data item.	Australian postcode corresponding to address of usual residence at the time of first diagnosis of cancer. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.
Laterality of Cancer	1 char Mandatory data item.	Where possible, for cancers of paired organs, such as ovary, breast, kidney and lung, indicate which the side is affected by the tumour. R= Right L= Left B= Bilateral N= Not applicable U= Unknown Please see the explanation at the front of this document. For all non-paired organ sites, not applicable is the default. Unknown is used for paired organs only.
Basis of Diagnosis	2 num Mandatory data item.	Refers to the basis of diagnosis AT THIS ADMISSION. Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number. 01=Unknown 02=Clinical Only 03=Clinical Investigations 04=Exploratory Surgery 05=Specific Biochemical and immunological testing 06=Cytology 07=Histology of Metastasis 08=Histology of Primary Site 09=Autopsy and histology The field will not be zero or space filled. (If 02 or 03 is entered, a reason for clinical diagnosis will be displayed in the CDX file)

Data Item	Requested Format	Source/Description
Comments	50 char Left adjusted, blank if null. Desirable – if applicable.	This free text field allows the user to provide any other relevant details regarding the cancer that may assist the registry staff or reduce queries for the hospital. The field will not be zero or space filled. Double quotes will be used as a text de-limiter. If there is a Previous Pathology field or a Radiological Investigations field, this would be ideal in the comments data item, otherwise we will not know of any other tests performed if the basis of diagnosis is not clinical.
Laboratory facility number	2 char	This field becomes mandatory when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis). The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows: 01 Auslab 02 S & N 03 QML 04 Private Laboratory 05 Other
Laboratory Specimen No.	50 char	The lab specimen number will record the specimen lab number (e.g. report number) and any other comments required (e.g. if Other lab is recorded, then the user can record the actual lab name along with the Laboratory specimen number). This is a non-mandatory free text field, and only becomes enabled when the codes of 06, 07 08 or 09 is entered into field 13.

Example of CAN file

00000695,000000000002,01,C54.0,"MALIGNANT NEOPLASM OF ISTHMUS UTERI",M8140/3,01MAY1999,N,"CANBERRA ACT",2600,U,01,"HISTORY",01,07-2555500001204,000000000001,01,C91.01,"ACUTE LYMPHOBLASTIC LEUKAEMIA IN REM",M9835/3,01JAN2001,Y,"ASPLEY",4034,N,03,,,
00001205,000000000001,01,C34.1,"MALGT NEOPLM UPPER LOBE BRONCHUS OR LUNG",M8140/3,01JAN2000,N,"HAWTHORNE",4171,R,01,
00001250,000000000002,01,D39.1,"NEOPLASM UNCERTAIN OR UNKNOWN BEH OVARY",M8000/1,15JUN2002,Y,"CARINA",4152,L,02,"CHECK FOR FURTHER NOTES"



Former/Alias Names (FAN) File
– If there are Alias Names this file is Mandatory

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the registry.
Former/Alias Name Identifier	2 num Right adjusted and zero filled from left. Mandatory data item.	Each alias entered for the patient will be reported in a separate FAN record. Therefore, the patient may have none, one or many FAN records. The alias details are linked to an individual patient but are not linked to an individual admission for that patient. Therefore, when the alias details are reported in the FAN record/s, each alias that exists for that patient will be reported, regardless of the admission number reported. If a patient has an alias and therefore a FAN record, the name identifier can not be '00'.
Patient Surname	24 char Left adjusted. Mandatory data item.	Any previous surname that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First Name	15 char Left adjusted. Mandatory data item.	Any previous first name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second Name	15 char Left adjusted. Desirable – if applicable.	Any previous second name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Example of FAN

00000695,000000000002,01,"LION","LENARD",
00001204,000000000001,01,"HERMIT","HERMAN", ← Same patient
00001204,000000000001,02,"NOODLEMAN","HERMIE",
00001205,000000000001,01,"PANTS","CRANKY",
00001301,000000000003,01,"ANDREWS","ANDROID",
00001301,000000000003,02,"ANDREWS","ANDREW",

00001301,000000000003,03,"ANDREWS","JULIE",

Ur number	Admission number	Name Identifier	Surname	First name

Reason for Clinical Diagnosis (CDX) File
– If notifying of a Basis of Diagnosis in the CAN file of 02 or 03, then this file is Mandatory

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the registry.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each reason for clinical diagnosis for each primary site for the cancer registration will be reported in a separate CDX record. Therefore, the patient may have none, one or many CDX records and the patient may have none, one or many CDX records for a given primary site.
Reasons for clinical diagnosis code	2 num Right adjusted and zero filled from left. Mandatory data item.	Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows: 01=Pallative care admission 02=Doctors notes/Referral 03=Pathology 04=Radiological investigations 05=Other non invasive investigations 06=Invasive investigation 07=Non cancer admission 09=Other The field will not be zero or space filled. You cannot have more than one of the above codes for the same primary site. ie: for patient UR number 123456 ; primary site number 01, the code 03 cannot be used more than once. You need to use another code if there is another reason, therefore use 03 and 09.
Reasons for clinical diagnosis text	50 char Blank if reasons for clinical diagnosis code = 01.	Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in this field. The extract will simply include the details if available for that reason for

Data Item	Requested Format	Source/Description
	Desirable – if applicable.	clinical diagnosis item or leave the field in the CDX record blank if the details field is blank for that reason for clinical diagnosis item. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

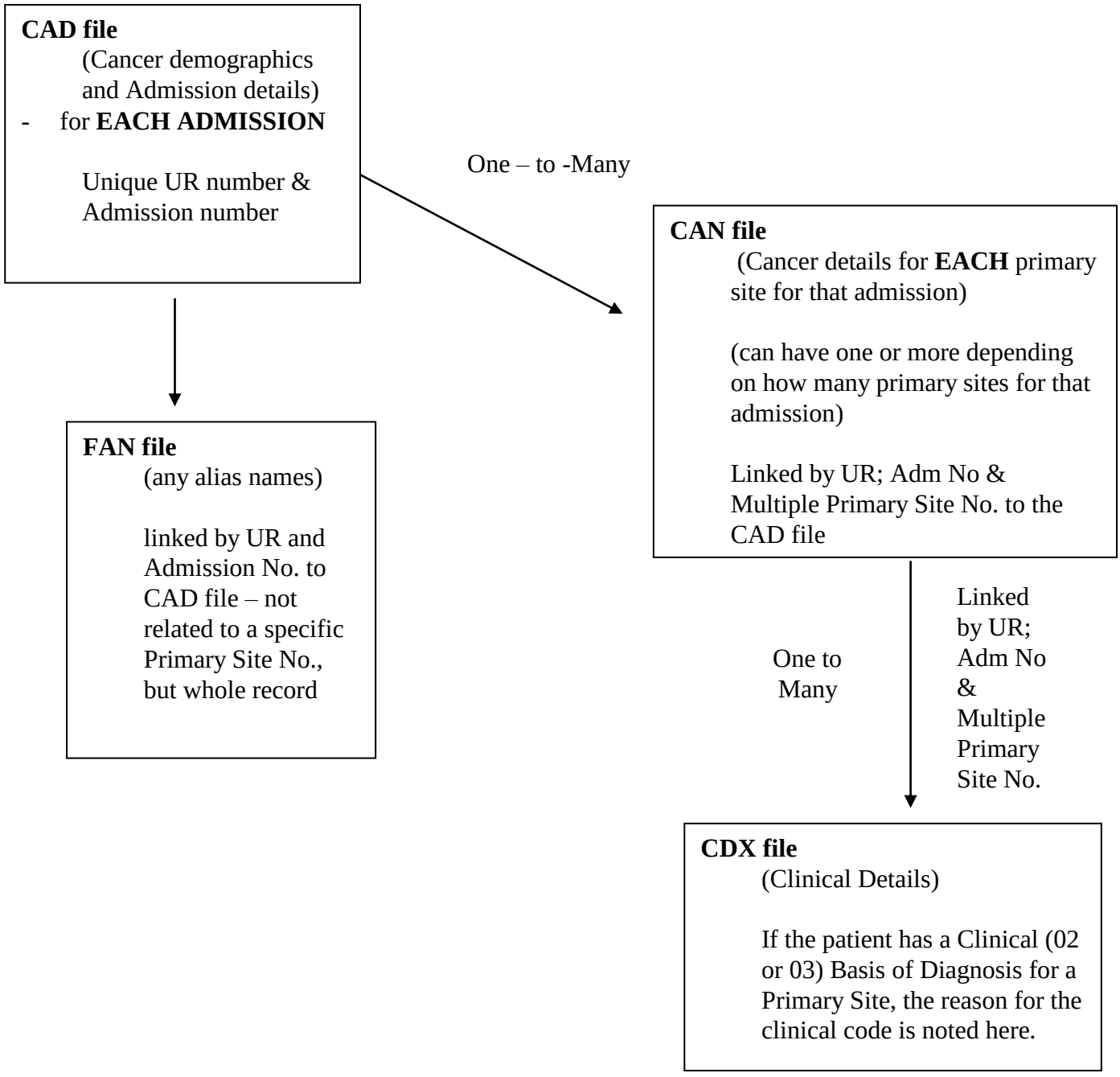
Example of CDX

00001204,000000000001,01,02,"MEDICAL RECORD NOTES"
00001204,000000000001,01,03,"SEE MEDICAL RECORD"

00001250,000000000002,01,04,"SEE EXAMINATION REPORT"

How the Files are Linked together

The CAD record relates to a specific admission, so if the patient is admitted twice in the extract period (can happen if the extract period is for a month) then there will be 2 CAD records for the patient, and subsequent CAN records from that admission.
There could also be more than one CDX file if the second CAD admission and subsequent CAN/s have a CDX (ie: Clinical Details) as well as the first admission ....as the CDX file is linked to the CAN file for that specific primary site number....



Appendix C - Example of how QCR displays the data supplied in a form.

QUEENSLAND CANCER REGISTRY – HBCIS FORM

CANCER REGISTRATION REGULATIONS,Health Act 1937

QCR REGISTRATION NO:	
1. Name of Hospital/Institution	00000 NOT HOSPITAL DEATH
2. Medicare Number	0000000000
3. Ur Number	00001480
4. Surname	SMITHERS
5. Given Names	SILLY
6. Former Names/Alias	SAUSAGE, SILLY SMITHERS, SOMEONE SMITHERS, SALLY
7. No. and Street	798 SIR FRED SCHONELL DRIVE
8. Suburb/Locality	ST LUCIA
9. Postcode	4067
10. Date of Birth	01–JAN–1952
11. Occupation	
12. Sex	M [–]
13. Country of Birth	1101 [Australia]
14. Marital Status	NM [–]
15. Indigenous Status	14 [–]
16. Admission Date	10–JAN–2004
17. Separation Date	13–JAN–2004
18. Separation Mode	01
If transferred, Name of Institution	
If died, was autopsy held	
19. Underlying cause of death	
20. Primary Site of Cancer	C22.9 MALIGNANT NEOPLASM OF LIVER UNSPECIFIED
ICDO Primary Site	
21. Histological Type of Cancer	M8000/9 Neoplm, malgt, unc, primary/met
22. Date of First Diagnosis	10–JAN–2004
23. Usual Suburb at FIRST Diagnosis	ST LUCIA
24. Postcode	4067
25. Laterality	N [–]
26. More than one Primary Site	Y [02 site(s)]
27. Most valid Basis of Diagnosis	05 [SPECIFIC BIOCHEMISTRY OR IMMUNOLC
28. Reasons for Clinical Diagnosis	
COMMENT	
Diagnosis at Separation	C34.2 Malg neoplasm mid lobe bronchus or lung
29. Name of Treating Doctor	DR Lorne (LORNE) Blake

Appendix D - ICD-10-AM Codes required

Further information on ICD-10-AM Codes required which may assist programmers to identify the cancer registrations to be sent to QCR

Private Hospitals are required to notify QCR for the following:

- All invasive cancers
- All cancers with an uncertain behaviour
- All in-situ conditions
- Benign central nervous system and brain tumours
- Do not need Basal Cell Carcinomas and Squamous Cell Carcinomas of the Skin.

A form should be completed for each of the following events:

(i) at discharge or transfer of a patient being **first** diagnosed with cancer, or when a **new site** is diagnosed, or the same site but a **different histological type** of cancer is diagnosed.

(ii) a patient's **first** date of attendance in each calendar year for chemotherapy or radiotherapy.

(iii) at the **death** of a patient suffering from or with a history of cancer.

(iv) at discharge or transfer from the **first** date of attendance for each calendar year for all other patients suffering from or with a history of cancer (where the history of cancer has been coded in their morbidity record).

A **separate form** is required for each primary site.

Modifications you may like to use for your system to identify cases to be sent:
In the HBCIS system used by the public hospitals, there are **non-notifiable cancer** and **history of cancer parameter**s that are hard-coded ie: they are not modifiable by users.

1.The non-notifiable parameter lists the paired combinations of neoplasm and morphology codes that do not require cancer registration. The parameter lists the following excluded skin codes:

- malignant neoplasm of skin codes (other than melanoma) C44.0, C44.1, C44.2, C44.3, C44.4, C44.5, C44.6, C44.7, C44.8 and C44.9.
- carcinoma in-situ of skin codes D04.0, D04.1, D04.2, D04.3, D04.4, D04.5, D04.6, D04.7, D04.8, D04.9.
- neoplasm of uncertain or unknown behaviour of skin D48.5

and the following selected morphology codes:

- basal cell and squamous cell morphologies M805, M806, M807, M808, M809, M810, M811.

2. The history of cancer parameter enables the reporting of episodes where the history of cancer has been coded and the episode is the first presentation in a calendar year. The following codes are included:

- personal history of malignant neoplasm Z85.0, Z85.1, Z85.2, Z85.3, Z85.4, Z85.5, Z85.6, Z85.7, Z85.8. The coder is prompted if entered.

3. In addition, a prompt appears if any of the following required ICD10-AM v4 Site Codes are entered on the screen (irrespective of the morphology code entered). These Site codes follow the cancers required to be sent to the registry eg. invasive, in-situ etc. as above.

ICD-AM-10 version 4 Site Codes

Site	*Description*
C00.0	MALIGNANT NEOPLASM OF EXTERNAL UPPER LIP
C00.1	MALIGNANT NEOPLASM OF EXTERNAL LOWER LIP
C00.2	MALIGNANT NEOPLASM EXTERNAL LIP NOS
C00.3	MALGT NEOPLASM UPPER LIP INNER ASPECT
C00.4	MALGT NEOPLASM LOWER LIP INNER ASPECT
C00.5	MALGT NEOPLASM LIP NOS INNER ASPECT
C00.6	MALIGNANT NEOPLASM OF COMMISSURE OF LIP
C00.8	OVERLAPPING MALIGNANT LESION OF LIP
C00.9	MALIGNANT NEOPLASM OF LIP UNSPECIFIED
C01	MALIGNANT NEOPLASM OF BASE OF TONGUE
C02.0	MALGT NEOPLASM DORSAL SURFACE OF TONGUE
C02.1	MALIGNANT NEOPLASM OF BORDER OF TONGUE
C02.2	MALGT NEOPLASM VENTRAL SURFACE TONGUE
C02.3	MALGT NEOPLASM ANT TONGUE PART UNSPEC
C02.4	MALIGNANT NEOPLASM OF LINGUAL TONSIL
C02.8	MALGT NEOPLASM OVERLAPPING LESION TONGUE
C02.9	MALIGNANT NEOPLASM TONGUE UNSPECIFIED
C03.0	MALIGNANT NEOPLASM OF UPPER GUM
C03.1	MALIGNANT NEOPLASM OF LOWER GUM
C03.9	MALIGNANT NEOPLASM OF GUM UNSPECIFIED
C04.0	MALIGNANT NEOPLASM ANT FLOOR OF MOUTH
C04.1	MALIGNANT NEOPLASM LAT FLOOR OF MOUTH
C04.8	OVERLAPPING MALGT LESION FLOOR OF MOUTH
C04.9	MALGT NEOPLASM OF FLOOR OF MOUTH NOS
C05.0	MALIGNANT NEOPLASM OF HARD PALATE
C05.1	MALIGNANT NEOPLASM OF SOFT PALATE
C05.2	MALIGNANT NEOPLASM OF UVULA
C05.8	OVERLAPPING MALIGNANT LESION OF PALATE
C05.9	MALIGNANT NEOPLASM OF PALATE UNSPECIFIED
C06.0	MALIGNANT NEOPLASM OF CHEEK MUCOSA
C06.1	MALIGNANT NEOPLASM OF VESTIBULE OF MOUTH
C06.2	MALIGNANT NEOPLASM OF RETROMOLAR AREA
C06.8	OVERLAP MALGT LESION OTH/UNSPEC MOUTH
C06.9	MALIGNANT NEOPLASM OF MOUTH UNSPECIFIED
C07	MALIGNANT NEOPLASM OF PAROTID GLAND

C08.0	MALIGNANT NEOPLASM SUBMANDIBULAR GLAND
C08.1	MALIGNANT NEOPLASM OF SUBLINGUAL GLAND
C08.8	OVERLAPPING MALGT LESION MAJOR SAL GLD
C08.9	MALGT LESION MAJOR SALIVARY GLAND NOS
C09.0	MALIGNANT NEOPLASM OF TONSILLAR FOSSA
C09.1	MALGT NEOPLASM TONSILLAR PILLAR
C09.8	OVERLAPPING MALIGNANT LESION OF TONSIL
C09.9	MALIGNANT NEOPLASM TONSIL UNSPECIFIED
C10.0	MALIGNANT NEOPLASM OF VALLECULA
C10.1	MALGT NEOPLASM ANT SURFACE EPIGLOTTIS
C10.2	MALIGNANT NEOPLASM LAT WALL OROPHARYNX
C10.3	MALIGNANT NEOPLASM POST WALL OROPHARYNX
C10.4	MALIGNANT NEOPLASM OF BRANCHIAL CLEFT
C10.8	OVERLAPPING MALIGNANT LESION OROPHARYNX
C10.9	MALIGNANT LESION OROPHARYNX UNSPECIFIED
C11.0	MALGT NEOPLASM SUPERIOR WALL NASOPHRYNX
C11.1	MALIGNANT NEOPLASM POST WALL NASOPHARYNX
C11.2	MALIGNANT NEOPLASM LAT WALL NASOPHARYNX
C11.3	MALIGNANT NEOPLASM ANT WALL NASOPHARYNX
C11.8	OVERLAPPING MALGT NEOPLASM NASOPHARYNX
C11.9	MALIGNANT NEOPLASM NASOPHARYNX NOS
C12	MALIGNANT NEOPLASM OF PYRIFORM SINUS
C13.0	MALIGNANT NEOPLASM OF POSTCRICOID REGION
C13.1	MALGT NEOPLM HYPOPHRNGL ARYEPIGLTC FOLD
C13.2	MALIGNANT NEOPLASM POST WALL HYPOPHARYNX
C13.8	OVERLAPPING MALIGNANT LESION HYPOPHARYNX
C13.9	MALIGNANT LESION HYPOPHARYNX UNSPECIFIED
C14.0	MALIGNANT NEOPLASM PHARYNX UNSPECIFIED
C14.2	MALIGNANT NEOPLASM OF WALDEYER'S RING
C14.8	OVERLAP MALGT NEOPLM LIP ORAL CV PHRYNX
C15.0	MALIGNANT NEOPLASM CERVICAL OESOPHAGUS
C15.1	MALIGNANT NEOPLASM THORACIC OESOPHAGUS
C15.2	MALIGNANT NEOPLASM ABDOMINAL OESOPHAGUS
C15.3	MALGT NEOPLASM UPPER THIRD OESOPHAGUS
C15.4	MALGT NEOPLASM MIDDLE THIRD OESOPHAGUS
C15.5	MALGT NEOPLASM LOWER THIRD OESOPHAGUS
C15.8	OVERLAPPING MALIGNANT LESION OESOPHAGUS
C15.9	MALIGNANT LESION OESOPHAGUS UNSPECIFIED
C16.0	MALIGNANT NEOPLASM OF CARDIA
C16.1	MALIGNANT NEOPLASM OF FUNDUS OF STOMACH
C16.2	MALIGNANT NEOPLASM OF BODY OF STOMACH
C16.3	MALIGNANT NEOPLASM OF PYLORIC ANTRUM
C16.4	MALIGNANT NEOPLASM OF PYLORUS
C16.5	MALGT NEOPLASM LESSER CURVE STOMACH NOS
C16.6	MALGT NEOPLASM GREATER CURVE STOMACH NOS
C16.8	OVERLAPPING MALIGNANT LESION OF STOMACH
C16.9	MALIGNANT NEOPLASM STOMACH UNSPECIFIED
C17.0	MALIGNANT NEOPLASM OF DUODENUM
C17.1	MALIGNANT NEOPLASM OF JEJUNUM
C17.2	MALIGNANT NEOPLASM OF ILEUM
C17.3	MALIGNANT NEOPLASM MECKEL'S DIVERTICULUM
C17.8	OVERLAP MALGT LESION SMALL INTESTINE
C17.9	MALIGNANT LESION SMALL INTESTINE NOS

C18.0	MALIGNANT NEOPLASM OF CAECUM
C18.1	MALIGNANT NEOPLASM OF APPENDIX
C18.2	MALIGNANT NEOPLASM OF ASCENDING COLON
C18.3	MALIGNANT NEOPLASM OF HEPATIC FLEXURE
C18.4	MALIGNANT NEOPLASM OF TRANSVERSE COLON
C18.5	MALIGNANT NEOPLASM OF SPLENIC FLEXURE
C18.6	MALIGNANT NEOPLASM OF DESCENDING COLON
C18.7	MALIGNANT NEOPLASM OF SIGMOID COLON
C18.8	OVERLAPPING MALIGNANT LESION OF COLON
C18.9	MALGT NEOPLASM COLON UNSPECIFIED PART
C19	MALIGNANT NEOPLASM RECTOSIGMOID JUNCTION
C20	MALIGNANT NEOPLASM OF RECTUM
C21.0	MALIGNANT NEOPLASM OF ANUS UNSPECIFIED
C21.1	MALIGNANT NEOPLASM OF ANAL CANAL
C21.2	MALIGNANT NEOPLASM OF CLOACOGENIC ZONE
C21.8	OVERLAP MALGT LSN RECTUM ANUS ANAL CNL
C22.0	LIVER CELL CARCINOMA
C22.1	INTRAHEPATIC BILE DUCT CARCINOMA
C22.2	HEPATOBLASTOMA
C22.3	ANGIOSARCOMA OF LIVER
C22.4	OTHER SARCOMAS OF LIVER
C22.7	OTHER SPECIFIED CARCINOMAS OF LIVER
C22.9	MALIGNANT NEOPLASM OF LIVER UNSPECIFIED
C23	MALIGNANT NEOPLASM OF GALLBLADDER
C24.0	MALIGNANT NEOPLM EXTRAHEPATIC BILE DUCT
C24.1	MALIGNANT NEOPLASM OF AMPULLA OF VATER
C24.8	OVERLAPPING MALGT LESION BILIARY TRACT
C24.9	MALIGNANT LESION BILIARY TRACT NOS
C25.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS
C25.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS
C25.2	MALIGNANT NEOPLASM OF TAIL OF PANCREAS
C25.3	MALIGNANT NEOPLASM OF PANCREATIC DUCT
C25.4	MALIGNANT NEOPLASM OF ENDOCRINE PANCREAS
C25.7	MALIGNANT NEOPLASM OTHER PARTS PANCREAS
C25.8	OVERLAPPING MALIGNANT LESION OF PANCREAS
C25.9	MALIGNANT NEOPLASM PANCREAS PART UNSPEC
C26.0	MALGT NEOPLASM INTEST TRACT PART UNSPEC
C26.1	MALIGNANT NEOPLASM OF SPLEEN
C26.8	OVERLAP MALGT LESION DIGESTIVE SYSTEM
C26.9	MALGT NEOPLM ILL-DEF SITE DIGEST SYSTEM
C30.0	MALIGNANT NEOPLASM OF NASAL CAVITY
C30.1	MALIGNANT NEOPLASM OF MIDDLE EAR
C31.0	MALIGNANT NEOPLASM OF MAXILLARY SINUS
C31.1	MALIGNANT NEOPLASM OF ETHMOIDAL SINUS
C31.2	MALIGNANT NEOPLASM OF FRONTAL SINUS
C31.3	MALIGNANT NEOPLASM OF SPHENOIDAL SINUS
C31.8	OVERLAP MALGT LESION ACCESSORY SINUSES
C31.9	MALIGNANT NEOPLASM ACCESSORY SINUS NOS
C32.0	MALIGNANT NEOPLASM OF GLOTTIS
C32.1	MALIGNANT NEOPLASM OF SUPRAGLOTTIS
C32.2	MALIGNANT NEOPLASM OF SUBGLOTTIS
C32.3	MALIGNANT NEOPLASM LARYNGEAL CARTILAGE
C32.8	OVERLAPPING MALIGNANT LESION OF LARYNX

C32.9	MALIGNANT NEOPLASM LARYNX UNSPECIFIED
C33	MALIGNANT NEOPLASM OF TRACHEA
C34.0	MALIGNANT NEOPLASM OF MAIN BRONCHUS
C34.1	MALGT NEOPLM UPPER LOBE BRONCHUS OR LUNG
C34.2	MALGT NEOPLASM MID LOBE BRONCHUS OR LUNG
C34.3	MALGT NEOPLM LOWER LOBE BRONCHUS OR LUNG
C34.8	OVERLAP MALGT LESION BRONCHUS OR LUNG
C34.9	MALIGNANT NEOPLASM BRONCHUS OR LUNG NOS
C37	MALIGNANT NEOPLASM OF THYMUS
C38.0	MALIGNANT NEOPLASM OF HEART
C38.1	MALIGNANT NEOPLASM ANTERIOR MEDIASTINUM
C38.2	MALIGNANT NEOPLASM POSTERIOR MEDIASTINUM
C38.3	MALGT NEOPLASM MEDIASTINUM, PART UNSPEC
C38.4	MALIGNANT NEOPLASM OF PLEURA
C38.8	OVERLAP MALGT LSN HEART MEDIAST & PLEURA
C39.0	MALGT NEOPLM UPPER RESP TRACT PRT UNSPEC
C39.8	OVERLAP MALGT LSN RESP & INTRATHOR ORG
C39.9	MALGT NEOPLM ILL-DEF SITES RESP SYSTEM
C40.0	MALGT NEOPLM SCAPULA LONG BONES UPP LMB
C40.1	MALGT NEOPLASM SHORT BONES UPPER LIMB
C40.2	MALIGNANT NEOPLASM LONG BONES LOWER LIMB
C40.3	MALGT NEOPLASM SHORT BONES LOWER LIMB
C40.8	OVERLAP MALGT LSN BONE ARTLR CART LIMB
C40.9	MALGT NEOPLM BONE & ARTLR CART LIMB NOS
C41.0	MALIGNANT NEOPLASM OF CRANIOFACIAL BONES
C41.0	MALIGNANT NEOPLASM MAXILLOFACIAL BONES
C41.1	MALIGNANT NEOPLASM OF MANDIBLE
C41.2	MALIGNANT NEOPLASM OF VERTEBRAL COLUMN
C41.3	MALIGNANT NEOPLASM RIBS STERNUM CLAVICLE
C41.4	MALGT NEOPLM PELVIC BONES SACRUM COCCYX
C41.8	OVERLAP MALIGNANT LESION BONE ARTLR CART
C41.9	MALGT NEOPLASM BONE & ARTLR CART NOS
C43.0	MALIGNANT MELANOMA OF LIP
C43.1	MALGT MELANOMA EYELID INCLUDING CANTHUS
C43.2	MALGT MELANOMA EAR & EXT AURICULAR CANAL
C43.3	MALGT MELANOMA OTHER & UNSPEC PARTS FACE
C43.4	MALIGNANT MELANOMA OF SCALP AND NECK
C43.5	MALIGNANT MELANOMA OF TRUNK
C43.6	MALGT MELANOMA UPPER LIMB INCL SHOULDER
C43.7	MALIGNANT MELANOMA LOWER LIMB INCL HIP
C43.8	OVERLAPPING MALIGNANT MELANOMA OF SKIN
C43.9	MALIGNANT MELANOMA OF SKIN UNSPECIFIED
C44.0	MALIGNANT NEOPLASM OF SKIN OF LIP
C44.1	MALGT NEOPLASM SKIN EYELID INCL CANTHUS
C44.2	MALGT NEOPLM SKIN EAR & EXT AURIC CANAL
C44.3	MALGT NEOPLM SKIN OTH/UNSPEC PARTS FACE
C44.4	MALIGNANT NEOPLASM SKIN OF SCALP & NECK
C44.5	MALIGNANT NEOPLASM OF SKIN OF TRUNK
C44.6	MALGT NEOPLM SKIN UPP LMB INCL SHOULDER
C44.7	MALGT NEOPLASM SKIN LOWER LIMB INCL HIP
C44.8	OVERLAPPING MALIGNANT LESION OF SKIN
C44.9	MALIGNANT NEOPLASM OF SKIN UNSPECIFIED
C45.0	MESOTHELIOMA OF PLEURA

C45.1	MESOTHELIOMA OF PERITONEUM
C45.2	MESOTHELIOMA OF PERICARDIUM
C45.7	MESOTHELIOMA OF OTHER SITES
C45.9	MESOTHELIOMA UNSPECIFIED
C46.0	KAPOSI'S SARCOMA OF SKIN
C46.1	KAPOSI'S SARCOMA OF SOFT TISSUE
C46.2	KAPOSI'S SARCOMA OF PALATE
C46.3	KAPOSI'S SARCOMA OF LYMPH NODES
C46.7	KAPOSI'S SARCOMA OF OTHER SITES
C46.8	KAPOSI'S SARCOMA OF MULTIPLE ORGANS
C46.9	KAPOSI'S SARCOMA UNSPECIFIED
C47.0	MALGT NEOPLM PERPH NERVE HEAD FACE NECK
C47.1	MALGT NEOPLM PERPH NRV UPP LMB SHOULDER
C47.2	MALGT NEOPLM PERPH NRV LOW LIMB INCL HIP
C47.3	MALGT NEOPLASM PERIPHERAL NERVES THORAX
C47.4	MALGT NEOPLM PERIPHERAL NERVES ABDOMEN
C47.5	MALGT NEOPLASM PERIPHERAL NERVES PELVIS
C47.6	MALGT NEOPLASM PERPH NERVES OF TRUNK NOS
C47.8	OVERLAP MALGT LSN PERPH NRV/AUT NRVS SYS
C47.9	MALGT NEOPLM PERPH NRV/AUT NRVS SYS NOS
C48.0	MALIGNANT NEOPLASM OF RETROPERITONEUM
C48.1	MALGT NEOPLM SPEC PARTS OF PERITONEUM
C48.2	MALIGNANT NEOPLASM PERITONEUM NOS
C48.8	OVERLAP MALGT LSN RETPERITONM PERITONEUM
C49.0	MALGT NEOPLM CON/SFT TIS HEAD FACE NECK
C49.1	MALGT NEOPLM CON/SFT TIS UPP LMB SHOLD
C49.2	MALGT NEOPLM CON/SFT TIS LOWER LIMB HIP
C49.3	MALGT NEOPLASM CON & SOFT TISSUE THORAX
C49.4	MALGT NEOPLASM CON & SOFT TISSUE ABDOMEN
C49.5	MALGT NEOPLASM CON & SOFT TISSUE PELVIS
C49.6	MALGT NEOPLM CON/SOFT TIS TRUNK NOS
C49.8	OVERLAP MALGT LESION CON & SOFT TISSUE
C49.9	MALGT NEOPLASM CON & SOFT TISSUE NOS
C50.0	MALIGNANT NEOPLASM OF NIPPLE AND AREOLA
C50.1	MALGT NEOPLASM CENTRAL PORTION BREAST
C50.2	MALGT NEOPLASM UPP INNR QUADRANT BREAST
C50.3	MALGT NEOPLASM LOW INNR QUADRANT BREAST
C50.4	MALGT NEOPLASM UPP OUTR QUADRANT BREAST
C50.5	MALGT NEOPLASM LOW OUTER QUADRANT BREAST
C50.6	MALIGNANT NEOPLASM AXILLARY TAIL BREAST
C50.8	OVERLAPPING MALIGNANT LESION OF BREAST
C50.9	MALIGNANT NEOPLASM BREAST PART UNSPEC
C51.0	MALIGNANT NEOPLASM OF LABIUM MAJUS
C51.1	MALIGNANT NEOPLASM OF LABIUM MINUS
C51.2	MALIGNANT NEOPLASM OF CLITORIS
C51.8	OVERLAPPING MALIGNANT LESION OF VULVA
C51.9	MALIGNANT NEOPLASM OF VULVA UNSPECIFIED
C52	MALIGNANT NEOPLASM OF VAGINA
C53.0	MALIGNANT NEOPLASM OF ENDOCERVIX
C53.1	MALIGNANT NEOPLASM OF EXOCERVIX
C53.8	OVERLAP MALIGNANT LESION CERVIX UTERI
C53.9	MALIGNANT NEOPLASM CERVIX UTERI NOS
C54.0	MALIGNANT NEOPLASM OF ISTHMUS UTERI

C54.1	MALIGNANT NEOPLASM OF ENDOMETRIUM
C54.2	MALIGNANT NEOPLASM OF MYOMETRIUM
C54.3	MALIGNANT NEOPLASM OF FUNDUS UTERI
C54.8	OVERLAP MALIGNANT LESION CORPUS UTERI
C54.9	MALIGNANT NEOPLASM CORPUS UTERI NOS
C55	MALIGNANT NEOPLASM UTERUS PART UNSPEC
C56	MALIGNANT NEOPLASM OF OVARY
C57.0	MALIGNANT NEOPLASM OF FALLOPIAN TUBE
C57.1	MALIGNANT NEOPLASM OF BROAD LIGAMENT
C57.2	MALIGNANT NEOPLASM OF ROUND LIGAMENT
C57.3	MALIGNANT NEOPLASM OF PARAMETRIUM
C57.4	MALIGNANT NEOPLASM UTERINE ADNEXA NOS
C57.7	MALGT NEOPLM OTHER SPEC FEMLE GEN ORG
C57.8	OVERLAP MALGT LSN FEMALE GENITAL ORGANS
C57.9	MALGT NEOPLASM FEMALE GENITAL ORGAN NOS
C58	MALIGNANT NEOPLASM OF PLACENTA
C60.0	MALIGNANT NEOPLASM OF PREPUCE
C60.1	MALIGNANT NEOPLASM OF GLANS PENIS
C60.2	MALIGNANT NEOPLASM OF BODY OF PENIS
C60.8	OVERLAPPING MALIGNANT LESION OF PENIS
C60.9	MALIGNANT NEOPLASM OF PENIS UNSPECIFIED
C61	MALIGNANT NEOPLASM OF PROSTATE
C62.0	MALIGNANT NEOPLASM OF UNDESCENDED TESTIS
C62.1	MALIGNANT NEOPLASM OF DESCENDED TESTIS
C62.9	MALIGNANT NEOPLASM OF TESTIS UNSPECIFIED
C63.0	MALIGNANT NEOPLASM OF EPIDIDYMIS
C63.1	MALIGNANT NEOPLASM OF SPERMATIC CORD
C63.2	MALIGNANT NEOPLASM OF SCROTUM
C63.7	OTHER SPECIFIED MALE GENITAL ORGANS
C63.8	OVERLAP MALGT LESION MALE GENITAL ORGANS
C63.9	MALGT NEOPLASM MALE GENITAL ORGAN NOS
C64	MALGT NEOPLASM KIDNEY EX RENAL PELVIS
C65	MALIGNANT NEOPLASM OF RENAL PELVIS
C66	MALIGNANT NEOPLASM OF URETER
C67.0	MALIGNANT NEOPLASM OF TRIGONE OF BLADDER
C67.1	MALIGNANT NEOPLASM OF DOME OF BLADDER
C67.2	MALIGNANT NEOPLASM LATERAL WALL BLADDER
C67.3	MALIGNANT NEOPLASM ANTERIOR WALL BLADDER
C67.4	MALGT NEOPLASM OF POSTERIOR WALL BLADDER
C67.5	MALIGNANT NEOPLASM OF BLADDER NECK
C67.6	MALIGNANT NEOPLASM OF URETERIC ORIFICE
C67.7	MALIGNANT NEOPLASM OF URACHUS
C67.8	OVERLAPPING MALIGNANT LESION OF BLADDER
C67.9	MALIGNANT NEOPLASM OF BLADDER NOS
C68.0	MALIGNANT NEOPLASM OF URETHRA
C68.1	MALIGNANT NEOPLASM OF PARAURETHRAL GLAND
C68.8	OVERLAP MALIGNANT LESION URINARY ORGANS
C68.9	MALIGNANT NEOPLASM URINARY ORGAN NOS
C69.0	MALIGNANT NEOPLASM OF CONJUNCTIVA
C69.1	MALIGNANT NEOPLASM OF CORNEA
C69.2	MALIGNANT NEOPLASM OF RETINA
C69.3	MALIGNANT NEOPLASM OF CHOROID
C69.4	MALIGNANT NEOPLASM OF CILIARY BODY

C69.5	MALIGNANT NEOPLASM LACRIMAL GLAND & DUCT
C69.6	MALIGNANT NEOPLASM OF ORBIT
C69.8	OVERLAP MALIGNANT LESION EYE & ADNEXA
C69.9	MALIGNANT NEOPLASM OF EYE UNSPECIFIED
C70.0	CEREBRAL MENINGES
C70.1	SPINAL MENINGES
C70.9	MENINGES UNSPECIFIED
C71.0	MALGT NEOPLM CEREBRUM EX LOBES & VENTRL
C71.1	MALIGNANT NEOPLASM OF FRONTAL LOBE
C71.2	MALIGNANT NEOPLASM OF TEMPORAL LOBE
C71.3	MALIGNANT NEOPLASM OF PARIETAL LOBE
C71.4	MALIGNANT NEOPLASM OF OCCIPITAL LOBE
C71.5	MALIGNANT NEOPLASM OF CEREBRAL VENTRICLE
C71.6	MALIGNANT NEOPLASM OF CEREBELLUM
C71.7	MALIGNANT NEOPLASM OF BRAIN STEM
C71.8	OVERLAPPING MALIGNANT LESION OF BRAIN
C71.9	MALIGNANT NEOPLASM OF BRAIN UNSPECIFIED
C72.0	MALIGNANT NEOPLASM OF SPINAL CORD
C72.1	MALIGNANT NEOPLASM OF CAUDA EQUINA
C72.2	MALIGNANT NEOPLASM OF OLFACTORY NERVE
C72.3	MALIGNANT NEOPLASM OF OPTIC NERVE
C72.4	MALIGNANT NEOPLASM OF ACOUSTIC NERVE
C72.5	MALGT NEOPLASM OTH/UNSPEC CRANIAL NERVES
C72.8	OVERLAP MALGT LESION BRAIN & OTHER CNS
C72.9	MALIGNANT NEOPLASM CNS UNSPECIFIED
C73	MALIGNANT NEOPLASM OF THYROID GLAND
C74.0	MALIGNANT NEOPLASM CORTEX ADRENAL GLAND
C74.1	MALIGNANT NEOPLASM MEDULLA ADRENAL GLAND
C74.9	MALIGNANT NEOPLASM ADRENAL GLAND NOS
C75.0	MALIGNANT NEOPLASM OF PARATHYROID GLAND
C75.1	MALIGNANT NEOPLASM OF PITUITARY GLAND
C75.2	MALIGNANT NEOPLASM CRANIOPHARYNGEAL DUCT
C75.3	MALIGNANT NEOPLASM OF PINEAL GLAND
C75.4	MALIGNANT NEOPLASM OF CAROTID BODY
C75.5	MALGT NEOPLM AORTIC BODY OTH PARAGANGLIA
C75.8	MALGT NEOPLASM PLURIGLANDULAR INV NOS
C75.9	MALIGNANT NEOPLASM ENDOCRINE GLAND NOS
C76.0	MALIGNANT NEOPLASM HEAD FACE & NECK
C76.1	MALIGNANT NEOPLASM OF THORAX
C76.2	MALIGNANT NEOPLASM OF ABDOMEN
C76.3	MALIGNANT NEOPLASM OF PELVIS
C76.4	MALIGNANT NEOPLASM OF UPPER LIMB
C76.5	MALIGNANT NEOPLASM OF LOWER LIMB
C76.7	MALIGNANT NEOPLASM OTHER ILL-DEF SITES
C76.8	OVERLAP MALGT LESION OTH & ILL-DEF SITES
C80	MALIGNANT NEOPLASM WO SITE SPECIFICATION
C81.0	HODGKINS DIS LYMPHOCYTIC PREDOMINANCE
C81.1	HODGKIN'S DISEASE NODULAR SCLEROSIS
C81.2	HODGKIN'S DISEASE MIXED CELLULARITY
C81.3	HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION
C81.7	OTHER HODGKIN'S DISEASE
C81.9	HODGKIN'S DISEASE UNSPECIFIED
C82.0	SMALL CLEAVED CELL FOLLICULAR NHL

C82.1	MIXED SMALL CLEAVED LARGE CELL FOL NHL
C82.2	LARGE CELL FOLLICULAR NHL
C82.7	OTHER TYPES FOLLICULAR NHL
C82.9	FOLLICULAR NHL UNSPECIFIED
C83.0	SMALL CELL (DIFFUSE) NHL
C83.1	SMALL CLEAVED CELL (DIFFUSE) NHL
C83.2	MIXED SMALL & LARGE CELL (DIFFUSE) NHL
C83.3	LARGE CELL (DIFFUSE) NHL
C83.4	IMMUNOBLASTIC (DIFFUSE) NHL
C83.5	LYMPHOBLASTIC (DIFFUSE) NHL
C83.6	UNDIFFERENTIATED (DIFFUSE) NHL
C83.7	BURKITT'S TUMOUR
C83.8	OTHER TYPES DIFFUSE NHL
C83.9	DIFFUSE NHL UNSPECIFIED
C84.0	MYCOSIS FUNGOIDES
C84.1	S,ZARY'S DISEASE
C84.2	T-ZONE LYMPHOMA
C84.3	LYMPHOEPITHELIOID LYMPHOMA
C84.4	PERIPHERAL T-CELL LYMPHOMA
C84.5	OTHER AND UNSPECIFIED T-CELL LYMPHOMAS
C85.0	LYMPHOSARCOMA
C85.1	B-CELL LYMPHOMA UNSPECIFIED
C85.7	OTHER SPECIFIED TYPES OF NHL
C85.9	NHL UNSPECIFIED TYPE
C88.0	WALDENSTROMS MACROGLOBULINAEMIA WO REM
C88.0	WALDENSTROMS MACROGLOBULINAEMIA IN REM
C88.1	ALPHA HEAVY CHAIN DISEASE WO REMISSION
C88.1	ALPHA HEAVY CHAIN DISEASE IN REMISSION
C88.2	GAMMA HEAVY CHAIN DISEASE WO REMISSION
C88.2	GAMMA HEAVY CHAIN DISEASE IN REMISSION
C88.3	IMMUNOPROLIFERATIVE SM INTEST DIS WO REM
C88.3	IMMUNOPROLIFERATIVE SM INTEST DIS IN REM
C88.7	OTH MALGT IMMUNOPROLIFERATIVE DIS WO REM
C88.7	OTH MALGT IMMUNOPROLIFERATIVE DIS IN REM
C88.9	UNSPEC IMMUNOPROLIFERATIVE DIS WO REM
C88.9	UNSPEC IMMUNOPROLIFERATIVE DIS IN REM
C90.0	MULTIPLE MYELOMA WITHOUT REMISSION
C90.0	MULTIPLE MYELOMA IN REMISSION
C90.1	PLASMA CELL LEUKAEMIA WO REMISSION
C90.1	PLASMA CELL LEUKAEMIA IN REMISSION
C90.2	PLASMACYTOMA EXTRAMEDULLARY WO REMISSION
C90.2	PLASMACYTOMA EXTRAMEDULLARY IN REM
C91.0	ACUTE LYMPHOBLASTIC LEUKAEMIA WO REM
C91.0	ACUTE LYMPHOBLASTIC LEUKAEMIA IN REM
C91.1	CHRONIC LYMPHOCYTIC LEUKAEMIA WO REM
C91.1	CHRONIC LYMPHOCYTIC LEUKAEMIA IN REM
C91.2	SUBACUTE LYMPHOCYTIC LEUKAEMIA WO REM
C91.2	SUBACUTE LYMPHOCYTIC LEUKAEMIA IN REM
C91.3	PROLYMPHOCYTIC LEUKAEMIA WO REMISSION
C91.3	PROLYMPHOCYTIC LEUKAEMIA IN REMISSION
C91.4	HAIRY-CELL LEUKAEMIA WITHOUT REMISSION
C91.4	HAIRY-CELL LEUKAEMIA IN REMISSION
C91.5	ADULT T-CELL LEUKAEMIA WITHOUT REMISSION

C91.5	ADULT T-CELL LEUKAEMIA IN REMISSION
C91.7	OTHER LYMPHOID LEUKAEMIA WO REMISSION
C91.7	OTHER LYMPHOID LEUKAEMIA IN REMISSION
C91.9	LYMPHOID LEUKAEMIA UNSPEC WO REMISSION
C91.9	LYMPHOID LEUKAEMIA UNSPEC IN REMISSION
C92.0	ACUTE MYELOID LEUKAEMIA WO REMISSION
C92.0	ACUTE MYELOID LEUKAEMIA IN REMISSION
C92.1	CHRONIC MYELOID LEUKAEMIA WO REMISSION
C92.1	CHRONIC MYELOID LEUKAEMIA IN REMISSION
C92.2	SUBACUTE MYELOID LEUKAEMIA WO REMISSION
C92.2	SUBACUTE MYELOID LEUKAEMIA IN REMISSION
C92.3	MYELOID SARCOMA WITHOUT REMISSION
C92.3	MYELOID SARCOMA IN REMISSION
C92.4	ACUTE PROMYELOCYTIC LEUKAEMIA WO REM
C92.4	ACUTE PROMYELOCYTIC LEUKAEMIA IN REM
C92.5	ACUTE MYELOMONOCYTIC LEUKAEMIA WO REM
C92.5	ACUTE MYELOMONOCYTIC LEUKAEMIA IN REM
C92.7	OTHER MYELOID LEUKAEMIA WO REMISSION
C92.7	OTHER MYELOID LEUKAEMIA IN REMISSION
C92.9	MYELOID LEUKAEMIA UNSPEC WO REMISSION
C92.9	MYELOID LEUKAEMIA UNSPEC IN REMISSION
C93.0	ACUTE MONOCYTIC LEUKAEMIA WO REMISSION
C93.0	ACUTE MONOCYTIC LEUKAEMIA IN REMISSION
C93.1	CHRONIC MONOCYTIC LEUKAEMIA WO REMISSION
C93.1	CHRONIC MONOCYTIC LEUKAEMIA IN REMISSION
C93.2	SUBACUTE MONOCYTIC LEUKAEMIA WO REM
C93.2	SUBACUTE MONOCYTIC LEUKAEMIA IN REM
C93.7	OTHER MONOCYTIC LEUKAEMIA WO REMISSION
C93.7	OTHER MONOCYTIC LEUKAEMIA IN REMISSION
C93.9	MONOCYTIC LEUKAEMIA UNSPEC WO REMISSION
C93.9	MONOCYTIC LEUKAEMIA UNSPEC IN REMISSION
C94.0	AC ERYTHRAEMIA & ERYTHROLEUKAEMIA WO REM
C94.0	AC ERYTHRAEMIA & ERYTHROLEUKAEMIA IN REM
C94.1	CHRONIC ERYTHRAEMIA WITHOUT REMISSION
C94.1	CHRONIC ERYTHRAEMIA IN REMISSION
C94.2	ACUTE MEGAKARYOBLASTIC LEUKAEMIA WO REM
C94.2	ACUTE MEGAKARYOBLASTIC LEUKAEMIA IN REM
C94.3	MAST CELL LEUKAEMIA WITHOUT REMISSION
C94.3	MAST CELL LEUKAEMIA IN REMISSION
C94.4	ACUTE PANMYELOSIS WITHOUT REMISSION
C94.4	ACUTE PANMYELOSIS IN REMISSION
C94.5	ACUTE MYELOFIBROSIS WITHOUT REMISSION
C94.5	ACUTE MYELOFIBROSIS IN REMISSION
C94.7	OTHER SPECIFIED LEUKAEMIAS WO REMISSION
C94.7	OTHER SPECIFIED LEUKAEMIAS IN REMISSION
C95.0	ACUTE LEUKAEMIA UNSPEC CELL TYPE WO REM
C95.0	ACUTE LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.1	CHR LEUKAEMIA UNSPEC CELL TYPE WO REM
C95.1	CHR LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.2	SUBAC LEUKAEMIA UNSPEC CELL TYPE WO REM
C95.2	SUBAC LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.7	OTH LEUKAEMIA OF UNSPEC CELL TYPE WO REM
C95.7	OTH LEUKAEMIA OF UNSPEC CELL TYPE IN REM

C95.9	LEUKAEMIA UNSPECIFIED WITHOUT REMISSION
C95.9	LEUKAEMIA UNSPECIFIED IN REMISSION
C96.0	LETTERER-SIWE DISEASE
C96.1	MALIGNANT HISTIOCYTOSIS
C96.2	MALIGNANT MAST CELL TUMOUR
C96.3	TRUE HISTIOCYTIC LYMPHOMA
C96.7	OTHER SPEC NEOPLM LYMPHOID, HAEMAT & TIS
C96.9	NEOPLASM LYMPHOID HAEMAT TISSUE NOS
D00.0	CA IN SITU LIP ORAL CAVITY PHARYNX
D00.1	CARCINOMA IN SITU OF OESOPHAGUS
D00.2	CARCINOMA IN SITU OF STOMACH
D01.0	CARCINOMA IN SITU OF COLON
D01.1	CA IN SITU RECTOSIGMOID JUNCTION
D01.2	CARCINOMA IN SITU OF RECTUM
D01.3	CARCINOMA IN SITU OF ANUS AND ANAL CANAL
D01.4	CA IN SITU OTH/UNSPEC PARTS INTESTINE
D01.5	CA IN SITU LIVER GALLBLADDER BILE DUCTS
D01.7	CA IN SITU OTHER SPEC DIGESTIVE ORGANS
D01.9	CA IN SITU DIGESTIVE ORGAN NOS
D02.0	CARCINOMA IN SITU OF LARYNX
D02.1	CARCINOMA IN SITU OF TRACHEA
D02.2	CARCINOMA IN SITU OF BRONCHUS AND LUNG
D02.3	CA IN SITU OTH PARTS RESPIRATORY SYSTEM
D02.4	CA IN SITU RESPIRATORY SYSTEM NOS
D03.0	MELANOMA IN SITU OF LIP
D03.1	MELANOMA IN SITU EYELID INCL CANTHUS
D03.2	MELANOMA IN SITU EAR & EXT AURIC CANAL
D03.3	MELANOMA IN SITU OTH/UNSPEC PARTS FACE
D03.4	MELANOMA IN SITU OF SCALP AND NECK
D03.5	MELANOMA IN SITU OF TRUNK
D03.6	MELANOMA IN SITU UPP LIMB INCL SHOULDER
D03.7	MELANOMA IN SITU LOWER LIMB INCL HIP
D03.8	MELANOMA IN SITU OF OTHER SITES
D03.9	MELANOMA IN SITU UNSPECIFIED
D04.0	CARCINOMA IN SITU OF SKIN OF LIP
D04.1	CA IN SITU SKIN EYELID INCL CANTHUS
D04.2	CA IN SITU SKIN EAR & EXT AURIC CANAL
D04.3	CA IN SITU SKIN OTH/UNSPEC PARTS FACE
D04.4	CARCINOMA IN SITU SKIN SCALP & NECK
D04.5	CARCINOMA IN SITU OF SKIN OF TRUNK
D04.6	CA IN SITU SKIN UPPER LIMB INCL SHOULDER
D04.7	CA IN SITU SKIN LOWER LIMB INCL HIP
D04.8	CARCINOMA IN SITU OF SKIN OF OTHER SITES
D04.9	CARCINOMA IN SITU OF SKIN UNSPECIFIED
D05.0	LOBULAR CARCINOMA IN SITU OF BREAST
D05.1	INTRADUCTAL CARCINOMA IN SITU OF BREAST
D05.7	OTHER CARCINOMA IN SITU OF BREAST
D05.9	CARCINOMA IN SITU OF BREAST UNSPECIFIED
D06.0	CARCINOMA IN SITU OF ENDOCERVIX
D06.1	CARCINOMA IN SITU OF EXOCERVIX
D06.7	CA IN SITU OTHER PARTS OF CERVIX
D06.9	CARCINOMA IN SITU OF CERVIX UNSPECIFIED
D07.0	CARCINOMA IN SITU OF ENDOMETRIUM

D07.1	CARCINOMA IN SITU OF VULVA
D07.2	CARCINOMA IN SITU OF VAGINA
D07.3	CA IN SITU OTH/UNSPEC FEMALE GEN ORG
D07.4	CARCINOMA IN SITU OF PENIS
D07.5	CARCINOMA IN SITU OF PROSTATE
D07.6	CA IN SITU OTH/UNSPEC MALE GENITAL ORG
D09.0	CARCINOMA IN SITU OF BLADDER
D09.1	CA IN SITU OTHER & UNSPEC URINARY ORGANS
D09.2	CARCINOMA IN SITU OF EYE
D09.3	CA IN SITU THYROID & OTH ENDOCRINE GLAND
D09.7	CA IN SITU OTHER SPECIFIED SITES
D09.9	CARCINOMA IN SITU UNSPECIFIED
D18.02	HAEMANGIOMA INTRACRANIAL STRUCTURES
D32.0	BENIGN NEOPLASM OF CEREBRAL MENINGES
D32.1	BENIGN NEOPLASM OF SPINAL MENINGES
D32.9	BENIGN NEOPLASM OF MENINGES UNSPECIFIED
D33.0	BENIGN NEOPLASM BRAIN SUPRATENTORIAL
D33.1	BENIGN NEOPLASM BRAIN INFRATENTORIAL
D33.2	BENIGN NEOPLASM OF BRAIN UNSPECIFIED
D33.3	BENIGN NEOPLASM OF CRANIAL NERVES
D33.4	BENIGN NEOPLASM OF SPINAL CORD
D33.7	BENIGN NEOPLASM OTHER SPEC PARTS OF CNS
D33.9	BENIGN NEOPLASM CNS UNSPECIFIED
D37.0	NEOPLM UNCRT/UNK BEH LIP ORAL CV PHARYNX
D37.1	NEOPLM UNCERTAIN OR UNKNOWN BEH STOMACH
D37.2	NEOPLM UNCRT/UNK BEH SMALL INTESTINE
D37.3	NEOPLM UNCERTAIN OR UNKNOWN BEH APPENDIX
D37.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH COLON
D37.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH RECTUM
D37.6	NEOPLM UNCRT/UNK BEH LVR GALLB BILE DUCT
D37.7	NEOPLM UNCRT/UNK BEH OTH DIGESTIVE ORGAN
D37.9	NEOPLASM UNCRT/UNK BEH DIGEST ORGAN NOS
D38.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH LARYNX
D38.1	NEOPLM UNCRT/UNK BEH TRACHEA BRONC LUNG
D38.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH PLEURA
D38.3	NEOPLM UNCRT OR UNKNOWN BEH MEDIASTINUM
D38.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH THYMUS
D38.5	NEOPLASM UNCRT/UNK BEH OTHER RESP ORG
D38.6	NEOPLASM UNCRT/UNK BEH RESP ORG NOS
D39.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH UTERUS
D39.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH OVARY
D39.2	NEOPLM UNCERTAIN OR UNKNOWN BEH PLACENTA
D39.7	NEOPLASM UNCRT/UNK BEH OTH FEMLE GEN ORG
D39.9	NEOPLASM UNCRT/UNK BEH FEMLE GEN ORG NOS
D40.0	NEOPLASM UNCERTAIN OR UNK BEH PROSTATE
D40.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH TESTIS
D40.7	NEOPLASM UNCRT/UNK BEH MALE GENITAL ORG
D40.9	NEOPLM UNCRT/UNK BEH MALE GEN ORG NOS
D41.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH KIDNEY
D41.1	NEOPLASM UNCRT/UNK BEH RENAL PELVIS
D41.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH URETER
D41.3	NEOPLM UNCERTAIN OR UNKNOWN BEH URETHRA
D41.4	NEOPLM UNCERTAIN OR UNKNOWN BEH BLADDER

D41.7	NEOPLASM UNCRT/UNK BEH OTH URINARY ORGAN
D41.9	NEOPLASM UNCRT/UNK BEH URIN ORGAN NOS
D42.0	NEOPLASM UNCRT/UNK BEH CEREBRAL MENINGES
D42.1	NEOPLM UNCRT/UNK BEH SPINAL MENINGES
D42.9	NEOPLASM UNCRT/UNK BEH MENINGES NOS
D43.0	NEOPLASM UNCRT/UNK BEH BRAIN SUPRATENTOR
D43.1	NEOPLASM UNCRT/UNK BEH BRAIN INFRATENTOR
D43.2	NEOPLASM UNCRT/UNK BEH BRAIN NOS
D43.3	NEOPLASM UNCRT/UNK BEH CRANIAL NERVES
D43.4	NEOPLASM UNCRT/UNK BEH SPINAL CORD
D43.7	NEOPLM UNCRT/UNK BEH OTHER PARTS CNS
D43.9	NEOPLM UNCERTAIN OR UNKNOWN BEH CNS NOS
D44.0	NEOPLASM UNCRT/UNK BEH THYROID GLAND
D44.1	NEOPLASM UNCRT/UNK BEH ADRENAL GLAND
D44.2	NEOPLASM UNCRT/UNK BEH PARATHYROID GLAND
D44.3	NEOPLM UNCRT/UNK BEH PITUITARY GLAND
D44.4	NEOPLM UNCRT/UNK BEH CRANOPHARNGL DCT
D44.5	NEOPLASM UNCRT/UNK BEH PINEAL GLAND
D44.6	NEOPLASM UNCRT/UNK BEH CAROTID BODY
D44.7	NEOPLM UNCRT/UNK BEH AORTIC BD OTH PARAG
D44.8	NEOPLASM UNCRT/UNK BEH PLURIGLNDR INV
D44.9	NEOPLASM UNCRT/UNK BEH ENDOCRINE GLD NOS
D45	POLYCYTHAEMIA VERA
D46.0	REFRACT ANAEMIA WO SIDEROBLASTS SO STATE
D46.1	REFRACTORY ANAEMIA WITH SIDEROBLASTS
D46.2	REFRACTORY ANAEMIA WITH EXCESS OF BLASTS
D46.3	RAEB WITH TRANSFORMATION
D46.4	REFRACTORY ANAEMIA UNSPECIFIED
D46.7	OTHER MYELODYSPLASTIC SYNDROMES
D46.9	MYELODYSPLASTIC SYNDROME UNSPECIFIED
D47.0	HISTIOCYTIC MAST CELL TUM UNCRT/UNK BEH
D47.1	CHRONIC MYELOPROLIFERATIVE DISEASE
D47.2	MONOCLONAL GAMMOPATHY
D47.3	ESSENTIAL THROMBOCYTHAEMIA
D47.7	OTH SPEC NEOPLM UNCRT/UNK BEH LYMPH HAEM
D47.9	NEOPLM UNCRT/UNK BEH LYMPH HAEM TIS NOS
D48.0	NEOPLM UNCRT/UNK BEH BONE ARTICULAR CART
D48.1	NEOPLM UNCRT/UNK BEH CONN OTH SFT TISSUE
D48.2	NEOPLASM UNCRT/UNK BEH PERPH & AUT NRVS
D48.3	NEOPLM UNCRT/UNK BEH RETROPERITONEUM
D48.4	NEOPLASM UNCERTAIN OR UNK BEH PERITONEUM
D48.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH SKIN
D48.6	NEOPLASM UNCERTAIN OR UNKNOWN BEH BREAST
D48.7	NEOPLASM UNCRT/UNK BEH OTH SPEC SITES
D48.9	NEOPLASM UNCERTAIN OR UNKNOWN BEH NOS
D76.0	LANGERHANS' CELL HISTIOCYTOSIS NEC
Q85.0	NEUROFIBROMATOSIS (NONMALIGNANT)

(We do not require the following site codes and therefore these are not in the above list:

C77, C78 and C79 – secondary sites
D10-D31.9 – Benign, not Brain
D34 – D36.9 – Benign, not Brain)

These are the Ranges in the Site Codes (as above) we DO require:

Invasive
C00.0 – C76.8
C80.0 – C96.9
and exclude C44.0 to C44.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Insitu and Benign Brain/CNS
D00.0 – D09.9
D32.0 – D33.9
but want D18.02 Benign Brain
and exclude D04.0 to D04.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Uncertain
D37.0 to D48.9
and exclude D48.5 AND M80500 to M81109 (Skin SCC's and BCC's)

We also require:
Q85.0
D76.0
