USER GUIDE: CANCER REGISTRATION SUBMISSION TO THE VICTORIAN CANCER REGISTRY

This guide incorporates the Victorian Cancer Registry

- Guide to the identification and submission of reportable cancers
- Data dictionary, inclusive of reporting guides for clinical coders

Victorian Cancer Registry
Cancer Council Victoria
200 Victoria Parade
EAST MELBOURNE VIC 3002

September 2024

Cancer Council Victoria acknowledges the Traditional Owners and Custodians of the land and water ways throughout Victoria and pays respect to their cultures, knowledge and heritages and Elders past, present and future.

Cancer Council Victoria

1. PURPOSE OF THIS DOCUMENT

This document is intended to assist health services to understand:

1) reporting requirements to the Victorian Cancer Registry including which cancers are notifiable;
2) how to initiate the cancer registration process;
3) the definition of each data element in the cancer registration and assist clinical coders in completing the registration.

This document replaces the Hospital Information Kit *Reportable Cancers Guide for Hospitals*. A companion document *Technical Guide: Cancer Registration Submissions to the Victorian Cancer Registry* is available to assist health service information management services in submitting data to the Victorian Cancer Registry. It is available at **www.cancervic.org.au/**, or may be requested via email **vcr@cancervic.org.au**.

The Victorian Cancer Registry is committed to providing ongoing support to all notifiers to facilitate accurate and timely reporting of the required information. Please do not hesitate to contact the Victorian Cancer Registry for advice if you are unsure whether to report a particular cancer case at any time.

Victorian Cancer Registry contact details

Email vcr@cancervic.org.au
Website www.cancervic.org.au

2. TABLE OF CONTENTS

3. TERMS AND ACRONYMS USED IN THIS DOCUMENT

Term	Definition
ACS	Australian Coding Standards
Health Service	Public and private hospitals, radiotherapy centres and day procedure centres
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
METeOR	Metadata Online Registry- Developed by Australian Institute of Health and Welfare and available at https://meteor.aihw.gov.au/
Notifier	Organisations required to report to the Victorian Cancer Registry - health service, pathology and radiotherapy services
PAS	Patient Administration System
VCR	Victorian Cancer Registry
VCRIP	Victorian Cancer Registry Internet Portal

4. OVERVIEW OF THE VICTORIAN CANCER REGISTRY

The Victorian Cancer Registry is a population-based registry that is responsible for accurate and timely reporting of cancer incidence, mortality, and survival in Victoria. The Registry is located at Cancer Council Victoria.

All Victorian health services and pathology laboratories are required to notify the Victorian Cancer Registry of patients with cancers reportable under the *Improving Cancer Outcomes Act 2014 (Vic)*.[1] This includes hospitals and radiotherapy centres. The Act requires notifiers to submit details of all patients diagnosed with cancer, recurrence of a cancer and a precursor of a prescribed cancer type. The Act provides the Cancer Council Victoria with authority to maintain the Victorian Cancer Registry on behalf of the Secretary of the Department of Health and authorises the collection of cancer diagnoses, including the diagnoses of a cancer recurrence.

The *Improving Cancer Outcomes (Diagnostic Reporting) Regulations 2015* [2] provides comprehensive guidelines on the types of cancer, including precursors to cancer, that health services are required to report. It outlines the responsibilities of reporting entities, specifies the format of the reports, sets the timelines for reporting, and specifies the essential information to be included in these reports.

All cancer data held by the Victorian Cancer Registry is subject to rigorous quality assurance to ensure that the data is complete and accurate. It is used to monitor cancer trends, to assist in the planning, management and assessment of Victorian cancer control activities. The data also contributes to the national Australian Cancer Database and international cohorts.

The success of the Victorian Cancer Registry in supporting improved outcomes for people with cancer is reliant on accurate and complete ascertainment of cancer information for all cancers diagnosed in Victoria.

5. DATA SUBMISSION

Cancer registrations to the Victorian Cancer Registry can be made either by:

- uploading file extracts from patient administration systems (PAS); or
- directly entering data into an electronic form (eForm). This method is suitable for smaller hospitals that do not have large numbers of reportable cancer cases, and for health services resubmitting corrected registrations.

Where possible, health services are encouraged to use functionality within their PAS which uses reportable ICD-10-AM site codes to flag potentially eligible cases at the time of coding. Refer to the **Technical Guide: Submission of Cancer Registrations to the Victorian Cancer Registry** for instruction on how to establish data extracts from the PAS.

Health services are required to keep a log of cases registered with the Victorian Cancer Registry, to avoid duplicate registration and to ensure that registrations are provided in accordance with their requirements under the Act and its accompanying Regulations.

5.1 Victorian Cancer Registry Internet Portal (VCRIP)

Both data submission approaches mentioned above use the Victorian Cancer Registry Internet portal (VCRIP), established and maintained by the Victorian Cancer Registry. All health service personnel wishing to submit cancer registrations to the Victorian Cancer Registry are required to register and set up their own VCRIP account in SharePoint. Applications for VCRIP access should be made to the Electronic Notifications Coordinator at Victorian Cancer Registry via email **vcr@cancervic.org.au**, including the following details:

- **First name**
- **Last name**
- **Department**
- **Position**
- **Organisation phone number**
- **Alternative phone number**
- **Organisation fax number**
- **Email address (preferably the user's organisation email)**
- **Name of organisation**
- **VCR Parent Notifier number (if known)**

Instruction on how to register and use VCRIP will be provided by the Electronic Notifications Coordinator at the Victorian Cancer Registry. Once full registration has been completed, health services staff may commence completion of an eForm cancer registration or use VCRIP to upload their cancer registration file extracted from the PAS.

For details on registering or using VCRIP, please contact the VCR Electronic Notification Coordinator on: vcr@cancervic.org.au

6. REPORTING REQUIREMENTS

6.1 Entities required to complete a cancer registration

According to Victorian legislation,[1] any of the following services as defined by section 3(l) of the Health Services Act 1988 are required to submit cancer registrations-

a. Health services, which include any of the following:
   - a day procedure centre
   - a denominational hospital
   - a private hospital
   - a privately-owned hospital
   - a public health service
   - a public hospital

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

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

* This document is relevant only to those outlined in (a) and (b), which together will be referred to as "Health services". A guide for reporting by pathology providers (c) is found elsewhere. Please contact the Victorian Cancer Registry if you require this information.

6.2 Timeliness of cancer registration

Reportable cancer cases are to be notified by health services **within 60 days from the date the person in charge of the service becomes aware that a person has cancer**. [2]

A Reporting Schedule which indicates the 'within 60 days' reporting expectation for the current year is available from the Victorian Cancer Registry at **vcr@cancervic.org.au**, and can be downloaded from the VCRIP.

6.3 Identification of a cancer registration

The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) is used by Health Information Managers and Clinical Coders to assign codes for neoplasms and thus identify reportable cancers (see Table 1).

The ICD-10-AM (current edition) Australian Coding Standards (ACS) must be followed in order to accurately assign ICD-10-AM codes for neoplasms. These include the following standards:

- *All standards in Chapter 2 Neoplasms*
- *ACS 0010 Clinical documentation and general abstraction.*
- *ACS 0002 Additional diagnoses*
- *ACS 0051 Same-day endoscopy - diagnostic*
- *ACS 0052 Same-day endoscopy - surveillance*

****NOTE**** ACS 0012 Suspected conditions provides guidance on when there is uncertainty about the final diagnosis and may result in a neoplasm being coded as a suspected condition. A suspected neoplasm coded in accordance with this ACS does not require a cancer registration to be submitted to the Victorian Cancer Registry.

6.4 Updating data requirements

Any changes to cancer reporting are primarily governed by legislative changes, such as the ***Improving Cancer Outcomes Act 2014***[1] and its associated regulations (***Improving Cancer Outcomes [Diagnosis Reporting] Regulations 2015***[2]). However, on occasions, the way the stated information within the regulations is collected may change. Generally, changes are kept to a minimum and only implemented every 2-3 years, as the Victorian Cancer Registry recognises the impact these changes have on notifiers and software vendors. Every effort is made to communicate changes at least 6 months prior to the expected implementation date. Any major change in legislation will be communicated by the Secretary, Department of Health.

6.5 Cancer registration submitted in error

On occasion, a cancer is registered in error. For example, a registration may have been sent based on preliminary lung cancer diagnosis on CT scan findings. The later performed biopsy of lung is diagnostic of sarcoidosis. If a cancer has been incorrectly registered, please email **vcr@cancervic.org.au** indicating the hospital site registered from, unit record number, date of birth, admission and discharge date, and cancer site and morphology codes.

7. REPORTABLE CANCERS

Health services are required to report in situ and malignant tumours from all sites other than certain skin cancers.

There are restrictions on what skin cancers are to be reported. Only squamous cell skin cancers originating from sites outlined in Table 2 of section 7.1 require a cancer registration. Skin cancers exempt from reporting are outlined in section 7.2.

Tumours of uncertain behaviour are only reported if they relate to tumours of the central nervous system and nearby endocrine glands, the ovary, urinary tract, and haematological and lymphoid tumours.

The only benign tumours to be reported are those of the central nervous system and nearby endocrine glands.

Table 1 details the reportable cancers and associated ICD-10-AM codes to be reported to the Victorian Cancer Registry.

Table 1: ICD-10-AM (current edition) site codes to be reported to the Victorian Cancer Registry

Site Code	Description
MALIGNANT ***Report all sites excluding some skin cancers (see section 7.1)***	
C00-C75	Malignant neoplasms
C76	Malignant neoplasm of other and ill-defined sites
C77-C79	Secondary and unspecified malignant neoplasm of lymph nodes
C80	Malignant neoplasm without specification of site
C81-C96	Malignant neoplasms of lymphoid, haematopoietic and related tissue
C44.5	Other malignant neoplasms of skin - trunk (refer 7.1 Reportable Skin Cancers)
IN SITU ***Report all sites excluding some skin cancers (see section 7.1)***	
D00	Carcinoma in situ of oral cavity, oesophagus and stomach
D01	Carcinoma in situ of other and unspecified digestive organs
D02	Carcinoma in situ of middle ear and respiratory system
D03	Melanoma in situ
D04.5	Carcinoma in situ of skin of trunk (refer 7.1 Reportable Skin Cancers)
D05	Carcinoma in situ of breast
D06	Carcinoma in situ of cervix uteri
D07	Carcinoma in situ of other and unspecified genital organs
D09	Carcinoma in situ of other and unspecified sites
BENIGN ***Only report the following tumours of the central nervous system and nearby endocrine glands***	
D18.02	Haemangioma, intracranial structures (cavernous haemangioma)
D32	Benign neoplasm of meninges
D33	Benign neoplasm of brain and other parts of central nervous system
D35.2	Benign neoplasm of pituitary gland
D35.3	Benign neoplasm of craniopharyngeal duct
D35.4	Benign neoplasm of pineal gland
UNCERTAIN OR UNKNOWN BEHAVIOUR ***Only report the following tumours of the central nervous system and nearby endocrine glands, ovary, urinary tract and haematological and lymphoid tumours***	
D39.1	Neoplasm of uncertain or unknown behaviour of female genital organs - ovary
D41.1	Neoplasm of uncertain or unknown behaviour renal pelvis
D41.2	Neoplasm of uncertain or unknown behaviour ureter
D41.3	Neoplasm of uncertain or unknown behaviour urethra
D41.4	Neoplasm of uncertain or unknown behaviour bladder
D42	Neoplasm of uncertain or unknown behaviour of meninges
D43	Neoplasm of uncertain or unknown behaviour of brain and central nervous system
D44.3	Neoplasm of uncertain or unknown behaviour pituitary gland
D44.4	Neoplasm of uncertain or unknown behaviour craniopharyngeal duct
D44.5	Neoplasm of uncertain or unknown behaviour pineal gland
D45	Polycythaemia vera
D46	Myelodysplastic syndromes
D47	Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue

7.1 Reportable skin cancers

Melanoma

- All melanoma skin cancers must be reported to the Victorian Cancer Registry.

Non-melanoma

- All in situ and malignant other skin cancers (e.g. Merkel cell carcinoma, Kaposi sarcoma) of any site must be registered with the Victorian Cancer Registry.
- Only certain squamous cell carcinomas (SCC) which originate from sites outlined in Table 2 must be registered with the Victorian Cancer Registry.

Table 2: Squamous cell carcinoma site locations which must be registered to the Victorian Cancer Registry

Site Codes	Location name
C00.0-C00.2, C00.9, D00.0	Lip - vermilion border (the coloured portion of the lip)
C51.0-C51.9, D07.1	Vulva
C60.0, C60.1, C60.8, C60.9, D07.4	Penis
C63.2, D07.61	Scrotum
C44.5, D04.5	Perianal skin including anal margin if they have morphology codes M8050-M8084

7.2 Non-reportable skin cancers

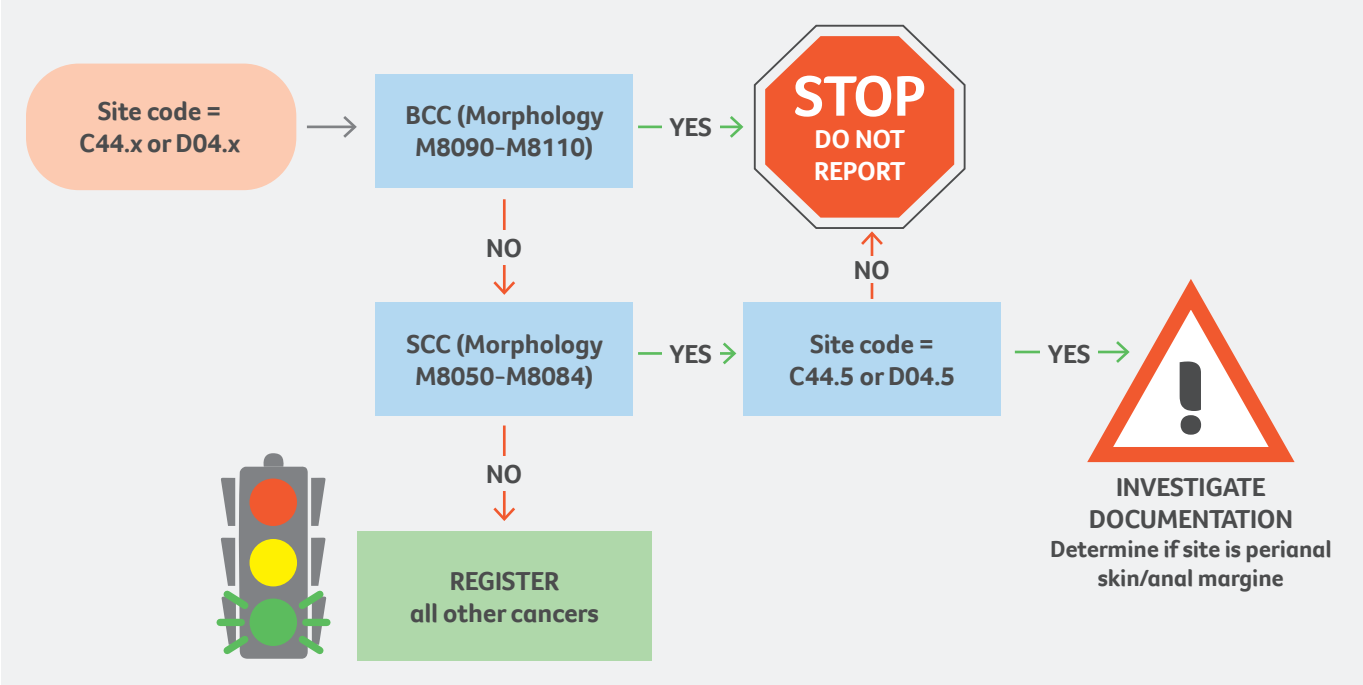
Basal Cell Carcinomas (BCC) with morphology codes M8090-M8110 arising from skin sites C44 and D04 are non-reportable.

Squamous cell carcinoma (SCC) arising from sites other than those listed in the reportable skin cancers (above) are non-reportable.

A non-reportable skin cancer with a metastatic site classified to C77-C79 does not require registration.

Figure 1 provides a schematic to assist in determining whether a skin cancer is reportable.

Figure 1: Schematic of skin cancer registration eligibility



8. INDICATIONS REQUIRING A CANCER REGISTRATION

This section outlines when a cancer registration is required by health services.

A cancer registration should be submitted by health services in the following scenarios:

1. when a patient is diagnosed with cancer during an admission;
2. when a patient presents for the **first time**, with an already known cancer that has been diagnosed at another facility **and** the cancer is treated during the admission;
3. when there is an **update or change to cancer-specific information** on a previously submitted cancer registration e.g. change in primary site, change in morphology type, new information about cancer stage;
4. when there is a **change in the status** of the cancer e.g. disease progression/relapse, recurrence or metastatic disease);
5. for each primary cancer diagnosed in a patient with synchronous or metachronous cancers.

Table 3 provides examples and tips for each of these five scenarios when a cancer registration is required by health services.

If your cancer registration module does not have the ability to register a cancer without coding it as part of the inpatient episode you will need to complete an eForm on the Victorian Cancer Registry Internet Portal (VCRIP).

Table 3: Tips and examples of when a cancer registration must be submitted by health services

Indications when a cancer registration is required	Tip/s	Examples
1. A cancer must be registered when a patient is **diagnosed** with cancer during an admission even if the cancer is not treated	■ Any cancer diagnosed during an inpatient admission at your health service should be registered. ■ Registration is required when a cancer is first detected at time of death. Review the death certificate, autopsy report (if performed) or clinical notes.	**Example 1:** Patient admitted for colonoscopy, with biopsy that is diagnostic of adenocarcinoma of sigmoid colon. **Example 2:** Patient admitted for appendectomy due to acute appendicitis, the histopathology report indicates incidental findings of appendiceal carcinoid. **Example 3:** A patient dies at your health service and an autopsy was performed. The autopsy reported incidental findings of prostate cancer. The incidental findings of prostate adenocarcinoma require a cancer registration to be submitted to the VCR.
2. A cancer must be registered when a patient presents to your health service for the **first time** with an already known cancer that has been diagnosed at another facility. Cancer is treated during the stay	■ The first admission for cancer treatment at your health service should be registered.	**Example 4:** Patient with breast cancer diagnosed at another hospital, admitted for first time at your health service for surgical treatment of the breast cancer. **Example 5:** Patient admitted for chemotherapy, if it is patient's first admission for chemotherapy. **Example 6:** Patient with lung cancer diagnosed at another hospital, admitted for acute tonsillitis. An oncologist also reviews the patient and adjusts the cancer medication during the stay.
3. A cancer must be registered when there is **an update or change to cancer-specific** information on a previously submitted cancer registration	■ A change in primary site, change in morphology type, or new information about cancer stage are indications to submit an updated or new cancer registration. ■ Ensure that any updates to a cancer registration will be re-extracted if the original registration has already been sent to the VCR. Your system administrator or person responsible for the cancer registration extracts should be able to advise if updates to registrations can be performed.	**Example 7:** Lung cancer diagnosed by biopsy of lung. After submission of a cancer registration to the VCR, the stage at diagnosis is available in Multidisciplinary meeting (MDM) notes. Stage was reported as T3N1M1. The new cancer stage information should trigger a new registration to the VCR. The stage should be reported in designated data fields: TNM- T=T3, TNM-N=N1, and TNM-M=M1. **Example 8:** Colorectal tumour detected on CT scan. Case reported to the VCR. Patient is readmitted for a left hemicolectomy. The pathology report is diagnostic of adenocarcinoma of descending colon with lymph node metastases and the cancer stage reported by the pathologist is pT3pN1pMx.The reported stage at diagnosis and nodal metastases should trigger a new registration to the VCR. The stage should be reported in designated data fields: TNM-T=pT3, TNM-N=pN1, TNM-M=pMX. **Example 9:** A B-cell non-Hodgkin lymphoma, NOS diagnosed on imaging and pathology of a lymph node. Cancer reported to the VCR. After external review of the pathology specimen, the final diagnosis was updated to more specific type: Diffuse Large B-cell lymphoma The changed morphology should trigger a new cancer registration to the VCR. **Example 10:** A patient was diagnosed with multiple metastases to the liver, brain and lung on imaging, the site of origin unknown. Cancer reported to the VCR as unknown primary. During a subsequent admission a biopsy of lung was performed. The biopsy is diagnostic of primary adenocarcinoma of lung and further clinical documentation confirms lung cancer with distant metastases. The updated primary site from Unknown to Lung should trigger a new cancer registration to the VCR.

Indications when a cancer registration is required	Tip/s	Examples
4. A cancer must be registered when there is a **change in the status of the cancer** i.e. disease recurrence or progression/relapse	Change in the cancer disease status would include: ■ **Recurrence**: Cancer recurrence refers to the reappearance of cancer after treatment, and after a disease-free period. There are different types of recurrence: ▶ ***Local recurrence***: the cancer has come back at the primary site. ▶ ***Regional recurrence:*** the cancer has come back in the regional nodes. ▶ ***Distant recurrence:*** the cancer has come back in another part of the body Any new secondary sites relating to the recurrent primary should also be included in the registration. ■ **Disease progression/relapse:** Disease progression/relapse (or transformation) is often indicated by a change in morphology. If the morphology of a previously reported cancer changes, then a new registration is required.	**Example 11:** Patient with history of breast cancer three years ago is now diagnosed with brain metastasis. The new cancer findings should trigger a new cancer registration to the VCR with reported brain metastasis. **Example 12:** Patient with stage I breast cancer in 2016 re-presents to your health service with newly diagnosed metastases to regional axillary node in 2022, requiring further assessment. At the latest MDM meeting the breast cancer was re-staged to cTxcN2cM0. A new cancer registration to the VCR is required with recorded ICD-10-AM code for the metastases to the axillary lymph nodes (C773); recorded new stage as TNM-T=cTX, TNM-N=cT2, TNM-M=cM0. **Example 13:** Patient with Caecal carcinoma surgically treated, now re-presents with a cancer recurrence at the anastomotic site two years after resection. A new cancer registration the VCR is required to report the local recurrence. **Example 14:** A patient diagnosed in 2019 with chronic myeloid leukaemia (CML). During another admission in 2020 the treating doctor reported a relapse of CML after a disease-free period. A new cancer registration to the VCR is required. **Example:15:** A patient was diagnosed on bone marrow biopsy with chronic lymphocytic leukaemia (CLL) in 2020. During another admission at your health service in 2021 the patient was diagnosed with Richter transformation (the CLL is transformed into Diffuse Large B-cell Lymphoma). A new cancer registration to the VCR is required for Diffuse large B-cell lymphoma. **Example 16:** A patient was diagnosed with lung cancer in March 2021. During another admission at your health service in July 2021, the patient was diagnosed with new bone metastases (disease progression). A new cancer registration to the VCR is required with recorded ICD-10-AM code for bone metastasis. **Example 17:** Patient diagnosed in 2019 with fibrous meningioma. During another admission in 2021 the patient is diagnosed with anaplastic meningioma (disease progression/relapse). A new cancer registration to the VCR is required for the anaplastic meningioma due to change in tumour behaviour from benign to malignant.
5. A cancer must be registered for each primary cancer diagnosed in a patient	■ If a person presents to your health service and is diagnosed with multiple primary cancers - synchronous or metachronous, then a separate cancer registration is required for each tumour.	**Example 18:** A patient has a cystoprostatectomy for a urothelial cell bladder cancer. The pathology report reports prostate adenocarcinoma as well. Both cancers require separate registrations to the VCR: Bladder (C679, 8120/3) and Prostate (C619, 8140/3). **Example 19:** Patient has a bowel resection and is diagnosed with mucinous carcinoma of the ascending colon and adenocarcinoma of the rectum. Both tumours require separate registrations to the VCR: Ascending colon (C182, 8480/3) and Rectum (C209, 8140/3) **Example 20:** Patient diagnosed with bilateral lobular carcinoma of breast. Two separate cancer registrations to the VCR are required for left and right breast lobular cancers.

9. INDICATIONS NOT REQUIRING A CANCER REGISTRATION

A cancer registration is not required for each presentation at a health services. A cancer registration **is not** required to be submitted by health services if the patient:

1. presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility AND the cancer is **not treated or monitored** during the stay
2. has a cancer diagnosis which has been reported by another campus/heath service that shares the same patient administration system, unit record number and medical record.
3. has multiple admissions **with no change** in cancer disease status (eg - no change in morphology, no new metastases)
4. has a non-reportable skin cancer with a metastatic site classified to C77-C79
5. has only a 'suspected' cancer, as defined in ACS 0012.

Table 4 is intended to provide clarity on when a health service is not required to submit a cancer registration through the inclusion of tips and examples. If you remain uncertain about whether to register a cancer after discussing with your supervisor, please contact the Victorian Cancer Registry on **vcr@cancervic.org.au**. Refer to section 6.5 on action to take if a cancer registration was submitted in error.

Table 4: Tips and examples of when a cancer registration is not required to be submitted by health services

Indications when a cancer registration is not required	Tips	Examples
1. A cancer does not require registration if a patient presents to your health service for the first time with an already known cancer that has been diagnosed at another facility AND the cancer is **not treated or monitored** during the stay.	■ If a patient with a history of cancer has an admission for a non-cancer related health condition in your health service, **a cancer registration is not required**.	**Example 1:** Patient admitted for pneumonia, in medical notes it is mentioned previous history of prostate cancer 5 years ago. There was no previous admission related to the prostate cancer. No cancer registration required as the patient was not diagnosed, treated, or monitored for the prostate cancer during the admission.
2. A cancer does not require registration if it has been reported by another campus/ health service sharing the same patient administration system, unit record number and medical record	■ If a health service has multiple campuses or affiliated health services that are using the one patient administration system, one unit record number and a single medical record, then a separate cancer registration is not required from each campus/health service.	**Example 2:** Patient admitted for internal fixation of fractured humerus due to bone metastases from a breast primary. Patient is sent from the acute campus to a rehabilitation campus of a multi-site health service. A registration is completed at the acute campus (breast primary & bone metastases). No registration is required from the rehabilitation campus.
3. A cancer does not require registration if the patient has multiple admissions with no change in cancer disease status	■ When a cancer has been registered, every subsequent presentation is not required to be registered unless there is a change in the disease status.	**Example 3:** Patient is admitted for next dose administration of the chemotherapy drug. There is no need to register this case every admission after the initial registration.
4. A cancer does not require registration if a patient presents to your health service with metastases from a non-reportable skin cancer	■ If a patient has been diagnosed or treated for metastasis from a non-reportable skin cancer such as SCC or BCC during an admission at your health service, a cancer registration is not required.	**Example 4:** Patient with a history of skin SCC, has been admitted for further investigation of a new lump in the neck. A biopsy of head and neck lymph node was positive for metastatic SCC. There is no need for cancer registration.
5. A cancer does not require registration if the cancer was coded as "suspected condition" as per ACS 0012 coding standard	■ If the clinical documentation clearly indicates uncertainty about the patient's final cancer diagnosis and no specific cancer treatment was initiated during the admission, a cancer registration is not required. ■ This includes the cancer being documented as "probable', "suspected", "possible", "likely", "? cancer", "cannot be ruled out", or a cancer is one of conditions considered in differential diagnosis.	**Example 5:** Patient diagnosed with suspected lung cancer on CT scan during an admission at your healthcare service. The patient was transferred to another healthcare service for bronchial endoscopy to confirm lung cancer diagnosis.

10. HOW TO REGISTER CANCER STAGE

Cancer stage is an important field to indicate the extent to which the tumour has spread from its point of origin. The relevant data elements to be considered when capturing cancer stage are:

- Staging Scheme
- Stage Group
- TNM Stage-T category
- TNM Stage-N category
- TNM Stage-M category

The Data Dictionary (see section 11) provides a reporting guide for each of these data elements. This section gives an overview of how you might record stage in the cancer registration using the clinical documentation available to you.

STAGING SCHEMES

There are numerous **Staging Schemes** (see Data Dictionary Data Element Staging Scheme for list) but the vast majority of solid tumours are staged using the TNM classification system. Both the Union for International Cancer Control (UICC) and the American Joint Committee on Cancer (AJCC) use the same TNM classification system.

Medical records often do not contain documentation of the staging scheme. In this case, record 99 and continue to capture the stage group and/or stage categories. Not having a stage scheme should not prevent you from capturing other stage data elements.

STAGE GROUP

Both UICC and AJCC staging schemes use a combination of the T (tumour), N (lymph nodes) and M (distant metastases) categories to derive a stage group. For each of the T, N and M, there is a set of categories, most often defined by a number (e.g. T1, N2 etc). An example of how stage group is calculated using a combination of the T, N and M categories is shown in Table 5. Importantly, combinations differ according to tumours and for this reason, clinical coders should record stage group and each TNM category but should not attempt to derive a stage group from the TNM categories.

Stage groups are often recorded using Roman numerals. Clinical coders should translate Roman numerals to Arabic when recording stage group in the cancer module as follows:

- IA = Stage 1A; IIA = Stage 2A; IIIA = Stage 3A; IV = Stage 4 stage group.

STAGE PREFIXES AND SUFFIXES

Stage may be defined at several time points in the care of a cancer patient. ***Prefixes*** are sometimes added to TNM categories as classifications to identify the time point it was determined. Only record prefixes if they appear in the medical documentation, otherwise leave blank. Commonly used time points are:

- clinical classification (**cTNM**), where the tumour is staged pretreatment
- pathological classification (**pTNM**), where the tumour is staged after surgical treatment.
- after treatment for patients receiving systemic (e.g. chemotherapy) and/or radiation therapy alone or a component of their initial treatment, or as neoadjuvant therapy before planned surgery (**ycTNM** or **ypTNM**)
- at recurrence or retreatment (**rTNM**)
- at autopsy (**aTNM**).

Clinical coders may also see ***suffixes*** added to the end of the stage category. For example, you may see N0(sn) indicating that sentinel nodes were biopsied and reported or N0(i+) indicating isolated tumour cells in regional lymph nodes on histology. Other suffixes include an (m) to indicate that multiple primaries are reported. Clinical coders **should not** record suffixes, as they either do not alter the stage or are collected using an alternate pathway by the registry.

STAGE CATEGORIES- T, N, AND M

Most tumours are staged using either the UICC or the AJCC staging schemes. Stage groups for each tumour type are calculated using a combination of the T-, N- and M- categories.

Medical staff often record stage categories in a combined way, so clinical coders must separate them into their component parts. Table 5 provides examples of how stage categories might be written in documents.

Clinical coders should not attempt to derive a stage group from the stage categories, as these differ across tumour types. Clinical coders should just record what is documented in the medical notes in the correct field in the cancer registration. Stage is only required for invasive tumours (C00-C97).

Table 5: Examples of how clinical text should be translated to data in stage group and TNM- category data fields.

In clinical notes, it is written as:	In cancer registration form, it should be registered by clinical coders as:			
	Stage group	T category	N category	M category
T1cN0	9	T1c	N0	9
cT2N1Mx	9	cT2	N1	MX
pT2acN1cM1	9	pT2a	cN1	cM1
Stage IVA	4A	9	9	9
Stage IIIa (pT3aN1cM0)	3A	pT3a	N1	cM0
pT1b N0(sn) MX	9	pT1b	N0	MX
pT2NXM0	9	pT2	NX	M0
pT2aN1miMX	9	pT2a	N1mi	MX

11. DATA DICTIONARY

A data dictionary ensures that there is consistency in the definition, format and interpretation of data elements required to be completed for each cancer registration. The data dictionary is also known as the dataset specifications.

Where possible, data elements to be reported to the Victorian Cancer Registry have been sourced from the following state-based, national and international data sources:

- the National Health Data Dictionary (NHDD) available at **Metadata Online Registry (METeOR)**[3]
- the **Health Data Standard Systems (HDSS) reference files**[4] maintained by the Victorian Department of Health
- the **International Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)**.[5]

Each data element required to be submitted to the Victorian Cancer Registry is defined in this section. Table 6 provides a guide for use of the data dictionary. It describes attributes collected for each data element, including how data are defined, collected, and structured. It provides meaning and context and helps to interpret the data. The Reporting Guide (highlighted in grey) within each data element is included to assist clinical coders in completing the registration.

Table 6: Guide for use of metadata descriptors used in the Victorian Cancer Registry dataset specification

DESCRIPTOR	DEFINITION
Definition	A statement that expresses the essential nature of a data item and its differentiation from all other data items
Purpose	The main reason(s) for collection of this data item
Reporting Guide	Additional comments or advice on reporting the data item
Reporting Obligation	Indicates whether the data item is: ■ **Mandatory** (must be reported for all cases, no blanks permitted) or ■ **Mandatory if available/applicable** (must be reported if data is available or applicable, otherwise leave blank). Some data items may not always apply, for example Metastatic Site
ASCII Field/Line No.	The 4-digit field identifier (or line number) associated with this data item for ASCII text file extracts. Further details of the ASCII files are outlined in the Technical Guide: Submission of Cancer Registrations to the Victorian Cancer Registry
Data Type	The type of data expected in this field There are four different data types: **Alphabetic** = only letters (upper and lower case A-Z) **Numeric** = only numbers (0-9) **String** = a string of characters which may contain letters, numbers, and punctuation characters such as apostrophe, hyphen and space. **Date** = a valid date in the specified format (DDMMYYYY)
Format	The expected format or layout of the data item **A** = any alphabetic character **N** = any numeric character **X** = any string character **DDMMYYYY** = standard date format, DD=day, MM=Month, YYYY=Year, e.g. 30062018 Other format examples: NNNN denotes a 4-digit number (e.g. Postcode 3000) N(11) denotes a number containing 11 digits (e.g. Medicare Number) X(30) denotes a string with maximum character limit of 30 (e.g. Patient Surname)
Field Size	The required or maximum length of characters for this data item
Code Set	The set of permissible values for this data item as specified
Validations	Any constraints or restrictions that apply to this data item
Missing Data	Indicates whether missing data is acceptable or not for this item
Related Items	Other data items related to this data item
Definition Source	Identifies the authority that defined this data item e.g. NHDD For METeOR sources, the unique numeric identifier of the related METeOR data item is included in brackets e.g. METeOR (613331)
Code Set Source	Identifies the authority that developed the code set (if any) for this data item
XML Tag	XML label associated with this data item (for XML extracts)

Note: The default value for all data entry fields is NULL unless otherwise specified.

Additional Information

Definition	Any additional or other information relating to the cancer diagnosis.
Purpose	To collect any relevant additional information not captured by other fields.
Reporting Guide	This field may be used to report: □ **Pathology report number and name of pathology provider of** surgical or diagnostic procedure performed during the admission. □ **Other stage or staging classification** if *Staging Scheme* is coded as 96. □ **Other investigations** if *Investigations* data field is coded as a 9. □ **Other performance status** score if the *ECOG Performance Status* is coded as a 9. Additional information can be sourced from the patient medical record (including clinical notes, correspondence, investigations and results sections) and multidisciplinary team meeting notes.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1373
Data Type	String
Format	X(225)
Field Size	Maximum 225
Code Set	Nil
Validations	Nil, free text field.
Missing Data	Acceptable
Related Items	Primary Site, Investigations, ECOG Performance Status, Stage, Staging System
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	AdditInfo

Building/Property Name

Definition	The name of a building or property where a person resides, as represented by text.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported. Used in conjunction with other address components (i.e. street address, suburb and postcode), forms a complete geographical/physical address of a person.
Reporting Guide	**Report the building or property name.** For example: ■ Bayside Caravan Park (site name of caravan park) ■ Chatswood House Aged Care (site name of aged care home) ■ Pinewood Lodge Nursing Home (site name of nursing home) ■ Yallambee Village Retirement Village (site name of gated property) ■ Blue Hills Farm (name of the property)
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1100
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Street Address, Suburb, Postcode
Definition Source	METeOR (270028)
Code Set Source	Not applicable
XML Tag	PropertyName

Campus Code

Definition	A physically distinct site owned or occupied by a public health service/hospital, where treatment and/or care is regularly provided to patients.
Purpose	To identify the hospital making the report.
Reporting Guide	Report the hospital campus code as allocated by the Department of Health.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1235
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Campus Code Table
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Hospital Name
Definition Source	Victorian Admitted Episodes Dataset (VAED) manual 2024-25. Section 2 Concepts [6]
Code Set Source	Department of Health Campus Code Table
XML Tag	CampusCode

Cancer Diagnosed Prior to Admission Flag

Definition	Indicator as to whether the cancer has been previously diagnosed.
Purpose	To indicate that further information is provided in Where Previously Diagnosed.
Reporting Guide	Report the relevant code.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1280
Data Type	Alphabetic
Format	A
Field Size	1

Code Set

Code	Descriptor
Y	Yes
N	No
U	Unknown

Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Where Previously Diagnosed
Definition Source	Victorian Cancer Registry
Code Set Source	Victorian Cancer Registry
XML Tag	PriorDiagFlag

Country of Birth

Definition	The country in which the person was born, as represented by a code.
Purpose	To facilitate epidemiological studies.
Reporting Guide	**Report the country in which the patient was born, not the country of residence.** For patients born in Australia, report code 1101. If the patient's country of birth is not stated, report code 0003.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1140
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Country of Birth and Country of Residence Standard Australian Classification of Countries (SACC) for Health Data Standards and Systems (HDSS) collections (DH modified). [7]
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (659454)
Code Set Source	Australian Bureau of Statistics - Standard Australian Classification of Countries (SACC), 2016 [8]
XML Tag	COB

Date of Admission

Definition	The date on which an admitted patient commences an episode of care, expressed as DDMMYYYY.
Purpose	Used with Date of Discharge to define an episode of care.
Reporting Guide	Report the date the patient attended your facility for this episode of care.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1260
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Date of Admission must be on or after Date of Birth. Date of Admission cannot be after Date of Registration.
Missing Data	Not acceptable
Related Items	Date of Discharge
Definition Source	METeOR (695137)
Code Set Source	Not applicable
XML Tag	AdmissionDate

Date of Birth

Definition	The date of birth of the person, expressed as DDMMYYYY
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	Report the patient's date of birth. If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1040
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Date of Birth must be on or before Date of Admission. Year (YYYY) can only be 19xx or 20xx.
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (287007)
Code Set Source	Not applicable
XML Tag	DOB

Date of Diagnosis of Primary Cancer

Definition	The date when the cancer was first diagnosed. This may not necessarily be a date during the current episode.
Purpose	Collected for accurate identification of the diagnosis date of the cancer and population cancer statistics and research.
Reporting Guide	Report the date of primary cancer diagnosis. This information should be obtained from the patient's diagnostic pathology report, imaging result, exploratory surgery, clinical diagnosis or a date within a letter or referral, multi-disciplinary team meeting notes or correspondence from another institution or hospital. In the case of pathology, the date of diagnosis should be the service date, not the date authorised by the pathologist. If the **exact date is not known**, do not default to the current date. Instead, record the best estimate based on whatever information is available. For example: ■ If only month and year is known, report the date as **01/MM/YYYY** ■ If only the year is known, report the date as **01/01/YYYY** ■ If a specified number of months ago (e.g. 6 months ago), record your best estimate If this **date is unavailable**, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: ■ Date of the consultation at, or admission to the hospital, clinic or institution when the cancer was first diagnosed. DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer. ■ Date of first diagnosis as stated by a recognised medical practitioner or dentist. ■ Date the patient states they were first diagnosed with cancer. Note: this may be the only date available in a few cases (e.g. patient was first diagnosed in a foreign country). If the Date of Diagnosis is unknown or unavailable, flag or tick Estimated Date field. **Unknown Primary** If the primary site is unknown and metastases have been diagnosed during this episode, report the date of the newly diagnosed metastatic disease.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1270
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	If the primary cancer was diagnosed prior to admission, diagnosis date must be prior to admission date. If the primary cancer was NOT diagnosed prior to admission, diagnosis date must be on or after admission date but prior to date of discharge. Diagnosis date cannot be after registration date. Diagnosis date must be greater or equal to date of birth Diagnosis date cannot be after date of death (if patient died at facility)

Missing Data	Not acceptable
Related Items	Estimated Date Flag
Definition Source	METeOR (416129), Victorian Cancer Registry modified
Code Set Source	Not applicable
XML Tag	DiagnosisDate

Date of Discharge

Definition	The most recent date of discharge or separation from your facility. Also referred to as separation date (date on which an admitted patient completes an episode of care).
Purpose	Used with Date of Admission to define an episode of care.
Reporting Guide	Report the most recent date of discharge or separation from your facility.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1290
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Discharge date cannot be before admission date. Discharge date cannot be after cancer registration date
Missing Data	Not acceptable
Related Items	Date of Admission
Definition Source	Victorian Admitted Episodes Dataset (VAED) manual 2024-25[9] (Victorian Cancer Registry modified from Separation Date)
Code Set Source	Not applicable
XML Tag	DischargeDate

Date of Registration

Definition	The date the cancer registration is completed.
Purpose	To differentiate between similar cancer registrations sent at a later date which may contain further information.
Reporting Guide	Report the date of completing the cancer registration.
Reporting Obligation	Mandatory
ASCII Field/Line No.	2910
Data Type	Date
Format	DDMMYYYY
Field Size	8
Code Set	Valid date
Validations	Default to current system date
Missing Data	Not acceptable
Related Items	Name of Person Completing the Registration
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	RegDate

ECOG Performance Status

Definition	Eastern Cooperative Oncology Group (ECOG) is a score given at the time of diagnosis outlining the extent to which a person with cancer's disease affects their daily living abilities, as represented by a code.
Purpose	To measure the quality of life of adult cancer patients and monitor best practice treatment.
Reporting Guide	ECOG performance status recorded at diagnosis or prior to treatment. ECOG information can be sourced from multi-disciplinary team meeting notes, other clinical notes or correspondence section of the medical record. ECOG performance status scale does not apply to paediatric oncology patients. If a performance status other than ECOG is recorded e.g. Lansky or Karnofsky performance status scales, select Unknown/Not stated/Not applicable (9) and record status and scale in Additional Information.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1372
Data Type	Numeric
Format	N
Field Size	1

Code Set

Code	Descriptor
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
9	Unknown/Not stated/Not applicable

Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Additional Information
Definition Source	METeOR (412327)
Code Set Source	METeOR (Victorian Cancer Registry modified)
XML Tag	ECOG

Estimated Date Flag

Definition	Indicates whether any component of a reported Date of Diagnosis was estimated.
Purpose	To indicate that Date of Diagnosis of Primary Cancer is estimated.
Reporting Guide	Report the relevant code.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1271
Data Type	Numeric
Format	N
Field Size	1
Code Set	**Code** **Descriptor** 0 Date of diagnosis is not estimated 1 Date of diagnosis is estimated
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Date of Diagnosis of Primary Cancer
Definition Source	METeOR (270909)
Code Set Source	Victorian Cancer Registry
XML Tag	EstDateFlag

General Practitioner Address

Definition	The address of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the address of the patient's general practitioner/local doctor/local medical officer if available. Include the name of the medical centre or practice if known/applicable. Report the street number, street name, suburb and postcode separated by a space.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2220
Data Type	String
Format	X(250)
Field Size	Maximum 250
Code Set	Not applicable
Validations	Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Family Name, General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Medicare Provider Number
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	GPAddress

General Practitioner Family Name

Definition	The family name of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the family name of the patient's general practitioner/local doctor/local medical officer.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2210
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	METeOR (613331)
Code Set Source	Not applicable
XML Tag	GPSurname

General Practitioner First Given Name

Definition	The first given name of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the first given name of the patient's general practitioner/local doctor/local medical officer if available
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2215
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Family Name, General Practitioner Second Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	GPFirstName

General Practitioner Medicare Provider Number

Definition	The Medicare Provider number is a concatenation of the: ■ Medicare service provider identifier, defined as the unique numeric identifier for the Medicare service provider to facilitate the payment of patient/provider claims, and the ■ Medicare service provider practice location identifier, defined as the unique alphanumeric identifier for a **Medicare service provider's** location, which may be the place of a provider's practice or the place of equipment
Purpose	Collected for administrative purposes.
Reporting Guide	Report the Medicare provider number of the patient's general practitioner/local doctor/local medical officer if available.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2225
Data Type	String
Format	X(8)
Field Size	8
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	General Practitioner Family Name, General Practitioner First Given Name, General Practitioner Second Given Name, General Practitioner Address
Definition Source	METeOR (601809) and METeOR (601956)
Code Set Source	METeOR (601809), Victorian Cancer Registry modified from N(6) to X(6) METeOR (601956), Victorian Cancer Registry modified from X(1) to X(2).
XML Tag	GPMediProvidNo

General Practitioner Second Given Name

Definition	The second given name or second initial of the patient's general practitioner/local doctor/local medical officer.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the second given name or second initial of the patient's general practitioner/ local doctor/local medical officer if available.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	2216
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	General Practitioner Family Name, General Practitioner First Given Name, General Practitioner Address, General Practitioner Medicare Provider Number
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	GPSecondName

Grade

Definition	The histopathological grade or differentiation in a person with cancer, as represented by a code.
Purpose	To record the grade or severity of the primary tumour.
Reporting Guide	Histopathological grade or differentiation describes how little the tumour resembles the normal tissue from which it arose. Grade can only be recorded if there is a pathological examination. When more than one grade is documented for the primary tumour **within the same specimen report**, use the highest grade. For example, if grade 2-3 is documented, record the grade as 3. If the grade differs on **multiple pathology reports for the same tumour**, use the value from the larger specimen (for example, the grade from a surgical excision specimen would be used over the grade from a specimen from a diagnostic biopsy). Grade should not be mistaken for Stage Group. Grade examines the cells and how aggressive they look, while stage refers to how large and far the cancer has spread. For an invasive tumour with an in situ component, record the grade for the invasive component only. If the grade of the invasive component is not reported, record the grade as unknown. ***Prostate cancer coding rules:*** Use the International Society of Urological Pathology (ISUP) grade group (Grades 1-5)
Reporting Obligation	Mandatory
ASCII Field/Line No.	1365
Data Type	Numeric
Format	N
Field Size	1

Code Set

Code	Descriptor
1	Grade 1: Low grade; well differentiated, differentiated, NOS ISUP Grade Group 1
2	Grade 2: Intermediate grade; moderately differentiated, moderately well differentiated, intermediate differentiation. ISUP Grade Group 2
3	Grade 3: High grade, poorly differentiated. ISUP Grade Group 3
4	Grade 4: Undifferentiated, anaplastic. ISUP Grade Group 4
5	ISUP Grade Group 5
9	Grade or differentiation not determined, not stated or not applicable

Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (422555)- modified to include code 5: Grade 5- ISUP grade group
Code Set Source	METeOR
XML Tag	Grade

Hospital Name

Definition	A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients. A hospital may be located at one physical site or may be a multi campus hospital. For the purposes of these definitions, 'hospital' includes satellite units managed and staffed by the hospital and private homes used for service provision under the Hospital in the Home program.
Purpose	To identify the hospital making the report.
Reporting Guide	Report the name of your hospital or hospital campus where the patient was treated.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1230
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Campus Code Table 3
Validations	Valid name as per code set
Missing Data	Not acceptable
Related Items	Hospital Campus Code
Definition Source	Victorian Admitted Episodes Dataset (VAED) manual 2024-25. Section 2 Concepts.[6]
Code Set Source	Department of Health Campus Code Table
XML Tag	HospitalName

Indigenous Status

Definition	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code.
Purpose	To enable planning, service delivery, and monitoring of indigenous health at a state and national level.
Reporting Guide	Report the relevant indigenous status of the patient.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1070
Data Type	Numeric
Format	N
Field Size	1
Code Set	**Code** **Descriptor** 1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal nor Torres Strait Islander origin 8 Question unable to be asked 9 Patient refused to answer
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (291036)
Code Set Source	Victorian Admitted Episodes Dataset (VAED) manual 2024-25 [9]
XML Tag	IndigStatus

Individual Healthcare Identifier

Definition	The numerical identifier that uniquely identifies each individual in the Australian healthcare system.
Purpose	To uniquely identify individuals in the healthcare system.
Reporting Guide	Report the patient's Individual Healthcare Identifier.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1056
Data Type	Numeric
Format	N(16)
Field Size	16
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Nil
Definition Source	METeOR (432495)
Code Set Source	Not applicable
XML Tag	IHI

Investigations

Definition	All investigations relevant to the diagnosis of this cancer both at your facility and elsewhere.
Purpose	To derive the best basis of diagnosis.
Reporting Guide	Include all investigations relevant to the diagnosis of cancer both at your facility and elsewhere if known. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. Select one or more applicable codes in the hierarchy order specified i.e. 8 through 1, then 9. If 9 (Other/Unknown) is selected, enter the details in **Additional Information.**
Reporting Obligation	Mandatory
ASCII Field/Line No.	1370
Data Type	String
Format	X(15)
Field Size	Maximum 15
Code Set	**Code** **Descriptor** 1 Clinical only 2 Biochemistry/Immunology 3 Imaging (including CT scan) 4 Endoscopy 5 Exploratory surgery 6 Cytology/Haematology 7 Histology of metastatic tumour 8 Histology of primary tumour 9 Other/Unknown
Validations	Multi-selection field. One or more valid codes permitted, separated by a space
Missing Data	Not acceptable
Related Items	Additional Information
Definition Source	Victorian Cancer Registry
Code Set Source	Victorian Cancer Registry
XML Tag	Investigations

Language Spoken At Home

Definition	The language reported by a person as the main language spoken by that person in their home.
Purpose	To facilitate epidemiological studies and ensure cancer control initiatives are communicated adequately to all Victorian communities.
Reporting Guide	This may be another language, even where the person can speak fluent English. English - report code 1201. Not Stated - report code 0002.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1150
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Preferred Language Australian Standard Classification of Languages (ASCL) for HDSS collections [10]
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	METeOR (746554)
Code Set Source	Australian Bureau of Statistics - Australian Standard Classification of Languages (ASCL), 2016 version (DH modified)[10]
XML Tag	Language

Laterality of Primary Cancer

Definition	The side of a paired organ that is the origin of the primary cancer
Purpose	Collected to determine exact location and history of tumour.
Reporting Guide	Report laterality for relevant paired body organs. Each side of a paired organ is considered separate and described as lateral. Bilateral tumours are very rare and include 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) and bilateral ovarian tumours (C569). For other body sites that are not a paired organ select 'Not applicable'.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1325
Data Type	Numeric
Format	N
Field Size	1

Code Set

Code	Descriptor
1	Right
2	Left
4	Bilateral
8	Not applicable
9	Unknown

Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Primary Site, Morphology
Definition Source	METeOR (422769)
Code Set Source	Victorian Cancer Registry
XML Tag	Laterality

Medicare Number

Definition	Person identifier, as allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	Report the patient's full Medicare number including the individual reference number (number against patient name).
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1055
Data Type	Numeric
Format	N(11)
Field Size	11
Code Set	The patient's Medicare number and individual reference number as issued by Medicare Australia
Validations	Valid code as per code set
Missing Data	Acceptable
Related Items	Nil
Definition Source	METeOR (270101)
Code Set Source	Medicare Australia
XML Tag	MedicareNo

Metastatic Site

Definition	The metastatic site is the anatomical position (topography) of the secondary cancer (can be localised or distant) which has spread from the primary tumour, as represented by an ICD-10-AM code.
Purpose	To record the spread of cancer which is vital information required to stage a cancer.
Reporting Guide	Report all applicable metastatic site codes. Use ICD-10-AM codes in the range C77-C79 only. If a patient with a previously registered primary tumour now presents with metastatic disease, a new cancer registration is required. The new registration must contain the original primary tumour details plus the new metastatic site code(s). Section 8 Indications requiring a cancer registration. Refer also to section 8 of this User Guide for further details.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1340
Data Type	String
Format	X(75)
Field Size	Maximum 75
Code Set	ICD-10-AM metastatic site code in the range C77-C79 as listed in Table 1, Reportable Cancers.
Validations	Do not use ICD-10-AM primary site specific topography codes (example- C220 for liver mets instead of C787) One or more valid codes as per code set. First character of each code must be 'C'. Do not include punctuation within the code (i.e. omit dot). For example, report C770 instead of C77.0, report C7988 instead of C79.88 Multiple codes must be separated by a space e.g. C770 C775 C788 C7988
Missing Data	Acceptable
Related Items	Morphology
Definition Source	Victorian Cancer Registry
Code Set Source	ICD-10-AM
XML Tag	MetSite

Morphology

Definition	The histological classification of the cancer tissue (histopathological type) in a person with cancer, and a description of the course of development that a tumour is likely to take- benign or malignant (behaviour), as represented by a code.
Purpose	Collected to classify tumours into clinically relevant groupings on the basis of both their morphology and degree of invasion or malignancy. It is also used for monitoring numbers of new cases of cancer and for cancer statistics and epidemiological studies.
Reporting Guide	Report the morphology code including the behaviour of the primary tumour.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1360
Data Type	Numeric
Format	N(5)
Field Size	5
Code Set	ICD-10-AM
Validations	Valid code as per code set. Do not report the M prefix or forward slash, for example, report 81403 instead of M8140/3
Missing Data	Not acceptable
Related Items	Primary Site, Metastatic Site
Definition Source	METeOR (399491)
Code Set Source	ICD-10-AM
XML Tag	Morph

Name of Person Completing the Registration

Definition	The full name of the person completing the cancer registration.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the given name and family name of the person completing the cancer registration.
Reporting Obligation	Mandatory
ASCII Field/Line No.	2900
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	System-derived
Missing Data	Not acceptable
Related Items	Date of Registration
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	RegName

Patient Family Name

Definition	The name a person has in common with some other members of their family, as represented by text. It is often hereditary, and is distinguished from that person's first given name.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	A person's family name is one of the following: • the hereditary or tribal surname of a person's family • acquired by a person in accordance with a due process defined in a state or territory Act relating to the registration of births, deaths, marriages and changes of name and sex, and for related purposes • any other name distinguished from a person's given name. Record the person's full family name on the information system.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1010
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Nil
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Patient First Given Name, Patient Second Given Name, Previous/Maiden Name/Other Names
Definition Source	METeOR (613331) VCR modified
Code Set Source	Not applicable
XML Tag	PatSurname

Patient First Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	Report the first given name of the patient.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1020
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Patient Family Name, Patient Second Given Name, Previous/Maiden/Other Names
Definition Source	METeOR (613340) VCR modified
Code Set Source	Not applicable
XML Tag	PatFirstName

Patient Second Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified, as represented by text.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	Report the second given name(s) of the patient if available. A person may refer to themselves, or be known by their middle name e.g. Peter John may be known as John. In this scenario, record John here and also in the *Previous/Original family name/Other Names* field. Do not use quotation marks or brackets.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1030
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Multiple names must be separated by a space.
Missing Data	Acceptable
Related Items	Patient Family Name, Patient First Given Name, Previous/Maiden/Other Names
Definition Source	METeOR (613340) VCR modified
Code Set Source	Not applicable
XML Tag	PatSecondName

Postcode

Definition	The Australian numeric descriptor for a postal delivery area for an address.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Guide	Report the usual residential postcode of the patient.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1130
Data Type	Numeric
Format	NNNN
Field Size	4
Code Set	Australia Post
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Suburb, Street Address, Building/Property Name
Definition Source	METeOR (611398)
Code Set Source	Australia Post
XML Tag	Postcode

Previous/Original family name /Other Names

Definition	Any previous family names, original family name (i.e. maiden name), or any other names the patient may be known by i.e. alias.
Purpose	Previous or other names of the patient assist with data linkage.
Reporting Guide	Report any previous name or other family names or given names/alias by which the patient may be known. A person may refer to themselves, or be known by their middle name e.g. Peter John may be known as John. In this scenario, record John in the *Patient Second Given Name* and also in this field. Do not use quotation marks. A person may abbreviate their name e.g. Elizabeth may be known as Liz. In this scenario, record Liz here without quotation marks or brackets.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1060
Data Type	String
Format	X(50)
Field Size	Maximum 50
Code Set	Not applicable
Validations	The first character must be alphabetic. Multiple names must be separated by a space.
Missing Data	Acceptable
Related Items	Patient Family Name, Patient First Given Name, Patient Second Given Name
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	PatOtherName

Primary Site of Cancer

Definition	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code
Purpose	Collected to classify tumours into clinically-relevant groupings on the basis of both their site and histological type. It is used for cancer surveillance and monitoring, cancer statistics and epidemiological studies.
Reporting Guide	Only one primary site can be reported per registration. For **multiple primaries**, a separate registration is required for each primary site. For example, multiple tumours of the large intestine identified on a pathology report, such as an invasive mucinous adenocarcinoma of the caecum (M8480/3) and an invasive adenocarcinoma of the sigmoid colon (M8140/3). This would require two cancer registrations. Refer also to section 7 of this User Guide for further details. **DO NOT REPORT METASTATIC SITE CODES IN THIS FIELD**
Reporting Obligation	Mandatory
ASCII Field/Line No.	1320
Data Type	String
Format	X(5)
Field Size	Maximum 5
Code Set	ICD-10-AM Chapter 2: Neoplasms - Primary Site Codes
Validations	One of the ICD-10-AM primary site codes in the range listed in Table 2 of the Reportable Cancers guide. Do NOT include metastatic site codes (C77-C79). First character must be 'C' or 'D'. Do not include punctuation within the code (i.e. omit dot). For example, report C509 instead of C50.9 or C9291 instead of C92.91
Missing Data	Not acceptable
Related Items	Laterality of Primary Tumour, Morphology, Additional Information
Definition Source	METeOR (270182)
Code Set Source	ICD-10-AM
XML Tag	PrimarySite

Sex at birth

Definition	The sex of the person as recorded at birth or infancy. The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code.
Purpose	Identifies the patient uniquely when combined with other demographic data items.
Reporting Guide	The term 'sex' refers to a person's biological characteristics. A person's sex is usually described as being either male or female; some people may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or infancy. Hospitals should refrain from making assumptions about a person's sex based on indicators such as their name, voice or appearance **Another term** applies to Persons whose sex at birth or infancy was recorded as another term (not male or female
Reporting Obligation	Mandatory
ASCII Field/Line No.	1050
Data Type	Numeric
Format	N
Field Size	1
Code Set	**Code** **Descriptor** 1 Male 2 Female 5 Another term
Validations	Valid code as per code set
Missing Data	Not acceptable
Related Items	Nil
Definition Source	Victorian Admitted Episodes dataset (VAED) manual 2024-25.[9]
Code Set Source	Victorian Admitted Episodes dataset (VAED) manual 2024-25.[9]
XML Tag	Sex

Stage Group

Definition	The summary stage documented at the time of diagnosis or shortly thereafter before any treatment is initiated, as represented by a code, to indicate how far a cancer has spread from the point of origin.
Purpose	To define the extent of cancer at diagnosis. Cancer stage is an important determinant of treatment and prognosis and is used to evaluate new treatments and analyse outcomes.
Reporting Guide	Stage group information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. Record the stage group using the respective staging scheme (see Staging Scheme definition). The most commonly recorded stage group is the TNM stage group. TNM is used by the UICC (01) and the AJCC (12) stage schemes. If it is not documented, select '9'. If registering a previously diagnosed cancer and patient is now returning with newly diagnosed metastatic disease, provide the updated stage group if known.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1391
Data Type	String
Format	XX
Field Size	Maximum 2

Code Set

Valid codes	Staging scheme (see page 59)	Description
0, 1, 1A, 1B, 1C, 2, 2A, 2B, 2C, 3, 3A, 3B, 3C, 4, 4A, 4B, 4C	TNM (01,12)	Most solid tumours other than brain. It may be recorded in medical notes as Arabic (1-4) or Roman numerals (I, II, III, IV) followed by subgroups (is, A, B, C) in upper or lower case. Should be coded using Arabic numbers
1A, 1B, 2A, 2B, 3A, 3B	Durie-Samon (02)	Myeloma. It may be recorded in medical notes as Arabic (1-4) or Roman numerals (I, II, III, IV) followed by subgroups (is, A, B, C) in upper or lower case. Should be coded using Arabic numbers.
M0, M1, M2, M3, M4, M5, M6, M7	FAB (03)	Acute Myeloid Leukaemia (AML)
A, B, C, D	ACPS (04)	Colorectal (bowel) cancer
As per TNM (01, 12)	FIGO (05)	Gynaecological cancers
A, B, C, D	Dukes (06)	Colorectal (bowel) cancer

Code Set	Code	Abbreviation	Descriptor
	1A, 1B, 1E, 2A, 2B, 2E, 3A, 3B, 3E, 3S, 4A, 4B, 4E, 4S	Ann Arbor (07)	Lymphoma. It may be recorded in medical notes as Arabic (1-4) or Roman numerals (I, II, III, IV) followed by subgroups (A, b, E, S) in upper or lower case. Should be coded using Arabic numbers. (For all stages A or B subgroups are valid. For stages 1 to 3, subgroup E is valid. For stage 3 and 4, subgroup E and S are valid
	A, B, C	Binet (08)	Chronic Lymphocytic Leukaemia
	0, 1, 2, 3, 4	Rai (09)	Chronic Lymphocytic Leukaemia. It may be recorded in medical notes as Arabic (1-4) or Roman numerals (I, II, III, IV) Should be coded using Arabic numbers
	1,2, 3	CML (10)	Chronic Myeloid Leukaemia. Chronic=1, Accelerated =2, Blast=3
	1, 2, 3	ISS / R-ISS (11)	Multiple Myeloma. May be recorded as ISS or R-ISS. It may be recorded in medical notes as Arabic (1-3) or Roman numerals (I, II, III). Should be coded using Arabic numbers.
	1, 2, 3	Pancreas (13)	Resectable disease= 1, Borderline resectable= 2, Unresectable=3
	9	Not applicable/Not available/Unknown/ Other	

Validations	Valid code as per code set. Enable predictive text to limit value domain.
Missing Data	Not acceptable
Related Items	TNM Stage - T category, TNM Stage - N category, TNM Stage - M category, Staging Scheme, Additional Information
Definition Source	Victorian Cancer Registry
Code Set Source	Victorian Cancer Registry
XML Tag	Stage

Staging Scheme

Definition	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
Purpose	To provide context to the stage value.
Reporting Guide	Record the cancer staging scheme documented alongside the stage of cancer. This information should be obtained from the patient's medical record or multidisciplinary team meeting documentation. If 'Other' is selected, record the staging scheme in **Additional Information** data field.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1392
Data Type	Numeric
Format	NN
Field Size	2

Code Set

Code	Abbreviation	Descriptor
01	UICC	Union for International Cancer Control (UICC) TNM Classification of Malignant Tumours
02	Durie & Salmon	Durie & Salmon for multiple myeloma staging
03	FAB	French-American-British (FAB) for leukaemia classification
04	ACPS	Australian Clinico-Pathological Staging (ACPS) System for colorectal cancer
05	FIGO	International Federation of Gynaecologists and Obstetricians (FIGO) for gynaecological cancers
06	Dukes	Dukes/Modified Dukes for colorectal cancer
07	Ann Arbor	Ann Arbor staging system for lymphomas
08	Binet	Binet Staging Classification for chronic lymphocytic leukaemia
09	Rai	Rai staging system for chronic lymphocytic leukaemia
10	CML	Chronic Myeloid Leukaemia (CML) staging system
11	ISS	International Staging System (ISS) for myeloma

Code Set	Code	Abbreviation	Descriptor
	12	AJCC	American Joint Committee on Cancer (AJCC) Cancer **Staging System**
	13	Pancreatic cancer	Resectable/borderline resectable/ locally advanced- unresectable-metastatic coding scheme
	96	Other	Other reference
	97	Not applicable	Not applicable

Validations	A valid code as per code set. Enable predictive text to facilitate selection
Missing Data	Acceptable
Related Items	Stage Group, TNM Stage - T category, TNM Stage - N category, TNM Stage - M category, Additional Information
Definition Source	METeOR (720534)
Code Set Source	METeOR (Victorian Cancer Registry modified with additional code 13 added)
XML Tag	StagingSystem

Street Address

Definition	The usual residential street address where a person lives under normal circumstances.
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Guide	Report the street number, name, and type of the patient's usual residential address e.g. 18 Lincoln St. Use acceptable Australia Post abbreviations. Apartment, flats or units are to be recorded as 15/18 Lincoln St. Post Office (PO) boxes and Roadside Delivery (RSD) should only be provided when no other residential address is available.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1110
Data Type	String
Format	X(200)
Field Size	Maximum 200
Code Set	Not applicable
Validations	Nil
Missing Data	Not acceptable
Related Items	Building/Property Name, Suburb, Postcode
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	StreetAddr

Suburb/Town/Locality name

Definition	The name of the locality/suburb of the address, as represented by text
Purpose	Collected for administrative purposes, individual identification, and identification of the regions where the first incidence of cancer was reported.
Reporting Guide	Report the suburb of the patient's usual residential address. The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1120
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Australia Post
Validations	The first character must be alphabetic.
Missing Data	Not acceptable
Related Items	Building/Property Name, Street Address, Postcode
Definition Source	Victorian Cancer Registry
Code Set Source	Australia Post
XML Tag	Suburb

TNM Stage - T category

Definition

The size and extent of the primary **tumour** (T) in a person with cancer, as represented by a code. TNM staging applies to most solid tumours. A prefix is applied before the stage to denote what source was used to determine the T category.

Purpose

To define the extent of cancer at diagnosis looking at the primary tumour level

Reporting Guide

This field is only used when the UICC (01), AJCC (12) or FIGO (05) staging system is used. If another staging scheme is used, record the stage in the Stage Group field.

This information should be obtained from the patient's medical record, doctors' correspondence, or multidisciplinary team meeting documentation.

Record the stage in Arabic numerals and the appropriate upper or lower case alphabetic character.

Record TX if this is how it is recorded in clinical notes.

Record '9' only if a T category cannot be located after reviewing medical record, and MDM software if available.

Time period for reporting diagnosis T category

A diagnostic T category is to be captured if it is recorded:

- within a period of 4 months of diagnosis, or
- up to the date of cancer progression if this occurs within the 4-month period or
- up to the completion of definitive surgery if the surgery occurs later than 4 months after diagnosis and the cancer has clearly not progressed during this time period.
- at recurrence of a tumour
- any change in the stage of cancer compared with previous admission

Where possible, T category should be assigned before the start of neoadjuvant therapy (chemotherapy or radiotherapy).

Prefixes to T category

If recorded, also include the relevant prefix code

Prefix code	Definition
c	assigned based on *clinical examination* e.g. imaging report, x-rays, in MDM meeting based on a number of inputs
p	assigned based only on the *pathology report*
yc	assigned based on *clinical examination after patient has commenced neoadjuvant therapy* such as chemotherapy or radiotherapy but before surgery
yp	assigned based on *pathology report after patient has commenced neoadjuvant therapy* such as chemotherapy or radiotherapy but before definitive surgery
r	assigned based on therapeutic procedures or clinically, to denote recurrence or retreatment
a	assigned postmortem, based on an autopsy report

Reporting Obligation

Mandatory if available

ASCII Field/Line No.

1393

Data Type

String

Format

X(6)

Field Size

Maximum 6

Code Set	Code	Descriptor
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank Tis, Ta	Stage Tis or Ta category (in situ tumours)
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank T0	Stage T0 category
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank T1, T1mi, T1a, T1b, T1c, T1c1, T1c2, T1c3	Stage T1 category and relevant sub-category (if known)
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank T2, T2a, T2b, T2c	Stage T2 category and relevant sub-category (if known)
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank T3, T3a, T3b, T3c	Stage T3 category and relevant sub-category (if known)
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank T4, T4a, T4b, T4c, T4d	Stage T4 category and relevant sub-category (if known)
	TX	Medical team have recorded TX in clinical notes to indicate that medical review has determined that there is no information about the T category for the primary tumour, it is unknown or cannot be assessed.
	9	Clinical coder has found no information documented on the T category for the primary tumour. **NOTE: Use of 9 category should be minimised**

Validations	Nil
Missing Data	Acceptable.
Related Items	TNM Stage - N category, TNM Stage - M category, Stage Group, Staging Scheme
Definition Source	METeOR (403564) VCR modified
Code Set Source	AJCC (American Joint Committee on Cancer) Cancer Staging Manual[11]
XML Tag	TNM-T

TNM Stage - N category

Definition	The absence or presence and extent of regional lymph node metastasis in a person with cancer, as represented by a code. A prefix is applied before the stage to denote what source was used to determine the N category.
Purpose	To define the extent of cancer at diagnosis.
Reporting Guide	This field is only used when the UICC (01), AJCC (12) or FIGO (05) staging system is used. If another staging scheme is used, record the stage in the Stage Group field. Record the presence or absence and extend of regional lymph node metastasis at the time of diagnosis of the cancer. Record the stage in Arabic numerals and the appropriate upper- or lower-case alphabetic character. Record NX if this is how it is recorded in clinical notes. Record '9' only if a N category cannot be located after reviewing medical record, and MDM software if available. **Time period for reporting diagnosis N category** As per time period for recording T category (above). **Prefixes to N category** As per instruction for T category (above).
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1394
Data Type	String
Format	X(6)
Field Size	Maximum 6

Code Set

Code	Descriptor
'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank N0	Stage N0- cancer has not spread to nearby or distant
'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank N1, N1mi, N1a, N1b, N1c	Stage N1- cancer has spread to a lymph node and relevant sub-categories.
'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank N2, N2a, N2b, N2c	Stage N2
'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank N3, N3a, N3b, N3c	Stage N3
NX	Medical team have recorded NX in clinical notes to indicate that medical review has determined that there is no i information about the N category for the regional lymph nodes, or it is unknown or cannot be assessed. NOTE: use of NX should be minimised.

9	Clinical coder has found no information documented on the N category for the regional lymph nodes, or it is unknown or cannot be assessed primary tumour. **NOTE: Use of 9 category should be minimised**

Validations	Nil
Missing Data	Acceptable
Related Items	TNM Stage - T category, TNM Stage - M category, Stage Group, Staging Scheme
Definition Source	METeOR (403661) VCR modified
Code Set Source	AJCC (American Joint Committee on Cancer) Cancer Staging Manual[11]
XML Tag	TNM-N

TNM Stage - M category

Definition	The absence or presence of distant metastasis in a person with cancer, as represented by a code.
Purpose	To define the extent of cancer at diagnosis.
Reporting Guide	This field is only used when the UICC (01), AJCC (12) or FIGO (05) staging system is used. If another staging scheme is used, record the stage in the Stage Group field. Record the absence or presence of distant metastasis at the time of diagnosis of the cancer. Record MX if this is how it is recorded in clinical notes. Record '9' only if a M category cannot be located after reviewing medical record, and MDM software if available. **Time period for reporting diagnosis M category** As per time period for recording T category (above) **Prefixes to M category** As per instruction for T category (above)
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1395
Data Type	String
Format	X(5)
Field Size	Maximum 5

Code Set	Code	Descriptor
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank M0	Stage M0- cancer has not spread to another part of the body
	'c' or 'p' or 'yc' or 'yp' or 'r' or 'a' or blank M1, M1a, M1b	Stage M1- cancer has spread to another part of the body and relevant sub-category
	MX	Medical team have recorded MX in clinical notes to indicate that medical review has determined that there is no information about the M category, or it is unknown or cannot be assessed.
	9	Clinical coder has found no information documented on the M category for the metastatic disease, or it is unknown or cannot be assessed. **NOTE: Use of 9 category should be minimised**

Validations	Nil
Missing Data	Acceptable
Related Items	TNM Stage - T category, TNM Stage - N category, Stage Group, Staging Scheme
Definition Source	METeOR (403720) VCR modified
Code Set Source	AJCC (American Joint Committee on Cancer) Cancer Staging Manual[11]
XML Tag	TNM-M

Treating Doctor Address

Definition	The business address of the patient's treating doctor.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the street number, street name, suburb and postcode separated by spaces.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1220
Data Type	String
Format	X(250)
Field Size	Maximum 250
Code Set	Not applicable
Validations	Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	Treating Doctor Family Name, Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Medicare Provider Number
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	TDAddress

Treating Doctor Family Name

Definition	The name a person has in common with some other members of their family, as represented by text. It is often hereditary and is distinguished from that person's first given name.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the treating doctor's family name. The treating doctor is the doctor in charge of the case, responsible for the patient's treatment or care during their admission. Often this is recorded in the hospital patient administration system as the Head of Unit. **NOTE:** Do NOT report the name of a registrar or resident.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1210
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Not acceptable
Related Items	Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	METeOR (613331) VCR modified
Code Set Source	Not applicable
XML Tag	TDSurname

Treating Doctor First Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the first given name of the treating doctor.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1215
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Not acceptable
Related Items	Treating Doctor Family Name, Treating Doctor Second Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	METeOR (613340) VCR modified
Code Set Source	Not applicable
XML Tag	TDFirstName

Treating Doctor Medicare Provider Number

Definition	The Medicare Provider number is a concatenation of the: ■ Medicare service provider identifier, defined as the unique numeric identifier for the Medicare service provider to facilitate the payment of patient/provider claims, and the ■ Medicare service provider practice location identifier, defined as the unique alphanumeric identifier for a **Medicare service provider's** location, which may be the place of a provider's practice or the place of equipment
Purpose	Collected for administrative purposes.
Reporting Guide	Report the treating doctor's Medicare Provider Number if known.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1225
Data Type	String
Format	X(8)
Field Size	8
Code Set	Not applicable
Validations	Nil
Missing Data	Acceptable
Related Items	Treating Doctor Family Name, Treating Doctor First Given Name, Treating Doctor Second Given Name, Treating Doctor Address.
Definition Source	METeOR (601809) and METeOR (601956)
Code Set Source	METeOR (601809) VCR modified, from N(6) to X(6) METeOR (601956) VCR modified, from X(1) to X(2).
XML Tag	TDMediProvidNo

Treating Doctor Second Given Name

Definition	The person's identifying name(s) within the family group or by which the person is socially identified, as represented by text.
Purpose	Collected for administrative purposes.
Reporting Guide	Report the second given name of the treating doctor.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1216
Data Type	String
Format	X(30)
Field Size	Maximum 30
Code Set	Not applicable
Validations	The first character must be alphabetic. Can be auto-extracted from the patient administration system.
Missing Data	Acceptable
Related Items	Treating Doctor Family Name, Treating Doctor First Given Name, Treating Doctor Address, Treating Doctor Medicare Provider Number
Definition Source	METeOR (613340) VCR modified
Code Set Source	Not applicable
XML Tag	TDSecondName

Unit Record Number

Definition	An identifier, unique to a patient within this hospital or campus (patient's record number/unit record number)
Purpose	To enable relevant episodes to be updated and provide the potential for episodes to be linked across patient settings
Reporting Guide	Report the Unit Record Number of the patient at your hospital or campus. This can also be referred to as the patient's record number, medical record number or UR number.
Reporting Obligation	Mandatory
ASCII Field/Line No.	1240
Data Type	String
Format	X(15)
Field Size	Maximum 15
Code Set	Not applicable
Validations	Nil
Missing Data	Not acceptable
Related Items	Nil
Definition Source	Victorian Admitted Episodes Dataset (VAED) manual 2024-25[9]
Code Set Source	Not applicable
XML Tag	URN

Where Previously Diagnosed

Definition	Information regarding where cancer diagnosis was made if made prior to this episode.
Purpose	Collected to determine history of cancer.
Reporting Guide	Report where previously diagnosed in free text if known. If you know that the patient was diagnosed at a particular hospital previously, please name this hospital. If the cancer was diagnosed prior to consultation with your facility, but not at another hospital, please provide any information you may have. For example: □ previous pathology laboratory used and biopsy number if available □ diagnostic imaging centre name □ state/territory of diagnosis if other than Victoria □ overseas or country name If the patient was diagnosed interstate or overseas, it is important that you inform us of this information to enable us to exclude these cases from our Victorian incidence statistics.
Reporting Obligation	Mandatory if available
ASCII Field/Line No.	1285
Data Type	String
Format	X(250)
Field Size	Maximum 250
Code Set	Not applicable
Validations	Required if Cancer Diagnosed Prior to Admission Flag is 'Y'
Missing Data	Acceptable if Cancer Diagnosed Prior to Admission Flag is 'N' or 'U'
Related Items	Cancer Diagnosed Prior to Admission Flag
Definition Source	Victorian Cancer Registry
Code Set Source	Not applicable
XML Tag	WhereDiagnosed

Amendment History

A full history of amendments made to the *Reportable Cancers Guide for Hospitals* is available on request. Please contact the Electronic Notification Coordinator on **vcr@cancervic.org.au**

The Hospitals Information Kit and Reportable Cancers Guide for Hospitals have been merged into one document to provide a single source of information for health services to use when coding cancer registrations. Technical requirements for the extraction of data elements are now found in the reference guide Technical Guide: Cancer Registration Submissions to the Victorian Cancer Registry.

Table 7 provides a summary of changes incorporated in this document from both the Reportable Cancers Guide for Hospitals and the Hospital Information Kit. Importantly, it contains changes to reportable cancers and data elements which are required to be updated in cancer Registration software..

Table 7: Document Amendment History- summary of changes based on previous version of the User Guide: Cancer Registration Submission to the Victorian Cancer Registry

Date	Section	Description	Rationale
	Whole document		
August 2023		Merge of Reportable Cancer guide for Hospitals (July 2018) and Hospitals Information Kit (December 2017) into one document	To provide a single reference document for health services to use when registering cancers
		Creation of Technical guide for submission of cancer registrations to the Victorian Cancer Registry.	To provide a stand-alone technical document for health services to use when establishing data extracts for submission to the Victorian Cancer Registry
	Chapter 6 – data submission		
August 2023		Removal of VCRIP submission details from section 1: Registration of cancer, Section 2: Data Submission Appendix 1: E-Form webpage screenshot.	A detailed description of the VCRIP data submission process and e-form is available in the External User Guide for available on request from **vcr@cancervic.org.au**
	Section 7 – Reportable cancers		
August 2023		New cancers requiring a cancer registration: ■ D1802: Haemangioma intracranial structures	
		■ Cancers no longer requiring a cancer registration: ■ D410: Neoplasm uncertain or unknown behaviour kidney ■ D417: Neoplasm uncertain or unknown urinary organ ■ D419: Neoplasm uncertain ■ or unknown behaviour urinary organ unspecified	

Date	Section	Description	Rationale
	Section 8 – Indications when cancer registration is required		
August 2023		Removal of the cancer registration requirement that cancer registration is required when a patient presents to your healthcare service for the first time with an already known cancer that has been diagnosed at another facility and cancer is not treated during the stay. (section 4.1 item 3 in previous Reportable Cancer Guide).	It is no longer a requirement to report when no cancer treatment is delivered by the health service
	Section 9 – Indications when a cancer registration is not required		
August 2023		New section added	Provides greater clarity to health services on when a registration is not required
	Section 10 - How to register cancer stage		
September 2024		Statement included on page 17 "Stage is only required for invasive tumours (C00-C97)."	To clarify that in situ, benign and tumours of unknown behaviour (those with a D prefix code) are not staged.
	Section 11 - Data dictionary		
August 2023		Data dictionary previously located in the Hospital Information Kit and referred to as Data Specifications.	Incorporated into the Cancer Registration User Guide to provide a single source to describe coding requirements and coding instruction
September 2024		All references to Victorian Admitted Episodes Dataset (VAED) manual 2023-24 updated to 2024-25	To reflect current VAED Dataset
August 2023	[Field 1010] Patient Surname	**Title changed** from Surname to Patient Family Name **Definition source changed** from VCR to METeOR (613331)	To reflect national consistency in terminology
August 2023	[Field 1040] Date of Birth	**Definition source changed** from METeOR (375191-MMYYYY) to 287007-DDMMYYYY)	To clarify requirement for date field
September 2024	[Field 1050] Sex	**Title changed** from Sex to Sex at Birth **Field Description** and **Reporting Guide updated** **Code set changed** to include option 5 'Another term' and remove options 3 'Indeterminate' and 4 'Other'	To reflect current VAED dataset

Date	Section	Description	Rationale
	Section 11 - Data dictionary		
August 2023	[Field 1060] Previous/Maiden/ Other Names	**Title changed** from Previous/ Maiden/Other Names to Previous/ Original family name /Other Names	To reflect national consistency in terminology
August 2023	[Field 1070] Indigenous status	**Definition source changed** from NHDD to METeOR (290136)	To reflect national consistency in terminology
August 2023	[Field 1100] Building/Property name	**Definition source changed** from VCR to METeOR (270028)	To reflect national consistency in terminology
August 2023	[Field 1110] Street Address	**Format changed** from X(50) to X(200) **Field size** increased from maximum 50 to maximum of 200.	To prevent truncation of addresses due to inadequate field size
August 2023	[Field 1150] Language Spoken at Home	**Definition source changed** from METeOR 460125(main language other than English spoken at home) to746554 (main language other than English spoken at home)	To reflect English being included as a valid field in the data set
August 2023	[Field 1210] Treating Doctor Surname	**Title changed** from Treating Doctor Surname to Treating Doctor Family Name **Definition source changed** from VCR to METeOR (613331)	To reflect national consistency in terminology
August 2023	[Field 1215] Treating Doctor First Given Name	**Definition source changed** from VCR to METeOR (613340)	To reflect national consistency in terminology
August 2023	[Field 1216] Treating Doctor Second Given Name	**Definition source changed** from VCR to METeOR (613340) **Field size increased** from maximum 20 to maximum of 30	To reflect national consistency in terminology To prevent truncation of contents due to inadequate field size
August 2023	[Field 1220] Treating Doctor Address	**Format changed** from X(75) to X(250) **Field size** increased from maximum 75 to maximum of 250.	To prevent truncation of addresses due to inadequate field size
August 2023	[Field 1225] Treating Doctor Medicare Provider Number	**Definition source changed** from VCR to the combined METeOR (601809- Medicare service provider identifier) and METeOR (601956- Medicare service provider practice location identifier)	To reflect national consistency in terminology
August 2023	[Field 1260] Date of Admission	**1.Definition source changed** from VCR to the METeOR (695137- Episode of admitted patient care- admission date DDMMYYYY)	To reflect national consistency in terminology

Date	Section	Description	Rationale
	Section 11 - Data dictionary		
August 2023	[Field 1271] Estimated Date Flag	**Definition source changed** from VCR to the METeOR (270909-Estimated Data Flag Code) however, code set source remains with VCR, as discrepancies with METeOR codes	To reflect national consistency in terminology
August 2023	[Field 1285] Where previously diagnosed	**Format changed** from X(75) to X(250) **Field size** increased from maximum 75 to maximum of 250	To prevent truncation of contents due to inadequate field size
August 2023	[Field 1320] Primary Site	**Title changed** from Primary Site to Primary Site of Cancer **Definition source changed** from VCR to METeOR (270182-Primary Site of Cancer, code ICD-10-AM 3rd edn)	To reflect national consistency in terminology
August 2023	[Field 1325] Laterality of Primary Tumour	**Definition source changed** from VCR to the METeOR (422769-Laterality of Primary Cancer) however, code set source remains with VCR, as discrepancies with METeOR codes	To reflect national consistency in terminology
August 2023	[Field 1365] Grade	**Code Set changed** to include code 5: Grade 5 ISUP Grade Group. **Code set definitions amended** to include definition of ISUP grade groups.	To cater for the addition of a new cancer grading system for prostate cancer (ISUP) which has five grade groups
August 2023	[Field 1373] Additional Information	**1.Reporting Guide amended** to remove the need to record in this field Gleason scores, size of tumour, precise location of melanoma, melanoma Clark's level and thickness, recurrence details, neoadjuvant or adjuvant therapy given	To decrease the burden of data collection by coders when this data is provided through alternate sources to the Victorian Cancer Registry
August 2023	[Field 1391] Stage	**Title changed** from Stage to Stage Group **Code set changed** to permit capture of stage groups from other stage schemes.	Title changed to distinguish between Stage group and Stage categories and Stage scheme. Code set expanded to encourage the capture of stage group from the various tumour types
September 2024	[Field 1391] Stage Group	**1.Code set changed** to include M	An error of omission

Date	Section	Description	Rationale
	Section 11 - Data dictionary		
August 2023	[Field 1392] Staging System	**Title changed** from Staging System to Staging Scheme Definition source changed from METeOR 393364 to 720534-Cancer Staging Scheme Source. **Code set changed** to include code 13: Pancreatic cancer resectability staging scheme.	To be consistent with METeOR title, replace superseded METeOR code and cater for a staging scheme used exclusively for pancreatic cancer
September 2024	[Field 1392] Stage Scheme	**Reporting Obligation amended** from 'Mandatory' to 'Mandatory if available'.	It is sometimes not possible to locate a Stage Scheme in documentation.
August 2023	[Field 1393] TNM Stage-T code	**Title changed** from TNM Stage T code to TNM-T category **Code set changed** to enable coders to record prefix, T label and category. TX included as a valid code.	Title changed to be consistent with AJCC Cancer Staging manual. Inclusion of 'T' code (e.g. pT1a rather than p1a as in previous version) enables coders to directly record what is documented in medical notes.
September 2024	[Field 1393] TNM Stage – T Category	**Code set changed** to include additional prefix options 'r' and 'a' **Code set changed** to include Tis, Ta and T0 values for in situ and T0 tumours **Code set changed** to include T1mi, T1c1, T1c2, T1c3 **Format changed** from X(5) to X(6) **Field size increased** from maximum 5 to maximum of 6.	To be consistent with staging classifications
August 2023	[Field 1394] TNM Stage-N code	**Title changed** from TNM Stage N code to TNM-N category **Code set changed** to enable coders to record prefix, N label and category. NX included as a valid code.	Title changed to be consistent with AJCC Cancer Staging manual. Inclusion of 'N' code (e.g. pN1 rather than p1 as in previous version) enables coders to directly record what is documented in medical notes.

References

1. Victorian Government 2016. Improving Cancer Outcomes Act. Victorian Government, 2014. No. 78 of 2014. Version 2 released 1st October 2016. Accessed 29 April 2024, **www.legislation.vic.gov.au/in-force/acts/improving-cancer-outcomes-act-2014/002**.
2. Victorian Government 2015. Improving Cancer Outcomes (Diagnosis Reporting) Regulations 2015. Statutory rule number 107/2015. Released 1st October 2015. Accessed 29 April 2024 at **www.legislation.vic.gov.au/in-force/statutory-rules/improving-cancer-outcomes-diagnosis-reporting-regulations-2015/001**.
3. Australian Institute of Health and Welfare 2023. Metadata Online Registry (METeOR). Accessed 29 April 2024 at **https://meteor.aihw.gov.au/content/181162**.
4. Victorian Government. Health Data Standard Systems (HDSS) reference files. Accessed 29 April 2024 at **www.health.vic.gov.au/data-reporting/health-data-standards-and-systems**.
5. Independent Health and Aged Care Pricing Authority (IHACPA) 2022. International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). Twelfth edition. 1 July 2022.
6. Victorian Government 2023. Campus Code Table. Released 10th February 2023. Accessed 29 April 2024 at **https://www.health.vic.gov.au/sites/default/files/2023-11/campus-code-table-nov-2023.xlsx.**
7. Victorian Government 2017. Country of birth and country of residence SACC codeset. Released 3rd April 2017. Accessed 29 April 2024 at **www.health.vic.gov.au/publications/country-of-birth-and-country-of-residence-sacc-codeset**.
8. Australian Bureau of Statistic 2016. 1269.0 Standard Australian Classification of Countries, 2016. Released 27th June 2016. Accessed 29 April 2024 at **www.abs.gov.au/statistics/classifications/standard-australian-classification-countries-sacc/latest-release**.
9. Victorian Government 2024. Victorian Admitted Episodes Dataset (VAED) manual 2024-25 Section 3 Data Definitions Victorian State Government, 2024. Accessed 29th April 2024.
10. Victorian Government 2021. Preferred language ASCL codeset. Released 18th March 2021. Accessed 29 April 2024 at **www.health.vic.gov.au/publications/preferred-language-ascl-codeset**.
11. Amin MB, Edge S, Greene F, Byrd DR, Brookland RK, Washington MK, Gershenwald JE, Compton CC, Hess KR, et al. (Eds.). AJCC Cancer Staging Manual (8th edition). Springer International Publishing: American Joint Commission on Cancer; 2017

USER GUIDE: CANCER REGISTRATION SUBMISSION TO THE VICTORIAN CANCER REGISTRY

Cancer Council Victoria