FAQs

Catalogue of Requirements for Gynaecological Cancer Centres

of the German Cancer Society (*Deutsche Krebsgesellschaft* - DKG)

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Within the framework of the certification procedure, questions regularly crop up which require an explanation of the Technical and Medical Requirements. This document contains answers to the questions which the centres can refer to when implementing, and the experts can refer to when assessing the Technical and Medical Requirements.

Version FAQs and Catalogue of Requirements (CR)

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The FAQs in this document refer to the following documents which are now in force:

Catalogue of Requirements Gyn.	Version H1	13.12.2021
Indicator Sheet Gyn.	Version H1.1	13.12.2021

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FAQs - Catalogue of Requirements Gyn

1.1 Structure of the network

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.1.3	Gynaecological dysplasia units and consulting hours • The separate certification of gynaecological dysplasia units and consulting hours can be done by the Gynaecological Cancer Centre or by one of its cooperation partners in line with the Catalogue of Requirements "Gynaecological Dysplasia". http://www.onkozert.de/praxen_kooperationspartner.htm • Cooperation with certified gynaecological dysplasia units/consulting hours must be in place and the names must be given. Reasons for non-compliance are to be given separately.	FAQ (27.08.2019) How is the requirement to be demonstrated? Answer: If cooperation cannot be proven, the reasons must be explained in the audit. If the reasons are comprehensible (e.g. no certified dysplasia consultation/unit available within a radius of >45km or regionally related lack of incidence, etc.), there is no deviation.	

1.2 Interdisciplinary cooperation

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.2.1	Performance indicators Gynaecological Cancer Centre Number of cases with a genital malignoma (i.e. invasive neoplasias of the female genitals (no precancerous) borderline tumours of the ovaries and serous tubal intraepithelial carcinoma (STIC)) per year: ≥ 75 cases (= total case number), of which ≥ 50 primary cases Definition primary case: • A primary case includes all stays and treatments (surgery, radio(-chemo)therapy) of a patient to treat a disease • Recurrence/metastasis of a patient is a new case, not a primary case • Histology report, medical report and, where appropriate, treatment/surgical report should be available • Planning/conduct of therapy via the Gynaecological Cancer Centre Count time is the time of the initial diagnosis or the time of the recurrence/metastasis	FAQ (14.07.2016) Is it correct that in the case of gynaecological tumours only the date of the postoperative histology "counts" as the initial diagnosis date, i.e. not the finding of the smear/pipelle de cornier/imaging procedures? Answer: The counting date depends on the examination method that first gives the definitive diagnosis. This can be a smear, but also the surgical histology.	
1.2.6	If a radiotherapy unit cooperates with several clinics, then all primary case patients with a cervical carcinoma, who are to undergo radiochemotherapy, should be presented in a centre. To this end, the radiotherapy unit is to draw up a list of all patients presented to it that includes a centre assignment (certified centre, certification ongoing, not a centre). The presentation rate of 90% is to be achieved in each of the cooperating centres.	FAQ (12.10.2017) How should the requirement that all primary case patients with cervical carcinoma who are to be treated with radiochemotherapy should present at one centre be interpreted? Answer: Patients who are primarily seen in radiation oncology should be systematically brought to the tumour board. In order to facilitate the complete	

1.2 Interdisciplinary cooperation

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
	This assignment of the patients is also of relevance for the tumour documentation.	presentation of these patients and their verifiability in the audit, a corresponding requirement was included in the data collection form (section 1.2.6.). The aim should be that the patients are presented in a certified Gynaecological Cancer Centre.	

1.4 Psycho-oncology

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.4.2	Offer and access Each patient must be offered the option of psycho-oncological counselling in a timely manner in the vicinity. The offer must be made in a low-threshold manner.	FAQ (21.07.2016) Can an on-site contact replace screening? Answer: No. In order to identify the need for treatment, it is necessary to carry out a standardised screening for psychological stress (see S3 guideline Psychooncology: e.g. Disress-Thermometer or HADS) and to document the result.	
	Documentation and evaluation In principle, the number of patients, who received psycho-oncological counselling, the frequency, duration and contents of the sessions are to be recorded. To identify treatment needs it is necessary to conduct standardised screening for mental strain (see S3 Guidelines Psycho-Oncology: e.g. distress thermometer (DT) or the Hospital Anxiety and Depression Scale - HADS), and to document the result.		

1.7 Study management

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.7.5	Proportion study patients 1. Initial certification: At the time of initial certification ≥ 1 patients must have been included in the studies. 2. After one year: at least 5% of the primary case number	FAQ (28.01.2022) Do patients with gynaecological tumours who were enrolled in the Heredi-CaRe study count towards the gynaecological cancer centre's student quota? Answer: For the counting of HerediCaRe patients (proof of study participation required), exclusive use of the checklist and referral of the patients to an FBREK centre is not sufficient.	
	• All study patients can be taken into account when calculating the study rate (share study patients based on the Centre's primary case number). • Only the inclusion of patients in studies with an ethical vote counts as study participation (non-interventional/diagnostic studies are also recognised).		
	General preconditions for the definition of the study quota: • Patients can be counted once per study, time: Date of patient consent • All patients of the Centre can be counted	FAQ (10.02.2022) Can negatively screened study patients be counted? Answer: Patients who have signed a informed consent form for screening for study participation can be counted for the numerator of the respective study	

1.7 Study management

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
	• Study patients can be counted for 2 centres, provided that the sending centre itself conducts at least one own study for patients of the Gynaecological Cancer Centre. If this method of counting is chosen (optional), the centre must show how many patients are brought into its own studies, sent to other centres/clinics for study participation and taken over from other centres/clinics for study participation.	indicator, even if the results of screening examinations performed with special diagnostics (no routine diagnostics) do not allow the patients to participate in the study. FAQ (25.07.2022) Can studies with an ethical vote but without patient informed consent - e.g. patient surveys - be counted? Answer: No, these cannot be counted.	

2.1 Consulting hours

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
2.1.7	Hereditary stress Cooperation with certified centres for familial breast and ovarian cancer (FBREK centres) for counselling and genetic testing must be demonstrated. Check lists to record hereditary stress are to be applied in the case of: • Patients with breast/ovarian cancer (mainly familial breast/ovarian cancer) • Patients with endometrial cancer (EC) (mainly HNPCC/Lynch syndrome The current check lists and the algorithm can be downloaded from https://www.krebsgesellschaft.de/zertdokumente.htmll in the section Gynaecological types of cancer.	FAQ (17.08.2021) Does the non-fulfilment of the requirement "Cooperation with certified centres for familial breast and ovarian cancer (FREBK centres) for counselling and genetic testing must be demonstrated." result in a deviation? Answer: If cooperation cannot be proven, the reasons must be explained in the audit. If the reasons are comprehensible to the auditor (e.g. distance), no deviation is formulated.	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
5.2.1	Specialists for the Gynaecological Cancer Centre • At least 2 specialists for gynaecology with the focus designation Gynaecological Oncology in line with the staffing schedule working for the Gynaecological Cancer Centre • The names of the specialists are to be given. Initial certification: At least 1 specialist for gynaecology with the focus designation Gynaecological Oncology. A second specialist for gynaecology should be undergoing specialty training for the focus designation Gynaecological Oncology. This must	FAQ (14.07.2016) What is the procedure to be followed in the event of the departure/absence of the second focal point holder? Answer: If no second focal point holder is available for the centre after re-certification (e.g. departure/absence), the replacement must take place within 12 months of the date of departure/absence. FAQ (14.07.2016) What should be done if there is no evidence of a second focal point holder at the time of recertification? Answer:	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
	have been successfully concluded before recertification (after 3 years) and notified.	It must be proven that activities to establish a second focal point holder took place after the initial certification (e.g. new appointment, training, ...). The reasons for the lack of a second focal point holder must be explained by the centre in a written statement prior to re-certification. On the basis of this statement, a decision is made as to whether admission to the audit is possible. In general, if there is no second focal point holder, the certificate can only be extended by 12 months (proof of second focal point holder is a prerequisite for extension). FAQ (12.10.2017) According to Chapter 5.2.1 of the data collection form, two specialists with a specialisation in gynaecological oncology must be shown in the staffing plan in relation to their work in the Gynaecological Cancer Centre. How is the specification "according to the staffing plan in activity for the Gynaecological Cancer Centre" to be understood? What scope of activity is to be demonstrated? Answer: This formulation means that both specialists must regularly work for the Gynaecological Cancer Centre, which also takes into account deputising arrangements (guideline: 0.5 HC/specialist with a focus on the Gynaecological Centre). A substitute on an hourly basis is not sufficient. For a positive evaluation, a concrete description of the activities of the specialist with a specialisation is required (detailed naming in the questionnaire). At the time of re-certification, the involvement of the second specialist with a speciality must be proven for at least three months.	
5.2.6	Definition of surgical oncology Stage-appropriate surgical treatment including cross-organ and reconstructive measures Number of operated cases with a genital malignoma (i.e. invasive neoplasias of the female genitals and borderline tumours of the ovaries (BOT) and serous tubal intraepithelial carcinoma (STIC)) a year: 40	Specification in indicator sheet (Excel template)	
	Number of surgeries per named operator: 20 surgeries a year, also possible when senior surgeon supervises surgery as an assisting surgeon	FAQ (12.10.2017) How are the OPs to be counted for the surgeons? Answer: All OPs that are counted for the implementation of indicator 7 (operated cases with genital malignancy) can be assigned to one surgeon.	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
		FAQ (15.05.2019) Who can be appointed as an operator? Answer: A gynaecology specialist who fulfils the quantitative requirements (at least 20 operations per year) and is at least in further training to become a specialist (proof of expertise: certificate from the head of the centre).	

6.2 Organ-specific medicinal oncological therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
6.2.3	Qualification treatment unit/partner • at least 50 drug-based tumour therapies (cytostatic therapies and / or targeted therapeutics and / or antibody / immune therapies, no hormone therapies) every year in the case of patients with gynaecological / senologic forms of cancer or at least 200 drug-based tumour therapies (cytostatic therapies and / or targeted therapeutics and / or antibody / immune therapies, no hormone therapies) every year (in the case of different types of tumour • Calculation method: completed systematic/ cytostatic / targeted therapy per patient (consisting of several cycles or administrations). • When this number is not reached, expertise cannot be proven by means of cooperation.	FAQ (12.10.2017) Can patients who receive both chemotherapy and antibody therapy be counted twice for the treatment unit expertise? Answer: If chemotherapy and AK therapy are administered in parallel, the patient cannot be counted twice.	

8 Pathology

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
8.4	Specialists - Expertise 20 histologies/year per designated specialist (incl. PE)	FAQ (17.08.2021) What histologies can be counted? Response: Only histologies of invasive neo-plasias of the female genitalia, borderline tu-mors of the ovary (BOT) and serous tubular intraepithelial carcinomas (STIC) can be counted, not histologies of precancerous lesions.	

10. Tumour documentation / Outcome quality

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
10.10	Recording follow-up	FAQ (14.07.2016)	

10. Tumour documentation / Outcome quality

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
	Details are to be given of how aftercare data are collected and what the current follow-up status is (see outcome matrix) Functioning cancer registers present the follow-up status. […]	Does the centre need to obtain follow-up data from tumour types other than cervical? Answer: No. The presentation of the matrix outcome quality for cervical carcinoma is sufficient.	

FAQs - Indicator Sheet Gyn

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				FAQ (27.08.2019) Is it sufficient if the recurrence of an ovarian carcinoma is diagnosed solely on the basis of a resurgent tumour marker and imaging suspicion of a recurrence, or is histological confirmation always required as well? Answer: In the case of ovarian carcinoma, imaging and/or tumour markers are sufficient; histological confirmation is not obligatory. FAQ (29.06.2020) Can patients with SEIC (serous endometrioid in-traepithelial carcinoma) be counted for the Gyn. Cancer Centre be counted? Answer: Yes, they can be counted. FAQ (02.07.2020) Can extramammary Paget's disease of the vulva be counted as a primary case? Answer: No, it cannot be counted. FAQ (17.08.2021) Does a goiter carcinoid of the ovary (morphology code: 9091/1) count as "other cases"? No, it does not count because it is benign. FAQ (17.08.2021) How should a bilateral mucinous ovarian carcinoma, one with a proportion of borderline tumour, be documented in the indicator sheet? Answer: The patient is evaluated as one primary case despite the fact that she has both tumours. The FIGO stage of the mucinous ovarian carcinoma and not the borderline tumour is decisive for the entry in the data sheet.

				FAQ (17.08.2021) Does a granulosa cell tumour of the ovaries count as a primary case? Answer: A granulosa cell tumour with ICD-O-M 8620/1 does not count, only the malignant granulosa cell tumour with ICD-O-M 8620/3. The latter counts as "other cases". FAQ (17.08.2021) Does extramammary Paget's disease of the vulva count as a primary case for the Gyn. Cancer Centre? Answer: No, it does not count. FAQ (17.08.2021) Does an angiomyxoma of the vulva count as a primary case? Answer: No, only inv. Neoplasms of the female genital tract (incl. BOT and STIC) can be counted.
		Columns J-K	Non-primary cases	FAQ (24.05.2016) Can non-primary cases also include progressions? Answer: No, progressions cannot be counted.
----	Basic data	Columns A-C	Other carcinomas	FAQ (14.07.2016) Do dysgerminomas of the ovary and sarcomas count as other carcinomas? Answer: Yes. FAQ (14.07.2016) What counts as non-cancerous ovaries? Answer: Germ cell tumours and germ cell stromal tumours. FAQ (12.10.2017) Does carcinosarcoma of the ovary count as ovarian carcino-men or as other tumours? Answer: Other tumours.

				FAQ (12.10.2017) Does a malignant melanoma of the vulva count as a primary case for the Gyn. Cancer Centre? Answer: No, it cannot be counted. FAQ (21.08.2018) es basal cell carcinoma of the vulva count as a vulvar carcinoma? Answer: Yes, it counts as a vulvar carcinoma. Only for code 26 (inguinofemoral staging) it is not counted according to the definition of the code. FAQ (21.08.2018) Do dermoid cysts of the ovary (ICD-O-M 9084/0) count as primary cases for the Gyn. Cancer Centre? Answer No, these cannot be counted. FAQ (27.08.2019) Does malignant mixed müllerian tumour count as other carcinoma? Answer: Yes.
-----	Basic data	Columns A-C	Borderline Ovarian	FAQ (12.10.2017) Do borderline tumours of the ovary also include those with the dignity "uncertain behaviour (ICD-10 D39.1)? Answer: Yes, these are counted as BOT.
9	Surgical staging early ovarian cancer	Numerator	Primary cases of the denominator with surgical staging with: •Laparotomy •Peritoneal cytology •Peritoneal biopsies •Bilateral adnex exstirpation •Hysterectomy, where appropriate extraperitoneales procedure •Omentectomy at least infracolic	FAQ (14.07.2016) Peritoneal biopsies should be performed even if the peritoneum is macroscopically unremarkable. Macroscopically unremarkable peritoneum is not sufficient justification for not performing biopsies. In these cases, a deviation should be pronounced.

			•Bilateral pelvic and paraaortal lymphonodectomy	
		Denominator	Surgical primary cases ovarian cancer FIGO I – IIIA	
		Target value	No target value	
10	Macroscopic complete resection advanced ovarian cancer	Numerator	Primary cases of the denominator with macroscopic complete resection	FAQ (25.07.2016) What does "macroscopically complete resection" mean? Answer: The final ope-rative result is < R2, i.e. R0 or R1. FAQ (14.07.2016) In the case of multiple operations, does the macroscopically complete resection refer to the first tumour-specific operation or also to the last tumour-specific operation on the tumour? Answer: The macroscopically complete resection is decisive, regardless of the number of operations..
		Denominator	Surgical primary cases with an ovarian cancer FIGO IIB-IV	
		Target value	≥ 30%	
11	Operation advanced ovarian cancer by a gynaecological oncologist	Numerator	Primary cases of the denominator whose definitive surgical treatment was performed by a gynaecological oncologist	FAQ (14.07.2016) The operations were performed by a gynaecological oncologist as a training assistant. The main surgeon was not a gynaecological oncologist. Can the operations still be included in the numerator? Answer: Yes.
		Denominator	Surgical primary cases ovarian cancer FIGO IIB-IV after completion of surgial treatment	
		Target value	≥ 80% Optional fulfilment of target in audit year 2022	
13	First-line chemotherapy advanced ovarian cancer	Numerator	Primary cases of the denominator with first-line chemotherapy with carboplatin and paclitaxel	FAQ (17.08.2021) Can patients who - in the context of a trial - also receive another immunotherapy/PARP inhibitor (or a placebo) be counted in the numerator? Answer: Yes, they can be counted.
		Denominator	Primary cases ovarian cancer FIGO IIA-IV	
		Target value	No target value	
14	Details in the pathology report in the case of first diagnosis and tumour resection	Numerator	Primary cases of the denominator with pathology reports with details of: • Histological type according to WHO • Grading • Detection/non-detection lymph and vein infiltration (L and V status)	FAQ (12.10.2017) Are patients with conisation also to be included here? Answer: No. This indicator includes patients after surgical tumour resection.

			• Detection/non-detection perineural infiltrates (Pn status) • Staging (pTNM und FIGO) in the case of conizated patients bearing in mind the conisation results • Depth of invasion and spread in mm in the case of pT1a1 and pT1a2 • Specification of the maximum tumor size (from pT1b1) • Minimum distance to the resection margins	
		Denominator	Surgical primary cases cervical carcinoma and tumour resection	
		Target value	≥ 80%	
16	Cytological / histological lymph node staging	Numerator	Primary cases of the denominator with cytological/histological lymph node staging	FAQ (14.07.2016) In the numerator, both primary cases with cytological/histological lymph node staging in the context of diagnostics and primary cases with therapeutic lymph node removal in the context of surgical therapy can be taken into account. LK staging in the context of diagnostics as well as primary cases with therapeutic lymph node removal in the context of surgical therapy can be taken into account in the counter. FAQ (12.10.2017): Can purely imaging LK staging be counted for the ratio? Answer: No, such staging does not count towards the indicator.
		Denominator	Primary cases cervical carcinoma FIGO stage ≥ IA2-IVA	
		Target value	≥ 60%	
17	Brachytherapy as a component of primary radio(chemo) therapy	Numerator	Primary cases of the denominator in which brachytherapy was administered as part of primary radio(chemo) therapy	FAQ (17.08.2021) What is meant by primary radio(chemo)therapy? Answer: The intention of primary radio(chemo)therapy (= radiochemotherapy planned as the first and only the-rapy) is decisive for the counting for the denominator. In exceptional cases, a so-called **secondary** (not primarily planned) hysterectomy or so-called **extended**
		Denominator	Primary cases with cervical carcinoma and primary radio(chemo) therapy, without primary Distant Metastasis	
		Target value	≥ 80%	

				chemotherapy may be performed, but this is ultimately irrelevant for the denominator, because these patients can also be counted. FAQ (17.08.2021) Can brachytherapy equivalents such as Cyberknife or Boost also be counted? Answer: No, these cannot be counted.
19	Details in pathology report in the case of first diagnosis and tumour resection	Numerator	Primary cases of the denominator with pathology reports containing details of: •Histological type according to WHO, •Grading, •Detection/non-detection of lymph or blood vessel infiltration (L and V status), •Detection/non-detection of perineural invasion (Pn status), •Staging (pTNM), •Depth of invasion and spread in mm in the case of pT1a, three-dimensional tumour size in cm (ab pT1b), •Metric details of the minimum distance of the carcinoma and VIN from the vulvar resection margin in the histological specimen; •In the case of resection of the vulvar-vaginal or vulvar-anal transition zone and, where applicable, of the urethra metric details of the minimum distance to the vulvar-vaginal or vulvar-anal and, where applicable, urethral resection margin; •Metric details of the minimum distance to the soft tissue resection margin (basal margin)	FAQ (12.10.2017) Does the pTNM (staging) have to be complete? Answer: The key figure refers to the content of the pathological report. If no lymph node removal was performed, no pN can be given. cN cannot be a substitute because it was not determined by the pathologist. FAQ (12.10.2017) Is a separate resection margin expected here from the invasive carcinoma and VIN respectively? Answer: Yes, separate indication of the resection margin of invasive carcinoma and VIN. FAQ (12.10.2017) Are VIN III lesions to be considered or are VIN I and VIN II also included? Answer: The guideline only specifies VIN, therefore VIN I-III are meant. FAQ (17.08.2021) How is the three-dimensional tumour size to be indicated? Answer: Three-dimensional tumour size in cm = length in cm (horizonal extension) x width in cm (vertical extension) x depth in cm (infiltration depth). But it is not the cubic centimetres that are asked for, but the extent of the
		Denominator	Primary cases vulvar carcinoma with tumour resection	
		Target value	≥ 80%	

				expansion, i.e. cm in each case.
20	Details in pathology report in the case of lymphonodectomy	Numerator	Primary cases of the denominator with pathology report with details of: • Number of affected lymph nodes in relation to the number of removed lymph nodes classified by removal localisation (inguinal/pelvic) • Non-detection/detection of a capsel infiltration of the lymph node metastatis and/or detection lymph node infiltrations in perinodal fatty tissue and/or the lymph node capsule (>=pN2c) • Biggest spread of metastases (through pN details)	FAQ (27.08.2019) Are patients with only sentinel lymphonodectomy (without conventional LNE) taken into account here? Answer: No.
		Denominator	Primary cases vulvar cancer with lymphonodectomy	
		Target value	≥ 80%	
21	Conduct inguinofemoral staging	Numerator	Primary cases of the denominator with surgical staging (systematic lymphadenectomy and sentinel biobsy) of inguinofemoral lymph nodes	FAQ (12.10.2017) Which operation codes are to be documented for this key figure? Answer: It concerns lymph node staging, which is usually coded with its own OPS. There are several OPS that can be used for this, depending on the operation performed. The surgeons are responsible for entering these OPSs, if necessary in consultation with Controlling.
		Denominator	Primary cases vulvar cancer ≥ pT1b (no basal cell carcinoma and no verrucous carcinoma)	
		Target value	≥ 90%	
22	Sentinel lymph nodes biopsy	Numerator	Primary cases of the denominator with the following characteristics: • Clinical tumour size < 4 cm and • Unifocal tumour (= no multiple tumours; TNM m-symbol) and • Clinically inconspicuous lymph nodes (cN0) and • Pathohistological ultrastaging of lymph nodes (= in line with LL), only if all sentinel lymph nodes are tumor-free in the H&E staining	FAQ (17.08.2021) What is pathohistological ultrastaging? Answer: Ultrastaging, i.e. the immunohistochemical examination of the lymph nodes with a pancytokeratin antibody, is carried out if all sentinel lymph nodes are negative in the HE stain. If the LK are positive in the conventional staining (= HE), no ultrastaging is carried out.
		Denominator	Primary cases vulvar cancer and sentinel lymph node biopsy	

		Target value	≥ 80%	
25a 25b	Hysterectomy without morcellement for sarcoma confined to the uterus (25a: in the centre, 25b: in the centre)	Numerator	Primary cases of the denominator with hysterectomy without morcellement	
		Denominator	25a: Cases operated on at the centre Primary cases with sarcoma confined to the uterus (ICD-O T C54, C55 iVm morphology codes sarcoma centres), M0 with hysterectomy 25b: Primary cases operated on outside the centre with sarcoma confined to the uterus (ICD-O T C54, C55 iVm morphology codes sarcoma centres), M0 with hysterectomy	FAQ (19.11.2021) Which morphology codes count? Answer Morphology codes 8930/3 (high grade endometrial stromal sarcoma) and 8931/3 (low grade endometrial stromal sarcoma) count. FAQ (26.04.2022) What does "primary cases operated on outside the centre" mean? Answer This means, for example, patients who have had a hysterectomy outside the centre, who have evidence of a sarcoma in the histology and who then come to the centre and are primary cases of the centre because the centre takes over the therapy and further care of the patients.
		Target value	No target value	