EUROPEAN CANCER CENTRES

FAQs

Catalogue of Requirements for the Neuro-oncology Centres

In Oncology Centres

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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 FAQ and Catalogue of Requirements (CR)

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The FAQs listed in this document are continuously checked to ensure that they are up to date and adapted in the event of changes to the Technical and Medical Requirements

Overview of FAQs

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Indicator Sheet

Indicator		Last update
---	Basic Data	31.08.2022
2a	Interdisciplinary case reviews (tumour board)	14.07.2016
2b	Pretherapeutic tumour board	31.08.2022
3	Psycho-oncological distress screening	19.07.2018
4	Counselling social services	19.07.2018
7a	Revision surgeries	14.07.2016

FAQs - Catalogue of Requirements - Neuro

1.1 Structure of the network

Section	Requirements		
1.1.2	Cooperation agreements Main cooperation partners Neurosurgery, neurology, neuroradiology, neuropathology, radio-oncology, haematology and oncology and medicinal oncology Cooperation partners In addition to the cooperation partners mentioned in the Catalogue of Requirements, cooperation agreements are to be entered into with: pathology, neuropsychology, psychiatry, paediatric haematology and oncology, occupational therapy, ophthalmology, endocrinology and speech therapy.	FAQ (14.07.2016) Neurology and neurosurgery must be located at one clinical site.	

1.2 Interdisciplinary cooperation

Section	Requirements		
1.2.1	Number of primary cases The Centre must treat 100 patients annually with a primary diagnosis of a neuro-oncological tumour. Definition: • Patients and not stays and not operations; in line with the list of primary cases at the end of the Catalogue of Requirements. • Histology report must be available (biopsy or resection). Justified exceptions are to be listed (e.g. acoustic neurinoma, meningeoma, etc.). • Patient with initial disease. • The time of counting is the time of the histological confirmation of diagnosis or the time of clinical diagnosis by way of tumour board decision in the case of non-histologically confirmed tumours (e.g. acoustic neurinoma, meningeoma, etc.). Patients, who are only presented for the purposes of seeking a second opinion or for the purposes of consultation, are not included. (see also 5.2.3 Surgical primary cases)	FAQ (07.11.2024) How should meningiomas be coded - the current version of the WHO classification only lists 9530/0? Answer: There is currently a coding gap for meningiomas in the WHO classification (Blue Book, 5th Edition, 2021). In order to continue to ensure that the different dignities of meningiomas are recorded, meningiomas should be recorded as follows • all WHO grade 1 meningiomas (benign) →9530/0 • all WHO grade 2 meningiomas (unspecified biological behaviour) →9530/1 • all WHO grades	

1.2.2	Interdisciplinary pre-intervention tumour board Cycle A tumour board must be staged at least once a week. Participants: Neurosurgeon, neurologist, neuroradiologist, neuropathologist, radiotherapist, internal oncologist**. Related to the indication, e.g. in the case of cerebral metastases the presenting specialties are to be invited to the tumour conference. **Haematologist/oncologist If the haematologist/oncologist is unable to attend the conference, he/she may be represented by medical specialist responsible for chemotherapy (qualification in line with section 6.2 OC).	FAQ (29.07.2020) In principle, the participation of a haemato-oncologist is required. In exceptional cases, this can be represented by the qualified neurologist or neurosurgeon responsible for chemotherapy.	
1.2.3	Interdisciplinary tumour board All primary case patients should be presented in the interdisciplinary tumour conference: Elective patients: pre-intervention, emergency patients: at least post-intervention (Patient can only be taken into account 1x for the numerator). Scale of the discussed primary cases ≥95%	FAQ (19.07.2018) All primary cases should be presented at the interdisciplinary tumour conference. Whenever possible, all patients should be presented pre-interventionally. However, the following must be ensured as a minimum: elective patients pre-interventionally and emergency patients (at least) post-interventionally. (at least) post-intervention. Each patient can only be considered once for the numerator.	

1.4 Psycho-oncology

Section	Requirements		
1.4.2	Documentation and Evaluation In order to identify the need for treatment, screening of the level of mental stress is mandatory (Indicator "Psycho-oncological distress screening) and document the results. The proportion of patients with excessive stress in the distress screening should be presented. Psycho-oncological counselling Psycho-oncological care, in particular for patients with excessive stress in the distress screening, must be presented.	FAQ (28.08.2023) How should the proportion of patients with excessive distress in distress screening and further psycho-oncological care be presented? Answer: The number of screened patients who have shown an excessive test should be described. The processes of psycho-oncological care should be described; the number of counselling sessions carried out should be recorded. See separate FAQ document on psycho-oncology	

1.4.4	Neuropsychology
	• 1 psychologist with the additional designation Clinical Neuropsychologist (GNP) is available to the Centre (if necessary via cooperation).
	• Cooperation must be presented by way of documented cases during the assessment period.
	• The following processes are to be described with details of responsibilities:
	  • patient presentation criteria;
	  • communication within the Centre;
	  • participation in events, quality circles, tumour boardand similar events of the Centre.
		FAQ (31.08.2022)
		Does the neuro-oncology centre have to have a psychologist who is also a neuropsychologist?
		
		Answer:
		No, 1 psychologist must have the additional training in clinical neuropsychology GNP. In addition, other psychologists without the additional training may work for the NOC (Neuro-oncology Centres).	

1.6 Patient involvement

Section	Requirements		
1.6	Self-help groups	FAQ (29.07.2020) If there are no regional brain tumour self-help groups, supraregional self-help initiatives (e.g. Deutsche Hirntumorhilfe) should also be considered and included.	
1.6.5	If patient events are (co-)financed by industry, this fact, including potential conflicts of interest of the speakers, must be revealed. The Centre must exclude any direct influence on patients by industry stakeholders.	FAQ (16.08.2024) How can the centre prove the exclusion of direct influence by industry representatives? Answer: Proof can be provided e.g. via internal compliance rules or alternatively via a self-declaration by the centre. In this, the centre should provide information on free access to the event, excluding the industry exhibition/information stands and remarks on contact between industry representatives and patients.	

1.7 Study management

Section	Requirements		
1.7.4	Proportion study patients 1. Initial certification: At the time of initial certification ≥1 patient must have been included in studies. 2. after 1 year: at least 5% of malignant primary case number (ICD C70-72, C75.1-3) Only the inclusion of patients in studies with an ethical vote counts as study participation (non-interventional/diagnostic studies and prevention studies are also recognised, sole biobank collections are excluded). All study patients can be taken into account when calculating the study rate (share study patients based on the Centre's primary case number). General preconditions for the definition of the study quota: • Patients can be counted 1x per study, time: Date of patient's informed consent. • Patients in the palliative and adjuvant situation can be counted, no limitations regarding stage of disease. • Patients who are taking part in several studies simultaneously can be counted several times. • The study rate can also be achieved in cooperation with other active units. • Study patients can be counted for 2 centres, provided that the sending centre itself conducts at least one study for patients of the haematological neoplasms centre. If this counting method is chosen (optional), the centre must show how many patients are included in studies at their own centre, sent to other centres/clinics to participate in studies and taken from other centres/clinics to participate in studies – see also Excel template Data Sheet.	<u>FAQ (14.07.2016)</u> Patients of centre A can participate in studies in another clinic/centre and be counted for the study quota of centre A. Patients can only be counted for study quota of centre A, no double counting. <u>FAQ (31.08.2022)</u> Can negatively screened study patients be counted? Patients who have signed a informed consent form for screening for study participation can be counted for the numerator of the respective study indicator, even if the results of screening examinations carried out with special diagnostics (no routine diagnostics) do not allow the patient to participate in the study. <u>FAQ (28.08.2023)</u> Can patients referred to a Centre for Personalised Medicine (CPM) for the purpose of complex diagnostics, interdisciplinary consultation and individual therapy recommendations who participate in a study there be counted towards the study quota of the sending centre? Answer: Yes, in this case the study inclusion can be counted by both the sending centre and the CPM. The other requirements for study inclusion according to the survey form will apply.	

5.2 Cross-organ surgical therapy

5.2.3 a	5.2.3a Surgical primary cases At least 60 primary cases (Definition see CR 1.2.1) are operated every year. All surgeries (primary cases and recurrences) are to be performed under the supervision of the named surgeon (as 1. or 2. surgeon or along the lines of documented supervision). Definition surgical therapy German procedure classification (OPS): 5-015.0; 5-015.1; 5-015.3; 5-015.4; 5-016.0; 5-016.2; 5-016.4; 5-016.6; 5-017.1, 5-035, 5-075	FAQ (31.08.2022) The OPS code 5-016.0 does not stand for a specific procedure, but represents a kind of heading/trunk. Should a 0, 1, 2 or 3 be added in the eighth position? Answer: Subsumed codes are included in each case.	
5.2.3b	Biopsies: Recording biopsies for primary cases: German procedure classification (OPS): 1-510.; 1-511; - 1-512.; 1-514; - 1-515		
5.2.4	Qualification surgeons • Per surgeon evidence of at least 25 open neuro-oncological operations/year (as 1st or 2nd surgeon as part of training of new surgeons). • The special qualification of surgeons is documented via curricula. OPS classification: 5-015.0; 5-015.1; 5-015.3; 5-015.4; 5-016.0; 5-016.2; 5-016.4; 5-016.6; 5-017.1; 5-035; 5-075		

8 (Neuro-) pathology

Section	Requirements		
8.6.1	Assessment frozen sections / specimens • All frozen sections / sections are to be diagnosed by specialist for neuropathology (as a rule on site, possibly via cooperation; cooperations > 45km are to be justified). • In exceptional cases the cutting of the frozen section may be undertaken by pathologists on site. In these cases, the telemedical microscopic assessment of the frozen sections must be done by the neuropathology specialist.	FAQ (19.07.2018) All preparations and frozen sections must be evaluated by a specialist in neuropathology. As a rule, this specialist should be on site at the centre. - In justified individual cases, a distance of >45 km between the centre and neuropathology is permissible. - If no neuropathologist is available on site, the pathology specialist may, in exceptional cases, carry out the cutting of the frozen section preparation and the histological assessment may be carried out by the neuropathologist via telemedicine.	

10 Tumordokumentation / Ergebnisqualität

Section	Requirements		
10.2	Tumour documentation system • Tumour documentation, which contains the patient data for a minimum period of 3 months, must be in place at the time of initial certification. • The patients with neuro-oncological tumours must be recorded in one tumour documentation system. Name of the tumour documentation system in a cancer registry and/or Centre A data set in line with the Uniform Oncological Basic Data Set (*Einheitlicher Onkologischer Basisdatensatz*) and its modules of the Working Group of German Tumour Centres (*Arbeitsgemeinschaft Deutscher Tumorzentren* - ADT) and the Association of Population-based Cancer Registries in Germany (*Gesellschaft der epidemiologischen Krebsregister in Deutschland* - GEKID) must be used. The Centre must ensure that the data transfer to the competent cancer registry is done in a timely manner. Any existing federal state laws for notification deadlines are to be complied with.	FAQ (19.07.2018) Do Kaplan-Meier curves have to be drawn up by the centre with the patients of the neuro-oncology centre? Answer: The presentation of Kaplan-Meier curves is not obligatory for the NOZ. The presentation of the clinical course, i.e. the quality of outcome, is the task of the cancer registries. FAQ (19.07.2018) Does the centre have to collect follow-up data for the patients of the neuro-oncology centre? Answer: No, follow-up data do not have to be collected. The presentation of the clinical course, i.e. the quality of outcome, is the task of the cancer registries.	

FAQs - Indicator Sheet Neuro

<table>
<tr><td colspan="5">Basic data</td><td>FAQ (31.08.2022)
Can peripheral neurological tumours and peripheral cavernomas also be counted?

Answer

No, these tumours cannot be counted. See ICD-O list in the Data Sheet</td></tr>
<tr><td colspan="5"></td><td>FAQ (14.07.2016):
It seems implausible that the same patient with first e.g. astrocytoma WHO grade II or III and then glioblastoma cannot be recorded twice as a primary case.

Answer:
In principle, counting according to the procedural instruction 1x as primary case, in the same year additionally 1x with first diagnosis recurrence/ metastasis countable, otherwise 1x annually with recurrence/ metastasis.</td></tr>
<tr><td colspan="5"></td><td>FAQ (26.06.2019):
Some patients have been diagnosed with an intracranially located epidermoid (histologically confirmed). Can these tumours be counted as primary cases?

Answer:
Intracranial epidermoid cysts may not be counted as primary cases for the Neuro-oncology Centre.</td></tr>
<tr><td colspan="5"></td><td>FAQ (16.08.2024):
Where are patients with dexamethasone-only therapy categorised?

Answer:
For non-interventional/non-surgical primary cases..</td></tr>
<tr><td rowspan="3">2a</td><td rowspan="3">Interdisciplinary case reviews (tumour board)</td><td>Numerator</td><td>Elective primary cases that were presented at the tumour board before intervention (= including biopsy, BSC)</td><td rowspan="5">FAQ (16.08.2024):
Can patients with e.g. biopsy findings and subsequent surgery be counted twice for the numerator if they were presented twice in the tumour board?

Answer:
No, each patient is only counted once for the numerator.</td></tr>
<tr><td>Denominator</td><td>Primary cases (= Indicator 1a)</td></tr>
<tr><td>Target value</td><td>No target value</td></tr>
<tr><td rowspan="3">2b</td><td rowspan="3">Pretherapeutic tumour board</td><td>Numerator</td><td>Primary cases with histological/molecular pathological findings that were presented (again, if necessary) at the tumour board</td></tr>
<tr><td>Denominator</td><td>Primary cases (= Indicator 1a)</td></tr>
<tr><td>Target value</td><td>≥ 95%</td></tr>
</table>

3	Psycho-oncological distress screening	Numerator	Patients of the denominator who received psycho-oncological distress screening	FAQ (19.07.2018): Per patient, one recurrence/progression of the primary tumour per calendar year can be counted for the denominator.
		Denominator	Primary cases (= Indicator 1a) and patients with recurrence / progress (= Indicator 1b)	
		Target value	≥ 65%	
4	Social service counselling	Numerator	Patients of the denominator who received counselling by social services in an inpatient or outpatient setting	FAQ (19.07.2018) For each patient, 1 recurrence/progression of the primary tumour per calendar year can be counted for the denominator.
		Denominator	Primary cases (= Indicator 1a) and patients with recurrence / progress (= Indicator 1b)	
		Target value	No target value	
7	Revision surgeries	Numerator	Primary cases of the denominator with revision surgeries as a consequence of postsurgical complications within 30d of surgery	FAQ (14.07.2016) Revision operations are defined by the documentation of an OPS code. FAQ (14.07.2016) Post-operative resections should not be counted for the numerator. However, postoperative CSF fistulas are counted.
		Denominator	Surgical primary cases (= indicator 6a)	
		Target value	≤ 10%	