FAQs

Catalogue of Requirements for Skin 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

Version status FAQ: 16.08.2024

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.

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FAQ's - Catalogue of Requirements – Skin Cancer Centre

1.1 Structure of the network

Section	Requirements	Explanations of the Skin Cancer Centre	
1.1.1 c	Cooperation partners (external cooperation also possible) Mandatory • The names of at least 1 representative from OMS, ENT and/or plastic surgery • Nuclear medicine • Neurosurgery • Pathology • Surgery (general and/or visceral) • Psycho-oncology • Social work • Self-help associations • Pastoral care • Palliative network Optional • Dermatohistology • Urology • Ear, nose and throat medicine • Oral and maxillofacial surgery • Genetic counselling (*inter alia* familial melanomas, Gorlin-Goltz syndrome, XP) • Laboratory (with interlaboratory experiment certificate) • Plastic surgery • Thoracic surgery • Gynaecology	FAQ (29.05.2017) Is it sufficient that 1 of the 3 specialties OMS, ORL and plastic surgery is an obligatory cooperation partner? Response: Yes, is sufficient. At least 1 representative from OMS and/or ENT and/or plastic surgery.	
1.1.3	Primary cases • Cases with malignant epithelial tumours (excl. *in situ* tumours) for each year: ≥ 100 patients (details Data Sheet) • Cases with invasive malignant melanoma for each year: ≥ 40 patients (details Data Sheet) Cases with cutaneous lymphoma and rare malignant skin tumours (angiosarcoma, Merkel, DFSP) are recorded in the Data Sheet. Definition primary case: • Patients (not stays and not surgical interventions, not aftercare patients, not recurrences) newly diagnosed with skin cancer during the calendar year • A second tumour of another entity that presented during the calendar year is recorded as another primary case. • Histopathology report must be available. • Case can only be counted for 1 centre Therapy planning (interdisciplinary tumour board) and therapy conduct through the Centre (main therapy).	FAQ (29.05.2017) Generally, no histological confirmation is performed for choroidal melanomas. Can these still be counted as primary cases? Answer: Yes, choroidal melanomas can be counted as primary cases even if there is no histological confirmation. FAQ (17.08.2020) Can these tumours be counted as primary cases under indicator 1.3? ICD - Localisation + Histology - Code: C44 - C44 - 8407/3 Microcystic carcinoma of the skin adnexa C46 - C44 - 9140/3 Kaposi's sarcoma C49 - C44 - 8890/3 Leiomyosarcoma C49 - C44 - 8810/3 Fibrosarcoma o.n.a. C49 - C44 - 8802/3 Dermal superficial pleomorphic sarcoma C49 - C44 - 8811/3 Myxofibrosarcoma C49 - C44 - 8854/3 Pleomorphic liposarcoma C49 - C44 - 8890/3 Cutaneous leiomyosarcoma	

Section	Requirements	Explanations of the Skin Cancer Centre	
	Exception: In the treatment of cutaneous lymphomas/sarcomas and cooperation with a corresponding certified centre or module, primary or patient cases can be counted for both partners. In a cooperation agreement or SOP, it must be defined which treatment sections are provided by which cooperation partner. The cooperating centres must be named. • The time of counting is the time of the histolopathological confirmation of diagnosis Data Sheet (= Excel template)	C49 - C44 - 9120/3 Angiosarcoma cutaneous C63.2 - C44 - 8542/3 extram. M Paget C82.6 - C44 - Cutaneous follicular centre lymphoma - M9597/3 Primary cutaneous follicular centre lymphoma C83.0 - C44 - Small B-cell lymphoma - M9699/3 Marginal zone B-cell lymphoma o.n.a. C83.3 - C44 - Diffuse large B-cell lymphoma - M9680/3 Diffuse large B-cell lymphoma n.e.c. C84.0 - C44 - Mycosis fungoides [MF] - M9700/3 Mycosis fungoides C84.8 - C44 - Cutaneous T-cell lymphoma, unspecified - M9709/3 Cutaneous T-cell lymphoma C85.1 - C44 - B-cell lymphoma, unspecified - M9699/3 Marginal zone B-cell lymphoma o.n.a. C86.6 - C44 - Primary cutaneous CD30-positive T-cell proliferation - M9718/3 Lymphomatoid papulosis Answer: Yes, the listed tumours can be counted for indicator 1.3. <u>FAQ (24.03.2023)</u> Can anal cancer also be counted as an epithelial tumour? Answer: Anal cancers only count for the Skin Cancer Centre if they are not counted in parallel for the certified Anal Cancer Centre (no double counting).	

1.2 Interdisciplinary cooperation

Section.	Requirements	Explanatory remarks by the Skin Cancer Centre	
1.2.1 b)	Participants in the skin tumour board For the following specialties participation by specialists in the tumour board is mandatory and to be documented in a list of participants: • Dermatologist • Radiologist • Radiotherapist • Surgeon (organ-specific/oncological) • Internal oncologist If the internal oncologist cannot participate in the conference, he /she may in exceptional cases be represented by the specialist responsible for the chemotherapy (qualification according to section 6.2).	<u>FAQ (14.07.2016)</u> Deviation if the participation rate falls below 80% per subject area. <u>FAQ (05.03.2019)</u> Which specialist discipline is meant by surgeon? Answer: The specialist discipline that operates on the tumour, the lymph nodes and/or the metastases (e.g. dermatosurgeon).	

1.2 Interdisciplinary cooperation

Section.	Requirements	Explanatory remarks by the Skin Cancer Centre	
1.2.1 g)	Tumour board Irrespective of the stage and tumour entity, the following are to be presented: • All problem cases • All patients with an interdisciplinary issue • Switch in therapy with deviation from specified treatment pathways The presentation of the remaining patients in the specialised consultation hours/tumour boards is to be defined via binding internal SOPs.	FAQ (13.06.2017) Table templates for clear patient histories can be created (e.g. differentiation into "standard" and "discussion").	
1.2.1. h	In principle, patients with the following conditions are to be presented: • Malignant melanoma from stage IIB, • Malignant melanoma and stage shift/recurrence • Extracutaneous melanoma • Cutaneous lymphoma from stage IB • Problem cases with malignant, epithelial tumours (BCC, SCC) with an interdisciplinary issue: for instance complicated localisation, spread/infiltration (e.g. *Ulcus rodens*, *Ulcus terebrans*), metastasised tumours, immunosuppressed patients • All rare malignant skin tumours (*inter alia* Merkel carcinoma, DFSP, MFH, leiomyosarcomas, Kaposi's sarcoma, angiosarcoma): irrespective of the stage		
1.2.4. a	Therapy conduct/recommendation The tumour board is to be informed of any deviation in the conduct of therapy from the original therapy recommendation. The reasons for the changes and new therapy are to be documented.	FAQ (24/03/2023) If the recommended therapy is rejected due to the patient's wishes, is it necessary to present the patient again at the tumour board? Answer: No, not in principle. The rejection of a therapy must be documented. The tumour board must be informed of the rejection of the treatment recommendation and, if necessary, a new treatment recommendation based on the patient's preference must be made in the tumour board.	
1.2.4. b	Documented stating of reasons: • Patient's wish • Change in the clinical situation • Side effects/morbidity If a therapy is not started at the patient's request (despite an existing indication) or is terminated prematurely, this must also be recorded.		

1.4 Psycho-oncology

Section	Requirements	Explanations of the Skin Cancer Centre	
1.4.1	Psycho-oncology qualifications • Graduate psychologists/ Master's degree in psychology qualifying for a scientifically recognised psychotherapy procedure, or • Doctors of human medicine, • Diploma/ Master in Social Pedagogy qualifying for a scientifically recognised psychotherapy procedure.	FAQ (24.10.2018) Can the continuing education programme "Systemic Therapist" be accepted as psychotherapeutic continuing education? Answer: The further training "Systemic Therapy" can be accepted.	

1.4 Psycho-oncology

Section	Requirements	Explanations of the Skin Cancer Centre	
	each with at least 1 psychotherapeutic further training: behavioural therapy, psychodynamic psychotherapy (analytical psychotherapy and depth psychology-based psychotherapy), systemic therapy, neuropsychological therapy (for mental disorders caused by brain injuries), interpersonal therapy (IPT; for affective disorders and eating disorders), EMDR for the treatment of post-traumatic stress disorders, hypnotherapy for addictive disorders and for psychotherapeutic co-treatment of somatic illnesses and psycho-oncological training (DKG-recognised). Licensing: At least 1 person in the psycho-oncological team of the network (inpatient or outpatient) must be licensed (psychological or medical psychotherapist). Protection of the status quo for all those who are currently approved as well as those who have started a DKG-approved psycho-oncological further training by 31.12.2019. The representatives of other psychosocial professional groups can be approved on presentation of the above-mentioned additional qualifications. This requires a case-by-case assessment.		
1.4.2	Psycho-oncology – Offer and access Each patient must be offered the option of psycho-oncological counselling in a timely manner in the vicinity (proof required). The offer must be made in a low-threshold manner.	FAQ (12.06.2017) Does proof have to be provided for each patient that the possibility of a psycho-oncological consultation was offered? Answer: No, the implementation of the process is to be proven.	
1.4.7	Documentation and evaluation To identify the need for treatment, it is necessary to carry out a screening on psychological stress (see indicator “psycho-oncological distress-screening”) and document the result. The proportion of patients with excessive stress in the distress screening should be presented. Screening should be conducted for patients with melanoma (from stage IIB) and recurrence/remote metastases Psycho-oncological counselling Psycho-oncological care, in particular for patients with excessive stress in the distress screening, must be presented.	FAQ (21.07.2016) Can an on-site contact replace the screening? Answer: No. To identify the need for treatment, it is necessary to carry out a **standardised** screening on psychological stress (see S3 guideline Psychooncology: e.g. Distress Thermometer or HADS) and to document the result. FAQ (16.08.2024)) 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.	

1.4 Psycho-oncology

Section	Requirements	Explanations of the Skin Cancer Centre	
		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.	

1.5. Social work and rehabilitation

Section.	Requirements	Explanations of the Skin Cancer Centre	
1.5.3	Offer and access Every patient must be offered the possibility of counselling by the social service in all phases of the disease, locally and promptly (proof required). The offer must never be made in a threshold manner.	FAQ (12.06.2017) Does proof have to be presented for each patient that the possibility of counselling by the social service was offered? Answer: No, the implementation of the process is to be proven.	

1.6.. Patient involvement

Section.	Requirements	Explanations of the Skin Cancer Centre	
1.6.6	Event for patients The Skin Cancer Centre should stage a regular information event for its patients. If patient events are (co-)financed by industry, this fact including potential conflicts of interest of the speakers must be disclosed. The centre must rule out any direct influence on patients by industry representatives.	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-disclosure 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 patrons.	

1.7 Study management

Section	Requirements	Explanations of the Skin Cancer Centre	
1.7.5	Share study patients (malignant melanoma stages lll-IV). 1. Initial certification: At the time of initial certification ≥ 1 patients must have been included in studies. 2. After 1 year: The names of at least 5% of patients should be included in studies.	FAQ (13.06.2017) May register studies with an ethical vote also be counted? Answer: Yes. ADOREG documentation can also count towards the study quota. FAQ (16.08.2022) Can negatively screened study patients be counted?	

1.7 Study management

Section	Requirements	Explanations of the Skin Cancer Centre	
	All study patients can be taken into account when calculating the study rate. Only the inclusion of patients in studies with an ethical vote counts as study participation. Exclusive biobank collections are excluded. Data Sheet (= Excel template)	Answer: Patients who have signed an informed consent form for screening for study participation can be counted for the numerator of the respective study indicator, even if study participation of the patient is not possible due to the results of screening examinations performed with special diagnostics (no routine diagnostics). FAQ (24.03.2023) Can patients from Skin Cancer Centre A who are included in a study at another Skin Cancer Centre B be counted as study patients for Skin Cancer Centre A? Answer: For the study quota, all patients of Skin Cancer Centre A who were included in a study in the indicator year are counted, regardless of whether the study is conducted in-house or whether the patient is sent to another centre for the study. FAQ (24.03.2023) Can patients referred to a Centre for Personalized Medicine (CPM) for the purpose of complex diagnostics, interdisciplinary consultation and individual therapy recommendations who participate in a study there be counted for the study quota of the sending centre? Answer: Yes, in this case the study inclusion can be counted by both the sending center and the CPM. The other requirements for study inclusion according to the Catalouge of Requirement apply.	

1.8 Nursing Care

Section	Requirements	Explanations of the Skin Cancer Centre	
1.8.1	Specialist oncology nurses • At least 1 specialist oncological nurse must be actively employed on day duty in the Skin Cancer Centre. • The names of specialist oncology nurses are to be provided. • ….	FAQ (26.03.2019) "Active in day shift" means no deployment in night shift.	
1.8.2	Subject-specific, nursing, patient-related tasks for example: • …. • Initiation of and participation in multiprofessional case discussions / nursing visits; the aim is to find solutions in complex nursing situations; Criteria for selecting patients should	FAQ (24.03.2023) Do 12 case reviews and 12 care visits have to be completed, or a total of 12 per year? Answer: A total of at least 12 case reviews/care visits per year must be demonstrated.	

1.8 Nursing Care

Section	Requirements	Explanations of the Skin Cancer Centre	
	be defined; At least 12 case reviews / nursing visits per year and per center must be proven ….		

2 Organ-specific diagnostics

2.1 Consulting hours

Section.	Requirements	Explanatory remarks by the Skin Cancer Centre	
2.1.1	Information/dialogue with the patient Adequate information on diagnosis, prognosis and treatment planning must be provided in accordance with the current state of medical knowledge. This includes *inter alia*: • Information consultation about preventive health care, diagnosis, prognosis, therapy, aftercare and self-examination • Possibility of participating in clinical studies • Presentation of further treatment concepts • Offer and sourcing of psychosocial • Offer and sourcing of second opinions A general description is to be given of the way in which information is provided and the dialogue organised. This is to be documented for each patient in medical reports and minutes/records.	FAQ (12.06.2017) Is it compulsory for every patient to be offered a second opinion? Answer: No, it does not have to be offered to all patients.	
2.1.4	Waiting times How long are the waiting times • during the consulting hours: < 60 min target • for an appointment for first presentation (melanoma, lymphoma, rare, highly malignant skin tumours): < 2 weeks All other tumours: < 4 weeks • for an appointment for an outpatient, instrument-based examination (no aftercare patients): < 2 weeks The waiting times are to be recorded in a representative random sample and statistically evaluated once a year.	FAQ (14.07.2016) Is the waiting time "Appointment for an outpatient, apparative examination (not a follow-up pat.)" only for emergency patients? Answer: No.	

6.2 Organ-specific systemic therapy

Section	Requirements	Explanatory remarks by the Skin Cancer Centre	
6.2.2	Specialist nurse/ specialist medical assistant …requirements for the nurse who administers chemotherapy according to a doctor's instructions: •	FAQ (14.07.2016) Is the requirement a "must" requirement? Answer: Must-demand.	

6.2 Organ-specific systemic therapy

Section	Requirements	Explanatory remarks by the Skin Cancer Centre	
	• nursing counselling **and/or education of the patient is to be documented**.		
6.2.3.	Qualifications of treatment unit/partner In the case of skin tumour patients: Every year at least 50 systemic therapies (cytostatic therapies and/or targeted therapeutics and/or anticoagulant/immune therapies). Calculation method: systemic/cytostatic/targeted therapy for each patient (consisting of **several** cycles or applications, combination therapies count as one therapy) In the case of cross-year therapies, the therapy commenced in the survey year counts. Possible cooperation with treatment partners where there is no proof of competence: • Haematology/Oncology: Documentation of 200 cross-organ cytostatic therapies • Conduct of systemic therapy for skin tumour patients in a medical centre or a multidisciplinary systemic therapeutic unit: 200 cross-organ cytostatic/targeted therapies of which at least 15 cytostatic/targeted in skin tumour patients. The head of this unit bears the main responsibility for the therapy.	FAQ (24/03/2023) Can osteoprotective therapies such as denosumab therapy be counted as systemic therapy? Answer: Osteoprotective therapies alone, such as denosumab therapy, cannot be counted as systemic therapy. As a rule, these therapies are used in combination with antineoplastic therapy, in which case the antineoplastic therapy counts.	
6.2.9	Standards comorbidities and secondary diseases Standards are to be drawn up for the treatment of comorbidities and secondary diseases, in particular for the treatment of paravasates, infections and thromboembolic complications.	FAQ (14.07.2016) Instead of producing the standards and SOPs, some centres refer to the "blue book" of the Cancer Aid. Should we, as reviewers, recognise this as sufficient? Answer: No, not enough	
6.2.13	Information/dialogue with the patient With regard to diagnosis, prognosis and therapy planning, sufficient information is to be provided about the current medical level of knowledge. This includes *inter alia*: • Information consultation about preventive health care, diagnosis, prognosis, therapy and aftercare • Possibility of participating in clinical studies • Presentation of alternative treatment concepts • Offer and sourcing of psychosocial care • Offer of and aid in obtaining second opinions • A general description is to be given of the way in which information is provided and the dialogue organised. This is to be documented for each patient in medical reports and minutes/records..	FAQ (12.06.2017) Is it compulsory for every patient to be offered a second opinion? Answer: No, it does not have to be offered to all patients.	

8 Pathology

Section	Requirements	Explanatory remarks by the Skin Cancer Centre	
8.2.	Dermatohistological/pathological experience • Every year at least 250 histologies of malignant skin tumours (not only primary cases) • Assessment of lymph nodes (all tumour entities): Every year at least 100 histologies of lymph nodes (After a lymphadenectomy (LAD) the lymph nodes must be examined by a pathology specialist. If necessary, this can also be done within the framework of a second diagnosis by a specialist in dermatology with an additional qualification in dermatohistology. Sentinel for skin tumours: Assessment by dermatology specialist with the additional designation "dermatohistology" or pathology specialist)	FAQ (24.03.2023) How can the requirement of at least 100 histological lymph node findings be achieved with 40 required primary cases of malignant melanoma per year? Answer: The findings of lymph nodes refers not only to malignant melanoma, but to all tumour entities (not limited to skin).	
8.6	Procedures that must be available • Immunohistochemical tests • Molecular pathology These special services may only be commissioned externally from Pathology Institutes which are to be named on submission of a cooperation agreement. The institutes should have a recognised QM system or valid accreditation or document successful participation in interlaboratory experiments.	FAQ (11.03.2021) Can molecular pathological and immunohistochemical examinations be carried out by the in-house pathology department or does it have to be a pathological institute? Answer: If immunohistochemical or molecular pathological examinations are carried out in-house, then these can be performed by pathology and/or dermatopathology. If such examinations are performed by an external cooperation partner, then this must be done by a pathological or dermatopathological institute with corresponding competence. The institute is to be named in a cooperation agreement. The institutes should have a recognised QM system or a valid accreditation or prove successful participation in interlaboratory tests.	

8.12.1	8.12 Lymph nodes (LN)
	• All lymph nodes in the surgical specimen are to be examined macroscopically and microscopically.
	• Deviations from the minimum numbers in the Guidelines are to be discussed on an interdisciplinary level.
	• The lymph nodes must be examined in line with the guidelines.
	• The localisation of the lymph node (at least regional versus distance from the tumour) is to be indicated.
	• The following information should be included in the histopathological report on the sentinel lymph node:
	  ○ detection of nevus or melanoma cells
	  ○ in the case of melanoma cells, indication of prognostically important parameters (e.g. according to GL: largest diameter of the largest tumor cell accumulation, maximum penetration depth of
		FAQ (14.07.2016)
		Does the documentation of the lymph nodes have to be done only for the centre patients or for all skin cancer findings of the pathology?
		
		Answer:
		Skin Cancer Patients are sufficient.	

8 Pathology

Section	Requirements	Explanatory remarks by the Skin Cancer Centre	
	melanoma cells into the lymph node parenchyma, invasion of melanoma cells into the lymph node capsule or capsule rupture, localisation of melanoma cells in perinodal lymph vessels) ○ largest diameter of the micrometastasis		

9 Palliative care and hospice work

Section.	Requirements	Explanatory remarks by the Skin Cancer Centre	
9.1	Palliative care • The group of target patients for specialised palliative-medical support offers is to be defined (SOP). • …. • **The number of primary cases with incurable cancer is to be documented.**	FAQ (22.08.2016) How is the sentence "The number of primary cases with non-curable cancer shall be documented" interpreted? Answer: The requirement is to be considered in conjunction with the sentence: "The group of target patients for the specialised palliative care support services shall be defined (SOP)". to be considered. The background to this requirement is the new S3 guideline on palliative care, which, among other things, provides for the early integration of palliative care into the treatment strategy of patients. So far, there are no uniform definitions by the professional societies as to which patients are considered palliative patients and thus as patients who should receive "specialised palliative care support services". In order to improve the integration of palliative care, each centre should therefore define for itself which patients are "target patients for the specialised palliative care support services" and count them in the collective of primary cases.	

10 Tumour documentation / Outcome quality

Chap.	Requirements		
10.4	Cooperation with cancer registry • Cooperation with the competent 65c cancer registry is to be documented on the basis of the cooperation agreement **(www.tumorzentrum.de)** • …..	FAQ (13.07.2017) Does each individual centre have to provide evidence of a cooperation agreement? Answer: The cooperation agreements can also be concluded centrally via the Oncology Centre, if available. FAQ (16.08.2024) Is it necessary to use the Association of German Tumour Centres (ADT) model cooperation agreement?	

10 Tumour documentation / Outcome quality

Chap.	Requirements		
		Answer: It is not mandatory to use the cooperation agreement.	
10.6.	Provision of resources The required staff capacity should be made available for the carrying out of documentation tasks and the collection of data (for instance by a cancer registry) (Indicative value: for each 200 primary cases 0.5 full-time position and for each 200 aftercare cases 0.1 full-time position).	FAQ (24.03.2023) Is the specified guideline binding or can it be deviated from? Answer: This is a guideline that serves as orientation for the centres and auditors across all organs. For Skin Cancer Centres, the assessment of the guideline must take into account that epithelial tumours are not documented as comprehensively as melanomas. If there is a deviation from the specified guideline , this must be justified in the audit. It must be clear to the auditors in the audit that the available resources are sufficient	

FAQ's – Indicator Sheet - Skin Cancer Centre

Basic data

Explanation

Each patient can only be counted once per calendar year for 5a) and once for 7) (order according to the headings), but several cases per patient can be counted in the calendar year.

FAQ (01.08.2016)

Invasive Malignant Melanoma	**Example:**
5. a) Patients with primary disease (= patients with initial diagnosis malignant melanoma)	Mr. S was admitted in 3/2015 with the initial diagnosis of MM at 2 different skin locations. Localisations of the skin: 1x stad. IA and 1x stad. IB = Mr. S is counted once with the highest stage (= IB) for heading 5a). This counting remains, even if further diagnoses with a higher stage occur in the calendar year.
b) Number of cases with primary disease (= In the calendar year, further diag. malignant melanoma of other localisation, no recurrence, no stage shift)	Mr. S. is counted twice for category 5b) with his diagnoses (IA and IB from 3/2015). 10/2015 Mr. S. has further diag. MM at other localisations (IB and IIB) of the skin, which are neither stage shift nor recurrence of diagnosis 3/2015 =both diagnoses (IB and IIB) are counted for heading 5b).
6. a) Patients with second/third melanoma at different location (= patient already diagnosed with a malignant melanoma in a previous calendar year. Now: second/third malignant melanoma at a different site).	Ms. U. had already been diagnosed with MM for the first time in 2008. In 4/2015, 1 finding occurred again at a different localisation of the skin (= IA), which is neither a stage shift nor a recurrence of the previous findings. Ms. U is thus counted for rubric 6a) and 6b).
b) Number of cases with second/third melanoma (= in the calendar year further synchronous/metachronous diagnoses of malignant melanomas at a different location, no recurrence, no stage shift)	In 4/2015, Ms U. receives another diagnosis of MM at a different location (=IIB), i.e. in addition to the case from 4/2015 (=IA), Ms U. is now counted again as a case for category 6b).
7. Patients with stage shift/recurrence (= patient already diagnosed with a malignant melanoma in a previous or in the current calendar year. Now: recurrence, stage shift including new remote metastasis)	Mr. M. has a recurrence of a primary disease from 3/2014 in 8/2016. The recurrence (= IIC) is counted for heading 7). Other recurrences/stage shifts occurring in Mr. M in this calendar year are NOT counted. If another stage shift/recurrence occurs in the following calendar year, it can be counted again.
Optional: **8. Patients with ongoing therapy** (= patients with ongoing therapy who have not already been counted in the categories 5-7 for the calendar year, counted 1x/calendar year)	Headings 8 and 9 can be filled in optionally. These patients cannot belong to headings 5-7 in parallel.
Optional: **Patients in aftercare** (= patients who are not undergoing therapy in aftercare who have not already been counted in the categories 5-7 for the calendar year, counted 1x/calendar year)	
Primary cases patients with malignant melanoma =5a) + 6a)	Basic comment: - Primary cases malignant melanoma = 5a) + 6a) (target value: >= 40) - Centre pat. = 5a) + 6a) + 7) (no target value) - Additional to count (optional): 8) u 9)
Centre pat. = 5a) + 6a) + 7)	
All Pat. malignant melanoma (with optional)	

FAQ (01.08.2016)
How to count patients who are both primary cases and have new distant metastases or recurrence in one calendar year. How are these counted?

Answer:
Based on the new table: 1 x as a patient with primary disease (= 5) and 1 x as a patient with stage shift/recurrence (= 7) = 2 centre patients.

FAQ (12.06.2017)
Can line 34 "7. Pat. with stage shift/recurrence" also count pat. with stage shift/recurrence who did not receive the initial diagnosis in the skin cancer centre?

Answer: Yes, the patient does not have to have been treated at the centre when first diagnosed.

Indicator sheet

6	Melanoma: Patients enrolled in a study	Numerator	Patients with a melanoma who were included in a study with an ethical vote	FAQ (12.06.2017) Can patients with secondary distant metastasis also be counted for the Numerator? Answer: All patients with malignant melanoma can be counted for the numerator, not only primary cases. FAQ (23.11.2021) Patients who have signed an informed consent form for screening for study participation can be counted for the numerator of the indicator, even if the results of screening examinations carried out with special diagnostics (no routine diagnostics) do not allow the patients to participate in the study.
		Denominator	Primary cases with a melanoma stages III - IV	
		Target value	≥ 5%	
7	Sentinel node biopsy (SNB)	Numerator	SNB surgeries of the denominator with sentinel lymph node confirmed intraoperatively	FAQ (14.07.2016) We would like to know whether a frustrated SLNB counts as an intervention performed (= counting for the denominator)? Currently we have assumed this to be the case and in CN 7 these cases therefore appear in the denominator, which makes sense in our eyes. Answer: yes FAQ (26/03/2019) Which OPS codes can be counted as SNB surgery? Answer: • 5-401.01 - .03 ; 5-401.0x
		Denominator	SNB surgeries (multiple mentioning per patient possible)	
		Target value	≥ 90%	

				• 5-401.11 - .13 ; 5-401.1x • 5-401.51 - .53 ; 5-401.5 x; • 5-401.ax
8	Surgical interventions with safety margin defined in the guideline (= malignant melanomas, Merkel cell carcinomas, sarcomas and other rare malignant skin tumours)	Numerator	Surgical interventions with safety margin in primary cases (= malignant melanomas, Merkel cell carcinomas, sarcomas and other rare malignant skin tumours	FAQ (01.08.2016) Are only the operated cases counted or also the partial operations (for patients with tumour resection at multiple locations in the same operation)? Answer: Each tumour resection is counted. FAQ (01.08.2016) Should plastic reconstructions be counted? Answer: No, purely plastic surgery does not count. In the case of tumour resection and plastic coverage in the same procedure, the tumour resection is counted. FAQ (20.09.2017) Can all dermatology operations be counted? Answer: No, only operations on primary cases can be counted.
		Denominator	-----	
		Rate	≥ 30	
9	Surgical interventions with histological margin control (= epithelial tumours)	Numerator	Surgical interventions with histological margin control in primary cases (= epithelial tumours)	FAQ (01.08.2016) Are only the operated cases counted or also the partial operations (for patients with tumour resection at multiple locations in the same operation)? Answer: Each tumour resection is counted. FAQ (01.08.2016) If plastic reconstrucons be counted? Answer: No, purely plastic surgery does not count. In the case of tumour resection and plastic coverage in the same procedure, the tumour resection is counted.
		Denominator	-----	
		Rate	≥ 100	

				FAQ (20.09.2017) Can all dermatology operations be counted? Answer: No, only operations on primary cases can be counted.
11	Revision surgery in the case of secondary bleeding after SNB and LAD	Numerator	Revision surgery (OPS: 5-893) because of post-operative secondary bleeding (T81.0) after surgeries of the denominator	FAQ (01.08.2016) How should the counting of complications be done? Answer: The count should be made per partial operation, i.e. each tumour resection is counted.
		Denominator	SNB surgeries (= denominator indicator 7) + therapeutic LADs for stages III (multiple mentioning per patient possible)	
		Rate	≤ 3%	
12	Revision surgery after post-operative wound infections	Numerator	Revision surgery (OPS: 5-893) because of post-operative wound infections (T81.4) after surgeries of the denominator	FAQ (01.08.2016) How should the counting of complications be done? Answer: The count should be made per partial operation, i.e. each tumour resection is counted.
		Denominator	Sum numerators Indicators 8 + 9	
		Rate	≤ 3%	
13	Melanoma: Sentinel node biopsy	Numerator	Primary cases of the denominator where SNB is carried out	FAQ (14.07.2016) We are not quite sure at KN 13 whether the frustrated SLNB also occurs in the numerator. Answer: Yes, the intraoperative frustrated SLNB is counted for the numerator. FAQ (13.06.2017) Is the SNB also mandatory for localisation in the head and neck area? Answer: Localisation in the head and neck region is not an argument against performing a sentinel.
		Denominator	Primary cases cutaneous melonoma with a curative radical excision in case of a tumour density ≤ 2 mm	
		Rate	≥ 80%	