EUROPEAN CANCER CENTRES

FAQs

Catalogue of Requirements for the Uro- oncological Centres

of the German Cancer Society

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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 FAQ's

Catalogue of Requirement

Section CR	Requirement		Last update
1.2 Interdisciplinary cooperation	1.2.1	Prostate: number of cases in the centre	29.09.2017
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	1.2.5	All: Tumour board	05.06.2018
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10 Tumour documentation/Outcome quality	10.4	Cooperation with cancer registry	19.04.2024

Data Sheet Prostate

If the R1 rate is exceeded for pT2 c/pN0 or Nx M0, a course of action was determined by the Certification Commission at the Prostate meeting on June 18, 2019: see page 7.

Indicator		last update
Indicator 10	Procedure if the indicator is exceeded	18.06.2019
Matrix outcome quality	Number of primary cases (post-therapeutic tumour-free)	27.04.2022

Further interpretations regarding the indicator prostate are not shown in this document, as the FAQs for this organ are stored in the specification document.
Download: http://www.xml-oncobox.de/de/Zentren/ProstataZentren

Data Sheet Bladder

Excel Template			last update
Basic data	Documentation preliminary stages		12.06.2018
	Counting method: Bladder		12.06.2018
Indicator Sheet	No. 2b)	Presentation tumour board	26.08.2019

Data Sheet Kidney

Excel Template			last update
Indicator Sheet	No. 7	If possible, confirm diagnosis with histology before systemic therapy.	05.05.2020

FAQ's - Catalouge of Requirement for uro-oncological centres

1.2 Interdisciplinary cooperation

Section	Requirements		
1.2.1 - All -	**Number of cases in the centre** Definition of centre case • all patients with initial diagnosis, localised and/or metastatic, as well as all patients with recurrence or secondary metastasis who are presented at the centre or the TC and receive essential parts of the therapy there (surgery, radiotherapy, systemic therapy, watchful waiting, active surveillance, etc.) • Patients and not stays and not operations • Patient can only be counted as a Centre case for 1 centre • Patients who are only presented for a second opinion or consultation are not taken into account. • Interdisciplinary therapy plan must be available • Prostate: Counting time is the time of (first) presentation at the centre; • Penile carcinoma: the time of (first) presentation at the centre is counted • For the other entities, the counting time is the time of diagnosis (date of biopsy) • Histological findings must be available • Complete recording in the tumour documentation system Definition of primary case (subset of Centre case): • Patients with primary disease (incl. primary M1	Prostate-specific FAQ (14/07/2016) Are patients who were not presented at either the pretherapeutic or postoperative tumor conference primary cases (lack of interdisciplinary treatment plan)? Answer: These are to be counted as primary cases, but this may cause a discrepancy in the tumor conference metrics. FAQ (29.09.2017) Can pat. who do not receive guideline-guided therapy (e.g., HIFU pat.) be counted as a primary case? Answer: To the extent that this is done in the context of interventional studies, the patients may be counted.	
- Kidney -	The centre must treat 35 patients per year with a diagnosis of kidney cell carcinoma (ICD-10 C64)	FAQ (17/12/2018) Can a patient with a renal carcinoma be counted more than once as a primary case? Answer: 1 primary case can be counted per page.	
1.2.5 - All -	**Tumour board** • The tumour board must be held weekly at specialist level for the purpose of therapy planning. • The responsibilities for preparation,	FAQ (05.06.2018) Does the tumor board always have to take place in the mentioned rotation or can it be cancelled sometimes?	

	implementation and follow-up must be defined • Participation rate of the specialisations > 95 %	Answer: If no patients are registered for the tumor board, it can be omitted.	

- Prostata -	Participants:
	• Urology
	• Radiotherapy
	• Haematology/Internal Oncology
	• If the haematologist/oncologist is unable to attend the conference, the urologist responsible for chemotherapy (qualification in accordance with Section 6.2) may represent him/her in exceptional cases.
	• Pathology
	• Radiology
	• Nuclear medicine
	• To be presented:
	  • All primary cases with histology worthy of discussion (≥ pT3a, and/or R1, and/or pN+); generally no binding obligation for other patients undergoing primary radiotherapy or curative surgery
	  • All patients with recurrences or metastases
	  • At least 10 patients with castration-resistant Prostate carcinoma/year
		FAQ (14/07/2016)
		Are patients with recurrence or distant metastasis who did not receive their primary treatment at the centre also to be presented?
		
		Answer:
		Yes (see definition of centre cases)
			-

1.2.8 - All-	**Morbidity/mortality conferences** • Invited participants are the participants of the tumour board. • Conference can be scheduled to coincide with the pre-therapeutic conference/tumour board conference. • A list of participants will be kept. • M&M conferences must be held at least twice a year. • Cases with a special or improvable course (e.g. ≥ grade 3 CTC) should be discussed. Patients • who have died postoperatively/interventionally must always be discussed. • M&M conferences must be recorded.	FAQ (29.10.2018) How should the requirement "Patients who died postoperatively/interventionally must be discussed in every case" be interpreted? What is the time period here? Answer: The corresponding patients are to be discussed in the next M&M conference. Since the M&M conference has to take place twice a year, the key figure year can usually be well covered. All patients who died postoperatively/interventionally within the calendar year (audit year before) must be discussed.	

1.4 Psycho-oncology

Section	Requirements	Explanations of the centre	
1.4.1 - All -	**Psycho-oncology - Qualification** • Psycho-oncology - Qualification • Diploma/Master's degree in psychology that qualifies for a scientifically recognised psychotherapy method, • Doctors of human medicine, • Diploma/Master's degree in social pedagogy that qualifies for a scientifically recognised psychotherapy method Each with at least 1 further psychotherapeutic training course: behavioural therapy, psychodynamic psychotherapy (analytical psychotherapy and depth psychology-based psychotherapy), systemic therapy, neuropsychological therapy (for psychological 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 addiction disorders and for the psychotherapeutic co-treatment of somatic illnesses. and psycho-oncological training (DKG-recognised). Grandfathering for all those who are currently recognised and those who have started DKG-recognised psycho-oncological training by 31 December 2019. Licence: At least 1 person in the psycho-oncological team of the network (inpatient or outpatient) must be licensed (psychological or medical psychotherapist) Representatives of other psychosocial professions may be authorised if they can provide proof of the above-mentioned additional qualifications. A case-by-case assessment is required for this	FAQ (20/08/2018) Can the continuing education "Systemic Therapist" be recognized as psychotherapeutic continuing education? Answer: The continuing education "Systemic Therapy" can be recognized	
1.4.2 - All -	**Psycho-oncology - services and access** Every patient must be offered the opportunity of a psycho-oncological consultation in a timely and appropriate manner. The offer must be low-threshold.	FAQ (21/07/2016) Can an on-site contact replace the screening? Answer: No. To identify the need for treatment, it is necessary to perform a standardized screening on psychological stress (see S3 guideline Psychooncology: e.g. Distress Thermometer o. HADS) and to document the result.	
1.4.4 - All -	**Scope of supply** Psycho-oncological care, in particular for patients with high levels of distress in the distress screening, should be presented.	FAQ (27/01/2023) 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 above-threshold test result must be presented. The processes of psycho-oncological care must be described; the number of care sessions carried out should be provided. See separate document FAQ Distress Screening.	

	The frequency and duration of the conversations must be recorded		

1.6 Patient participation

Section	Requirements	Explanations of the centre	
1.6.6 - All -	**Event for patients** The centre must hold an information event for patients and/or interested parties at least once a year. 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 representatives.	FAQ (27/09/2022) How can the centre prove the exclusion of direct influence by industry representatives? Answer: Proof can be provided, for example, 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 information on contact between industry representatives and patients.	

1.7 Study management

Section	Requirements	Explanations of the centre	
1.7.5 - All -	**Share of study pat.** Initial certification: at least 1 patient in studies after 1 year: at least5 % of primary cases Only the inclusion of patients in studies for which a valid ethics vote can be presented counts as study participation. The requirement applies per tumour entity. Only the inclusion of patients in studies with an ethics vote counts as study participation (non-interventional/diagnostic studies and prevention studies, health services research are recognised, biobank collections are excluded). All study patients can be taken into account for the calculation of the study quota (proportion of study patients in relation to the primary case number of the Centre) • Patients can be counted once per study, time: date of patient consent (exception: CPM patients, see FAQ document) • Study patients can be counted for 2 centres, provided that the sending Centre itself conducts at least one study for patients of the Centre (per entity). If this counting method is chosen (optional), the Centre must show how many patients are included in studies in its own Centre, sent to other Centres/clinics for study participation and transferred from other Centres/clinics for study participation - see also Excel template Data Sheet. • Patients in the palliative and adjuvant situation can be counted, no restriction of stages. • Patients who are enrolled in several studies at the same time can be counted more than once	FAQ (16/08/2022) Can negatively screened study patients be counted? Answer Patients who have signed a informed consent form for the screening for study participation can be counted for the numerator of the respective study code, even if the patient's participation in the study is not possible due to the results of screening examinations carried out with special diagnostics (no routine diagnostics). FAQ (06/06/2023) 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 data collection form apply FAQ (06/06/2023) Do the requirements “1 patient at initial certification” and “after 1 year: at least 5% of primary cases” also apply? Answer: If no patients are included in a study when a Penis Cancer Centre is certified (regardless of the audit phase), the centre must prove its activity for study inclusion. If there are no relevant studies, it must fulfil the study quota for the Prostate Cancer Centre.	

2.2 Diagnostics

Section	Requirements	Explanations of the centre	
2.2.9 - Pros-tata -	**Biopsies** • The correct indication for TRUS biopsy of the prostate must be demonstrated. • At least 20% of patients with punch biopsies must be positive. • At least 10 punch biopsy cylinders, each at least 1 cm long, must be taken. An evaluation must be submitted.	FAQ (12/04/2016) What about when multiple punch biopsies are taken from the region because none were 1 cm long. But together they add up to 1.0 cm? Does that count as a punch over 1cm in length? Answer: Yes, it counts	

5 Surgical oncology

Section	Requirements		
5.2.1	**Operational expertise centre**		
- Pros-tata -	**Surgical expertise prostate** Number of prostatectomies as part of uro-oncological operations/year/Centre (related to primary cases and patients with new recurrence) • 50-74 Prostatectomies: If only 1 surgeon is appointed, a 2nd surgeon must be appointed by the next audit (qualification EB 5.2.6) • ≥ 75 prostatectomies => nomination of at least 2 surgeons Prostatectomies: • Radical prostatectomy (primary intervention) • Radical cystoprostatectomy for bladder carcinoma AND PCa (primary intervention) • Radical cystoprostatectomy for prostate carcinoma (primary intervention) • Radical prostatectomy (recurrence therapy) - Salvage prostatectomy Indication of prostatectomies in basic data (Excel template) • For 25-49 prostatectomies: Individual case decision; the audit report must contain a recommendation to maintain the certificate without restriction (including ≥ 100 primary cases) Naming of surgeons in table Prostate surgeons	FAQ (06/06/2023) Why can there be a discrepancy between the surgical expertise in the Data Sheet and in the Catalouge of Requirement? Answer: The surgical expertise in the Data Sheet refers to centre cases in the indicator year (primary cases counted = date of presentation at the centre); however, the information on surgeries in the Catalouge of Requirement provided by the named surgeons is generally based on the date of surgery. Discrepancies must be explained in the audit.	

- Kidney -	**Surgical expertise kidney** • At least 30 partial kidney resections and/or nephrectomies (OPS 5-553, 5-554) of malignant kidney tumours /year/Centre (= carcinomas (ICD-10 C 64,C65) are counted) Key data sheet kidney (Excel template; basic data)	FAQ (29/10/2018) Only operations for renal carcinoma are counted as proof of surgical expertise. Why can operations for a benign finding detected in the prepa- rate not be taken into account if it is exactly the same operation as for a malignant finding? Answer: All quantitative and qualitative requirements of the Catalouge of Requirement Kidney are tailored to renal carcinoma. The addition of benign diagnoses as proof of surgical expertise would mean that the necessary minimum quantity would have to be increased. This would not result in any advantage.	
- Bladder -	**Bladder surgical expertise** • 20 cystectomies (OPS 5-576) for bladder carcinoma/year/Centre (= carcinomas (ICD-10 C 67, D09.0, D41.4) are counted) • Likewise front /complete exenteration (OPS 5-687.0, 5-687.2) in patients with bladder carcinoma (ICD-10 C67) and patients with any C-diagnosis. Data Sheet Bladder (Excel template; Basic Data)	FAQ (29/10/2018) Why is partial bladder resection OPS code 5- 575 not taken into account? Answer: OPS 5-575 (= partial bladder resection) can be entered in the basic data sheet under "Other surgery" if a corresponding operation was performed. However, it cannot be used as proof of surgical expertise. The "Surgical expertise" requirement is intended to record expertise for complex procedures. Partial bladder resection is not counted as a complex procedure. FAQ (19/06/2018) Can the anterior exenteration also be counted for the operative expertise? Answer: In patients with bladder carcinoma, the previous exenteration (OPS 5-687.0) can be used for surgical treatment. tive expertise can be recognised.	
- Bladder -	**White light cystoscopy** Requirement Implementation: • FA for urology The following diagnostics must be made possible: • Flexible or rigid cystoscopy • Fluorescence-assisted cystoscopy (hexylami- nolaevulinate) (see also chapter 5) • Biopsy **Techniques** • Fluorescence-assisted TUR-B (with hexylaminolevulinate) must be made possible • In the context of a transurethral bladder resection, the following findings should be described in the surgical report: estimated size of the tumour (in cm), location and number of tumours, appearance of the tumour as well as the presence of other mucosal abnormalities	FAQ (29/10/2018) Can methods other than white light /fluorescence cystoscopy be recognised? Answer: As an alternative to the established methods of white light/fluorescence cystoscopy, cystoscopy using the narrow band imaging (NBI) method can also be recognised.	

5.2.8
- Prostate-
	Prostate surgeons
	
	Expertise per surgeon
	• Every prostate surgeon must provide evidence of at least 25 prostatectomies per year or 75 prostatectomies in 5 years. For initial certification, this number must be proven in the year prior to the initial certification (extract from the clinic information system).
	• Description of the special qualification (training) of prostate surgeons via curricula.
	  • Radical prostatectomy (retropubic, perineal or laparoscopic)
	  • Nerve-sparing radical prostatectomy
	  • Removal of the pelvic lymph nodes (including extended-field lymphadenectomy)
	  • Transurethral palliative therapy of prostate carcinoma (in particular transurethral resection of the prostate)
	  • Monitoring of complications after surgery
	  • Metastatic surgery
	  • At least 1 dedicated prostate training event for each surgeon each year (length > 0.5 day)
	  • Metastatic surgery
	
	Naming of surgeons in table
	Prostate surgeons
	(at the end of the sectopm)
		FAQ (30/05/2018)
		If a designated prostate surgeon performs a Radical Cystoprostatectomy for prostate cancer, can this surgery also count for surgical expertise of the bladder?
		
		Answer:
		If a surgeon is designated for both modules, performing cystoprostatectomy may be counted for both prostate (prostatectomy) and bladder (cystectomy) surgical expertise.	

-testicles-	**Testicle surgeons** • At least 2 testicular surgeons must be named (surgeons can also be prostate/kidney/bladder/penile surgeons) **Expertise per surgeon** • 3 (nerve-sparing) retroperitoneal (paraaortic, paracaval) lymphadenectomies (OPS 5-404.d/e, 5-407.2) per year **Authorisation of new surgeons** • In the last 3 years cumulatively 9 retroperitoneal (paraaortic, paracaval) lymphadenectomies as first surgeon (extract from the clinic information system or submission of certificates).	FAQ (27/09/2022) Which lymph node dissections can be counted towards the testicular cancer module for the expertise per surgeon and the approval of new surgeons? Answer: For the expertise per surgeon and the admission of new surgeons, (nerve-splitting) retroperitoneal (paraaortic/caval) lymphadenectomies (OPS 5-404.d/e, 5-407.2) can be counted in conjunction with any C diagnosis.	

6.2 Organ-specific oncological drug therapy

Section	Requirements	Explanations of the centre	
6.2.1 - All -	**Medical qualification** The physcician performing the procedure must fulfil the following criteria: • Specialist in internal medicine and haematology and oncology or • Specialist for radiotherapy or • Specialist for urology Requirements for urology specialists • until MWBO 2018: + additional qualification in medical tumour therapy; alternatively: participation in the "Oncology Agreement" Appendix 7 to the Federal Coverage Agreements in regional implementation and • 5 years of experience in drug-based tumour therapy for uro-oncological diseases (proof) The specialists named here must actively carry out the drug-based tumour therapy. It is not possible to delegate responsibilities to doctors without the above-mentioned qualifications.the above qualification is not possible.	FAQ (18/06/2019) Does the urology specialist still need to fulfill the requirement for the additional designation of drug tumor therapy? Answer: In accordance with the 2018 Model Advanced Training Regulations, the Medicinal Tumor Therapy qualification will in future already be an integral part of the advanced training in urology. In this respect, physicians who are trained according to the new model further training regulations (2018) will no longer be required to acquire the additional designation Medicinal Tumor Therapy.	

7 Radiation oncology

Section	Requirements		
7.3	Expertise in radiotherapy for prostate cancer • Definitive or postoperative (adjuvant or salvage) radiotherapy: at least 50 cases/year; For 25-49 cases/year: at least 75 def. or postoperative radiotherapies in the last 5 years before the audit • Prerequisite: Recommendation in the audit report to issue/maintain the certificate without restriction Composite structure see section "7.4 Composite"	FAQ (26/04/2017) How is salvage radiotherapy differentiated from adjuvant radiotherapy? Answer: Radiotherapy is a salvage therapy, • When radiation therapy is given for a persistent PSA level, or • if the radiotherapy is given after a diagnosis of biochemical recurrence or • if the radiotherapy is performed > 6 months after surgery. is performed.	
7.11	Expertise in brachytherapy (optional) • LDR brachytherapy (permanent seed implantation) • HDR brachytherapy Expertise LDR/HDR must be proven in accordance with the G-BA decision of 18.06.2015 (guideline value without consideration of special regulations is one-time proof of at least 100 therapies carried out within the last 5 years).	FAQ (14/07/2016) Performing brachytherapy is optional - why is it necessary to formulate an expertise? Answer: When brachytherapy is offered, the appropriate expertise must also be provided.	

8 Pathology

Section	Requirements		
8.11	Punch biopsy report: • The result of the preoperative histology is available within 5 working days. • Items must be labelled according to the clinical information. • Processing while retaining the item labelling. • Number and localisation of carcinoma-positive tissue samples • **Estimation of the percentage of the total carcinoma area/total tumour area.** • Gleason grading according to the modifications agreed by the ISUP in 2005. Indicated separately for each tumour-infected punch. • Lymph vessel (L) and vein (V) invasion (L0 or L1, V0 or V1). • Perineural infiltration (Pn0 or Pn1), • If assessable, capsular infiltration, growth beyond the capsule and seminal vesicle infiltration should be indicated. become.	FAQ (29/09/2017) To what does the percentage of total carcinoma area/total punch cylinder area refer: to all punch cylinders together or to the respective punch cylinder. Answer: For the pathology report: it refers to the respective punch cylinder.	

10. Tumour documentation / quality of results

Section	Requirements	Explanations of the centre
10.4	Cooperation with cancer registry • Cooperation with the competent 65c cancer registry is to be documented on the basis of the cooperation agreement Link Tumorzentren.de • [...]	FAQ (19/04/2024) Must the Association of German Tumour Centres (ADT) model cooperation agreement be used? Answer: The use of the cooperation agreement is not mandatory.

FAQ's - Data Sheet Prostate

<table>
<tr><td rowspan="3">10</td><td rowspan="3">Detection of R1 resections for pT2 c/pN0 or Nx M0</td><td>Numerator</td><td>Operations of the denominator with R1</td><td rowspan="3">FAQ (18/06/2019):
How is an overshoot of the target value dealt with?

Answer:
• Centers exceeding the target have to present their R1 cases differentiated by width (≤ / > 3 mm) and occurrence (unifocal / multifocal) of R1 positive incision margins for the audit
• Centers with a majority of R1 cases with positive incision margins > 3 mm and/or a majority of multifocal R1 cases will receive a deviation of the target.
• If the majority of R1 cases are multifocal, the auditor will decide on the further procedure depending on the situation on site (e.g. measures taken, patient collective of the center, etc.).</td></tr>
<tr><td>Denominator</td><td>Surgery for primary cases with pT2 c/pN0 or Nx M0</td></tr>
<tr><td>Target value</td><td>≤ 15%</td></tr>
<tr><td colspan="2">Matrix</td><td colspan="3">FAQ (27/04/2022):
Question:
Which primary cases are considered post-therapy tumour-free?

Response:
• Pat. with R0 resection after radical prostatectomy/cystoprostatectomy, without metastases.
• Patients with R1 resection after radical prostatectomy/cystoprostatectomy and adjuvant radiotherapy and at least 1 follow-up in the year before the indicator year (= calendar year preceding the indicator year) without recurrence and without metastases.
• Patients with definitive radiotherapy and at least 1 follow-up in the year before the indicator year (= calendar year preceding the indicator year) without recurrence and without metastases.

A recurrence after definitive or adjuvant radiotherapy is present if the PSA value has increased by 2ng/ml in the course of the follow-up compared to the nadir (lowest value) (Phoenix definition).</td></tr>
</table>

FAQ's - Data Sheet Bladder

Basic data	• Documentation of precursors (carcinoma in situ ("flat tumour")) and of papillomas and non-invasive papillary carcinomas under "0 a/is" Counting method: Bladder 1) Pat. with TUR-B outside and presentation at the centre, e.g. due to abnormal histology (>T1, Cis etc.) --> patient is presented at the tumour board, primary case for the centre. Counting is independent of the recommendation of the tumour board (e.g. intervention or pure observation).

	2) Patient with TUR-B outside the centre and presentation at the centre for/after re-TUR-B --> recurrence, patient counts as centre case Footnote 2) 2) Each patient can only be assigned 1 form of treatment per calendar year and counted for this (e.g. cystectomy after TUR-B in the calendar year: count for cystectomy). The patient is assigned to the leading therapy in each case. → *In patients with TUR-B before radiochemotherapy and subsequent repeat TUR-B to monitor treatment success, radiochemotherapy counts as the leading treatment for the patient and the patient is to be entered in the "Other therapies" column.*

Data Sheet Bladder				
2b)	Presentation tumour board	Numerator	Patients of the denominator who were presented in the TC	FAQ (26/08/2019) A patient had a superficial tumour in the past (<T1 high grade without CIS), was treated with a TUR bladder, received a post-resection without tumour or only minor tumour parts of the above classification and is then followed up. He then had a recurrence in a cystoscopic check-up during the course of the treatment. The repeat TUR-B then shows another <T1 high grade without CIS [...]. According to indicator 2b, it would formally be a recurrence. It is now unclear to us whether these cases should also be reported. Answer: The following applies to indicator 2b: Recurrences after TUR-B due to suspected recurrence in the cystoscopic control must be presented if at least T1 high-grade and / or Cis can be detected in the histological findings (i.e. the histological requirements that also apply to the presentation of primary tumours). All other patients with (suspected) recurrence and/or secondary distant metastasis must present to the TC regardless of the findings. be provided.
		Denominator	Patients with new recurrence and/or distant metastases (= indicator 1b) + Primary cases with M1	
		Target Value	≥ 95%	

FAQ's - Data Sheet Kidney

Data Sheet Kidney				
7	Diagnosis with histology as often as possible before systemic therapy	Numerator	Pat. of the denominator with histology before systemic Therapy	FAQ (05/05/2020) Is a histological confirmation of the metastasis(es) also necessary in patients with primary metastases if a nephrectomy is planned? Answer: In principle, histological confirmation should be sought before initiating exclusively systemic therapy. This applies in particular to secondary metastasis. An exception are primarily metastasised patients if a nephrectomy is or has been performed.
		Denominator	Centre cases with exclusive systemic therapy	
		Target Value	≥ 90%	