**Catalogue of Requirements**

**Visceral Oncology Centre**

**of the German Cancer Society**

**Prepared by the DKG Certification Committee Visceral Oncology Centre**

**Chairs of the Certification Committee:** Prof. Dr. J. Mayerle, Prof. Dr. C. Reißfelder

**Members (in alphabetical order):**

ABO Working Group for Imaging in Oncology

ACO Working Group for Surgical Oncology

ADT Association of German Tumour Centres

ADDZ Working Group of DKG-certified Colorectal Cancer Centres

AET Working Group on Hereditary Tumour Diseases

OPH Working Group for Oncological Phamacy

AIO Working Group for Internal Oncology

AOP Working Group for Oncological Pathology

APM Working Group for Palliative Medicine

PRIO Working Group for Prevention and Integrative Medicine in Oncology

PSO Working Group for Psycho-Oncology

ARO Working Group for Radio-Oncology

AGORS Working Group for Rehabilitation and Social Medicine

ASO Working Group for Social Work in Oncology

AGSMO Working Group for Supportive Measures in Oncology

AUO Working Group for Radio-Oncology

AdP Working Group of Pancreatectomy Patients

BNHO Association of Practice-based Haematologists and Oncologists in Germany

BNG Professional Association of Practice-based Gastro-enterologists Germany

VDOE/VDD - Professional Association of Oecotrophology / Association of Dietitians

BDP Association of German Pathologists

BVDST Professional Association of German Radiotherapists

BVGD Federal Association of Gastroenterology in Germany

CAO Surgical Working Group for Oncology

DGPRÄC German Society of Plastic, Reconstructive and Aesthetic Surgeons

DGAV German Society for General and Visceral Surgery

DGCh German Society of Surgery

DGHO German Association of Haematology and Oncology

DeGIR German Society for Interventional Radiology

DGK German Society for Coloproctology

DGN German Society of Nuclear Medicine

DGP German Society of Palliative Medicine

DGP German Society of Pathology

DEGRO German Society of Radio-Oncology

DGVS German Society for Digestive and Metabolic Diseases

German ILCO

German Liver-Help e.V.

DRG German X-Ray Society

DVSG German Association of Social Work in Health Care

Audtors

KOK Conference on Oncological and Paediatric Oncological Care

Self-helping Group on Gastric Cancer

Self-helping Group on Oesophageal Disease

Representative of S3 Guideline Anal Cancer, HCC, Colorectal Carcinoma, Gastric Carcinoma, Oesophageal Carcinoma, Pancreatic Carcinoma

Self-helping Group on Gastric Cancer

Self-helping Group on Oesophageal Disease

Permanent guests:

* OncoSuisse

**Comments on the Catalogue of Requirements**

The Catalogue of Requirement and its appendices are binding for all centres.

**Entry into force on 14. September 2023**

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| Audit year: | **2025** |
| Version: | **O1** |
| Date: | **22.10.2024** |

The changes marked in green in this Catalogue of Requirement (CoR) were decided in 2024 and are valid for all audits carried out from 01.01.2025

Incorporated:

* S3 Guidelines "Diagnosis and treatment of adenocarcinomas of the stomach and the esophagogastric junction"
* S3 Guidelines "Exocrine pancreatic cancer"
* S3 Guidelines "Diagnosis and treatment of colorectal cancer"
* S3 Guidelines "Diagnosis and treatment of the hepatocellular carcinoma"
* S3 Guidelines “Diagnosis and treatment of squamous cell carcinomas and esophageal adenocarcinomas”
* S3 Guideline “Diagnosis, Treatment and Follow up of Anal Canal and Cancers of the perianal Skin”

The Catalogue of Requirements is based on the TNM classification of malignant tumours, 8th edition 2017, the ICD classification ICD-10-GM 2024 (DIMDI) and the OPS classification OPS 2024 (DIMDI).

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| --- | --- |
| Colour legend | "black" .... relevant for all organs |
|  | only relevant for "colorectal" |
|  | only relevant for "pancreas" |
|  | only relevant for "stomach" |
|  | only relevant for "liver" |
|  | only relevant for "esophagus"  only relevant für “anal cancer” |

**Prologue**

In the Certified Centres interdisciplinary, inter-professional and trans-sectoral networks are established that cover the entire chain of care from the patient angle.[[1]](#footnote-1) The contents of the evidence-based Guidelines are the basis for clinical work. A series of Visceral-oncological Guidelines, with the related quality indicators, have been published within the framework of the [**Oncology Guidelines Programme**](http://www.leitlinienprogramm-onkologie.de/). Based on these Guidelines the Certification Committee (see cover) has drawn up the contents that are used in the Visceral Oncology Centres.

In order to facilitate practical implementation and to reduce the number of Catalogues of Requirements and audit procedures, the individual tumour entities (Definition "Area of application" on page 2) have been grouped together under the umbrella "Visceral Oncology Centre" (VC). In line with their specific specialisation and expertise, the Centres can lay down their area of application themselves.

A VC fulfils at least the requirements (in line with the definition "area of application" on page 2) for:

1 Colorectal Cancer Centre + 1 additional tumour entity (liver, stomach, pancreas, esophagus) or for 3 of the 4 modules (liver, stomach, pancreas and esophagus)

For certification of the Visceral Oncology Modules (liver, stomach, pancreas, oesophagus), it is necessary that a DKG-certified Colorectal Cancer Centre or Oncology Centre is located at the site or is certified at the same time. Certification for Anal Cancer is only possible in combination with certification as a Colorectal Cancer Centre. A Colorectal Cancer Centre and an Anal Cancer Centre together do not form a Visceral Oncology Centre.

Aside from this, the certification of an independent Colorectal Cancer Centre is still possible.

Certification is undertaken, irrespective of the number of modules selected, during the audit. It is possible to change the area of application at a later date. The area of application is indicated on the certificate

For single Colorectal Cancer Centres, the fulfilment of the requirements must be stated in the Catalogue of Requirements for Visceral Oncology Centres (a separate Catalogue of Requirements for Colorectal Cancer Centres is no longer available). Requirements marked with ‘OC’ in the ‘Section.’ column are relevant for all organsand thus apply to both Visceral Oncology Centres and single Colorectal Cancer Centres.

**Information on the Visceral Oncology Centre (VC)**

|  |  |
| --- | --- |
| Centre |  |
| Director Centre |  |
| Coordinator of the Centre |  |

|  |  |
| --- | --- |
| Clinical site 1 (hospital/place) |  |
|  |  |
| Clinical site 2 (hospital/place) |  |

**Centre’s area of application:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Colorectal |  | Pancreas |  | Stomach | |
|  |  |  |  |  |  |  | |
|  |  | Liver (HCC and biliary tract cancer) |  | Esophagus |  | Anal Cancer |  | |

Certification for anal cancer is only possible in combination with a certification as a Colorectal Cancer Centre.

**Network/Main cooperation partners**

The Centre's cooperation partners are registered in a master data sheet with OnkoZert. The details in the master data sheet are published on [www.oncomap.de](http://www.oncomap.de/). Any new or no longer valid cooperation is to be notified immediately to OnkoZert, outside the certification period, too. Other updates (e.g. changes to management, contact data) are to be indicated in the corrected master data sheet in the run-up to the annual surveillance audit. The master data sheet with the registered cooperation partners can be requested from OnkoZert as a file.

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**1. General information on the Breast Cancer Centre**

| **1.1 Structure of the network** | | |
| --- | --- | --- |
| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.1.1 - CC, MP, MG, ML, ME, MA | The names of the persons holding the following positions are to be given:   * Director of the Centre (max. 2 directors/Centre, of whom 1 named contact) * Centre Coordinator     Centre Coordinator – tasks   * Coordination internal/external audits * Monitoring of Technical and Medical Requirements and ensuring compliance with them * Communication interface * Steering/monitoring of cross-specialty activities |  |
| 1.1.2 - CC, MP, MG, ML, ME, MA | Main cooperation partners and cooperation partners can be part of a clinic or also be independent practices.    Main cooperation partners  Visceral surgery (only Anal Cancer: with additional qualification in Proctology according to the model further training regulations (MWBO) or EBSQ coloproctology), gastroenterology, radiotherapy, haematology/oncology, pathology, radiology (only LCC: interventional radiology)    Cooperation partners  Psycho-oncology, social work, stomatherapy (only colorectal), nutritional counselling, physiotherapy, genetics, pain therapy and self-help group, palliative medicine, diabetology (only pancreas), for Anal Cancer additional: plastic surgery, gynaecology |  |
| 1.1.3.a - CC, MP, MG, ML, ME, MA | Cooperation agreements  A cooperation agreement is to be entered into with cooperating treatment partners. Documentation must be provided that they meet the appropriate Technical and Medical Requirements of the Catalogue of Requirements (not every service provider has to be a cooperation partner as well). The cooperation partners are to be listed in the "Master Data Sheet" (administration by OnkoZert).  If the cooperation partners of a Centre work under a funding body or at a clinical site, written agreements are not necessary (nonetheless the implementation of the following points must be ensured).    The following points are to be regulated:   * Competences and responsibilities * Description of the treatment processes of relevance for the Centre bearing in mind the interfaces * Obligation to implement indicated Guidelines * Description of cooperation on tumour documentation * Declaration of willingness to cooperate on internal/external audits * Undertaking to comply with the relevant DKG criteria and the annual submission of the relevant data * Upholding of medical confidentiality * Participation in continuing education/specialty training programmes and public relations work * Declaration of consent to be publicly identified as part of the Centre (e.g. homepage) * 24/7 reachability of main clinical cooperation partners in CC/VC: surgeons, gastro-enterologists, radio-oncologists, radiologists |  |
| 1.1.3.b - MP | For the definition of treatment steps (incl. local treat-ment algorithms), the use of the "Patient Pathway" of the S3 Guideline Pancreatic Cancer (available at <https://www.krebsgesellschaft.de/zertdokumente.html> (tab "Visceral Oncology Centres")) is recommended. |  |
| 1.1.3.c - CC, MP, MG, ML, ME, MA | Tumour board  (only to the extent that participation is required under "1.2 Interdisciplinary cooperation")   * Binding participation * Ensuring availability of specialist for the specialty to which binding participation applies * Participation and consensus provisions in the case of more than 1 cooperation partner for each specialty (see also provisions "Interdisciplinary cooperation") |  |
| 1.1.3.d - ML | * Visceral Oncology Centres, which do not perform liver transplantations, must document cooperation with one of the transplantation centres recognised by the federal state ministry. * Cooperation is to be documented using concrete pa-tient medical records for each calendar year. * Transplantation should be evaluated in all patients with LCC within the Milan criteria without contraindications. * Patients with LCC who are eligible for a transplant in line with the recommendation of the tumour board must be presented in a recognised transplantation centre. |  |
| 1.1.4 - CC, MP, MG, ML, ME, MA | Presentation of the Centre  The overall structure of the Centre is to be presented and made public (e.g. Internet). This also encom-passes giving the names of all internal/external coop-eration partners with the following details:  - Name, address of cooperation partner  - Cooperation partner with tel./email |  |
| 1.1.5 - CC, MP, MG, ML, ME, MA | Strategy planning/Reporting  It is recommended to conduct an annual review on the management level in which the following aspects, for instance, are examined:   * Goal definition/assessment, where appropriate new orientation of goals * Consideration of audit results * (internal/external) * Human resources for Centre management * (Centre Coordinator) * Public relations work/Patient information * Tumour documentation/Outcome quality |  |
| 1.1.6 - CC, MP, MG, ML, ME, MA | Cooperation with Centres for Personalised Medicine  A Cooperation agreement with a certified Centre for Personalised Medicine (CPM) should be sought (see also 1.2.3.b). If the CPM and the CC/VC are under the same sponsorship or at the same clinical location, written agreements are not necessary (implementation of the points mentioned under 1.1.3a must nevertheless be ensured). |  |

| **1.2 Interdisciplinary cooperation** | | |
| --- | --- | --- |
| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.2.0.a - CC | CR CC  5.2.4    Surgical expertise Centre   * 30 colon cancer * 20 rectal cancer     Primary case definition, see last page of this Catalogue of Requirements  Data Sheet - Colorectal  (Excel-Template) |  |
| 1.2.0.b - MP | Number of primary cases    The Centre must treat 25 patients annually with a primary diagnosis of pancreatic cancer (ICD-10 C 25).    Definition:   * Patients and not stays or surgical procedures * Adeno cancer, neuroendocrine cancer are counted. IPMNs (intraductal papillary mucinous neoplasms) are not counted. * Histological/cytological findings must be available (biopsy or resection) from primary tumour or metastasis with concomitant presence of a pancreatic tumour in medical imaging. * Patients with initial disease (incl. primary M1) who are presented at the centre or the tumour board and receive essential parts of the therapy there * The time of counting is the time of the histological confirmation of diagnosis * Patients, who are only presented for the purposes of seeking a second opinion or for the purposes of consultation, are not included.     Data Sheet Pancreas  (Excel template)    For further explanations, see FAQ. |  |
| 1.2.0.c - MG | Number of primary cases    The Centre must treat 30 patients annually with a primary diagnosis of an adenocarcinoma of the stomach and of the esophagogastric junction (ICD-10 C, 16.01, 16.1-16.9). If the Centre is not certified as an esophageal cancer centre at the same time, the ICD-10 C 15.2 and 15.5 and 16.022 can be included in the scope of the stomach cancer centre.    Definition:   * Patients and not stays or surgical procedures * Histology / cytology report must be available (biopsy or resection). * Patients with initial disease (incl. primary M1) who are presented at the centre or the tumour board and receive essential parts of the therapy there * The time of counting is the time of the histological confirmation of diagnosis * Patients, who are only presented for the purposes of seeking a second opinion or for the purposes of consultation, are not included.     1 Tumours, whose centre is > 2 cm from the esophagogastric junction, are classified as stomach cancer even if the esophagogastric junction is affected.    2 Tumors that involve the esophagogastral junction and their center within the prox. 2 cm of the esophagogastral junction (proportion Siewert type I / Siewert type II) is counted as esophageal carcinoma.    Data Sheet Stomach  (Excel template)    For further explanations, see FAQ. |  |
| 1.2.0.d - ML | Number of primary cases    The Centre must treat 40 patients annually with a primary diagnosis of an liver cancer or biliary cancer (ICD-10: C22.0, C22.1., C23)  Definition:   * Patients and not stays or surgical procedures * Patient with initial disease (incl. primary M1), who are presented at the centre or the tumour board and receive essential parts of the therapy there * The time of counting is the time of the histological/imaging confirmation of diagnosis * Patients, who are only presented for the purposes of seeking a second opinion or for the purposes of consultation, are not included.     Data Sheet Liver  (Excel template) |  |
| 1.2.0.e - ME | Number of primary cases    The Centre must treat 40 patients annually with the diagno-sis of a high-grade dysplasia (HYIEN, HGD) or an invasive squamous cell carcinoma or an esophageal adenocarcinoma (= Centre cases).  of which at least 20 patients with a primary diagnosis  (ICD-10 C15, 16.02, D00.1 (HGD, HGIEN))    Definition primary diagnosis:   * Patients and not stays or surgical procedures * Patient with initial disease (incl. primary M1), who are presented at the centre or the tumour board and receive essential parts of the therapy there * The time of counting is the time of the histological/imaging confirmation of diagnosis * Patients, who are only presented for the purposes of seeking a second opinion or for the purposes of consultation, are not included.     2 Tumours that affect the esophagogastric junction and whose centre is within the prox. 2 cm of the esophagogastric junction (proportion Siewert type I/Siewert type ll), are counted as esophageal cancer.    Data Sheet Esophagus  (Excel template)    For further explanations, see FAQ. |  |
| 1.2.0.f - MA | Number of primary cases    The centre must treat 12 patients per year with a primary diagnosis of Anal Cancer.  Definition:   * Anal Cancer: C21.1 * Cancers of the perianal skin: C44.50 * Patients and not stays and no operations * Patients with first disease (incl. primary M1), which are presented at the centre or at the tumour board and receive essential parts of the therapy there * Counting time is the time of histological confirmation of diagnosis * Patients who are only presented for a second opinion or only on a consultative basis are not taken into account.     Data Sheet Anal Cancer  (Excel template) |  |
| 1.2.1 - CC, MP, MG, ML, ME, MA | Cycle/Participants tumour board  A tumour board must be held at least once a week.    For the following specialties participation by specialists in the tumour board is mandatory:   * Visceral surgery * Gastro-enterology * Radiotherapy * Haematology/Oncology * Pathology * Radiology (LCC: interventional radiology     Metastases:  In the case of organ metastases a surgeon with the corresponding specialisation and specific expertise is to be consulted.  Depending on the indication, other participants (palliative medicine, psycho-oncology, etc.) are to be invited.    If the haematologist/oncologist is unable to attend the tumour board, he/she may be represented by the specialist responsible for chemotherapy who complies with the requirements in Section 6.2. |  |
| 1.2.2 - CC, MP, MG, ML, ME, MA | General requirements tumour board    Several cooperation partners  If several cooperation partners are named for a specialty, then the presence of one representative is sufficient as long as the formalised exchange of information between the partners is in place (e.g. via quality circles).  Independently thereof, each cooperation partner must take part in the tumour board at least once a month.    Web/online tumour board  If web tumour board are used, it must be possible to transmit the sound and documents presented. It must be possible for each main cooperation partner to present its own documents/imaging material. Telephone tumour board with no imaging material are not an option. |  |
| 1.2.3.a - CC, MP, MG, ML, ME, MA | Indicator Presentation tumour board  Pretherapeutic case presentation  Post-operative case presentation  All pretherapeutic/post-operative cases are to be presented at the tumour board in line with the respective indicator definition. If no presentation is made, clear reasons must be given in the patient’s medical record. |  |
| 1.2.3.b - CC, MP, MG, ML, ME, MA | For patients with advanced cancer,   * who have already undergone guideline-based therapy, * who, according to the assessment of the clinical parameters, are able to receive molecular-based therapy, * who agree in principle to a possible therapy based on the molecular findings,   should be referred to a Centres for Personalised Medicine. The prerequisite for this is the existence of a tumour board decision from an organ-specific centre. The MTB recommendation will be made available to the referring centre. |  |
| 1.2.3.c - CC | Presentation tumour board  Patients with a rectal carcinoma should be presented again in the tumour board after termination of neoadjuvant therapy and in the case of full clinical remission in order to discuss the indication of a Watch &Wait strategy. |  |
| 1.2.4 - CC | Recurrence/metastasis   * Surgical responsibilities for metastasis resection are to be laid down (in particular liver, lung) where appropriate by means of cooperation. * Therapeutic approaches (curative and palliative) for metastasis surgery and radiotherapy (e.g. stereotactic irradiation of brain tumours) are to be laid down in the descriptions of the procedures. * Patients with primary unresectable liver metastasis should be regularly presented during systemic therapy for evaluation in the tumour board. |  |
| 1.2.5.a - CC, MP, MG, ML, ME, MA | Demonstration imaging material  Patient-related imaging material must be available at the tumour board and suitable technical equipment must be provided for the presentation of this material. |  |
| 1.2.5.b - MP | The resectability should be assessed on the basis of   * structured CT/MRI findings according to the template of the S3 guideline on pancreatic cancer (available at <https://www.krebsgesellschaft.de/zertdokumente.html> (tab "Visceral Oncology Centres")) * tumour biology (N+; CA 19-9 > 500 U/ml) criteria as well as conditional criteria (e.g. ECOG) |  |
| 1.2.6 - CC, MP, MG, ML, ME, MA | Preparation tumour board   * The main patient and treatment data are to be compiled in writing beforehand and made available to the participants at the tumour board. * A pre-appraisal of suitable study patients is to be undertaken. * All patients with recurrences and/or metastases, who have entrusted the Centre with their care, are to be presented. |  |
| 1.2.7 - CC, MP, MG, ML, ME, MA | Minutes of the tumour board   * The results of the tumour board consist, inter alia, of a written, interdisciplinary treatment plan ("Minutes tumour board"). * The minutes of the tumour board must be available at all times in a secure manner to all main cooperation partners and can, at the same time, constitute the medical report. * The "minutes of the tumour board" should be automatically generated from the tumour documenta-tion system. * The outcome of the tumour board is to be recorded in the tumour documentation system. |  |
| 1.2.8 - CC, MP, MG, ML, ME, MA | Participation tumour board as continuing education  For The following functions/professional groups should attend~~, a one-time mandatory participation~~ in the tumour board once ~~is to be made possibl~~e (refresher every 3 years):   * Non-medical staff ~~Assistant staff (MTA, MTRA, ...)~~ from the fields of radiology and radiotherapy * ~~Social services and~~ Psycho-oncology staff * Participation in the tumour board is recognised as continuing education for the aforementioned functions/professional groups. |  |
| 1.2.9 - CC, MP, MG, ML, ME, MA | Therapy deviation   * The therapeutic procedure should be oriented to-wards the treatment plans or recommendations of the tumour board. * If any deviations from the original therapy plan or deviations from the Guidelines are observed, they must be recorded and evaluated. Depending on the cause, avoidance measures are to be taken. * If therapy is not started or terminated prematurely at the patient's request (despite an existing indication), this must also be recorded. |  |
| 1.2.10 - CC, MP, MG, ML, ME, MA | Supportive therapy and symptom relief   * The options for supportive/palliative inpatient therapy must be described (process description/algorithm). * A specialised pain therapist must be available. The process for pain therapy (algorithm) must be described and documented cases must be provided for the assessment period. * Access to nutritional counselling (in accordance with section 1.9) must be described and documented cases must be provided for the assessment period * Access to psycho-oncological and psychosocial counselling as well as pastoral care must be described. * In the case of implementation via cooperation partners, a cooperation agreement must be concluded for the aforementioned requirements. |  |
| 1.2.11 - CC, MP, MG, ML, ME, MA | Basic oncological screening  In order to optimise outpatient and inpatient care, it is recommended that symptoms, burden, consultation and treatment needs be recorded in the form of a basic oncological screening.    The basic screening includes, for example (see SOP at <https://www.krebsgesellschaft.de/zertdokumente.html>):   * Screening for psychosocial stress (see section 1.4) * Symptom screening using validated instruments (e.g. MIDOS/IPOS (see section 9)) * Needs assessment for socio-legal counselling (see chapter 1.5) * Screening for malnutrition (e.g. NRS, see section 1.9) * Screening for geriatric risks for all patients > 70 years of age (e.g. G8) * Therapeutic movement screening for restrictions in movement and mobility * Recording the burden on relatives of incurable cancer patients     The processes and the involvement of the relevant support areas (e.g. nutritional counselling) must be described. Basis for this: "SOP basic oncological screening"at <https://www.krebsgesellschaft.de/zertdokumente.html> |  |
| 1.2.12 - CC, MP, MG, ML, ME, MA | Morbidity/mortality conference   * The conference can be staged on the same date as the tumour board. * A list of participants is kept. * Conferences are to be held at least twice a year. * Cases with a special course of the disease or a course that needs to be improved are to be discussed. Patients who died post-surgery/post-intervention must definitely be discussed. * Minutes are to be taken of conferences. |  |
| 1.2.13 - CC, MP, MG, ML, ME, MA | Quality circles   * Tasks, circle of participants and contents of the quality circles are to be laid down. * Conferences are to be held at least four times a year. * A list of participants is kept. * The quality circles must produce clear results (ac-tions, decisions) which seem likely to bring about a major further development of/improvement in the Centre. * The outcome of the quality circles is to be recorded.     Possible topics:   * Analysis of outcome quality (benchmarking) * Interdisciplinary continuing education * Interdisciplinary case reviews * Structural improvements to the Centre * Public relations     At the time of initial certification one quality circle must have taken place. |  |
| 1.2.14 - CC, MP, MG, ML, ME, MA | Continuing education   * Continuing education events are to be staged for the network of the Visceral Oncology Centre at least twice a year (where appropriate also after the morbidity & mortality conferences/quality circles). * Contents/results and participation are to be record-ed. A continuing education plan is to be presented. |  |
| 1.2.15 - CC, MP, MG, ML, ME, MA | Events of the Centre  Each main cooperation partner must participate in at least two of the Centre's events. The following are recognised:   * Quality circles * Morbidity/mortality conference * Continuing education |  |

| **1.3 Cooperation with referring physicians and providers of aftercare treatment** | | |
| --- | --- | --- |
| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.3.1 - CC, MP, MG, ML, ME, MA | Cooperating referrers  An up-to-date list is to be kept of the cooperating referrers. The referrers are to be informed about cooperation within the Centre with regard to the following details:    Obligations of the Centre:   * Referrers are entitled to attend the tumour board when their patients are presented. * Referrers are to be given the opportunity to present patients in the tumour board. |  |
| 1.3.2 - CC, MP, MG, ML, ME, MA | Contacts  The Centre's contacts are to be given to the referrers in line with their function (e.g. telephone number, email). This can be done with the required publication of the cooperation partners. |  |
| 1.3.3 - CC, MP, MG, ML, ME, MA | Provision of documents  The co-attending physicians are to be given the following information in a timely manner (individual docu-ments and/or summaries in the medical report):   * Histology * Tumour board minutes / treatment plan * Surgical report (optional) * Changes to therapy     Timeline for the provision of the necessary information to the co-attending physicians < 2 weeks |  |
| 1.3.4 - CC, MP, MG, ML, ME, MA | Feedback system  For the co-attending physicians a written standard operating procedure (SOP) for the recording, processing and feeding back of the general and case-related concerns/questions/complications is to be put in place. |  |
| 1.3.5 - CC, MP, MG, ML, ME, MA | Referrer satisfaction survey   * Every three years a referrer satisfaction survey must be conducted. The results of this survey are to be evaluated and analysed. A cross-department survey can be recog-nised. * The referrer satisfaction survey must be available for the first time for the first surveillance audit (1 year after initial certification). |  |
| 1.3.6 - CC, MP, MG, ML, ME, MA | Continuing education  Events for the exchange of experience and continuing education events are to be proposed at least twice a year by the Centre. Contents/results and participation are to be recorded. |  |

| **1.4 Psycho-oncology** | | |
| --- | --- | --- |
| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.4.1 - CC, MP, MG, ML, ME, MA | Psycho-oncology – qualifications   * Qualified psychologists / Master in Psychology, which qualifies for a scientifically recognised psychotherapy procedure or * physicians * Diploma/master's degree in social pedagogy qualifying for a scientifically recognised psychotherapy     with at least 1 psychotherapeutic specialty training: behavioural therapy, psychodynamic psychotherapy (analytical psychotherapy and psychotherapeutic depth psychotherapy), systematic therapy, neuropsychological therapy (for psychological disorders caused by brain injuries), interpersonal therapy (IPT; for effective disorders and eating disorders), EMDR for the treatment of post-traumatic stress disorders, hypnotherapy for addictions and psychotherapeutic treatment for somatic disorders    and psycho-oncological continuing education (recognised by the German Cancer Society - DKG).    Licence to practise: 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 recognised and those who have started a psycho-oncological specialty training by 31.12.2019 recognised by the German Cancer Society - DKG.  The representatives of other psychosocial professional groups can be accepted on presentation of the above-mentioned psycho-oncological qualifications. For this, a case-by-case examination is required.    The assumption of psycho-oncological tasks by the social services, self-help groups or pastoral care is not sufficient. They supplement psycho-oncological care.    The process of patient care in the centre (screening, evaluation of screening results, care) must be demonstrated in the audit based on examples.    For further explanations, see FAQ. |  |
| 1.4.2.a - CC, MP, MG, ML, ME, MA | Psycho-oncology – 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. |  |
| 1.4.2.b - CC, MP, MG, ML, ME, MA | Documentation and evaluation  To identify treatment needs, screening of mental strain must be undertaken (see Indictaor "Psycho-oncological distress screening") ) and the outcome is to be documented. The proportion of patients subjected to distress over-threshold screening should be reported. |  |
| 1.4.2.c - CC, MP, MG, ML, ME, MA | Psycho-oncological counselling  Psycho-oncological care, in particular for patients with excessive stress in the distress screening, must be presented.    For further explanations, see FAQ. |  |
| 1.4.3 - CC, MP, MG, ML, ME, MA | Psycho-oncology resources  Needs-based at least 1 psycho-oncologist with the above qualifications is available to the Centre (name is to be given). |  |
| 1.4.4 - CC, MP, MG, ML, ME, MA | Premises  A suitable room is to be provided for psycho-oncological patient consultations. |  |
| 1.4.5 - CC, MP, MG, ML, ME, MA | Organisation plan  If psycho-oncological care is provided by external cooperation partners or for several clinical sites and clinic facilities, the performance of tasks is to be laid down in an organisation plan that contains details, inter alia, of the availability of resources and local presence. |  |
| 1.4.6 - CC, MP, MG, ML, ME, MA | Psycho-oncology – tasks  The psycho-oncological care of patients is to be offered at all stages of care (diagnosis, inpatient, post-inpatient).    Goals and tasks of care:   * Diagnostic clarification after positive screening * Prevention/treatment of resulting psychosocial problems * Activation of personal coping mechanisms * Maintenance of quality of life * Consideration of social environment * Organisation of further outpatient care through cooperation with outpatient psycho-oncological service providers * Public relations (patient event or the like) |  |
| 1.4.7 - CC, MP, MG, ML, ME, MA | The following are also recommended:   * Provision of supervision, initial and continuing education courses for staff * Twice yearly discussions between psycho-oncologists and the nursing and medical areas * Regular written and, where appropriate, oral feedback on psycho-oncological activities to the medical staff (e.g. through a referral report or documentation in the medical record) * Regular participation in ward conferences and tumour boards * Close cooperation with the social services * Interface/exchange with self-help and pastoral care * The psycho-oncologists should present their work at least twice a year at the ~~tumour boards~~ quality circle. |  |
| 1.4.8 - CC, MP, MG, ML, ME, MA | Continuing education/specialty training  At least 1 dedicated continuing education/specialty training session a year for each staff member (at least 1 day a year) |  |

| **1.5 Social work and rehabilitation** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.5.1 - CC, MP, MG, ML, ME, MA | Qualifications social services:   * Social workers/social pedagogues * Individual case examinations according to the specifications of the professional society are possible * ~~Additional qualification: Experience in the medical/oncological field~~ |  |
| 1.5.2 - CC, MP, MG, ML, ME, MA | Social services - resources:  For the counselling of patients in the centre, there is at least 1 social worker available for 400 counseled patients (not cases) of the centre (= primary cases, secondary metastases, recurrences). The personnel resources can be provided centrally; an organisational plan must be available. |  |
| 1.5.3 - CC, MP, MG, ML, ME, MA | 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 be made without any barriers. |  |
| 1.5.4 - CC, MP, MG, ML, ME, MA | The number of patients ~~who received counselling from the social services is to be recorded~~ who have received counselling from social services must be documented and evaluated. |  |
| 1.5.5 - CC, MP, MG, ML, ME, MA | Premises:  A suitable room must be provided for social counselling work. |  |
| 1.5.6 - CC, MP, MG, ML, ME, MA | Organisation plan  The performance of tasks is to be regulated by means of an organisation plan, in which, among other things, the availability of resources and the local presence can be identified. |  |
| 1.5.7 - CC, MP, MG, ML, ME, MA | Tasks of the psychosocial counselling:  Contents of counselling: using the DVSG catalogue of services and the expert standards PEOPSA (Psychosocial Initial Counselling of Oncological Patients by Social Work)   * Identification of social, economic and mental health emergencies * Start of medical rehabilitation measures * Advice on social law and economic issues (e.g. severely disabled persons' legislation, wage replacement benefits, pension, benefit requirements, co-payments, and many other issues) * Support for submitting applications * Advice on outpatient and inpatient care treatment options * Referral to support schemes and specialised services, nursing care services * Support for professional and social reintegration * Cooperation with service funding agencies and service providers, specialist services * Discharge management * Intervention in emergencies * Placement in palliative care concepts and hospice care (outpatient/inpatient) |  |
| 1.5.8 - CC, MP, MG, ML, ME, MA | Further tasks:   * Public relations and networking * Participation in multiprofessional case reviews, supervision, continuing education * Offering continuing education/ information events for other disciplines of the Centre and/or patients * Multiprofessional cooperation particularly with physicians, nursing staff, physiotherapists, psycho-oncologists, pastoral services, self-help groups inter alia |  |
| 1.5.9 - CC, MP, MG, ML, ME, MA | Documentation and evaluation  The activities of the social services must be documented (e.g. CareSD, KIS) and evaluated. |  |
| 1.5.10 - CC, MP, MG, ML, ME, MA | Continuing education/specialty training   * At least 1 dedicated continuing education/specialty training session a year for each staff member (at least 1 day a year) * Offer supervision |  |

| **1.6 Patient participation** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.6.1.a - CC, MP, MG, ML, ME, MA | Patient surveys:   * At least every 3 years all Centre patients are given the opportunity over a period of at least 3 months to take part in a patient survey. |  |
| 1.6.1.b - CC, MP, MG, ML, ME, MA | The "return rate patient survey" should be higher than 50%. |  |
| 1.6.2 - CC, MP, MG, ML, ME, MA | Evaluation patient survey   * Responsibility for the evaluation is to be specified. * The evaluation must encompass the patients of the Centre. * A recorded evaluation is to be made and presented during the audit. * Actions are to be laid down on the basis of the evaluation. * The evaluation can be considered in connection with a quality circle. |  |
| 1.6.3 - CC, MP, MG, ML, ME, MA | Patient information (general)   * The Centre should give a full presentation of itself and its treatment options (e.g. in a brochure, patient folder, homepage). * The names of the cooperation/treatment partners are to be given with details of the contact. A description is to be given of the treatment on offer. * The presented treatment offering must encompass: Rehabilitation/post-hospital rehabilitation, self-help, treatment measures and alternatives * Information provided: for instance patient guidelines and/or S3 Guidelines of the Oncology Guidelines Programme |  |
| 1.6.4.a - CC, MP, MG, ML, ME, MA | Discharge consultation:  Each patient is given a discharge consultation (short documentation/check list) in which at least the following topics are addressed:   * Therapy planning * Individual aftercare plan (where appropriate handing over of an aftercare pass) |  |
| 1.6.4.b - ML | * Information on continued treatment of an HCV/HBV infection in line with S3-LL of the German Society for Digestive and Metabolic Disorders (DGVS) and continuation of other liver-specific treatment methods |  |
| 1.6.4.c - MG | * Information on need for vitamin B12 substitution |  |
| 1.6.4.d - MP | * Information on possible secondary diseases (e.g. diabetes) and the related risks (e.g. hypoglycaemias) |  |
| 1.6.4.e - MA | * Information on the procedure for assessing the success of therapy after curative radiochemotherapy * Assessment of therapy success by digital-rectal examination and proctoscopy 11 weeks, 18 weeks and 26 weeks after the start of radiochemotherapy. |  |
| 1.6.5 - CC, MP, MG, ML, ME, MA | Patient information (case-related):  The patient is given the following documents:   * Medical report / discharge letter (including details tumour board / treatment plan) * Aftercare plan / aftercare pass * where applicable, study documents   It is recommended that patients are given a central /structured folder for the documents. The procedure for the provision of patient information is to be standardised. |  |
| 1.6.6 - CC, MP, MG, ML, ME, MA | Event for patients  The Centre is to stage an information event for patients and/or interested persons at least once a year.  (can be considered together with 1.6.9)  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.    For further explanations, see FAQ. |  |
| 1.6.7 - CC, MP, MG, ML, ME, MA | Complaint management  An official procedure for complaint management is in place. Patients are given feedback. Complaints are taken into account in the improvement process. |  |
| 1.6.8 - CC, MP, MG, ML, ME, MA | Self-help groups  The self-help groups, with which the Cancer Cen-tre actively cooperates, are to be named. If possible, the self-help group should consider the specific needs of visceral oncology patients (keyword - affected by the same condition). |  |
| 1.6.9 - CC, MP, MG, ML, ME, MA | Self-help groups  Self-help can be active in the field of patient involvement, psychosocial support and as an interest group. And, where appropriate, in the audit in these areas.  The self-help groups, with which the Cancer Centre actively cooperates, are to be named. Written agreements with the self-help groups are to be entered into which cover the following points:     * Access to self-help groups at all stages of treatment (initial diagnosis, hospitalisation, chemotherapy, ...); * Provision of contact data of self-help groups (e.g. in patient brochures, homepage of the VC) * Options to display information brochures of self-help groups * Regular provision of rooms at the VC for patient consultations * Quality circles with the participation of representatives of psycho-oncology, self-help groups, social services, pastoral care, nursing care and medicine * Personal discussions between the self-help groups and the Centre with a view to jointly staging or mutually agreeing on actions and events. The results of the discussions are to be recorded. * Involvement of medical staff in the events of the self-help group |  |

| **1.7 Study management** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.7.1 - CC, MP, MG, ML, ME, MA | Access to studies  It must be possible for patients to access studies. The studies conducted at the Centre must be listed and published, for instance on the Centre's homepage (including short description of the study). |  |
| 1.7.2 - CC, MP, MG, ML, ME, MA | Study manager  The name of the investigator in charge of the study is to be given.    Study assistance   * The name of a study assistant is to be included in the "study organisation chart" for "each active study unit". * He/she can work in a parallel manner for several "units conducting studies". |  |
| 1.7.3 - CC, MP, MG, ML, ME, MA | Study assistance – qualifications    Professional training  Continuing education courses (e.g. MTA, nurse/health care assistant, physician's assistant)    Training  Special training for the study assistance function must be documented (guidance value: several day course).  At the time of initial certification at least one registration for a course must be available. The course is to be completed within one year. During training the investigator / study manager must compensate for qualification deficits. |  |
| 1.7.4 - CC, MP, MG, ML, ME, MA | Study assistant - Tasks  The range of tasks is to be laid down in writing (via position/function descriptions) and can encompass, inter alia, the following contents:   * Conduct of studies together with the investigator in charge of the studies * Patient care during the study and aftercare * Organisation, coordination of diagnosis, laboratory, sample dispatch and test medication * Collection and documentation of all data of relevance for the studies * Preparation of and support for audits and authority inspections * The activity of the study assistant can be combined with other activities like tumour documentation. |  |
| 1.7.5 - CC, MP, MG, ML, ME, MA | Cooperation study assistant – investigator  Direct availability of investigator or study manager for the study assistant is to be ensured (Documentation, for instance, about regular exchange). |  |
| 1.7.6.a - CC, MP, MG, ML, ME, MA | Proportion study patients    1. Initial certification: At the time of initial certification ≥ 1 patients must have been included in studies ~~(guidance value: ≤ 6 months prior to certification)~~  2. after 1 year: at least 5% of the primary case number    The requirement applies to each tumour entity.    Data Sheets (Excel templates)  Colorectal / Pancreas / Stomach / Liver / Esophagus / Anal Cancer    For further explanations, see FAQ. |  |
| 1.7.6.b - CC, MP, MG, ML, ME, MA | 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). Exclusive 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 consent (exception patients CPM, 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 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. * Patients in a palliative and adjuvant situation can be counted, no limitations regarding stage of disease. * Patients for colorectal prevention studies can be counted. * Patients who are taking part in several studies simultaneously can be counted several times. * Patients in the follow-up of a study are no longer included in the study rate. * Special feature of Colorectal Cancer Centres: The StudyBox Colorectal is binding for the calculation of the study quota ([www.studybox.de](https://www.studybox.de/search)). This means that studies that are not accredited or for which no accreditation has been applied for cannot be counted towards the study quota. The list of accredited programmes that can be counted towards the study quota can be found at [www.studybox.de](https://www.studybox.de/search).     For further explanations, see FAQ. |  |
| 1.7.7 - CC, MP, MG, ML, ME, MA | Standard operating procedures (SOPs):  The SOPs including responsibilities are to be laid down for the launch/initiation of new studies and the conduct of studies for each "active unit". This encompasses for instance:   * Selection of new studies including release decision * Internal announcement of new studies (update study list, ...) * Study organisation (special features care study patients, documentation, ...) * Type of announcement of study results (e.g. MA, patients) |  |
| 1.7.8 - CC, MP, MG, ML, ME, MA | Study assignment  Before study participation can be recommended to a patient, there must be a patient-based discussion beforehand in the interdisciplinary tumour board. |  |

| **1.8 Nursing care** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.8.1 - CC, MP, MG, ML, ME, MA | Specialised oncological nurses   * At least 1 specialist oncology nurse must be actively employed on day duty. * Oncological nurses are to be designated by name. * In inpatient areas where patients are cared for, the activity of an oncology nurse must be verified. The performance of duties/representation must be regulat-ed and documented in writing.     The precondition for recognition as a specialist oncology nurse is   * specialty training specialist oncology nurse in line with the respective federal state regulations * or with the Model Federal State Ordinance of the German Hospital Federation (Deutsche Krankenhausgesellschaft e.V.) * or advanced practice nurse (master title) plus 2 years’ practical professional experience (equivalent to a full-time position) in the Colorectal Cancer Centre or Visceral Oncology Centre |  |
| 1.8.2 - CC, MP, MG, ML, ME, MA | Responsibilities/Tasks   * Specialised assessment and management of strains, symptoms and side-effects * Individual derivation of interventions from nursing standards * Conduct and evaluation of nursing and therapeutic measures * Establishment of individual patient-based need for counselling * The need for specialised counselling is to be defined already in the nursing concept of the Colorectal Cancer Centre. * Ongoing provision of information to and counselling of patients (and their family members) throughout the entire course of the disease * Conduct, coordination and documentation of structured counselling sessions and instructions to patients and their family members. Depending on the concept these activities may also be carried out by other long-serving specialist nurses with oncological expertise. * Participation in the tumour according to chapter 1.2) * Initiation of and participation in multi-professional case discussions/nursing visits. The objective is to find solutions in complex nursing situations. Criteria for the selection of patients are to be laid down. At ~~least 12~~ case discussions/nursing visits are to be regularly documented for each year and Centre.     Superordinate activities:   * A nursing concept is to be developed and implemented in which the organ-specific aspects of oncological nursing care are taken into account in the Visceral Oncology Centre. * Drawing up of specialised, in-house standards on the basis of (if possible) evidence-based guidelines (e.g. S3-LL Supportive). * Offer of consultation with/supervision by colleagues * Networking between oncology nurses in a joint quality circle and participation in the quality circle in the Visceral Oncology Centre * Interdisciplinary exchange with all professional groups involved in treatment * Responsibility for implementing the requirements for specialist nurse responsible for carrying out chemotherapy (see Section 6) |  |
| 1.8.3 - CC, MP, MG, ML, ME, MA | On-the-job training  The process of familiarising new members of staff must follow a specified oncological on-the-job training concept. |  |
| 1.8.4 - CC, MP, MG, ML, ME, MA | Continuing education   * A plan for the continuing education of the nurs-ing staff is to be submitted in which the training measures for the forth-coming year are set out. * At least one specific continuing education course per staff member and year (at least 1 day per year) if the staff member performs tasks relevant to the quality of the centre. |  |
| 1.8.5 - CC | Stomatherapy – Staff    Qualification head of stomatherapy    Recognised training stomatherapy:  • The following continuing education courses run by the FgSKW (Expert association for stoma, continence and wound) as nursing care experts for stoma, continence and wound encompassing 720 continuing education hours or other comparable continuing education courses. The following protection applies to stomatotherapists who were named in the centers before 01/01/2019:  Length of continuing education at least 400 hours plus practical units (contents like “Curriculum nursing expert stoma, continence, wound” of the FgSKW excluding sections incontinence and wound).    A qualified replacement must be guaranteed. Members off staff must be named. If stomatherapy services are provided externally, a cooperation agreement must be entered into.    For further explanations, see FAQ. |  |
| 1.8.6 - CC | Stomatherapy – Definition of tasks   * Pre-inpatient or pre-operative and post-inpatient instructions, counselling and training of patients and their relatives. * Participation in pre-operative marking (or regulated exchange of experience) * Where appropriate, holding of stoma consulting hours     Further outpatient care after discharge for stoma therapy must be described, including the provision of information for patients.    For further explanations, see FAQ. |  |
| 1.8.7 - CC | Stomatherapy – Equipment / infrastructure   * Own premises * Possibilities presentation of demonstration material * Storage opportunities for material for stoma care |  |
| 1.8.8 - CC | Communication with other specialties   * Formalised interprofessional information exchange with surgeons, radio-oncology and oncology |  |
| 1.8.9 - CC | Stomatherapy – documentation of therapy   * Documentation in inpatient patient record (documents of the stoma therapists alone not sufficient) * Stoma pass for patients * OPS coding of stoma systems (analogue to discharge letter) or details of stoma type (Colon/Ileo/Urostomy) / double or terminal in the stoma passport. |  |
| 1.8.10 - CC | Stomatherapy – continuing education/specialty training   * Regular training for nurses in inpatient units and relevant specialty units * Regular continuing education for all other professional groups involved and for patients and their relatives * Active support for the work of the self-help organisations through professional further training schemes * Regular own participation in continuing education courses in professional and extracurricular areas |  |

| **1.9 General service areas (pharmacy** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 1.9.1 - CC, MP, MG, ML, ME, MA | Pastoral care   * Pastoral care in the Centre is to be ensured * Patients must be given the option of care (need is to be actively identified) |  |
| 1.9.2.a - CC, MP, MG, ML, ME, MA | Nutritional counselling   * Qualified nutritional counselling (carried out by dietitians / ecotrophologists/ nutritionists or specialist with additional training in nutritional medicine) must be an integral part of the Centre * Cooperation is to be regulated in a cooperation agreement * Qualified deputisation must be ensured. * Need for nutritional counselling is to be actively identified and carried out for each patient. This is especially true during the post-oprative phase. The process must be documented in the patient records. * An SOP for nutrition management should be set out in writing.     For further explanations, see FAQ. |  |
| 1.9.2.b - CC, MP, MG, ML, ME, MA | Further and continuing training for the above-mentioned nutritionists   * At least 1 specific training programme per employee per year |  |
| 1.9.2.c - CC, MP, MG, ML, ME, MA | Screening for malnutrition and therefore the metabolic risk (nutritional risk) should be recorded at the latest on inpatient admission for, if possible, all tumour patients using e.g. Nutritional Risk Screening (NRS), for instance in line with Kondrup 2003.The measures should be analogue to the tumour entity-specific S3 GL.  The subsequent, process-guided nutritional consultation / therapy (e.g. German Nutrition Care Process) should be demonstrated accordingly and documented in the discharge letter. |  |
| 1.9.2.d - MG, ME | * The measures implemented in line with the S3 Guidelines are to be documented for all patients. * Pretherapeutic counselling, with dieticians / ecotrophologists/ nutritionists should be carried out and documented. * after esophagectomy/gastrectomy: before discharge documented dietary counselling (e.g. German Nutrition Care Process) and, where appropriate, training in using enterostomy tubes This should be documented in the patient file and in the discharge letter. |  |
| 1.9.2.e - MP | * The implemented measures according to the S3 guideline are to be verified for all patients. * after pancreatectomy: Documented dietary advice (e.g. German Nutrition Care Process) and, if necessary, training in dealing with pancreatic enzymes and enterostomy tubes before discharge. This should be documented in the patient file and in the discharge letter. * after pancreatectomy: training through qualified diabetes counselling and documentation in the discharge letter. |  |
| 1.9.2.f - ML | The implemented measures according to the S3 guideline are to be verified for all patients and documented in the discharge letter. |  |

**2. Organ-specific diagnostics**

| **2.1 Consultation hours** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 2.1.1 - CC, MP, MG, ML, ME, MA | General contents of the consultation at the clinical sites   * Identification of risk groups and individualised prevention planning * Planning clarification of dignity * Therapy planning, aftercare |  |
| 2.1.2 - CC | Special consulting hours colorectal   * Basis for staging? (Participating physician, personal authorisation, institute authorisation, polyclinic authorisation) * At least 1 x week |  |
| 2.1.3 - CC | Waiting times special consulting hours   * < 2 weeks waiting time for a consulting hours appointment * < 60 minute waiting time during consulting hours |  |
| 2.1.4 - CC | Clarification tumour dignity  100% clarification dignity already prior to radical surgical procedure  (Reasons for deviations are to be given) |  |
| 2.1.5 - CC | Diagnostics for staging  Within one week the following tests must be un-dertaken:   * Abdominal ultrasound * X-ray (lung) * CEA test     If necessary (again within 1 week)   * Other x-ray examinations * CT/MRI; PET-CT (optional) * Scintigraphy * Urological examination * Gynaecological examination |  |
| 2.1.6.a - CC | Rectum diagnosis    Access to the following procedures shall be ensured   * Rectal endosonography * Rigid rectoscopy * Chromoendoscopy * Proctology |  |
| 2.1.6.b - CC | Height localisation rectum   * Rigid rectoscopy, the flexible endoscopy or MRI examination can be used for height localisation. * The height localisation as well as the used method must be specified in the diagnostic report.     For further explanations, see FAQ. |  |
| 2.1.7 - CC | Stenosis  In the case of a non-passable coloscopic stenosis, a renewed full coloscopy must be undertaken post-operatively for 100% of all patients within 3-6 months.    The unit responsible for performing (monitoring appointments) the coloscopy must be clearly defined. |  |
| 2.1.8 - CC | Prevention / screening for asymptomatic population   * External or in-house programmes for counselling risk groups, lifestyle and nutritional recommendations (information events, information material...) * Activities to increase attendance of coloscopy check-ups and FOBT |  |
| 2.1.9 - CC | List with co-attending physicians / screening net-work  An up-do-date internal list with co-attending phy-sicians and members of the screening network is to be kept (differentiated presentation of co-attending physicians/screening). |  |
| 2.1.10 - CC | Genetic counselling  Cooperation with genetic counselling is to be regulated in a cooperation agreement.    Cooperation must be proven by way of docu-mented cases during the current assessment pe-riod.    The "Centres for Familial Colorectal Cancer" listed by German Cancer Aid (Deutsche Krebshilfe) are particularly suited for this. (<http://www.hnpcc.de/>). |  |
| 2.1.11.a - CC | Identification and procedure for risk groups (familial and elevated risk)  Risk persons are to be identified and documented in line with the risk classification in the S3 Guidelines when recording their medical history on admission. They have the following characteristics in particular:   * age < 50 years * prior colorectal carcinoma or endometrial carcinoma * one or more colorectal cancer in close family members * Endometrial urothelial, small intestine or gastric carcinoma in close family members |  |
| 2.1.11.b - CC | The algorithms for the genetic diagnostic procedure and molecular-pathological clarification in the case of suspected HNPCC and medical history sheets for the identification of risk persons to clarify the familial and hereditary risk and an information letter about elevated risk of disease onset and recommended early detection tests for close family members can be downloaded on <http://www.krebsgesellschaft.de/deutsche-krebsgesellschaft-wtrl/deutsche-krebsgesellschaft/zertifizierung/erhebungsboegen/organkrebszentren.html> in the section colorectal cancer. |  |
| 2.1.12 - CC | Individual care plan   * In the case of identified risk persons individual care planning must be undertaken in line with the S3 Guidelines.     Procedure in the event of suspected Lnych syndrome  In the SOP for confirming/ruling out Lynch syndrome, the following points are to be borne in mind:   * Responsibility for identifying risk persons * Responsibility for organising the primary immunohistochemical MSI examination and further analyses thereafter * Responsibility for MSI testing * Responsibility for passing on information to patients * Responsibility for referral for genetic counselling/testing |  |
| 2.1.13.a - MP | Diagnostics for staging / diagnostic confirmation  Within one week the following tests must be undertaken:   * Abdominal ultrasound * Endosonography upper gastrointestinal tract * Endoscopic ultrasound fine needle biopsy in the abdomen (not only pancreas punctures required) * Multidetector CT * MRI with MRCP * Interventional ERCP * X-ray (lung) |  |
| 2.1.13.b - MP | If necessary (again within 1 week):   * Other X-ray examinations * CT/MRI; PET-CT (optional) * Scintigraphy |  |
| 2.1.13.c - MP | Specialist expertise:   * Upper gastrointestinal tract endosonography: Proof of at least 30 endosonographies / examiner / year * Endosonography-guided fine needle biopsy in the abdomen (not exclusively pancreatic punctures required): Proof of at least 10 / examiner / year * Interventional ERCP: evidence of at least 50 / examiner / year   Each of the examinations must be performed by an specialist who can demonstrate the experience required above.    Named in the table "Specialist experience - endosonograms / fine needle punctures / ERCPs"  (at the end of the section) |  |
| 2.1.13.d - MP | Complications endoscopy  Proportion endoscopy-specific complications   * Bleeding (onset after ERCP), perforation: < 5% * Pancreatitis (onset after ERC) (=documented in the results system, each degree of severity): ≤ 10%     Data Sheet Pancreas  (Excel template) |  |
| 2.1.13.e - MG | Consulting hours stomach  After appointment during consulting hours the following tests must be guaranteed within 1 week:   * endoscopy * endoscopic biopsy * chromoendoscopy * endosonography upper gastrointestinal tract * endoscopic ultrasound fine needle biopsy * Sonography: abdomen, throat * Multidetector CT: thorax, abdomen |  |
| 2.1.13.f - MG | Specialist examiner expertise:   * Endosonography upper gastrointestinal tract: evidence ≥ 30/examiner/year * Endosonography-guided fine needle aspiration: evidence ≥ 10/examiner/year (not limited to stomach)   Each of the examinations must be performed by an specialist who can demonstrate the experience required above.    Named in the table "Specialist experience - endosonograms / fine needle aspirations / ERCPs" (at the end of the section) |  |
| 2.1.13.g - MG | The following topics are to be covered in the consulting hours in particular:   * Pre-operative therapy-accompanying record-ing of malnutrition with, if necessary, targeted nutritional therapy covering the entire spectrum of nutrition. * Access to nutritional counselling (according to No. 1.9) must be ensured * genetic factors in the case of gastric cancer |  |
| 2.1.13.h - ML | Conduct of consulting hours  Specialist for internal medicine and gastroenterology  Experience in treating chronic liver disease |  |
| 2.1.13.i - ML | After appointment during consulting hours the following tests must be undertaken within one week:   * dynamic, contrast-enhanced ultrasound (CM-US), CT, (CM-CT) and MRI (CM-MRI) * tumour biopsy |  |
| 2.1.13.j - ML | LCC staging and evaluation of clinical condition   * In addition to TNM classification, the BCLC classification is to be used for the therapy stratification of the LCC. * Documentation based on the patient's medical record |  |
| 2.1.13.k - ML | Follow-up LCC after curative procedures (transplanta-tion, resection, RFA)   * According to S3-GL every 3 months in 1st year and every 3-6 month in 2nd year with biphasic CECT or dynamic MRI. * After completion of follow-up: inclusion in screening program every 6 month     Follow-up of biliary cancer after resection/ablation:  according to S3-GL biphasic CT or dynamic MRI after 4-12 weeks for the first time, in the 1st year every 3 months, in the 2nd year every 3-6 months |  |
| 2.1.13.l - ME | Consulting hours esophagus  After appointment during consulting hours the following tests must be guaranteed within 1 week:   * esophagogastroduodenoscopy with high-resolution video endoscopy (see 2.2) * bronchoscopy * chromoendoscopy oder computer-aided chromendoscopy * endosonography upper gastrointestinal tract * endoscopic ultrasound fine needle biopsy * Sonography: abdomen, throat * Multidetector CT: throat, thorax, abdomen * ENT consultation |  |
| 2.1.13.m - ME | Specialist examiner expertise:   * Endosonography upper gastrointestinal tract: evidence ≥ 30/examiner/year * Endosonography-guided fine needle aspiration: evidence ≥ 10/examiner/year (not limited to the oesopagus)   Each of the examinations must be performed by an specialist who can demonstrate the experience required above.    Named in the table "Specialist experience - endosonograms / fine needle aspirations / ERCPs" (at the end of the section) |  |
| 2.1.13.n - MA | Special Proctology Consultation hours   * At least 1 x per week * Waiting times for special consultations: < 2 weeks waiting time for a consultation appointment, < 60 minutes waiting time during consultation hour     Dispersion Diagnostics  The following examinations are obligatory within 1 week:   * Proctoscopy * Endosonography anorectal     If necessary (also within 1 week)   * CT/MRI; PET-CT (optional) * Gyn. Examination     Anal Cancer diagnostics  Access to the following procedures must be ensured:   * Rectal Endosonography * Rigid Rectoscopy * Proctoscopy     Identification and procedure for high-risk groups:  Persons at risk are to be identified, documented and, if necessary, screened as part of the admission history. Risk groups are in particular HIV-positive patients and women with HPV-related genital dysplasia. |  |

| **2.2 Diagnostics** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 2.2.1.a - CC | Qualification of diagnosticians performing colonoscopy   * Specialist in internal medicine and gastroenterology * Specialist in visceral surgery * Surgeons and internists with a qualification in colonoscopy or colonoscopy authorisation by the responsible health insurance fund |  |
| 2.2.1.b - CC | At least 2 specialists (in the practice-based sector 1 specialist with corresponding cross staff provision)   * The names of the specialists are to be given.     Experience examining physician:   * Coloscopies: 200 patients annually * Polypectomies (only loop): 25 patients annually     Listing of names in the table "Experience examining physician colorectal)  (at the end of this section) |  |
| 2.2.1.c - CC | Authorisation of new examining physicians in the last 3 years at least 200 coloscopies and 50 polypectomies (only loop). |  |
| 2.2.1.d - CC | Each coloscopy and polypectomy is to performed/supervised by an examining physician who has the above-mentioned qualifictaions and experience. |  |
| 2.2.1.e - CC | Assistance  Recognition as an assistant is possible if this is done as part of the training (no parallel recognition of cases with 2 named examiners) |  |
| 2.2.2 - CC | Performance coloscopy   * Signed declared consent * Patient monitoring   Pulse oxymetry  Documentation using surveillance sheet after examination with sedation   * Photo documentation   Completeness of the examination  (ileocecal valve, cecal pole, terminal ileum)  Polyp removal points (before - after)   * Aftercare recommendation   Timing control coloscopy |  |
| 2.2.3 - CC | Complications   * Reference to possible complications after coloscopy (information material) * Recording / evaluation complication rates |  |
| 2.2.4 - CC | Requirements coloscopy   * Full coloscopy with biopsy of each suspected spot including a rectal examination * Comparison with the results of the referrer |  |
| 2.2.5 - CC | Outpatient polyp removal   * Possibilities of stypsis * Recording of complications * Procedure for handing over non-removable polyps in office-based practices to the inpatient departments of the Colorectal Cancer Centre.   - Names of contacts  - Definition passing on of information |  |
| 2.2.6 - CC | Pathology report for adenoma   * Distinction between low-grade versus high-grade intraepithelial neoplasms * Details of completeness of removal     Pathology report for carcinoma in adenoma   * Scale of in-depth infiltration (sm-/pT category) * Degree of histological differentiation (grading) * Presence or lack of lymph vessel invasion (L classification) * Evaluation of resection margins (R classification) * Low-risk/high-risk classification |  |
| 2.2.7 - CC | Presentation in the tumour board  Each carcinoma in the adenoma must be presented in the tumour board. |  |
| 2.2.8 - CC | Communication of results polypectomy  In-person discussion/information about malignant findings (not on the phone) by coloscopy unit or GP |  |
| 2.2.9 - CC | Infrastructure/work environment   * Emergency equipment   Available emergency equipment and written action plan for emergencies   * Preparation, sterilisation and traceability of instruments   Compliance with the RKI recommendation for the preparation and sterilisation of flexible endoscopes (inter alia traceable batch documentation of preparation and sterilisation) |  |
| 2.2.10 - CC | Diagnostics  The MSI test should be carried out:   * according to the GL algorithm for positive patient questionnaires with mainly hereditary CRC (GL CRC: "Algorithm: Genetic Diagnosis and Prevention") * in patients between 50 and 60 years of age with MSI-suspected histology * for mcRC, optional for the definition of the therapeutic strategy * before adjuvant chemotherapy in stage II if indicated |  |
| 2.2.11.a - ML | Requirement contrast-enhanced ultrasound    Requirement performance:   * Specialist for internal medicine and gastroenterology * Specialist for radiology     Requirement ultra-sound enhanced ultrasound devices:   * Instrument class DEGUM level II   (<http://www.degum.de/fileadmin/dokumente/service/geraeteliste/geraeteliste_legende.html>) |  |
| 2.2.11.b - ML | Diagnosis confirmation/intrahepatic spread diag-nosis of LCC is done using  3-phase contrast-enhanced medical imaging methods:   * CM-CT or * CM-MRI (preferably, if necessary via cooperation) |  |
| 2.2.11.c - ML | Intrahepatic diagnostics for staging  Diagnostic report with details of scale and vessel infiltration:   * Number of LCC-suspicious foci (description of up to 5 foci) * Dimensions of individual foci in mm * Vessel infiltration (macroinvasion)   Diagnosis of biliary cancer   * KM-MRI/MRCP (before biliary drainage) * KM-CT * Endoscopic ultrasound * ERCP     Basis of diagnosis of biliary cancer  Mandatory histological or, if necessary, cytological basis of diagnosis before or as part of non-surgical tumour therapy |  |
| 2.2.11.d - ML | Extrahepatic Diagnostics for staging   * Performance CM-CT |  |
| 2.2.11.e - ME | Primary diagnosis   * Esophagogastroduodenoscopy: using high-resolution video endoscopy incl. HDTV resolution, chromoendoscopy, virtual chromoendoscopy) with * biopsies of all suspect lesions * Particularly in the case of Barrett mucosa: 4-Q-PEs |  |
| 2.2.11.f - MA | Qualification Proctoscopy and Endosonography anorectal   * Specialist in general or visceral surgery or * Specialist in internal medicine and gastroenterology or * Specialist in dermatology,   in each case with additional further training in Proctology according to the model further training regulations (MWBO) or European additional qualification EBSQ coloproctology    Requirement for pre-therapeutic documentation of findings:  The tumour should be delimited about its location (indicated in lithotomy position (German: SSL)), maximum diameter, perianal and intraanal extension (in cm and positional relationship to the L. anocutanea and L. dentata), mobility and with regard to infiltration of other organs, especially the sphincter apparatus and, for women, the vagina. |  |

**3. Radiology**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 3.1 - CC, MP, MG, ML, ME, MA | Specialists   * At least 1 radiology specialist * Cover arrangements with the same qualification is to be documented in writing. * Specialists and their cover staff are to be designated by name. |  |
| 3.2 - CC, MP, MG, ML, ME, MA | Radiology RTAs:  At least 2 qualified RTAs must be available and their names given. |  |
| 3.3 - CC, MP, MG, ML, ME, MA | Radiology methods/ devices to be offered   * conventional X-ray * spiral-CT * MRI (field strength at least 1.5 tesla) (only for Anal Cancer, multiparametric MRI, angulated on Anal Canal) |  |
| 3.4 - CC, MP, MG, ML, ME, MA | Standard operating procedures (SOPs) for radiology  The imaging techniques are to be described and checked once a year to ensure they are up to date. |  |
| 3.5 - CC, MP, MG, ML, ME, MA | Diagnosis  The written report of the radiologists must be available to the co-attending physicians at the latest 24 h after the test. |  |
| 3.6 - CC, MP, MG, ML, ME, MA | Continuing education/specialty training   * A training plan for medical and nursing staff is to be presented listing the planned training courses for the period of one year. * At least 1 dedicated continuing education/specialty training course for each staff member (at least 1 day a year) who carries out quality-relevant activities for the Centre. |  |
| 3.7.1 - MP, MG, ME | Availability/On-call  Presence of a radiology specialist during working hours, 24-hour on-call service outside working hours, if necessary through cooperation (including weekends and public holidays) |  |
| 3.8.1 - ML | Interventional radiology    Specialists  At least 1 radiology specialist  with proof of competence of DeGIR/DGNR (German Society for Interventional Radiology/German Society for Neuroradiology) level 2 certificate |  |
| 3.8.2 - ML | Interventional radiology must be available and reachable at the Centre's clinical site 24/7. |  |
| 3.8.3 - ML | The following procedures, along with the SOPS and the names of the responsible persons, must be available:  - TACE/TAE (60 visceral- vascular interventions in the last 3 years/interventionist in malignomas)  - Percutaneous ablations (20 percutaneous liver ablations in the last 3 years/interventional oncologist |  |
| 3.8.4 - ML | Percutaneous ablation   * Specialist for internal medicine and gastroenterology * Specialist for radiology     Implementation:   * SOP with names of responsible persons is to be documented * Pretherapeutic embolisation in line with the requirements of S3-LL LCC. * Post-interventional follow-up using CM-US, CM-CT or CM-MRI mandatory |  |
| 3.8.5 - ML | Transarterial chemoembolisation (TACE)   * SOP with names of responsible persons is to be documented * Post-interventional presentation in the tumour board within 4-12 weeks after the end of the complete cycle * Evaluation of response using modified RECIST- or/ and EASL classification |  |
| 3.9 - ME | Reachability/on-call and handling complications   * Presence of a radiology specialist with proof of competence DeGIR/DGNR level 1 certificate during working hours, a representative with the same qualifications, if necessary in cooperation, must be ensured. * 24-hour on-call service outside working hours of a radiology specialist (including weekends and public holidays) * The option of CT-guided drainage must be available 24/7. |  |

**4. Nuclear medicine**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 4 - CC, MP, MG, ML, ME, MA | The Catalogues of Requirements of the Organ Cancer Centres and Oncology Centres have a uniform table of contents.  For the Visceral Oncology Centres this section does not specify any Technical and Medical Requirements. |  |

**5. Surgical oncology**

| **5.1 Multiple organ surgical therapy** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 5.1 - CC, MP, MG, ML, ME, MA | The Catalogues of Requirements of the Organ Cancer Centres and Oncology Centres have a uniform table of contents.  For the Visceral Oncology Centres this section does not specify any Technical and Medical Requirements. |  |

| **5.2 Organ-specific surgical therapy** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 5.2.1 - CC, MP, MG, ML, ME, MA | Inpatient care  Designation of the wards (centralisation should be the goal when there are several wards) |  |
| 5.2.2.a - CC | Colorectal resection should be embedded in a multimodal perioperative management concept (mPOM). Perioperative management must be regulated in a procedure description in accordance with the S3-GL Perioperative Management of Gastrointestinal Tumours (POMGAT), which includes, among other things   * Perioperative intravenous antibiotic prophylaxis * Preoperative bowel preparation * Drainage management * Intraoperative perfusion control of the anastomosis * Management of nasogastric and transurethral bladder catheters * Pain therapy * Early mobilisation |  |
| 5.2.2.b - CC, MP, MG, ML, ME, MA | Post-operative care  Care in the following areas is to be laid down in a standard operating procedure (SOP):   * Intensive care (incl. e.g. artificial respiration, tracheotomy etc.) * Physiotherapy * Post-operative pain management * Return to normal food intake |  |
| 5.2.2.c - CC | Discharge (in case of stoma therapy)   * ~~Further outpatient care after discharge in the case of stoma therapy must be described, including the provision of information for patients.~~ * Patients should be informed about post-resection syndrome (LARS - low anterior re-section syndrome) before the first operation. * ~~If possible,~~ An outpatient consultation should be offered after stoma repositioning, in which, among other things, the LARS score is measured. * Information on behaviour with high output syndrome. |  |
| 5.2.3 - CC, MP, MG, ML, ME, MA | Surgical capacity  At least 1 operating theatre must be regularly available for surgical procedures. |  |
| 5.2.4.a - CC | Surgical expertise colorectal   * 30 surgical primary cases colon * 20 surgical primary cases rectum     If the number of primary rectal surgical cases falls below the threshold, patients listed in the Data Sheet as "Watch and Wait" can be added to the number of primary rectal surgical cases during surveillance and repeat audits. At least 17 primary surgical cases with rectal cancer must be proven.  For the definition of primary cases, see the last page of this survey form.    Data Sheet Colorectal  (Excel template) |  |
| 5.2.4.b - MP | Surgical expertise pancreas     * At least 20 pancreatic resections/year * At least 12 surgical primary cases pancreatic cancer/year     Definitions   * Primary cases   counted: adeno cancer, neuroendocrine cancer; not counted IPMNs (intraductal papillary mucinous neoplasms); for full definition see CR 1.2.0   * Surgical primary cases   Ony ICD-10 C25 in combination with OPS: 5-524\*, 5-525\* = adenocarcinoma, neuroendocrine carcinoma, NO IPMNs   * Pancreatic resections   Benign + malignant ICDs, also IPMNs; only type of surgical procedure is relevant (=left resection of the pancreas, pancreatic head resection, total pancreatectomy; OPS: 5-524\*, 5-525\*)    Data Sheet Pancreas  (Excel template)    For further explanations, see FAQ. |  |
| 5.2.4.c - MG | Surgical expertise stomach   * At least ≥ 20 surgical resections stomach/AEJ (abdominal gastrectomies, sub-total stomach resections and/or transhiatal/abdominothoracic extended gastrectomies in patients with gastric cancer or AEJ) independent of the primary case status     Definition surgical resection stomach/AEJ:  • ICD-10 C16.01, 16.1-16.9, OPS: 5-425\*, 5-426\*, 5-435\* to 5-438\*  If the centre is not certified as an esophageal cancer centre at the same time, resections according to ICD-10 C15.2 and 15.5 and 16.022 can be included (see also Chapter 1.2.0).    1 Tumours, whose centre is > 2 cm from the esophagogastric junction, are classified as stomach cancer even if the esophagogastric junction is affected.    2 Tumors that involve the esophagogastral junction and their center within the prox. 2 cm of the esophagogastral junction (proportion Siewert type I / Siewert type II) is counted as esophageal carcinoma.    Data Sheet Stomach  (Excel template)    For further explanations, see FAQ. |  |
| 5.2.4.d - ML | Surgical expertise   * 40 surgical interventions in malignant tumours of the liver (resections/transplantations)/ Centre/year * Definition resection/transplantation: 5-502\*, 5-504\* * Up to 15 atypical liver resections (OPS 5-501.0; 5-501.2) can be counted towards these 40 surgeries.     Data Sheet Liver  (Excel template)    For further explanations, see FAQ. |  |
| 5.2.4.e - ME | Surgical expertise esophagus   * At least 20 complex surgical procedures on the esophagus/year (not restricted to C15/C16.02, incl. benign diagnoses) * Definition complex surgical procedures: OPS: 5-423\*, 5-424\*, 5-425\*, 5-426\*, 5-438.0 and 1 and x     2 Tumours that affect the esophagogastric junction and whose centre is within the prox. 2 cm of the esophagogastric junction (proportion Siewert type I/Siewert type ll), are counted as esophageal cancer.    Data Sheet Esophagus  (Excel template)    For further explanations, see FAQ. |  |
| 5.2.4.f - MA | Operative expertise Anal Cancer  Definition of surgical resection: OPS 5-485\* or 5-49\*\*\*, each in combination with ICD C21 or C.44.50    Data Sheet Anal Cancer  (Excel template) |  |
| 5.2.5.a - CC, MP, MG, ML, ME, MA | Surgeons   * Basic qualification surgeon   The basic qualification is specialist for visceral surgery with additional specialty training  Special visceral surgery (from Model specialty training ordinance [Muster-WbO] 2003, status 25 June 2010). The specialist for visceral surgery with the focus on visceral surgery in line with the older Model specialty training ordinance is deemed to be equivalent. The specialist for general surgery or the specialist for visceral surgery without specialty training in line with the MWbO 2010 or later is not recognised |  |
| 5.2.5.b - CC | * or specialist for general surgery with the European qualification EBSQ Coloproctology |  |
| 5.2.5.c - MP, ML | * or specialist for general surgery with the Eu-ropean qualification EBSQ Hepato-Pancreatico-Biliary Surgery (HPB) |  |
| 5.2.5.d - MA | Anal Cancer Surgeon  Specialist in general or visceral surgery with additional training in proctology according to the model further training regulations (MWBO) or additional European qualification EBSQ coloproctology. |  |
| 5.2.5.e - CC, MP, MG, ML, ME, MA | * All patients of the Centre must be operated on directly by one of these surgeons or under his/her supervision (second surgeon). |  |
| 5.2.5.f - CC, MP, MG, ML, ME, MA | * Assistant   Recognition as assistant only possible if this is done as part of training (no parallel recognition of cases with 2 surgeons). |  |
| 5.2.5.g - CC | Colorectal surgeons   * The names of at least 2 colorectal surgeons are to be given.     Expertise for each colorectal surgeon (primary cases)  15 colon cancer a year  10 rectal cancer a year    Authorisation of new colorectal surgeons in the previous 3 years cumulative at least 20 rectal and at least 30 colon cancer as leading surgeon (proof of competence based on surgical reports).    Names listed in the table "colorectal surgeons" (at the end of this section) |  |
| 5.2.5.h - CC | Senior colorectal surgeon (optional/alternative)   * Maximum 1 senior colorectal surgeon for each Centre (not clinical site) * Application for qualification evaluation is to be submitted to OnkoZert. * Appointment made under the responsibility of the Centre (precondition - positive qualification evaluation by OnkoZert) * Annual rotation possible |  |
| 5.2.5.i - CC | Expertise senior colorectal surgeon (primary cases)   * On appointment  45 colon cancer and 30 rectal cancer in the previous 5 years * On extension Valid qualification certificate 5 years; requirement for extension 45 colon cancer and 30 rectal cancer in the previous 5 years |  |
| 5.2.5.j - MP | Pancreas surgeon   * The names of at least 2 pancreas surgeons are to be given (pancreas surgeon can also be colorectal, oesophageal, stomach, liver or anal cancer surgeon)   Expertise of each pancreas surgeon   * 10 pancreatic resections a year   Authorisation of new pancreas surgeons   * In the previous 3 years cumulative at least 20 pancreatic resections as leading surgeon     Names given in the table "Pancreas surgeons" (at the end of this section) |  |
| 5.2.5.k - MG | Gastric surgeon   * The names of at least 2 gastric surgeons are to be given (gastric surgeon can also be colorectal/pancreas, oesophageal, liver or anal cancer surgeon)     Expertise for each gastric surgeon   * ≥ 10 surgical resections for gastric carcinoma/AEJ a year     Authorisation of new gastric surgeons   * In the previous 3 years cumulative at least 15 surgical procedures for gastric carcinoma as leading surgeon |  |
| 5.2.5.l - ML | Liver surgeon   * The names of at least 2 liver surgeons are to be given (liver surgeon can also be colorectal , pancreas,gastric,oesophageal, anal cancer surgeon)      * Authorisation of new liver surgeon In the previous 3 years cumulative at least 20 surgical liver interventions (not just LCC) as leading surgeon: typical liver resections (5-502\*), liver transplantation (5-504\*) |  |
| 5.2.5.m - ME | Esophagus surgeon   * The names of at least 2 esophagus surgeons are to be given (esophagus surgeon can also be colorectal , pancreas,gastric,liver,oesophageal surgeon) * Expertise for each esophagus surgeon ≥ 10 complex surgical procedures on the esophagus/year (OPS: 5-423\*, 5-424\*, 5-425\*, 5-426\*, 5-438.0 and 1 and x) * Authorisation of new surgeons: In the previous 3 years cumulative at least 10 complex surgical procedures on the esophagus as first surgeon     Named in  Table "colorectal surgeons"  (at the end of this section) |  |
| 5.2.5.n - MA | At least 2 anal cancer surgeons must be named (anal cancer surgeon can also be a co-lon/pancreas/stomach/liver/ esophagus surgeon).    Named in  Table "colorectal surgeons"  (at the end of this section) |  |
| 5.2.6 - CC, MP, MG, ML, ME, MA | Emergency treatment   * Emergency treatment (e.g. bowel obstruction, bleeding) is to be laid down in a standard operating procedure (SOP). * Shift planning for qualified staff (roster/on call rota) |  |
| 5.2.7.a - CC | Surgically removed lymph nodes  The right oncological decision is to operate (inter alia at least 12 lymph nodes). Any deviation from this is to be discussed with the pathologist. |  |
| 5.2.7.b - MP | The right oncological decision is to operate (inter alia at least 12 regional lymph nodes.) Any deviation from this is to be discussed with the pathologist. |  |
| 5.2.7.c - MG | * The operation should be performed oncologically correctly (including at least 16 regional LNs). If there is any deviation from this, this must be discussed with the pathologist. * D2 lymphadenectomy: ≥ 25 lymph nodes |  |
| 5.2.7.d - ME | Lymph nodes  Two-field lymphadenectomy: ≥ 20 lymph nodes in patients receiving no neoadjuvant therapy |  |
| 5.2.8 - CC, MP, MG, ML, ME, MA | Induction of new staff members  Systematic, documented induction of new staff members is to be ensured, which imparts knowledge about the Oncology Centre's respective field of activity.  This induction must take place within three months of commencement of employment. |  |
| 5.2.9 - CC, MP, MG, ML, ME, MA | Information/dialogue with patient:  Adequate information must be provided about diagnosis and therapy planning and a dialogue is to be entered into. This includes inter alia:   * Presentation of alternative treatment concepts * Offer of and ~~aid~~ support in obtaining second opinions * Discharge consultation as a standard procedure     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. |  |
| 5.2.10 - CC, MP, MG, ML, ME, MA | Continuing education/specialty training   * A training plan for medical and nursing staff is to be presented listing the planned training courses for the period of one year. * Every year at least 1 dedicated continuing education/specialty training session for each staff member (at least 1 day a year) who carries out quality-relevant activities for the Centre. |  |
| 5.2.11.a - MG, ME | Endoscopic resection (endoscopic submucosal dissection (ESD/endoscopic mucosal resection (EMR)/ total wall excision)     * should be offered as an option in the case of gastric carcinoma T1a, N0, M0 as an en bloc resection. * should be performed, in the case of HGIEN or mucosal carcinoma (L0, V0, G1/2, without ulcerations) in the Barrett esophagus as full endoscopic resection * should be performed, in the case of HGIEN or mucosal carcinoma (L0, V0 no ulcerations, G1/2, sm1/m2) in the squamous epithelium as an endoscopic en bloc resection.     For the esophagus module, the option of offering endoscopic therapy is mandatory, for the stomach module it is optional.    For performance the following applies:  Specialist for   * Gastro-enterology * Visceral surgery with additional specialty training   Special visceral surgery (Model specialty training ordinance (Muster-WbO) 2003, status 25 June 2010 or specialist for visceral surgery in line with older MWBO) The specialist for general surgery or the specialist for visceral surgery in line with the MWbO 2010 or later is not recognised. |  |
| 5.2.11.b - MG, ME | Expertise for each endoscopic surgeon:   * Endoscopic en-bloc resections stomach or endoscopic resection esophagus ≥ 30 resections cumulative total and * 3 endoscopic en bloc resections or endo-scopic resections of esophagus/stomach/year (Proof of competence based on surgical /endoscopy reports as first surgeon or assistant, as trainer; no parallel recognition of cases with 2 surgeons/endoscopic surgeons) * Inpatient follow-up surveillance after endoscopic en bloc resection * Aftercare after endoscopic en bloc resection for Pt1a, N0, M0 in line with LL     For further explanations, see FAQ. |  |
| 5.2.11.c - MG, ME | The following SOPS are to be described with details of responsibilities:   * Carrying out of stenting * Thermal ablation (not stomach) * Laying of an alimentary fistula * Available emergency equipment and written action plan for emergencies * Preparation, sterilisation and traceability of instruments Compliance with the RKI (=Robert Koch-Institut) recommendation for the preparation and sterilisation of flexible endoscopes (inter alia traceable batch documentation of preparation and sterilisation) * Availability/On-call * Presence of an endoscopy medical specialist for radiotherapy during working hours, 24-hour on-call service outside working hours, if necessary through cooperation (including weekends and public holidays) including the possibility of stenting |  |
| 5.2.11.d - ME | Aftercare after endoscopic resection for HGIEN and early carcinoma:   * after endoscopic therapy regular control endoscopies should be performed (after 3 months, then every six months for 2 years and thereafter once a year). * The SOP and the responsible persons are to be described. |  |

**6. Medicinal oncology/ Systemic therapy**

| **6.1 Medical oncology** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 6.1 - CC, MP, MG, ML, ME, MA | The Catalogues of Requirements of the Organ Cancer Centres and Oncology Centres have a uniform table of contents.  For the Visceral Oncology Centres this section does not specify any Technical and Medical Requirements. |  |

| **6.2 Organ-specific systemic therapy** | | |
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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 6.2.1 - CC, MP, MG, ML, ME, MA | Physicians' qualifications  Specialist for internal medicine and haematology and oncology or specialist for internal medicine and gastroenterology or specialist for radiotherapy  The radio-oncologist can perform chemotherapy in conjunction with radio-chemotherapy concepts.    The name of one representative with the above-mentioned qualification is to be given.    The specialists named here must actively carry out the medicinal tumour therapy. The delegation of responsibilities to physicians without the above-mentioned qualification is not possible. |  |
| 6.2.2 - CC, MP, MG, ML, ME, MA | Specialist nurse (outpatient/inpatient)  Requirements for a specialist nurse who is responsible for administering chemotherapy:   * at least 1 year's professional experience in oncology * 50 chemotherapy administrations/year are to be documented (In the case of initial certification an estimate can be given, in the following years this must be documented in the audit). * documentation of training in line with the recommendations of the Conference of Oncological Nursing and Paediatric Nursing Care (Konferenz Onkologischer Kranken- und Kinderkrankenpflege - KOK) (KOK recommended actions, administration of cytostatics by specialised nurses) * active involvement in the implementation of the requirements to be met by emergency treatment and therapy of comorbidities and secondary diseases * nursing counselling and/or education of patients is to be documented. |  |
| 6.2.3 - CC, MP, MG, ML, ME, MA | On call/reachability medical staff   * 24-hour outside normal working hours including weekends and public holidays * During 24-hour reachability access to therapy data must be possible. |  |
| 6.2.4.a - CC, MP, MG, ML, ME, MA | Case numbers per treatment unit   * Calculation method: completed systemic / cytostatic / targeted therapy per patient (consisting of several cycles or applications, combined therapies count as one therapy). For therapies lasting over a year, the therapy started in the audit year counts. 1 therapy per patient = 1 therapy line per disease per patient. * In the event of a shortfall, expertise cannot be documented via cooperation (must be documented for each individual treatment unit).     At least 200 drug tumour therapy sessions (cytostatic therapies and / or targeted therapeutics and / or AB / immune therapies, no hormone therapies) a year **or**    For further explanations, see FAQ. |  |
| 6.2.4.b - CC | at least 50 patients with a specific indication (colon/rectum) |  |
| 6.2.4.c - MP | at least 20 patients with a specific indication (pancreas) |  |
| 6.2.4.d - MG | at least 20 patients with indication gastric cancer/AEJ tumour |  |
| 6.2.4.e - ME | at least 20 patients with indication esophageal cancer |  |
| 6.2.5 - CC, MP, MG, ML, ME, MA | Structural details per treatment unit   * Number of therapy places outpatient * Number of therapy places inpatient |  |
| 6.2.6 - CC, MP, MG, ML, ME, MA | Basic diagnosis laboratory  Basic diagnosis including emergency laboratory must be possible 24 h. If laboratory is not staffed 24 h, written rules/agreement for 24 h emergency laboratory are required. |  |
| 6.2.7 - CC, MP, MG, ML, ME, MA | Basic diagnosis medical imaging  Cooperation for ultrasound and radiological emergency and routine diagnosis If medical imaging is not staffed 24 h, written rules/agreement for 24 h emergency diagnosis is required. |  |
| 6.2.8 - CC, MP, MG, ML, ME, MA | ~~Treatment plan / tumour board protocol~~   * ~~The therapeutic procedure should be based on the treatment plans or recommendations of the tumour board.~~ * ~~The treatment plan / tumour board protocol must be available in the patient-related documentation.~~ * ~~If there is a deviation from the recommended treatment plan, this must be presented in the tumour board.~~ |  |
| 6.2.9 - CC, MP, MG, ML, ME, MA | Systemic therapy regimens   * The drawing up of / changes to existing therapy regimens must be undertaken by means of regulated release. * Prior to release or changes to therapy regimens, the expert opinion of pharmacists can be sought. * The therapy regimens are to be protected from any unauthorised changes. * The therapy regimens are comparable between the outpatient and inpatient units.     Therapy plans   * All systemic therapy must be planned on the basis of a therapy regimen. * The therapy plans are to be checked and released. |  |
| 6.2.10 - CC, MP, MG, ML, ME, MA | Cytostatic preparation   * Production is undertaken with due consideration of statutory provisions (inter alia Medicinal Products Act (AMG), GMP, GCP, Eudralex (Volume 10) in a pharmacy. If it is not part of the facility, a care agreement must be entered into. * It must be possible to speak to the pharmacy during the period in which therapy is administered. 24-hour on-call service is required for inpatients. * Standard operating procedures (SOPs) are to be drawn up for production. |  |
| 6.2.11 - CC, MP, MG, ML, ME, MA | Standard operating procedures (SOPs)   * The SOP for medicinal oncological therapy is to be described for all phases (start, conduct and conclusion of therapy). * Supportive measures in accordance with the guidelines are to be described for the individual therapy concepts and documented in detail for each patient. |  |
| 6.2.12 - CC, MP, MG, ML, ME, MA | 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. |  |
| 6.2.13 - CC, MP, MG, ML, ME, MA | Emergency treatment  Available emergency equipment and written action plan for emergencies |  |
| 6.2.14 - CC, MP, MG, ML, ME, MA | Case-related information/dialogue with patient  Adequate information must be provided about diagnosis and therapy planning and a consultation is to be given. This includes inter alia:   * Presentation of alternative treatment concepts * Offer of and ~~aid~~ support in obtaining second opinions * Discharge consultation as a standard procedure     Patient consultations are to be documented for each patient in medical reports or in other minutes/records. |  |
| 6.2.15 - CC, MP, MG, ML, ME, MA | Information therapy administration/planning  After each administration of systemic therapy, the patient and/or the physician responsible for further treatment are given information about the current therapy status and the next steps (blood test, ...), e.g. via the aftercare pass.    Preparation medical report  After the completion of systemic therapy (last administration) the physician responsible for further treatment or the co-attending physician is given the final report within 7 days. |  |
| 6.2.16 - CC, MP, MG, ML, ME, MA | Induction of new staff members  Systematic, documented induction of new staff members is to be ensured, which imparts knowledge about the Oncology Centre's respective field of activity.  This induction must take place within three months of commencement of employment. |  |
| 6.2.17 - CC, MP, MG, ML, ME, MA | Continuing education/specialty training   * A training plan for medical and nursing staff is to be presented listing the planned training courses for the period of one year. * At least 1 dedicated continuing education/specialty training course for each staff member (at least 1 day a year) who carries out quality-relevant activities for the Centre. |  |

**7. Radio-oncology**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 7.0 - CC, MP, MG, ML, ME, MA | The Technical and Medical Requirements to be met by radio-oncology are summed up in the "Catalogue of Requirements Radio-Oncology" in a cross-organ manner. Independently of the number of Organ Cancer Centres / Modules, which work with a radio-oncology unit, this "Cata-logue of Requirements Radio-Oncology" is only to be processed once and also only updated once per audit year (goal: no multiple presentations or on-site inspections within one audit year). The "Catalogue of Requirements Radio-Oncology" therefore constitutes an annex to this Catalogue of Requirements.    Download cross-organ "Catalogue of Require-ments Radio-oncology" on <www.ecc-cert.org> and <www.onkozert.de>. |  |

**8. Pathology**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 8.0 - CC, MP, MG, ML, ME, MA | The Technical and Medical Requirements to be met by pathology are summed up in the "Catalogue of Requirements Pathology" in a cross-organ manner. Independently of the number of Organ Cancer Centres / Modules, which work with a pathology, this "Catalogue of Requirements Pathology" is only to be processed once and also only updated once per audit year (goal: no multiple presentations or on-site inspections within one audit year). The "Catalogue of Requirements Pathology" therefore constitutes an annex to this Catalogue of Requirements.    Download cross-organ "Catalogue of Requirements Pathology" on <www.ecc-cert.org> and <www.onkozert.de>. |  |

**9. Palliative care and hospice care**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 9.1 - CC, MP, MG, ML, ME, MA | * Documentation is to be provided of cooperation agreements with service providers offering specialist outpatient and inpatient palliative care and inpatient hospices. Regional care concepts for the integration of palliative care are to be described on the basis of the treatment pathway for patients and family members from the S3 Guidelines Palliative Medicine (Figure 3, p. 174) with the names of all involved persons. * A physician with additional specialty training must be available for consultations and tumour boards. * The group of patients with incurable cancer is to be defined. They are to be informed in a timely manner about palliative medical support services (SOP). * To identify the treatment requirement, it is necessary to carry out a screening to record symptoms and stress (see S3 guideline on palliative care)(e.g. MIDOS, iPOS). * The access to palliative care can be offered in parallel to tumour-specific therapy. The procedure in the Centre is to be described in an SOP. * The number of primary cases with incurable cancer is to be documented. |  |

**10. Tumour documentation / Outcome quality**

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| **Section** | **Requirements** | **Explanatory remarks by the Cancer Centre** |
| 10.1 - CC, MP, MG, ML, ME, MA | Requirements tumour documentation    Tumour documentation, which contains the patient data for a minimum period of 3 months, must be in place at the time of initial certification.    Name of the tumour documentation system in a cancer registry and/or Centre    A data set must be used in line with the Uniform Oncological Basic Data Set and the modules of the Working Group of German Tumour Centres (ADT) and the Association of Population-based Cancer Registries in Germany (GEKID).  The Centre must ensure that data are transferred to the competent cancer registry in a timely manner. Any existing regional laws for notification deadlines are to be complied with. |  |
| 10.2 - CC, MP, MG, ML, ME, MA | Period covered by the data  The full data are to be presented for the respective last calendar year. |  |
| 10.3 - CC, MP, MG, ML, ME, MA | Cooperation with cancer register   * Cooperation with the competent 65c cancer registry is to be documented on the basis of the cooperation agreement. * The OncoBox is to be fed by the competent cancer registry. The full data are to be made available to the cancer register in an ongoing manner. * The presentation of the Catalogue of Re-quirements and outcome quality should be ensured via the cancer registry to the extent that this information is of relevance for the cancer registry. * As long as the competent cancer registry is unable to meet the requirements imposed, the Centre is to use additional or alternative solutions. The Centre is responsible in the case of a non-functioning external solution. If the responsible cancer registry is unable to provide the follow-up data, the cancer registry and centre should explain in writing why the data cannot be provided.     For further explanations, see FAQ. |  |
| 10.4 - CC, MP, MG, ML, ME, MA | Documentation officer  The name of at least 1 documentation officer is to be given, name/function:    Tasks documentation officer:   * Ensuring and monitoring the timely, full, complete and correct transfer and quality of the patient data that are relevant for certification by all cooperation partners to the cancer registry. * Motivation of trans-sectoral cooperation with participating specialty units in the cancer registry (pathology reports, radiotherapy and medicinal treatments). * Qualification and support for the staff involved in data collection * Regular analysis of evaluations particularly over the course of time. |  |
| 10.5 - CC, MP, MG, ML, ME, MA | Provision of resources:  The required staff capacity should be made available (for instance 0.5 full-time position for 200 primary cases and 0.1 full-time position for 200 aftercare cases) to perform the documentation tasks and to record data (e.g. by a cancer registry). |  |
| 10.6 - CC, MP | Selection options  The tumour documentation system must offer the following selection options:   * Cohorts * TNM classification or comparable classifications and prognosis factors * Forms of therapy (surgical therapy, radiotherapy, hormone therapy, immunotherapy, chemotherapy) * Date of recurrence/metastasis * Deaths * Follow-up status (latest update) |  |
| 10.7 - CC, MP | Indicators for outcome quality/scale of aftercare data:    Kaplan-Meier curves:   * Overall survival (OAS) for all patients in sub-groups by pT categories, stages * metastasis-free survival for all patients and subgroups * Progression-free survival or disease-free survival for all patients and subgroups * Local recurrence rate for all patients and for subgroups * Survival after progression (PDS)      * At the start all cohorts are to be grouped together (3 years). In the case of larger patient numbers and outcome numbers, several cohorts can be evaluated separately. * A table with patient numbers and survival data is a component of each Kaplan-Meier curve. |  |
| 10.8 - CC, MP, MG, ML, ME, MA | Data evaluation   * The depiction of outcome quality (see point above) must be possible for re-certifications. * The data in the tumour documentation system are to be evaluated at least once a year in line with the corresponding parameters. * If benchmarking/an annual report is offered, the benchmarking results are to be taken into account in the analysis. * Concrete actions are to be derived from the analysis. * The discussion of results must be done in an interdisciplinary manner and in cooperation with the Centres in the network within the Visceral Oncology Centre. |  |
| 10.9.1 - CC, MP | Requirements for the follow-up of patients recorded in the matrix Outcome quality    (valid from first surveillance audit after first re-certification) |  |
| 10.9.2 - CC, MP | Minimum requirement for successful recertification  ≥ 80 % |  |
| 10.9.3 - CC, MP | Recertification or maintenance of certification only possible subject to conditions (e.g. reduced validity term, concept for increasing the return rate).  60 – 79 % |  |
| 10.9.4 - CC, MP | Certification was not reconfirmed or maintained.  < 60 % |  |

**Data Sheet**

A Data Sheet (EXCEL template) is available for presenting the Basic Data, indicators and other data from the Centre. The Data Sheet is an appendix to the Catalogue of Requirement.

The EXCEL template can be downloaded from <http://ecc-cert.org/> and [www.onkozert.de](http://www.onkozert.de/)

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| **Period** | General information for processing the annex   * The actual current values are to be given (no estimates). * Data must normally refer to a calendar year. * Data may be no older than 1 year (data from 2008 are not acceptable for an audit in 2011). * if the "target values" are not achieved for one point, then an explanation is to be given at the corresponding spot in the Catalogue of Requirements | Definition period initial certifications   * At the time of initial certification, the data must be available at least for a period of 3 months (an entire year is ideal); in the case of information on primary cases (CR 5.2.4), surgical procedures per surgeon (CR 5.2.5) and experience of examining physicians (CR 2.2.1), the data for an entire year are always needed * If a full calendar year is not depicted, the period may be more than 4 full months beforehand (based on the certification date). * The selected period must consist of full months (if possible select full quarters) |

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| **Primary case definition**  - Colorectal - |  |  |
| Total primary cases for the Colorectal Cancer Centre are the sum of the types of primary cases given below.   * Malignant diagnosis (adenocarcinoma) must be available * Requirements tumour board, tumour documentation and aftercare are valid in full.   Types of primary cases   * only endoscopic * surgical * palliative (not surgical) * watch and wait (not surgical curative, not endoscopic) | Primary case definition (only endoscopic)   * No additional surgical tumour removal * Time of counting endoscopic removal   Primary case definition (surgical)   * Malignant first diagnosis rectum (up to 16 cm from an cutaneous line)/colon * Resecting surgical care (stoma installation alone is not sufficient) * Transanal total wall excision * Time of counting = date of surgical tumour removal   Primary case definition palliative (not surgical)   * No surgical tumour removal planned * Time of counting is date of histology report   Primary case definition watch and wait   * Watch and wait patients have newly diagnosed rectal carcinomas which are not initially going to undergo surgical treatment after radiotherapeutic and/or chemotherapeutic pre-treatment in the case of full clinical remission. When these patients undergo secondary surgery in the event of tumour recurrence or for other reasons, they count as surgical primary cases. * Time of counting is date of histology report | The following, *inter alia*, are not recognised as surgical primary cases:   * Anal cancer * Palliative bypass surgery * High-grade intraepithelial neoplasms * Palliative stoma installation * Neoadjuvant chemotherapy (tumour has still to be removed surgically) * Port implantation (tumour has still to be removed surgically) * Recurrence * Metastasis surgery |

1. http://www.bmg.bund.de/fileadmin/dateien/Downloads/N/Nationaler\_Krebsplan/Ziel\_5-Nationaler\_Krebsplan.pdf [↑](#footnote-ref-1)