FAQs

Catalogue of Requirements for Gynaecological Cancer Centres

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

Chairs of the Certification Committee: Prof. Dr. M.W. Beckmann, Prof. Dr. C. Dannecker

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

Version FAQs and Catalogue of Requirements (CR)

Version status FAQ: 27 November 2025

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

Overview of FAQs

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18	Details in pathology report in the case of lymphonodectomy (Vulvaca.)	27.08.2019
19	Details in pathology report in the case of first diagnosis and tumour resection (Vulvaca.)	22.08.2025
20	Details in pathology report in the case of lymphonodectomy (Vulvaca.)	22.08.2025
22	POLE examination (endometrial cancer)	22.08.2025
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FAQs - Catalogue of Requirements Gyn

1.1 Structure of the network

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

1.2 Interdisciplinary cooperation

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

1.2 Interdisciplinary cooperation

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

1.4 Psycho-oncology

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.4.2 b	Documentation and evaluation To identify treatment needs it is necessary to conduct standardised screening for mental strain (see Indicator "Psycho-oncological distress screening"), and to document the result. The proportion of patients with excessive stress in the distress screening should be presented. Psycho-oncological counselling Psycho-oncological care, in particular for patients with excessive stress in the distress screening, must be presented.	FAQ (21.07.2016) Can an on-site contact replace screening? Answer: No. In order to identify the need for treatment, it is necessary to carry out a **standardised** screening for psychological stress (see S3 guideline Psychooncology: e.g. Disress-Thermometer or HADS) and to document the result. FAQ (28.08.2023) How should the proportion of patients with excessive distress in distress screening and further psycho-oncological care be presented? Answer: The number of screened patients who have shown an excessive test should be described. The processes of psycho-oncological care should be described; the number of counselling sessions carried out should be recorded.	

1.6. Patient involvement

Section	Requirements	Explanatory remarks by the Cancer Centre
1.6.7	Event for patients An information event for patients is to be staged by the Gynaecological Cancer Centre at least once a year. If patient events are (co-)financed by industry, this fact including potential conflicts of interest of the speakers must be disclosed. The centre must rule out any direct influence on patients by industry representatives.	FAQ (26.05.2023) How can the centre prove the exclusion of direct influence by industry representatives? Answer: Proof can be provided, for example, via internal compliance rules or, alternatively, via a self-declaration by the centre. In this, the centre should provide information on free access to the event, excluding the industry exhibition/information stands and remarks on contact between industry representatives and patrons.

1.7 Study management

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
1.7.5 c	Proportion study patients 1. Initial certification: At the time of initial certification ≥ 1 patients must have been included in the studies. 2. After one year: at least 5% of the primary case number All study patients can be taken into account when calculating the study rate (share study patients based on the Centre's primary case number). Only the inclusion of patients in studies with an ethical vote counts as study participation (non-interventional/diagnostic studies are also recognised).	FAQ (28.01.2022) Do patients with gynaecological tumours who were enrolled in the Heredi-CaRe study count towards the gynaecological cancer centre's student quota? Answer: For the counting of HerediCaRe patients (proof of study participation required), exclusive use of the checklist and referral of the patients to an FBREK centre is not sufficient. FAQ (10.02.2022) Can negatively screened study patients be counted? Answer: Patients who have signed a informed consent form for screening for study participation can be counted for the numerator of the respective study indicator, even if the results of screening examinations performed with special diagnostics (no routine diagnostics) do not allow the patients to participate in the study. FAQ (25.07.2022) Can studies with an ethical vote but without patient informed consent - e.g. patient surveys - be counted? Answer: No, these cannot be counted. FAQ (28.08.2023) Can patients referred to a Centre for Personalised Medicine (CPM) for the purpose of complex diagnostics, interdisciplinary consultation and individual therapy recommendations who participate in a study there be counted towards the study quota of the sending centre? Answer: Yes, in this case the study inclusion can be counted by both the sending centre and the CPM. The other requirements for study inclusion according to the survey form will apply.	
	General preconditions for the definition of the study quota: • Patients can be counted once per study, time: Date of patient consent • All patients of the Centre can be counted • Patients that are included in several studies at the same time, can be counted several times • Study patients can be counted for 2 centres, provided that the sending centre itself conducts at least one study for patients of the Gynaecological Cancer Centre. If this method of counting is chosen (optional), the centre must show how many patients are brought into studies at the centre itself, sent to other centres/clinics for study participation and taken over from other centres/clinics for study participation. • Registry studies can be counted if an ethics vote and a study plan with a defined research question are available. • Prevention/screening studies of the **own** dysplasia consultation/unit can be counted for the own Gynaecological Cancer Centre..		

2.1 Consulting hours

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
2.1.7	Hereditary stress Cooperation with certified centres for familial breast and ovarian cancer (FBREK centres) for counselling and genetic testing must be demonstrated in writing in accordance with the	FAQ (26.05.2023) Does the non-fulfilment of the requirement "Cooperation with certified centres for familial breast	

2.1 Consulting hours

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
	FBREK (familial breast and ovarian cancer) co-operation agreement of the vdek (=Association of substitute health insurance funds) Check lists to record hereditary stress are to be applied in the case of: • Patients with breast/ovarian cancer (mainly familial breast/ovarian cancer) • Patients with endometrial cancer (EC) (mainly HNPCC/Lynch syndrome The current check lists and the algorithm can be downloaded from this Link in the section Gynaecological types of cancer. If you encounter any contractual issues, please contact the office of the German Consortium for Familial Breast and Ovarian Cancer at dk-fbrek@uk-koeln.de.	and ovarian cancer (FREBK centres) for counselling and genetic testing must be demonstrated." result in a deviation? Answer: A written cooperation with an FBREK centre must be bindingly proven. FAQ (22.08.2025) Hereditary predisposition check list: Why is the line '*unilateral or bilateral breast cancer in the patient (male)*' listed twice? Answer: The line '*unilateral or bilateral breast cancer in the patient (male)***' was included because, with a weighting of 2 and in combination with a 'woman with breast and/or ovarian cancer' in the family, it corresponds to the EBM '*unilateral or bilateral breast cancer in a patient and additionally breast and/or ovarian cancer in a female patient*'. The line '*unilateral or bilateral breast cancer in the patient (male)**' corresponds to the criterion that only applies in cooperation with certified FBREK centres and which they validate within the framework of knowledge-generating care.	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
5.2.1	Specialists for the Gynaecological Cancer Centre • At least 2 specialists for gynaecology with the focus designation Gynaecological Oncology in line with the staffing schedule working for the Gynaecological Cancer Centre • The names of the specialists are to be given. Initial certification: At least 1 specialist for gynaecology with the focus designation Gynaecological Oncology. A second specialist for gynaecology should be undergoing specialty training for the focus designation Gynaecological Oncology. This must have been successfully concluded before recertification (after 3 years) and notified. A concept for the training of gynaecological oncology specialists must be available. In addition, the doctors undergoing training (+ proof of logbook) should be named. Deviations should be justified.	FAQ (14.07.2016) What is the procedure to be followed in the event of the departure/absence of the second focal point holder? Answer: If no second focal point holder is available for the centre after re-certification (e.g. departure/absence), the replacement must take place within 12 months of the date of departure/absence. FAQ (14.07.2016) What should be done if there is no evidence of a second focal point holder at the time of recertification? Answer: It must be proven that activities to establish a second focal point holder took place after the initial certification (e.g. new appointment, training, ...). The reasons for the lack of a second focal point holder must be explained by the centre in a writ-	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
		ten statement prior to re-certification. On the basis of this statement, a decision is made as to whether admission to the audit is possible. In general, if there is no second focal point holder, the certificate can only be extended by 12 months (proof of second focal point holder is a prerequisite for extension). FAQ (12.10.2017) According to Chapter 5.2.1 of the data collection form, two specialists with a specialisation in gynaecological oncology must be shown in the staffing plan in relation to their work in the Gynaecological Cancer Centre. How is the specification "according to the staffing plan in activity for the Gynaecological Cancer Centre" to be understood? What scope of activity is to be demonstrated? Answer: This formulation means that both specialists must regularly work for the Gynaecological Cancer Centre, which also takes into account deputising arrangements (guideline: 0.5 HC/specialist with a focus on the Gynaecological Centre). A substitute on an hourly basis is not sufficient. For a positive evaluation, a concrete description of the activities of the specialist with a specialisation is required (detailed naming in the questionnaire). At the time of re-certification, the involvement of the second specialist with a speciality must be proven for at least three months. FAQ (26.05.2023) Can the "Optional further training in special surgical gynaecology" according to the (model) further training regulations (MWBO) 1992 be recognised in terms of the specialisation in gynaecological oncology? Answer: Yes, it can be recognised if it is recognised as equivalent by the State Medical Association. There must be at least 1 specialist in Gynaecology with a specialisation in Gynaecological Oncology.	
5.2.6 b	Number of surgeries per named operator: 20 surgeries a year, also possible when senior surgeon supervises surgery as an assisting surgeon. All surgical cases of the GC must be operated on by designated surgeons (first surgeon or as training assistant).	FAQ (26.05.2023) How are the surgeries to be counted for the surgeons? Answer: All surgeries that are counted for the implementation of indicator 7 (operated cases with genital malignancy) can be assigned to 1 surgeon. Any difference between the sum of "Operations per	

5.2 Organ-specific surgical therapy

Section	Requirements	Explanatory remarks of the Gyn. Cancer Centre	
		named surgeon" and the "Operative cases" indicator must be explained (e.g. surplus from the year before the indicator year). FAQ (15.05.2019) Who can be appointed as an operator? Answer: A gynaecology specialist who fulfils the quantitative requirements (at least 20 operations per year) and is at least in further training to become a specialist (proof of expertise: certificate from the head of the centre). FAQ (26.05.2023) Is there a specification as to which surgical procedures can be counted? - E.g. laparoscopy with PEs to secure an advanced ovarian carcinoma (1) - lymph node staging for cervical carcinoma as a surgical case if followed by radiotherapy (2) - HSK/ curettage for endometrial cancer (3)? Answer: For 1) and 2): Counts as a surgical case, To 3): Does not count if only on the basis of diagnosis.	

6.2 Organ-specific medicinal oncological therapy

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

8 Pathology

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

FAQs - Indicator Sheet Gyn

Basic Data Columns A-I:

FAQ (14.07.2016)
Do **dysgerminomas of the ovary** and **sarcomas** count as other carcinomas?
Answer:
Yes.

FAQ (14.07.2016)
What counts as **non-cancerous ovaries**?
Answer:
Germ cell tumours and germ cell stromal tumours.

FAQ (12.10.2017)
Does carcinosarcoma of the ovary count as ovarian carcino-men or as other tumours?
Answer:
Other tumours.

FAQ (12.10.2017)
Does a **malignant melanoma of the vulva** count as a primary case for the Gyn. Cancer Centre?
Answer:
No, it cannot be counted.

FAQ (21.08.2018)
Does **basal cell carcinoma of the vulva** count as a vulvar carcinoma?
Answer:
Yes, it counts as a vulvar carcinoma. Only for code 26 (inguinofemoral staging) it is not counted according to the definition of the code.

FAQ (21.08.2018)
Do **dermoid cysts of the ovary** (ICD-O-M 9084/0) count as primary cases for the Gyn. Cancer Centre?
Answer:
No, these cannot be counted.

FAQ (23.07.2025)
Does malignant mixed müllerian tumour count as other carcinoma?
Answer:
No. It should be classified as endometrial carcinoma.

FAQ (12.10.2017)
Do **borderline tumours of the ovary** also include those with the dignity "uncertain behaviour (ICD-10 D39.1)?
Answer:
Yes, these are counted as BOT.

FAQ (12.10.2017)
Do operated patients with ovarian cancer without R0 resection have to be shown in column D "**Not complete surgery**"?Answer:
No. Patients with definitive surgery and R1 resection are to be shown in column E "Definitive surgery = staging surgery". In column D "Incomplete surgery", only those patients are shown who prove to be inoperable during the surgical intervention.

FAQ (14.11.2017)
Can primary **peritoneal carcinomas** (ICD-10 C48) be counted as primary cases?
Answer:
Yes.

FAQ (27.08.2019)
Is it sufficient if the **recurrence of an ovarian carcinoma** is diagnosed solely on the basis of a resurgent tumour marker and imaging suspicion of a recurrence, or is histological confirmation always required as well?

Answer:
In the case of ovarian carcinoma, imaging and/or tumour markers are sufficient; histological confirmation is not obligatory.

FAQ (29.06.2020)
Can patients with **SEIC** (serous endometrioid in-traepithelial carcinoma) be counted for the Gyn. Cancer Centre be counted?
Answer:
Yes, they can be counted.

FAQ (02.07.2020)
Can **extramammary Paget's disease of the vulva** be counted as a primary case?
Answer:
No, it cannot be counted.

FAQ (17.08.2021)
Does a **goiter carcinoid of the ovary** (morphology code: 9091/1) count as "other cases"?
Answer:
No, it does not count because it is benign.

FAQ (17.08.2021)
Does a **granulosa cell tumour of the ovaries** count as a primary case?
Answer:
A granulosa cell tumour with ICD-O-M 8620/1 does not count, only the malignant granulosa cell tumour with ICD-O-M 8620/3. The latter counts as "other cases".

FAQ (17.08.2021)
How should a **bilateral mucinous ovarian carcinoma**, one with a **proportion of borderline tumour**, be documented in the indicator sheet?
Answer:
The patient is evaluated as one primary case despite the fact that she has both tumours. The FIGO stage of the mucinous ovarian carcinoma and not the borderline tumour is decisive for the entry in the data sheet.

FAQ (17.08.2021)
Does an **angiomyxoma of the vulva** count as a primary case?
Answer:
No, only inv. Neoplasms of the female genital tract (incl. BOT and STIC) can be counted.

FAQ (03.05.2023)
Does a **malignant GIST** count for the Gynaecological Cancer Centre?
Answer: Yes, it counts as an "Other case".

FAQ (03.05.2023):
Does an **epithelioid sarcoma / myoepithelial differentiated tumour of the mons pubis** count for the Gynaecological Cancer Centre?
Answer:
Yes, it counts as an "Other case".

FAQ (10.05.2023):
Can **primary peritoneal mesotheliomas** be counted as primary cases for the Gynaecological Cancer Centre?
Answer:
No, they cannot be counted. See also: Mesothelioma units certification system.

FAQ (10.05.2023)
Can **STIL** (serous tubular intraepithelial lesion) of the ovary be counted in addition to STIC?
Answer:
No.

FAQ (10.05.2023)

Does large **cell neuroendocrine (LCNEC) corpus carcinoma** count for the Gynaecological Cancer Centre?
Answer:
Yes, it counts as an "Other case".

FAQ (10.05.2023)
Does a **neuroendocrine cancer of the ovary** (large cell neuroendocrine cancer, 8013/3) count for the Gynaecological Cancer Centre?
Answer:
Yes, it counts as an "Other case".

FAQ (10.05.2023)
How do patients with cervical carcinoma who undergo brachytherapy at the Gynaecological Cancer Centre count? Cancer Centre have received brachytherapy only?
Answer:
Patients who only receive brachytherapy at the centre and no other measures such as TC cannot be counted as (primary) cases for the centre.

FAQ (16.05.2023)
Do **germinally mixed tumours** (9085/3) of the ovary count as cases for the Gynaecological Cancer Centre?
Answer:
Yes, they count as "Other cases".

FAQ (22.08.2015)
How should neuroendocrine cervical carcinoma (small cell and large cell) be classified?
Answer:
Neuroendocrine cervical carcinomas should be classified under cervical carcinoma. The current key figures of the certification system for cervical carcinoma also apply to this group.
Neuroendocrine carcinomas of other locations (ovarian/tubal/peritoneal, uterine/endometrial, vulvar, vaginal) are to be classified under 'Other cases'.

Basic Data Columns J-K:

FAQ (24.05.2016)
Can non-primary cases also include **progressions**?

Answer:
No, progressions cannot be counted.

9	Surgical staging early ovarian cancer	Numerator	Primary cases of the denominator with surgical staging with: •Laparotomy •Peritoneal cytology •Peritoneal biopsies •Bilateral adnex exstirpation •Hysterectomy, where appropriate extraperitoneales procedure •Omentectomy at least infracolic •Bilateral pelvic and paraaortal lymphonodectomy	FAQ (14.07.2016) Peritoneal biopsies should be performed even if the peritoneum is macroscopically unremarkable. Macroscopically unremarkable peritoneum is not sufficient justification for not performing biopsies. In these cases, a deviation should be pronounced. FAQ (10.05.2023) Does surgical staging have to be performed in one session or can it also be performed in two sessions? Answer: Both a one-session and a two-session procedure are permitted. FAQ (22.08.2025)
		Denominator	Surgical primary cases ovarian cancer FIGO I – IIIA	
		Target value	≥ 40%	

<table>
<tr><td></td><td></td><td></td><td></td><td>Which patients who have undergone surgery should be entered in column F of the basic data sheet under definitive surgery =
staging surgery (ovary/tubes/peritoneal, BOT, STIC)?

Answer:
Patients who have undergone complete, stage-appropriate surgery according to S3-LL Ovar should be entered here.

Which surgical steps comprise ‘staging’ or complete surgery according to LL?

Answer:

<table>
<tr><td>Definitive ovarian surgery</td><td>FIGO IA-IIB</td><td>FIGO IIIA-IV</td><td>BOT</td></tr>
<tr><td>Laparotomy</td><td>X</td><td>X</td><td></td></tr>
<tr><td>Peritoneal cytology</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Peritoneal biopsies</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Bilateral adnex exstirpation</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Hysterectomy</td><td>X</td><td>X</td><td></td></tr>
<tr><td>Omentectomy</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Bilateral lymphonodectomy (pelvic, paraaortal)</td><td>X</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td rowspan="3">10</td><td rowspan="3">Macroscopic complete resection advanced ovarian cancer</td><td>Numerator</td><td>Primary cases of the denominator with macroscopic complete resection</td><td rowspan="3">FAQ (25.07.2016)
What does "macroscopically complete resection" mean?

Answer:
The final ope-rative result is < R2, i.e. R0 or R1.

FAQ (14.07.2016)
In the case of multiple operations, does the macroscopically complete resection refer to the first tumour-specific operation or also to the last tumour-specific operation on the tumour?

Answer:
The macroscopically complete resection is decisive, regardless of the number of operations.

FAQ (22.08.2025)</td></tr>
<tr><td>Denominator</td><td>Surgical primary cases with an ovarian cancer
FIGO IIB-IV without prior chemotherapy</td></tr>
<tr><td>Target value</td><td>≥ 30%</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td></td><td>Which patients who have undergone surgery should be entered in column F of the basic data sheet under definitive surgery =
staging surgery (ovary/tubes/peritoneal, BOT, STIC)?

Answer:
Patients who have undergone complete, stage-appropriate surgery according to S3-LL Ovar should be entered here.

Which surgical steps comprise ‘staging’ or complete surgery according to LL?

Answer:

<table><tr><td>Definitive ovarian surgery</td><td>FIGO IA-IIB</td><td>FIGO IIIA-IV</td><td>BOT</td></tr><tr><td>Laparotomy</td><td>X</td><td>X</td><td></td></tr><tr><td>Peritoneal cytology</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Peritoneal biopsies</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Bilateral adnex exstirpation</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Hysterectomy</td><td>X</td><td>X</td><td></td></tr><tr><td>Omentectomy</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Bilateral lymphonodectomy (pelvic, paraaortal)</td><td>X</td><td></td><td></td></tr></table></td></tr>
<tr><td>11</td><td>Operation advanced ovarian cancer by a gynaecological oncologist</td><td>Numerator</td><td>Primary cases of the denominator whose definitive surgical treatment was performed by a gynaecological oncologist</td><td rowspan="3">FAQ (14.07.2016)
The operations were performed by a gynaecological oncologist as a training assistant. The main surgeon was not a gynaecological oncologist. Can the operations still be included in the numerator?

Answer:
Yes.</td></tr>
<tr><td></td><td></td><td>Denominator</td><td>Surgical primary cases ovarian cancer FIGO IIB-IV after completion of surgial treatment</td></tr>
<tr><td></td><td></td><td>Target value</td><td>≥ 80%</td></tr>
<tr><td>13</td><td>First-line chemotherapy advanced ovarian cancer</td><td>Numerator</td><td>Primary cases of the denominator with first-line chemotherapy with carboplatin and paclitaxel</td><td rowspan="3">FAQ (10.05.2023)
Can patients who receive additional substances - e.g. as part of a study - be counted in the numerator?

Answer:
Yes, these can be counted.

FAQ (10.05.2023)
Does the administration of carboplatin/paclitaxcel refer to adjuvant or neoadjuvant administration?</td></tr>
<tr><td></td><td></td><td>Denominator</td><td>Primary cases ovarian cancer FIGO IIA-IV</td></tr>
<tr><td></td><td></td><td>Target value</td><td>≥ 60%</td></tr>
</table>

				Answer: to the adjuvant administration. FAQ (22.08.2025) Is this about post-operative chemotherapy? Answer: Yes, it is about post-operative chemotherapy. FAQ (22.08.2025) Does this refer to the substances used in first-line chemotherapy? Answer: Yes, according to the LL recommendation, carboplatin and paclitaxel should be used as first-line chemotherapy. Only patients receiving this chemotherapy should be counted in the numerator. FAQ (22.08.2025) If adjuvant chemotherapy with carboplatin and paclitaxel has already begun, can the case still be counted for the Numerator? Answer: Yes, it can be counted.
14	Cytological/ histological lymph node staging	Numerator	Primary cases of the denominator with cytological/histological lymph node staging	FAQ (14.07.2016) The numerator can include both primary cases with cytologic/histologic lymph node staging as part of diagnosis and primary cases with therapeutic lymph node removal as part of surgical treatment. LN staging in the context of diagnostics as well as primary cases with therapeutic lymph node removal in the context of surgical therapy can be taken into account. FAQ (12.10.2017) Can pure imaging LN staging be counted for the indicator? Answer: No, this does not count for the indicator.
		Denominator	Primary cases cervical cancer FIGO stage ≥ IA2-IVA	
		Target value	≥ 60%	

15	Brachytherapy as a component of primary radio(chemo) therapy	Numerator	Primary cases of the denominator in which brachytherapy was administered as part of primary radio(chemo) therapy	FAQ (17.08.2021) What is meant by primary radio(chemo)therapy? Answer: The intention of primary radio(chemo)therapy (= radiochth planned as the first and only therapy) is decisive for the denominator. In exceptional cases, a so-called **secondary** (not primarily planned) hysterectomy or so-called **extended** chemotherapy may be performed, but ultimately this is irrelevant for the denominator, because these patients can also be counted. FAQ (17.08.2021) Can brachytherapy equivalents such as Cyberknife or Boost also be counted? Answer: No, they cannot be counted.
		Denominator	Primary cases with cervical cancer and primary radio(chemo) therapy, without primary Distant Metastasis	
		Target value	≥ 80%	
17	Details in pathology report in the case of first diagnosis and tumour resection	Numerator	Primary cases of the denominator with pathology reports containing details of: •Histological type according to WHO, •Grading, •Detection/non-detection of lymph or blood vessel infiltration (L and V status), •Detection/non-detection of perineural invasion (Pn status), •Staging (pTNM), •Depth of invasion and spread in mm in the case of pT1a, three-dimensional tumour size in cm (ab pT1b), •Metric details of the minimum distance of the carcinoma and VIN from the vulvar resection margin in the histological specimen; •In the case of resection of the vulvar-vaginal or vulvar-anal transition zone and, where applicable, of the urethra metric details of the minimum distance to the vulvar-vaginal or vulvar-anal and, where applicable, urethral resection margin; •Metric details of the minimum distance to the soft	FAQ (12.10.2017) Does the pTNM (staging) have to be complete? Answer: The key figure refers to the content of the pathological report. If no lymph node removal was performed, no pN can be given. cN cannot be a substitute because it was not determined by the pathologist. FAQ (12.10.2017) Is a separate resection margin expected here from the invasive carcinoma and VIN respectively? Answer: Yes, separate indication of the resection margin of invasive carcinoma and VIN. FAQ (12.10.2017) Are VIN III lesions to be considered or are VIN I and VIN II also included? Answer: The guideline only specifies VIN, therefore VIN I-III are meant.

			tissue resection margin (basal margin)	FAQ (17.08.2021) How is the three-dimensional tumour size to be indicated? Answer: Three-dimensional tumour size in cm = length in cm (horizonal extension) x width in cm (vertical extension) x depth in cm (infiltration depth). But it is not the cubic centimetres that are asked for, but the extent of the expansion, i.e. cm in each case.
		Denominator	Primary cases vulvar cancer with tumour resection	
		Target value	≥ 90%	
18	Details in pathology report in the case of lymphonodectomy	Numerator	Primary cases of the denominator with pathology report with details of: • Number of affected lymph nodes in relation to the number of removed lymph nodes classified by removal localisation (inguinal/pelvic) • Non-detection/detection of a capsel infiltration of the lymph node metastatis and/or detection lymph node infiltrations in perinodal fatty tissue and/or the lymph node capsule (>=pN2c) • Biggest spread of metastases (through pN details)	FAQ (27.08.2019) Are patients with only sentinel lymphonodectomy (without conventional LNE) taken into account here? Answer: No.
		Denominator	Primary cases vulvar cancer with lymphonodectomy	
		Target value	≥ 90%	
19	Conduct inguinofemoral staging	Numerator	Primary cases of the denominator with surgical staging (systematic lymphadenectomy and sentinel biobsy) of inguinofemoral lymph nodes	FAQ (12.10.2017) Which operation codes are to be documented for this key figure? Answer: It concerns lymph node staging, which is usually coded with its own OPS. There are several OPS that can be used for this, depending on the operation performed. The surgeons are responsible for entering these OPSs, if necessary in consultation with Controlling. FAQ (22.08.2025) Are the surgical procedures listed in the indicator (systematic lymphadenectomy and/or sentinel lymph node biopsy) the appropriate course of action for 'abnormal' LNs, or is
		Denominator	Primary cases vulvar cancer ≥ pT1b (no basal cell carcinoma and no verrucous carcinoma)	
		Target value	≥ 90%	

				excision of these LNs sufficient? Answer: In the case of clinically unremarkable LNs that are macroscopically conspicuous during surgery, or so-called 'bulky nodes', excision of these LNs is sufficient. These cases can be included in the numerator.
20	Sentinel lymph nodes biopsy	Numerator	Primary cases of the denominator with the following characteristics: • Clinical tumour size < 4 cm and • Unifocal tumour (= no multiple tumours; TNM m-symbol) and • Clinically inconspicuous lymph nodes (cN0) and • Pathohistological ultrastaging of lymph nodes (= in line with LL), only if all sentinel lymph nodes are tumor-free in the H&E staining	<u>FAQ (17.08.2021)</u> What is pathohistological ultrastaging? Answer: Ultrastaging, i.e. the immunohistochemical examination of the lymph nodes with a pan-cytokeratin antibody, is carried out if all sentinel lymph nodes are negative in the HE stain. If the LK are positive in the conventional staining (= HE), no ultrastaging is carried out. <u>FAQ (22.08.2025)</u> Should only primary cases with sentinel lymph node biopsy (SNB) alone be counted in the denominator, or should primary cases with SNB and additional lymph node dissection (LNE) also be counted? Answer: No, only primary cases in which a pure SNB was performed and no additional LNE was performed are counted in the denominator.
		Denominator	Primary cases vulvar cancer and sentinel lymph node biopsy	
		Target value	≥ 90%	
22	Endometrial cancer: POLE examination	Numerator	Primary cases of the denominator with POLE investigation	<u>FAQ (22.08.2025)</u> a) How should the denominator of indicator 22 be understood? Answer: The denominator lists the criteria mentioned with an 'and/or' link. This means that primary cases are to be counted in the denominator if they are a primary case of endometrial carcinoma and, for example, all other criteria apply or at least one of the criteria mentioned applies. <u>Example of only 1 criterion</u>
		Denominator	Primary cases of endometrial cancer >pT1a u./o. G3 u./o. p53-abn u./o. LVSI pos. u./o. MSI/MMR pos. or first diagnosis of type 2-Endometrial cancer (serous, clear cell, cancer sarcoma) (ICD-O: 8380/3, 8441/3, 8310/3, 8020/3, 8323/3, 9110/3, 8070/3, 8144/3, 9111/3, 8980/3)	
		Target value	No target value	

				• Primary case of endometrial carcinoma • AND type 2 (serous, clear cell, carcinosarcoma) <u>Example of all criteria:</u> • Primary case of endometrial carcinoma • AND >pT1a • AND G3 • AND p53-abn • AND LVSI pos. • AND MSI/MMR pos. • AND initial diagnosis type 2 endometrial carcinoma (serous, clear cell, carcinosarcoma) b) Why are ICD-O morphology codes for type 1 and type 2 endometrial carcinomas listed in the denominator? Answer: The denominator lists ICD-O codes for type 1 and type 2 endometrial carcinomas because one of the criteria mentioned is the presence of type 2 endometrial carcinoma (this includes the corresponding codes for 'type 2 endometrial carcinomas') and therefore a POLE examination is indicated for all primary cases with type 2 carcinoma. However, type 1 endometrial carcinomas may also belong in the denominator. For type 1 endometrial carcinoma (ICD-O 8380/3), at least one additional criterion must be met.
23	Endometrial cancer: post-operative vaginal brachytherapy alone	Numerator	Primary cases of the denominator with post-operative brachytherapy alone vaginal brachytherapy	<u>FAQ (22.08.2025)</u> a) How should the denominator of indicator 23 be understood? Answer: Indicator 23 corresponds to one of the GL-QI indicators in the S3 guideline on endometrial cancer. The denominator lists the specified criteria with an AND operator. The procedure is as follows: Primary case of endometrial carcinoma? If yes
		Denominator	Primary cases of endometrial cancer stage pT1b, G1 or G2 pNX/0, p53-wt, L1CAM negative, without extensive LVSI, M0 with surgery	
		Target value	No target value	

				Stage pT1b? If yes G1 or G2? If yes pNX/0? If yes p53-wt? If yes L1CAM negative? If yes without extensive LVSI? If yes M0? If yes with surgery? then the case belongs in the denominator b) What does the term extensive LVSI mean? Answer: See definitions in the S3-LL: • LVSI lymphovascular space invasion • Extensive LVSI, compare LL recommendation 4.27: "(...) Focal lymphatic vessel infiltration is defined as involvement of <3 lymphatic vessels and extensive ("substantial") lymphatic vessel infiltration as involvement of ≥ 3 lymphatic vessels.
24	Endometrial cancer: percutaneous radiotherapy with simultaneous chemotherapy (PORTEC 3 regimen)	Numerator	Primary cases of the denominator with simultaneous chemotherapy (PORTEC 3 regimen)	FAQ (22.08.2025) What is the PORTEC-3 scheme? Answer: Percutaneous radiation 48.5 Gy ± brachytherapy + 2 × cisplatin 50 mg/m² followed by 4 × carboplatin AUC 5 + paclitaxel 175 mg/m².
		Denominator	Primary cases with endometrioid (morphology code: 8380/3) endometrial cancer pT1b or pT2, p53-abn, POLE-wt M0 and percutaneous radiotherapy	
		Target value	No target value	