ICD11 revision - neoplasm chapter

Summary of proposals from Cancer Registries - Jan 2012

1. Haemopoietic and lymphoid tissues: align ICD with WHO Classification and ICD-O-3 revision

85% of respondents (N=165) agree, 2% disagree; 80% judge it feasible.

Specific requests and caveats:

1. Concomitance of more than one subtype of lymphoma at presentation and evolution over time: what can be considered a transformation (progression) and what should be considered second primary. *[PP note: the proposer also suggests the coding of all subtypes/conditions, but this is beyond ICD classification].*
2. Translation of ICD-O-3 M codes into ICD very difficult in developing countries due to lack of non-specific entity definitions in WHOBB Classification; often only diagnostic evidence comes from cytology smears (China, Qatar). "Make it more user-friendly". *pp interpretation: to avoid misclassification one would need a system that maps all relevant ICDO3-M codes into ICD.*

2. Morphology as a separate classification axis

1. Morphology details specifically requested for skin, breast, oesophagus.
2. High grade dysplasia of GI should be recognized as equivalent to *in situ* and therefore made reportable (currently it is not).
3. Allow for the identification of neuroendocrine tumours.
4. Currently there is conflict between C45 (mesothelioma) and C48 (peritoneum & retroperitoneum). Would be solved with separate axis for morphology.
5. Similar to point 4. is the ambiguity (and misclassification leading to non-comparability) of sarcomas of soft tissue. Would be solved with separate axis for morphology.

3. Topography subdivisions/distinctions

1. Separate intrahepatic bile duct (C22.1) from liver C22.
2. Separate cardia from gastro-oesophageal junction. However: in developing countries (China) may not be feasible since most cases present at advanced stage.
3. Align ICD with 7th revision of TNM/AJCC, specifically:
    - Extrahepatic bile ducts (C24.0): split into proximal/perihilar
    - Lacrimal gland and duct (C69.5): separate Lacrimal Duct/Sac from Lacrimal Gland/Lacrimal NOS.
    - Melanoma/skin cancer of vulva/testis.
4. Introduce specific category for neoplasms in transplanted organs.
   61% of polls in favour, 6% against. 56% state it feasible, 11% not feasible.
5. Distinguish left/right for paired organs, to permit different rules for second primary tumours.

6. Delete C97=Malignant neoplasms of independent (primary) multiple sites *[several proposers]*: not understood and misused. Causes a lot of misclassification and loss of information.

7. Introduce topography codes for multifocal/multicentric breast and bladder cancers.

8. “More logical” categories for sites and sub-sites C00-C14 (?).

9. Greater detail in sub-categories for C43 and C44 (skin).

4. Proposals for the clinical panel

1. Provide for the coding of 1) local recurrence, 2) regional recurrence, 3) loco-regional recurrence, maintaining codes for distant metastasis, for use in hospital discharge records. Would make it easier to capture recurrence data by linking cancer registry or clinical trial records of the primary tumour to hospitalization records. Currently demand for routine clinical follow-up is strong, but can be performed only by active regular consultation of clinical records and *ad hoc* investigations —too expensive and therefore not feasible routinely.

2. Provide for the coding of adverse events in health facilities for the purpose of risk management evaluation. Distinguish accident (e.g. fall, suicide) from complications of therapy (intra-operative death).

5. Generic requests:

1. (China) Make ICD-11 simpler/more convenient/more user-friendly to better serve public health and cancer registration.