**ICD Neoplasms Topic Advisory Group**

**Summary of TAG work since Pisani and Speakman took responsibility to chair the group (September 2011)**

First step was to review all the material collected by IARC on proposed/requested modifications to ICD, originated by a variety of sources. A web-based survey among cancer registries was conducted in December 2011 to assess their needs (**D1**). Input from TAGs Internal Medicine, Gastroenterology and Haematology was also considered (**D2**). The Neoplasm TAG considered and discussed topics proposed in weekly TC.

This work produced a list of strategic principles on structure and content of the new ICD that were examined at the face-to-face meeting in Lyon (March 2012) and can be summarized as follows:

1. Expand the classification to accommodate tumour morphology (macro-groups), possibly at the 3-character level in order to use it in routine analyses and tabulations of both mortality and morbidity data;
2. Align topographic entities with the 7th revision of TNM;
3. Align the classification of haemo-lymphopoietic malignances with the new WHO Classification of Tumours (Blue Book series)
4. Add coding of stage and extension of disease at single care events; the purpose is two-fold:  
   - evaluation of the performance of the health system with respect to timeliness of diagnosis  
   - facilitate long-term follow-up of cases to evaluate survival (both population-based and clinical series)

Achieve those goals with the following constrains:

1. Maintain continuity with ICD10 at least at the 3-char level: ensure that 3-char entities classified in ICD10 can be identified comparably in the new classification;
2. The code structure of ICD11 will be (**D3** 4/3/2012): E1D213.E4E5   
   Where E corresponds to a base 34 number (0-9 and A-Z ; excluding O,I) ;D corresponds Base 24 number (A-Z ; excluding O,I); and 1 corresponds to the base 10 integers (0-9)
3. Chapter Neoplasms may use 2 letters at character 1, and all combinations of the following characters. Chapter neoplasms can therefore use 480 3-char codes (**D4**, April 2012).

Options and proposals of content to meet the requirements listed above and how to accommodate it in the code structure were discussed at the face-to-face meeting in Lyon. The minutes of the meeting include a list of decisions taken (**D5** March 2012).

Given the structure of ICD11, it was decided to maintain tumour behaviour as the main parent classification, even if the first char of the code will no longer distinguish behaviours.

Following the meeting in Lyon, much of the work in April-May concentrated on defining relevant morphology groups within topographic entities (which is the main classification criterion of ICD10 and is to be maintained in ICD11). This was done with the aid of the Cancer Incidence in Five Continents (CI5) database maintained by IARC from which we obtained the relative frequencies of major morphology groups (as defined in ICD-O(3)) by tumour site. The categories “Other specified types (morphology)” and “Morphology unknown” were systematically added to every major topographic entity to make the classification exhaustive.

Adjustements to major topographic entities (identifiable at the 3-char level) were made to align the new classification with TNM 7th revision (20 April).

The haemo-lymphopoietic section was replaced with the WHOBB classification. An attempt to link entities coded by ICD10 in this section to the new classification was made through ICD-O.

Stage/extension of disease was assigned to the 5th character as an independent classification criterion, not relevant to mortality use (**D6**).

The complete beta-proposal is presented in “ ICD11NeoplasmsTAGproposal 2012 07.xlsx”

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Torino, 7/9/2012