Queensland Cancer Register Instruction Manual for Notifying Cancer

Private hospitals

Version 4.0

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Queensland Cancer Register

Cancer Alliance Queensland

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NOTE. Items above marked with an * are mandatory requirements when completing a cancer registration.

1. Introduction

1.1. Establishment of the Cancer Register

The Queensland Cancer Register (QCR) operates under the *Public Health Act 2005,* to receive information on cancer in Queensland. The Cancer Register is a population-based register and maintains a Register of all cases of cancer diagnosed in Queensland since the beginning of 1982. Cancer is a notifiable disease in all States and Territories and is the only major disease category from which an almost complete coverage of incidence data is available. It is also the only major cause of death in Australia that is continuing to increase. Through the National Cancer Statistics Clearing House – a collaborative enterprise of the Australian Association of Cancer Registries and the Australian Institute of Health and Welfare, Queensland data is used in the compilation of Australia-wide figures and can be compared with cancer statistics from other States.

1.2. Aims of the Register

The main aim of the Register is to collect data to describe the nature and extent of cancer in Queensland. This can be combined with related data to assist in the control and prevention of cancer. To this end, Queensland Cancer Register data is available for use:

- in research projects on the causes, treatment and prevention of cancer,
- in the planning and assessment of cancer treatment and prevention services,
- in monitoring survival times of cancer patients, and
- for the education of health professionals and members of the general public.

1.3. Notification and sources of data

Notification of cancer is a statutory requirement for all public and private hospitals, nursing homes and pathology services. Notifications are received for all persons with cancer separated from public and private hospitals and nursing homes. Queensland pathology laboratories provide copies of pathology reports for cancer specimens. Data on all persons who die of cancer or cancer patients who die of other diseases are abstracted from the mortality files of the Registrar of Births, Deaths and Marriages and linked to hospital and pathology data.

1.4. The Act and Regulations

The *Public Health Act 2005,* Division 3 – Notifications about cancer 234 and 235 that the person in charge of a hospital or residential care facility must give a notification to the chief executive of Queensland Health if a person known to be suffering from cancer who is a patient in the hospital or a resident of the residential care facility, or under the direction of the chief executive to Metro South Hospital and Health Service ('the contractor'), within one month.

The legislation may be viewed on the following website:
https://www.legislation.qld.gov.au/view/html/inforce/current/act-2005-048

1.5. Confidentiality of data

All unit record information collected by the Queensland Cancer Register is treated as strictly confidential. All information collected is used for statistical or research purposes only.

1.6. Enquiries

If you would like more information about the Queensland Cancer Register or you wish to obtain any publications you may contact the:

Senior Director
Cancer Alliance Queensland
Level 1, B2, 2 Burke St
Woolloongabba Q 4102

PH (07) 3176 4400
Email QCR@health.qld.gov.au

Further information about cancer may also be obtained from the following web sites:

https://canceralliancеqld.health.qld.gov.au/

https://www.aihw.gov.au/

2. Electronic notification

2.1. Background

Since early 2002, the Register has been receiving data electronically on a monthly basis from all public hospitals in Queensland. Notifying cancer electronically is also available for private hospitals. However we understand that private hospitals utilise different electronic systems and each system has unique functionality and specifications for notifying cancer to the Register.

Small private hospitals that lack the capability to send cancer notifications electronically can instead notify via a PDF document through secure file transfer or by printing and submitting the standard form.

3. Business rules

3.1. What hospitals should notify?

All private hospitals in Queensland are required to report cancer details to the Queensland Cancer Register.

3.2. What cancers should be notified?

All cancers as defined in Part 2 Division 1, Section 229 of the *Public Health Act* 2005 are to be notified. The Act defines cancer as:

(a) a neoplasm of human tissue—
  (i) in which cell multiplication is uncontrolled and progressive; and
  (ii) that, if unchecked, may invade adjacent tissues or extend beyond its site of origin; and
  (iii) that has the propensity to recur, either locally or remotely in the body;

(b) skin cancer and non-invasive carcinoma, other than skin cancer and non-invasive carcinoma of a type prescribed under a regulation.

Therefore, all invasive cancers are to be reported (excluding Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin where the ICD-10-AM site code range is C44.0 to C44.9 and morphology is M805 to M811). Merkel cell tumours of the skin and Kaposi's Sarcoma are also to be reported.

Please report any cancer with uncertain behaviour.

Please notify **all** in-situ conditions as well. The Register collects for example, in-situ cancers of the cervix (CIN III - cervical intra-epithelial neoplasm), vagina (VAIN III - vaginal intra-epithelial neoplasm), vulva (VIN III - vulval intra-epithelial neoplasm), prostate (PIN - prostatic intra-epithelial neoplasm) bladder, breast and in-situ melanomas.

Benign central nervous system and brain tumours are also of interest to the Register and must be reported.

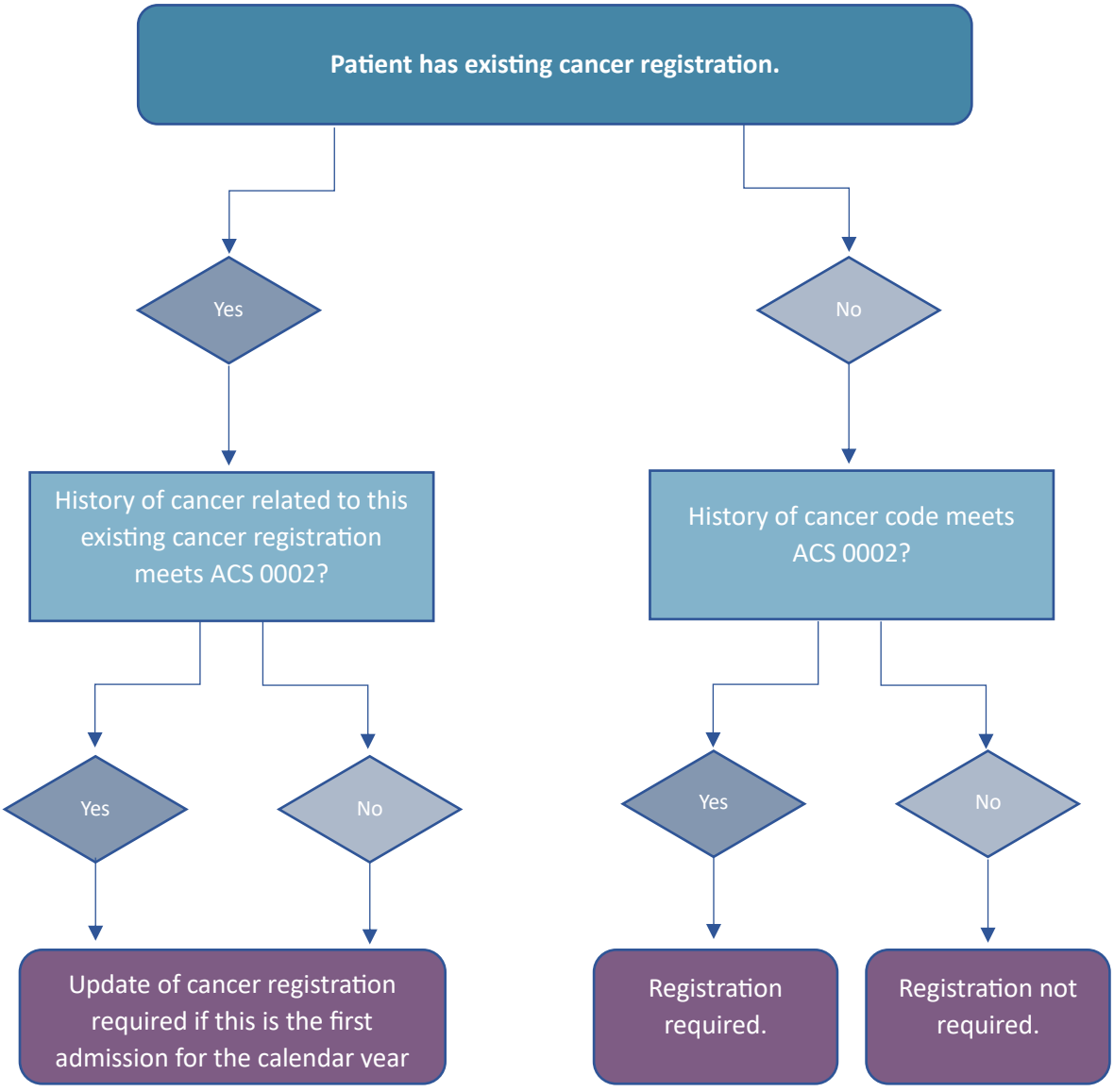
Non-malignant conditions, such as CIN I or II, VAIN I or II, VIN I or II, solar keratosis or keratoacanthoma, are outside the scope of the collection.

3.3. When should a notification be completed?

A notification should be completed and filed within 30 days for each of the following events:

i. at discharge or transfer of a patient being **first** diagnosed with cancer, or when a **new site** is diagnosed, or the same site but a **different histological type** of cancer is diagnosed.
ii. at discharge or transfer of a patient's **first** admission in each calendar year when:
    a. attendance is for chemotherapy or radiotherapy. (Note that as per the Queensland Health admission policy patients should be admitted for chemotherapy).
    b. patient is being currently being treated for cancer.
    c. patient's history of cancer is relevant to the admission. *Note: It is a requirement to follow current coding standards and to only code history of cancer in the ICD-10-AM diagnosis codes where it is relevant to the admission.* See figure 1 below.
iii. at the **death** of a patient suffering from or with a **history** of cancer, where the patient died within the hospital.

Figure 1: Existing cancer registration flowchart



A **separate notification** is required for each primary site.

Only notifications that have been filed will be forwarded as part of the extract. A print option is available for sites to use for retaining a record in their own charts. This is not a mandatory requirement of the Cancer Register. The print option also serves as a back-up if at any time the electronic notification process fails. The Register will notify hospitals if this is a required.

3.4. Deletions

Deletions cannot be provided electronically. If a notification has been filed it will be reported through to the Register. To inform the Register of a deletion, please email QCR@health.qld.gov.au with the details and if possible, provide a reason e.g. duplicate patient, not cancer, etc.

3.5. Further information required

After processing a cancer notification, the Register may identify a need for further information. A response to the request for further information is required within 30 days and should be supplied electronically e.g. updated cancer notification and/or supporting information to email address QCR@health.qld.gov.au

It is recommended that hospitals maintain a record of the completion and dispatch of the responses to the requests for further information.

3.6. When and how should a notification be sent?

Notifications should be sent on a monthly basis.

An extract is to be sent on a certain day of the month e.g. the 10th day of each month. The extract should include all notifications completed in the previous month.

Extract files are to be uploaded to the Kiteworks secure online portal. For instructions on how to access this portal and upload the files, please refer to the QCR KiteWorks Facility User Guide available on the website.

Each set of cancer registration extract files will contain a header (HDR) details file. The HDR file will provide counts of the total number of records for that facility (including nil returns).

The paper form used to report cancer notifications to the Queensland Cancer Register is a standard form. To obtain the form, download from the website QCR Form or contact the QCR (see section 1.6 for contact details).

Completed Cancer Notification paper forms must be uploaded to the Kiteworks secure online portal. For instructions on how to access this portal and upload the files, please refer to the QCR KiteWorks Facility User Guide available on the website.

4. Facility details

4.1. Facility number

The facility number is a unique numerical code assigned to each health care facility and can be found in the Queensland Health Corporate Reference Data System.

Patients moving between these hospitals are counted as separate admissions and separations and are therefore reported by both facilities.

Nursing home residents should be reported under the facility number of the nursing home. Nursing home residents moving from a nursing home bed to an acute bed at another facility should be admitted as an acute patient from the date that they occupy the acute bed and reported as such.

This is not to be confused with a person's status as a nursing home type patient in an acute bed.

5. Patient details

5.1. UR number (Patient Number) *

A unique number allocated to each patient by the hospital. Allocation might be done manually or automatically by the computer. The number is used for each admission to identify the patient within the facility.

5.2. Patient surname/family name

The current surname of the patient.

5.3. Given names

5.3.1. First name

The current given name of the patient.

5.3.2. Second name

Second names or initials where known.

5.4. Former names/alias

Record any previous surname or other names that the patient or resident is now or has previously been known as. Record the complete name (first name, second name and surname).

5.5. Sex

Record the sex of the patient using the following:

M= Male

F= Female

I= Indeterminate / Intersex

To avoid problems with edits, transgender individuals undergoing gender confirmation surgery should have their sex at the time of the hospital admission recorded.

Note that indeterminate will generally only be used for neonatal patients where the sex has not been determined.

5.6. Date of birth

Record the date of birth of patient using the full date (i.e. ddmmmyyyy).

- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients) use 15-JUN-1900.
- If estimated or unknown, specify in the comments in the CAN file.

5.7. Address of usual residence

5.7.1. Number and street of usual residence

Record the building number and street name of the usual residential address of the patient. The usual residence is where the patient lives. For example, it is not the address where the patient might be staying temporarily before or after the period of hospitalisation.

Post Office box numbers or Mail Service Numbers should not be recorded. Use a building number and street name whenever possible. Even country properties have access roads that have names.

You may use standard abbreviations, see appendix A for examples.

5.7.2. Suburb/Town of usual residence

Record the location of the usual residence of the patient as the suburb or town in which the patient usually lives. Do not record the location of temporary accommodation, or a (farm) property name in this field.

Interstate and overseas patients

If the patient lives interstate, the actual suburb or town of usual residence should be recorded.

If the patient is from overseas, also record the country in which he/she normally resides.

Patients diagnosed outside Queensland, while not reported by the Register, are recorded on the Register. This assists with identifying duplicate registrations, notifying interstate cases, and assists matching for subsequent treatment notifications.

5.7.3. Postcode of usual residence

Record the postcode of the usual residential address of the patient.

If the patient is not an Australian resident or has no fixed address, use one of the supplementary codes:

0989 = not stated/unknown

9301 = Papua New Guinea

9302 = New Zealand

9399 = Overseas - other (not PNG or NZ)

9799 = at sea

9899 = Australian External Territories

9989 = no fixed address

5.8. Medicare number

If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card.

If the person does not have an Australian Medicare Number or if it is not available, leave this blank.

5.9. Marital status

Use the following to record the current marital status of the patient:

NM= Never married

M= Married

F=De facto

W= Widowed

D= Divorced

A= Separated

N= Unknown

Separated means those people who are legally separated or socially separated, not persons who are temporarily living apart (e.g. construction workers living in hotels or camps).

5.10. Country of birth

Record the country of birth of the patient using the appropriate numerical codes (as found in the Australian Standard Classification of Countries for Social Statistics ASCCSS)) eg:

- If the patient was born in Australia, use code 1101;
- If the patient was born in New Zealand, use code 1201.

5.11. Indigenous status

Use the following to record indigenous status:

11= Indigenous-Aboriginal but not Torres Strait Islander origin.

12= Indigenous-Torres Strait Islander but not Aboriginal origin.

13= Indigenous-Aboriginal and Torres Strait Islander origin.

14= Not indigenous-not Aboriginal or Torres Strait Islander origin.

19= Not Stated

5.12. Occupation

Record the patient's occupation. Use the codes from the Australian Standard Classification of Occupations (ASCO). Ideally the Register would like principal lifetime occupation. Only use pensioner/ housewife/retired if lifetime occupation is unable to be ascertained.

6. Admission details

6.1. Admission number (Episode Number) *

The admission number denotes a specific admission at the facility. Admission number is important as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission.

6.2. Admission date

Record the full date (that is, ddmmmyyyy) of admission to hospital.

6.3. Separation date

At separation, record the full date (that is, ddmmmyyyy). This is the date that the patient was discharged, transferred or died.

6.4. Mode of separation (Discharge Status)

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital or indicates whether this is a statistical separation due to a change in the type of episode of care.

If the patient died in hospital, please record the appropriate details for whether an autopsy was held and cause of death details.

6.5. Transferring to facility

Record the facility number (extended source code) for the hospital, nursing home or correctional facility to which the patient is referred as an admitted patient.

6.6. Treating doctor

To assist in improving the quality of this data, all fields should be completed.

Record the individual doctor chiefly responsible for treating the patient e.g. the Senior Treating Medical Officer, Specialist or Consultant in charge of the care. This is not the registrar or resident medical officer.

6.7. Cause of death *

If the patient died in the hospital, the description for the principal diagnosis code, for this admission, should be displayed in this field. Check and update the text details as required.

Please only complete the cause of death if the patient dies in the hospital.

6.8. Autopsy held *

Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.

Please only complete the autopsy held item if the patient dies in the hospital.

6.9. Diagnosis at separation

The principle diagnosis ICD-10-AM code for this admission.

7. Cancer details

7.1. Multiple primary site *

This is a two digit item field, indicating multiple primary sites of cancer for any single patient.

7.2. Primary site of cancer *

A primary site is defined as the site at which a neoplasm originated. Thus, a cancer CASE includes each primary site in a cancer patient, and a patient with two primary sites is considered as being two different cases of cancer. A patient with one primary site and one or more secondary sites is one case of cancer only.

See Section 3.2 for the cancers in the scope of the collection.

Where possible be specific when coding the primary site, for example, if known, code site as "upper lobe of lung" or "upper-inner quadrant of breast".

If the initial diagnosis is a secondary tumour, report the primary tumour site if possible. This may be indicated by the morphology or clinical notes. If it is not possible to identify the primary tumour, then code the cancer as an unknown primary site.

Details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the cancer than can be coded in ICD-10-AM. This may include more precise topography for melanomas, connective and soft tissue sites, meninges and brain, insitu cancers, etc. The Register codes in ICD-O and has to convert or recode the ICD-10-AM codes. Any information that can assist this process would be useful.

7.3. Morphology *

See Section 3.2 for the cancers in the scope of the collection.

The behaviour code (5th digit) should relate to the primary cancer. While the Register does not collect information on secondary sites, details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the type of cancer than can be coded in ICD-10-AM. This may include more precise details for lymphomas and leukaemias, etc. The Register codes in ICD-O and records details down to the descriptor level. ICD-10-AM codes have to be converted or recoded to ICD-O. Any information that can assist this process would be useful.

7.4. Date of first diagnosis *

Try to accurately identify the full date of original diagnosis for this cancer where possible. Where unknown, please provide best estimate and enter Y in the Estimated field. If you are unable to provide an estimate, enter 15 JUN 1900 and enter Y in the Estimated field.

7.5. Date of first diagnosis flag *

Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.

7.6. Suburb/Locality at first diagnosis *

Name of suburb or town of usual residence at the time of first diagnosis of this cancer. If precise details of the suburb are not known but the State is, then include ‘Not stated/unknown’ as the suburb descriptor and the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

Supplementary suburb/postcodes:

0989 = not stated/unknown
1989 = New South Wales
2989 = Victoria
3989 = Queensland

4989 = South Australia
5989 = Western Australia
6989 = Tasmania
7989 = Northern Territory
8989 = Australian Capital Territory
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

7.7. Postcode at first diagnosis *

Australian postcode corresponding to address of usual residence at the time of first diagnosis of cancer. Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the postcode are not known but the State is, then use the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

Supplementary suburb/postcodes:

0989 = not stated/unknown
1989 = New South Wales
2989 = Victoria
3989 = Queensland
4989 = South Australia
5989 = Western Australia
6989 = Tasmania
7989 = Northern Territory
8989 = Australian Capital Territory
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories

7.8. Laterality of cancer *

Where possible, for cancers of paired organs, such as Breast (C50), Lung (C34), Kidney (C64), Ovary (56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62) indicate the side affected by the tumour.

The valid inputs are:

L Left

R Right

B Bilateral

U Unknown

N Not applicable

Bilateral cancers are extremely rare. Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)).

Unknown: It is unknown whether, for a paired organ, the origin of the cancer was on the left or right side of the body.

Not applicable is the default value. This should be recorded for all non-paired organ sites.

7.9. Basis of diagnosis *

Refers to the most valid basis of diagnosis AT THIS ADMISSION. The following notes may assist.

Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number.

1. Unknown

Usually refers to a tumour which was diagnosed and treated elsewhere and the current hospital has no information regarding that treatment. This code would only apply if the current admission is unrelated to the cancer (ie a history of cancer only admission). Please provide details explaining unknown codes in the comments field. Any indication of where the person was diagnosed would avoid further follow-up.

2. Clinical only

When a tumour has been diagnosed by clinical examination (eg palpation) only at this admission or where the tumour has been diagnosed at a previous admission or different hospital and the diagnosis is supported only by clinical evidence at this admission.

3. Clinical investigations

When a tumour is diagnosed at this admission without invasive surgical procedures but may include diagnostic radioscopy and endoscopy.

4. Exploratory surgery

When a tumour is diagnosed at this admission by exploratory surgery without biopsy and histology. Include here an incidental autopsy finding of cancer without biopsy and histology.

5. Specific biochemical or immunological testing

Tumour diagnosed using particular laboratory techniques only, eg. Prostate specific antigen (PSA) for prostate.

6. Cytology or haematology

Tumour diagnosed using particular laboratory techniques only, eg. Fine needle aspiration without biopsy.

7. Histology of metastasis

When a histology is performed on a tissue sample of secondary tumour. Please identify the primary tumour if possible.

8. Histology of primary

When histology is performed on a tissue sample of primary tumour. NB: Bone marrow aspirates are considered to be histology - basis of 08.

9. Autopsy and histology

When histology is performed on a tissue sample taken during an autopsy.

7.10. Reasons for clinical diagnosis *

Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. This item has been designed to reduce the number of queries back to hospitals. Multiple reasons may be completed. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows:

01	Palliative Care Admission
02	Doctor's Notes/Referral (Provide doctor details)
03	Previous Pathology (Provide laboratory details)
04	Radiological Investigation (Specify investigation details)
05	Other Non-invasive Investigation (Specify investigation details)
06	Invasive Investigation (Specify investigation details)
07	Non Cancer Admission (Specify details)
09	Other /Chemo/ RT (Specify details)

Patients with a clinical admission for chemotherapy should be recorded with a code 09 and chemotherapy specified.

7.11. Details for clinical diagnosis *

This free text field allows the user to provide the relevant details as outlined above in Reasons for Clinical Diagnosis.

7.12. Comments *

This free text field allows the user to provide any other relevant details regarding the cancer that may assist the register staff or reduce queries for the hospital.

This may include a more precise description of the cancer than is able to be coded in ICD-10-AM. Also include any indication as to whether the cancer has metastasised and to which site.

Where possible, specify grading or differentiation - that is:

1	Grade I	(Well) differentiated
2	Grade II	Moderately (well) differentiated
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated, anaplastic

7.13. Laboratory facility number *

This field becomes mandatory when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis).

The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows:

01	Pathology Queensland (Auslab)
02	S & N
03	QML
04	Private Laboratory
05	Other

7.14. Laboratory specimen number *

The lab specimen number will record the specific pathology specimen number collected during the current admission (e.g., report number) and any additional comments required. (Please note: If "Other lab" is recorded, the user should include the actual lab name along with the laboratory specimen number). This is a non-mandatory free text field, which only becomes enabled when codes 06, 07, 08, or 09 are entered into Basis of Diagnosis.

8. Version control

Version no.	Date	Created/modified by	Modifications made
3	01/07/2022		
4	17/01/2025	Phoebe Woodrow	Version control introduced

9. Appendices

Appendix A - Address street type abbreviations

- Alley - AL
- Approach – APP
- Arcade - ARC
- Avenue – AV
- Bend - BND
- Boulevard – BVD
- Break/Brook – BR
- Broadway – BWY
- Brow – BRW
- Bypass – BPS
- Centre – CTR
- Chase – CH
- Circle – CIR
- Circuit – CCT
- Circus - CRC
- Close – CL
- Concourse – CNC
- Copse – CPS
- Corner – CNR
- Corso - CSO
- Court – CT
- Courtyard – CYD
- Cove - COV
- Crescent – CR
- Crest – CST
- Cross – CS
- Crossing – CSG
- Dale – DLE
- Downs – DN
- Drive – DR
- Edge – EDG
- Elbow – ELB
- Entrance – ENT
- Esplanade – ESP
- Expressway – EXP
- Freeway – FWY
- Retreat – RT
- Ridge – RDG
- Rise - RI
- Road – RD
- Roadway – RDY
- Route – RTE
- Square – SQ
- Street – ST
- Tarn – TN
- Terrace – TCE
- Tollway – TWY
- Frontage – FR
- Garden/s – GDN
- Gate/s – GTE
- Glade – GLD
- Glen – GLN
- Grange – GRA
- Green – GRN
- Grove - GR
- Heights - HTS
- Highway – HWY
- Junction – JNC
- Lane – LA
- Link – LK
- Loop – LP
- Mall – ML
- Meander – MDR
- Mews – MW
- Motorway – MWY
- Nook – NK
- Outlook - OUT
- Parade – PDE
- Park – PK
- Parkway – PKY
- Pass – PS
- Pathway – PWY
- Place – PL
- Plaza – PLZ
- Pocket – PKT
- Port/Point – PT
- Promenade – PRM
- Quadrant – QD
- Quay – QY
- Ramble – RA
- Reach – RCH
- Reserve – RES
- Rest – RST
- Track – TR
- Trail – TRI
- Underpass – UPS
- Vale – VA
- View – VW
- Vista – VST
- Walk – WK
- Walkway – WKY
- Way – WY
- Wynd - WYN

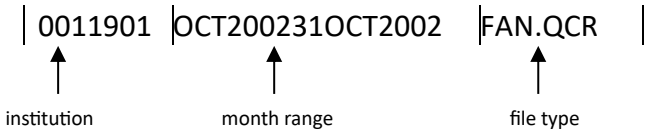
Appendix B – File formats

All fields are to be provided in the extract in the format specified in the Requested Format column, unless otherwise stated in the Source/Description column. The files will be supplied in ascii comma delimited format with double quotes as a text delimiter. Field which are reported with double quotes as text delimiters will have any embedded double quotes replaced by single quotes. Other punctuation, including commas, will not be stripped from the data.

File Names

The following file names are used when sending the data to the Register.
- the first five digits denote the Institution number
- the range of the month will change as per which month you are sending
- please ensure the file names are in CAPITALS.

0011901OCT200231OCT2002HDR.QCR
0011901OCT200231OCT2002CAD.QCR
0011901OCT200231OCT2002CAN.QCR
0011901OCT200231OCT2002CDX.QCR



Header Details (HDR) File

Data Item	Requested Format	Source/Description
Facility number	5 num Right adjusted and zero filled from left	The facility code for the set of files being reported.
Number of CAD records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer admission records for that facility.
Number of CAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer primary site records for that facility.
Number of FAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of former/alias name records for that facility.
Number of CDX records	5 num Right adjusted and zero filled from left; zero if null	Total number of reasons for clinical diagnosis records for that facility.

Example of data in the HDR file

00000,00008,00009,00007,00003

Cancer Admission Details (CAD) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR Number)	8 char Right adjusted and zero filled from left. Mandatory data item.	The unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Count	2 num Right adjusted and zero filled from left. Mandatory data item.	The total number of primary sites for the cancer registration (ie. for the patient) will be reported. Only a single CAD file will be reported for the cancer registration, even if there are multiple primary sites.
Medicare Number	11 num Blank if not available or if null. Desirable - if available.	The Medicare number of patient. The field will not be zero or space filled. This comprises the 10 digit Medicare number and then the 1 digit reference number together.
Patient Surname	24 char Mandatory data item.	The current surname of the patient or resident. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First name	15 char If Unknown put 'Unknown' Mandatory data item.	The current given names of the patient or resident. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second name	15 char Blank if null. Desirable – if applicable.	Second names or initials where known. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Address of Usual Residence	50 char Mandatory data item. If Unknown type "Unknown"	Number and street of usual residential address of patient. Note: this is NOT a Post Office box or Mail Service No. - identify street name where possible. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Use Street Directory abbreviations (eg. St-street, Av- Avenue etc. see section 5.7.1)
Location (suburb/ town) of Usual Residence	40 char Mandatory data item.	Name of suburb, town or locality of usual residence. Note: this item is mandatory even if patient has a Property Name or mail service number. The field will not be zero or

Data Item	Requested Format	Source/Description
		space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.
Postcode of Usual Residence	4 num Mandatory data item.	Australian postcode corresponding to Address of usual residence. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.
Date of Birth	9 date ddmmmyyyy Mandatory data item.	Full date of birth of patient. If year is unknown, estimate the year. If the DOB is unknown, specify 15-JUN-1900. In addition, specify in the comments in the CAN file that the DOB is estimated.
Occupation (before retirement) Description	50 char Left adjusted, blank if null. Desirable – if known.	Means principal lifetime occupation. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Sex	1 char Mandatory data item.	The sex of the person. Only use the following: M= Male F= Female I= Indeterminate / Intersex
Country of Birth Code	4 num Right adjusted and zero filled from left. Mandatory data item.	The country in which the person is born. 4 digit code from the Australian Standard Classification of Countries for Social Statistics (ASCCSS).
Marital Status	2 char Mandatory data item.	The patients current marital status. Only use the following: NM= never married M= married F= Defacto W= widowed D= divorced A= separated N= not stated/unknown The field will not be zero or space filled.
Indigenous Status	2 num Mandatory data item	This item must be asked of the patient to collect the category to which the patient considers himself/herself to belong. 11=Indigenous-Aboriginal but not Torres Strait Islander origin. 12=Indigenous-Torres Strait Islander but not Aboriginal origin. 13=Indigenous-Aboriginal and Torres Strait Islander origin.

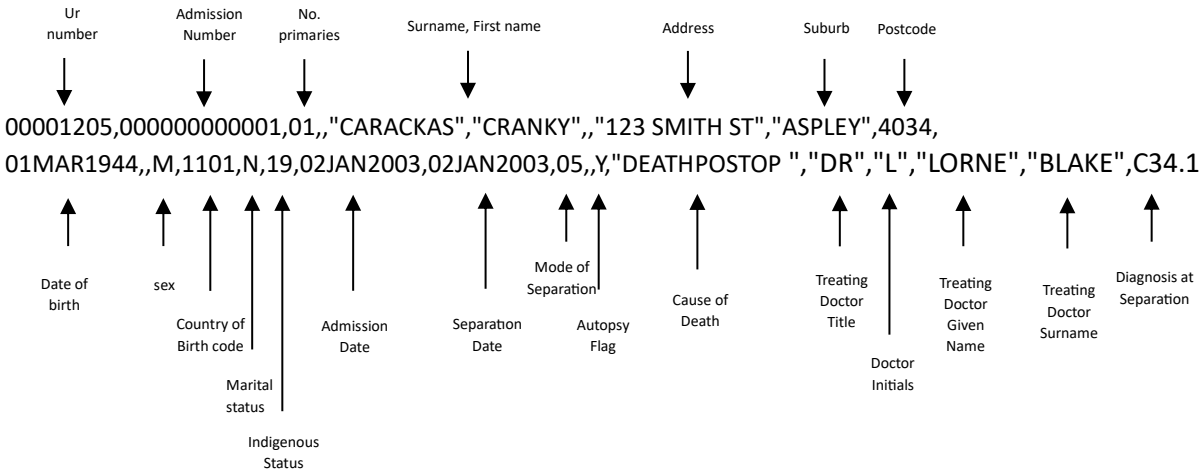
Data Item	Requested Format	Source/Description
		14=Not indigenous-not Aboriginal or Torres Strait Islander origin. 19=Not Stated The field will not be zero or space filled.
Admission Date	9 date ddmmmyyyy Mandatory data item.	This is the date on which an admitted patient commences an episode of care. Enter the full date of admission. DDMMMYYYY.
Separation Date	9 date ddmmmyyyy Mandatory data item.	This is the date that the patient was discharged, transferred or died. DDMMMYYYY.
Mode of Separation	2 char Mandatory data item.	Code which indicates the place to which a patient is referred immediately following separation from hospital. 01=Home/usual residence 04=Other health care establishment 05=Died in hospital 06=Care Type change 07=Discharge at own risk 09=Non return from leave 12=Correctional facility 13=Organ procurement 14=Boarder 15=Residential aged care service 16=Transferred to another hospital 19=Other 99=Unknown The field will not be zero or space filled.
Transferring to Facility	5 char Mandatory - If Transferred (Mode 16)	If the patient was transferred please complete facility number of the receiving facility. The field will not be zero or space filled.
Autopsy Flag	1 char Blank if null. Mandatory – If Died (Mode 05)	Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.
Cause of Death	50 char Left adjusted, blank if null. Mandatory – If Died (Mode 05)	Please only complete the cause of death if the patient dies in the hospital or nursing home. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Title	4 char Left adjusted, blank if null. Mandatory data item.	Refers to the Tile of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Initials	9 char Left adjusted, blank if null.	Refers to the Initials of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this

Data Item	Requested Format	Source/Description
	Mandatory data item.	admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Given Names	55 char Left adjusted, blank if null. Mandatory data item.	Refers to the Given Names of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Surname	29 char Left adjusted. Mandatory data item.	Refers to the Surname of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Diagnosis at Separation	9 char Left adjusted. Mandatory data item.	The principle diagnosis ICD 10-AM code for this admission. The field will not be zero or space filled.

Example of data in a CAD file

00000695,000000000002,01,,"LION","LARRY",,"15 DEN ROAD","JINDALEE",4074, 23JUN1940,, M, 1101,D,14,20MAY1999,20JUL1999,01,,,,"DR","J","JOHN","FROGLE",J46

00001204,000000000001,01,,"NOODLEMAN","HERMAN",,"123 EAGLE PDE","ASPLEY", 4034, 01APR1955,,M,1101,M,14,01JAN2003,10JAN2003,01,,,,"DR","LORNE","LORNE","BLAKE",C91.01



Cancer Details (CAN) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each primary site for the cancer registration for that admission (for the patient) will be reported in a separate CAN record. Therefore, the patient, for that admission, may have one or many CAN records.
Primary Site of Cancer Code	9 char Left adjusted Mandatory data item.	Indicates the site where the neoplasm originated. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Primary Site of Cancer Description	40 char Left adjusted. Mandatory data item.	Where possible, be specific when describing the primary site, for example, if known, state site as "upper or lower lobe of lung" or "upper-inner quadrant of breast". The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Morphology Code	7 char Mandatory data item.	4 digit Morphology code from ICD 10 AM and 5th digit indicting the behaviour of the tumour, for example invasive or insitu etc. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Date of First Diagnosis	9 date ddmmmyyyy Mandatory data item.	Try to accurately identify the full date of original diagnosis for this cancer where possible. If the date is unknown, the users will be required to enter 15 JUN 1900 in this field.
Date of First Diagnosis Flag	1 char Blank if null. Mandatory data item.	Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.
Location (suburb/ town) of usual residence at diagnosis	40 char Mandatory data item.	Name of suburb or town of usual residence at the time of first diagnosis of this cancer. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.

Data Item	Requested Format	Source/Description
Postcode of Usual Residence at Diagnosis	4 num Mandatory data item.	Australian postcode corresponding to Address of usual residence at the time of first Diagnosis of cancer. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.
Laterality of Cancer	1 char Mandatory data item.	Where possible, for cancers of paired organs, such as ovary, breast, kidney and lung, indicate which the side is affected by the tumour. R= Right L= Left B= Bilateral N= Not applicable U= Unknown Please see the explanation at the front of this document. For all non-paired organ sites, not applicable is the default. Unknown is used for paired organs only.
Basis of Diagnosis	2 num Mandatory data item.	Refers to the basis of diagnosis AT THIS ADMISSION. Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number. 01=Unknown 02=Clinical Only 03=Clinical Investigations 04=Exploratory Surgery 05=Specific Biochemical and immunological testing 06=Cytology 07=Histology of Metastasis 08=Histology of Primary Site 09=Autopsy and histology The field will not be zero or space filled. (If 02 or 03 is entered, a reason for clinical diagnosis will be displayed in the CDX file)

Data Item	Requested Format	Source/Description
Comments	50 char Left adjusted, blank if null. Desirable – if applicable.	This free text field allows the user to provide any other relevant details regarding the cancer that may assist the Register staff or reduce queries for the hospital. The field will not be zero or space filled. Double quotes will be used as a text de-limiter. If there is a Previous Pathology field or a Radiological Investigations field, this would be ideal in the comments data item, otherwise we will not know of any other tests performed if the basis of diagnosis is not clinical.
Laboratory facility number	2 char	This field becomes mandatory when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis). The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows: 01 Auslab 02 S & N 03 QML 04 Private Laboratory 05 Other
Laboratory Specimen No.	50 char	The lab specimen number will record the specimen lab number (e.g. report number) and any other comments required (e.g. if Other lab is recorded, then the user can record the actual lab name along with the Laboratory specimen number). This is a non-mandatory free text field, and only becomes enabled when the codes of 06, 07 08 or 09 is entered into field 13.

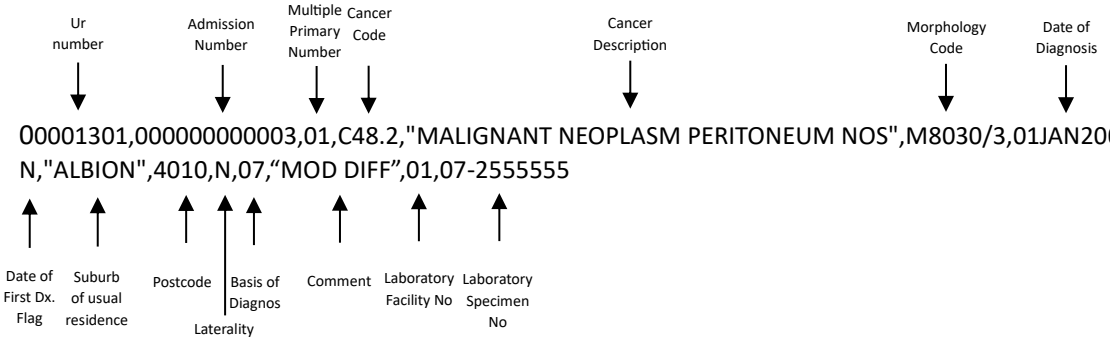
Example of CAN file

00000695,000000000002,01,C54.0,"MALIGNANT NEOPLASM OF ISTHMUS UTERI",M8140/3,01MAY1999, N,"CANBERRA ACT",2600,U,01,"HISTORY",01,07-25555

00001204,000000000001,01,C91.01,"ACUTE LYMPHOBLASTIC LEUKAEMIA IN REM",M9835/3,01JAN2001, Y,"ASPLEY",4034,N,03,,,

00001205,000000000001,01,C34.1,"MALGT NEOPLM UPPER LOBE BRONCHUS OR LUNG",M8140/3, 01JAN2000,N,"HAWTHORNE",4171,R,01,

00001250,000000000002,01,D39.1,"NEOPLASM UNCERTAIN OR UNKNOWN BEH OVARY",M8000/1, 15JUN2002,Y,"CARINA",4152,L,02,"CHECK FOR FURTHER NOTES"



Reason for Clinical Diagnosis (CDX) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each reason for clinical diagnosis for each primary site for the cancer registration will be reported in a separate CDX record. Therefore, the patient may have none, one or many CDX records and the patient may have none, one or many CDX records for a given primary site.
Reasons for clinical diagnosis code	2 num Right adjusted and zero filled from left. Mandatory data item.	Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows: 01=Pallative care admission 02=Doctors notes/Referral 03=Pathology 04=Radiological investigations 05=Other non invasive investigations 06=Invasive investigation 07=Non cancer admission 09=Other The field will not be zero or space filled.

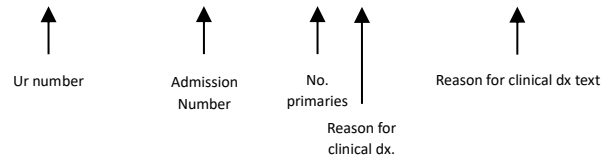
Data Item	Requested Format	Source/Description
		You cannot have more than one of the above codes for the same primary site. ie: for patient UR number 123456 ; primary site number 01, the code 03 cannot be used more than once. You need to use another code if there is another reason, therefore use 03 and 09.
Reasons for clinical diagnosis text	50 char Blank if reasons for clinical diagnosis code = 01. Desirable – if applicable.	Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in this field. The extract will simply include the details if available for that reason for clinical diagnosis item or leave the field in the CDX record blank if the details field is blank for that reason for clinical diagnosis item. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Example of CDX

00001204,000000000001,01,02,"MEDICAL RECORD NOTES"

00001204,000000000001,01,03,"SEE MEDICAL RECORD"

00001250,000000000002,01,04,"SEE EXAMINATION REPORT"



Former/Alias Names (FAN) File
– If there are Alias Names this file is Mandatory

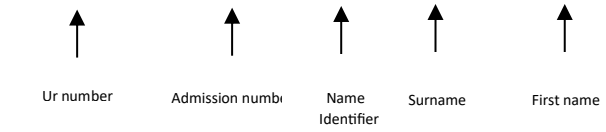
Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Former/Alias Name Identifier	2 num Right adjusted and zero filled from left. Mandatory data item.	Each alias entered for the patient will be reported in a separate FAN record. Therefore, the patient may have none, one or many FAN records. The alias details are linked to an individual patient but are not linked to an individual admission for that patient. Therefore, when the alias details are reported in the FAN record/s, each alias that exists for that patient will be reported, regardless of the admission number reported. If a patient has an alias and therefore a FAN record, the name identifier can not be '00'.
Patient Surname	24 char Left adjusted. Mandatory data item.	Any previous surname that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First Name	15 char Left adjusted. Mandatory data item.	Any previous first name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Patient Second Name	15 char Left adjusted. Desirable – if applicable.	Any previous second name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Example of FAN

00000695,000000000002,01,"LION","LENARD",
00001204,000000000001,01,"HERMIT","HERMAN",
00001204,000000000001,02,"NOODLEMAN","HERMIE",
00001205,000000000001,01,"PANTS","CRANKY",
00001301,000000000003,01,"ANDREWS","ANDROID",
00001301,000000000003,02,"ANDREWS","ANDREW",

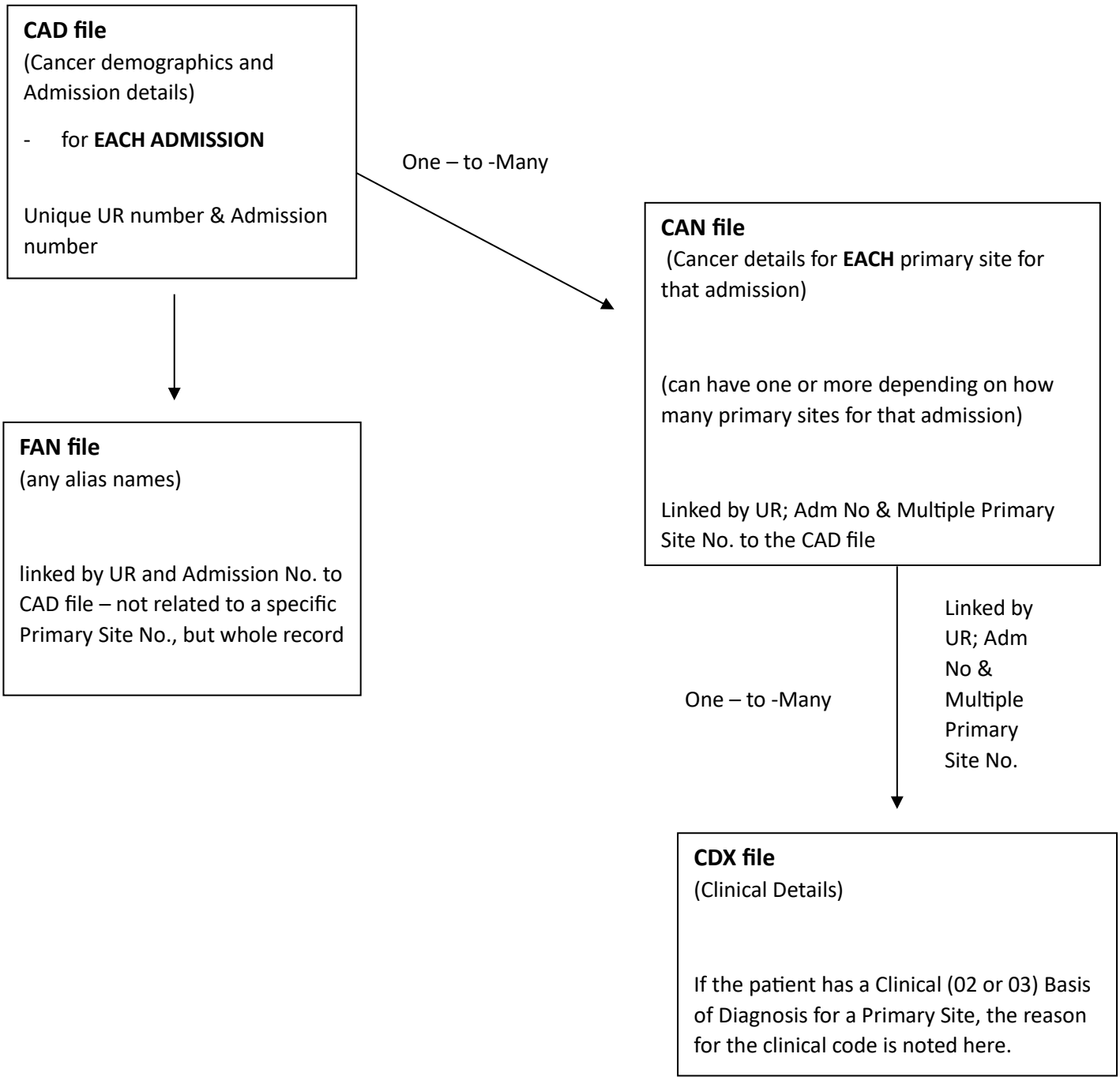
00001301,000000000003,03,"ANDREWS","JULIE",



How the files are linked together?

The CAD record relates to a specific admission, so if the patient is admitted twice in the extract period (can happen if the extract period is for a month) then there will be 2 CAD records for the patient, and subsequent CAN records from that admission.

There could also be more than one CDX file if the second CAD admission and subsequent CAN/s have a CDX (ie: Clinical Details) as well as the first admission ....as the CDX file is linked to the CAN file for that specific primary site number....



Appendix C – Example of how QCR displays the data supplied

Facility	Name of Hospital/Institution	Test Hospital (00123)
Patient	Medicare Number	1234567890
	UR Number	0987654
	Patient Surname	Smith
	Given Name(s)	Jane
	Former Surname(s)	-
Patient Address	No. and Street	123 Smart Street
	Suburb/Locality	Brisbane
	Postcode	4000
Demographics	Date of Birth	15/06/1950
	Occupation	Teacher
	Sex	F
	Country of Birth	1101 Australia
	Marital Status	Married/De Facto
	Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Admission	Admission Date	06/03/2023
	Separation Date	07/03/2023
	Separation Mode	01 Home/usual residence
	If transferred, name of institution	-
Death	Was an autopsy held?	-
	State underlying cause of death	-
	Date of Death	-
Cancer Diagnosis	Primary site of cancer	D059 Carcinoma in situ of breast, unspecified
	Histological type of cancer	82302 Ductal ca insit, solid type
	Date of first diagnosis of cancer	06/03/2023
	Estimated?	N
	Suburb at Diagnosis	Brisbane
	State at Diagnosis	QLD
	Postcode at Diagnosis	4000
	Laterality of cancer	Right
	Is there more than one primary site?	N
	Most valid basis of diagnosis at this admission	8 Histology of Primary Tumour
	Reason for clinical diagnosis	-
	Comments	-
	Diagnosis at separation	D05.9 Carcinoma in situ of breast unspecified
	Treating Doctor	DR Anthony Harper (A Harper)
Additional details	Lab facility	02 – SNP
	Lab specimen number	12345-67BR

Appendix D – ICD-10-AM neoplasm site codes required to be notified to the QCR

All hospitals are required to notify QCR for the following:

- All invasive cancers
- All cancers with an uncertain behaviour
- All in-situ conditions
- Benign central nervous system and brain tumours

- Do NOT need to notify Basal Cell Carcinomas and Squamous Cell Carcinomas of the Skin

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A prompt appears if any of the following required ICD-10-AM neoplasm site codes are entered on the screen.

(The following site codes ARE NOT required and therefore these are not in the above list:
C44 with morphology M805-8110 – BCC and SCC of skin
C77, C78 and C79 – secondary sites
D10-D31.9 – Benign, not brain
D34 – D36.9 – Benign, not brain)

These are the ranges in the ICD-10-AM neoplasm site codes (as above) that ARE required:

Invasive

C00.0 – C76.8
C80.0 – C96.9
and exclude C44.0 to C44.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Insitu and Benign Brain/CNS

D00.0 – D09.9
D32.0 – D33.9
D35.2 Benign pituitary
D18.02 Benign brain
D18.06 Benign eye
and exclude D04.0 to D04.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Uncertain

D37.0 to D48.9
and exclude D48.5 AND M80500 to M81109 (Skin SCC's and BCC's)

Personal history of malignant neoplasm

Z85.0, Z85.1, Z85.2, Z85.3, Z85.4, Z85.5, Z85.6, Z85.7, Z85.8, Z85.9, Z86.0

We also require ICD-10-AM Site Codes:
Q85.0
D76.1
O01.0 – O01.9

Modifications you may like to use for your system to identify cases to be sent:

In the HBCIS system used by the public hospitals, there are **non-notifiable cancer** and **history of cancer parameters** that are hard coded i.e.: they are not modifiable by users.

1. The non-notifiable parameter lists the paired combinations of neoplasm and morphology codes that do not require cancer registration. The parameter lists the following excluded skin codes:

    - malignant neoplasm of skin codes (other than melanoma)
      C44.0, C44.1, C44.2, C44.3, C44.4, C44.5, C44.6, C44.7, C44.8 and C44.9.
    - carcinoma in-situ of skin codes
      D04.0, D04.1, D04.2, D04.3, D04.4, D04.5, D04.6, D04.7, D04.8, D04.9.
    - neoplasm of uncertain or unknown behaviour of skin D48.5

    and the following selected morphology codes:

    - basal cell and squamous cell morphologies
      M805, M806, M807, M808, M809, M810, M811.

2. The history of cancer parameter enables the reporting of episodes where the history of cancer has been coded and the episode is the first presentation in a calendar year. The following codes are included:

    - personal history of malignant neoplasm
      Z85.0, Z85.1, Z85.2, Z85.3, Z85.4, Z85.5, Z85.6, Z85.7, Z85.8, Z85.9. The coder is prompted if entered.

Full list of notifiable ICD-10-AM neoplasm site codes

ICD Code	Description	Exclusions
C00.0	MALIGNANT NEOPLASM OF EXTERNAL UPPER LIP	
C00.1	MALIGNANT NEOPLASM OF EXTERNAL LOWER LIP	
C00.2	MALIGNANT NEOPLASM EXTERNAL LIP UNSP	
C00.3	MALG NEOPLASM UPPER LIP INNER ASPECT	
C00.4	MALG NEOPLASM LOWER LIP INNER ASPECT	
C00.5	MALG NEOPLASM LIP UNSP INNER ASPECT	
C00.6	MALIGNANT NEOPLASM OF COMMISSURE OF LIP	
C00.8	OVERLAPPING MALIGNANT LESION OF LIP	
C00.9	MALIGNANT NEOPLASM OF LIP UNSPECIFIED	
C01	MALIGNANT NEOPLASM OF BASE OF TONGUE	
C02.0	MALG NEOPLASM DORSAL SURFACE OF TONGUE	
C02.1	MALIGNANT NEOPLASM OF BORDER OF TONGUE	
C02.2	MALG NEOPLASM VENTRAL SURFACE TONGUE	
C02.3	MALG NEOPLASM ANT TONGUE PART UNSP	
C02.4	MALIGNANT NEOPLASM OF LINGUAL TONSIL	
C02.8	MALG NEOPLASM OVERLAPPING LESION TONGUE	
C02.9	MALIGNANT NEOPLASM TONGUE UNSPECIFIED	
C03.0	MALIGNANT NEOPLASM OF UPPER GUM	
C03.1	MALIGNANT NEOPLASM OF LOWER GUM	
C03.9	MALIGNANT NEOPLASM OF GUM UNSPECIFIED	
C04.0	MALIGNANT NEOPLASM ANT FLOOR OF MOUTH	
C04.1	MALIGNANT NEOPLASM LAT FLOOR OF MOUTH	
C04.8	OVERLAPPING MALG LESION FLOOR OF MOUTH	
C04.9	MALG NEOPLASM OF FLOOR OF MOUTH UNSP	
C05.0	MALIGNANT NEOPLASM OF HARD PALATE	
C05.1	MALIGNANT NEOPLASM OF SOFT PALATE	
C05.2	MALIGNANT NEOPLASM OF UVULA	
C05.8	OVERLAPPING MALIGNANT LESION OF PALATE	
C05.9	MALIGNANT NEOPLASM OF PALATE UNSPECIFIED	
C06.0	MALIGNANT NEOPLASM OF CHEEK MUCOSA	
C06.1	MALIGNANT NEOPLASM OF VESTIBULE OF MOUTH	
C06.2	MALIGNANT NEOPLASM OF RETROMOLAR AREA	
C06.8	OVERLAP MALG LESION OTH / UNSP MOUTH	
C06.9	MALIGNANT NEOPLASM OF MOUTH UNSPECIFIED	
C07	MALIGNANT NEOPLASM OF PAROTID GLAND	
C08.0	MALIGNANT NEOPLASM SUBMANDIBULAR GLAND	
C08.1	MALIGNANT NEOPLASM OF SUBLINGUAL GLAND	
C08.8	OVERLAPPING MALG LESION MAJOR SAL GLANDS	
C08.9	MALG NEOPLASM MAJOR SALIVARY GLAND UNSP	
C09.0	MALIGNANT NEOPLASM OF TONSILLAR FOSSA	
C09.1	MALG NEOPLASM TONSILLAR PILLAR	
C09.8	OVERLAPPING MALIGNANT LESION OF TONSIL	

C09.9	MALIGNANT NEOPLASM TONSIL UNSPECIFIED	
C10.0	MALIGNANT NEOPLASM OF VALLECULA	
C10.1	MALG NEOPLASM ANT SURFACE EPIGLOTTIS	
C10.2	MALIGNANT NEOPLASM LAT WALL OROPHARYNX	
C10.3	MALIGNANT NEOPLASM POST WALL OROPHARYNX	
C10.4	MALIGNANT NEOPLASM OF BRANCHIAL CLEFT	
C10.8	OVERLAPPING MALIGNANT LESION OROPHARYNX	
C10.9	MALIGNANT NEOPLASM OROPHARYNX UNSP	
C11.0	MALG NEOPLASM SUPERIOR WALL NASOPHRYNX	
C11.1	MALIGNANT NEOPLASM POST WALL NASOPHARYNX	
C11.2	MALIGNANT NEOPLASM LAT WALL NASOPHARYNX	
C11.3	MALIGNANT NEOPLASM ANT WALL NASOPHARYNX	
C11.8	OVERLAPPING MALG LESION OF NASOPHARYNX	
C11.9	MALIGNANT NEOPLASM NASOPHARYNX UNSP	
C12	MALIGNANT NEOPLASM OF PYRIFORM SINUS	
C13.0	MALIGNANT NEOPLASM OF POSTCRICOID REGION	
C13.1	MALG NEOPLASM HYPOPHRNGL ARYEPIGLTC FOLD	
C13.2	MALIGNANT NEOPLASM POST WALL HYPOPHARYNX	
C13.8	OVERLAPPING MALIGNANT LESION HYPOPHARYNX	
C13.9	MALIGNANT NEOPLASM HYPOPHARYNX UNSP	
C14.0	MALIGNANT NEOPLASM PHARYNX UNSPECIFIED	
C14.2	MALIGNANT NEOPLASM OF WALDEYER RING	
C14.8	OVERLAP MALG NEOPLASM LIP ORAL CV PHRYNX	
C15.0	MALIGNANT NEOPLASM CERVICAL OESOPHAGUS	
C15.1	MALIGNANT NEOPLASM THORACIC OESOPHAGUS	
C15.2	MALIGNANT NEOPLASM ABDOMINAL OESOPHAGUS	
C15.3	MALG NEOPLASM UPPER THIRD OESOPHAGUS	
C15.4	MALG NEOPLASM MIDDLE THIRD OESOPHAGUS	
C15.5	MALG NEOPLASM LOWER THIRD OESOPHAGUS	
C15.8	OVERLAPPING MALIGNANT LESION OESOPHAGUS	
C15.9	MALIGNANT NEOPLASM OESOPHAGUS UNSP	
C16.0	MALIGNANT NEOPLASM OF CARDIA	
C16.1	MALIGNANT NEOPLASM OF FUNDUS OF STOMACH	
C16.2	MALIGNANT NEOPLASM OF BODY OF STOMACH	
C16.3	MALIGNANT NEOPLASM OF PYLORIC ANTRUM	
C16.4	MALIGNANT NEOPLASM OF PYLORUS	
C16.5	MALG NEOPLASM LESSER CURVE STOMACH UNSP	
C16.6	MALG NEOPLASM GREATER CURVE STOMACH UNSP	
C16.8	OVERLAPPING MALIGNANT LESION OF STOMACH	
C16.9	MALIGNANT NEOPLASM STOMACH UNSPECIFIED	
C17.0	MALIGNANT NEOPLASM OF DUODENUM	
C17.1	MALIGNANT NEOPLASM OF JEJUNUM	
C17.2	MALIGNANT NEOPLASM OF ILEUM	
C17.3	MALIGNANT NEOPLASM MECKEL'S DIVERTICULUM	
C17.8	OVERLAP MALG LESION OF SMALL INTESTINE	
C17.9	MALIGNANT NEOPLASM SMALL INTESTINE UNSP	

C18.0	MALIGNANT NEOPLASM OF CAECUM	
C18.1	MALIGNANT NEOPLASM OF APPENDIX	
C18.2	MALIGNANT NEOPLASM OF ASCENDING COLON	
C18.3	MALIGNANT NEOPLASM OF HEPATIC FLEXURE	
C18.4	MALIGNANT NEOPLASM OF TRANSVERSE COLON	
C18.5	MALIGNANT NEOPLASM OF SPLENIC FLEXURE	
C18.6	MALIGNANT NEOPLASM OF DESCENDING COLON	
C18.7	MALIGNANT NEOPLASM OF SIGMOID COLON	
C18.8	OVERLAPPING MALIGNANT LESION OF COLON	
C18.9	MALG NEOPLASM OF COLON PART UNSPECIFIED	
C19	MALIGNANT NEOPLASM RECTOSIGMOID JUNCTION	
C20	MALIGNANT NEOPLASM OF RECTUM	
C21.0	MALIGNANT NEOPLASM OF ANUS UNSPECIFIED	
C21.1	MALIGNANT NEOPLASM OF ANAL CANAL	
C21.2	MALIGNANT NEOPLASM OF CLOACOGENIC ZONE	
C21.8	OVERLAP MALG LESION RECTUM ANUS ANAL CNL	
C22.0	LIVER CELL CARCINOMA	
C22.1	INTRAHEPATIC BILE DUCT CARCINOMA	
C22.2	HEPATOBLASTOMA	
C22.3	ANGIOSARCOMA OF LIVER	
C22.4	OTHER SARCOMAS OF LIVER	
C22.7	OTHER SPECIFIED CARCINOMAS OF LIVER	
C22.9	MALIGNANT NEOPLASM OF LIVER UNSPECIFIED	
C23	MALIGNANT NEOPLASM OF GALLBLADDER	
C24.0	MALIGNANT NEOPLM EXTRAHEPATIC BILE DUCT	
C24.1	MALIGNANT NEOPLASM OF AMPULLA OF VATER	
C24.8	OVERLAPPING MALG LESION OF BILIARY TRACT	
C24.9	MALIGNANT NEOPLASM BILIARY TRACT UNSP	
C25.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS	
C25.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS	
C25.2	MALIGNANT NEOPLASM OF TAIL OF PANCREAS	
C25.3	MALIGNANT NEOPLASM OF PANCREATIC DUCT	
C25.4	MALIGNANT NEOPLASM OF ENDOCRINE PANCREAS	
C25.7	MALIGNANT NEOPLASM OTHER PARTS PANCREAS	
C25.8	OVERLAPPING MALIGNANT LESION OF PANCREAS	
C25.9	MALIGNANT NEOPLASM PANCREAS PART UNSP	
C26.0	MALG NEOPLASM INTEST TRACT PART UNSP	
C26.1	MALIGNANT NEOPLASM OF SPLEEN	
C26.8	OVERLAP MALG LESION OF DIGESTIVE SYSTEM	
C26.9	MALG NEOPLASM ILL-DEF SITE DIGEST SYSTEM	
C30.0	MALIGNANT NEOPLASM OF NASAL CAVITY	
C30.1	MALIGNANT NEOPLASM OF MIDDLE EAR	
C31.0	MALIGNANT NEOPLASM OF MAXILLARY SINUS	
C31.1	MALIGNANT NEOPLASM OF ETHMOIDAL SINUS	
C31.2	MALIGNANT NEOPLASM OF FRONTAL SINUS	
C31.3	MALIGNANT NEOPLASM OF SPHENOIDAL SINUS	

C31.8	OVERLAP MALG LESION OF ACCESSORY SINUSES	
C31.9	MALIGNANT NEOPLASM ACCESSORY SINUS UNSP	
C32.0	MALIGNANT NEOPLASM OF GLOTTIS	
C32.1	MALIGNANT NEOPLASM OF SUPRAGLOTTIS	
C32.2	MALIGNANT NEOPLASM OF SUBGLOTTIS	
C32.3	MALIGNANT NEOPLASM LARYNGEAL CARTILAGE	
C32.8	OVERLAPPING MALIGNANT LESION OF LARYNX	
C32.9	MALIGNANT NEOPLASM LARYNX UNSPECIFIED	
C33	MALIGNANT NEOPLASM OF TRACHEA	
C34.0	MALIGNANT NEOPLASM OF MAIN BRONCHUS	
C34.1	MALG NEOPLM UPPER LOBE BRONCHUS OR LUNG	
C34.2	MALG NEOPLASM MID LOBE BRONCHUS OR LUNG	
C34.3	MALG NEOPLM LOWER LOBE BRONCHUS OR LUNG	
C34.8	OVERLAP MALG LESION OF BRONCHUS & LUNG	
C34.9	MALIGNANT NEOPLASM BRONCHUS OR LUNG UNSP	
C37	MALIGNANT NEOPLASM OF THYMUS	
C38.0	MALIGNANT NEOPLASM OF HEART	
C38.1	MALIGNANT NEOPLASM ANTERIOR MEDIASTINUM	
C38.2	MALIGNANT NEOPLASM POSTERIOR MEDIASTINUM	
C38.3	MALG NEOPLASM MEDIASTINUM, PART UNSP	
C38.4	MALIGNANT NEOPLASM OF PLEURA	
C38.8	OVERLAP MALG LSN HEART MEDIAST & PLEURA	
C39.0	MALG NEOPLM UPPER RESP TRACT PART UNSP	
C39.8	OVERLAP MALG LESION RESP & INTRATHOR ORG	
C39.9	MALG NEOPLASM ILL-DEF SITES RESP SYSTEM	
C40.0	MALG NEOPLASM SCAPULA LONG BONES UPP LMB	
C40.1	MALG NEOPLASM SHORT BONES UPPER LIMB	
C40.2	MALIGNANT NEOPLASM LONG BONES LOWER LIMB	
C40.3	MALG NEOPLASM SHORT BONES LOWER LIMB	
C40.8	OVERLAP MALG LESION BONE ARTLR CART LIMB	
C40.9	MALG NEOPLM BNE & ARTLR CART LIMB UNSP	
C41.01	MALIGNANT NEOPLASM OF CRANIOFACIAL BONES	
C41.02	MALIGNANT NEOPLASM MAXILLOFACIAL BONES	
C41.1	MALIGNANT NEOPLASM OF MANDIBLE	
C41.2	MALIGNANT NEOPLASM OF VERTEBRAL COLUMN	
C41.3	MALIGNANT NEOPLASM RIBS STERNUM CLAVICLE	
C41.4	MALG NEOPLASM PELVIC BONES SACRUM COCCYX	
C41.8	OVERLAP MALIGNANT LESION BONE ARTLR CART	
C41.9	MALG NEOPLM BNE & ARTLR CARTILAGE UNSP	
C43.0	MALIGNANT MELANOMA OF LIP	
C43.1	MALG MELANOMA EYELID INCLUDING CANTHUS	
C43.2	MALG MELANOMA EAR & EXT AURICULAR CANAL	
C43.3	MALG MELANOMA OTHER & UNSP PARTS FACE	
C43.4	MALIGNANT MELANOMA OF SCALP AND NECK	
C43.5	MALIGNANT MELANOMA OF TRUNK	
C43.6	MALG MELANOMA UPPER LIMB INCL SHOULDER	

C43.7	MALIGNANT MELANOMA LOWER LIMB INCL HIP	
C43.8	OVERLAPPING MALIGNANT MELANOMA OF SKIN	
C43.9	MALIGNANT MELANOMA OF SKIN UNSPECIFIED	
C44.0	MALIGNANT NEOPLASM OF SKIN OF LIP	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.1	MALG NEOPLASM SKIN EYELID INCL CANTHUS	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.2	MALG NEOPLM SKIN EAR & EXT AURIC CANAL	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.3	MALG NEOPLASM SKIN OTH / UNSP PARTS FACE	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.4	MALIGNANT NEOPLASM SKIN OF SCALP & NECK	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.5	MALIGNANT NEOPLASM OF SKIN OF TRUNK	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.6	MALG NEOPLASM SKIN UPP LMB INCL SHOULDER	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.7	MALG NEOPLASM SKIN LOWER LIMB INCL HIP	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.8	OVERLAPPING MALIGNANT LESION OF SKIN	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C44.9	MALIGNANT NEOPLASM OF SKIN UNSPECIFIED	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
C45.0	MESOTHELIOMA OF PLEURA	
C45.1	MESOTHELIOMA OF PERITONEUM	
C45.2	MESOTHELIOMA OF PERICARDIUM	
C45.7	MESOTHELIOMA OF OTHER SITES	
C45.9	MESOTHELIOMA UNSPECIFIED	
C46.0	KAPOSI SARCOMA OF SKIN	
C46.1	KAPOSI SARCOMA OF SOFT TISSUE	
C46.2	KAPOSI SARCOMA OF PALATE	
C46.3	KAPOSI SARCOMA OF LYMPH NODES	
C46.7	KAPOSI SARCOMA OF OTHER SITES	
C46.8	KAPOSI SARCOMA OF MULTIPLE ORGANS	
C46.9	KAPOSI SARCOMA UNSPECIFIED	
C47.0	MALG NEOPLM PERPH NERVE HEAD FACE & NECK	
C47.1	MALG NEOPLM PERPH NERVE UPP LMB SHOULDER	
C47.2	MALG NEOPLM PERPH NRV LOW LIMB INCL HIP	
C47.3	MALG NEOPLASM PERIPHERAL NERVES THORAX	
C47.4	MALG NEOPLASM PERIPHERAL NERVES ABDOMEN	
C47.5	MALG NEOPLASM PERIPHERAL NERVES PELVIS	
C47.6	MALG NEOPLASM PERPH NERVES OF TRUNK UNSP	
C47.8	OVERLAP MALG LSN PERPH NRV AUT NRVS SYS	
C47.9	MALG NEOPLM PERPH NRV & AUT NRVS SYS ?	
C48.0	MALIGNANT NEOPLASM OF RETROPERITONEUM	
C48.1	MALG NEOPLASM SPEC PARTS OF PERITONEUM	
C48.2	MALIGNANT NEOPLASM PERITONEUM UNSP	
C48.8	OVERLAP MALG LSN RETPERITONM PERITONEUM	
C49.0	MALG NEOPLM CON & SOFT TIS HEAD FACE NEK	
C49.1	MALG NEOPLM CON / SOFT TIS UPP LMB SHOLD	
C49.2	MALG NEOPLM CON & SOFT TIS LOW LIMB HIP	
C49.3	MALG NEOPLASM CON & SOFT TISSUE THORAX	
C49.4	MALG NEOPLASM CON & SOFT TISSUE ABDOMEN	

C49.5	MALG NEOPLASM CON & SOFT TISSUE PELVIS	
C49.6	MALG NEOPLASM CON / SOFT TIS TRUNK UNSP	
C49.8	OVERLAP MALG LESION CON & SOFT TISSUE	
C49.9	MALG NEOPLASM CON & SOFT TISSUE UNSP	
C50.0	MALIGNANT NEOPLASM OF NIPPLE AND AREOLA	
C50.1	MALG NEOPLASM OF CENTRAL PORTION BREAST	
C50.2	MALG NEOPLASM UPP INNER QUADRANT BREAST	
C50.3	MALG NEOPLASM LOW INNER QUADRANT BREAST	
C50.4	MALG NEOPLASM UPP OUTER QUADRANT BREAST	
C50.5	MALG NEOPLASM LOW OUTER QUADRANT BREAST	
C50.6	MALIGNANT NEOPLASM AXILLARY TAIL BREAST	
C50.8	OVERLAPPING MALIGNANT LESION OF BREAST	
C50.9	MALIGNANT NEOPLASM BREAST PART UNSP	
C51.0	MALIGNANT NEOPLASM OF LABIUM MAJUS	
C51.1	MALIGNANT NEOPLASM OF LABIUM MINUS	
C51.2	MALIGNANT NEOPLASM OF CLITORIS	
C51.8	OVERLAPPING MALIGNANT LESION OF VULVA	
C51.9	MALIGNANT NEOPLASM OF VULVA UNSPECIFIED	
C52	MALIGNANT NEOPLASM OF VAGINA	
C53.0	MALIGNANT NEOPLASM OF ENDOCERVIX	
C53.1	MALIGNANT NEOPLASM OF EXOCERVIX	
C53.8	OVERLAP MALIGNANT LESION CERVIX UTERI	
C53.9	MALIGNANT NEOPLASM CERVIX UTERI UNSP	
C54.0	MALIGNANT NEOPLASM OF ISTHMUS UTERI	
C54.1	MALIGNANT NEOPLASM OF ENDOMETRIUM	
C54.2	MALIGNANT NEOPLASM OF MYOMETRIUM	
C54.3	MALIGNANT NEOPLASM OF FUNDUS UTERI	
C54.8	OVERLAP MALIGNANT LESION CORPUS UTERI	
C54.9	MALIGNANT NEOPLASM CORPUS UTERI UNSP	
C55	MALIGNANT NEOPLASM UTERUS PART UNSP	
C56	MALIGNANT NEOPLASM OF OVARY	
C57.0	MALIGNANT NEOPLASM OF FALLOPIAN TUBE	
C57.1	MALIGNANT NEOPLASM OF BROAD LIGAMENT	
C57.2	MALIGNANT NEOPLASM OF ROUND LIGAMENT	
C57.3	MALIGNANT NEOPLASM OF PARAMETRIUM	
C57.4	MALIGNANT NEOPLASM UTERINE ADNEXA UNSP	
C57.7	MALG NEOPLM OTHER SPEC FEMLE GEN ORGAN	
C57.8	OVERLAP MALG LESION FEMALE GENITAL ORGAN	
C57.9	MALG NEOPLASM FEMALE GENITAL ORGAN UNSP	
C58	MALIGNANT NEOPLASM OF PLACENTA	
C60.0	MALIGNANT NEOPLASM OF PREPUCE	
C60.1	MALIGNANT NEOPLASM OF GLANS PENIS	
C60.2	MALIGNANT NEOPLASM OF BODY OF PENIS	
C60.8	OVERLAPPING MALIGNANT LESION OF PENIS	
C60.9	MALIGNANT NEOPLASM OF PENIS UNSPECIFIED	
C61	MALIGNANT NEOPLASM OF PROSTATE	

C62.0	MALIGNANT NEOPLASM OF UNDESCENDED TESTIS	
C62.1	MALIGNANT NEOPLASM OF DESCENDED TESTIS	
C62.9	MALIGNANT NEOPLASM OF TESTIS UNSPECIFIED	
C63.0	MALIGNANT NEOPLASM OF EPIDIDYMIS	
C63.1	MALIGNANT NEOPLASM OF SPERMATIC CORD	
C63.2	MALIGNANT NEOPLASM OF SCROTUM	
C63.7	OTHER SPECIFIED MALE GENITAL ORGANS	
C63.8	OVERLAP MALG LESION MALE GENITAL ORGANS	
C63.9	MALG NEOPLASM MALE GENITAL ORGAN UNSP	
C64	MALG NEOPLASM KIDNEY EXCEPT RENAL PELVIS	
C65	MALIGNANT NEOPLASM OF RENAL PELVIS	
C66	MALIGNANT NEOPLASM OF URETER	
C67.0	MALIGNANT NEOPLASM OF TRIGONE OF BLADDER	
C67.1	MALIGNANT NEOPLASM OF DOME OF BLADDER	
C67.2	MALIGNANT NEOPLASM LATERAL WALL BLADDER	
C67.3	MALIGNANT NEOPLASM ANTERIOR WALL BLADDER	
C67.4	MALG NEOPLASM OF POSTERIOR WALL BLADDER	
C67.5	MALIGNANT NEOPLASM OF BLADDER NECK	
C67.6	MALIGNANT NEOPLASM OF URETERIC ORIFICE	
C67.7	MALIGNANT NEOPLASM OF URACHUS	
C67.8	OVERLAPPING MALIGNANT LESION OF BLADDER	
C67.9	MALIGNANT NEOPLASM OF BLADDER UNSP	
C68.0	MALIGNANT NEOPLASM OF URETHRA	
C68.1	MALIGNANT NEOPLASM OF PARAURETHRAL GLAND	
C68.8	OVERLAP MALIGNANT LESION URINARY ORGANS	
C68.9	MALIGNANT NEOPLASM URINARY ORGAN UNSP	
C69.0	MALIGNANT NEOPLASM OF CONJUNCTIVA	
C69.1	MALIGNANT NEOPLASM OF CORNEA	
C69.2	MALIGNANT NEOPLASM OF RETINA	
C69.3	MALIGNANT NEOPLASM OF CHOROID	
C69.4	MALIGNANT NEOPLASM OF CILIARY BODY	
C69.5	MALIGNANT NEOPLASM LACRIMAL GLAND & DUCT	
C69.6	MALIGNANT NEOPLASM OF ORBIT	
C69.7	MALG NEOPLM OTH SPEC PARTS OF EYE	
C69.8	OVERLAP MALIGNANT LESION EYE & ADNEXA	
C69.9	MALIGNANT NEOPLASM OF EYE UNSPECIFIED	
C70.0	MALIGNANT NEOPLASM OF CEREBRAL MENINGES	
C70.1	MALIGNANT NEOPLASM OF SPINAL MENINGES	
C70.9	MALIGNANT NEOPLM OF MENINGES, UNSP	
C71.0	MALG NEOPLASM CEREBRUM EX LOBES & VENTRL	
C71.1	MALIGNANT NEOPLASM OF FRONTAL LOBE	
C71.2	MALIGNANT NEOPLASM OF TEMPORAL LOBE	
C71.3	MALIGNANT NEOPLASM OF PARIETAL LOBE	
C71.4	MALIGNANT NEOPLASM OF OCCIPITAL LOBE	
C71.5	MALIGNANT NEOPLASM OF CEREBRAL VENTRICLE	
C71.6	MALIGNANT NEOPLASM OF CEREBELLUM	

C71.7	MALIGNANT NEOPLASM OF BRAIN STEM	
C71.8	OVERLAPPING MALIGNANT LESION OF BRAIN	
C71.9	MALIGNANT NEOPLASM OF BRAIN UNSPECIFIED	
C72.0	MALIGNANT NEOPLASM OF SPINAL CORD	
C72.1	MALIGNANT NEOPLASM OF CAUDA EQUINA	
C72.2	MALIGNANT NEOPLASM OF OLFACTORY NERVE	
C72.3	MALIGNANT NEOPLASM OF OPTIC NERVE	
C72.4	MALIGNANT NEOPLASM OF ACOUSTIC NERVE	
C72.5	MALG NEOPLASM OTH / UNSP CRANIAL NERVES	
C72.8	OVERLAP MALG LESION BRAIN & OTHER CNS	
C72.9	MALIGNANT NEOPLASM CNS UNSPECIFIED	
C73	MALIGNANT NEOPLASM OF THYROID GLAND	
C74.0	MALIGNANT NEOPLASM CORTEX ADRENAL GLAND	
C74.1	MALIGNANT NEOPLASM MEDULLA ADRENAL GLAND	
C74.9	MALIGNANT NEOPLASM ADRENAL GLAND UNSP	
C75.0	MALIGNANT NEOPLASM OF PARATHYROID GLAND	
C75.1	MALIGNANT NEOPLASM OF PITUITARY GLAND	
C75.2	MALIGNANT NEOPLASM CRANIOPHARYNGEAL DUCT	
C75.3	MALIGNANT NEOPLASM OF PINEAL GLAND	
C75.4	MALIGNANT NEOPLASM OF CAROTID BODY	
C75.5	MALG NEOPLM AORTIC BODY OTH PARAGANGLIA	
C75.8	MALG NEOPLASM PLURIGLANDULAR INV UNSP	
C75.9	MALIGNANT NEOPLASM ENDOCRINE GLAND UNSP	
C76.0	MALIGNANT NEOPLASM HEAD FACE & NECK	
C76.1	MALIGNANT NEOPLASM OF THORAX	
C76.2	MALIGNANT NEOPLASM OF ABDOMEN	
C76.31	MALG NEOPLASM OF MALE PELVIC ORGANS	
C76.32	MALG NEOPLASM OF FEMALE PELVIC ORGANS	
C76.39	MALG NEOPLASM OF PELVIC ORGANS NEC	
C76.4	MALIGNANT NEOPLASM OF UPPER LIMB	
C76.5	MALIGNANT NEOPLASM OF LOWER LIMB	
C76.7	MALIGNANT NEOPLASM OTHER ILL-DEF SITES	
C76.8	OVERLAP MALG LESION OTH & ILL-DEF SITES	
C80.0	MALG NEOPLM PRIM SITE UNK SO STATED	
C80.9	MALIGNANT NEOPLASM PRIMARY SITE UNSP	
C81.0	NODULAR LYMPHOCYTE PREDOM HODGKIN LYMPH	
C81.1	NODULR SCLERS (CLASSICAL) HODGKIN LYMPH	
C81.2	MX CELLULARITY (CLASSICAL) HODGKIN LYMPH	
C81.3	LYMPHT DEPLETN (CLASSICAL) HODGK LYMPH	
C81.4	LYMPHOCYTE-RICH (CLASSICAL) HODGK LYMPH	
C81.7	OTHER (CLASSICAL) HODGKIN LYMPHOMA	
C81.9	HODGKIN LYMPHOMA UNSPECIFIED	
C82.0	FOLLICULAR LYMPHOMA GRADE 1	
C82.1	FOLLICULAR LYMPHOMA GRADE 2	
C82.2	FOLLICULAR LYMPHOMA GRADE 3 UNSPECIFIED	
C82.3	FOLLICULAR LYMPHOMA GRADE 3A	

C82.4	FOLLICULAR LYMPHOMA GRADE 3B	
C82.5	DIFFUSE FOLLICLE CENTRE LYMPHOMA	
C82.6	CUTANEOUS FOLLICLE CENTRE LYMPHOMA	
C82.7	OTHER TYPES OF FOLLICULAR LYMPHOMA	
C82.9	FOLLICULAR LYMPHOMA UNSPECIFIED	
C83.0	SMALL CELL B-CELL LYMPHOMA	
C83.1	MANTLE CELL LYMPHOMA	
C83.3	DIFFUSE LARGE B-CELL LYMPHOMA	
C83.5	LYMPHOBLASTIC (DFS) NON-FOLLICULAR LYMPH	
C83.7	BURKITT LYMPHOMA	
C83.8	OTHER NON-FOLLICULAR LYMPHOMA	
C83.9	NON-FOLLICULAR DIFFUSE LYMPH UNSPECIFIED	
C84.0	MYCOSIS FUNGOIDES	
C84.1	SEZARY DISEASE	
C84.4	PERIPHERAL T-CELL LYMPHOMA NEC	
C84.5	OTHER MATURE T/NK-CELL LYMPHOMAS	
C84.6	ANAPLASTIC LARGE CELL LYMPH ALK-POSITIVE	
C84.7	ANPLST LARGE CELL LYMPH ALK-NEGATIVE	
C84.8	CUTANEOUS T-CELL LYMPHOMA UNSPECIFIED	
C84.9	MATURE T/NK-CELL LYMPHOMA UNSPECIFIED	
C85.1	B-CELL LYMPHOMA UNSPECIFIED	
C85.2	MEDIASTINAL THYMIC LARGE B-CELL LYMPHOMA	
C85.7	OTHER SPECIFIED TYPES OF NHL	
C85.9	NHL UNSPECIFIED	
C86.0	EXTRANODAL NK/T-CELL LYMPHOMA NASAL TYPE	
C86.1	HEPATOSPLENIC T-CELL LYMPHOMA	
C86.2	ENTEROPATHY-TYPE INTESTINAL T-CELL LYMPH	
C86.3	SBC PANNICULITIS-LIKE T-CELL LYMPHOMA	
C86.4	BLASTIC NK-CELL LYMPHOMA	
C86.5	ANGIOIMMUNOBLASTIC T-CELL LYMPHOMA	
C86.6	PRIM CUTAN CD30-POSITIVE T-CL PROLF	
C88.00	WALDENSTROM MACROGLOBULINAEMIA WO REM	
C88.01	WALDENSTROM MACROGLOBULINAEMIA IN REM	
C88.20	OTHER HEAVY CHAIN DISEASE WO REMISSION	
C88.21	OTHER HEAVY CHAIN DISEASE IN REMISSION	
C88.30	IMMUNOPROLIFERATIVE SM INTEST DIS WO REM	
C88.31	IMMUNOPROLIFERATIVE SM INTEST DIS IN REM	
C88.40	MALT-LYMPHOMA WO REMISSION	
C88.41	MALT-LYMPHOMA IN REMISSION	
C88.70	OTH MALG IMMUNOPROLIFERATIVE DIS WO REM	
C88.71	OTH MALG IMMUNOPROLIFERATIVE DIS IN REM	
C88.90	UNSP IMMUNOPROLIFERATIVE DIS WO REM	
C88.91	UNSP IMMUNOPROLIFERATIVE DIS IN REM	
C90.00	MULTIPLE MYELOMA WITHOUT REMISSION	
C90.01	MULTIPLE MYELOMA IN REMISSION	
C90.10	PLASMA CELL LEUKAEMIA WO REMISSION	

C90.11	PLASMA CELL LEUKAEMIA IN REMISSION	
C90.20	EXTRAMEDULLARY PLASMACYTOMA WO REMISSION	
C90.21	EXTRAMEDULLARY PLASMACYTOMA, IN REM	
C90.30	SOLITARY PLASMACYTOMA WO REMISSION	
C90.31	SOLITARY PLASMACYTOMA IN REMISSION	
C91.00	ALL WITHOUT MENTION OF REMISSION	
C91.01	ALL IN REMISSION	
C91.10	CHR LYMPHOCYTIC LEUK B-CELL TYPE WO REM	
C91.11	CHR LYMPHOCYTIC LEUK B-CELL TYPE IN REM	
C91.30	PROLYMPHOCYTIC LEUK B-CELL TYPE WO REM	
C91.31	PROLYMPHOCYTIC LEUK B-CELL TYPE IN REM	
C91.40	HAIRY-CELL LEUKAEMIA WITHOUT REMISSION	
C91.41	HAIRY-CELL LEUKAEMIA IN REMISSION	
C91.50	ADLT T-CELL LEUK LYMPH HTLV-1-ASS WO REM	
C91.51	ADLT T-CELL LEUK LYMPH HTLV-1-ASS IN REM	
C91.60	PROLYMPHOCYTIC LEUK T-CELL TYPE WO REM	
C91.61	PROLYMPHOCYTIC LEUK T-CELL TYPE IN REM	
C91.70	OTHER LYMPHOID LEUKAEMIA WO REMISSION	
C91.71	OTHER LYMPHOID LEUKAEMIA IN REMISSION	
C91.80	MATURE B-CELL LEUK BURKITT-TYPE WO REM	
C91.81	MATURE B-CELL LEUK BURKITT-TYPE IN REM	
C91.90	LYMPHOID LEUKAEMIA UNSP WO REMISSION	
C91.91	LYMPHOID LEUKAEMIA UNSP IN REMISSION	
C92.00	ACUTE MYELOBLASTIC LEUKAEMIA AML WO REM	
C92.01	ACUTE MYELOBLASTIC LEUKAEMIA AML IN REM	
C92.10	CML BCR/ABL-POSITIVE WO REMISSION	
C92.11	CML BCR/ABL-POSITIVE IN REMISSION	
C92.20	ATYPICAL CML BCR/ABL-NEG WO REM	
C92.21	ATYPICAL CML BCR/ABL-NEGATIVE IN REM	
C92.30	MYELOID SARCOMA WITHOUT REMISSION	
C92.31	MYELOID SARCOMA IN REMISSION	
C92.40	ACUTE PML WITHOUT MENTION OF REMISSION	
C92.41	ACUTE PML IN REMISSION	
C92.50	ACUTE MYELOMONOCYTIC LEUKAEMIA WO REM	
C92.51	ACUTE MYELOMONOCYTIC LEUKAEMIA IN REM	
C92.60	ACUTE MYELOID LEUK WITH 11Q23 ABN WO REM	
C92.61	ACUTE MYELOID LEUK WITH 11Q23 ABN IN REM	
C92.70	OTHER MYELOID LEUKAEMIA WO REMISSION	
C92.71	OTHER MYELOID LEUKAEMIA IN REMISSION	
C92.80	AC MYELOID LEUK MULTILINEAGE DYSP WO REM	
C92.81	AC MYELOID LEUK MULTILINEAGE DYSP IN REM	
C92.90	MYELOID LEUKAEMIA UNSP WO REMISSION	
C92.91	MYELOID LEUKAEMIA UNSP IN REMISSION	
C93.00	AC MONOBLASTIC MONOCYTIC LEUK WO REM	
C93.01	AC MONOBLASTIC MONOCYTIC LEUK IN REM	
C93.10	CHRONIC MYELOMONOCYTIC LEUK WO REMISSION	

C93.11	CHRONIC MYELOMONOCYTIC LEUK IN REMISSION	
C93.30	JUVENILE MYELOMONOCYTIC LEUKAEMIA WO REM	
C93.31	JUVENILE MYELOMONOCYTIC LEUKAEMIA IN REM	
C93.70	OTHER MONOCYTIC LEUKAEMIA WO REMISSION	
C93.71	OTHER MONOCYTIC LEUKAEMIA IN REMISSION	
C93.90	MONOCYTIC LEUKAEMIA UNSP WO REMISSION	
C93.91	MONOCYTIC LEUKAEMIA UNSP IN REMISSION	
C94.00	ACUTE ERYTHROID LEUKAEMIA WO REM	
C94.01	ACUTE ERYTHROID LEUKAEMIA IN REM	
C94.20	ACUTE MEGAKARYOBLASTIC LEUKAEMIA WO REM	
C94.21	ACUTE MEGAKARYOBLASTIC LEUKAEMIA IN REM	
C94.30	MAST CELL LEUKAEMIA WITHOUT REMISSION	
C94.31	MAST CELL LEUKAEMIA IN REMISSION	
C94.40	ACUTE PANMYELOSIS W MYELOFIBROSIS WO REM	
C94.41	ACUTE PANMYELOSIS W MYELOFIBROSIS IN REM	
C94.60	MYELODYSP & MYLOPROL DISEASE NEC WO REM	
C94.61	MYELODYSP & MYLOPROL DISEASE NEC IN REM	
C94.70	OTHER SPECIFIED LEUKAEMIAS WO REMISSION	
C94.71	OTHER SPECIFIED LEUKAEMIAS IN REMISSION	
C95.00	ACUTE LEUKAEMIA UNSP CELL TYPE WO REM	
C95.01	ACUTE LEUKAEMIA UNSP CELL TYPE IN REM	
C95.10	CHR LEUKAEMIA UNSP CELL TYPE WO REM	
C95.11	CHR LEUKAEMIA UNSP CELL TYPE IN REM	
C95.70	OTH LEUKAEMIA OF UNSP CELL TYPE WO REM	
C95.71	OTH LEUKAEMIA OF UNSP CELL TYPE IN REM	
C95.90	LEUKAEMIA UNSPECIFIED WITHOUT REMISSION	
C95.91	LEUKAEMIA UNSPECIFIED IN REMISSION	
C96.0	MLTFO & MLTSYS LANGERHANS-CELL HSTCYT	
C96.2	MALIGNANT MAST CELL TUMOUR	
C96.4	SARCOMA OF DENDRITIC CELLS	
C96.5	MLTFO & UNISYSTEMIC LANGERHANS CL HSTCYT	
C96.6	UNIFOCAL LANGERHANS-CELL HISTIOCYTOSIS	
C96.7	OTHER SPEC NEOPLM LYMPHOID, HAEMAT & TIS	
C96.8	HISTIOCYTIC SARCOMA	
C96.9	NEOPLASM LYMPHOID HAEMAT TISSUE UNSP	
D00.0	CA IN SITU LIP ORAL CAVITY PHARYNX	
D00.1	CARCINOMA IN SITU OF OESOPHAGUS	
D00.2	CARCINOMA IN SITU OF STOMACH	
D01.0	CARCINOMA IN SITU OF COLON	
D01.1	CA IN SITU RECTOSIGMOID JUNCTION	
D01.2	CARCINOMA IN SITU OF RECTUM	
D01.3	CARCINOMA IN SITU OF ANUS AND ANAL CANAL	
D01.4	CA IN SITU OTH / UNSP PARTS INTESTINE	
D01.5	CA IN SITU LIVER GALLBLADDER BILE DUCTS	
D01.7	CA IN SITU OTHER SPEC DIGESTIVE ORGANS	
D01.9	CA IN SITU DIGESTIVE ORGAN UNSP	

D02.0	CARCINOMA IN SITU OF LARYNX	
D02.1	CARCINOMA IN SITU OF TRACHEA	
D02.2	CARCINOMA IN SITU OF BRONCHUS AND LUNG	
D02.3	CA IN SITU OTH PARTS RESPIRATORY SYSTEM	
D02.4	CA IN SITU RESPIRATORY SYSTEM UNSP	
D03.0	MELANOMA IN SITU OF LIP	
D03.1	MELANOMA IN SITU EYELID INCL CANTHUS	
D03.2	MELANOMA IN SITU EAR & EXT AURIC CANAL	
D03.3	MELANOMA IN SITU OTH / UNSP PARTS FACE	
D03.4	MELANOMA IN SITU OF SCALP AND NECK	
D03.5	MELANOMA IN SITU OF TRUNK	
D03.6	MELANOMA IN SITU UPP LIMB INCL SHOULDER	
D03.7	MELANOMA IN SITU LOWER LIMB INCL HIP	
D03.8	MELANOMA IN SITU OF OTHER SITES	
D03.9	MELANOMA IN SITU UNSPECIFIED	
D04.0	CARCINOMA IN SITU OF SKIN OF LIP	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.1	CA IN SITU SKIN EYELID INCL CANTHUS	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.2	CA IN SITU SKIN EAR & EXT AURIC CANAL	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.3	CA IN SITU SKIN OTH / UNSP PARTS FACE	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.4	CARCINOMA IN SITU SKIN SCALP & NECK	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.5	CARCINOMA IN SITU OF SKIN OF TRUNK	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.6	CA IN SITU SKIN UPPER LIMB INCL SHOULDER	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.7	CA IN SITU SKIN LOWER LIMB INCL HIP	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.8	CARCINOMA IN SITU OF SKIN OF OTHER SITES	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D04.9	CARCINOMA IN SITU OF SKIN UNSPECIFIED	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)
D05.0	LOBULAR CARCINOMA IN SITU OF BREAST	
D05.1	INTRADUCTAL CARCINOMA IN SITU OF BREAST	
D05.7	OTHER CARCINOMA IN SITU OF BREAST	
D05.9	CARCINOMA IN SITU OF BREAST UNSPECIFIED	
D06.0	CARCINOMA IN SITU OF ENDOCERVIX	
D06.1	CARCINOMA IN SITU OF EXOCERVIX	
D06.7	CA IN SITU OTHER PARTS OF CERVIX	
D06.9	CARCINOMA IN SITU OF CERVIX UNSPECIFIED	
D07.0	CARCINOMA IN SITU OF ENDOMETRIUM	
D07.1	CARCINOMA IN SITU OF VULVA	
D07.2	CARCINOMA IN SITU OF VAGINA	
D07.3	CA IN SITU OTH / UNSP FEMALE GEN ORG	
D07.4	CARCINOMA IN SITU OF PENIS	
D07.5	CARCINOMA IN SITU OF PROSTATE	
D07.6	CA IN SITU OTH / UNSP MALE GENITAL ORG	
D09.0	CARCINOMA IN SITU OF BLADDER	
D09.1	CA IN SITU OTHER & UNSP URINARY ORGANS	
D09.2	CARCINOMA IN SITU OF EYE	

D09.3	CA IN SITU THYROID & OTH ENDOCRINE GLAND	
D09.7	CA IN SITU OTHER SPECIFIED SITES	
D09.9	CARCINOMA IN SITU UNSPECIFIED	
D18.02	HAEMANGIOMA INTRACRANIAL STRUCTURES	
D18.06	HAEMANGIOMA STR OF EYE AND ADNEXA	
D32.0	BENIGN NEOPLASM OF CEREBRAL MENINGES	
D32.1	BENIGN NEOPLASM OF SPINAL MENINGES	
D32.9	BENIGN NEOPLASM OF MENINGES UNSPECIFIED	
D33.0	BENIGN NEOPLASM BRAIN SUPRATENTORIAL	
D33.1	BENIGN NEOPLASM BRAIN INFRATENTORIAL	
D33.2	BENIGN NEOPLASM OF BRAIN UNSPECIFIED	
D33.3	BENIGN NEOPLASM OF CRANIAL NERVES	
D33.4	BENIGN NEOPLASM OF SPINAL CORD	
D33.7	BENIGN NEOPLASM OTHER SPEC PARTS OF CNS	
D33.9	BENIGN NEOPLASM CNS UNSPECIFIED	
D35.2	BENIGN NEOPLASM OF PITUITARY GLAND	
D37.0	NEOPLM UNC / UNK BEH LIP ORAL CV PHARYNX	
D37.1	NEOPLM UNCERTAIN OR UNKNOWN BEH STOMACH	
D37.2	NEOPLM UNC / UNK BEH SMALL INTESTINE	
D37.3	NEOPLM UNCERTAIN OR UNKNOWN BEH APPENDIX	
D37.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH COLON	
D37.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH RECTUM	
D37.6	NEOPLM UNC / UNK BEH LVR GALLB BILE DUCT	
D37.71	NEOPLM UNCERTAIN OR UNKNOWN BEH PANCREAS	
D37.79	NEOPLM UNC / UNK BEH OTH SPEC DIGEST ORG	
D37.9	NEOPLASM UNC / UNK BEH DIGEST ORGAN UNSP	
D38.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH LARYNX	
D38.1	NEOPLM UNC / UNK BEH TRACHEA BRONC LUNG	
D38.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH PLEURA	
D38.3	NEOPLM UNC OR UNKNOWN BEH MEDIASTINUM	
D38.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH THYMUS	
D38.5	NEOPLASM UNC / UNK BEH OTHER RESP ORG	
D38.6	NEOPLASM UNC / UNK BEH RESP ORG UNSP	
D39.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH UTERUS	
D39.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH OVARY	
D39.2	NEOPLM UNCERTAIN OR UNKNOWN BEH PLACENTA	
D39.7	NEOPLASM UNC / UNK BEH OTH FEMLE GEN ORG	
D39.9	NEOPLM UNC / UNK BEH FEMLE GEN ORG UNSP	
D40.0	NEOPLASM UNCERTAIN OR UNK BEH PROSTATE	
D40.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH TESTIS	
D40.7	NEOPLASM UNC / UNK BEH MALE GENITAL ORG	
D40.9	NEOPLM UNC / UNK BEH MALE GEN ORG UNSP	
D41.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH KIDNEY	
D41.1	NEOPLASM UNC / UNK BEH RENAL PELVIS	
D41.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH URETER	
D41.3	NEOPLM UNCERTAIN OR UNKNOWN BEH URETHRA	

D41.4	NEOPLM UNCERTAIN OR UNKNOWN BEH BLADDER	
D41.7	NEOPLASM UNC / UNK BEH OTH URINARY ORGAN	
D41.9	NEOPLASM UNC / UNK BEH URIN ORGAN UNSP	
D42.0	NEOPLASM UNC / UNK BEH CEREBRAL MENINGES	
D42.1	NEOPLM UNC / UNK BEH SPINAL MENINGES	
D42.9	NEOPLASM UNC / UNK BEH MENINGES UNSP	
D43.0	NEOPLASM UNC / UNK BEH BRAIN SUPRATENTOR	
D43.1	NEOPLASM UNC / UNK BEH BRAIN INFRATENTOR	
D43.2	NEOPLASM UNC / UNK BEH BRAIN UNSP	
D43.3	NEOPLASM UNC / UNK BEH CRANIAL NERVES	
D43.4	NEOPLASM UNC / UNK BEH SPINAL CORD	
D43.7	NEOPLM UNC / UNK BEH OTHER PARTS CNS	
D43.9	NEOPLM UNCERTAIN OR UNKNOWN BEH CNS UNSP	
D44.0	NEOPLASM UNC / UNK BEH THYROID GLAND	
D44.1	NEOPLASM UNC / UNK BEH ADRENAL GLAND	
D44.2	NEOPLASM UNC / UNK BEH PARATHYROID GLAND	
D44.3	NEOPLM UNC / UNK BEH PITUITARY GLAND	
D44.4	NEOPLM UNC / UNK BEH CRANOPHARNGL DCT	
D44.5	NEOPLASM UNC / UNK BEH PINEAL GLAND	
D44.6	NEOPLASM UNC / UNK BEH CAROTID BODY	
D44.7	NEOPLM UNC / UNK BEH AORTIC BD OTH PARAG	
D44.8	NEOPLASM UNC / UNK BEH PLURIGLNDR INV	
D44.9	NEOPLM UNC / UNK BEH ENDOCRINE GLD UNSP	
D45	POLYCYTHAEMIA VERA	
D46.0	REFRACT ANM WO RING SDBLST SO STATE	
D46.1	MDS RING SIDEROBLASTS & SGL LINEAGE DYSP	
D46.2	MDS WITH EXCESS BLASTS	
D46.4	MDS WITH SINGLE LINEAGE DYSPLASIA	
D46.5	MDS W MULTILINEAGE DYSPLASIA	
D46.6	MDS W ISOLATED DEL 5Q	
D46.7	OTHER MYELODYSPLASTIC SYNDROMES	
D46.9	MYELODYSPLASTIC SYNDROME UNSPECIFIED	
D47.0	HISTIOCYTIC MAST CELL TUM UNC / UNK BEH	
D47.1	CHRONIC MYELOPROLIFERATIVE DISEASE	
D47.2	MONOCLONAL GAMMOPATHY UNDET SIGNIF	
D47.3	ESSENTIAL THROMBOCYTHAEMIA	
D47.4	OSTEOMYELOFIBROSIS	
D47.5	CHRONIC EOSINOPHILIC LEUKAEMIA	
D47.7	OTH SPEC NEOPLM UNC / UNK BEH LYMPH HAEM	
D47.9	NEOPLM UNC / UNK BEH LYMPH HAEM TIS UNSP	
D48.0	NEOPLM UNC / UNK BEH BONE ARTICULAR CART	
D48.1	NEOPLM UNC / UNK BEH CON OTH SFT TISSUE	
D48.2	NEOPLASM UNC / UNK BEH PERPH & AUT NRVS	
D48.3	NEOPLM UNC / UNK BEH RETROPERITONEUM	
D48.4	NEOPLASM UNCERTAIN OR UNK BEH PERITONEUM	
D48.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH SKIN	Exclude when in combination with M80500 to M81109 (Skin SCC's and BCC's)

D48.6	NEOPLASM UNCERTAIN OR UNKNOWN BEH BREAST	
D48.7	NEOPLASM UNC / UNK BEH OTH SPEC SITES	
D48.9	NEOPLASM UNCERTAIN OR UNKNOWN BEH UNSP	
D76.1	HAEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS	
O01.0	CLASSICAL HYDATIDIFORM MOLE	
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE	
O01.9	HYDATIDIFORM MOLE UNSPECIFIED	
Q85.0	NEUROFIBROMATOSIS (NONMALIGNANT)	
Z85.0	PERSL H/O MALG NEOPLASM DIGESTIVE ORGANS	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.1	PERSL H/O MALG NEOPLASM TRACH BRONC LUNG	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.2	PERSL H/O MALG NEOPLASM OTH RESP ORGAN	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.3	PERSL H/O MALIGNANT NEOPLASM OF BREAST	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.4	PERSL H/O MALIGNANT NEOPLASM GENITAL ORG	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.5	PERSL H/O MALG NEOPLASM URINARY TRACT	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.6	PERSONAL HISTORY OF LEUKAEMIA	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.7	PERSL H/O OTH MALG NEOPLASM LYMPH HAEMAT	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.8	PERSL H/O MALG NEOPLM OTH ORGAN & SYSTEM	If not previously notified as C code at your facility (see Figure 1, pg7)
Z85.9	PERSONAL HISTORY OF MALG NEOPLASM UNSP	If not previously notified as C code at your facility (see Figure 1, pg7)
Z86.0	PERSONAL HISTORY OF OTHER NEOPLASMS	If not previously notified as C code at your facility (see Figure 1, pg7)