QCR
Queensland Cancer Register

QCR Notifier Guidelines

Public and Private Pathology

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Queensland Cancer Register

Cancer Alliance Queensland

Level 1, B2, 2 Burke St, Woolloongabba QLD 4102

QCR@health.qld.gov.au

(07) 3176 4400

Queensland Government

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Definition of terms

Term	Definition
Approved form	Accepted messaging format for cancer notifications.
BCC	Basal Cell Carcinoma
HL7	An internationally recognised standard for exchanging healthcare information electronically. Within pathology, HL7 messages are used to transmit patient, procedure and report information between healthcare organisations and the Queensland Cancer Register.
MedTex Pathology	Natural language processing software developed in partnership with CSIRO that assists the QCR in identifying and flagging pathology reports that meet cancer notification criteria.
Notification	The submission of cancer-related information to the Queensland Cancer Register in accordance with legislative requirements.
Notifier	Organisations required to report to the Queensland Cancer Register. Includes hospitals, day surgeries, pathology laboratories, medical imaging and treatment centres.
PHA	*Public Health Act 2005* (Qld)
QCR	Queensland Cancer Register
SCC	Squamous Cell Carcinoma

1. Purpose

This document aims to support notifiers by providing guidelines on:

1. The reporting requirements to the Queensland Cancer Register, including which cancers are to be notified.
2. The steps required to register a cancer.
3. The definitions of each data element within a notification of cancer to assist in accurately completing registrations.

If there is uncertainty about whether a cancer case should be notified or which pathology reports are notifiable based on the range of services offered by your laboratory, the Queensland Cancer Register team is available for support. Contact details can be found below, and our team is always happy to provide guidance, ensuring accurate and timely reporting of cancer diagnoses across Queensland.

Queensland Cancer Register contact details

Email: QCR@health.qld.gov.au

Website: canceralliance qld.health.qld.gov.au

2. Overview of the Queensland Cancer Register

The Queensland Cancer Register (QCR) operates under the *Public Health Act 2005 (QLD)*(PHA), 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 one of the only major disease categories from which an almost complete coverage of incidence data is available. Cancer is a leading cause of disease burden in Australia. 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.

2.1. 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. Queensland Cancer Register data is available for use:

- in monitoring trends in cancer incidence, mortality and survival times of persons with cancer,
- in supporting health service planning and policies for cancer prevention and treatment,
- in research on the causes, treatment and prevention of cancer,
- for the education of health professionals and members of the general public.

2.2. The Public Health Act and Regulations

All cancers as defined in Part 2 Division 1, Section 229 of the PHA 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.

2.3. Non-notifiable cancers

Under Division 3, Section 45 of the Public Health Regulation 2018, the following cancers are **not notifiable**:

(a) basal cell carcinoma (BCC) of the skin
(b) squamous cell carcinoma (SCC) of the skin
(c) benign neoplasm; unless present in central nervous system or brain.

Exception:

As of May 2025, BCC and SCC of the skin are notifiable only when **perineural invasion, lymphovascular invasion, or metastasis** are present. Assessment of these features is undertaken by **pathology and medical imaging** (metastases only) **providers**; therefore, notification in these cases will be provided by these notifiers.

The legislation may be viewed on the following website(s):
Public Health Act 2005 - Queensland Legislation - Queensland Government
Public Health Regulation 2018

2.4. Compliance Monitoring

Under Section 235(3) of the *Public Health Act 2005*, the QCR is responsible for conducting regular compliance monitoring of cancer notifications submitted by all notifiers. Any breach of the Act must be reported to the Director-General of Queensland Health.

As part of this function, the QCR undertakes routine audits and prepares compliance reports to identify and address instances of non-compliance.

In accordance with Section 236, the QCR may also request additional information from notifiers to verify the accuracy, completeness, and integrity of cancer notifications and to ensure the ongoing quality of the register.

2.5. Confidentiality and privacy

All QCR employees are bound by an obligation of confidentiality and must not disclose any individual's confidential or personal information except where authorised statutory, regulatory, or organisational obligations.

A patient's information whether it be; confidential, personal, sensitive or health, must be managed in accordance with the *Public Health Act 2005*, Part 2 and the *Information Privacy Act 2009*.

2.6. Enquiries

If you would like more information about the Queensland Cancer Register 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://canceralliance qld.health.qld.gov.au/
https://www.aihw.gov.au/

3. Reporting requirements

3.1. Entities required to notify cancer

Notifications about cancer are required to be submitted to the Queensland Cancer Register (QCR) by the following services:

1. Public and private hospitals and day surgeries
2. Treatment centres
3. **Pathology laboratories***
4. Medical imaging practices

*This document applies specifically to **pathology laboratories**. Reporting guidelines for hospitals, treatment centres and medical imaging practices can be found on our website.

Pathology

In 2024, 92% of cancer cases diagnosed were histologically verified. The pathology report is, in many cases, the initial notification of a person with cancer making the pathology report a key data source.

Pathology laboratories have been integral to the QCR since its inception, playing a vital role in providing cancer notifications to the Register. Additionally, the importance of cytogenetics and molecular studies in cancer diagnostics has long been recognised, with their roles in diagnosis, prognosis, and treatment prediction offering crucial insights throughout the cancer care continuum.

3.2. When a notification should be completed

According to the *Public Health Act 2005*, the Director of a pathology laboratory is required to submit a notification about a pathological examination **30 days once validated** if:

> *(a) a pathological examination of a specimen of human origin is carried out at the laboratory; and*
>
> *(b) either—*

*i) the examination indicates the person from whom the specimen was taken **has,** or **has had**, cancer; or*

*(ii) the director reasonably suspects the examination is a **cancer-related follow-up examination**.*

cancer-related follow-up examination means a pathological examination of a specimen of human origin that is—

(a) carried out after the person from whom the specimen was taken has been diagnosed with cancer; and

(b) carried out—

(i) to determine the characteristics or status of the cancer; or

(ii) to support or inform the treatment of the cancer.

Cancer-related follow-up examples include (but are not limited to):

- Wider excision for melanoma (including those that contain no cancer)
- Lung or liver biopsy taken to confirm presence or absence of metastases (including those that contain no cancer)
- Lymph node specimens such as node biopsy or surgery (including those with all nodes clear)
- Bronchial cytology or pleural effusion sample intended to detect cancer/metastases
- Examinations that provide the genomic profile of a tumour to inform stage, prognosis or treatment decisions.
- Measurable residual disease (MRD) monitoring by molecular/cytogenetic/flow techniques and liquid biopsy results including informative negatives
- Protein chemistry and immunoassays for cancer such as M band tests and flow cytometry
- Inflammatory markers that indicate the presence or absence of disease
- Biochemical markers related to cancer presence and/or monitoring (e.g. PSA, CEA)

See **Appendix 1b – Cancer Notification Requirements: Test List** for the full list of investigations and test types that must be provided under the *Public Health Act 2005*.

3.3. Reportable cancers

Pathology laboratories are required to notify the QCR for the following:

- All invasive cancers (including high risk BCC and SCC of the skin (ie when perineural invasion, lymphovascular invasion, or metastasis are present))
- All cancers with an uncertain behaviour
- All in-situ conditions
- Benign central nervous system and brain tumours
- Gestational trophoblastic disease (GTD) (benign, malignant or uncertain)

4. Data submission

4.1. Approved form

Pathology laboratories must notify validated reports within a message file that conforms to the current HL7 Australia Diagnostic Messaging standard.

The QCR requires submission of the validated report text only. **Diagnostic images, scanned documents and PDF versions of reports should not be submitted**.

Pathology results must have titles that consistently and accurately describe the contents of the report, i.e., the panel names (Universal service identifier name) must reflect the test results found in the report.

Where available, the standardised requesting and reporting content, terminology, codes, and units must be applied, as specified in the RCPA Standardised Pathology Informatics in Australia (SPIA) guidelines, associated reference sets and information models, published as RCPA resources on the National Clinical Terminology Service website3.

For cancer resections, reports must conform to the structured pathology reporting of cancer protocols, specified on the RCPA website (or linked from there to the International Collaboration on Cancer Reporting data sets), including precise adherence to the reporting proforma and data sets, with all ancillary test results and use of standardised terminology where specified.

For genetic testing of neoplasms, standardised terminology must be applied, including Human Genome Variation Society (HGVS) nomenclature for variations to DNA sequences and amino acids, as specified in the SPIA reference material and the accreditation requirements for medical testing for human genetic variation6.

The format and content of the message file are specified in the Approved form: Pathology Notifiers.

Outsourced testing and reporting to another laboratory

For tests referred to other laboratories, the referring laboratory must ensure the report is notified to the QCR in the Approved form. However arrangements can

be made with the referral laboratory to set up a direct connection with the QCR to meet this compliance requirement. Which means the referring laboratory will be outsourcing the act of notifying to referral laboratory, as a part of an existing referral arrangement.

4.2. Electronic transfer method

Various options for secure transfer of notifications from pathology laboratories to the QCR are available and arrangements are currently in place with each laboratory.

If transfer arrangements change for your laboratory, immediately contact QCR@health.qld.gov.au to support a smooth transition. Pathology laboratories should ensure the QCR receives the most current version of a cancer-related report, including any supplementary, amended or corrected reports.

Where a report is withdrawn, cancelled, or identified as having been submitted in error, the QCR should be notified promptly.

5. FAQs

Q. What is the timeframe for notifying a pathological examination to the QCR?

A. Pathology laboratories must submit the notification in the **approved form** within **30 days once validated.**

Q. What security measures are in place to prevent unauthorised access to submitted reports?

A. The QCR utilises robust security measures to protect the confidentiality of cancer-related data, including secure access controls, data encryption, and regular system updates.

All reports submitted to the QCR are protected by these safeguards to prevent unauthorised access. These measures align with industry best practices and relevant legislation to ensure data integrity and security.

Q. Who is responsible to notify the QCR if my laboratory outsources testing and reporting to another laboratory in a referral arrangement?

A. For tests referred to other laboratories, your laboratory must ensure the report is notified to the QCR. However arrangements can be made with the referral laboratory to set up a direct connection with the QCR to meet this compliance requirement. Which means your laboratory will be outsourcing the act of notifying to referral laboratory, as a part of an existing referral arrangement.

Q. Is there a risk of non-notifiable reports being sent to the QCR?

A. Yes, there is a possibility that the QCR may receive reports that are not cancer related. Text-based reports, such as histopathology reports, are processed through **MedTex Pathology** within QCR's internal environment to identify cancer related notifiable reports.

Reports that are found to be not cancer-related, will be processed according to the QCR Records Retention and Disposal Policy. This process will apply in accordance with the Queensland Government Records governance policies.

Q. What are the consequences of non-compliance?

A. As reporting is mandated by law, failure to comply may result in financial penalties may apply under the PHA. However, the QCR is committed to working with each notifier to ensure compliance.

Q. Are BCC and SCC of the skin cancer notifiable?

A. Yes, notification is required where pathology specimens of BCC or SCC of the skin indicate the presence of perineural invasion (excluding intra-tumoural invasion), lymphovascular invasion, or metastasis.

Q. What if the specimen is negative for cancer?

A. A report may still be notifiable even if cancer is not identified in the specimen. Under the PHA, pathology laboratories must notify cancer-related follow-up examinations undertaken after a cancer diagnosis to determine the characteristics or status of the cancer, or to support or inform treatment. This includes informative negative results, such as clear lymph nodes, wider excisions that contain no residual tumour, or biopsies performed to confirm the presence or absence of metastases.

Q. Is patient consent required before reports can be provided to the QCR?

A. No. Under the PHA, pathology laboratories are legally required to provide identifiable cancer-related information to the QCR. As this reporting is authorised and mandated by legislation, patient consent is not required for notifications to be submitted to the QCR. The QCR manages all information in accordance with the PHA and the *Information Privacy Act 2009* (Qld)

Q. How were the list of investigations and report types determined to be in scope for notification to the QCR?

A. A comprehensive pathology review workshop was undertaken, involving representatives from all pathology disciplines and relevant specialist groups. Participants assessed each investigation and report type to determine whether it was cancer-related and should be notified to the QCR under the PHA. The list reflects expert consensus and is intended to support consistent reporting. As clinical practice and diagnostic technologies evolve, the list will be reviewed and updated periodically and is not intended to be exhaustive.

Version control

Version no.	Date	Created/modified by	Modifications made
4.0	28/01/2026	Courtney Jurd	Inclusion of PHA 2005 amendments
4.0	29/10/2026	Julie Moore	Final review

Appendices

Appendix 1a – Cancer Notification Requirements: Summary Table

Pathology discipline	Description
Anatomical pathology including ancillary tests	**Anatomical pathology reports** including morphological reports and **ancillary tests** that are diagnostic in nature or could be considered a cancer-related follow-up examination, including: • Reports that provide detailed characteristics of a tumour, inform staging and/or treatment of cancer, or monitor disease over time. • Reports that provide information about the spread of disease (local, regional or distant), including where the disease is found to be not present. • All ancillary tests specified in the RCPA and ICCR Cancer reporting protocols.
Molecular examinations for neoplasia	Reports for **molecular examinations** that further characterise the tumour, inform staging and/or treatment of cancer, or monitor disease over time, including: • Reports that identify genetic variants of a tumour/neoplasm or haem malignancy/solid tumour. • Reports that identify other genetic alterations or structural changes associated with the disease, such as chromosomal abnormalities, DNA repair defects or gene amplification. • Reports that include findings of other molecular biomarkers associated with the cancer, such as post-diagnosis germline testing to classify disease. • Molecular testing that is carried out to inform treatment of cancer, such as pharmacogenomic screening for chemotherapy response or toxicity risk. • All molecular tests specified in the RCPA and ICCR Cancer reporting protocols. Please note that even if the QCR receives molecular results in an anatomical pathology report, the original molecular report is also notifiable.
Haematology examinations for neoplasia	Reports for **haematological examinations** directly related to the diagnosis and classification of cancer, such as: • Bone marrow trephine, aspiration and biopsy
Immunology and protein chemistry examinations for neoplasia	Reports for **immunological procedures** that assist in the detection, diagnosis, classification, prognosis or monitoring of cancer. For example, peripheral blood flow cytometry for diagnosis of lymphoproliferative disease, and peripheral blood molecular testing for TCR rearrangements.
Chemical pathology examinations for neoplasia	**Chemical pathology procedures** that are used to detect or monitor cancer over time, such as to indicate presence or absence of disease, response to treatment, or toxicity of treatment. For example, CEA, PSA, CA 125, CA 19-9, CA 15-3, alpha-fetoprotein, neuron-specific enolase, HCG quantitation tumour marker, thyroglobulin, beta-2-microglobulin, etc.

Appendix 1b – Cancer Notification Requirements: Test List

The following list aims to support pathology laboratories in identifying examinations and report types that must be notified to the QCR under the PHA. It includes diagnostic and cancer-related follow-up examinations and serves as a compliance reference. The list is not exhaustive and will be reviewed and updated as clinical practice and diagnostic technologies evolve.
If you are unsure whether an examination or report is notifiable, please contact the QCR at QCR@health.qld.gov.au

Pathology report type	Notes (if applicable)
Histology	These reports historically received at diagnosis but scope now expanded to include informative negatives (e.g. negative node reports) and post treatment surveillance
Cytology	
Flow cytometry/Cell marker analysis/Immunophenotyping	
Bone marrow summary	
Genomics reports – somatic reports	
Karyotype analysis - somatic	Tests performed on tumour tissue/cells at diagnosis and/or used for residual disease monitoring
FISH - diagnostic	
FISH - MRD	
Microarray analysis - somatic	
Molecular screening assays	
Gene panel - diagnostic haematological	
Gene panel - diagnostic solid tumour	
Gene panel - MRD haematological	
Gene panel - MRD solid tumour	
Fusion gene panel - diagnostic haematological	
Fusion gene panel - diagnostic solid tumour	
Fusion gene panel - MRD haematological	
Fusion gene panel - MRD solid tumour	
Gene rearrangement assays (polycloncal vs monoclonal)	
Homologous recombination deficiency (HRD)	
Liquid biopsy - diagnostic	
Liquid biopsy - MRD	
DNA methylation profile - somatic	
MSI status - somatic	
Gene expression/risk of recurrence - somatic	
Tumour mutation burden (TMB)	
Genomics reports – germline reports	
Inherited cancer predisposition gene – single gene	When test is undertaken at or after diagnosis of cancer

Pathology report type	Notes (if applicable)
Inherited cancer predisposition genes – gene panel	
Familial known variant - inherited	Germline tissue testing to confirm origin of variants detected by somatic testing
HLA tissue typing	Recipients of stem cell transplants
Pharmacogenomics for Allopurinol (*HLA–B*58:01*)	Pharmacogenomic testing for cancer related therapies
Pharmacogenomics for Capecitabine (*DPYD*)	
Pharmacogenomics for Fluorouracil (*DPYD*)	
Pharmacogenomics for Irinotecan (*UGT1A1*)	
Pharmacogenomics for Mercaptopurine (*TPMT* and *NUDT15*)	
Pharmacogenomics for Thioguanine (*TPMT* and *NUDT15*)	
Biochemical, haematological and serological reports	
5-HIAA	Diagnosis and monitoring of NETs
Adrenocorticotropic hormone (ACTH)	Informs treatment decisions
Alpha-fetoprotein (AFP) - tumour	Informs treatment decisions
Beta-2-microglobulin	Diagnosis and monitoring of MM, CLL and lymphomas
Calcium (Serum)	Informs treatment decisions
Carbohydrate antigens (CA 19.9, CA 125, CA 15.3)	Monitors treatment response
Carcinoembryonic antigen (CEA)	Monitors treatment response
Catecholamines	Diagnosis and monitoring of NETs
Chromogranin A	Diagnosis and monitoring of NETs
Complete blood count	Diagnosis and monitoring of haematological malignancies
Cortisol	Informs treatment decisions
C-peptide	Diagnosis and monitoring of insulinomas
Creatinine (Serum)	Informs treatment decisions
Free light chains	Diagnosis and monitoring of plasma cell disorders eg MM
Gastrin	Informs treatment decisions
Glucagon	Diagnosis and monitoring of glucagonomas
Homovanillic acid/creatinine urine	Diagnosis and monitoring of neural crest tumours
Human chorionic gonadotropin (hCG)	Diagnosis and monitoring of germ cell tumours
Immunoglobulin levels	Informs treatment decisions
Inhibin B	Diagnosis and monitoring of ovarian tumours
Insulin free level	Diagnosis and monitoring of insulinomas
Lactate dehyrogenase (LDH)	Staging, prognostication and monitoring
Liver function tests	Informs treatment decisions
Metanephrine plasma	Diagnosis and monitoring of catecholamine-secreting tumours
Metanephrine urine 24h	Diagnosis and monitoring of catecholamine-secreting tumours

Pathology report type	Notes (if applicable)
Neuron-specific enolase	Monitors treatment response
Paraprotein concentration urine (Bence Jones protein)	Diagnosis and monitoring of plasma cell disorders eg MM
Prostate specific antigen (PSA)	Diagnosis and monitoring of prostate cancer
Protein electrophoresis (serum)	Diagnosis and monitoring of plasma cell disorders eg MM
Thyroglobulin	Diagnosis and monitoring of thyroid cancer
Vasoactive intestinal polypeptide	Diagnosis and monitoring of VIPomas
Infectious disease reports	
Helicobacter pylori (H.pylori) status	A class-I carcinogen for gastric cancer
Hepatitis B Virus (HBV) status	Relevant in the setting of hepatocellular carcinomas and in guiding systemic therapy
Hepatitis C Virus (HCV) status	Relevant in the setting of hepatocellular carcinomas and in guiding systemic therapy
Human papillomavirus (HPV) status	Relevant to cervical, anal, vaginal, vulva, penile and oropharyngeal/throat cancers
Human T-cell leukemia virus-1 (HTLV-1) status	Required for WHO classification of lymphomas
Kaposi sarcoma-associated herpesvirus (KSHV)/ human herpesvirus 8 (HHV8)	A class-I carcinogen for gastric cancer