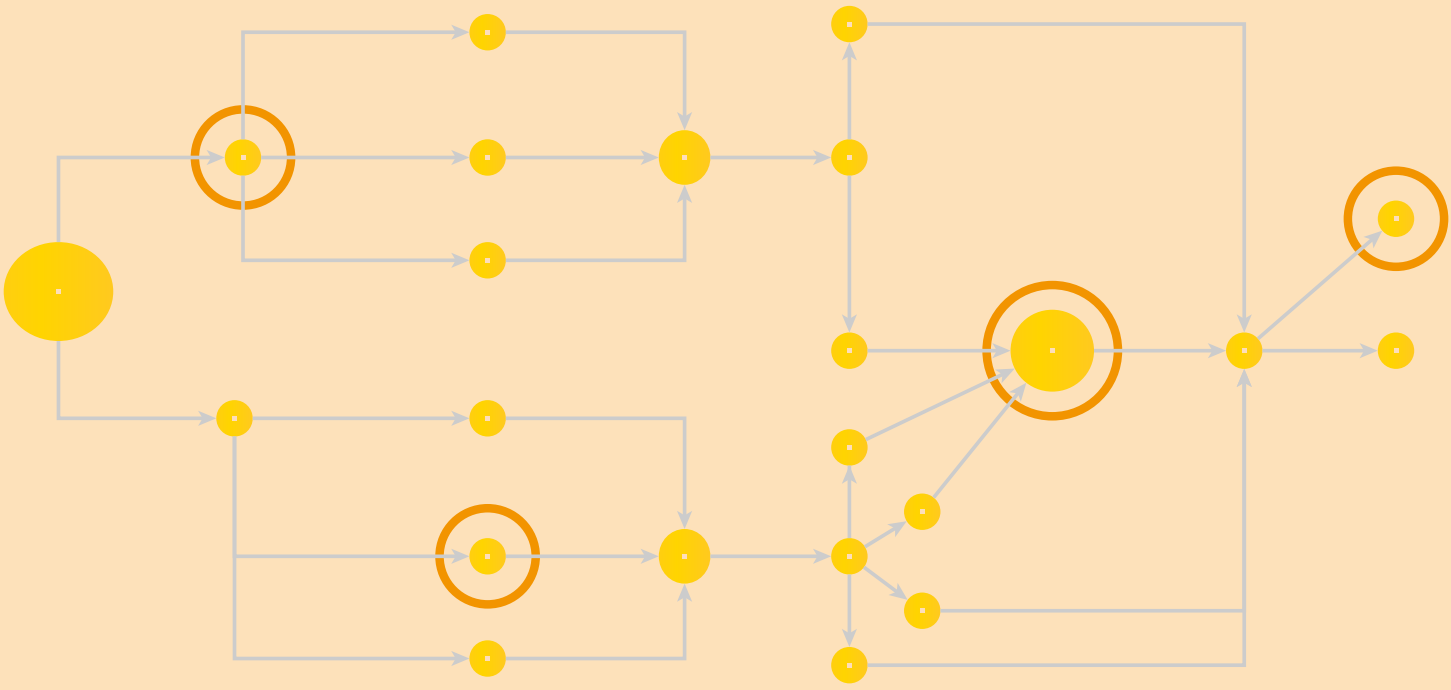
Leitlinienprogramm
Onkologie

Oncological quality indicators

Guideline-based quality indicators in the German Guideline Program in Oncology (GGPO)

Version 8 – January 2026



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1 Foreword

Within the Oncology Guidelines Programme of the Association of Scientific Medical Societies (AWMF), the German Cancer Society (DKG) and German Cancer Aid (DKH), quality indicators are regularly derived for the current guidelines according to a defined process. The methodology for this is described here.

This document is a comprehensive overview of all guideline-based quality indicators defined to date and is updated regularly. The current quality indicators for the guidelines in the Oncology Guidelines Programme are published in the respective guideline versions at: https://www.leitlinienprogramm-onkologie.de/leitlinien/.

2 Changes compared to version 7

The indicators for the following topics have been added to the document:

- Thyroid carcinoma – Version 1.0, July 2025
- Salivary gland tumours – Version 1.0, August 2025

Quality indicators for the following topics have been reviewed or revised as part of updates:

- Chronic lymphocytic leukaemia (CLL), Version 2.0, January 2025
- Bladder carcinoma, version 3.0, April 2025
- Colorectal carcinoma, version 3.0, September 2025
- Lung carcinoma, version 4.0, April 2025
- Gastric carcinoma, version 3.1, October 2025
- Breast cancer , Version 5.2, 12 May 2025
- Prostate carcinoma, version 8.1, September 2025
- Supportive therapy, version 2.0, May 2025

3 Overview

Guideline topic	Version number, date	Number
Adult soft tissue sarcomas	Version 1.1, 14 June 2022	14
Actinic keratosis and squamous cell carcinoma of the skin	Version 2.0, 12 January 2023	1
Anal carcinoma	Version 1.2, 17 December 2020	13
Chronic lymphocytic leukaemia (CLL)	Version 2.0, 24 January 2025	5
Diffuse large B-cell lymphoma (DLBCL)	Version 1.0, 1 November 2022	7
Endometrial carcinoma	Version 3.0, 8 July 2024	9
Follicular lymphoma	Version 1, 22 June 2020	3
Bladder carcinoma	Version 3.0, 7 April 2025	12
Hepatocellular carcinoma and biliary carcinomas	Version 5.2, 25 June 2025	7
Testicular tumours	Version 1.1, 4 March 2020	11
Hodgkin's lymphoma	Version 3.2, 23 October 2022	9
Colorectal carcinoma	Version 3.0, 26 September 2025	15
Laryngeal carcinoma	Version 1.1, 19 December 2019	6
Lung carcinoma	Version 4.0, 14 April 2025	16
Gastric carcinoma	Version 3.1, 30 October 2025	14
Malignant ovarian tumours	Version 6.0, 23 October 2024	10
Malignant melanoma	Version 3.3, 14 November 2019	9
Breast cancer	Version 5.2, 12 May 2025	18

Guideline topic	Version number, date	Number
Multiple myeloma	Version 1.0, 18 February 2022	1
Oral cavity carcinoma	Version 3.0, 26 March 2021	10
Renal cell carcinoma	Version 5.0, 26 September 2024	9
Oro- and hypopharyngeal carcinoma	Version 1.0, 11 March 2024	13
Palliative medicine	Version 2.2, 22 September 2020	11
Pancreatic carcinoma	Version 3.1, 10 October 2024	7
Penile carcinoma	Version 1.0, 14 October 2020	8
Perioperative management of gastrointestinal tumours (POMGAT)	Version 1.0, 5 December 2023	4
Prostate cancer	Version 8.1, 1 September 2025	15
Prevention of cervical cancer	Version 1.1, 01.04.2020	10
Psycho-oncology	Version 2.1, 01.09.2023	9
Thyroid carcinoma	Version 1.0, 16 July 2025	7
Salivary gland tumours	Version 1.0, 1 August 2025	10
Supportive therapy	Version 2.0, 16 May 2025	3
Cervical carcinoma	Version 2.2, 29 March 2022	9
Oesophageal carcinoma	Version 4.0, 18 December 2023	13
	Total	**318**

4 Adult soft tissue sarcomas

(Version 1.1, 14 June 2022)

Quality indicator	Reference Recommendation	Evidence base/further information
WGT 1: Pre-therapeutic presentation to the tumour board (initial diagnosis of soft tissue sarcoma)		
Numerator Patients of the denominator presented at the pre-therapeutic tumour board **Denominator** All patients with a primary diagnosis of soft tissue sarcoma	**4.2** The treatment of sarcomas should be planned pretherapeutically in an interdisciplinary tumour board. At least one surgical discipline specialising in the treatment of soft tissue sarcomas should be represented, as well as haematology/oncology, pathology, radiology and radio-oncology. Localisation-specific expertise should be consulted on a case-by-case basis.	**Consensus-based recommendation** Quality objective: Pre-therapeutic presentation of patients with newly diagnosed soft tissue sarcoma in an interdisciplinary tumour board as often as possible
Note Tumour board participants: surgical disciplines with a focus on the treatment of soft tissue sarcomas, haematology/oncology, pathology, radiology and radiation oncology		
WGT 2: Treatment in a certified sarcoma centre		
Numerator Patients in the denominator receiving care at a certified sarcoma centre **Denominator** All patients with soft tissue sarcoma	**4.1** The diagnosis and treatment of soft tissue sarcoma should be carried out by or in consultation with a certified sarcoma centre or associated cooperation partner.	**Consensus-based recommendation** Quality objective: Treatment of as many patients with soft tissue sarcoma as possible in certified sarcoma centres
WGT 3: Complete findings report after resection of soft tissue sarcoma		
Numerator Patients in the denominator with a findings report	**4.21** The minimum distances to relevant resection margins	**4.21: Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
specifying: Grading according to FNCLCC Minimum distances to relevant resection margins and critical structures WHO classification Biological behaviour ICD-O **Denominator** All patients with a primary diagnosis of soft tissue sarcoma and resection	and critical structures should be specified in the histopathological findings. R0 status is defined as "no tumour on ink". **4.2** Histopathological subtyping should be based on the currently valid WHO classification. The tumour should be classified into the biological behaviours benign, intermediate (locally aggressive), intermediate (rarely metastatic) or malignant. The ICD-O code (if available) should be added as additional information.	**4.25: Consensus-based recommendation** Quality objective: Complete findings report after resection of a soft tissue sarcoma as often as possible
Note Biological behaviours: benign, intermediate (locally aggressive), intermediate (rarely metastatic) or malignant FNCLCC: see Chapter 4.1.4.3, Table "FNCLCC Grading System: Definition of Parameters" and Table "FNCLCC Grading System: Tumour Differentiation Score According to Histologic Type"		
WGT 4: Risk assessment GIST		
Numerator Patients in the denominator with risk assessment of GIST **Denominator** All patients with initial diagnosis of localised GIST, M0 and resection	**4.3** An assessment of individual recurrence risk should be performed on the resected primary localised GIST without evidence of distant metastases (cM0) in order to evaluate the indication for adjuvant imatinib therapy.	**Consensus-based recommendation** Quality objective: Assessment of the risk of recurrence after resection of a GIST, M0, as often as possible

Quality indicator	Reference Recommendation	Evidence base/further information
WGT 5: Mutation analysis of GIST		
Numerator Patients in the denominator with mutation analysis of the KIT (exon 9, 11) and PDGFRA (exon 18) genes **Denominator** All patients with initial diagnosis of GIST with intermediate/high risk and/or M1	**4.38** For every GIST with intermediate/high risk and for every metastatic GIST, a mutation analysis should be performed on at least the KIT (exon 9, 11) and PDGFRA (exon 18) genes. If no mutation is detected in these three loci, further hot spot regions should be examined using molecular pathology or the case should be sent to a reference laboratory.	**Consensus-based recommendation** Quality objective: Mutation analysis should be performed as often as possible in GIST with intermediate/high risk and/or M1
Note: GIST risk classification: see Chapter 10.1.1.3 of the guideline		
WGT 6: Primary histological confirmation of soft tissue sarcomas		
Numerator Patients in the denominator with pre-therapeutic histological confirmation **Denominator** All patients with soft tissue sarcoma and therapy, except for superficial soft tissue sarcomas ≤3 cm	**5.1** In cases of clinical suspicion and/or imaging suspicion of soft tissue sarcoma, this should primarily be confirmed histologically. **5.3** In cases of clinical suspicion and/or imaging suspicion of soft tissue sarcoma that is smaller than 3 cm in diameter and located superficially, primary R0 resection may be performed.	**5.1: Consensus-based recommendation** **5.3: Consensus-based recommendation** Quality objective: Pre-therapeutic histological confirmation of soft tissue sarcomas as often as possible, except for superficial soft tissue sarcomas ≤3 cm, in cases where treatment is planned
Note: Therapy: surgery, radiotherapy, chemotherapy, hyperthermia, isolated limb perfusion		

Quality indicator	Reference Recommendation	Evidence base/further information
WGT 7: R0 resection for soft tissue sarcoma		
Numerator Patients in the denominator with R0 resection **Denominator** All patients with initial diagnosis of soft tissue sarcoma and resection	**5.6** Resection of a primary soft tissue sarcoma of the extremities should be performed as a wide resection. The goal is R0 resection.	**GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** Quality objective: R0 resection of primary soft tissue sarcomas as often as possible (except for planned R1 resections)
WGT 8: Hysterectomy without morcellation for sarcoma confined to the uterus		
Numerator Patients in the denominator with hysterectomy without morcellation **Denominator** All patients with sarcoma confined to the uterus (ICD-O T C54, C55 in conjunction with morphology codes Chapter 13.1), M0 with hysterectomy	**5.4** In cases of leiomyosarcoma confined to the uterus, complete removal of the uterus without morcellation or uterine injury should be performed. **5.4** In cases of high-grade endometrial stromal sarcoma confined to the uterus, complete removal of the uterus without morcellation or uterine injury should be performed.	**5.44: Consensus-based recommendation** **5.48: Consensus-based recommendation** Quality objective: Hysterectomy without morcellation should be performed as often as possible for sarcoma confined to the uterus.
WGT 9: Pre-/postoperative radiotherapy for soft tissue sarcoma		
Numerator Patients in the denominator with pre- or post-operative radiotherapy **Denominator** All patients with initial diagnosis of soft tissue sarcoma on the extremities or trunk (excluding cutaneous sarcomas ICD-0 T C44), G2 or G3, M0 and resection	**5.6** Pre- or post-operative radiotherapy should be performed for G2 and G3 soft tissue sarcomas.	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** ; Quality objective: Pre- or postoperative radiotherapy as often as possible for soft tissue sarcomas of the extremities or trunk (, G2 or G3, M0)

Quality indicator	Reference Recommendation	Evidence base/further information
Note: ICD-O topography extremities or trunk: C47.1 - C47.8, C48.0, C49.1 – C49.8		
WGT 10: Pre-therapeutic presentation to the tumour board (recurrence and/or secondary distant metastasis of a soft tissue sarcoma)		
Numerator Patients in the denominator with pre-therapeutic presentation to the tumour board **Denominator** All patients with local recurrence and/or newly diagnosed secondary distant metastases of a soft tissue sarcoma	**6.4** In cases of local recurrence of soft tissue sarcomas that have not been treated with neoadjuvant or adjuvant therapy, a multimodal treatment plan should be determined by an interdisciplinary sarcoma board. **7.10** The indication for local therapy of metastases should be determined on a multidisciplinary basis.	**6.4: Consensus-based recommendation** **7.10: Consensus-based recommendation** Quality objective: Pre-therapeutic presentation of recurrences and/or secondary distant metastases of soft tissue sarcomas in an interdisciplinary tumour board as often as possible
Note Tumour board participants: surgical discipline with a focus on the treatment of soft tissue sarcomas, haematology/oncology, pathology, radiology and radio-oncology		
WGT 11: Postoperative presentation in the tumour board (local recurrence and R1/R2 resection of a soft tissue sarcoma)		
Numerator Patients in the denominator who were presented in the tumour board postoperatively **Denominator** All patients with local recurrence of soft tissue sarcoma and R1/R2 resection	**6.1** After incomplete resection of an isolated local recurrence, regardless of whether chemotherapy has been administered in accordance with guidelines, a multidisciplinary treatment decision should be made.	**Consensus-based recommendation** Quality objective: As often as possible, postoperative presentation of R1/R2-resected local recurrences of soft tissue sarcomas in the interdisciplinary tumour board
Note:		

Quality indicator	Reference Recommendation	Evidence base/further information
Tumour board participants: surgical discipline with a focus on the treatment of soft tissue sarcomas, haematology/oncology, pathology, radiology and radio-oncology		
WGT 12: First-line chemotherapy for soft tissue sarcoma		
Numerator Patients in the denominator receiving doxorubicin monotherapy or anthracycline-containing combination therapy **Denominator** All patients with soft tissue sarcoma and first-line chemotherapy	**7.2** The choice of systemic therapy should be made taking into account toxicity and objectives, either doxorubicin monotherapy or anthracycline-containing combination therapy.	**Consensus-based recommendation** Quality objective: Use doxorubicin monotherapy or anthracycline-containing combination therapy as often as possible for first-line chemotherapy
WGT 13: Complete findings report after GIST resection		
Numerator Patients in the denominator with findings reports specifying: R status Primary location Number of mitoses per 5 mm² Tumour rupture **Denominator** All patients with initial diagnosis of GIST and resection	**10.11** When diagnosing GIST in the resected specimen, the pathological report should indicate the R status, primary location, tumour size (largest longitudinal diameter), number of mitoses per 5 mm² and whether tumour rupture is present.	**Consensus-based recommendation** Quality objective: Complete findings report after resection of a GIST as often as possible
WGT 14: Postoperative mortality in retroperitoneal sarcoma		
Numerator Patients in the denominator who died within 30 days postoperatively **Denominator** All patients with a first diagnosis of retroperitoneal sarcoma (RPS) (ICD-10 C48.0	None Sources: [1]	As a result of the discussion of the international QI, the LL defines as a specific goal that postoperative mortality for patients with retroperitoneal sarcoma (RPS) should be collected. Since is the basis of the existing international QI, its population is also adopted.

Quality indicator	Reference Recommendation	Evidence base/further information
or C48.8) and tumour resection		Wording of the source: *QPI 11a - 30-day mortality following curative oncological treatment* *30-day mortality following curative treatment for extremity and retroperitoneal sarcoma.* *Numerator: Number of patients with extremity or retroperitoneal sarcoma who receive oncological treatment with curative intent who die within 30 days of treatment.* *Denominator: All patients with extremity or retroperitoneal sarcoma who receive curative oncological treatment.* *Exclusions: No exclusions.* *Source: Sarcoma National Managed Clinical Network, N., South East and West of Scotland Cancer Networks Audit Report Sarcoma Quality Performance Indicators. Clinical Audit Data: 1 April 2014 to 31 March 2015. 2016.*

5 Actinic keratosis and squamous cell carcinoma of the skin

(Version 2.0, 12 January 2023)

Quality indicator	Reference Recommendation	Evidence base/further information
AK/PEK 1: Pathology report		
Numerator Number of patients with the following information in the histological findings report: · histological tumour type, · histological depth of invasion (description and measurement), · perineural spread, · Vascular invasion, · degree of differentiation and · R classification of invasive tumour proportion **Denominator** All patients with PEK and excision	**4.19** In addition to the diagnosis, the histological findings of squamous cell carcinoma of the skin should also include the following: Histological tumour type (for specific subtypes of squamous cell carcinoma of the skin) Description of the histological depth of invasion in relation to the anatomical layers (especially from level V onwards, corresponding to infiltration of the subcutis) Measurement of depth of invasion from an invasion depth of 2 mm (corresponds approximately to the diameter of a 10x field of view) in positive cases, information on the presence of perineural spread, vascular invasion or low differentiation Completeness of resection of the invasive tumour portion	**Consensus-based recommendation**
Note: Quality objective: As often as possible, complete information in pathology reports for excision of a PEK. The numerator is always a subset of the denominator. The quality indicator is not to be documented with the basic oncological data set of the cancer registries (as of 10/2018).		

6 Anal carcinoma

(Version 1.2, 17 December 2020)

Quality indicator	Reference Recommendation	Evidence base/further information
ANAL 1: Pre-therapeutic MRI examination – pelvis		
Numerator Patients in the denominator who underwent a pre-therapeutic MRI examination of the pelvis **Denominator** All patients with a primary diagnosis of anal carcinoma and therapy	**7.2** An MRI scan of the pelvis **should** be performed to determine the tumour category. This **should** include a multiparametric MRI scan focused on the anal canal. **7.4** An MRI scan of the pelvis **should** be performed to detect locoregional lymph node metastases. This **should** be supplemented by a PET/CT* scan. A CT scan of the pelvis **may** be performed. *CAVE: PET scans are not covered by statutory health insurance as part of the diagnostic process for anal carcinoma (cost coverage not guaranteed).	**7.2: Consensus-based recommendation** **7.4: Consensus-based recommendation** **Quality objective:** Pre-therapeutic MRI scan of the pelvis should be performed as often as possible in cases of initial diagnosis of anal carcinoma with therapy.
ANAL 2: Pathological confirmation of lymph nodes		
Numerator Patients in the denominator with pathological confirmation of lymph node involvement **Denominator** All patients with initial diagnosis of anal carcinoma, cN+ and definitive radiochemotherapy	**7.5** If imaging suggests locoregional lymph node metastasis and definitive chemoradiotherapy is planned, **no** histopathological or cytopathological confirmation of the suspicious lymph nodes **should** be performed.	**Consensus-based recommendation** **Quality objective:** No pathological confirmation of lymph nodes in cases of suspected locoregional lymph node metastasis based on imaging findings in cases of initial diagnosis of anal carcinoma and definitive

Quality indicator	Reference Recommendation	Evidence base/further information
		chemoradiotherapy.
ANAL 3: Preoperative examination – anal canal		
Numerator Patients in the denominator who underwent preoperative multiparametric MRI angulated to the anal canal or anal endosonography **Denominator** All patients with initial diagnosis of stage I anal carcinoma and resection	**7.8** To determine the presence of sphincter contact before performing therapeutic excision for stage I (T1N0M0) anal canal carcinoma or stage I (T1N0M0) or IIA (T2N0M0) anal margin carcinoma, a multiparametric MRI angulated to the anal canal or an anal endosonography **should** be performed.	**Consensus-based recommendation** **Quality objective:** Preoperative multiparametric MRI examination angulated to the anal canal or anal endosonography should be performed as often as possible in cases of initial diagnosis of stage I anal carcinoma with resection.
ANAL 4: Pre-therapeutic tumour board – stoma creation		
Numerator Patients in the denominator who were discussed in the pre-therapeutic tumour board **Denominator** All patients with initial diagnosis of anal carcinoma and pre-therapeutic stoma creation.	**8.10** Patients who require a stoma before the start of therapy **should** be discussed in the interdisciplinary tumour board.	**Consensus-based recommendation** **Quality objective** Presentation of patients with a primary diagnosis of anal carcinoma and planned stoma creation in the pre-therapeutic tumour board as often as possible.
ANAL 5: Combined radiochemotherapy Stage II or III		
Numerator Patients in the denominator with combined radiochemotherapy **Denominator** All patients with a primary	**9.7** Anal carcinomas stages **II-III** should be treated with combined radiochemotherapy .	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **A** **GRADE** Low (⊕⊕◯◯) to moderate (⊕⊕⊕◯)

Quality indicator	Reference Recommendation	Evidence base/further information
diagnosis of stage II or III anal carcinoma.		**Quality objective:** Combined radiochemotherapy as often as possible for initial diagnosis of stage II or II anal carcinoma
ANAL 6: Combined radiochemotherapy with mitomycin and 5-FU		
Numerator Patients in the denominator receiving a chemotherapy regimen of mitomycin and 5-FU **Denominator** All patients with a primary diagnosis of stage II or III anal carcinoma and combined radiochemotherapy	**9.10** As part of combined radiochemotherapy, stage II-III anal carcinomas **should** be treated with a chemotherapy regimen consisting of mitomycin and 5-FU.	**GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** **A** **GRADE** Moderate (⊕⊕⊕◯) to High (⊕⊕⊕⊕) Quality **objective:** Frequent use of mitomycin and 5-FU regimen for initial diagnosis Anal carcinoma stage II or III with combined radiochemotherapy
ANAL 7: Combined radiochemotherapy with IMRT		
Numerator Patients in the denominator who received radiation therapy using intensity-modulated radiotherapy (IMRT) **Denominator** All patients with a primary diagnosis of stage II or III anal carcinoma and combined chemoradiotherapy	**9.16** As part of combined radiochemotherapy, radiation **should** be administered using intensity-modulated radiotherapy (IMRT).	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊖⊖⊖** **A** **GRADE** Very low (⊕◯◯◯) to moderate (⊕⊕⊕◯) Quality **objective:** Intensity-modulated radiotherapy (IMRT) at initial diagnosis of stage II or III anal carcinoma with radiochemotherapy

Quality indicator	Reference Recommendation	Evidence base/further information
ANAL 8: Radiochemotherapy and biopsy		
Numerator All patients in the denominator with biopsy after completion of radiochemotherapy **Denominator** All patients with initial diagnosis of anal carcinoma and radiochemotherapy and complete clinical response	**10.3** In cases of complete clinical response, **no** biopsy should be performed for histopathological confirmation of response.	**Consensus-based recommendation** **Quality objective:** No biopsy after completion of radiochemotherapy in patients with a primary diagnosis of anal carcinoma and complete clinical response.
ANAL 9: Tumour board for residual or recurrent tumours		
Numerator Patients in the denominator who were presented to the tumour board (postoperatively or pretherapeutically) **Denominator** All patients with a primary diagnosis of anal carcinoma and R1/R2 resection or residual tumour after primary radiochemotherapy, or patients with recurrent anal carcinoma	**12.1** In the case of residual or recurrent tumours after primary therapy, further treatment planning **should** be carried out within the framework of an interdisciplinary tumour board.	**Consensus-based recommendation** **Quality objective:** Presentation to the tumour board (postoperatively or pretherapeutically) as often as possible in cases of residual or recurrent tumour after primary therapy for initial diagnosis of anal carcinoma
ANAL 10: Resection in case of local recurrence		
Numerator Patients in the denominator with resection intended to be curative **Denominator** All patients with local recurrence of an anal carcinoma , M0 and after primary radiochemotherapy.	**12** In cases of residual or recurrent tumour in the primary site (anal/perianal) after primary radiochemotherapy without evidence of distant metastasis, surgical resection **should** be performed with curative intent.	**Consensus-based recommendation** **Quality objective:** surgical resection with curative intent should be performed as often as possible in cases of local recurrence of anal carcinoma, M0 and Status post primary

Quality indicator	Reference Recommendation	Evidence base/further information
		radiochemotherapy.
ANAL 11: Resection in cases of residual tumour		
Numerator Patients in the denominator with resection intended to be curative **Denominator** All patients with residual tumour of anal carcinoma, M0 and after primary chemoradiotherapy	**12** In cases of residual or recurrent tumour in the primary site (anal/perianal) after primary radiochemotherapy without evidence of distant metastasis, surgical resection **should** be performed with curative intent.	**Consensus-based recommendation** **Quality objective:** Curative resection should be performed as often as possible in cases of residual tumour of anal carcinoma, M0 and following primary chemoradiotherapy.
ANAL 12: Marking the stoma position		
Numerator Number of patients with preoperative marking of stoma position **Denominator** All patients with anal carcinoma who underwent surgery with stoma creation	**8.11** Adaptation of S3 guideline on colorectal cancer The stoma position **should** be marked preoperatively.	**Consensus-based recommendation** **Quality objective:** Preoperative marking of the stoma position should be performed as often as possible in patients with anal carcinoma who have undergone surgery with stoma creation.
ANAL 13: Tumour board for stage IV, M1		
Numerator Patients in the denominator with pre-therapeutic presentation in the tumour board **Denominator** All patients with stage IV, M1 anal carcinoma (primary or secondary)	**13.** In cases of metastatic anal carcinoma stage IV (distant metastases), further treatment planning **should** be carried out within the framework of an interdisciplinary tumour board.	**Consensus-based recommendation** **Quality objective:** Presentation of patients with stage IV, M1 anal carcinoma to the tumour board as often as possible prior to treatment

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Tumour board participants: visceral surgery, radiotherapy, oncology, pathology, radiology		

7 Chronic lymphocytic leukaemia (CLL)

(Version 2.0, 24 January 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
CLL 1: Examination procedures for the initial diagnosis of CLL (deleted in 2024)		
Numerator **Denominator**	None	Rationale for deletion: Disproportionate effort required for data collection compared to benefits/potential for improvement.
CLL 2: Determination of TP53 deletion and TP53/IGHV mutation status prior to first systemic CLL therapy (modified 2024)		
Numerator Patients in the denominator with: - Determination of TP53 deletion and mutation status (FISH for del17p and TP53 mutation analysis ≤ 12 weeks before start of therapy) and - Assessment of IGHV mutation status **Denominator** All patients diagnosed with CLL and undergoing first systemic therapy	**3.12** The following examination procedures should be performed before initiating a new line of therapy: Determination of TP53 deletion and mutation status (FISH for del(17)(p13) and TP53 mutation analysis) Determination of IGHV mutation status (if not already known)	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖ to LoE no data** sgrade: A Level of Evidence/GRADE assessment: ⊕⊕⊖⊖ (overall survival) (IGHV status, FISH to determine del(17p)) ⊕⊕⊕⊖ (progression-free survival) (IGHV status, FISH to determine del(17p)) No data: QoL, safety **Quality objective:** Determination of TP53 deletion and mutation status as frequently as possible (FISH for del17p and TP53 mutation analysis ≤ 12 weeks before the start of the first systemic therapy) and assessment of IGHV mutation status

Quality indicator	Reference Recommendation	Evidence base/further information
CLL 3: No chemotherapy alone as first-line therapy for CLL (deleted in 2024)		
Numerator **Denominator**	None	Rationale for deletion: Elimination of the underlying strong .
CLL 4: Inclusion of patients with recurrence in clinical trials (modified 2024)		
Numerator Patients in the denominator who are included in a clinical trial **Denominator** All patients with CLL and recurrence and therapy	**5** Patients with recurrence ***should*** be offered treatment as part of a clinical trial, provided that a suitable clinical trial is available.	**Consensus-based recommendation** , **Quality objective:** Inclusion of patients with recurrence in clinical trials as often as possible
CLL 5: Bcl-2 or BTK inhibitor-based therapy as first-line treatment (new in 2024)		
Numerator Numerator Denominator with Bcl-2 or BTK inhibitor-based therapy **Denominator** All patients with CLL and first-line therapy	**4.** Patients with CLL ***should*** be treated with BCL2 or BTK inhibitor-based therapy as first-line treatment.	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** Grade: A Level of evidence/GRADE assessment: ⊕⊕⊕⊖ overall survival ⊕⊕⊕⊖ progression-free survival) ⊕⊕⊖⊖ quality of life ⊕⊕⊕⊖ safety **Quality objective:** Bcl-2 or BTK inhibitor-based therapy as often as possible in the first line

8 Diffuse large B-cell lymphoma (DLBCL)

(Version 1.0, 01.11.2022)

Quality indicator	Reference Recommendation	Evidence base/further information
DLBCL 1: PET/CT before the start of therapy at initial diagnosis (new 2022)		
Numerator Patients in the denominator who underwent PET/CT before the start of therapy. **Denominator** All patients with a first diagnosis of diffuse large B-cell lymphoma and treatment with curative intent.	**5.9** In curative therapy concepts, positron emission tomography/computed tomography (PET/CT) should be performed to determine the stage of spread of diffuse large B-cell lymphoma.	**GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** , high to moderate quality.
Note: Quality objective: PET/CT should be performed as often as possible before the start of therapy in cases of initial diagnosis of DLBCL and curative therapy intention.		
DLBCL 2: R-CHOP for initial diagnosis ≤ 80 years and curative treatment intention (new 2022)		
Numerator Patients in the denominator receiving immunochemotherapy with R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or R-CHOP-like protocol **Denominator** All patients with initial diagnosis of diffuse large B-cell lymphoma* (ICD-10 C82.4, C83.3, C83.8, C85.2) ≤ 80 years and curative treatment intention	**6.3** For all young patients (≤ 60 years) without treatment restrictions, immunochemotherapy with R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or an R-CHOP-like protocol should be administered outside of clinical trials with curative intent. **6.24** Similar to younger patients, patients aged 61–80 years without limitations to treatment eligibility should also receive potentially	**6.3: GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** **6.24: GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** **7.4: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.5: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.43: Consensus-based recommendation** **7.21: Consensus-based recommendation** **7.25: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.37: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.41: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.46: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖**

Quality indicator	Reference Recommendation	Evidence base/further information
	curative immunochemotherapy according to the R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone) or R-CHOP-like regimen. **7.4** Double expressor DLBCL represents a morphological subgroup of DLBCL, NOS and should be treated in the same way as DLBCL, NOS. **7.5** DLBCL with *MYC* translocation alone should be treated in the same way as DLBCL, NOS. **7.4** Isolated or grouped foci in patients with leg-type DLBCL should be treated in the same way as nodal DLBCL, NOS. **7.21** Treatment should be carried out in accordance with nodal DLBCL. **7.25** In cases of primary testicular DLBCL, immunochemotherapy should be administered in the same way as for nodal DLBCL. **7.37** Patients with primary DLBCL of the bone should receive immunochemotherapy analogous to nodal DLBCL, NOS. **7.41** In cases of primary extranodal DLBCL of the breast, treatment	**7.53: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.54: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.6: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.12: Consensus-based recommendation** **7.31: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.47: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** , High to moderate (DLBCL, NOS) or moderate to low (analogous to DLBCL, NOS) quality.

Quality indicator	Reference Recommendation	Evidence base/further information
	should be similar to that for nodal DLBCL, NOS. **7.46** Patients with grade 3B follicular lymphoma should be treated in the same way as DLBCL, NOS. **7.53** Patients with grade 3 lymphomatoid granulomatosis should be treated in the same way as DLBCL, NOS. **7.54** Patients with intravascular large B-cell lymphoma should be treated in the same way as DLBCL, NOS. In addition, CNS prophylaxis should be administered. **7.6** Outside of clinical trials, DLBCL/high-grade B-cell lymphomas with *MYC* translocation and *BCL2* and/or *BLC6* translocation should be treated in the same way as DLBCL, NOS. **7.12** Patients with primary mediastinal B-cell lymphoma should be treated with R-CHOP-based immunochemotherapy. **7.3** Systemic therapy for gastrointestinal DLBCL without indolent components should be administered in the same way as for DLBCL, NOS.	

Quality indicator	Reference Recommendation	Evidence base/further information
	7.47 Patients who are diagnosed with diffuse large B-cell lymphoma at the same time as their initial diagnosis of follicular lymphoma (primarily transformed follicular lymphoma or secondary simultaneous DLBCL) should be treated in the same way as DLBCL, NOS.	
Note: Quality target: R-CHOP or similar protocol as often as possible for initial diagnosis of DLBCL ≤ 80 years and curative treatment intention **Note:** R-CHOP-like = rituximab; cyclophosphamide; doxorubicin, other anthracyclines, mitoxantrone; vincristine, polatuzumab vedotin; prednisone, other glucocorticosteroids; etoposide		
DLBCL 3: 4 cycles of CHOP + 6 doses of rituximab for initial diagnosis ≤ 60 years of age and very favourable prognosis (new 2022)		
Numerator Patients in the denominator with 4 cycles of CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) in combination with 6 doses of rituximab **Denominator** All patients with initial diagnosis of diffuse large B-cell lymphoma ≤ 60 years of age and very favourable prognosis (aaIPI=0 without bulk) and systemic therapy	**6.5** Young patients (≤ 60 years) with a very favourable prognosis (aaIPI=0 without bulk) should be treated with 4 cycles of CHOP in combination with 6 doses of rituximab.	**GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖** , High to moderate quality.
Note: Quality objective: 4 cycles of CHOP + 6 doses of rituximab as often as possible for initial diagnosis ≤ 60 years and very favourable prognosis		

Quality indicator	Reference Recommendation	Evidence base/further information
DLBCL 4: PET/CT after completion of first-line immunochemotherapy (new 2022)		
Numerator Patients in the denominator who underwent a PET/CT scan after completion of immunochemotherapy **Denominator** All patients with initial diagnosis of DLBCL and completed first-line immunochemotherapy	**6.1** In patients with DLBCL, remission should be monitored using PET/CT after completion of the planned immunochemotherapy cycles. CAVE: A final PET/CT scan is not covered by statutory health insurance in the outpatient sector (cost coverage not guaranteed, as of March 2022).	**GRADE: ⊕⊕⊕⊖** , Moderate quality.
Note: Quality objective: PET/CT as often as possible after completion of first-line immunochemotherapy for initial diagnosis		
DLBCL 5: Radiation therapy for PET-positive residual disease after first-line immunochemotherapy (new 2022)		
Numerator Patients in the denominator with radiation therapy **Denominator** All patients with initial diagnosis of DLBCL* (ICD-10 C82.4, C83.3, C83.8, C85.2) incl. genetically defined subgroups (DLBCL/high-grade B-cell lymphoma with translocation of MYC, BCL2 and/or BCL6) and completed first-line immunochemotherapy and PET-positive residual disease in final staging	**6.14** Patients with PET-positive residual disease should receive consolidation radiotherapy. **7.2** Residual findings in PET/CT should be treated with consolidation radiotherapy in the same way as DLBCL, NOS.	**6.14: GRADE: ⊕⊕⊖⊖** **7.2: GRADE: ⊕⊖⊖⊖** , low (DLBCL, NOS) or very low (analogous to DLBCL, NOS) quality.
Note: Quality objective: Radiation therapy as often as possible at initial diagnosis and PET-positive residual disease after first-line immunochemotherapy		

Quality indicator	Reference Recommendation	Evidence base/further information
DLBCL 6: Histological confirmation of recurrence (new 2022)		
Numerator Patients in the denominator with histological confirmation of recurrence **Denominator** All patients with DLBCL and recurrence	**8** If there are indications (clinical, laboratory, imaging) of recurrence, a biopsy should be performed with the aim of histological confirmation. **9.8** If there are indications (clinical, laboratory, imaging) of recurrence, a biopsy should be performed with the aim of obtaining histological confirmation.	**8.1: Consensus-based recommendation** **9.8: Consensus-based recommendation**
Note: Quality objective: Histological confirmation of recurrence as often as possible		
DLBCL 7: PET/CT before starting recurrence therapy (new 2022)		
Numerator Patients in the denominator who underwent PET/CT before starting relapse therapy **Denominator** All patients with recurrence of diffuse large B-cell lymphoma and treatment with curative intent	**8.2** A PET/CT scan should be performed as a baseline finding prior to recurrence therapy and for staging of recurrent or persistent DLBCL, as well as for monitoring response over time in potentially curative therapy concepts. CAVE: PET examinations are not covered by statutory health insurance in the outpatient sector (cost coverage not guaranteed, as of March 2022).	**Consensus-based recommendation**
Note: Quality objective: PET/CT should be performed as often as possible before starting curative therapy for a recurrence.		

9 Endometrial carcinoma

(Version 3.0, 08.07.2024)

Quality indicator	Reference Recommendation	Evidence base/further information
ENDO 1: No LNE for endometrial carcinoma c/pT1a, G1/2, cN0, LVSI neg. (modified 2022)		
Numerator Patients in the denominator with systematic LNE **Denominator** All patients with initial diagnosis of endometrial carcinoma, c/p T1a, G1/G2, cN0, LVSI neg.	**6.5** In cases of low-risk type I endometrial carcinoma pT1a, G1/2, no bulky nodes, p53-wt, L1CAM negative or not determined, no systematic lymphadenectomy should be performed.	**LoE 1** EG A, Quality objective: No systematic lymphadenectomy for endometrial carcinoma c/p T1a, G1/G2, cN0, LVSI neg.
ENDO 2: No adjuvant chemotherapy for type I endometrial carcinoma in stage pT1a/b, G1 or G2, cN0/pNsn0 p53-wt (modified 2022)		
Numerator Patients in the denominator with adjuvant chemotherapy **Denominator** All patients with a primary diagnosis of endometrioid or other type I endometrial carcinoma (ICD-0: 8380/3, 8570/3, 8263/3, 8382/3, 8480/3), pT1a/b G1 cN0/pNsn0 p53-wt or pT1a/b G2 cN0/pNsn0, p53-wt	**8.2** Patients with primary type I endometrial carcinoma in stage pT1a/b G1 and G2 cN0/ pNsn0, p53-wt and L1CAM-neg. or not determined should not receive adjuvant chemotherapy.	**Consensus-based recommendation** , Quality objective: No adjuvant chemotherapy for type I endometrial carcinoma pT1a/b G1 cN0/pNsn0 p53-wt or pT1a/b G2 cN0/pNsn0 p53-wt
ENDO 3: Consultation with social services		
Numerator Number of patients receiving counselling from social services **Denominator** All patients with a primary diagnosis of endometrial	**11.15** Medical oncological rehabilitation is used for the specific treatment of disorders resulting from disease and therapy. All patients with endometrial cancer should be informed and advised about the legal options for applying	**11.15: Consensus-based recommendation** **11.15: Consensus-based recommendation** , Quality objective: e consultations by social

Quality indicator	Reference Recommendation	Evidence base/further information
carcinoma and treatment at the facility	for and claiming rehabilitation services. **11.15** Medical oncological rehabilitation is used for the specific treatment of disorders resulting from disease and therapy. All patients with endometrial cancer should be informed and advised about the legal options for applying for and receiving rehabilitation services.	services as often as possible
ENDO 4: Presentation at the tumour conference (modified 2022)		
Numerator Patients in the denominator with presentation at the tumour conference **Denominator** All patients with endometrial carcinoma	**14** All patients with endometrial cancer should be presented at an interdisciplinary tumour conference.	**Consensus-based recommendation** , Quality objective: Presentation of patients at tumour conferences as often as possible
Note: Participants in tumour conference: Surgeon, radiologist, pathologist, radiotherapist, gynaecological oncologist, medical oncologist (if systemic therapy is performed by a medical oncologist)		
ENDO 5: Immunohistochemical determination of p53 and MMR proteins (new in 2022)		
Numerator Patients of the denominator with immunohistochemical determination of p53 and MMR proteins using the " " method **Nenner** All patients with histologically confirmed diagnosis of endometrial carcinoma (including M1)	**4.40** Immunohistochemical determination of p53 and MMR proteins should be performed in all histologically diagnosed primary EC.	**LoE 4** EG A, Quality objective: Determination of p53 and MMR proteins as frequently as possible

Quality indicator	Reference Recommendation	Evidence base/further information
ENDO 6: POLE examination (new in 2022)		
Numerator Patients in the denominator with POLE testing **Denominator** All patients with initial diagnosis of endometrial carcinoma >pT1a and/or G3 and/or p53-abn and/or LVSI pos. and/or MSI/MMR pos. or initial diagnosis of type 2 endometrial carcinoma (serous, clear cell, carcinosarcoma) (ICD-0: 8380/03,8441/3, 8310/3, 8020/3, 8323/3, 9110/3, 8070/3, 8144/3, 9111/3, 8980/3)	**4.41** In cases of G3 or intermediate, high intermediate and high risk EC, a mutation analysis of the exonuclease domain of POLE should be performed.	**LoE 4** EG A, Quality objective: POLE testing as often as possible
ENDO 7: Postoperative vaginal brachytherapy alone (new in 2022)		
Numerator Patients in the denominator with postoperative vaginal brachytherapy alone **Denominator** All patients with initial diagnosis of endometrial carcinoma stage pT1b, G1 or G2 pNX/0, p53-wt, L1CAM- -negative, without extensive LVSI with surgery	**7.** In stage pT1b, G1 or G2 pNX/0 and in stage pT1a (with myometrial involvement), G3 pNX/0, endometrioid endometrial carcinoma (type I), p53-wt, L1CAM negative or not determined, no extensive LVSI, postoperative vaginal brachytherapy alone with should be performed.	**LoE 2** EG A, Quality objective: Vaginal brachytherapy alone as often as possible
ENDO 8: Percutaneous radiotherapy with simultaneous chemotherapy (PORTEC 3 regimen) (new 2022)		
Numerator Patients in the denominator with simultaneous chemotherapy (PORTEC 3 regimen)	**7.1** Patients with endometrioid endometrial carcinoma (type 1) in stage pT1b and pT2 p53-abn, POLE-wt should receive	**LoE 3** EG A, Quality objective: Simultaneous chemotherapy (PORTEC 3 regimen) as often

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with initial diagnosis of endometrioid (morphology code: 8380/3) endometrial carcinoma pT1b or pT2, p53-abn, POLE-wt and percutaneous radiotherapy	percutaneous radiotherapy in combination with chemotherapy (PORTEC 3 regimen).	as possible.
ENDO 9: Adjuvant chemotherapy with carboplatin and paclitaxel (new in 2022)		
Numerator Patients in the denominator receiving chemotherapy with carboplatin and paclitaxel **Denominator** Patients with a primary diagnosis of endometrial cancer and adjuvant chemotherapy	**8.11** Adjuvant chemotherapy for endometrial carcinoma should be administered with carboplatin AUC 5 or AUC 6 and paclitaxel 175 mg per square metre. Following percutaneous radiotherapy, carboplatin AUC 5 should be administered.	**LoE 2** EG A, Quality objective: Adjuvant chemotherapy with carboplatin and paclitaxel as often as possible

10 Follicular lymphoma

(Version 1, 22 June 2020)

Quality indicator	Reference Recommendation	Evidence base/further information
FL 1: Confirmation of diagnosis Follicular lymphoma		
Numerator Number of patients with tissue biopsy* * Tissue biopsy = tissue or bone marrow **Denominator** All patients with initial diagnosis of follicular lymphoma (C82)	None	
Note: Quality objective: Tissue biopsy as often as possible in patients with a primary diagnosis of follicular lymphoma		
FL 2: Hepatitis and HIV serology before starting treatment for follicular lymphoma		
Numerator Number of patients with hepatitis B, C and HIV serology prior to systemic therapy **Denominator** All patients with a primary diagnosis of follicular lymphoma (C82) and systemic therapy	**4.11** Hepatitis B, C and HIV serology ***should*** be performed before initiating systemic therapy.	**Consensus-based recommendation**
Note: Quality objective: Hepatitis and HIV serology should be performed as often as possible before starting systemic therapy.		
FL 3: Involved-site or involved-field radiation therapy for follicular lymphoma		
Numerator Number of patients with involved-site or involved-field	**6.**	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
radiation therapy **Denominator** All patients with follicular lymphoma (C82) and radiotherapy as first-line therapy	Radiation ***should*** correspond to involved-site radiation.	
Note: Quality objective: Involved-site or involved-field radiotherapy as often as possible for first-line radiotherapy. Radiotherapy		

11 Bladder carcinoma

(Version 3.0, 07.04.2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Bladder cancer 1: Contents of the findings report		
Numerator Patient with findings report stating: - Localisation - Number of confirmed/affected lymph nodes - Capsule-transcending growth (y/n) - Max. metastasis size (mm, one-dimensional) **Denominator** N: All patients with initial diagnosis of bladder carcinoma pN+	**4.16** The findings should include the location (clinical information), the total number of histologically confirmed lymph nodes, the number of affected lymph nodes, the maximum metastasis size and capsular invasion.	**Consensus-based recommendation** **, A**
Quality objective: **Note:** Where possible, the findings report should include complete details of the parameters: location, number of detected/affected lymph nodes, capsular invasion and maximum metastasis size.		
Bladder cancer 2: Statement on detrusor muscle in findings report		
Numerator Patients with pathology report stating whether detrusor muscle is included **Denominator** All patients with bladder cancer and TUR-B	**6.1** If no cystectomy is planned, a second resection should be performed in patients with non-muscle-invasive urothelial carcinoma of the bladder with the following constellation: for tumours in which the primary TUR was incomplete if no muscle was detectable in the initial TUR	**LoE 1-**

Quality indicator	Reference Recommendation	Evidence base/further information
	histopathological e specimen, except for pTa low grade for pT1 tumours in all high-grade tumours, with the exception of patients with primary carcinoma in situ (pTis)	
Quality objective: **Note:** Where possible, state in the findings report whether detrusor muscle is involved		
Bladder cancer 3: Bilateral pelvic lymphadenectomy during radical cystectomy		
Numerator Patients with bilateral pelvic lymphadenectomy **Denominator** All patients with bladder cancer and radical cystectomy	**7.** In cases of invasive bladder cancer, bilateral pelvic lymphadenectomy should be performed at the same time as radical cystectomy.	**LoE 2**
Quality objective: **Note** Bilateral pelvic lymphadenectomy should be performed as often as possible during radical cystectomy.		
Bladder cancer 4: Radical cystectomy within 3 months of diagnosis		
Numerator Patients with radical cystectomy within 3 months of diagnosis **Denominator** All patients with initial diagnosis of bladder carcinoma >= pT2 and radical cystectomy without neoadjuvant chemotherapy	**7.3** In patients with muscle-invasive bladder cancer who do not receive neoadjuvant therapy, radical cystectomy should be performed within 3 months of diagnosis if possible.	**LoE 2**

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Radical cystectomy within 3 months of diagnosis without neoadjuvant chemotherapy as often as possible		
Bladder cancer 5: Simultaneous RCT		
Numerator Patients with simultaneous RCT **Denominator** All patients with bladder carcinoma >=cT2 and radiotherapy intended to be curative	**7.4** Simultaneous radiochemotherapy should be performed as part of a bladder-preserving procedure with curative intent.	**Consensus-based recommendation**
Note: Quality objective: Simultaneous RCT as often as possible for radiotherapy with curative intent		
Bladder cancer 6: Resection biopsy from the urinary bladder after RT/RCT		
Numerator Patients with resection biopsy from the urinary bladder after RT/RCT **Denominator** All patients with bladder cancer and completed RT/RCT	**7** As part of the response assessment, a repeat cystoscopy with sampling from the former resection site should be performed.	**Consensus-based recommendation**
Note: Quality objective: Resection biopsy from the urinary bladder after RT/RCT as often as possible		
Bladder cancer 7: Preoperative marking of stoma position		
Numerator Patients with preoperative marking of stoma position **Denominator** All patients with bladder	**8.** A possible stoma position should be marked preoperatively. The urostomy should be created	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
cancer who underwent surgery with stoma creation.	prominently, if technically possible.	
Note Quality objective: Preoperative marking of the stoma position as often as possible		
Bladder cancer 8: Pre-therapeutic multidisciplinary consultation		
Numerator Patients with pre-therapeutic multidisciplinary presentation **Denominator** All patients with initial diagnosis of bladder cancer >= cT2	None	
Note: Quality objective: Pre-therapeutic multidisciplinary presentation as often as possible		
Bladder cancer 9: Postoperative multidisciplinary presentation		
Numerator Patients with postoperative multidisciplinary presentation **Denominator** All patients with bladder cancer >= pT3 and/or pN+	**9.5** Patients with localised muscle-invasive bladder cancer (T2-T4a N0 M0) who are suitable for cisplatin-based chemotherapy should be offered neoadjuvant cisplatin-based combination therapy.	**LoE 1** In patients with organ-transcending, muscle-invasive bladder cancer (≥pT3) and/or pN+, multidisciplinary consultation should be held to plan further treatment.
Note: Quality objective: Postoperative multidisciplinary consultation as often as possible		
Bladder cancer 10: Consultation with social services		
Numerator Patients with counselling by social services	**11**	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with bladder cancer and cystectomy who received counselling from social services	Patients should be offered rehabilitation after cystectomy.	
Note: Quality objective: Consultation with social services as often as possible after cystectomy		
Bladder cancer 11: Consultation with a stoma therapist or nursing expert in stoma, continence and wound care for urostomy		
Numerator Patients with counselling by stoma therapist or nursing expert in stoma, continence and wound care **Denominator** All patients with bladder cancer and urostomy	**11** After creation of a urostomy or other urinary diversion, training should be provided with the aim of enabling independent care.	**Consensus-based recommendation**
Note: Quality objective: Consultation with a stoma therapist or nursing expert in stoma, continence and wound care as often as possible for urostomy		
Bladder cancer 12: Risk classification according to EORTC criteria		
Numerator Patients with information Risk classification according to EORTC criteria **Denominator** All patients with NMIBC and TUR	**1** After diagnosis of non-muscle-invasive bladder cancer, the tumour should be classified according to risk (low, intermediate, high risk) based on the risk of recurrence and progression according to EORTC criteria.	**Consensus-based recommendation**
Note: Quality objective: Specify the risk classification according to EORTC criteria as often as possible.		

12 Hepatocellular carcinoma and biliary carcinomas

(Version 5.2, 25 June 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
HCC 1: Classification according to WHO classification (since 2013; supplemented in 2020)		
Numerator Patients in the denominator with typing according to current WHO classification **Denominator** N1: All patients with histologically confirmed HCC N2: All patients with histologically confirmed CCA	**3.17** The typing of HCC should be based on the current WHO classification. Special forms (e.g. fibrolamellar HCC and mixed-differentiated tumours (combined HCC/iCCA)) and, if possible, early HCC should be distinguished from progressive HCC and premalignant lesions. A clear distinction should be made between special forms of intrahepatic cholangiocarcinoma, liver metastases and benign liver tumours. **4.9** Carcinomas of the bile ducts and gallbladder should be classified according to their anatomical location (intrahepatic, perihilar, distal bile ducts, gallbladder) and histological differentiation in accordance with the current WHO classification. In the case of intrahepatic cholangiocarcinomas, a distinction should be made between the 'small duct' and 'large duct' types . Sources: [2]	**3.17: Consensus-based recommendation** **4.9: Consensus-based recommendation** **Quality objective:** Typing according to WHO as often as possible

Quality indicator	Reference Recommendation	Evidence base/further information
HCC 2: Content of HCC reports (since 2013)		
Numerator Patients in the denominator with diagnostic reports containing information on: · Staging (according to TNM classification) · Typing (according to WHO classification) · Grading · Resection margin · Status of surrounding liver **Denominator** All patients with HCC and liver resection or liver transplantation	**3.18** The processing and evaluation of a resected specimen or explant should determine the extent of the tumour (staging) according to the current TNM classification, its type (typing) and degree of differentiation (grading), the status of the resection margin (R classification) and the status of the non-tumourous liver.	**Consensus-based recommendation** **Quality objective:** Complete diagnostic reports as often as possible
HCC 3: Presentation at tumour conference (since 2013, reviewed in 2024) (in accordance with long version)		
Numerator Patients in the denominator with pre-therapeutic presentation at the tumour conference **Denominator** All patients with HCC	**3.31** Patients with hepatocellular carcinoma should be presented at an interdisciplinary tumour conference before treatment and when changing the treatment strategy.	**Consensus-based recommendation** **Quality objective:** Pre-therapeutic presentation at the tumour conference as often as possible
TC participants: gastroenterologist, pathologist, interventional radiologist, visceral surgeon Video conferences are possible		
HCC 4: Presentation at tumour conference after TACE (modified 2020) (according to long version)		
Numerator Patients in the denominator with presentation in the tumour conference after two treatment cycles	**3.59** The indication for continuing TACE should be reviewed by the tumour board after two treatment cycles.	**Consensus-based recommendation** **Quality objective:** Presentation at the tumour

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with HCC and TACE		conference after TACE as often as possible
HCC 5: mRECIST/EASL/LI-RADS-TR classification after TACE (modified 2024) (according to long version)		
Numerator Patients in the denominator with assessment of remission using mRECIST, EASL or LI-RADS-TR classification **Denominator** All patients with HCC and TACE	**3.65** Remission assessment after ablation/TACE/TARE should be based on standardised criteria (mRECIST, EASL or LI-RADS-TR).	**Consensus-based recommendation** **Quality objective:** Use of the mRESCIST, EASL or LI-RADS-TR classification after TACE as often as possible
HCC 6: Bridging therapy (new in 2020) (in accordance with long version)		
Numerator Patients in the denominator who received bridging therapy **Denominator** All patients with HCC (BCLC A), Child A on the transplant waiting list	**3.38** Patients with HCC (BCLC A) within the Milan criteria should receive bridging therapy, provided that liver function allows it.	**LoE 1** A **Quality objective:** Bridging therapy should be used as often as possible in patients with HCC (BCLC A) within the Milan criteria.
Bridging: Local ablation, resection, or transarterial procedures (TACE, TARE) BCLC A: ECOG (PS): 0-2 Child-Pugh A to C Single tumour > 2 cm or early multifocal disease with up to 3 tumours < 3 cm		
HCC 7: Contents of CCA findings reports (new 2020) (corresponding to long version)		
Numerator Patients in the denominator for whom a histopathological findings report with the following information is available: · Staging (TNM	**4.10** The processing and evaluation of a resected specimen should determine the extent of the tumour (staging) according to the current TNM classification,	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
classification) · Typing (WHO classification) · Grading · Resection margin (R classification) · For intrahepatic cholangiocarcinomas (C22.1): status of non-tumourous liver **Denominator** All patients with CCA and resection or explantation	its type (typing) and degree of differentiation (grading), and the status of the resection margin (R classification) as well as, in the case of intrahepatic cholangiocarcinoma, the status of the non-tumourous liver. In specimens with premalignant lesions, careful processing should be used to clarify a possible transition to invasive carcinoma.	**Quality objective:** Complete findings reports as often as possible

13 Testicular tumours

(Version 1.1, 04.03.2020)

Quality indicator	Reference Recommendation	Evidence base/further information
Test 1: Presentation at tumour conference		
Numerator Number of patients presented at an interdisciplinary tumour conference* after chemotherapy *Tumour conference participants: urology, pathology, radiology, haematological oncology, radiotherapy, if necessary: visceral surgery **Denominator** All patients with germ cell tumours (ICD-10 C62) who have residual tumours after chemotherapy.	**3.2** Patients with GCTs with post-chemotherapy residual tumours should only undergo RTR after prior multidisciplinary consultation at centres with proven experience and the necessary facilities for multidisciplinary surgical procedures.	**Consensus-based recommendation** **Quality objective:** Therapy recommendation from an interdisciplinary tumour conference as often as possible for patients with residual tumours after chemotherapy
Test 2: Pathology report		
Numerator Number of patients with all of the following information in the pathohistological findings report: - Side - Testicle size - Maximum tumour size (in 3 dimensions) - Macroscopic characteristics of the epididymis, spermatic cord and tunica vaginalis - tumour at the margin of resection (yes/no) - Histological type with specification of individual components and percentage determination according to	**6.17** The pathohistological report of the testicular specimen should include the following information: Indication of side, size of the testicle, maximum tumour size (in 3 dimensions), macroscopic characteristics of the epididymis, spermatic cord and tunica vaginalis,	**Consensus-based recommendation** EG A, a **Quality objective:** Complete pathohistological reports as often as possible.

Quality indicator	Reference Recommendation	Evidence base/further information
WHO 2016 - Peritumoral venous and/or lymphatic invasion (yes/no) - Invasion of the tunica albuginea (yes/no) - Invasion of the tunica vaginalis (yes/no) - Invasion of the rete testis (yes/no) - Invasion of the soft tissue of the hilum, epididymis or spermatic cord (yes/no) - Germ cell neoplasia in situ in non-tumourous parenchyma (yes/no) - pT category according to the 2017 TNM classification **Denominator** All patients with a primary diagnosis of germ cell tumour (ICD-10 C62) and ablation of the testis	tumour at the margin of resection (yes/no), histological type with specification of individual components and percentage determination according to WHO 2016, peritumoral venous and/or lymphatic invasion (yes/no), invasion of the tunica albuginea (yes/no), Tunica vaginalis (yes/no), rete testis (yes/no), soft tissue of the hilum, epididymis or spermatic cord (yes/no), Germ cell neoplasia in situ in non-tumourous parenchyma (yes/no), pT category according to the 2017 TNM classification.	
Test 3: Offer cryopreservation		
Numerator Number of patients who were offered pre-therapeutic cryopreservation of spermatozoa **Denominator** All patients with a primary diagnosis of germ cell tumour (ICD-10 C62) and therapy (surgery, radiotherapy or chemotherapy)	**6.19** If a germ cell tumour is suspected, the patient should be offered sperm cryopreservation before the start of treatment (before testicular ablation, at the latest before chemotherapy or radiotherapy).	**LoE 5** EG A, **Quality objective:** Offer pre-therapeutic cryopreservation of sperm as often as possible.

Quality indicator	Reference Recommendation	Evidence base/further information
Test 4: IGCCCG prognostic criteria		
Numerator Number of patients classified according to the IGCCCG prognosis criteria **Denominator** All patients with metastatic germ cell tumours (ICD-10 C62, stage II and above)	**7.6** The classification of metastatic HCC should be based on the prognostic criteria of the IGCCCG.	**Consensus-based recommendation** **Quality objective:** Classification according to the IGCCCG prognostic criteria should be performed as often as possible in patients with metastatic germ cell tumours.
Note: - IGCCCG 1997		
Test 5: Active surveillance (seminoma)		
Numerator Number of patients with active surveillance **Denominator** All patients with initial diagnosis of seminoma (ICD-O-M 9061/3) in stage I (pT1-4, N0, M0)	**8.1** Patients with seminoma in cSI should be followed up using the surveillance strategy and, in the event of recurrence, treated according to the stage.	**GRADE:** ⊕⊖⊖⊖ EG A, b **Quality objective:** Active surveillance for follow-up of stage I seminoma patients as often as possible.
Test 6: Active surveillance (non-seminomatous germ cell tumour)		
Numerator Number of patients with active surveillance **Denominator** All patients with initial diagnosis of non-seminomatous germ cell tumour* in stage IA (pT1, N0, M0, S0)	**8.1** In low-risk situations, surveillance should be favoured.	**LoE 2b** EG A, b **Quality objective:** Active surveillance for follow-up of stage IA non-seminomatous germ cell tumours as often as possible.
Note: - *ICD-O morphology (3rd edition, 1st revision): Non-seminomatous germ cell tumour: 9070/3, 9071/3, 9100/3, 9104/1, 9105/3, 9085/3, 9080/1, 9063/3, 8240/3, 9085/3, 9071/3, 8650/1, 8650/3, 8640/1, 8640/3, 8642/1, 8643/1, 8620/1, 8622/1, 8600/0, 8592/1, 8591/1, 9073/1		

Quality indicator	Reference Recommendation	Evidence base/further information
Test 7: Systemic therapy Stage IIC/III and good prognosis		
Numerator Number of patients with 3 cycles of PEB (cisplatin, bleomycin, etoposide) over 5 days **Denominator** All patients with germ cell tumours (ICD-10 C62) in stage IIC or III of the good prognosis group according to IGCCCG	**8.3** Patients with metastatic GCT in stage IIC/III of the good prognosis group according to IGCCCG should receive polychemotherapy with three cycles of PEB with cisplatin and etoposide administered over five days.	**LoE 1b** EG A, b **Quality objective:** Systemic therapy with 3 cycles of PEB over 5 days should be used as often as possible in patients in stage IIC/III of the good prognosis group.
Note - Contraindications for bleomycin should be observed. Recommendations 9.34 and 9.38 apply to these patients. - IGCCG 1997		
Test 8: Systemic therapy for metastatic seminoma and intermediate prognosis group		
Numerator Number of patients with four cycles of PEB (cisplatin, bleomycin, etoposide) **Denominator** All patients with metastatic seminoma (ICD-O-M 9061/3; stage II-IIIC) with intermediate prognosis according to IGCCCG	**8** Patients with metastatic seminoma and intermediate prognosis should receive four cycles of PEB chemotherapy.	**LoE 1b** EG A, b **Quality objective:** Systemic therapy with four cycles of PEB as often as possible for metastatic seminoma and intermediate prognosis group
Note: - Contraindications for bleomycin must be observed. Recommendation 9.36 applies to these patients. - IGCCCG 1997		
Test 9: Systemic therapy for non-seminomatous germ cell tumours and intermediate prognosis group		
Numerator Number of patients with four cycles of PEB (bleomycin,	**8.39** Patients with metastatic non-seminomatous GCT and	**LoE 1b** EG A, b

Quality indicator	Reference Recommendation	Evidence base/further information
etoposide) **Denominator** All patients with metastatic non-seminomatous germ cell tumours* (stage II-IIIC) with intermediate prognosis according to IGCCCG	intermediate prognosis should receive four cycles of PEB chemotherapy.	**Quality objective:** Systemic therapy with four cycles of PEB should be used as often as possible for non-seminomatous germ cell tumours and intermediate prognosis groups.
Note: - Contraindications for bleomycin must be observed. Recommendation 9.40 applies to these patients. - *ICD-O morphology (3rd edition, 1st revision): Non-seminomatous germ cell tumour: 9070/3, 9071/3, 9100/3, 9104/1, 9105/3, 9080/3, 9084/3, 9085/3, 9080/1, 9063/3, 9084/0, 8240/3, 9085/3, 9071/3, 8650/1, 8650/3, 8640/1, 8640/3, 8642/1, 8643/1, 8620/1, 8622/1, 8600/0, 8592/1, 8591/1, 9073/1 - IGCCG 1997		
Test 10: Systemic therapy for non-seminomatous germ cell tumours and poor prognosis group		
Numerator Number of patients with four cycles of PEB (cisplatin, bleomycin, etoposide) **Denominator** All patients with metastatic non-seminomatous germ cell tumours* (stage II-IIIC) with poor prognosis according to IGCCCG	**8.41** Patients with metastatic non-seminomatous GCT and poor prognosis should receive four cycles of PEB chemotherapy.	**LoE 1b** EG A, b **Quality objective:** Systemic therapy with four cycles of PEB should be used as often as possible for non-seminomatous germ cell tumours and poor prognosis groups.
Note: - Contraindications for bleomycin must be observed. Recommendation 9.42 applies to these patients. - *ICD-O morphology (3rd edition, 1st revision): Non-seminomatous germ cell tumour: 9070/3, 9071/3, 9100/3, 9104/1, 9105/3, 9080/3, 9084/3, 9085/3, 9080/1, 9063/3, 9084/0, 8240/3, 9085/3, 9071/3, 8650/1, 8650/3, 8640/1, 8640/3, 8642/1, 8643/1, 8620/1, 8622/1, 8600/0, 8592/1, 8591/1, 9073/1 - IGCCG 1997		

Quality indicator	Reference Recommendation	Evidence base/further information
Test 11: Residual tumour resection Lung and retroperitoneum		
Numerator Number of patients with resection of residual tumour **Denominator** All patients with non-seminomatous SC* and completed chemotherapy with S 0 (measurement time approx. 6 weeks after end of chemotherapy) and residual tumour >1 cm in the retroperitoneum and/or lung (axial CT diameter)	**8.7** After completion of primary chemotherapy and achievement of marker normalisation in patients with non-seminomatous SC, residual tumours > 1 cm in the retroperitoneum and lungs should be resected. The management of residuals in other locations should be decided on an individual basis.	**LoE 2b** EG A, b **Quality objective:** Adequate resection of residual tumours of non-seminomatous germ cell tumours after chemotherapy and normalisation of serum markers as often as possible.
Note: - *ICD-O morphology (3rd edition, 1st revision): Non-seminomatous GCT: 9070/3, 9071/3, 9100/3, 9104/1, 9105/3, 9080/3, 9084/3, 9085/3, 9080/1, 9063/3, 9084/0, 8240/3, 9085/3, 9071/3, 8650/1, 8650/3, 8640/1, 8640/3, 8642/1, 8643/1, 8620/1, 8622/1, 8600/0, 8592/1, 8591/1, 9073/1		

14 Hodgkin's lymphoma

(Version 3.2, 23 October 2022)

Quality indicator	Reference Recommendation	Evidence base/further information
HL 1: Histological diagnosis (since 2013)		
Numerator Number of patients with biopsy and/or excision LK **Denominator** All patients with initial histological diagnosis of Hodgkin lymphoma	**3.** The histological diagnosis ***should*** be made on the basis of a biopsy of an entire lymph node or another primarily affected organ.	**Consensus-based recommendation** **, Strong** Quality objective: Biopsy and/or excision of a lymph node (LN) for histological diagnosis as often as possible in cases of initial diagnosis of Hodgkin lymphoma
HL 2: Diagnostic requirements (since 2013)		
Numerator Number of patients who underwent BSG diagnostics, CT (with contrast medium) of the neck, thorax and abdomen, chest X-ray and bone marrow biopsy **Denominator** All patients with a confirmed initial diagnosis of Hodgkin's lymphoma	**3.7** The initial ***diagnostic examinations*** should include medical history, physical examination, laboratory tests, imaging procedures (CT (with contrast medium) of the neck, thorax and abdomen, chest X-ray, sonography and PET/CT (see)).	**Consensus-based recommendation** **, quality objective:** Perform the above diagnostic examinations as often as possible in patients with a first diagnosis of Hodgkin's lymphoma
Note: The Numerator is currently not mapped to the updated standardised oncological basic data set (= BDS) of the German Tumour Centres Association (ADT) and the Society of Epidemiological Cancer Registries in Germany (GEKID) (as of 12 February 2014).		
HL 3: PET/CT in staging (new in 2018)		
Numerator Number of patients with PET/CT during staging **Denominator**	**3.1** PET/CT should be performed as part of the initial staging to	**GRADE: ⊕⊕⊕⊖** **Quality objective:** Perform PET/CT as often as possible as part of staging

Quality indicator	Reference Recommendation	Evidence base/further information
All patients with a primary diagnosis of Hodgkin's lymphoma	determine the stage of the disease .	
Note The Numerator is currently not mapped to the updated standardised oncological basic data set (= BDS) (as of 12 February 2014).		
HL 4: Interim PET/CT in advanced Hodgkin's lymphoma (new in 2018)		
Numerator Number of patients with interim PET/CT **Denominator** All patients with Hodgkin's lymphoma stage III A or B or stage IV A or B undergoing BEA-COPP chemotherapy	**7** PET/CT during ongoing chemotherapy (interim PET/CT) ***is*** used to detect individual response to therapy at an early stage. Studies (GHSG HD18) have shown that FDG-PET/CT after 2 cycles of chemotherapy with BEACOPP allows for the selection of patients in whom a further reduction in chemotherapy is possible (see also 7.1.3).	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖ to LoE no data** **Quality target:** Interim PET/CT as often as possible in advanced Hodgkin's lymphoma and BEA-COPP chemotherapy
Note: The Numerator cannot currently be mapped to the updated standardised oncological basic data set (= BDS) (as of 12 February 2014).		
HL 5: BEACOPP scaled for advanced Hodgkin's lymphoma (since 2013)		
Numerator Number of patients with BEACOPPeskaliert **Denominator** All adult patients up to 60 years of age with a primary diagnosis of Hodgkin's lymphoma in stage III A or B or stage IV A or B.	**7** Adult patients up to 60 years of age with advanced HL should be treated with BEACOPPeskaliert. **7.3** The number of cycles depends on the result of interim staging using PET/CT* after 2 cycles . PET/CT-negative	**7.2: GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊖⊖ to LoE no data** **7.3: GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖ to LoE no data** **Quality objective**: Treatment with BEACOP-Peskaliert as often as possible for advanced Hodgkin lymphoma

Quality indicator	Reference Recommendation	Evidence base/further information
	patients ***should*** receive 2 further cycles of BEACOPPeskaliert, while PET/CT-positive patients ***should*** receive 4 further cycles as before.	
HL 6: PET/CT after chemotherapy for advanced Hodgkin lymphoma (new in 2018)		
Numerator Number of patients with PET/CT after BEACOPPeskaliert **Denominator** All patients with initial diagnosis of Hodgkin's lymphoma stage III A or B or stage IV A or B and BEACOPP escalated	**7.** PET/CT after therapy ***is*** used to assess the individual response to chemotherapy.	**GRADE: ⊕⊕⊕⊖** **Quality objective**: PET/CT after BEACOPP chemotherapy as often as possible in patients with advanced Hodgkin's lymphoma
Note The Numerator is currently not mapped to the updated standardised oncological basic data set (= BDS) (as of 12 February 2014).		
HL 7: Radiotherapy for advanced Hodgkin's lymphoma (since 2013)		
Numerator Number of patients with local radiotherapy (30 Gy) **Denominator** All patients with a primary diagnosis of Hodgkin's lymphoma in stage III A or B or stage IV A or B, scaled according to BEACOPP and with PET-positive residual tumour	**7** Patients who have responded to chemotherapy but show PET/CT-positive residual tissue ***should*** receive local radiotherapy. **7.** Patients in advanced stages who have received prior polychemotherapy and for whom there is an indication for additive radiotherapy ***should*** be irradiated with a dose of 30 Gy.	**7.8: GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊖⊖⊖ to LoE no data** **7.9: GRADE: ⊕⊕⊕⊖** **Quality objective**: Local radiotherapy (30 Gy) as often as possible in patients with advanced Hodgkin's lymphoma
Note:		

Quality indicator	Reference Recommendation	Evidence base/further information
Positive residual tumour = not "no change" in BDS		
HL 8: Confirmation of diagnosis in cases of recurrence of NLPHL (new in 2018)		
Numerator Number of patients with LK biopsy to confirm diagnosis **Denominator** All patients with recurrence of NLPHL	**8.1** Patients with NLPHL who are suspected of having a recurrence should undergo a new diagnostic confirmation by means of lymph node biopsy, as there is a risk of NLPHL transforming into aggressive non-Hodgkin lymphoma.	**Consensus-based recommendation** **, Strong** **Quality objective**: Lymph node biopsy should be performed as often as possible to confirm the diagnosis in patients with recurrent NLPHL
HL 9: Recurrence therapy for Hodgkin lymphoma (since 2013)		
Numerator Number of patients with autologous stem cell transplantation **Denominator** All patients up to 60 years of age with 1st recurrence or progression of Hodgkin's lymphoma	**9.** Patients up to 60 years of age without severe comorbidities ***should*** receive high-dose chemotherapy with autologous stem cell transplantation in the event of recurrence or progression of Hodgkin's lymphoma.	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖ to LoE no data** **Quality objective**: Autologous stem cell transplantation as often as possible in patients up to 60 years of age with 1st recurrence or progression of Hodgkin's lymphoma

15 Colorectal carcinoma

(Version 3.0, 26 September 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
CRC 1: Recording family history (since 2017)		
Numerator Number of patients with completed patient questionnaire **Denominator** All patients with a first diagnosis of CRC	**5** The personal and family medical history of oncological diseases should be recorded for every patient with colorectal cancer.	**Consensus-based recommendation** Rationale for this QI: Analysis of QIs already in use internationally (primarily ASCO) has shown that international QIs for recording family medical history. The guideline group considers this area to be relevant, so it has defined a QI in the guideline without accompanying strong
Note: Quality objective: Complete the patient questionnaire for recording family medical history as often as possible. **Reason for reporting:** Diagnosis report **Note:** Patient questionnaire: https://www.krebsgesellschaft.de/unsere-themen/zertifizierung/erhebungsboegen-und-dokumente?file=files/content/unsere-themen/zertifizierung/erhebungsboegen-und-dokumente/darmkrebszentren/aktuell/patient questionnaire_genetics_dz-b2_190322_fillable.pdf		
CRC 2: Complete findings reports after tumour resection in CRC (modified 2025)		
Numerator Pat. of the denominator with findings report specifying: o tumour type according to WHO classification	**8.2** The following information should be collected by the pathologist from the resected specimen:	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
o tumour invasion depth (pT classification) o Tumour size* o Localisation of the tumour o Status of regional lymph nodes (pN classification)* o Number of lymph nodes examined, including ratio of examined to affected lymph nodes* o Grading according to WHO classification* o Evidence of lymphatic or blood vessel invasion (L and V categories)* o Evidence of perineural sheath infiltration (Pn category)* o Distance from resection margins (also circumferential in rectal carcinoma)* o R classification*	Tumour type according to WHO classification Tumour invasion depth (pT classification) Tumour size Localisation of the tumour Status of regional lymph nodes (pN classification) Number of lymph nodes examined, including ratio of examined to affected lymph nodes Minimum number of lymph nodes to be examined: 12 Grading according to WHO classification Evidence of lymphatic or blood vessel invasion (L and V categories) Evidence of perineural sheath infiltration (Pn category) Distance from resection margins (also circumferential in rectal carcinoma) R classification Degree of regression (in rectal	

Quality indicator	Reference Recommendation	Evidence base/further information
o Degree of regression (only for rectal carcinoma after neoadjuvant therapy) * Not applicable in cases of complete remission after neoadjuvant therapy **Denominator** All patients with CRC e and surgical resection	carcinoma after neo- r adjuvant therapy) Microsatellite status (if not already determined during biopsy) Mutation status of relevant genes (RAS and BRAF status before initiation of systemic therapy, Her2/neu and NTRK if necessary) Budding status For pT1 carcinomas, specify a risk score for the presence of lymph node metastases (see recommendation in) Indication of the quality of the TME specimen Presence of perforation	
Note: Quality objective: Complete reports of findings after tumour resection in CRC as often as possible **Reason for reporting:** Pathology report		
CRC 3: Mutation determination in mCRC (modified 2025)		
Numerator Patients in the denominator with	**8.8** The determination of RAS and BRAF mutations should	**LoE 1** EG A,

Quality indicator	Reference Recommendation	Evidence base/further information
determination of RAS (= KRAS and NRAS mutations) , and BRAF mutation with specification of the exact mutation type in the findings before the start of systemic drug therapy **Denominator** All patients with metastatic colorectal carcinoma (mCRC) and first-line therapy	be carried out before initiation of systemic drug therapy in the metastatic situation. If a mutation is detected, the exact mutation type should be specified in the findings. *See Supplement v3.0_Evidence Report and Appendix, Evidence Table "AG 6 Recommendation 9.4"*	
Note: Quality objective: Where possible, specify the exact mutation type in the findings. Mutation determination prior to first-line therapy for mCRC. **Reason for reporting:** Therapy report		
CRC 4: Complete findings of the pre-therapeutic MRI (modified 2025)		
Numerator Patients in the denominator with MRI findings, specifying 1. Tumou	**7.6** The following characteristics should be included in the MRI findings:	**Consensus-based recommendation** .,

Quality indicator	Reference Recommendation	Evidence base/further information
r size/infiltration (cT category) 2. Local lymph nodes (cN category) 3. Involvement of the mesorectal fascia (MRF) 4. Abnormality in lateral pelvic lymph nodes 5. Infiltration of extramural vessels (EMVI) **Denominator** All patients with rectal carcinoma and pre-therapeutic MRI	Tumour size/infiltration (cT category) Local lymph nodes (cN category) Mesorectal fascia (MRF) involved? Lateral pelvic lymph nodes conspicuous? Infiltration of extramural vessels (EMVI)	
Note: Quality objective: Complete pre-treatment MRI report as often as possible **Reason for reporting:** Progress report		
CRC 5: Quality TME (since 2013)		
Numerator Patients in the denominator with good or moderate	**8.4** Since the quality of a surgical resection specimen, taking into account the	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
quality (grade 1: mesorectal fascia preserved or grade 2: intramesorectal tears) of the TME **Denominator** All patients with radically operated rectal cancer	above categories, allows conclusions to be drawn about the prognosis regarding the development of local recurrence, this should be described in the pathohistological report as follows: The quality of the specimen is assessed based on the integrity of the mesorectal fascia in the case of resection, using 3 categories: Grade 1 (good): Mesorectal fascia preserved Grade 2 (moderate): Intramesorectal tears Grade 3 (poor): Muscularis propria or tumour reached In the case of rectal extirpation, specimen tears and a tumour-positive circumferential safety margin are less common with complete resection of the levator muscles. The patho-histological report must therefore include a description of the	

Quality indicator	Reference Recommendation	Evidence base/further information
	radicality in the area of the levator muscles. The following categories should be used for this purpose: Grade 1 (good): Levator muscles resected ly, no opening of the intestine or tumour Grade 2 (moderate): Muscularis propria preserved, no opening of the intestine or tumour Grade 3 (poor): Parts of the muscularis propria are missing or opening of the intestine or tumour These assessments are to be made by the pathologist.	
Note: Quality objective: Good or moderate quality of TME in rectal carcinoma as often as possible **Reason for reporting:** Pathology report		
CRC 6: Presentation at tumour conference (since 2013)		
Numerator Patients in the denominator who were presented in an interdisciplina	**7** All patients with CRC should be presented at an interdisciplinary tumour conference.	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
ry tumour conference prior to treatment **Denominator** All patients with rectal carcinoma and all patients with stage IV colon carcinoma	In addition, patients in the following situations should be presented pre-therapy: All rectal carcinomas all stage IV colon carcinoma metachronous distant metastases Local recurrence before any metastasis-targeted therapy	
Note: Quality objective: Presentation of patients with rectal cancer and patients with stage IV colon cancer at the pre-therapy tumour conference as often as possible **Reason for reporting:** Therapy report		
CRC 7: Adjuvant chemotherapy (since 2013)		
Numerator Patients in the denominator who received adjuvant chemotherapy **Denominator** All patients with colon cancer in UICC stage III who underwent R0 resection of	**9.3** Adjuvant chemotherapy should be administered to patients with stage III colon cancer who have undergone R0 resection.	**LoE 1a** EG B, a

Quality indicator	Reference Recommendation	Evidence base/further information
the primary tumour		
Note The AG QI continues to consider QI 8 relevant, so that it remains in place despite the downgrading of the recommendation to "should". **Quality objective:** Adequate implementation of adjuvant chemotherapy after R0 resection of stage III colon cancer **Reason for reporting:** Therapy		
CRC 8: Anastomotic leakage rectal carcinoma (since 2013)		
Numerator Patients in the denominator with grade B anastomotic leakage (with antibiotics or interventional drainage or transanal lavage/drainage) or grade C ((re-)laparotomy) **Denominator** All patients with rectal carcinoma who underwent anastomosis during elective primary tumour resection.	None	No evidence base classified as strong, as this indicator was not derived from such a basis. **Reason for this QI:** The guideline commission has decided that not only structural quality targets but also outcome quality targets should be taken into account. This results in the inclusion of this indicator even without a strong consensus in the guideline.

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality target: As few grade B or C anastomotic leaks as possible after anastomosis in rectal cancer surgery. **Reason for reporting:** Progress report		
CRC 9: Anastomotic leakage colon carcinoma (since 2013)		
Numerator Patients in the denominator requiring re-intervention e anastomotic leaks. **Denominator** All patients with colon carcinoma who underwent anastomosis during elective tumour resection.	None	No evidence base classified as strong, as this indicator was not derived from such a basis. **Reason for this QI:** The Guideline Commission has decided that should take into account not only structural quality targets but also outcome quality targets. This has resulted in the inclusion of this indicator even without a strong consensus in the guideline.
Note: Quality target: Minimise the incidence of grade B or C anastomotic leaks requiring re-intervention after anastomosis in colon cancer surgery **Reason for reporting:** Progress report		
CRC 10: Marking of stoma position (since 2013)		
Numerator Patients in the denominator with preoperative	**7.2** The stoma position should be marked preoperatively, if possible, in a	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
marking of the stoma position **Denominator** All patients with rectal cancer who underwent surgery with stoma creation	sitting, standing and lying position. In the case of emergency surgery, the stoma should be marked preoperatively at least in a lying position and, if possible, in a sitting position.	
Note: Quality objective: Mark the stoma position preoperatively as often as possible **Reason for reporting:** Surgery notification		
CRC 11: Germ line diagnostics for Lynch syndrome (new in 2025)		
Numerator Patients in the denominator offered genetic germline testing for Lynch syndrome **Denominator** Patients with MSI/dMMR CRC without evidence of sporadic origin (in the case of MLH1 deficiency: no MLH1 promoter methylation and no BRAF	**5.4** All patients with MSI/dMMR CRC without evidence of sporadic tumour disease (in the case of MLH1 deficiency: no MLH1 promoter methylation, no BRAF mutation p.Val600Glu) should be offered genetic germline testing for Lynch syndrome.	**LoE 2b** EG A, b

Quality indicator	Reference Recommendation	Evidence base/further information
p.Val600Glu mutation)		
Note: Quality objective: Offer genetic germline testing for Lynch syndrome as frequently as possible. **Reason for reporting:** Therapy notification		
CRC 12: unoccupied		
Numerator **Denominator**	None	
CRC 13: Reconstruction with reservoir formation during deep anterior rectal resection (new 2025)		
Numerator Patients in the denominator with reconstruction with reservoir formation (colon J-pouch or side-to-end anastomosis) **Denominator** All patients with rectal cancer and deep anterior rectal resection with reconstruction	**7.14** In reconstruction after deep anterior resection, reservoir formation (colon J-pouch or side-to-end anastomosis) should be performed to achieve better functional results.	**LoE 1a** EG A, a

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Reconstruction with reservoir formation (colon J-pouch or side-to-end anastomosis) as often as possible after deep anterior resection **Reason for reporting:** Surgery report		
CRC 14: immunohistochemical MMR diagnostics (new in 2025)		
Numerator Patients in the denominator with determination of nutritional status according to Nutritional Risk Score and Body Mass Index at the time of diagnosis **Denominator** All patients with initial diagnosis of colorectal carcinoma	**8.** All CRC patients should be tested for the presence of mismatch repair deficiency (dMMR) or microsatellite instability (MSI) at the time of initial diagnosis. For this purpose, quality-assured immunohistochemistry should be performed to detect the mismatch repair gene products MLH1, MSH2, MSH6 and PMS2. In cases of unclear or implausible immunohistochemistry, a molecular MSI analysis should be performed to confirm the findings. In cases of metastatic disease, the determination can be made in a biopsy of both the	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
	primary tumour and the metastases.	
Note: Quality objective: Structured recording of nutritional status as frequently as possible for early identification of malnutrition at the time of diagnosis **Reason for reporting:** Diagnosis		
CRC 15: Nutritional status (new 2025)		
Numerator Patients in the denominator with nutritional status determined according to Nutritional Risk Score and Body Mass Index at the time of diagnosis **Denominator** All patients with a first diagnosis of colorectal cancer	**12.6** From the time of diagnosis of a tumour disease, regular recording of food intake, weight change and BMI should be carried out using established methods (e.g. NRS 2002, MUST). Guideline adaptation ESPEN practical guideline: Clinical Nutrition in cancer	EG A, **Note:** Guideline adaptation ESPEN practical guideline: Clinical Nutrition in cancer https://www.clinicalnutritionjournal.com/action/showPdf?pii=S0261-5614%2821%2900079-0
Note: Quality objective: Structured assessment of nutritional status as frequently as possible for early identification		

16 Laryngeal carcinoma

(Version 1.1, 19 December 2019)

Quality indicator	Reference Recommendation	Evidence base/further information
Larynx 1: Findings report following tumour resection and lymph node removal		
Numerator Numerator: Number of patients with diagnostic reports specifying: · tumour location (ICD-O-3 topography) and size (in mm), · Histological tumour type (WHO classification), · local tumour spread and infiltrated structures (cT/pT), · lymph node metastases (cN/pN) separated by level and side: · number of lymph nodes examined, · number of affected lymph nodes, · largest diameter of lymph node metastases · Capsule-transcending tumour growth · Lymphatic/venous invasion and perineural invasion (L, V, Pn), · presence of an in situ component (cTis/pTis, with mm size), · Differentiation of the tumour according to the established grading scheme (G1-4) · Distance to the lateral and basal resection margins for all relevant margins as well as for the invasive and in situ components (specification: yes/no) **Denominator** All patients with laryngeal carcinoma and in situ tumour	**4.4** The following parameters should be specified: Tumour location and size, histological tumour type according to the current WHO classification, local tumour spread, infiltrated structures, lymph node metastases separated by level and side: number of lymph nodes examined, number of affected lymph nodes, largest diameter of lymph node metastases, tumour growth beyond the capsule lymphatic vessel/venous invasion and perineural invasion, presence of an in situ component (with size), differentiation of the tumour according to the established grading scheme Distance to the lateral and basal resection margins for all relevant margins as well as for the invasive and in situ components.	**Consensus-based recommendation** Strong,

Quality indicator	Reference Recommendation	Evidence base/further information
resection and lymph node removal		
Note: Quality objective: Complete findings reports after tumour resection and lymph node removal as often as possible		
Larynx 2: Performance of panendoscopy		
Numerator Number of patients with panendoscopy **Denominator** All patients with initial diagnosis of laryngeal carcinoma	**6.7** Panendoscopy should be performed in patients with laryngeal carcinoma.	**Consensus-based recommendation** ,
Note: Quality objective: Perform panendoscopy as often as possible in cases of initial diagnosis of laryngeal carcinoma		
Larynx 3: Pre-therapeutic tumour conference		
Numerator Numerator: Number of patients discussed in the pre-therapeutic tumour conference **Denominator** All patients with laryngeal carcinoma	**7.** The treatment of laryngeal carcinoma should be carried out on an interdisciplinary basis after consultation of each individual case within tumour boards involving the specialist disciplines of ear, nose and throat medicine, radiotherapy, medical oncology, pathology and radiology.	**Consensus-based recommendation** Strong, quality objective: Patients should be presented at the pre-therapeutic tumour conference as often as possible.
Note: Quality objective: Presentation of patients at the pre-therapeutic tumour conference as often as possible		

Quality indicator	Reference Recommendation	Evidence base/further information
Larynx 4: Postoperative radiochemotherapy		
Numerator Number of patients with postoperative radiochemotherapy **Denominator** All patients with initial diagnosis of laryngeal carcinoma and resection with · resection margins <5 mm or · R1 or · extracapsular LK growth (pN3b)	**7.38** Postoperative chemoradiotherapy should be performed: in cases of R1 or resection margin <5 mm in the area of the mucosa in the tumour parts not surrounded by cartilage or in the case of extracapsular tumour growth at the lymph nodes .	**Consensus-based recommendation** EG A, b
Note: Quality objective: Postoperative radiochemotherapy as often as possible for resection margins <5 mm or R1 or pN3b		
Larynx 5: R0 resection		
Numerator Number of patients with final surgical outcome R0 **Denominator** All patients with initial diagnosis of laryngeal carcinoma and resection	**7.** The aim of the surgical procedure should be R0 resection. If R0 resection does not appear possible, primary surgical treatment should not be performed. In the case of R1, a subsequent resection should be attempted.	**Consensus-based recommendation** ,
Note: Quality objective: R0 as the final resection result after resection should be achieved as often as possible		

Quality indicator	Reference Recommendation	Evidence base/further information
Larynx 6: Consultation with speech therapist/linguist		
Numerator Number of patients with consultation by speech therapist/linguist **Denominator** All patients with initial diagnosis of laryngeal carcinoma and therapy	**7.6** e voice function should be considered even before the start of tumour therapy. Patients should be informed about the various rehabilitation options, with the involvement of speech therapists and patient care providers from self-help groups.	**Consensus-based recommendation** Strong, quality objective: Speech therapy consultation by speech therapists/speech scientists as often as possible before therapy
Note: Quality objective: Consultation with speech therapists/speech scientists before therapy as often as possible		

17 Lung carcinoma

(Version 4.0, 14 April 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Lung 1: Molecular pathological examination in patients with stage IV NSCLC (modified 2022)		
Numerator Patients in the denominator with examination of at least EGFR mutations in exons 18-21 and BRAF V600 mutations and ALK fusions and ROS1 fusions and RET fusions and NTRK1-3 fusions **Denominator** All patients with initial diagnosis of stage IV NSCLC	**6.61** Based on the available tumour tissue/tumour cells from all stage IV NSCLC, molecular pathological examinations should be performed with regard to all therapeutically relevant molecular changes (according to the current state of knowledge prior to first-line therapy, the minimum requirement is EGFR mutations in exons 18-21, BRAF V600 mutations, ALK fusions, ROS1 fusions, RET fusions, NTRK 1-3 fusions, KRAS mutations (especially KRAS G12C mutation), MET exon 14 skipping mutations, NRG1 fusions and HER2 (ERBB 2) mutations in exons 8, 18, 19, 20 and 21).	**Consensus-based recommendation** ,
Note: Quality objective: Testing for at least EGFR mutations in exons 18-21 and BRAF V600 mutations and ALK fusions and ROS1 fusions and RET fusions and NTRK1-3 fusions as often as possible in patients with newly diagnosed stage IV NSCLC		
Lung 2: First-line therapy for patients with stage IV NSCLC with activating EGFR mutation (modified 2022)		
Numerators Patients in the denominator who started first-line therapy with EGFR-TKI **Denominator** All patients with a primary	**8,112** In stage IV NSCLC with a typical activating EGFR mutation (del 19, L858R), patients with ECOG 0-2 should	**LoE 1a** EG A, **a**

Quality indicator	Reference Recommendation	Evidence base/further information
diagnosis of stage IV NSCLC, typical activating EGFR mutation (del 19, L858R) and ECOG 0-2	be offered EGFR-TKI in first-line therapy.	
Note: Quality objective: First-line therapy with EGFR TKI as often as possible in cases of activating EGFR mutation in stage IV NSCLC with ECOG 0-2.		
Lung 3: First-line therapy for patients with stage IV NSCLC, ALK positive (modified 2022)		
Numerator Patients in the denominator with initiation of CNS-effective ALK-specific TKI therapy **Denominator** All patients with initial diagnosis of stage IV NSCLC, ALK positive	**8,126** Patients with stage IV NSCLC with an ALK translocation should be offered therapy with an approved CNS-active ALK inhibitor in first-line therapy, preferably lorlatinib, taking into account the side effects, or alternatively alectinib or brigatinib.	**LoE 1b** EG A, b
Note: Quality objective: ALK-specific, CNS-active TKI therapy should be used as first-line therapy for ALK-positive stage IV NSCLC as often as possible.		
Lung 4: First-line therapy with ROS1-specific TKI therapy in patients with ROS1-positive stage IV NSCLC (deleted 2022)		
Numerator **Denominator**	None	Rationale for deletion: The small patient cohort (small denominator) does not allow for a valid evaluation.
Lung 5: Pre-therapeutic presentation at tumour conference (modified 2022)		
Numerator Patients in the denominator who were presented pre-therapeutically at the interdisciplinary tumour conference	**17** Every newly diagnosed patient with lung cancer should be presented to a thoracic oncology tumour board.	**Consensus-based recommendation** , Strong

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with a primary diagnosis of lung cancer		
Note: Quality objective: Pre-therapeutic presentation at the interdisciplinary tumour conference as often as possible. **Participants in the tumour conference:** oncology, pneumology, radiotherapy, thoracic surgery, radiology and nuclear medicine, and localisation-related specialist disciplines (e.g. neurosurgery, visceral surgery)		
Lung 6: Adjuvant cisplatin-based chemotherapy for stage II – IIIA1/A2 NSCLC (reviewed in 2022)		
Numerator Patients in the denominator receiving adjuvant chemotherapy with a cisplatin-based combination **Denominator** All patients with a primary diagnosis of stage II or IIIA1/A2 NSCLC, ECOG 0/1, R0 resection and lymph node dissection	**8.25** After R0 resection and systematic lymph node dissection, patients with stage II NSCLC in good general condition (ECOG 0/1) should be offered adjuvant chemotherapy if no neoadjuvant therapy has been performed. **8.27** In adjuvant chemotherapy, patients with stage II NSCLC in good general condition (ECOG 0/1) should receive a cisplatin-containing combination over 4 cycles. **8.47** In stage III NSCLC with incidental N2 status (IIIA1 or IIIA2), adjuvant combination chemotherapy should be administered after complete resection (R0) and systematic lymph node dissection, provided there are no contraindications . Chemotherapy should be	**8.25: LoE 1a** **8.27: LoE 1a** **8.47: LoE 1a** **8.48: LoE 1b** : EC A, a, Strong : EC A, a, Strong : EG A, LoE 1a, Strong consensus : EG A, LoE 1b, Strong consensus

Quality indicator	Reference Recommendation	Evidence base/further information
	administered within 60 days of resection, once wound healing is complete. **8.48** Adjuvant chemotherapy for stage IIIA1 and IIIA2 NSCLC should be administered as a cisplatin-containing combination over 4 cycles, provided there are no contraindications. Carboplatin should only be considered if there are contraindications to cisplatin.	
Note: Quality objective: Adjuvant cisplatin-based chemotherapy as often as possible for stage II or IIIA1/A2 NSCLC with ECOG 0/1		
Lung 7: Combined radiochemotherapy for stage IIIA4/IIIB/IIIC NSCLC (modified 2022)		
Numerator Patients in the denominator with radiochemotherapy **Denominator** All patients with initial diagnosis of stage IIIA4, IIIB or IIIC NSCLC and ECOG 0/1	**8.65** Patients with stage IIIA4 / IIIB and IIIC NSCLC should generally receive a combination of radiotherapy and chemotherapy, provided that their general condition and tumour extent allow this. Chemotherapy should be administered simultaneously with definitive radiochemotherapy and only sequentially if there are medical contraindications.	**Consensus-based recommendation** (,)
Note: Quality objective: Radiochemotherapy should be used as often as possible for NSCLC stage IIIA4, IIIB or IIIC and ECOG 0/1		

Quality indicator	Reference Recommendation	Evidence base/further information
Lung 8: Combined radiochemotherapy for SCLC in tumour stages T3-4 N0-1 and T1-4N2-3M0 (limited disease) (modified 2022)		
Numerator Patients in the denominator with simultaneous radiochemotherapy (cisplatin/etoposide) **Denominator** All patients with initial diagnosis of SCLC in tumour stages T3-4 N0-1 and T1-4N2-3M0 (limited disease)	**9.15** Radiotherapy for SCLC in tumour stages T3-4 N0-1 and T1-4N2-3M0 (limited disease) should be administered simultaneously with chemotherapy with cisplatin and etoposide.	**LoE 1b** EG A, b, Strong
Note: Quality objective: Simultaneous chemoradiotherapy should be used as often as possible in SCLC stage IIB-IIIC, ECOG 0/1.		
Lung 9: Whole-body FDG-PET/CT for staging in NSCLC stages IB-IIIB (new 2022)		
Numerator Patients in the denominator with whole-body FDG-PET/CT for staging **Denominator** All patients with NSCLC clinical stage IB–IIIB	**6.6** In cases of suspected or confirmed non-small cell lung cancer and existing treatment options in clinical stages IB–IIIB and oligometastatic stage IV, whole-body FDG-PET/CT should be performed for staging. If an FDG-PET examination cannot be performed for medical reasons (e.g. diabetic metabolism), an examination for extrathoracic metastases is indicated, either by means of whole-body MRI or bone scintigraphy plus abdominal CT or bone scintigraphy plus abdominal sonography.	**LoE 2a** EG A, a, Strong
Note: Quality objective:		

Quality indicator	Reference Recommendation	Evidence base/further information
Whole-body FDG-PET/CT for staging in stage IB-IIIB NSCLC as often as possible		
Lung 10: Molecular pathological examination in patients with stage IB-IIIA NSCLC and curative tumour resection (new 2022)		
Numerator Patients in the denominator tested for EGFR mutations in exons 19 and 21 **Denominator** All patients with initial diagnosis of NSCLC IB–IIIA and curative tumour resection (anatomical lung resection [OPS code 5-323 – 5-328] and R0 resection)	None	,
Note: Quality objective: Molecular pathological examination for EGFR mutations in NSCLC stage IB-IIIA and curative tumour resection as often as possible		
Lung 11: Stereotactic radiotherapy in generally or functionally inoperable patients with NSCLC I/IIA (new in 2022)		
Numerator Patients in the denominator with stereotactic radiotherapy **Denominator** All patients with initial diagnosis of stage I/IIA NSCLC with tumour conference recommendation against resection	**8.11** Stereotactic radiotherapy should be offered to patients with stage I and IIA NSCLC who are generally or functionally inoperable.	**LoE 1b** EG A, b, Strong
Note: Quality objective: Stereotactic radiotherapy should be used as often as possible in generally or functionally inoperable patients with stage I/IIA NSCLC.		

Quality indicator	Reference Recommendation	Evidence base/further information
Lung 12: Multimodal therapy for stage IIIA3 NSCLC (new 2022)		
Numerator Patients in the denominator receiving multimodal therapy (definitive chemoradiotherapy or neoadjuvant therapy + surgery) **Denominator** All patients with initial diagnosis of stage IIIA3 NSCLC ECOG 0-1	**8.5** Patients with stage IIIA3 NSCLC and technical and functional operability should receive multimodal treatment. Current multimodal options are definitive chemoradiotherapy +/- durvalumab and surgery after neoadjuvant therapy.	**LoE 1a** EG A, a,
Note: Quality objective: Multimodal therapy as often as possible for stage IIIA3 NSCLC, ECOG 0-1		
Lung 13: Maintenance therapy after definitive chemoradiotherapy (new 2022)		
Numerator Patients in the denominator who have started durvalumab therapy **Denominator** All patients after definitive chemoradiotherapy without progression and with PD-L1 expression of ≥ 1% on tumour cells	**8.71** Patients with stage III NSCLC after definitive chemoradiotherapy without progression who do not have a typical activating EGFR mutation (del 19, L858R) should be offered consolidation with the PD-L1 antibody durvalumab for 1 year if PD-L1 expression is ≥1% on tumour cells.	**LoE 1b** EG A, b,
Note: Quality objective: Maintenance therapy with the PD-L1 antibody durvalumab should be offered as often as possible after definitive chemoradiotherapy without progression and PD-L1 expression ≥1% on tumour cells.		
Lung 14: (Chemo)immunotherapy NSCLC stage IV (modified 2023)		
Numerator Patients in the denominator with (chemo)immunotherapy	**8.7** Patients with stage IV squamous cell carcinoma and PD-L1 expression < 50% who	**8.72: LoE 1b** **8.100: LoE 1** **8.99: LoE 1a**

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with initial diagnosis of stage IV NSCLC and ECOG 0-1	are in good general health (ECOG 0-1) should be offered chemo-immunotherapy, e.g. platinum-based combination chemotherapy with taxane combined with pembrolizumab or platinum-based chemotherapy with nivolumab/ipilimumab. **8.100** For NSCLC patients with stage IV non-squamous carcinoma who do not have treatable mutations (e.g. EGFR, EML4-ALK, ROS1) and who have PD-L1 expression of ≥ 50% of tumour cells or >10% on immune cells in tissue samples, monotherapy with atezolizumab (≥ 50% of tumour cells or 10% of tumour-infiltrating lymphocytes) or cemiplimab (≥ 50% of tumour cells) or pembrolizumab (≥ 50% of tumour cells) should be offered as first-line therapy, unless patient- or tumour-related reasons indicate combination therapy. **8.99** , regardless of PD-L1 status, should be offered as first-line treatment in the form of chemo-immunotherapy to NSCLC patients with non-squamous histology in UICC stage IV and ECOG 0-1 who have no treatable mutations and no contraindications to checkpoint inhibitors.	**8.84: LoE 1b** **8.83: LoE 1b** EG A, b, Strong

Quality indicator	Reference Recommendation	Evidence base/further information
	Cisplatin/carboplatin + pemetrexed + pembrolizumab, every 3 weeks for 4 cycles, followed by maintenance therapy with pemetrexed and pembrolizumab Carboplatin + paclitaxel + bevacizumab + atezolizumab, every 3 weeks for 4-6 cycles, followed by maintenance therapy with bevacizumab and atezolizumab Carboplatin + nab-paclitaxel + atezolizumab every 3 weeks for 4 cycles, followed by maintenance therapy with atezolizumab Platinum-based chemotherapy + nivolumab + ipilimumab over 2 cycles, followed by maintenance therapy with nivolumab + ipilimumab over 2 years Platinum-based chemotherapy + durvalumab + tremelimumab every 3 weeks for 4 cycles, followed by maintenance therapy with durvalumab every 4 weeks and a 5th dose of tremelimumab together with the 6th dose of durvalumab. (In the approval study, pemetrexed could also be continued every 4 weeks in maintenance therapy if it was used in combination with platinum in the first four cycles.) Platinum-based chemotherapy + cemiplimab (for PD-L1 status ≥1%), every 3 weeks for 4 cycles, followed by cemiplimab every 3 weeks for . (In the	

Quality indicator	Reference Recommendation	Evidence base/further information
	approval study, pemetrexed could also be continued every 3 weeks in maintenance therapy if it was used in combination with platinum in the first four cycles). **8.84** In stage IV NSCLC patients with squamous cell carcinoma who do not have treatable mutations (e.g. EGFR, EML4-ALK, ROS1) and who have PD-L1 expression of ≥ 50% of tumour cells or >10% on immune cells in tissue samples, monotherapy with atezolizumab (≥ 50% of tumour cells or 10% of tumour-infiltrating lymphocytes), cemiplimab (≥ 50% of tumour cells) or pembrolizumab (≥ 50% of tumour cells) should be offered as first-line therapy, unless patient- or tumour-related reasons indicate combination therapy. **8.83** For NSCLC patients with squamous cell carcinoma in UICC stage IV and ECOG 0-1 who have no treatable mutations and no contraindications to checkpoint inhibitors, chemo-immunotherapy should be offered as first-line therapy, regardless of PD-L1 status: Carboplatin + paclitaxel or nab-paclitaxel + pembrolizumab, every 3 weeks for 4 cycles, followed by	

Quality indicator	Reference Recommendation	Evidence base/further information
	maintenance therapy with pembrolizumab Platinum-based chemotherapy + nivolumab + ipilimumab over 2 cycles, followed by maintenance therapy with nivolumab + ipilimumab over 2 years. Platinum-based chemotherapy + durvalumab + tremelimumab every 3 weeks for 4 cycles, followed by maintenance therapy with durvalumab every 4 weeks and a 5th dose of tremelimumab; together with the 6th dose of durvalumab Platinum-based chemotherapy + cemiplimab (for PD-L1 status ≥1%), every 3 weeks for 4 cycles, followed by cemiplimab every 3 weeks	
Note: Quality objective: As often as possible (chemo) immunotherapy for stage IV NSCLC and ECOG 0-1		
Lung 15: Prophylactic cranial irradiation for SCLC T3-4 N0-1 M0 and T1-4 N2-3 M0 (new 2022)		
Numerator Patients in the denominator with prophylactic cranial irradiation after completion of chemoradiotherapy **Denominator** All patients with SCLC in tumour stages T3-4 N0-1 M0 and T1-4 N2-3 M0 (limited disease) and remission after chemoradiotherapy	**9.17** Prophylactic cranial irradiation should be offered to all patients with stage III SCLC who are in remission after completion of chemoradiotherapy. Preferably, GHD up to 25 Gy in single doses of 2.5 Gy or 30 Gy in single doses of 2 Gy daily should be used.	**LoE 1a** EG A, a,
Note: Quality objective:		

Quality indicator	Reference Recommendation	Evidence base/further information
Prophylactic cranial irradiation should be used as often as possible in SCLC T3-4 N0-1 M0 and T1-4 N2-3 M0 with remission after chemoradiotherapy.		
Lung 16: Chemotherapy and immunotherapy SCLC stage IV (new 2022)		
Numerator Patients in the denominator in combination with PD-L1 antibody therapy (atezolizumab or durvalumab) **Denominator** All patients with initial diagnosis of SCLC stage IV and chemotherapy (platinum/etoposide)	**9.1** Patients with distant metastatic small cell lung cancer should, unless contraindicated, be offered primary chemo-immunotherapy with platinum/etoposide and a PD-L1 antibody (atezolizumab or durvalumab).	**LoE 1b** EG A, b, Strong
Note: Quality objective: As often as possible, chemo-immunotherapy with platinum/etoposide and a PD-L1 antibody (atezolizumab or durvalumab) for stage IV SCLC		

18 Gastric carcinoma

(Version 3.1, 30 October 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Stomach 1: 1 – Complete pathology report (modified 2024)		
Numerator Pat. of the denominator with at least the following information in the pathohistological findings report: · Type of material removed, · Tumour location (macroscopic/microscopic), · Minimum distance between the tumour and/or tumour bed and the resection margins, · Tumour size*, · microscopic tumour type (according to current WHO classification)*, · Grading* (current WHO classification), · TNM classification (specifying the lymph nodes examined and affected), · R classification. * Not applicable in cases of complete remission after neoadjuvant therapy **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) and surgical resection [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the	**8.2** The pathological-anatomical assessment should be carried out completely and in a standardised form (see information in the background text).	**Consensus-based recommendation** (,) **Quality objective:** Complete pathohistological reports should be provided as often as possible after surgical resection of a carcinoma of the stomach or gastroesophageal junction.

Quality indicator	Reference Recommendation	Evidence base/further information
gastroesophageal junction is involved.		
Stomach 2: 2 - Endoscopic en bloc resections		
Numerator Pat. of the denominator with en bloc resection **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) and endoscopic resection [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	**9.1** Intraepithelial neoplasia (known as dysplasia) of any size and early gastric carcinomas that meet all four of the following criteria should be resected en bloc endoscopically: a) 2 cm in diameter b) Not ulcerated c) Mucosal carcinoma d) intestinal type or good or moderate histological differentiation (G1/G2) **9.3** Endoscopic resection (ER) of early gastric carcinomas should be performed as a complete en bloc resection, allowing for a complete histological assessment of the lateral and basal margins.	**9.1: LoE 3b** **9.3: Consensus-based recommendation** Evidence-based (EG A, b) (,) **Quality objective:** En bloc resections as often as possible during endoscopic resection of carcinomas of the stomach or gastroesophageal junction.
Stomach 3: 3 - R0 resections (endoscopy)		
Numerator Patients in the denominator with R0 resection after completed endoscopic therapy **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) and endoscopic resection	**9.1** Intraepithelial neoplasia (known as dysplasia) of any size and early gastric carcinomas that meet all four of the following criteria should be resected en bloc endoscopically: a) 2 cm in diameter b) Not ulcerated	**9.1: LoE 3b** **9.3: Consensus-based recommendation** Evidence-based (EG A, b) (,) **Quality objective:** En bloc resection as often as possible during endoscopic resection of carcinomas of the

Quality indicator	Reference Recommendation	Evidence base/further information
¹Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	c) Mucosal carcinoma d) intestinal type or histological differentiation grade good or moderate (G1/G2) **9.3** Endoscopic resection (ER) of early gastric carcinomas should be performed as a complete en bloc resection, allowing for a complete histological assessment of the lateral and basal margins.	stomach or gastroesophageal junction.
Stomach 4: 4 - Nutritional status (modified 2024)		
Numerator Patients in the denominator with nutritional status determined according to Nutritional Risk Score and Body Mass Index at the time of diagnosis **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0¹, C16.1-16.9) ¹Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved .	**14.1** The nutritional status of all tumour patients should be assessed by means of screening at the time of diagnosis, at each inpatient admission and at each outpatient contact. In the event of an abnormal result, the nutritional status should be recorded in more detail (assessment) so that interventions can be initiated at an early stage.	**Consensus-based recommendation** (,) **Quality objective:** Assess the nutritional status of patients with carcinoma of the stomach or gastroesophageal junction as frequently as possible.
Stomach 5: 5 - Anastomotic leakage grade II/III (modified 2024)		
Numerator Pat. of the denominator with grade II/III anastomotic leakage	None	**Quality objective:** Minimise grade II/III anastomotic leaks after resection with reconstruction by anastomosis in patients

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) and resection with reconstruction by means of anastomosis [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.		with carcinoma of the stomach or gastroesophageal junction
Note: Classification of anastomotic leakage: I = locally defective, no change in therapy, only medication or diet modification II= localised defect requiring intervention, but no surgery, e.g., IR drain, stent, or bedside opening III= localised defect requiring surgical therapy (according to: Low, D.E., et al., International Consensus on Standardisation of Data Collection for Complications Associated with Esophagectomy: Esophagectomy Complications Consensus Group (ECCG). Ann Surg, 2015 Aug;262(2):286-94)		
Stomach 6: 6 - Vitamin B12 substitution after gastrectomy		
Numerator Numerator Patients with documented recommendation for vitamin B12 replacement (e.g. 1000 µg every 3 months) in the doctor's letter **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) after gastrectomy [1]Tumours whose centre is > 2 cm from the gastroesophageal	**15.4** After gastrectomy, regular vitamin B12 supplementation should be administered for life . This can be done parenterally or orally.	**Consensus-based recommendation** (,) **Quality objective:** As often as possible and administration of vitamin B12 supplementation after gastrectomy in patients with carcinoma of the stomach or gastroesophageal junction

Quality indicator	Reference Recommendation	Evidence base/further information
junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.		
Stomach 7: 7 - Preoperative chemotherapy for gastric carcinomas ≥cT3 and/or ≥N1, M0 (modified 2024)		
Numerator Patients in the denominator with preoperative chemotherapy **Denominator** All patients with initial diagnosis of gastric carcinoma (ICD-10 16.1-16.9) ≥cT3 and/or ≥N1 and M0 and resection	**11.2** In cases of localised gastric carcinoma in categories ≥ cT3 tumours and/or N+, perioperative chemotherapy should be administered, i.e. started preoperatively and continued postoperatively.	**LoE 1a** Evidence-based (EG A, a) **Quality objective:** Preoperative chemotherapy should be performed as often as possible in cases of localised gastric carcinoma ≥cT3 and/or ≥N1, M0 with resection.
Stomach 8: 8 - Preoperative chemotherapy or chemoradiotherapy for adenocarcinomas of the gastroesophageal junction with cT3 or cT4 and/or N+, M0 (modified 2024)		
Numerator Patients in the denominator with preoperative chemotherapy or chemoradiotherapy **Denominator** All patients with adenocarcinoma of the gastroesophageal junction gastroesophageal junction (ICD-10 16.0[1]) cT3 or cT4, M0 and resection [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	**11.3** In cases of non-distant metastatic adenocarcinoma of the gastroesophageal junction in categories cT3 and resectable cT4 and/or N+ tumours, e neoadjuvant radiochemotherapy followed by adjuvant immunotherapy should be performed if vital tumour cells are detected in the resected specimen, or perioperative chemotherapy should be performed. **See supplement, evidence report AG 4_Neoadjuvant radio- and perioperative chemotherapy in GEJ patients, Table 5**	**LoE 2** Evidence-based (EG A,) **Quality objective:** Preoperative chemotherapy or chemoradiotherapy as often as possible for cT3 or cT4, M0 a ic adenocarcinomas of the gastroesophageal junction and resection.

Quality indicator	Reference Recommendation	Evidence base/further information
Stomach 9: 9 - Preoperative presentation at interdisciplinary tumour conference (modified 2024)		
Numerator Patients in the denominator with preoperative presentation at the tumour conference **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) with neoadjuvant and surgical therapy (surgical resection) [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	**11.7** In the event of local tumour progression under neoadjuvant therapy, the decision on further therapy – in particular early surgery – should be made on an interdisciplinary basis.	**Consensus-based recommendation** Evidence-based (,) **Quality objective:** Preoperative presentation of patients with carcinoma of the stomach or gastroesophageal junction at interdisciplinary tumour conferences as often as possible
Stomach 10: 10 – Determination of HER-2, PD-L1 and MSI status prior to palliative tumour therapy (modified 2024)		
Numerator Patients in the denominator with determination of HER-2 status, PD-L1 status and MSI-status **Denominator** All patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0[1], C16.1-16.9) undergoing palliative drug therapy for tumours [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the	**12.7** Before using palliative drug-based tumour therapy, the HER-2 status, PD-L1 status (CPS) and MSI status should be determined as positive predictive factors for therapy with trastuzumab or PD-1 inhibitors.	**Consensus-based recommendation** (,) **Quality objective:** Determine HER-2 and PD-L1 status (CPS) and MSI status as often as possible before palliative drug therapy in patients with carcinoma of the stomach or gastroesophageal junction.

Quality indicator	Reference Recommendation	Evidence base/further information
gastroesophageal junction is involved.		
Stomach 11: 11 - H. pylori testing in early gastric carcinomas (new 2024)		
Numerator Numerator of the denominator with H. pylori testing **Denominator** Patients with endoscopic resection of early gastric cancer or surgical partial gastrectomy	**4.16** Before or after endoscopic resection of early gastric carcinomas and adenomas or surgical partial gastrectomy, testing for *Helicobacter* pylori infection should be performed. If the test result is positive, eradication therapy should be carried out, followed by a check to ensure that it has been successful.	**Consensus-based recommendation** (,) **Quality objective:** Highest possible proportion of patients tested for Helicobacter pylori before or after endoscopic resection of early gastric carcinomas or surgical partial gastrectomy.
Stomach 12: 12 – Clinical staging according to TNM classification (new 2024)		
Numerator Patients in the denominator with clinical staging according to the current TNM classification (cTNM) **Denominator** Patients with carcinoma of the oesophagogastric junction or stomach (ICD-10 C16.0[1], C16.1-16.9) [1]Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	**7.1** The clinical staging of carcinomas of the gastroesophageal junction and stomach should be based on endoscopic and imaging diagnostics in accordance with the current clinical TNM classification of the UICC.	**Consensus-based recommendation** (,) **Quality objective:** The highest possible proportion of patients with carcinoma of the gastroesophageal junction or stomach should undergo e clinical staging according to the current clinical TNM classification.
Stomach 13: 13 - Postoperative presentation at interdisciplinary tumour conference (new 2024)		
Numerator Patients in the denominator	**10.13**	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
with postoperative presentation at the tumour conference **Denominator** Patients with adenocarcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0¹, C16.1-16.9) and surgical treatment ¹Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	After R1 resection for adenocarcinoma of the stomach and gastroesophageal junction, the indication for curative re-resection should be reviewed. If this is not possible, postoperative radiochemotherapy may be performed according to the consensus reached in the interdisciplinary tumour conference.	(,) **Quality objective:** Highest possible proportion of patients with adenocarcinoma of the stomach or gastroesophageal junction with postoperative presentation at the tumour conference
Stomach 14: 14 - Histological determination of the degree of tumour regression (new 2024)		
Numerator Patients in the denominator with histological determination of the degree of tumour regression according to Becker or Mandard **Denominator** Patients with carcinoma of the stomach or gastroesophageal junction (ICD-10 C16.0¹, C16.1-16.9) and preoperative therapy ¹Tumours whose centre is > 2 cm from the gastroesophageal junction are classified as gastric carcinomas, even if the gastroesophageal junction is involved.	**11.8** Following preoperative therapy, a histological determination of the degree of tumour regression should be performed.	**LoE 1b** Evidence-based (EG A, b) **Quality objective:** histological determination of the degree of tumour regression as frequently as possible in patients with carcinoma of the stomach or gastroesophageal junction and preoperative therapy.

19 Malignant ovarian tumours

(Version 6.0, 23 October 2024)

Quality indicator	Reference Recommendation	Evidence base/further information
OvCa 1: Surgical staging of early ovarian cancer (since 2013)		
Numerator Patients in the denominator undergoing surgical staging with: · laparotomy · Peritoneal cytology · Peritoneal biopsies · Bilateral adnexal extirpation · Hysterectomy, extraperitoneal procedure if necessary · Omentectomy, at least infracolic · Bilateral pelvic and para-aortic lymph node dissection **Nenner** All patients with initial diagnosis of ovarian carcinoma FIGO I–IIIA	**7.4** Optimal staging should include the following surgical steps: Longitudinal laparotomy, inspection and palpation of the entire abdominal cavity, Peritoneal cytology, Biopsies from all conspicuous areas, Peritoneal biopsies from normal regions, Adnexal extirpation on both sides, hysterectomy, extraperitoneal procedure if necessary, Omentectomy at least infracolic, appendectomy (in cases of mucinous/unclear tumour type), bilateral pelvic and para-aortic lymph node dissection.	**Consensus-based recommendation** **Quality objective:** As complete surgical staging as possible for early ovarian cancer
OvCa 2: Offer of genetic testing (since 2019)		
Numerator Patent women in the denominator with offer of genetic testing **Denominator**	**5.1** Patients diagnosed with ovarian cancer should be informed about the risk of hereditary disease and offered genetic testing.	**LoE 2** **EG A,** **Quality objective:** Offer genetic testing as often as possible

Quality indicator	Reference Recommendation	Evidence base/further information
All patients with a primary diagnosis of ovarian cancer		
OvCa 3: Macroscopically complete resection of advanced ovarian cancer (since 2013)		
Numerator Patients in the denominator with macroscopically complete resection **Denominator** All patients with initial diagnosis of ovarian cancer ≥ FIGO IIB and surgical tumour removal without prior chemotherapy	**7.9** The goal of primary surgery for advanced ovarian cancer should be macroscopically complete resection.	**Consensus-based recommendation** **Quality objective:** Macroscopically complete resection as often as possible
OvCa 4: Surgery for advanced ovarian cancer by gynaecological oncologists (since 2013)		
Numerator Patients in the denominator whose definitive surgical treatment was performed by a gynaecological oncologist **Denominator** All patients with a primary diagnosis of ovarian cancer FIGO ≥IIB after completion of surgical treatment	**7.12** In the event of an unexpected diagnosis of advanced ovarian cancer, histological confirmation and description of the spread should be performed. Definitive treatment should then be carried out by a gynaecological oncologist in a suitable facility.	**LoE 4** **EG A,** **Quality objective:** Surgical treatment by gynaecological oncologists as often as possible
OvCa 5: Postoperative chemotherapy for advanced ovarian cancer (modified 2021)		
Numerator Patients in the denominator with postoperative chemotherapy **Denominator** All patients with initial diagnosis of ovarian cancer ≥ FIGO II and chemotherapy	**7.1** The primary surgery should be followed by chemotherapy as a course of treatment.	**LoE 1** **EG A,** **Quality objective:** Postoperative chemotherapy as often as possible for advanced ovarian cancer and chemotherapy

Quality indicator	Reference Recommendation	Evidence base/further information
OvCa 6: Deleted due to sufficient implementation in 2021: No adjuvant chemotherapy for early ovarian cancer		
Numerator Number of patients with adjuvant chemotherapy **Denominator** All patients with initial diagnosis of ovarian cancer FIGO IA, G 1 and complete surgical staging	**8.** No adjuvant chemotherapy should be administered to patients with stage IA grade 1 ovarian cancer after complete surgical staging.	**LoE 1+** **EG A,** **Quality objective:** No adjuvant chemotherapy in FIGO IA, G1 and complete surgical staging whenever possible
OvCa 7: Platinum-based chemotherapy for early ovarian cancer (since 2013)		
Numerator Patients in the denominator receiving platinum-based chemotherapy **Denominator** All patients with initial diagnosis of OC FIGO IC or IA/B with grade 3	**8.** Patients with stage IC or IA/B ovarian cancer and grade 3 should receive platinum-based chemotherapy over 6 cycles.	**LoE 1+** **EG A,** **Quality objective:** Platinum-based chemotherapy should be used as often as possible in patients with a primary diagnosis of FIGO IC or IA/B ovarian cancer with grade 3.
OvCa 8: First-line chemotherapy for advanced ovarian cancer (modified 2021)		
Numerator Patients in the denominator receiving first-line chemotherapy with carboplatin and paclitaxel **Denominator** All patients with a primary diagnosis of ovarian cancer ≥ FIGO II	**8.5** First-line chemotherapy for patients with advanced ovarian cancer (II–IV) should consist of carboplatin AUC 5 and paclitaxel 175 mg/m² administered intravenously over 3 hours for a total of 6 cycles every 3 weeks.	**LoE 1** **EG A,** **Quality objective:** First-line chemotherapy with carboplatin and paclitaxel should be used as often as possible in cases of initial diagnosis of ovarian cancer ≥ FIGO II.
Note Patients who are also administered additional substances (e.g. as part of studies) can be counted for the Numerator.		

Quality indicator	Reference Recommendation	Evidence base/further information
OvCa 9: Combination therapy for platinum-sensitive recurrence (suspended in 2021)		
Numerator Patients in the denominator receiving platinum-based combination therapy **Denominator** All patients with platinum-sensitive recurrence of ovarian cancer and recurrence chemotherapy, outside of clinical trials	**9.6** Before initiating systemic therapy in the first recurrence, the possibility of complete surgical resection of the recurrence in a gynaecological oncology centre should be considered.	**Consensus-based recommendation** **Quality objective:** Platinum-based chemotherapy should be used as often as possible in patients with platinum-sensitive recurrence of ovarian cancer and recurrence chemotherapy outside of clinical trials.
Note Suspended until the guideline recommendation is updated and the criteria for platinum-eligible and non-platinum-eligible recurrence are implemented.		
OvCa 10: Deleted due to sufficient implementation in 2021: No adjuvant therapy BOT (since 2013)		
Numerator Number of patients with adjuvant therapy **Denominator** All patients with initial diagnosis of borderline tumour	**12** Patients with borderline tumours should not receive adjuvant therapy.	**LoE 1+** **EG A,** **Quality objective:** No adjuvant therapy for borderline tumours

20 Malignant melanoma

(Version 3.3, 14 November 2019)

Quality indicator	Reference Recommendation	Evidence base/further information
MEL 1: Safety margin (1 cm) for radical excision (since 2013)		
Numerator Patients with radical excision with a safety margin of 1 cm **Denominator** Patients with primary cutaneous melanoma and curative radical excision with a tumour thickness ≤ 2 mm	**4.8** For malignant melanoma, radical excision with safety margins to the tumour edge (see table in background text) should be performed with curative intent in order to prevent local recurrence of the tumour.	**LoE 1a**
Note **Quality objective:** Where possible, a safety margin of 1 cm should be used for curative radical excision of a melanoma with a tumour thickness ≤ **2 mm.**		
MEL 2: Safety margin (2 cm) for radical excision (since 2013)		
Numerator Patients with radical excision with a safety margin of 2 cm **Denominator** Patients with primary cutaneous melanoma and curative radical excision with a tumour thickness > 2 mm	**4.8** For malignant melanoma, radical excision with safety margins to the tumour edge (see table in background text) should be performed with curative intent in order to prevent local recurrence of the tumour.	**LoE 1a**
Note: Quality objective: Where possible, a safety margin of 2 cm should be used for curative radical excision of melanoma with a tumour thickness > 2 mm.		

Quality indicator	Reference Recommendation	Evidence base/further information
MEL 3: Presentation to the skin tumour board (since 2013, formerly , modified in 2018)		
Numerator Patients presented to the interdisciplinary skin tumour board **Denominator** Patients with mucosal melanoma or stage IV cutaneous melanoma	**1** Patients with metastatic melanoma (stage III or higher) should be presented to an interdisciplinary skin tumour board to coordinate further diagnosis and treatment. The possibility of inclusion in clinical trials should be considered in all cases.	**Consensus-based recommendation**
Quality objective: Refer patients with mucosal melanoma or stage IV cutaneous melanoma to		
MEL 4: sentinel lymph node biopsy (since 2013)		
Numerator Patients undergoing SLNB **Denominator** Patients with primary cutaneous melanoma ≥ pT2a and no evidence of locoregional or distant metastasis	**4.36** For staging purposes, sentinel lymph node biopsy should be performed for tumours with a thickness of 1.0 mm or greater and without evidence of locoregional or distant metastasis.	**LoE 1a**
Note: Quality objective: Sentinel lymph node biopsy should be performed as often as possible in cases of primary cutaneous melanoma ≥ pT2a and without evidence of locoregional or distant metastasis.		
MEL 5: Therapeutic lymphadenectomy (suspended since 2016, modified in 2018)		
Numerator Patients with therapeutic LAD at any pT and c/pN1b , or c/pN2b, or c/pN3b and M0 **Denominator** Patients with malignant	**6.19** Therapeutic LAD should be performed when lymphogenous metastasis is detected (cytological or histological confirmation,	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
melanoma with any pT and c/pN1b or c/pN2b or c/pN3b and M0	lymph node sonography, CT, PET/CT) without evidence of distant metastases.	
Note: Quality objective: Therapeutic LAD should be performed as often as possible in cases of clinically confirmed lymphogenous metastasis and no evidence of distant metastases.		
MEL 6: Social services consultation (new in 2018)		
Numerator Number of patients who received social work counselling **Denominator** All patients with cutaneous melanoma	**9.1** Patients with malignant melanoma should be informed of their legal right to rehabilitation measures. The application process should be initiated during primary care for patients with impaired coping (also applies to in situ melanomas), functional impairments or participation restrictions. Further requirements are the presence of rehabilitation capacity and a positive rehabilitation prognosis.	**Consensus-based recommendation**
Note: Quality objective: Social services should provide counselling to patients with malignant melanoma as often as possible.		
MEL 7: First-line therapy for stage IV cutaneous melanoma (new in 2018)		
Numerator Number of patients receiving BRAF inhibitor + MEK inhibitor therapy or anti-PD-1-based first-line therapy **Denominator** All patients with stage IV cutaneous melanoma who	**7** In the case of BRAF V600 mutation, therapy with a BRAF inhibitor in combination with a MEK inhibitor or checkpoint inhibitor therapy (PD-1 monotherapy or PD-1+CTLA-4	**LoE 1b**

Quality indicator	Reference Recommendation	Evidence base/further information
have started systemic first-line therapy.	antibody therapy) should be administered. There are currently no data available on the best sequential therapy of BRAF/MEK inhibitors and checkpoint inhibitors.	
Note: Quality objective: BRAF inhibitor + MEK inhibitor therapy or anti-PD-1-based first-line therapy for stage IV cutaneous melanoma as often as possible		
MEL 8: Determination of mutation status (KIT, BRAF and NRAS) in mucosal melanoma (new in 2018)		
Numerator Number of patients with mutation status assessment for KIT, BRAF and NRAS **Denominator** All patients with mucosal melanoma cT4 and/or N+	**6.33** Adjuvant extremity perfusion with melphalan should not be administered in the adjuvant therapy of melanoma. **10.4** In cases of local inoperability or from the stage of lymph node metastasis onwards, the mutation status of mucosal melanomas should be determined for KIT, BRAF and NRAS.	**6.33: LoE 1b** **10.4: Consensus-based recommendation**
Note: Quality objective: Determine the mutation status for KIT, BRAF and NRAS as often as possible in cases of mucosal melanoma cT4 and/or N+.		
MEL 9: LDH determination (since 2013)		
Numerator Patients with LDH determination **Denominator** Patients with malignant	**7.1** LDH should be determined as part of the current AJCC classification in patients with	**LoE 1b**

Quality indicator	Reference Recommendation	Evidence base/further information
melanoma at admission Stage IV	suspected or confirmed distant metastases.	
Note: Quality objective: LDH should be determined as often as possible in patients with malignant melanoma at stage IV on admission.		

21 Breast cancer

(Version 5.2, 12 May 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
MamCa 1: Further treatment of breast cancers detected in screening at certified breast cancer centres		
Numerator Number of patients receiving treatment in a certified breast cancer centre (DKG/DGS, North Rhine-Westphalia) **Denominator** All patients detected in screening with histologically confirmed invasive breast cancer and/or DCIS	**3.10** To ensure the best possible treatment, further therapy for breast cancer should be carried out in certified breast cancer centres. Continuous quality assurance should be ensured through communication and data collection between the screening centre and the certified breast cancer centre.	**Consensus-based recommendation** **Quality objective:** Wherever possible, further treatment of breast cancer and/or DCIS detected in screening should be carried out in a certified breast cancer centre.
Note The QI can be evaluated using data from the Mammography Cooperation Group.		
MamCa 2: Pre-therapeutic histological confirmation (since 2012, formerly: MamCa 1)		
Numerator Patients with pre-therapeutic histological diagnosis confirmation by punch or vacuum biopsy **Denominator** Patients with initial surgery and histology "invasive breast cancer or DCIS " as primary disease	**4.15** Histological clarification of findings should be performed by punch biopsy, vacuum biopsy and, in justified exceptional cases, by open excisional biopsy.	**LoE 2** LOE 3a, **Quality objective**: As many patients as possible with pre-therapeutic histological confirmation by punch or vacuum biopsy during initial surgery and primary disease invasive breast cancer and/or DCIS

Quality indicator	Reference Recommendation	Evidence base/further information
MamCa 3: Intraoperative specimen radio/sonography (since 2012, formerly: MamCa 2)		
Numerator Operations with intraoperative X-ray or intraoperative ultrasound **Denominator** Operations with preoperative wire marking guided by mammography or sonography	**4.25** Pre- or intraoperative marking should be performed using a method that clearly displays the findings, particularly in the case of non-palpable changes. Proof of adequate resection should be provided intraoperatively by radiography or sonography of the specimen. If MR-guided marking has been performed, an MR check should be carried out within 6 months in the case of a histologically non-specific benign finding.	**Consensus-based recommendation** Quality objective: Intraoperative specimen sonography or radiography after preoperative marking as often as possible
MamCa 4: Axillary lymph node removal for DCIS (since 2012, formerly: MamCa 3)		
Numerator Patients with axillary lymph node removal (primary axillary dissection or SNB) **Denominator** Patients with histology "DCIS" and completed surgical treatment for primary disease and breast-conserving therapy	**4.31** Axillary dissection should not be performed in DCIS. A sentinel node biopsy should only be performed if a secondary sentinel node biopsy is not possible for technical reasons, e.g. in the case of mastectomy.	**LoE 2** LOE 1b, **Quality objective:** As few patients as possible undergoing primary axillary dissection or sentinel node biopsy (SNB) for DCIS with breast-conserving therapy
Note: Quality target <5%		

Quality indicator	Reference Recommendation	Evidence base/further information
MamCa 5: Endocrine therapy as the first treatment option for steroid receptor-positive metastatic breast cancer (since 2012, formerly: MamCa 11)		
Numerator Patients who received endocrine-based therapy as first-line therapy in the metastatic stage **Denominator** All patients with steroid receptor-positive and HER2-negative breast cancer and initial diagnosis of metastasis	None	LOE 1b, **Quality objective:** Endocrine-based therapy should be used as first-line therapy as often as possible in patients with breast cancer, positive hormone receptor status, negative HER2 status and initial diagnosis of metastasis.
MamCa 6: Indication for sentinel lymph node biopsy (since 2012, formerly: MamCa 4)		
Numerator Patients with sentinel node biopsy alone **Denominator** Patients with primary invasive breast cancer and negative pN staging and without preoperative tumour-specific therapy	None	Quality objective: As many patients as possible with sentinel node biopsy for lymph node-negative (pN0) invasive breast cancer without preoperative tumour-specific therapy
Note: *The quality indicator should be calculated separately for female and male patients* (see introduction)		
MamCa 7: Treatment of axillary lymph drainage areas in pN1mi (unoccupied 2025, formerly MamCa 5)		
Numerator **Denominator**	None	

Quality indicator	Reference Recommendation	Evidence base/further information
MamCa 8: Radiotherapy performed according to BET (since 2012, formerly: MamCa 6)		
Patients Patients with invasive carcinoma and BET who received radiotherapy to the breast **Denominator** Patients with primary invasive breast cancer and BET	None	LOE 1a, **Quality objective:** Adequate rate of radiotherapy after BET in patients with primary invasive breast cancer.
MamCa 9: Endocrine therapy for receptor-positive findings (since 2012, formerly: MamCa 7)		
Numerator Patients who have received adjuvant endocrine therapy. **Denominator** Steroid receptor-positive patients with primary invasive breast cancer.	**4,140** Patients with hormone receptor-positive invasive tumours should receive endocrine therapy.	**LoE 1** LOE 1a, **Quality objective:** Endocrine therapy should be administered as often as possible in receptor-positive patients with primary invasive breast cancer.
MamCa 10: Trastuzumab-based therapy for one year in HER2-positive cases (modified 2025, formerly: MamCa 8)		
Numerator Patients in the denominator who received (neo-)adjuvant trastuzumab-based therapy for 1 year **Denominator** All patients with primary invasive HER2-positive breast cancer (immunohistochemical score 3+ or 2+ and ISH positive), ≥ pT1c	**4,157** Patients with HER2-positive breast cancer (, immunohistochemical score 3+ or score 2+ and ISH positive) with a diameter >1 cm should receive chemotherapy with anti-HER2-targeted therapy. **4.162** Patients with HER2-positive breast cancer (immunohistochemical score 3+ or 2+ and ISH-	**4.157: LoE 2** **4.162: Consensus-based recommendation** : EG A, : , **Quality objective:** Trastuzumab-based therapy for 1 year as often as possible in HER2-positive patients with primary invasive breast cancer ≥ pT1c

Quality indicator	Reference Recommendation	Evidence base/further information
	positive) and histopathological complete remission should continue to receive trastuzumab until a total duration of one year is reached. In cases of initial clinically or pathohistologically proven ipsilateral axillary lymph node involvement, this therapy can be combined with pertuzumab for a total duration of one year.	
MamCa 11: R0 resection for invasive breast cancer (new 2025)		
Numerator Patients in the denominator with R0 resection as the final outcome **Denominator** All patients with invasive breast cancer and tumour resection	**4.4** The aim of surgical treatment is to remove the tumour completely. Survival rates after breast-conserving therapy (BCT) followed by radiotherapy of the entire breast are at least equivalent to those after mastectomy .	**LoE 1** EG A, **Quality objective:** Resection should be performed in healthy tissue as often as possible.
MamCa 12: Immunohistochemical findings of oestrogen and progesterone receptor status (new 2025)		
Denominator Pat. of the denominator with immunohistochemically determined findings of oestrogen and progesterone receptor status, stating the percentage of positive tumour cell nuclei and the average colour intensity	**4.72** The oestrogen and progesterone receptor status (ER/PR) should be determined immunohistochemically. The percentage of positive tumour cell nuclei and the average colour intensity should be specified in each case.	**Consensus-based recommendation** , **Quality objective:** Where possible, the percentage of positive tumour cell nuclei and the average staining intensity should be specified for all determinations of oestrogen and progesterone receptor status (ER/PR).

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with DCIS and/or invasive breast cancer, with biopsy and/or tumour resection and determination of oestrogen and progesterone receptor status (ER/PR)	A rating of ER- or PR-positive requires at least 1% positive tumour cell nuclei. Tumours with 1 to 10% positive tumour cell nuclei are classified as weakly positive.	
MamCa 13: Immunohistochemical score of HER2 status (new 2025)		
Numerator Numerator of the denominator with indication of the immunohistochemical score and the score-defining percentage of positive tumour cells (in accordance with ASCO/CAP recommendations) **Denominator** All patients with invasive breast cancer and biopsy and/or tumour resection and immunohistochemical determination of HER2 status	**4.73** For immunohistochemical determination of HER2 status, the immunohistochemical score and the percentage of positive tumour cells defining the score should be specified in accordance with ASCO/CAP recommendations : score 0, score 1+, score 2+ or score 3+. In the case of an immunohistochemical score of 2+, in situ hybridisation should be performed to determine HER2 status. Its evaluation should follow the ASCO/CAP recommendations.	**LoE 1** EG A, **Quality objective:** For as many HER2 status determinations as possible, the immunohistochemical score and the score-defining percentage of positive tumour cells should be specified in accordance with the ASCO/CAP recommendations : score 0, score 1+, score 2+ or score 3+.
MamCa 14: Radiation of regional lymph drainage areas in cases of ≥4 affected axillary lymph nodes (new 2025)		
Numerator Numerator of the denominator with radiation of the regional	**4,113** If 4 or more affected axillary lymph nodes are detected, radiation of the	**LoE 1** EG A,

Quality indicator	Reference Recommendation	Evidence base/further information
lymph drainage areas **Denominator** All patients with invasive breast cancer and tumour resection and evidence of ≥4 affected axillary lymph nodes	regional lymph drainage areas should be performed.	**Quality objective:** Radiation therapy of the regional lymph drainage areas should be performed in as many patients as possible with evidence of 4 or more affected axillary lymph nodes.
MamCa 15: Trastuzumab emtansine in cases of incomplete remission (new 2025)		
Numerator Patients in the denominator with 14 cycles of trastuzumab emtansine as post-neoadjuvant therapy **Denominator** All patients with HER2-positive breast cancer (-positive immunohistochemistry score 3+ or 2+ and ISH-positive) after anthracycline- or taxane-based chemotherapy in combination with anti-HER2-targeted therapy and non-achievement of histological complete remission (non-pCR).	**4,165** Patients with HER2-positive breast cancer (immunohistochemical score 3+ or 2+ and ISH-positive) and incomplete histological remission (non-pCR) after anthracyclineor taxane- -based chemotherapy regimen in combination with anti-HER2-targeted therapy should receive 14 cycles of trastuzumab emtansine as post-neoadjuvant therapy.	**LoE 2** EG A, **Quality objective:** As many patients as possible with HER2-positive breast cancer (immunohistochemical score 3+ or 2+ and ISH-positive) and non-achieved histological complete remission (non-pCR) after an anthracyclineor taxane-based chemotherapy regimen in combination with anti-HER2 targeted therapy should receive 14 cycles of trastuzumab emtansine as post-neoadjuvant therapy.
MamCa 16: Assessment of possible hereditary predisposition using a checklist (new in 2025)		
Numerator Patients in the denominator with recording of possible hereditary predisposition to breast and/or ovarian cancer using the checklist* **Denominator**	**3.42** The checklist for recording possible hereditary predisposition to breast and/or ovarian cancer should be used for patients with DCIS and/or invasive breast cancer.	**Consensus-based recommendation** EG B, **Quality objective:** The checklist* should be used to assess the possible hereditary risk of breast and/or ovarian cancer in as many patients with DCIS and/or invasive breast cancer as possible.

Quality indicator	Reference Recommendation	Evidence base/further information
All patients with a first diagnosis of DCIS and/or invasive breast cancer and all patients with a new recurrence and/or new distant metastasis(es)		*Checklist, see here: https://www.krebsgesellschaft.de/unsere-themen/zertifizierung/erhebungsboegen-und-dokumente
MamCa 17: Pre-therapeutic tumour conference (new in 2025)		
Numerator Patients in the denominator who were presented pre-therapeutically in an interdisciplinary tumour conference **Denominator** All patients with a primary diagnosis of DCIS and/or invasive breast cancer and all patients with a newly ly occurring recurrence and/or newly occurring distant metastases	**3.43** Patients with DCIS and/or invasive breast cancer should be presented at a pre-therapeutic and a post-operative interdisciplinary tumour conference.	**Consensus-based recommendation** , **Quality objective:** If possible, all patients with DCIS and/or invasive breast cancer should be presented in a pre-therapeutic interdisciplinary tumour conference.
MamCa 18: Postoperative tumour conference (new 2025)		
Numerator Patients in the denominator who were presented postoperatively in an interdisciplinary tumour conference **Denominator** All patients with a primary diagnosis of DCIS and/or invasive breast cancer and surgery (BET and/or mastectomy)	**3.43** Patients with DCIS and/or invasive breast cancer should be presented at a pre-therapeutic and postoperative interdisciplinary tumour conference.	**Consensus-based recommendation** , **Quality objective:** If possible, all patients who have undergone surgery (BET and/or mastectomy) for DCIS and/or invasive breast cancer should be presented at a post-operative interdisciplinary tumour conference.

22 Multiple myeloma

(Version 1.0, 18 February 2022)

Quality indicator	Reference Recommendation	Evidence base/further information
Myeloma 1: Staging using R-ISS		
Numerator Patients in the denominator with staging according to the revised International Staging System (R-ISS) **Denominator** All patients with multiple myeloma	**6.4** The International Staging System (ISS) of the International Myeloma Working Group (IMWG) ***should*** be used for prognostic staging. If genetic findings are available (reference to recommendation **7.21**), the revised ISS (R-ISS) ***should*** be used.	**Consensus-based recommendation** Quality objective: As many patients with multiple myeloma as possible should be staged using the revised International Staging System (R-ISS).

23 Oral cavity carcinoma

(Version 3.0, 26 March 2021)

Quality indicator	Reference Recommendation	Evidence base/further information
ORAL 1: R0 situation after curative surgery		
Numerator Number of patients with R0 as a result of surgical treatment **Denominator** All patients with a primary diagnosis of oral cavity carcinoma and resection with curative intent	**5.** To rule out synchronous secondary tumours, an ear, nose and throat examination and, if necessary, an endoscopy should be performed as part of the primary diagnosis of oral cavity carcinoma.	**Consensus-based statement** Quality objective: R0 status as often as possible after completion of curative surgical therapy
ORAL 2: Imaging procedures and further diagnostics/imaging procedures and diagnostics for the detection of metastasis		
Numerator Number of patients with examination of the region from the base of the skull to the upper thoracic aperture using CT or MRI to determine the N category **Denominator** All patients with oral cavity carcinoma	**6.10** To determine the N category, the entire region from the base of the skull to the upper thoracic aperture should be examined using CT or MRI. Sources: [3], [4], [5], [6], [7], [8], [9]	**LoE 2** Quality objective: Imaging as frequently as possible to rule out metastasis in patients with advanced oral cavity carcinoma
ORAL 3: Imaging procedures and further diagnostics/imaging procedures and diagnostics to rule out synchronous secondary tumours, distant metastases, unknown primary tumours (CUP) and recurrences		
Numerator Number of patients with chest CT to rule out pulmonary tumour involvement (filia, secondary carcinoma) **Denominator** All patients with stage III + IV oral cavity carcinoma	**6.1** In patients with advanced oral cavity carcinoma (stage III, IV), a chest CT scan should be performed to rule out pulmonary tumour involvement (filia, secondary carcinoma). Sources: [10], [11], [12], [13]	**LoE 3**

Quality indicator	Reference Recommendation	Evidence base/further information
ORAL 4: Biopsy and histopathology		
Numerator Number of patients for whom the histopathological findings are documented as follows: tumour location, macroscopic tumour size, histological tumour type according to WHO, histological tumour grade, depth of invasion, lymphatic vessel invasion, blood vessel invasion and perineural invasion, locally infiltrated structures, pT classification, details of affected areas and infiltrated structures, R status **Denominator** All patients with oral cavity carcinoma and surgery	**7.4** The histopathological findings should describe the exact location of any R+ situation in consultation with the clinician. The tumour specimen should be sent to the pathologist with a clear indication of the anatomical topography. This can be done by thread or colour marking. The histopathological findings should include: Tumour location, macroscopic tumour size, histological tumour type according to WHO, histological tumour grade, depth of invasion, lymphatic vessel invasion, blood vessel invasion and perineural invasion, locally infiltrated structures, pT classification, information on affected areas and infiltrated structures, R status. Sources: [14], [15], [16], [17], [18], [19], [20], [21], [22], [23], [24], [25], [26], [27], [28], [29], [30], [31]	**LoE 2++**
ORAL 5: Treatment recommendations		
Numerator Number of patients receiving interdisciplinary treatment following consultation with tumour boards involving specialists in oral and maxillofacial surgery, ear, nose and throat medicine, radiotherapy, oncology,	**8.1** The treatment of oral cavity carcinoma should be carried out on an interdisciplinary basis after consultation of each individual case within tumour boards involving the specialist disciplines of oral and maxillofacial surgery, ear, nose	**Consensus-based recommendation** ,

Quality indicator	Reference Recommendation	Evidence base/further information
pathology and radiology **Denominator** All patients with oral cavity carcinoma	and throat medicine, radiotherapy, oncology, pathology and radiology.	
Note: Interdisciplinary treatment was considered very important. The highest possible indicator score is to be aimed for		
ORAL 6: Treatment recommendations/neck lymph node dissection		
Numerator Number of patients with elective neck dissection **Denominator** All patients with oral cavity carcinoma and cNO of any T category	**8.1** In patients with clinically unremarkable lymph node status (cN0), elective neck dissection should be performed regardless of the T category. Sources: [32], [33], [34], [35], [36], [37], [38], [39], [40], [41], [42]	**LoE 3**
ORAL 7: Treatment recommendations/radiotherapy		
Numerator Number of patients without interruption of radiotherapy **Denominator** All patients with oral cavity carcinoma and radiotherapy	**8.2** Interruption of radiotherapy leads to a deterioration in tumour control and should be avoided. Sources: [43], [44], [45]	**LoE 2**
Note Definition of "interruption": An interruption occurs when it delays the recommended period of 11 weeks until completion.		
ORAL 8: Treatment recommendations/radiotherapy in combination with chemotherapy		
Numerator Number of patients with postoperative radiotherapy or radiochemotherapy	**8.35** Postoperative radiotherapy or radiochemotherapy should be performed in cases of advanced	**LoE 1++** ,

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with T3/T4 category, narrow or positive resection margins, perineural or vascular invasion or LK+	T category (T3/T4), narrow or positive resection margins, perineural invasion, vascular invasion and/or lymph node involvement. Sources: [46], [47], [48], [49], [50], [51], [52], [53]	
Note: Definition of "close" safety margin: 1-3 mm		
ORAL 9: Treatment recommendations/prevention and treatment of radiation-related side effects		
Numerator Number of patients with dental examination before starting radiotherapy or radiochemotherapy **Denominator** All patients with oral cavity carcinoma and radiotherapy or radiochemotherapy	**8.4** Before undergoing radiotherapy/radiochemotherapy in the oral cavity, patients should undergo a dental examination and, if necessary, conservative and/or surgical dental restoration to prevent osteoradionecrosis.	**Consensus-based recommendation** ,
ORAL 10: Aftercare and rehabilitation/psychosocial counselling and support		
Numerator Number of patients with documented offer of psychosocial care by a social worker **Denominator** All patients with oral cavity carcinoma	**9.8** Patients with oral cavity carcinoma should be offered psychosocial care by social workers.	**Consensus-based recommendation** ,
Note: The social worker should inform the patient of the availability of this service.		

24 Renal cell carcinoma

(Version 5.0, 26 September 2024)

Quality indicator	Reference Recommendation	Evidence base/further information
Kidney 1: Biopsy prior to ablative therapy		
Numerator Number of patients with diagnosis confirmed by punch biopsy prior to ablative therapy (RFA or cryoablation) **Denominator** All patients with initial diagnosis of renal cell carcinoma and ablative therapy (RFA or cryoablation)	**4.** A biopsy should be performed prior to ablative therapy.	**Consensus-based recommendation**
Quality objective: Confirm diagnosis with punch biopsy before ablative therapy as often as possible.		
Kidney 2: Biopsy before systemic therapy		
Numerator Number of patients with histology prior to systemic therapy **Denominator** All patients with renal cell carcinoma and systemic therapy	**4.6** If there is no histopathological confirmation of renal cell carcinoma and its subtype, a biopsy should be performed on the primary tumour or a metastasis prior to systemic therapy.	**Consensus-based recommendation** .
Quality objective: Confirm diagnosis with histology as often as possible before systemic therapy		
Kidney 3: Histological type according to current WHO classification		
Numerator Number of patients with findings reports with: Classification according to WHO and	**4.9** The histological type of renal cell carcinoma should be	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
Vancouver classification and Staging according to TNM **Denominator** All patients with renal cell carcinoma and histology	determined according to the current WHO classification .	
Note: Quality objective: Findings reports with the listed information as often as possible. **Comments:** Vancouver classification: G. Kristiansen, B. Delahunt, J.R. Srigley et al. Vancouver classification of renal tumours. Recommendations of the 2012 consensus conference of the International Society of Uropathology (ISUP). Pathologe 2014. DOI 10.1007/s00292-014-2030-z WHO Classification: 2004 TNM 7th edition		
Kidney 4: Tumour grade according to Fuhrman		
Numerator Number of patients with Fuhrman tumour grade specified in histological findings **Denominator** All patients with clear cell or papillary renal cell carcinoma.	**4.10** The current recommendations of the TNM classification should be applied. The tumour grade should be specified according to WHO-ISUP grading for clear cell and papillary renal cell carcinomas. In addition, the percentage of tumour necrosis should be specified. Sources: [54]	**Consensus-based recommendation**
Note: Quality objective: Where possible, specify the tumour grade according to Fuhrman for clear cell or papillary renal cell carcinoma. **Comments** WHO-ISUP grading		

Quality indicator	Reference Recommendation	Evidence base/further information
Kidney 5: R0 resection		
Numerator Number of patients with R0 resection **Denominator** All patients with initial diagnosis of renal cell carcinoma and surgical resection	**6.13** An R0 resection should be performed during kidney tumour removal.	**LoE 3**
Note: Quality objective: R0 resection as often as possible. **EG A, LoE 3**		
Kidney 6: Nephrectomy for pT1		
Numerator Number of patients with nephrectomy **Denominator** All patients with initial diagnosis of renal cell carcinoma pT1	**6.** Locally confined tumours in clinical category T1 **should** be treated with kidney-preserving surgery. Sources: [55], [56]	**LoE 3**
Note: Quality objective: low Nephrectomy should be performed as rarely as possible in pT1 cases. **EG A, LoE 3**		
Kidney 7: Dental examination prior to bisphosphonate/denosumab therapy		
Numerator Number of patients with dental examination before starting therapy	**13.3** To prevent osteonecrosis of the jaw, a dental examination and, if necessary, dental	**LoE 3**

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with renal cell carcinoma and bisphosphonate or denosumab therapy	restoration and instruction in oral hygiene should be carried out before starting drug therapy with bisphosphonates or denosumab. Sources: [57], [58], [59]	
Note: Quality objective: Dental examination as often as possible before starting therapy with bisphosphonates or denosumab **EG A, LoE 3+**		
Kidney 8: Two-year survival in metastatic renal cell carcinoma		
Numerator Number of living patients in the year prior to the year of recording **Denominator** All patients with initial diagnosis of metastatic renal cell carcinoma 3 years prior to the year of recording	None	
Note: Quality target: >=50% **Notes** Source: NHS (UK) http://www.londoncancer.org/media/61502/quality-performance-indicators-010813.pdf (as of 29 June 2015) **Reference recommendation:** **2-year survival rate for metastatic kidney cancer** Z: Number of patients with metastatic cancer at diagnosis for whom at least 2 years have elapsed since diagnosis who are alive 2 years after diagnosis N: Number of patients with metastatic cancer at diagnosis for whom at least 2 years have elapsed		

Quality indicator	Reference Recommendation	Evidence base/further information
since diagnosis		
Kidney 9: 30-day mortality after intervention		
Numerator Number of patients who died within 30 days post-intervention **Denominator** All patients with a primary diagnosis of renal cell carcinoma who underwent renal (partial) resection or ablative therapy (RFA, cryotherapy) as initial treatment	None	
Note: Quality target: <5% Comments Source: Scottish Cancer Taskforce. Renal Cancer Clinical Quality Performance Indicators. Published: January 2012. Updated: December 2014 (v2.1) Published by: Healthcare Improvement http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=211c7043-6d86-4417-acee-3296e0bfb7bd&version=-1 (as of 29 June 2015) **Reference recommendation:** **30-day mortality after surgery or ablation** Exclusions: Emergency surgery (nephrectomy). Please note: This QPI will be reported by treatment type as opposed to a single figure for all treatment options covered by the indicator (i.e. RFA, cryotherapy, SACT or surgery). Z: Number of patients who undergo minimally invasive or operative treatment as first treatment who die within 30 days N: All patients who undergo minimally invasive (RFA, cryotherapy, SACT) or operative treatment as first treatment for RCC. Targets: < 5% (This target reflects the fact that death from any cause, rather than death from renal cancer, is being measured by this indicator.)		

25 Oro- and hypopharyngeal carcinoma

(Version 1.0, 11 March 2024)

Quality indicator	Reference Recommendation	Evidence base/further information
OroHypo 1: p16 immunohistochemistry		
Numerator Patients in the denominator with p16 immunohistochemistry **Denominator** All patients with initial diagnosis of oropharyngeal carcinoma	**4.5** p16 immunohistochemistry should be performed for TNM-relevant assessment of HPV-16 association with HPV infection.	**Consensus-based recommendation** **(,)**
Note: Quality objective: Immunohistological examination should be performed as often as possible in patients with oropharyngeal carcinoma. **ICD codes Oropharynx:** ICD-10 C01, C02.4, C02.8, C02.9, C05.1, C05.2, C05.8, C05.9, C09, C10, C14.0, C14.2, C14.8.		
OroHypo 2: Information in the histopathological report after resection		
Numerator Pat. of the denominator with all of the following information in the histopathological findings report: · Tumour location and size · pTN status · Histological tumour type according to current WHO classification · Local tumour spread, infiltrated structures · Lymph node metastases separated by level and side: - Number of lymph nodes examined - Number of affected	**6.4** The following parameters should be specified in the histopathological report Tumour location and size pTN status Histological tumour type according to current WHO classification Local tumour spread, infiltrated structures Number of lymph nodes examined	**Consensus-based recommendation** **(,)**

Quality indicator	Reference Recommendation	Evidence base/further information
lymph nodes - Largest diameter of LK metastases · Tumour growth beyond the capsule (ECS, ENE) · Lymphatic vessel/venous invasion and perineural invasion · Presence of an in situ component (with size) · Differentiation of the tumour according to the established grading scheme · Distance to the lateral and basal resection margins for all relevant margins as well as for the invasive and in situ components in mm. · R classification · Oropharynx only: indication of p16 expression status (positive, negative). **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma and resection	Number of affected lymph nodes Largest diameter of lymph node metastases Tumour growth beyond the capsule (ECS, ENE) Lymphatic vessel/venous invasion and perineural invasion Presence of an in situ component (with size) Differentiation of the tumour according to the established grading scheme Distance to the lateral and basal resection margins for all relevant margins as well as for the invasive and in situ components in mm. R classification Oropharynx only: indication of p16 expression status (positive, negative). For a positive result, at least 70% of the tumour cells should show heterogeneous nuclear and cytoplasmic staining of moderate to strong intensity.	
Note: Quality objective: Complete findings report as often as possible after resection		
OroHypo 3: CT/MRI of the neck for lymph node staging		
Numerator Patients in the denominator with staging CT or MRI of the neck (base of skull to upper thoracic aperture)	**7.7** To determine the N category, the entire region from the base of the skull to the upper	**LoE 2+** **Evidence-based (EG A,)**

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma	thoracic aperture should be examined using CT or MRI.	
Note: Quality objective: Lymph node staging of the neck using CT/MRI as often as possible		
OroHypo 4: Chest CT to rule out pulmonary tumour involvement		
Numerator Patients in the denominator with thoracic CT to rule out pulmonary tumour involvement (metastases, secondary carcinoma) **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma	**7.10** In patients with confirmed oropharyngeal and hypopharyngeal carcinoma, a chest CT scan should be performed to rule out pulmonary tumour involvement (filia, secondary carcinoma).	**LoE 3** **Evidence-based (EG A,)**
Note: Quality objective: Perform a chest CT scan as often as possible to rule out pulmonary tumour involvement.		
OroHypo 5: Imaging to rule out liver metastases		
Numerator Patients in the denominator with imaging to rule out liver metastases **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma	**7.1** Imaging should be performed as part of the primary diagnosis to rule out liver metastases.	**Consensus-based recommendation** **(,)**

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Imaging should be performed as often as possible to rule out liver metastases. Definition of imaging: Ultrasound, CT (including chest CT with upper abdomen), MRI and PET in combination with contrast-enhanced cross-sectional imaging		
OroHypo 6: Performing panendoscopy		
Numerator Patients in the denominator with panendoscopy **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma	**7.** Panendoscopy should be performed as part of the primary diagnosis of oropharyngeal and hypopharyngeal carcinoma. It is a central component of primary diagnostics for determining the exact extent of the primary tumour and detecting secondary carcinomas.	**Consensus-based recommendation** **(,)**
Note: Quality objective: Perform panendoscopy as often as possible during primary diagnosis		
OroHypo 7: Pre-therapeutic tumour conference		
Numerator Patients in the denominator with pre-therapeutic presentation at the tumour conference **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma	**8.** The treatment of oropharyngeal and hypopharyngeal carcinoma should be carried out on an interdisciplinary basis after consultation of each individual case within tumour boards involving the specialist disciplines of ear, nose and throat medicine, oral and maxillofacial surgery, radiation oncology, oncology, pathology and radiology.	**Consensus-based recommendation** **(,)**

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Presentation of patients at tumour conferences as often as possible prior to treatment Participants in tumour conference: ENT, maxillofacial surgery, radiation oncology, oncology, pathology and radiology		
OroHypo 8: Cisplatin-based chemotherapy in primary radiochemotherapy		
Numerator Patients in the denominator receiving cisplatin-based chemotherapy **Denominator** All patients with initial diagnosis · Oropharyngeal carcinoma in stage I/II or III or · HPV/p16-negative oropharyngeal carcinoma in stage IV-A/IV-B or · Stage III/IV-A/IV-B hypopharyngeal carcinoma and primary simultaneous radiochemotherapy	**8.14** In HPV/p16-positive and -negative oropharyngeal carcinoma, simultaneous chemotherapy should be cisplatin-based in the case of primary radiochemotherapy. In patients who cannot receive cisplatin, e.g. due to impaired renal function, carboplatin + 5-FU, mitomycin C + 5-FU, a taxane or cetuximab (HPV/p16+) can be used as simultaneous systemic therapy. **8.35** In the case of **HPV/p16-positive** oropharyngeal carcinoma, simultaneous chemotherapy should be cisplatin-based in the case of primary chemoradiotherapy. **8.36** In the case of **HPV/p16-negative** oropharyngeal carcinoma, simultaneous chemotherapy should be cisplatin-based in the case of primary chemoradiotherapy. **8.71** In stage III-IVb hypopharyngeal carcinoma, simultaneous chemotherapy should be	**8.14: Consensus-based recommendation** **8.35: GRADE: ⊕⊕⊕⊕** **8.36: Consensus-based recommendation** **8.71: LoE 1a** **:** **(,)** **:** **Evidence-based (EG A, LoE ⊕⊕⊕⊕)** **:** **(,)** **:** **Evidence-based (a)**

Quality indicator	Reference Recommendation	Evidence base/further information
	cisplatin-based in the case of primary chemoradiotherapy.	
Note: Quality objective: Adequate rate of cisplatin-based chemotherapy in primary radiochemotherapy		
OroHypo 9: Primary radiochemotherapy		
Numerator Patients in the denominator with primary radiochemotherapy **Denominator** All patients with initial diagnosis · Stage III oropharyngeal carcinoma or · HPV/p16-negative stage IV-A/IV-B oropharyngeal carcinoma or · Stage III/IV-A/IV-B hypopharyngeal carcinoma ≤ 70 years of age without resection	**8.31** In patients with **HPV/p16-positive and -negative** oropharyngeal carcinoma who are not treated with surgery, primary chemoradiotherapy should be preferred to radiotherapy alone, especially in the age group up to 70 years. **8.33** The primary conservative treatment for patients with **HPV/p16-positive stage III and negative stage III-IVb** oropharyngeal carcinomas (UICC 8th edition) should be radiochemotherapy. **8.69** The primary non-surgical treatment for patients with stage III-IVb hypopharyngeal carcinoma (UICC 8th edition) should be radiochemotherapy.	**8.31: LoE 1a** **8.33: GRADE: ⊕⊕⊖⊖** **8.69: Consensus-based recommendation** **:** **Evidence-based (EG A, a)** **:** **Evidence-based (EG A, LoE ⊕⊕⊖⊖, ⊕⊕⊖⊖)** **:** **(,)**
Note: Quality objective: Adequate rate of combined radiochemotherapy in patients without primary resection		
OroHypo 10: Postoperative radiotherapy/radiochemotherapy (hypopharyngeal carcinoma)		
Numerator Patients in the denominator	**8.78**	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
with postoperative radiotherapy or radiochemotherapy **Denominator** All patients with initial diagnosis of hypopharyngeal carcinoma and surgical treatment and · pT3/pT4 and/or · pN2/pN3 and/or · R1 resection/R0<5mm and/or · L1 and/or · Pn1 and/or · extracapsular tumour growth	Postoperative radiotherapy or radiochemotherapy should be considered for hypopharyngeal carcinomas in pT3 carcinomas and pT4 carcinomas pN2-pN3 in carcinomas with narrow or positive resection margins (R0 < 5 mm; R1), perineural invasion, vascular invasion (lymphatic vessel invasion and/or venous invasion) in cases of affected lymph nodes with extracapsular tumour growth.	**:** **(,)**
Note: Quality objective: Adequate rate of postoperative radiotherapy or radiochemotherapy ICD codes Hypopharynx: ICD-10 C12, C13		
OroHypo 11: Postoperative/therapeutic examination of swallowing function		
Numerator Patients in the denominator with postoperative or post-therapeutic examination of swallowing function **Denominator** All patients with oropharyngeal/hypopharyngeal carcinoma	**10.3** In the case of a preoperative swallowing disorder, dysphagia diagnostics and, if necessary, swallowing training should be carried out preoperatively or pretherapeutically. Swallowing function should be examined as early as possible after surgery or therapy. The aim is to enable rapid oral food intake and, if necessary, swallowing training, depending on the healing process and the therapeutic methods used .	**Consensus-based recommendation** **(,)**

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Postoperative or post-therapeutic examination of swallowing function as often as possible		
OroHypo 12: Consultation with social services		
Numerator Patients in the denominator with counselling by social services **Denominator** All patients with initial diagnosis of oropharyngeal/hypopharyngeal carcinoma and patients with newly occurring (local) recurrence and/or distant metastases	**10.9** Patients with oropharyngeal/hypopharyngeal carcinoma should be informed that they are legally entitled to follow-up treatment (AHB) and, in the further course of treatment, to medical rehabilitation. Follow-up treatment and rehabilitation should be recommended by a doctor.	**Consensus-based recommendation** **(,)**
Note: Quality objective: Consultation with social services as often as possible		
OroHypo 13: 30d mortality		
Numerator a) Patients in the denominator who died within 30 days postoperatively b) Patients in the denominator who died within 30 days after completion of radiochemotherapy **Denominator** All patients with a primary diagnosis of oropharyngeal/hypopharyngeal carcinoma and a) Surgery b) primary radiochemotherapy with curative intent	None	Outcome indicator based on a QI from Scotland: 30-day mortality after curative treatment for head and neck cancer (QPI 11) Numerator: Number of patients with head and neck cancer who undergo curative treatment who die within 30 days of treatment Denominator: All patients with head and neck cancer who undergo curative treatment This indicator will be reported separately as 30-day mortality by treatment modality, i.e., surgery, radical radiotherapy,

Quality indicator	Reference Recommendation	Evidence base/further information
		chemoradiotherapy, etc., as opposed to a single figure. Scottish Cancer Taskforce Head and Neck Cancer QPI v (Nov. 2021)
Note: Quality target: a) Lowest possible rate of patients who die postoperatively b) Lowest possible rate of post-therapeutic deaths in patients with primary radiochemotherapy		

26 Palliative medicine

(Version 2.2, 22 September 2020)

Quality indicator	Reference Recommendation	Evidence base/further information
PAL 1: Reduction in shortness of breath		
Numerator Number of patients with reduction in dyspnoea within 48 hours **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV) with moderate/severe dyspnoea	**8.** Repeated assessment of dyspnoea before, during and after symptomatic therapy *should* be part of the recording process.	**Consensus-based recommendation** Screening instruments (open list of validated instruments): Modified Borg Visual analogue scale Numeric Rating Scale MIDOS, IPOS (HOPE/National Palliative Care Register)
Note: The screening instruments IPOS or MIDOS are used to record QIs 1, 2, 3, (4) and 10. Only QI 8 requires the use of a different screening instrument. The denominator of the QIs explicitly addresses APV and SPV patients in order to clarify that the QIs are to be implemented for both areas (see also point 4 of the section "Further results of the QI working group").		
PAL 2: Pain reduction		
Numerator Number of patients with pain reduction within 48 hours **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV) with moderate/severe pain	**9** Pain history and pain-related clinical examination *should* be part of every pain diagnosis.	**Consensus-based recommendation** Screening instruments (open list of validated instruments): McGill Pain Questionnaire Verbal Rating Scale Numeric Rating Scale MIDOS, IPOS (HOPE/National Palliative Care Register)

Quality indicator	Reference Recommendation	Evidence base/further information
		If neuropathic pain is suspected, also: painDETECT or DN4
PAL 3: Opiates and laxatives		
Numerator Number of patients not receiving treatment with osmotically active and/or stimulant laxatives **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV) receiving opiate medication	**13.6** Osmotic and/or stimulant laxatives *should* be used in monotherapy or combination therapy for the treatment of constipation in patients with incurable cancer. **9.2** Laxatives for the treatment or prevention of opioid-induced constipation *should* be prescribed routinely.	**13.6: LoE 1-** **9.25: LoE 1+** , LoE: 1+ EAPC/Caraceni et al. 2012; Candy et al. 2011 (SysRev) , LoE: 1- Bader et al. 2012 (SysRev) **Quality objective:** low
PAL 4: Symptom assessment in the dying phase		
Numerator Number of patients with symptom assessment using a validated screening instrument in the last 72 hours before death **Denominator** All deceased patients (APV and SPV)	**19.25** Anxiety occurring during the dying phase *should* be evaluated regularly. In addition to verbal expressions, attention *should* be paid to clinical signs such as restlessness, sweating, facial expressions or defensive reactions.	**Consensus-based recommendation** **Screening instruments** (open list of validated instruments: IPOS MIDOS (HOPE/National Palliative Care Register)
PAL 5: Recording restlessness in the dying phase		
Numerator Number of patients with evaluation of restlessness in the last 72 hours before death **Denominator** All deceased patients (APV and SPV)	**19** In cases of restlessness in the dying phase, the primary causes *should* be determined, e.g. pain, constipation, urinary retention, shortness of breath, anxiety and/or delirium.	**Consensus-based recommendation** **Screening instruments**: To be recorded via IPOS and MIDOS in future

Quality indicator	Reference Recommendation	Evidence base/further information
PAL 6: Discontinuation of tumour-specific measures in the dying phase		
Numerator Number of patients receiving tumour-specific measures (systemic therapy, radiotherapy) within 14 days prior to death **Denominator** All deceased patients (APV and SPV)	**19** Tumour-specific drugs and measures *should* be discontinued in the terminal phase.	**Consensus-based recommendation** **Quality target**: low
PAL 7: Oral care		
Numerator Number of patients receiving oral care **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV) and dry mouth (ICD-10-GM R 68.2)	**14.11** To alleviate dry mouth in patients with incurable cancer and MIO, oral care, including lip moisturising, *should* be offered and performed regularly and several times a day.	**Consensus-based recommendation** **Quality objective:** Oral care for patients with incurable cancer as often as possible
PAL 8: Assessment of malignant wounds		
Numerator Number of patients with assessment of ulcerating tumours using a specific assessment tool in accordance with the guideline **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV) and ulcerating tumour	**15.2** The assessment of the malignant wound with a complete analysis of the wound situation *should* be carried out in writing using structured wound documentation forms at the beginning of care and for further monitoring on a regular basis during the course of treatment.	**Consensus-based recommendation** **Quality objective:** Assessment of malignant wounds in patients with incurable cancer and ulcerating tumours as frequently as possible **Specific assessment instruments:** · HOPE · FKB-20 · FLQA-wk

Quality indicator	Reference Recommendation	Evidence base/further information
		· Wound-QoL Pain assessment in patients with chronic wounds
PAL 9: Documentation of therapy goals		
Numerator Number of patients with documented treatment goals at the time of diagnosis of "incurable cancer" **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV)	**7.7** Therapy goals in the treatment of patients with incurable cancer *should* be reviewed regularly and adapted to changes in the disease and treatment situation or to changes in the patient's wishes, values and goals.	**Consensus-based recommendation** **Quality objective:** Documentation of treatment goals for patients with incurable cancer as frequently as possible
PAL 10: Symptom assessment using MIDOS or IPOS		
Numerator Number of patients with symptoms recorded using MIDOS or IPOS **Denominator** All patients diagnosed with "incurable cancer" (APV and SPV)	**5.5** In cases of incurable cancer, the physical, psychological, social and spiritual needs as well as the stresses and information needs of patients and their relatives *should* be repeatedly assessed and recorded whenever there is a change in the clinical situation.	**Consensus-based recommendation** **Quality objective:** Symptom assessment using MIDOS/IPOS as often as possible in patients with incurable cancer
PAL 11: Specialised palliative care		
Numerator Number of patients who have received specialised palliative care (inpatient: palliative care unit, palliative care service, palliative care day clinic, inpatient hospice ; outpatient: SAPV, specialised palliative outpatient clinic)	None Sources: [60]	**Quality objective:** Evaluation of the care situation of cancer patients with regard to specialised palliative care

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients who died of cancer		
Note: International research on quality indicators: **QI: Specialised palliative care** **Numerator:** number of people who died with cancer who received specialised palliative care (hospital palliative unit OR palliative daycare centre OR multidisciplinary home care) in the last 2 years prior to death **Denominator:** number of people who died with cancer		

27 Pancreatic carcinoma

(Version 3.1, 10 October 2024)

Quality indicator	Reference Recommendation	Evidence base/further information
PanCa 1: R0 resection (since 2013)		
Numerator Patients in the denominator with R0 resection **Denominator** All patients with initial diagnosis of pancreatic cancer and resection	**6.7** The aim of resection in pancreatic carcinoma should be resection within healthy tissue (R0).	**LoE 1a** a) Quality objective Highest possible rate of local R0 resections b) Evidence base a
PanCa 2: Lymph node dissection (since 2013, modified in 2021)		
Numerator Patients in the denominator with removal of at least 12 LK **Denominator** All patients with a primary diagnosis of pancreatic carcinoma (excluding NEC/NET) and surgical resection	**6.29** At least 12 regional lymph nodes should be removed during resection of pancreatic carcinoma.	**Consensus-based recommendation** a) Quality target At least 12 regional lymph nodes in the surgical specimen b) Evidence base
Note Surgical resection: Pancreatic head resection, left resection, pancreatectomy		
PanCa 3: Contents of pathology reports (modified 2021)		
Numerator Patients in the denominator with diagnostic reports specifying: · pT, pN, M · Tumour grading · Ratio of affected to removed lymph nodes	**6.30** When resecting pancreatic carcinoma, the ratio of affected to total removed lymph nodes should be specified in the pathological-histological findings report.	**6.30: LoE 2b** **6.36: LoE 2b** a) Quality objective Complete pathology reports as often as possible

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with pancreatic carcinoma and tumour resection	**6.36** The pT, pN and M categories as well as the tumour grading should be specified in the pathology report.	b) Evidence base b
PanCa 4: Adjuvant chemotherapy (modified 2021)		
Numerator Patients in the denominator receiving adjuvant chemotherapy **Denominator** All patients with a primary diagnosis of pancreatic carcinoma UICC stage I-III (without NET/NEC) and R0 resection	**7.1** Adjuvant chemotherapy should be administered after R0 resection of pancreatic carcinoma in UICC stages I–III.	**LoE 1b** a) Quality objective Adjuvant chemotherapy as often as possible b) Evidence b
PanCa 5: Palliative chemotherapy (modified 2021)		
Numerator Patients in the denominator receiving palliative chemotherapy **Denominator** All patients ·with initial diagnosis of pancreatic carcinoma (without NET/NEC), ECOG 0-2, M0 and M1, without tumour resection and ·with pancreatic carcinoma (excluding NET/NEC), ECOG 0-2, with secondary metastasis (M1) without metastasis resection	**8.1** In cases of metastatic or locally advanced pancreatic cancer, palliative chemotherapy should be offered to patients with an ECOG performance status of 0 to 2 in order to improve quality of life, clinical benefit and survival time.	**LoE 5** a) Quality objective Palliative chemotherapy as often as possible for metastatic or locally advanced pancreatic carcinoma ECOG 0-2 b) Evidence base

Quality indicator	Reference Recommendation	Evidence base/further information
PanCa 6: No primary resection for metastatic pancreatic cancer (new in 2021)		
Numerator Patients in the denominator with primary resection of the tumour **Denominator** All patients with a primary diagnosis of ductal pancreatic carcinoma (excluding NET/NEC) with distant metastases (= organ metastases, peritoneal carcinomatosis, lymph node metastases considered distant metastases (M1))	**6.16** Primary resection of the tumour should not be performed in cases of proven distant metastases of ductal pancreatic carcinoma (organ metastases, peritoneal carcinomatosis, lymph node metastases considered to be distant metastases).	**LoE 3** a) Quality objective No primary tumour resection in cases of ductal pancreatic carcinoma with confirmed distant metastases b) Evidence base and 4
PanCa 7: Second-line therapy (new in 2021)		
Numerator Patients in the denominator receiving second-line therapy **Denominator** All patients with pancreatic carcinoma (excluding NET/NEC), ECOG 0-2 and progression under palliative first-line therapy	**8.2** In case of progression under first-line therapy, second-line therapy should be offered if ECOG ≤ 2.	**LoE 5** a) Quality objective Second-line therapy as often as possible in cases of progression under first-line therapy and ECOG ≤ 2 b) Evidence base

28 Penile carcinoma

(Version 1.0, 14 October 2020)

Quality indicator	Reference Recommendation	Evidence base/further information
Penis 1: Psychosocial screening		
Numerator Number of patients screened for psychosocial stress **Denominator** All patients with penile carcinoma	**3.7** All patients should undergo screening for psychosocial stress. Psycho-oncological screening should be carried out as early as possible at appropriate intervals, when clinically indicated or when there is a change in a patient's disease status (e.g. recurrence or progression of the disease), and repeated throughout the course of the disease.	**Consensus-based recommendation** **Quality objective:** Screening for psychosocial stress in penile carcinoma patients as often as possible
Note Validated screening instruments according to the S3 guideline on psycho-oncology		
Penis 2: Findings report following surgical resection		
Numerator Number of patients with the following information in the pathological findings report: - Histological subtype according to WHO classification - Grading - Anatomical location - TNM classification - perineural invasion - Depth of infiltration - Lymphatic vessel invasion - Venous vessel invasion - Presence of pre- ic lesions (yes/no) - Presence of inflammatory comorbidities	**4.6** In addition to the histological tumour type and grading of penile carcinoma, the pathological report on the primary tumour should include information on the following prognostic factors: anatomical location, perineural invasion, depth of infiltration, lymphatic vessel invasion, venous vessel invasion, Growth patterns at the invasion front.	**Consensus-based recommendation** **Quality objective:** Complete pathological report after surgical resection as often as possible in cases of initial diagnosis of penile carcinoma

Quality indicator	Reference Recommendation	Evidence base/further information
(yes/no) - Association with HPV infections (yes/no) **Denominator** All patients with a primary diagnosis of penile carcinoma (ICD-10: C60) and surgical resection		
Penis 3: Findings report after surgical lymph node removal		
Numerator Number of patients with the following information in the pathological findings report: - Number of lymph nodes (removed/affected) - Maximum metastasis size - Capsule-transcending growth (yes/no) **Denominator** All patients with a primary diagnosis of penile carcinoma (ICD-10: C60) and surgical lymph node removal	**4.7** The pathological report on the lymph nodes should include the number and location of the lymph nodes examined, the number of affected lymph nodes and the maximum size of the metastases, as well as information on whether the metastasis is confined to the lymph node or has spread beyond the lymph node capsule.	**Consensus-based recommendation** **Quality objective:** Complete pathological findings report after surgical lymph node removal as often as possible in the initial diagnosis of penile carcinoma
Penis 4: Invasive lymph node diagnostics		
Numerator Number of patients with invasive LN diagnostics (modified inguinal lymphadenectomy or sentinel lymph node biopsy) **Denominator** All patients with initial diagnosis of penile carcinoma >= pT1b, cN0	**6.5** In cases of penile carcinoma from category pT1b onwards, clinically inconspicuous, non-palpable inguinal lymph nodes should be examined invasively. This can be done by modified inguinal lymphadenectomy or by dynamic sentinel lymph node biopsy.	**LoE 3** **EG A,** **Quality objective:** Invasive lymph node diagnostics should be performed as often as possible in the initial diagnosis of penile carcinoma from stage pT1b and cN0 onwards.

Quality indicator	Reference Recommendation	Evidence base/further information
Penis 5: Control biopsy after topical drug therapy or laser therapy		
Numerator Number of patients with control biopsy **Denominator** All patients with initial diagnosis of penile carcinoma and topical drug therapy (5-FU, imiquimod) or laser therapy	**7.9** After topical drug therapy or laser therapy, a follow-up biopsy should be performed post-intervention to verify local tumour control, and regular long-term follow-up care should be provided.	**Consensus-based recommendation** **Quality objective:** Control biopsies should be performed as often as possible after topical drug therapy or laser therapy for initial diagnosis of penile carcinoma.
Penis 6: Ipsilateral pelvic lymph node removal		
Numerator Number of patients with ipsilateral pelvic lymph node removal **Denominator** All patients with initial diagnosis of penile carcinoma (ICD-10: C60), pN3	**7.36** Pelvic lymph node dissection (iliac lymph node group) should be performed ipsilaterally in patients with two or more affected inguinal lymph nodes or in cases of capsular lymph node metastases.	**Consensus-based recommendation** **Quality objective:** Ipsilateral pelvic lymph node removal as often as possible in cases of initial diagnosis of penile carcinoma with pN3
Penis 7: Presentation to the tumour board		
Numerator Number of patients presented to the tumour board **Denominator** All patients with metastatic penile carcinoma, M1	**7.43** Patients with metastatic penile carcinoma and/or requiring multimodal therapy should be discussed in an interdisciplinary tumour board.	**Consensus-based recommendation** **Quality objective:** Presentation of patients with metastatic penile carcinoma, M1, to the tumour board as often as possible
Penis 8: Neoadjuvant chemotherapy		
Numerator Number of patients with neoadjuvant chemotherapy **Denominator** All patients with initial diagnosis of penile carcinoma	**7.4** Penile carcinoma patients with fixed inguinal lymph nodes and good general condition (, ECOG < 2) should undergo neoadjuvant chemotherapy.	**LoE 3** **EG A,** **Quality objective:** Neoadjuvant chemotherapy should be administered as

Quality indicator	Reference Recommendation	Evidence base/further information
cN3 (fixed inguinal LK) and ECOG < 2		often as possible in cases of initial diagnosis of penile carcinoma with cN3 (fixed inguinal lymph nodes) and ECOG < 2.

29 Perioperative management of gastrointestinal tumours (POMGAT)

(Version 1.0, 05.12.2023)

Quality indicator	Reference Recommendation	Evidence base/further information
POMGAT 1: No intra-abdominal drainage after elective oncological colorectal resections (new 2023)		
Numerator Patients in the denominator with intra-abdominal drainage **Denominator** All patients with colon carcinoma (C18) or rectal carcinoma (C20) and elective resection	**6.** Intra-abdominal drainage **should not** be inserted in elective colorectal resections.	**GRADE: ⊕⊕⊕⊖**
Note: Quality objective As few intra-abdominal drains as possible after elective colorectal resection: Quality target 0%		
POMGAT 2: No drainage after uncomplicated oncological liver resections (new 2023)		
Numerator Patients in the denominator with drainage insertion **Denominator** All patients with gastrointestinal tumours and uncomplicated liver resection	**6.** **No** prophylactic drainage **should** be inserted in uncomplicated liver resections.	**GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖ to GRADE: ⊕⊖⊖⊖**
Note: Quality objective: As few drains as possible after uncomplicated oncological liver resections Note: Quality target 0% Uncomplicated liver resection = liver resection without biliary or vascular reconstruction		

Quality indicator	Reference Recommendation	Evidence base/further information
POMGAT 3: No feeding tube after extubation (new in 2023)		
Numerator Patients in the denominator without nasogastric tube after extubation **Denominator** All patients with · Gastrectomy or partial gastric resection or · elective liver resection or · elective colorectal surgery	**7.3** Following gastrectomy or partial gastric resection, an intraoperatively inserted gastric tube **should** be removed before anaesthesia is withdrawn. **7.5** In elective liver resections, an intraoperatively inserted gastric tube **should** be removed before anaesthesia is withdrawn. **7.6** In elective colorectal surgery, a nasogastric tube **should** be removed before anaesthesia is withdrawn.	**7.3: GRADE: ⊕⊕⊕⊕** **7.5: GRADE: ⊕⊕⊕⊕ to GRADE: ⊕⊕⊕⊖ to GRADE: ⊕⊕⊖⊖** **7.6: Consensus-based recommendation**
Note: Quality objective: As many patients as possible without a feeding tube after extubation		
POMGAT 4: No transurethral indwelling catheter 24 hours after the end of surgery (new 2023)		
Numerator Patients in the denominator without transurethral indwelling catheter 24 hours after the end of the operation in the denominator **Denominator** All patients with oncological colon resection	**7** The transurethral indwelling catheter **should** be removed within the first 24 hours after colorectal resection. ely, prolonged drainage **may** be performed until the third postoperative day in cases where there are risk factors for urinary retention (male gender, deep anterior rectal resection, rectal extirpation).	**Consensus-based recommendation**
Note: Quality objective:		

Quality indicator	Reference Recommendation	Evidence base/further information
As many patients as possible without a transurethral indwelling catheter 24 hours after the end of the operation		

30 Prostate cancer

(Version 8.1, 01.09.2025)

Quality indicator	Reference Recommendation	Evidence base/further information
PCa 1: Punch biopsy report (modified 2025)		
Numerator Patients in the denominator with findings report specifying: · Location and number of carcinoma-positive tissue samples in relation to the punch biopsies taken. · Quantitative assessment of tumour extent (in mm) · Gleason score according to current ISUP/WHO classification · Specification of the total Gleason score according to the current ISUP/WHO classification · Presence of intraductal tumour component (yes/no) (for Gleason score 7) · Cribriform tumour component (yes/no) (for Gleason score 7) **Denominator** All patients with a primary diagnosis of prostate cancer and punch biopsy	**5.8** An intraductal tumour component (IDC-P according to the WHO definition) should be mentioned in the diagnosis. **5.** In the case of a Gleason score of 7 (WHO/ISUP grading groups/grade groups 2-3), cribriform tumour components should be mentioned in the comments. **5.11** If carcinoma is detected, the pathologist should provide the following information to the sender: Number and location of carcinoma-positive tissue samples; Quantitative estimate of tumour extent (in mm); Gleason score according to the current ISUP/WHO classification; If assessable, perineural sheath infiltration (Pn1), capsular infiltration, capsular invasion and seminal vesicle infiltration should be specified. In targeted biopsies with multiple punches from an imaging focus, these are	**5.8: Consensus-based recommendation** **5.9: Consensus-based recommendation** **5.11: Consensus-based recommendation** .// , Quality objective: Complete findings report after punch biopsy as often as possible. Reason for reporting: Pathology report

Quality indicator	Reference Recommendation	Evidence base/further information
	summarised in the Gleason score. In systematic biopsies, the tumour extent and Gleason score are determined for each punch.	
PCa 2: vacant		
Numerator **Denominator**	None	
PCa 3: vacant		
Numerator **Denominator**	None	
PCa 4: Radiotherapy and hormone ablation therapy for high-risk localised prostate cancer (modified 2021)		
Numerator Patients in the denominator with additional neoadjuvant/adjuvant hormone ablation therapy **Denominator** All patients with a first diagnosis of high-risk T1-2 N0 M0 prostate cancer and percutaneous radiotherapy	**6.3** Patients with locally confined prostate cancer with a high-risk profile should be offered percutaneous radiotherapy (IMRT + IGRT). **6.31** Patients with locally confined high-risk prostate cancer should receive adjuvant hormone ablation therapy in addition to percutaneous radiotherapy (IMRT + IGRT). **6.32** Hormone ablation therapy should last 24 to 36 months. It	**6.30: LoE 1+, LoE 2+** **6.31: LoE 1+** **6.32: LoE 1** **6.33: Consensus-based recommendation** en /31/32: EG A, , 1+ : (,) Quality objective: Adjuvant hormone ablation therapy as often as possible for locally confined prostate cancer with high risk and percutaneous radiotherapy Reason for reporting: Therapy report

Quality indicator	Reference Recommendation	Evidence base/further information
	can begin up to 6 months before radiotherapy. **6.33** The decision on the duration of hormone ablation therapy should be made on an individual basis depending on comorbidity and tolerability.	
Note: Notes: High risk = PSA > 20 ng/ml and/or Gleason score = 8 and/or cT category 2c; percutaneous radiotherapy = definitive radiotherapy		
PCa 5: not assigned		
Numerator **Denominator**	None	
PCa 6: vacant		
Numerator **Denominator**	None	
PCa 7: Salvage radiotherapy for recurrent prostate cancer (since 2014)		
Numerator Patients in the denominator at the start of SRT and with PSA <0.5 ng/ml **Denominator** All patients Z.n. RPE and PSA recurrence and SRT	**7.18** a. Salvage radiotherapy should begin as early as possible (PSA before SRT <0.5 ng/ml). b. In the initial pN0 stage and with early initiation of radiation, the lymphatic drainage pathways should not	**LoE 2++, LoE 3** a) EG A, Quality objective: Start SRT as often as possible at PSA <0.5 ng/ml Reason for reporting: Therapy report

Quality indicator	Reference Recommendation	Evidence base/further information
	be irradiated.	
PCa 8: Prevention of osteonecrosis of the jaw (since 2014)		
Numerator Patients in the denominator with dental examination before start of therapy **Denominator** All patients with prostate cancer and bisphosphonate or denosumab therapy	**7.7** To prevent osteonecrosis of the jaw, a dental examination and any necessary dental treatment should be carried out before administering bisphosphonates or denosumab a dental examination and, if necessary, dental treatment, as well as instruction and motivation of the patient to maintain above-average oral hygiene.	**LoE 3** EG A, Quality objective: Dental examination as often as possible before starting bisphosphonate or denosumab therapy Reason for reporting: Therapy notification
PCa 9: Postoperative complications after radical prostatectomy (modified 2025)		
Numerator Patients in the denominator with Clavien-Dindo grade III or IV complications within the first 6 months after radical prostatectomy (RPE) **Denominator** All patients with a primary diagnosis of prostate cancer (M0) and radical prostatectomy (RPE)	None	Based on a corresponding ICHOM indicator. Corresponds to the guideline objective: recording postoperative complications Quality objective: Clavien-Dindo grade III or IV as rare as possible after RPE for localised prostate cancer Reason for reporting: Progress report
Note Comments: Classification according to Clavien-Dindo: Grade III Complications requiring surgical, endoscopic or radiological intervention: (IIIa without general anaesthesia, IIIb with general anaesthesia)		

Quality indicator	Reference Recommendation	Evidence base/further information
Grade IV Life-threatening complications requiring intensive care: (IVa dysfunction of one organ, IVb dysfunction of multiple organs)		
PCa 10: Complications following definitive radiotherapy (modified 2021)		
Numerator Patients in the denominator with CTCAE grade III or IV complications within the first 12 months after the end of radiotherapy **Denominator** All patients with a primary diagnosis of prostate cancer and definitive radiotherapy	None Sources: [61]	Based on a corresponding ICHOM indicator. Corresponds to the guideline objective: recording complications after definitive radiotherapy. Quality objective: CTCAE grade III or IV as rarely as possible after definitive radiotherapy Reason for reporting: Progress report
Note Comments: Source for classification: National Institutes of Health (NIH) and National Cancer Institute (NCI), Common Terminology Criteria for Adverse Events (CTCAE). Version 5.0 2017. [cited: 2025-07-11]. https://dctd.cancer.gov/research/ctep-trials/for-sites/adverse-events		
PCa 11: Targeted biopsy (new in 2021)		
Numerator Men in the denominator with targeted biopsy (according to pathology findings) of the suspicious foci **Denominator** All men with PI-RADS 4 or 5 in mpMRI and biopsy	**4.1** The foci suspected of being carcinoma (PI-RADS 4 and 5) described in the MRI should be specifically biopsied by removing 2-3 cylinders per focus.	**LoE 2** EG A Quality objective: Targeted biopsy as often as possible in men with PI-RADS 4 or 5 in mpMRI Reason for reporting: Pathology report
Note Comments: Targeted biopsy = information per punch; information provided by the practitioner performing the biopsy and/or information in the pathology report		
PCa 12: vacant		
Numerator	None	

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator		
PCa 13: Androgen deprivation therapy or bicalutamide in cases of high risk of progression (new in 2021)		
Numerator Patients in the denominator with additional androgen deprivation therapy (ADT) or bicalutamide **Denominator** All patients with PSA recurrence and salvage radiotherapy and PSA before SRT >0.7 ng/ml	**7.15** Patients at high risk of progression (PSA before SRT >0.7 ng/ml) should be offered androgen deprivation therapy (ADT) or bicalutamide in addition to percutaneous salvage radiotherapy (SRT).	**LoE 1-** EG A, Quality objective: Androgen deprivation therapy (ADT) or bicalutamide in addition to salvage radiotherapy as often as possible in cases of high risk of progression Reason for reporting: Therapy report
PCa 14: Active surveillance for localised low-risk prostate cancer (modified 2025)		
Numerator Patients in the denominator with active surveillance **Denominator** All patients with a primary diagnosis of locally confined prostate cancer with a low-risk profile (, group ISUP 1 and low risk according to d'Amico criteria)	**6.6** Patients with locally confined prostate cancer of low risk profile (ISUP group 1 and low risk according to D'Amico criteria) should be actively monitored.	**Consensus-based recommendation** (,) Quality objective: AS as often as possible in patients with a primary diagnosis of localised prostate cancer and low risk. Reason for reporting: Therapy report
PCa 15: BRCA 1/2 analysis in progressive, metastatic castration-resistant prostate cancer after ARPI therapy (modified 2025)		
Numerator Patients in the denominator with sequencing (germline and/or somatic) of homologous DNA recombination repair genes (at least BRCA 1/2) before initiation of the next systemic therapy (if sequencing is not yet available).	**7.42** If no positive results are available from previous germline testing, sequencing (germline, somatic) of genes involved in homologous DNA recombination repair (HRR) should be performed before initiating systemic therapy for	**LoE 1-** EG A, Quality objective: As many patients with mCRPC as possible and sequencing of homologous DNA recombination repair genes

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with metastatic castration-resistant prostate cancer after ARPI therapy	metastatic castration-resistant prostate cancer.	(BRCA1/2) before initiation of systemic therapy. Reason for reporting: Therapy report

31 Prevention of cervical cancer

(Version 1.1, 1 April 2020)

Quality indicator	Reference Recommendation	Evidence base/further information
PrevZxCa 1: Participation in cervical cancer screening		
Numerator Women who participated in screening **Denominator** All women who received an invitation for cervical cancer screening	**10.5** In the case of Group IIID1~ LSIL findings in organised cytological screening, clarification should be sought by means of an HR-HPV test within 6 months. If this HR-HPV test is positive, a colposcopic examination should be carried out within 3 months. If HPV is negative, a cytological and HPV check should be carried out after 12 months. **10.6** For Group IIID1~ LSIL findings in organised cytological screening, clarification can be provided by means of p16/Ki-67 testing in 6 months. If this p16/Ki-67 test is positive, colposcopic clarification should be performed within 3 months. If p16/Ki-67 is negative, a cytological and HPV check should be performed after 12 months. **10.7** a) If group III-p, III-x*, III-e* or III-g findings are detected in organised cytological screening, clarification can be obtained within 3 months using an HR-HPV test or p16/Ki-67 immunocytochemistry . If this	**10.5: GRADE: ⊕⊕⊕⊖** **10.6: GRADE: ⊕⊖⊖⊖** **10.7: Consensus-based recommendation** Quality objective: Participation in cervical cancer screening as often as possible

Quality indicator	Reference Recommendation	Evidence base/further information
	HR-HPV test or p16/Ki-67 detection is positive, a colposcopic clarification should be carried out within 3 months. If the clarification tests are negative, a cytological and HPV check should be carried out after 12 months. b) In the case of group III-x*, III-e* and III-g findings, an endometrium-specific examination should be performed to rule out endometrial neoplasia (vaginal sonography, hysteroscopy, fractional abrasion, etc.).	
PrevZxCa 2: HPV and Pap smear as part of screening		
Numerator Women with HPV and Pap smear within organised screening **Denominator** All women with HPV and/or Pap smears	None	Quality target: HPV and Pap smear as frequently as possible within the screening programme
PrevZxCa 3: Repeat Pap test during screening		
Numerator Women who have a repeat Pap test within 36 months of their first test **Denominator** All women who participated in cervical cancer screening and had a normal Pap test	None	Quality target: Repeat Pap test as often as possible within 36 months after a normal Pap test in screening

Quality indicator	Reference Recommendation	Evidence base/further information
PrevZxCa 4: Differential diagnostic test following screening result requiring clarification		
Numerator Women with subsequent differential diagnostic test (HPV, cytology, colposcopy, p16/Ki67) **Denominator** All women with a cervical cancer screening result requiring clarification	None	Quality objective: Differential diagnostic test as often as possible after unclear results of cervical cancer screening
Note: Result requiring clarification = Pap IIID2, IVa-p, IVa-g, IVb-p, IVb-g, V-p, V-g, V-e and V-x		
PrevZxCa 5: Treatment following abnormal differential diagnostic test in screening		
Numerator Women who received treatment within 6 months of an abnormal test result **Denominator** Women with abnormal differential diagnostic test in screening and thus indication for treatment	None	Quality target: Therapy as often as possible within 6 months of abnormal differential diagnostic test in screening
PrevZxCa 6: Diagnostic colposcopy in cases of abnormal Pap smear in certified dysplasia unit/consultation		
Numerator Patients with diagnostic colposcopy due to Pap IIID2, IVa-p, IVa-g, IVb-p, IVb-g, V-p, V-g, V-e and V-x in DKG/DGGG/AGO/AG-CPC/EFC certified dysplasia consultation/ Dysplasia unit **Denominator** All patients with Pap IIID2, IVa-	**10.8** In the case of findings in groups IIID2, IVa-p, IVa-g, IVb-p, IVb-g, V-p, V-g, V-e and V-x in organised cytological screening, a colposcopic examination should be carried out. **11.4**	**10.8: Consensus-based recommendation** **11.4: Consensus-based recommendation** Quality objective: Diagnostic colposcopy should be performed as often as possible for Pap IIID2, IVa-p, IVa-g, IVb-p, IVb-g, V-p, V-g, V-

Quality indicator	Reference Recommendation	Evidence base/further information
p, IVa-g, IVb-p, IVb-g, V-p, V-g, V-e and V-x	Colposcopy should be performed as a diagnostic colposcopy in a dysplasia consultation/dysplasia unit certified in accordance with the requirements of the DKG/DGGG/AGO/AG-CPC/EFC.	e and V-x in a certified dysplasia clinic/dysplasia unit. 10.8 and : GCP
PrevZxCa 7: Preoperative diagnostic colposcopy prior to excision		
Numerator Patients with one excision who underwent diagnostic colposcopy preoperatively **Denominator** All patients who underwent excision of the cervix uteri	None	Quality objective: Preoperative diagnostic colposcopy prior to excision as often as possible
Note: The representatives of the AG QI see potential for improvement in the implementation of diagnostic colposcopy in everyday clinical practice, not only in the area of screening but also in the area of therapy.		
PrevZxCa 8: Knife conisation as an excision procedure		
Numerator Patients with excision using knife conisation **Denominator** All patients who underwent excision of the cervix uteri	**14** Loop excision and laser excision should be the methods of choice for the treatment of squamous and glandular cervical intraepithelial neoplasia.	**GRADE: ⊕⊖⊖⊖** Quality target: <10% Knife conisation should be used as an excision procedure as rarely as possible. A, ⊕⊖⊖⊖
PrevZxCa 9: CIN 3 in the excision margin after excision		
Numerator Number of patients with CIN 3 in the resection margin **Denominator** All patients with excision and histological finding of CIN 3	**14.13** R0 resection of CIN 3 should be the goal.	**Consensus-based recommendation** Quality target: rare CIN 3 in the excision margin after excision should be as rare as possible.

Quality indicator	Reference Recommendation	Evidence base/further information
		A, ⊕⊖⊖⊖
PrevZxCa 10: HPV test and cytology after treatment of CIN 3		
Numerator Patients with HPV test and cytology within 12 months after treatment **Denominator** All patients 12 months after treatment (excision or ablation) of a first-time CIN 3 disease	**16** In follow-up care after treatment of CIN/ACIS, a combined examination with HPV test and cytology should be performed.	**GRADE: ⊕⊕⊖⊖** Quality objective: HPV testing and cytology as frequently as possible within 12 months after treatment of CIN 3 A, ⊕⊕⊖⊖

32 Psycho-oncology

(Version 2.1, 01.09.2023)

Quality indicator	Reference Recommendation	Evidence base/further information
PSO 1: Structural requirements for psycho-oncological care areas: Cross-sector coordination of psycho-oncological care (since 2014)		
Numerator Patients in the denominator who receive information about psycho-oncological support services **Denominator** All cancer patients with a primary diagnosis, recurrence or first distant metastasis	**4.10** Patient-oriented information about psycho-oncological support services should be provided at an early stage and throughout the course of the disease.	**Consensus-based recommendation**
Note Additional comments: Definition of "psycho-oncological support services": psychosocial counselling, individual or group psychotherapeutic intervention, psychoeducational intervention, couples intervention, relaxation techniques, carried out by appropriately qualified persons. The aim of the indicator: The institution should provide patients with specific contact persons as reference examples. This is intended to encourage the formation of networks within and across institutions.		
PSO 2: Structural requirements for psycho-oncological care areas: Self-help (modified 2022)		
Numerator Patients in the denominator who have received information about cancer self-help support services **Denominator** All cancer patients with a first diagnosis, recurrence or first distant metastasis of	**4.7** Cancer patients and their relatives should be informed about qualified support services offered by cancer self-help groups (discussions with other patients, assistance in dealing with the disease, therapies and the effects of therapy on everyday life) at at every stage of the care process.	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Additional note: The information can be provided in a flyer, which should be handed out in person. The relevant institution should specify in the flyer where each service can be found and provide contact details.		
PSO 3: Diagnostics: Screening, diagnostic procedures (modified 2022)		
Numerator Patients in the denominator who have undergone psycho-oncological screening* **Denominator** Primary case patients + patients with newly occurring (local) recurrence and/or distant metastases	**7.4** Validated and standardised screening instruments should be used to assess psychosocial distress. The screening instruments to be used are the Distress Thermometer (DT), the Hospital Anxiety and Depression Scale (HADS), the Cancer Patient Distress Questionnaire (FBK), the Depression Module of the Patient Health Questionnaire (PHQ-9) or the Generalised Anxiety Disorder Scale-7 (GAD-7). **7.2** All cancer patients should be screened for psychosocial stress. **7.3** Psycho-oncological screening should be carried out as early as possible at appropriate intervals, when clinically indicated or when there is a change in a patient's disease status (e.g. recurrence or progression of the disease).	**7.4: LoE 1b** **7.2: Consensus-based recommendation** **7.3: Consensus-based recommendation** Literature on validated screening instruments with a defined cut-off: see chapter .1.
Note		

Quality indicator	Reference Recommendation	Evidence base/further information
Distress screening involves the use of a valid distress instrument (analogous to best practice [1] or the S3 guideline on psycho-oncological diagnosis, counselling and treatment of adult cancer patients: Distress Thermometer (DT), the Hospital Anxiety and Depression Scale (HADS), the Cancer Patient Distress Questionnaire (FBK), the depression module of the Patient Health Questionnaire (PHQ-9) or the Generalised Anxiety Disorder Scale-7 (GAD-7)		
PSO 4: Diagnostics: Diagnostic procedures (since 2014)		
Numerator Patients in the denominator with a diagnostic interview to assess psychosocial stress and psychological comorbidity **Denominator** All cancer patients with a first diagnosis, recurrence or first distant metastasis and with positive screening for psychosocial stress	**7.6** In the event of positive screening and/or subjective need for support, a diagnostic consultation should be offered to assess psychosocial stress, psychological comorbidity and the need for support and treatment.	**Consensus-based recommendation**
Note Definition of "diagnostic consultation": The diagnostic consultation involves the identification of psychosocial stress, mental disorders and other problems with the aim of describing existing problems and disorders and how they can be changed. In addition, it is clarified whether these problems are sub-syndromal or meet the criteria for a mental disorder. The clarification and classification of the existing problems and disorders is carried out in accordance with a classification system (ICD-10 or DSM IV), whereby, in the diagnosis of a clinically relevant comorbid disorder, the distinction from somatic complaints or an appropriate psychological reaction to the tumour disease as well as the appropriate consideration of the biological-organic consequences of cancer or treatment must be taken into account. Actors: Psycho-oncology specialists		
PSO 5: Psycho-oncological interventions: Concepts and general principles for the indication of psycho-oncological treatment (deleted version 2)		
Numerator	None	

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator		
PSO 6: Psycho-oncological interventions: Concepts and general principles for the indication of psycho-oncological treatment, psychosocial counselling (modified 2022)		
Numerator Patients in the denominator offered psychosocial counselling with a psychological and social focus **Denominator** Cancer patients with initial diagnosis, recurrence or first distant metastasis	**8.27** Psychosocial counselling with a psychological and social focus should be offered to cancer patients and their relatives in all phases of the disease as early as possible and in line with their needs. **8.2** Patients with no or low stress levels (as determined by screening and further diagnostics) should be offered or referred to patient-oriented information and psychosocial counselling.	**8.27: Consensus-based recommendation** **8.2: Consensus-based recommendation**
Note Additional note: Psychosocial counselling should be offered in person by social workers/social educators and psycho-oncology specialists (see QI 2: handing over a flyer in person). Actors: Social workers/social educators and psycho-oncology specialists		
PSO 7: Patient-centred communication: Training measures to improve the communication skills of practitioners and their effectiveness (modified 2022)		
Numerator All doctors and nursing staff with quality-assured training in communication skills to improve their communication skills **Denominator** All doctors and nursing staff working in oncology	**11.12** Doctors and other professionals working in oncology should participate in quality-assured training in communication skills to improve their communication competence.	**Consensus-based recommendation** Literature: Barth and Lannen (2011)

Quality indicator	Reference Recommendation	Evidence base/further information
Note Additional note: Continuing education and training measures for teaching specific communication skills: Postgraduate; number of teaching units must be verified (e.g. participant certificate). The training should last at least 3 days (24 hours). Reason for deviation of the QI from the guideline recommendation: In accordance with the prioritisation of measures in the National Cancer Plan, the focus is on doctors and nursing professionals, as these two professional groups are considered to be a priority in patient care. It can be assumed that psychotherapists have acquired communication and conversation skills during their respective basic training.		
PSO 8: Human resources (new in 2022)		
Numerator Cumulative full-time equivalents in psycho-oncology at the centre/non-certified clinic **Denominator** All cancer patients with the exception of prostate or melanoma patients with primary diagnosis, locoregional recurrence or secondary distant metastasis at the centre/non-certified clinic.	**12.2** In certified centres and non-certified clinics, a full-time psycho-oncology specialist should be made available for 300 cases per year for all oncological diagnoses with the exception of prostate or melanoma patients.	**Consensus-based recommendation** Target: ≥ 0.0033
Note: Note: The denominator must be adjusted for each specific organ per entity. Prostate and melanoma patients should also be cared for, but the requirement for one full-time psycho-oncologist for 300 cases per year does not apply.		
PSO 9: Suitable premises (new in 2022)		
Numerator Number of suitable rooms available for psycho-oncological consultations **Denominator**	**12.2** In certified centres and non-certified clinics, a full-time psycho-oncology specialist should be made available for 300 cases per year for all	**12.2: Consensus-based recommendation** **12.5: Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
Full-time equivalents Psycho-oncology = Cancer patients with the exception of prostate or melanoma patients with a primary diagnosis, locoregional recurrence or secondary distant metastasis * 0.0033 in the centre / in the non-certified clinic	oncological diagnoses with the exception of prostate or melanoma patients. **12.5** With regard to equipment, suitable premises should be provided to enable undisturbed and confidential psycho-oncological counselling and treatment.	
Note: Note: Suitable rooms = undisturbed counselling, furniture, confidential and pleasant atmosphere		

33 Thyroid carcinoma

(Version 1.0, 16 July 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Thyr 1: Ratio of tumour-affected to examined lymph nodes		
Numerator Patients in the denominator with indication of the ratio of "tumour-affected to total examined lymph nodes" **Denominator** All patients with a primary diagnosis of thyroid carcinoma with resection and histopathologically examined lymph nodes	**4.** The histopathological findings should list the number of tumour-affected lymph nodes in relation to the total number of lymph nodes examined.	**Consensus-based recommendation**
Note: Quality objective: Where possible, state the ratio of "tumour-affected to total examined lymph nodes" as frequently as possible.		
Thyr 2: No histological confirmation of anaplastic thyroid carcinoma (ATC) or intrathyroidal lymphoma by fine needle biopsy		
Numerator Patients in the denominator with fine needle biopsy **Denominator** All patients with a primary diagnosis of anaplastic thyroid carcinoma or intrathyroidal lymphoma.	**4.11** If anaplastic thyroid carcinoma or lymphoma is suspected, a fine needle biopsy should not be performed; instead, histological confirmation should be obtained, e.g. by punch biopsy.	**Consensus-based recommendation**
Note: Quality objective: If possible, no histological confirmation of anaplastic thyroid carcinoma or lymphoma by fine needle biopsy		

Quality indicator	Reference Recommendation	Evidence base/further information
Thyr 3: Specification of TNM classification, histological type and extranodal tumour growth in histopathological findings report		
Numerator Patients in the denominator with all information in the histopathological report: - Staging according to the current TNM classification of the UICC - Classification of histological types of thyroid carcinoma according to the current WHO classification, histological subtypes if applicable - insofar as they are described in the current WHO classification. - Capsule-transcending growth of lymph node metastases. **Denominator** All patients with a primary diagnosis of thyroid carcinoma and resection	**4.24** The following information should be provided in the pathological findings of surgical specimens: Staging according to the current TNM classification of the UICC. Classification of the histological types of thyroid carcinoma according to the current WHO classification, including histological subtypes, if applicable, as described in the current WHO classification. Capsule-transcending growth of lymph node metastases.	**Consensus-based recommendation** Strong
Note: Quality objective: Complete findings reports as often as possible, including TNM classification, histological subtype and capsular invasion of lymph node metastases.		
Thyr 4: Intraoperative neuromonitoring		
Numerator Patients in the denominator with intraoperative neuromonitoring (IONM) **Denominator** All patients with thyroid carcinoma and bilateral thyroid surgery	**5.3** Intraoperative neuromonitoring (IONM) should be used in bilateral thyroid surgery, preferably in the form of continuous intraoperative neuromonitoring in cases involving particular risk factors.	**LoE 1a** Evidence-based GRADE ⊕⊕⊖⊖

Quality indicator	Reference Recommendation	Evidence base/further information
Note: Quality objective: Intraoperative neuromonitoring should be used as often as possible during bilateral thyroid surgery.		
Thyr 5: Interdisciplinary recommendation on radioiodine therapy in the tumour board		
Numerator Patients in the denominator with pre-therapeutic presentation in the interdisciplinary tumour conference **Denominator** All patients with thyroid carcinoma and radioiodine therapy	**5.3** The recommendation for radioiodine therapy should be made on an interdisciplinary basis by the tumour board based on the clinical and histopathological findings.	**Consensus-based recommendation** Strong
Note: Quality objective: Recommendation for radioiodine therapy based on clinical and histopathological findings, as often as possible on an interdisciplinary basis in the tumour board		
Thyr 6: Postoperative calcitonin/CEA levels and molecular genetic analysis of the RET proto-oncogene in medullary thyroid carcinoma		
Numerator a) Patients in the denominator with pTNM and postoperative calcitonin and CEA levels (6-8 weeks after surgery) b) Patients in the denominator with molecular genetic germline analysis RET proto-oncogene **Denominator** All patients with initial diagnosis of medullary thyroid carcinoma (MTC) and surgery	**8.15** The following findings should be available for planning risk-adapted postoperative follow-up care for histologically and immunohistologically confirmed MTC: pTNM classification = staging Postoperative basal Ctn and CEA levels (6–8 weeks after surgery) Molecular genetic analysis for pathogenic germline variants in the RET proto-oncogene	**Consensus-based recommendation** Strong

Quality indicator	Reference Recommendation	Evidence base/further information
Note: As often as possible Determination of pTNM, calcitonin and CEA Molecular genetic germline analysis RET proto-oncogene		
Thyr 7: Molecular pathological examination of the RET gene in sporadic medullary thyroid carcinoma		
Numerator Patients in the denominator with molecular pathological examination of the tumour for somatic variants in the RET gene prior to systemic therapy **Denominator** All patients with metastatic sporadic medullary thyroid carcinoma (MTC), N1 and/or M1 and systemic therapy	**8.3** In patients with metastatic sporadic MTC, molecular genetic analysis of the tumour for the presence of a somatic variant in the RET gene should be performed prior to the start of systemic therapy with regard to the use of selective RET inhibitors and vandetanib.	**Consensus-based recommendation**
Note: Quality objective: Perform molecular pathological analysis for the presence of a somatic variant in the RET gene as often as possible before starting systemic therapy.		

34 Salivary gland tumours

(Version 1.0, 01.08.2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Sal 1: Intraoperative neuromonitoring during surgery on the parotid gland		
Numerator Patients in the denominator with intraoperative neuromonitoring **Denominator** All patients undergoing surgery on the parotid gland	**4.** Neuromonitoring and magnifying aids (magnifying glasses, surgical microscope) **should** be used in all procedures on the parotid gland.	**Consensus-based recommendation** , **Quality objective:** Neuromonitoring* should be used as often as possible during surgical procedures on the parotid gland *OPS code 5- or 5- or 5- or 15 (OPS version 2025)
Sal 2: Interdisciplinary tumour conference		
Numerator Patients with presentation at the interdisciplinary tumour conference[1] [1]Participants in tumour conference: maxillofacial surgery, ENT, radiotherapy, oncology, radiology, pathology **Denominator** All patients with malignant tumours of the salivary gland	**4.11** The treatment recommendation for malignant tumours of the salivary glands **should** be made in the interdisciplinary tumour conference, consisting of representatives from the specialist departments of oral and maxillofacial surgery, ear, nose and throat medicine, radiotherapy, oncology, radiology and pathology.	**Consensus-based recommendation** , (100%) **Quality objective:** Presentation of patients with malignant salivary gland tumours at the interdisciplinary tumour conference as often as possible
Sal 3: Psycho-oncological distress screening		
Numerator Patients in the denominator with psycho-oncological distress screening **Denominator** All patients with a primary	**4.1** From the time of diagnosis of a malignant salivary gland tumour, the patient **should** be offered counselling by the Department of Psycho-Oncology .	**Consensus-based recommendation** , **Quality objective:** ly offer psycho-oncological distress screening as often as possible to patients with a first

Quality indicator	Reference Recommendation	Evidence base/further information
diagnosis of malignant salivary gland tumour		diagnosis of malignant salivary gland tumours
Sal 4: R0 resection for carcinomas of the parotid gland		
Numerator Patients in the denominator with R0 resection **Denominator** All patients with a primary diagnosis of parotid gland carcinoma without distant metastasis (M0) and surgical resection.	**4.14** The primary treatment for salivary gland carcinoma without distant metastasis is surgical resection, including removal of the surrounding salivary gland parenchyma, up to and including total parotidectomy (R0 resection).	**LoE 4** EG A, **Quality objective:** R0 resection of salivary gland carcinomas of the parotid gland as often as possible
Sal 5: Submandibulectomy and neck dissection for carcinomas of the submandibular gland		
Numerator Patients in the denominator with submandibulectomy and neck dissection (at least levels I-III) **Denominator** All patients with initial diagnosis of intracapsular carcinoma of the submandibular gland and surgical resection	**4.2** Malignant intracapsular carcinomas of the submandibular gland **should** be treated with submandibulectomy and neck dissection of levels I-III.	**Consensus-based recommendation** , **Quality objective:** Submandibulectomy and neck dissection of levels I-III* should be performed as often as possible in cases of intracapsular carcinoma of the submandibular gland *OPS code 5-40/.03/.04/.05, 5.-40, 5-40, 5-40 (OPS version2025)
Sal 6: Ipsilateral modified radical cervical lymph node dissection for ≥cN1		
Numerator Patients in the denominator with ipsilateral modified radical cervical lymph node dissection with **Denominator** All patients with clinically or	**4.25** If cervical lymph nodes are positive in pre-therapeutic diagnostics, a therapeutic, modified radical cervical lymph node dissection **should** be performed.	**LoE 4** EG A, **Quality objective:** Modified radical cervical lymph node dissection* should be performed as often as possible in cases of positive

Quality indicator	Reference Recommendation	Evidence base/further information
radiologically positive cervical lymph node findings (≥cN1) with malignant tumours of the salivary glands and surgical resection		cervical lymph node findings in pre-therapeutic diagnostics. *OPS code 5.-40, 5-40, 5-40 (OPS version 2025)
Sal: 7: Ipsilateral cervical lymphadenectomy for tumours of the parotid gland		
Denominator Pat. of the denominator with ipsilateral elective cervical lymphadenectomy **Denominator** All patients with tumours of the parotid gland with · high-grade histologies and/or · carcinoma with high-grade transformation and/or · Advanced tumour size (T3/T4) and/or · with extraparenchymal growth and surgical resection	**4.26** In cases of high-grade histologies and carcinomas with high-grade transformation, advanced tumour size (T3/T4) or tumours of the parotid gland with extraparenchymal growth, ipsilateral elective cervical lymphadenectomy **should** be performed even without evidence of cervical lymphogenous spread (cN0).	**LoE 4** EG A, . **Quality objective:** Ipsilateral elective cervical lymphadenectomy* as often as possible in patients with tumours of the parotid gland and high-grade histologies and/or carcinoma with high-grade transformation and/or advanced tumour size (T3/T4) and/or extraparenchymal growth *OPS code 5-40/.03/.04/.05, 5.-40, 5-40, 5-40 (OPS version 2025)
Sal 8: Postoperative radiotherapy		
Numerator Numerator of the denominator with postoperative radiotherapy **Denominator** All patients with salivary gland carcinoma with · T3-4 tumour and/or · high-grade tumour and/or · Presence of lymph node metastasis and/or · positive resection margin (<1 mm) and/or · perineural sheath infiltration and/or	**4.29** Postoperative radiotherapy **should** be performed in the following cases: At least one of the following risk factors is present : T3-4 tumour, high-grade tumour, presence of lymph node metastasis, positive resection margin (<1 mm), perineural sheath infiltration, lymphatic or blood vessel invasion (L1 or V1) all adenoid cystic carcinomas	**Consensus-based recommendation** , **Quality objective:** radiotherapy should be performed as often as possible in patients with salivary gland carcinoma with T3-4 tumours and/or with high-grade tumour and/or lymph node metastasis and/or

Quality indicator	Reference Recommendation	Evidence base/further information
· Lymphatic vessel/blood vessel invasion (L1 or V1) or adenoid cystic carcinoma and surgical resection	Postoperative radiotherapy **may** be performed in the following cases: Intermediate-grade tumours and narrow resection margin (1-3 mm).	positive resection margin (<1 mm) and/or Pn1 and/or L1 or V1 or adenoid cystic carcinoma and surgical resection
Sal 9: Total dose applied in definitive radiotherapy		
Numerator Patients in the denominator with application of a GD of ≥72 Gy (normofractionated) in the high-risk PTV (target volume) and ≥50 Gy in the elective PTV **Denominator** All patients with salivary gland carcinoma and radiotherapy as definitive therapy	**4.3** Dose prescription in the postoperative situation: In the high-risk PTV, a normofractionated dose of at least 60 Gy **should** be applied, and in the case of a narrow/positive resection margin and/or perineural sheath infiltration, a dose of at least 64-66 Gy should be applied. In elective PTV, a dose of 50 Gy **should** be administered. Dose prescription in the definitive situation: In high-risk PTV, a normofractionated dose of at least 72 Gy **should** be administered. In elective PTV, a dose of 50 Gy **should** be applied.	**Consensus-based recommendation** **Quality objective:** Application of ≥72 Gy (normofractionated) in high-risk PTV (target volume) and ≥50 Gy in elective PTV as often as possible in definitive radiotherapy for salivary gland carcinoma
Sal 10: Dental examination before radiotherapy or radiochemotherapy		
Numerator Numerator of the denominator with dental examination before the start of radiotherapy or radiochemotherapy	None	**Quality objective:** Application of ≥72 Gy (normofractionated) in high-risk PTV (target volume) and ≥50 Gy in elective PTV as often as possible during definitive

Quality indicator	Reference Recommendation	Evidence base/further information
Denominator All patients with malignant tumours of the salivary gland and radiotherapy or radiochemotherapy		radiation of salivary gland carcinoma

Note

Specific target **based on QPI5** (Healthcare Improvement Scotland and National Health Services Scotland, Head and Neck Cancer – Clinical QPI)

Numerator:
Number of patients with head and neck cancer undergoing treatment with curative intent who are identified by the Restorative Consultant and the MDT as requiring pre-treatment assessment and who have the assessment carried out before initiation of treatment.

Denominator:

All patients with head and neck cancer undergoing treatment with curative intent who are identified by the Restorative Consultant and the MDT as requiring pre-treatment assessment.

35 Supportive therapy

(Version 2.0, 16 May 2025)

Quality indicator	Reference Recommendation	Evidence base/further information
Supp 1: Antiemesis in highly emetogenic tumour therapy		
Numerator Patients administered 5-HT3 RA and NK1 receptor antagonist and dexamethasone prior to the first dose of drug therapy for cancer **Denominator** All patients who have completed highly emetogenic drug therapy for tumours	**5.13** **Low emetogenic – acute phase:** In drug-based tumour therapy with an emesis risk of 10–30%, antiemetic prophylaxis can be omitted or administered with dexamethasone, 5-HT_3receptor antagonist or metoclopramide.	**LoE 5** Level of evidence: A Level of evidence: 1a
Quality objective: Administer 5-HT3-RA, NK1 receptor antagonists and dexamethasone as often as possible before the first dose of drug therapy for tumours. **Comments** Highly emetogenic tumour therapy: Anthracycline/cyclophosphamide combination; carmustine, cisplatin, cyclophosphamide ≥ 1500 mg/m2, dacarbazine, mechlorethamine, streptozotocin, hexamethylmelamine, procarbazine		
Supp 2: Dental examination before bisphosphonates/denosumab		
Numerator Numerator: Number of patients with dental examination prior to initiation of bisphosphonate or denosumab therapy **Denominator** Denominator: All patients with malignant Tm (= breast, prostate, lung cancer) and bisphosphonate or denosumab therapy	**10.1** To prevent osteonecrosis of the jaw, a dental examination and any necessary dental treatment should be carried out before administering bisphosphonates or denosumab a dental examination and any necessary dental treatment, as well as instruction and motivation of patients on above-average	**LoE 1** EG A, LoE LA

Quality indicator	Reference Recommendation	Evidence base/further information
	(careful and regular) oral hygiene should take place and regular risk-adapted dental examinations should be carried out.	
Note: Quality objective: Dental examination as often as possible before starting bisphosphonate or denosumab therapy **Comments:** The dental examination also includes any necessary dental restoration.		
Supp 3: Dental examination before radiotherapy for head and neck tumours		
Numerator Numerator Patients with dental examination before the start of therapy **Denominator** Denominator All patients with KHT-Tm and curative radiotherapy	**11.74** The following measures should be taken to prevent osteoradionecrosis in the head and neck area: Before radiotherapy: Dental restoration under special precautions After radiotherapy: Dental restoration under special precautions, Masticatory rehabilitation with maximum protection of the mucous membrane and observance of special measures during dental/oral and maxillofacial surgery Very good oral hygiene before, during and after radiotherapy	**LoE 5**
Quality objective: Dental examination as often as possible before the start of therapy **Note:**		

Quality indicator	Reference Recommendation	Evidence base/further information
· The dental examination includes any necessary dental restoration · Head and neck tumours: All tumours in the head and neck area		

36 Cervical carcinoma

(Version 2.2, 29 March 2022)

Quality indicator	Reference Recommendation	Evidence base/further information
ZxCa 1: Presentation at tumour conference (reviewed in 2021)		
Numerator Number of patients presented at tumour conference **Denominator** All patients with initial diagnosis, recurrence or newly occurring distant metastasis of cervical carcinoma	**24** All patients with cervical carcinoma should be presented at an interdisciplinary tumour conference.	**Consensus-based recommendation** Quality objective: Presentation of patients at tumour conferences as often as possible
Note Participants in the tumour conference include gynaecological oncologists, pathologists, radiologists and radiation oncologists.		
ZxCa 2: Information in the findings report for initial diagnosis and tumour resection (reviewed in 2021)		
Numerator Number of patients with diagnostic reports containing information on: · histological type according to WHO · grading · Detection/absence of lymphatic or venous invasion (L and V status) · Detection/absence of perineural sheath infiltrates (Pn status) · Staging (pTNM and FIGO) in conised patients, taking into account the conisation findings · Depth of invasion and	**7.** The tumour classification of cervical carcinoma should be performed in accordance with the currently valid edition of the WHO classification. **7.3** The staging of cervical carcinoma should be performed according to the current edition of the TNM classification. **7.** The diagnosis of microinvasive cervical carcinoma should be	**7.1: Consensus-based recommendation** **7.3: Consensus-based recommendation** **7.4: Consensus-based recommendation** **7.10: Consensus-based recommendation** **7.11: Consensus-based recommendation** **7.12: Consensus-based recommendation** **7.15: Consensus-based recommendation** Quality objective:

Quality indicator	Reference Recommendation	Evidence base/further information
extent in mm for pT1a1 and pT1a2 · Depth of invasion in relation to cervical wall thickness (metric or percentage) in radical hysterectomy · Three-dimensional tumour size in cm (from pT1b1) · Minimum distance to resection margins (endocervical stroma for pT1b tumours) · R classification (UICC) **Denominator** All patients with a primary diagnosis of cervical carcinoma and tumour resection	based on the definition in the current edition of the WHO and TNM classifications. **7.10** Morphological analysis should be performed in such a way that all parameters relevant to treatment and prognosis can be recorded. The findings should be based on the currently valid WHO classification for tumour typing, the current TNM classification for staging and the R classification (UICC). **7.11** The findings report for trachelectomy should contain the following information: histological type according to WHO, grading, evidence/absence of lymphatic or venous invasion (L and V status), Evidence/absence of perineural sheath infiltrates (Pn status), staging (TNM), depth of invasion and extent in mm for pT1a1 and pT1a2, three-dimensional tumour size in cm (from pT1b1), minimum distance to resection margins (for pT1b tumours, endocervical stroma), R classification (UICC). **7.12**	reports as complete as possible for initial diagnosis of cervical carcinoma and tumour resection

Quality indicator	Reference Recommendation	Evidence base/further information
	Morphological analysis should be performed in such a way that all therapeutically and prognostically relevant parameters can be recorded. The findings should be based on the currently valid WHO classification for tumour typing and the current TNM classification for staging, as well as the R classification (UICC). **7.15** The findings report for radical hysterectomy should contain the following information: histological type according to WHO, grading, evidence/absence of lymphatic or venous invasion (L and V status), evidence/absence of perineural sheath infiltrates (Pn status), staging (TNM), taking into account the conisation findings in conised patients, Invasion depth and extent in mm for pT1a1 and pT1a2, Invasion depth in relation to cervical wall thickness (metric or percentage) Three-dimensional tumour size in cm (from pT1b1), Minimum distance to resection margins (for pT1b tumours: endocervical e stroma, pT2a tumours: vagina, pT2b: parametrium)	

Quality indicator	Reference Recommendation	Evidence base/further information
	R classification (UICC).	
ZxCa 3: Information in the diagnostic report for lymph node dissection (reviewed in 2021)		
Numerator Number of patients with diagnostic reports containing information on: · Number of affected lymph nodes in relation to removed lymph nodes · Assignment to the site of removal (pelvic/para-aortic) · Specification of the largest extent of the largest lymph node metastasis in mm/cm · Indication of the absence/presence of capsule rupture of the lymph node metastasis. · Evidence of isolated tumour cells or micrometastases **Denominator** All patients with cervical carcinoma and lymph node dissection	**7.17** In lymph node dissection specimens obtained during surgical treatment of cervical carcinoma, all removed lymph nodes should be examined histologically. **7.19** The detection of isolated tumour cells or micrometastases should be mentioned in the histological report and included in the TNM classification. **7.20** The findings report on the lymph nodes should contain the following information: Indication of the number of affected lymph nodes in relation to the number of lymph nodes removed, classified according to the location of removal (pelvic/para-aortic)	**7.17: Consensus-based recommendation** **7.19: Consensus-based recommendation** **7.20: Consensus-based recommendation** Quality objective: Complete diagnostic reports as often as possible for cervical carcinoma and lymph node dissection
ZxCa 4: Cytological/histological lymph node staging (reviewed in 2021)		
Numerator Number of patients with cytological/histological LN staging **Denominator** All patients with cervical carcinoma FIGO stage >= IA2 – IVA	**8.** Treatment should be based on the histological tumour stage, verified by intraoperative staging or interventional diagnostics .	**Consensus-based recommendation** Quality objective: Cytological/histological lymph node staging as often as

Quality indicator	Reference Recommendation	Evidence base/further information
		possible for cervical carcinoma FIGO stage >= IA2 – IVA
Note Cytological/histological LK staging = for diagnostics; no lymph node dissection.		
ZxCa 5: Radiochemotherapy containing cisplatin (reviewed in 2021)		
Numerator Number of patients with cisplatin-based radiochemotherapy **Denominator** All patients with a primary diagnosis of cervical carcinoma and primary radiochemotherapy	**10** In patients with cervical cancer, if primary radiotherapy is indicated from stage IB2 onwards, it should be administered in combination with cisplatin-based chemotherapy.	**LoE 1** EG A, Quality objective: Cisplatin-based radiochemotherapy should be used as often as possible in patients with a primary diagnosis of cervical carcinoma and primary radiochemotherapy.
ZxCa 6: Adjuvant radio(chemo)therapy (reviewed in 2021)		
Numerator Number of patients with adjuvant radio(chemo)therapy **Denominator** All patients with a primary diagnosis of cervical cancer and radical hysterectomy	None	Derived from a guideline objective: Survey of the status quo of medical care, in particular with reference to quality indicator 6 on adjuvant radio(chemo)therapy, as there is no data on how many patients receive stage-appropriate adjuvant treatment with combined cisplatin-based radio(chemo)therapy. Quality objective: current: recording the status quo; Long term: Reduction of adjuvant therapy in favour of primary surgery alone or

Quality indicator	Reference Recommendation	Evidence base/further information
		radio(chemo)therapy alone in the risk group (unimodal therapy)
ZxCa 7: Histological confirmation (reviewed in 2021)		
Numerator Number of patients with pre-therapeutic histological confirmation **Denominator** All patients with cervical carcinoma and treatment of local recurrence	**16** Routine monitoring of tumour markers for the diagnosis of recurrence should not be performed.	**Consensus-based recommendation** Quality objective: Pre-therapeutic histological confirmation as often as possible in patients with cervical carcinoma and treatment of local recurrence
ZxCa 8: Spread diagnostics in local recurrence (reviewed in 2021)		
Numerator All patients with imaging diagnostics (CT thorax and abdomen and scalene ultrasound) to rule out distant metastases **Denominator** All patients with local recurrence of cervical carcinoma	**17** In the event of local recurrence, appropriate imaging diagnostics should be performed to rule out distant metastases for the purpose of treatment planning.	**Consensus-based recommendation** Quality objective: Imaging diagnostics should be performed as often as possible in patients with local recurrence of cervical carcinoma.
ZxCa 9: Complete findings report for conisation (new in 2021)		
Numerator All patients in the denominator with findings reports containing Information on: · Type of lesion (CIN, AIS, SMILE)	**7.8** The histological report should note) the type of lesion (CIN, AIS and its variant in the form of stratified mucin-producing	**Consensus-based recommendation** Quality objective:

Quality indicator	Reference Recommendation	Evidence base/further information
· Location (endocervical, ectocervical) · Extent · in case of invasion, specifying size, lymphatic, blood vessel and perineural sheath invasion · Grading · Status of resection margins (R status) **Denominator** All patients with HSIL (CIN II/III), AIS, SMILE and/or cervical carcinoma who underwent conisation	lesion SMILE), its location (endocervical, ectocervical) and its extent, as well as the presence of an invasive tumour. If invasion is detected, the size of the lesion should also be specified and a statement made regarding lymphatic, blood vessel and perineural invasion as well as grading. A statement should be made regarding the status of the resection margins.	Complete findings report as often as possible for patients undergoing conisation
Note The indicator is to be collected by dysplasia units/clinics and gynaecological cancer centres.		

37 Oesophageal carcinoma

(Version 4.0, 18 December 2023)

Quality indicator	Reference Recommendation	Evidence base/further information
ECa 1: Information in biopsy reports (modified 2023)		
Numerator Patients in the denominator with findings reports containing information on: Type of neoplastic lesion (low-grade dysplasia/low-grade intraepithelial neoplasia, high-grade dysplasia/high-grade intraepithelial neoplasia, invasive carcinoma; for HGD/HGIEN: Tis classification according to UICC) histological type according to WHO, for invasive adenocarcinomas: grading according to current WHO classification, For biopsies from the distal oesophagus (C 15.5), indicate whether with goblet cell-containing Barrett's mucosa **Denominator** All patients with initial diagnosis of neoplasia of the oesophagus (D00.1, C15, C16.0) and biopsy	**6.20** The histopathological findings on the biopsy material should include the following information: Type of neoplastic lesion (LGD/LGIEN, HGD/HGIEN, carcinoma), in particular whether invasive carcinoma is present (for HGD/HGIEN: classification of biopsy specimen as Tis according to UICC) Histological type according to WHO (in particular, differentiation between squamous cell carcinoma and adenocarcinoma) For invasive adenocarcinomas: degree of differentiation (grading) according to the current WHO classification For lesions in the distal oesophagus: Is there a Barrett's mucosa containing goblet cells?	**Consensus-based recommendation**
Note: Quality objective: Complete pathology reports for biopsies as often as possible (Proposal for recording for 1 year in DKG-certified visceral oncology centres, followed by review of further requirements) Note: "Barrett's mucosa containing goblet cells" is not recorded in the ADT data set.		

Quality indicator	Reference Recommendation	Evidence base/further information
ECa 2: Information in the findings report for local excisions (modified 2023)		
Numerator Patients in the denominator with findings reports containing information on type of neoplastic lesion, histological type according to WHO, grading, lymphatic vessel and/or venous invasion, depth of invasion, information on circular and basal resection margins **Denominator** All patients with initial diagnosis of oesophageal neoplasia (D00.1, C15, C16.0) and endoscopic resection	**6.22** The histopathological findings on local excised tissue (endoscopic resection; ER) should include the following information: Size of the neoplastic lesion (in 3 dimensions if possible) Type of neoplastic lesion (LGD/LGIEN, HGD/HGIEN, carcinoma) – in particular, whether invasive carcinoma is present (for HGD/HGIEN: classification of the resected specimen as pTis according to UICC) If carcinoma is detected: histological type according to WHO (in particular, differentiation between squamous cell carcinoma and adenocarcinoma, other rare types) In the case of invasive adenocarcinomas: degree of differentiation (grading) according to current WHO classification Maximum depth of infiltration: pT1a (m1, m2, m3, m4)/pT1b (sm1, sm2, sm3) plus depth of infiltration in µm (or higher pT category) Lymphatic vessel and/or vein invasion (L0 vs. L1, V0 vs. V1) Summary assessment of the risk of lymph node metastasis: low risk vs. high risk Resection margins with regard to	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
	neoplasia (in the case of ER in toto, circular and basal resection margin; in the case of "piecemeal" ER, basal resection margin, as the circular resection margin must generally be assessed histopathologically as RX)	
Note: Quality objective: Complete pathology reports for excised specimens as often as possible To collect this indicator, data fields for specifying the circular and basal resection margins and the depth of invasion should be included in the specific module of the ADT's general basic data set. The size in three dimensions and the summary assessment of the LK metastasis risk cannot be documented.		
ECa 3: Information in the findings report after surgical resection (modified 2023)		
Numerator Pat. of the denominator with diagnostic reports containing information on size of the neoplastic lesion, type of lesion, histological type according to WHO, grading, pT, pN, ratio LK, L, V, R status (TNM) **Denominator** All patients with initial diagnosis of oesophageal neoplasia (D00.1, C15, C16.0) and surgical resection	**6.23** The histopathological findings from surgical resections should include the following information: Size of the neoplastic lesion (in 3 dimensions if possible) Localisation of the tumour centre in relation to the oesophagogastric junction (OGJ) and indication of whether the tumour crosses the OGJ (if possible) Type of neoplastic lesion (LGD/LGIEN, HGD/HGIEN, carcinoma) – in particular, whether carcinoma is present (for HGD/HGIEN: classification as pTis according to UICC) If carcinoma is detected: histological type according to the current WHO classification (in particular, distinction between squamous cell	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
	carcinoma and adenocarcinoma, other rare types) Degree of differentiation (grading) Maximum depth of infiltration (pT) Lymphatic vessel and/or vein invasion (L0 vs. L1, V0 vs. V1) Resection margins: oral, aboral and circumferential: R0 vs. R1 Status of regional lymph nodes according to current UICC classification (pN) and ratio of number of affected and examined lymph nodes (.../... lymph nodes)	
Note: Quality objective: Complete pathology reports for resected specimens as often as possible The location of the tumour centre in relation to the oesophagogastric junction (ÖGJ) and information on whether the tumour crosses the ÖGJ cannot be documented.		
ECa 4: Treatment recommendation from interdisciplinary tumour conference (modified 2023)		
Numerator Patients in the denominator with treatment recommendation from interdisciplinary tumour conference (for denominator groups 1 and 3: before treatment) **Denominator** 1 All patients with initial diagnosis of oesophageal neoplasia (D.00.1, C.15, C16.0) and completed staging 2 All patients with a primary diagnosis of	**8.** Treatment recommendations should be made in an interdisciplinary tumour conference. Staging information, patient comorbidities, nutritional status and patient preference should be taken into account as a basis for the treatment recommendation.	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
oesophageal neoplasia (D00.1, C15, C16.0) and completed surgery (endoscopic or surgical) 3 All patients with oesophageal neoplasia (D00.1, C15, C16.0) and recurrence and/or secondary distant metastasis		
Note: Quality objective: Pre-therapeutic presentation of all primary cases of oesophageal carcinoma as often as possible Postoperative presentation of all primary cases as often as possible Pre-therapeutic presentation of all patients with recurrence/metachronous metastasis as often as possible Only the first part of the recommendation was considered operationalisable. The guideline authors advocated that the participants in the tumour conference be determined by the DKG certification commission for visceral oncology centres. The primary case should be recorded.		
ECa 5: Complete endoscopic resection of intraepithelial neoplasia or early mucosal carcinoma in Barrett's oesophagus (modified 2023)		
Numerator Numerator of the denominator with R0 **Denominator** All patients with initial diagnosis of HGIEN/HGD or mucosal carcinoma (pT1sm1; <500 µm depth of invasion, L0, V0, G1/2, < 20 mm, no ulceration) and endoscopic resection	**8.2** **a** If high-grade intraepithelial neoplasia or mucosal carcinoma (L0, V0, no ulceration, grading G1/G2) is detected in Barrett's oesophagus, endoscopic resection should be performed, as this allows not only treatment but also staging of the lesion with regard to depth of infiltration. **b.** Therefore, endoscopic complete resection with curative intent should be the goal.	**Consensus-based recommendation**

Quality indicator	Reference Recommendation	Evidence base/further information
	c. In patients with superficial submucosal infiltration of adenocarcinoma and no risk criteria (pT1sm1; <500 µm depth of invasion, L0, V0, G1/2, < 20 mm, no ulceration), endoscopic resection may be a sufficient alternative to surgery. **d.** After successful resection of neoplasms in Barrett's oesophagus, the non-neoplastic Barrett's mucosa should be thermally ablated to reduce the rate of metachronous neoplasms .	
Note: Quality objective: Highest possible rate of endoscopic R0 resections Only parts a+b of the recommendation have been implemented. "No ulcerations" not reflected in documentation systems.		
ECa 6: Complete surgical resection (modified 2023)		
Numerator Patients in the denominator with R0 **Denominator** All patients with initial diagnosis of oesophageal neoplasia (D.00.1, C.15, C16.0) and surgical resection	**8.9** The aim of surgical resection in squamous cell carcinoma and adenocarcinoma is the complete removal of the tumour (oral, aboral and circumferential) and the regional lymph nodes.	**Consensus-based statement**
Note: Quality objective: Highest possible rate of surgical R0 resections		

Quality indicator	Reference Recommendation	Evidence base/further information
ECa 7: Preoperative chemoradiotherapy in operable patients with squamous cell carcinoma of the oesophagus (modified 2023)		
Numerator Patients in the denominator with preoperative chemoradiotherapy **Denominator** All patients with initial diagnosis of squamous cell carcinoma of the oesophagus (C15) cT3/cT4 or cN1-3 and surgical resection	**8.28** In operable patients with locally advanced **squamous cell carcinoma** of the oesophagus (category cT3/T4 resectable or category cN1-3), preoperative chemoradiotherapy followed by complete resection should be performed. See also recommendation 8.33 "Indication for definitive radiochemotherapy".	**LoE 1a**
Note: Quality objective: Highest possible rate of preoperative chemoradiotherapy in primary cases with cT3/cT4 or cN1-3 squamous cell carcinoma of the oesophagus Only the first part of the recommendation has been implemented. Caution: As the reference recommendation for the QI has been changed, the QI is suspended until the quality indicators have been updated.		
ECa 8: Perioperative chemotherapy or preoperative chemoradiotherapy in operable patients with adenocarcinoma of the oesophagus (modified 2023)		
Numerator Patients in the denominator with perioperative chemotherapy or preoperative chemoradiotherapy **Denominator** All patients with initial diagnosis of adenocarcinoma of the oesophagus (C15, C.16.0) and cT3/cT4 or cN1-3 and surgical resection	**8.25** Operable patients with locally advanced **adenocarcinoma** of the oesophagus or oesophagogastric junction (category cT3/T4 resectable or category cN1-3) should undergo perioperative chemotherapy or preoperative chemoradiotherapy.	**LoE 1a** Level of evidence 1a
Note: Quality objective:		

Quality indicator	Reference Recommendation	Evidence base/further information
Highest possible rate of perioperative chemotherapy or preoperative chemoradiotherapy in primary cases with cT3/cT4 or cN1-3 adenocarcinoma of the oesophagus Caution: As the reference recommendation for the QI has been changed, the QI is suspended until the quality indicators have been updated.		
ECa 9: Systemic therapy of metastatic adenocarcinoma of the oesophagus (modified 2023)		
Numerator Patients in the denominator receiving systemic therapy (first line) **Denominator** All patients with a primary diagnosis of metastatic adenocarcinoma of the oesophagus (C15, C16.0, M1)	**9.2** Patients with metastatic or locally advanced, non-curatively treatable **adenocarcinoma** of the oesophagus and oesophagogastric junction should be offered systemic therapy. The aim of therapy is to prolong survival and maintain quality of life.	**LoE 1a** Evidence level 1a
Note: Quality objective: Adequate rate of systemic first-line chemotherapy administration in metastatic adenocarcinoma of the oesophagus		
ECa 10: Anastomotic leakage after surgical resection (modified 2023)		
Numerator Patients in the denominator with anastomotic leakage who were treated endoscopically, interventionally or surgically **Denominator** All patients with a primary diagnosis of oesophageal neoplasia (D.00.1, C.15, C16.0) and elective surgical resection	None Sources: [62]	Outcome indicator based on a corresponding QI from Belgium: "OC9: Proportion of patients experiencing anastomotic leakage after oesophagectomy" Classification of anastomotic leakage into I-III. I=locally defective, no change in therapy, only medication or diet modification II: Localised defect requiring intervention, but no surgery, e.g. IR drain, stent or bedside opening

Quality indicator	Reference Recommendation	Evidence base/further information
		III: Localised defect requiring surgical therapy – to be recorded Definition as in Low et al, International Consensus on Standardisation of Data Collection for Complications Associated With Oesophagectomy: Oesophagectomy Complications Consensus Group (ECCG)., 2015
Note: Quality objective: Lowest possible rate of re-interventions due to anastomotic leakage after elective procedures on the oesophagus Outcome indicator based on a corresponding QI from Belgium: "OC9: Proportion of patients experiencing anastomotic leakage after oesophagectomy" Proposal by Prof. Hölscher: Classification of anastomotic leakage into I-III. I= locally defective, no change in therapy, only medication or diet modification II: Localised defect requiring intervention, but no surgery, e.g. IR drain, stent or bedside opening III: Localised defect requiring surgical therapy – to be recorded		
ECa 11: 11.1 and 11.2: Mortality after surgery		
Numerator Numerator 11.1: Number of patients who died postoperatively after 30 days Numerator 11.2 Number of patients who died postoperatively after 90 days **Denominator** Denominator 11. 1+11.2: All patients with neoplasia of the oesophagus (D.00.1, C.15x, C16x) and surgery (surgical resection OPS	None Sources: [63], [64], [65]	Based on the following publications: Mortality rate: 90 days better than 30 days to measure (Walters, D.M., et al. 2014; Talsma, A.K., et al. 2014)

Quality indicator	Reference Recommendation	Evidence base/further information
5.422.0, all 5.423, 5.424, 5.425, 5.426)		
Note Outcome indicator based on a corresponding QI from Belgium: OC6: Oesophageal resection mortality rate within 30 days (Vlayen Joan, et al. 2013)		
ECa 12: HER2/PD-L1 determination in metastatic adenocarcinoma of the oesophagus (new 2023)		
Numerator Numerator Patients with HER2 and PD-L1 CPS testing prior to initiation of systemic therapy **Denominator** All patients with initial diagnosis of adenocarcinoma of the oesophagus (C15, C16.0) and M1 and palliative systemic therapy	**9.3** Before initiating palliative systemic therapy, HER2 status should be determined as a predictive factor for therapy with trastuzumab and PD-L1 CPS as a predictive factor for therapy with an immune checkpoint inhibitor.	**Consensus-based recommendation**
Note: Quality objective: Testing for HER2 and PD-L1 CPS as often as possible in metastatic adenocarcinoma of the oesophagus and palliative systemic therapy.		
ECa 13: PD-L1 determination in metastatic squamous cell carcinoma (new 2023)		
Numerator Numerator Denominator with PD-L1 CPS and PD-L1 TPS testing before initiation of systemic therapy **Denominator** All patients with initial diagnosis of squamous cell carcinoma of the oesophagus (C15) and M1 and palliative systemic therapy	**9.** Before initiating palliative systemic therapy, PD-L1 CPS and PD-L1 TPS should be determined as predictive factors for therapy with an immune checkpoint inhibitor.	**Consensus-based recommendation**
Note: Quality objective:		

Quality indicator	Reference Recommendation	Evidence base/further information
Testing for PD-L1 CPS and PD-L1 TPS as often as possible in cases of metastatic squamous cell carcinoma of the oesophagus and palliative systemic therapy.		

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