

**A Comprehensive Approach to
International Cancer Survival Benchmarking
SurvMark-2**

Call for Data

Data specification

June 2016

The deadline for data submission will be **15 September 2016** and it is essential that this is respected.

Summary

General Information

- SurvMark-2 will produce cancer survival estimates for cancer diagnoses between 1 January 1995 to 31 December 2014, with follow-up information on vital status up to 31 December 2015. Registries are invited to contribute data for all 20 years, but that is not a requirement. SurvMark aims to provide the most up-to-date measures of cancer survival, incidence and mortality, but some registries may not yet have complete incidence and follow-up data for patients diagnosed as recently as 2014.
- **Eight index cancers** will be considered in this project: oesophagus, stomach, colon, rectum, liver, pancreas, lung, and ovary.
- The **deadline** for data submission is **15 September 2016**.

Checklist of Items Required

1. **Incidence data**, as a listing of individual cancer cases
2. **Population data**, from official censuses or intercensal/post-censal estimates
3. **Mortality data**, from official vital statistics offices
4. **Population life tables**, containing survival probabilities for all-cause mortality
5. **A coding file**, if the coding rules differ from those requested in this document

Data Quality and Coding

Incidence data should be verified and corrected prior to submission using, for example, [IARCcrgTools](#). Note that for some combinations of site/morphology/behavior, accurate recoding requires a decision to provide corrections. Users can use the IARC flag variable to mark validated records.

File Format and Data Submission

Please submit separate files for incidence, population, mortality and life table data. The datasets should be field-separated using any of the following: comma, semi-column, tab or pipe character (|). A fully automated and secured mechanism has been set up for submissions to CI5-XI at <https://cinportal.iarc.fr>. All registries are requested to use this facility for the submission of files and for completion of the questionnaire. Files should not be zipped together but may be zipped individually (if they are large). They may be protected by a password which is then to be provided on the system.

Permission to Use Data

When submitting the data file through the above-mentioned registry portal, it is necessary to select the relevant box for the current call for data (i.e. **SurvMark-2**). **The box selected indicates that permission is granted to use the material submitted for those purposes**. Registries can be assured that the submitted data will not be used for purposes outside of the SurvMark-2 framework, without the explicit permission of the individual registry.

Please contact for any questions: survival@iarc.fr

1. Incidence Dataset

Data on all primary tumors diagnosed between 1995 and 2014 at the following eight index sites should be submitted: *oesophagus, stomach, colon, rectum, liver, pancreas, lung, and ovary*.

If your data are not coded in ICDO-3, please contact us before submitting the data.

Data should be submitted as a case listing (one case per line).

Required variables (mandatory variables are in bold and preceded by a *):

Name	Variable	Format	Unknown/ Missing	Definition, notes
INCIDENCE DATA				
*VAR1	Person Code	Numeric or alphanumeric	Not allowed	Registry assigned unique number for each person
*VAR2	Date of Birth	YYYY-MM-DD	9999-99-99	At least year must be coded
*VAR3	Sex	1= Male; 2= Female	9	
VAR4	Socio-economic group	Numeric	99	See definition of variables
VAR5	Ethnic group	Numeric	99	See definition of variables
*VAR6	Tumor Sequence	0= Single tumor 1= 1 st of multiple tumors 2= 2 nd of multiple tumors	999	If a patient has only one tumor then this variable should be coded "0". If the patient has multiple tumors then the numbering should start at "1"
*VAR7	IARC flag	Numeric, values 0-4	9	See definition of variables
*VAR8a	Date of incidence, source A	YYYY-MM-DD	9999-99-99	Date of <u>1st consultation at outpatient clinic</u> See definition of variables
*VAR8b	Date of incidence, source B	YYYY-MM-DD	9999-99-99	Date of <u>1st admission to hospital</u> See definition of variables
*VAR8c	Date of incidence, source C	YYYY-MM-DD	9999-99-99	Date of <u>1st diagnosis of cancer by a physician</u> See definition of variables
*VAR8d	Date of incidence, source D	YYYY-MM-DD	9999-99-99	Date of <u>1st pathology report</u> See definition of variables
*VAR8e	Date of incidence, source E	YYYY-MM-DD	9999-99-99	Date of <u>death</u> , when cancer is first ascertained from death certificate and trace-back was unsuccessful See definition of variables
*VAR8f	Date of incidence, source F	YYYY-MM-DD	9999-99-99	Date of <u>death</u> , preceding an autopsy See definition of variables
VAR9	Date of registration	YYYY-MM-DD	9999-99-99	Date when case was first recorded in the registry database

Name	Variable	Format	Unknown/ Missing	Definition, notes
*VAR10	Age in years	Numeric	999	Last completed year of age at the time of diagnosis
*VAR11	Detection during screening	1=Screen-detected 2=Other	9	Detection of non-symptomatic cancer in an organised population-based screening programme
*VAR12	Incidental finding of cancer at autopsy	1=Yes 2=No	9	
*VAR13	ICDO-3 Topography	4-character, starting with letter C	C999	ICDO-3 Definition, e.g. C504 See definition of variables
*VAR14	ICDO-3 Morphology	Numeric, values 8000-9989	9999	ICDO-3 Definition, e.g. 8410
*VAR15	ICDO-3 Behavior	0= Benign 1= Uncertain 2= Carcinoma in situ 3= Malignant	999	ICDO-3 Definition, e.g. 3 See definition of variables if your data include codes 6 & 9
*VAR16	Grade	Numeric, values 1-4	9	ICDO-3 Definition, See definition of variables
*VAR17	Most valid basis of diagnosis	Numeric, values 0-7	9	ICDO-3 Definition, See definition of variables
*VAR18	Last known vital status	1= Alive 2= Dead 3= Lost to follow-up	9	See definition of variables
*VAR19	Date of last known vital status	YYYY-MM-DD	9999-99-99	At least year must be coded, See definition of variables
*VAR20	Cause of death	3-character	999	Code of underlying cause of death, e.g. C61; should only be coded if VAR18=2
*VAR21	ICD edition	6= ICD-6 7= ICD-7 8= ICD-8 9= ICD-9 10= ICD-10	99, only allowed if VAR20=999	Coding system used for cause of death
<p>DATA ON STAGE AT DIAGNOSIS Please provide as much data on tumor stage at diagnosis (i.e. before neo-adjuvant treatment) as possible and as provided to your cancer registry. If you have any questions, please contact us before submitted the data.</p>				
*VAR22	SEER summary staging 2000	Numeric, Values 0-7	9	Clinical extent of disease, See definition of variables
*VAR23	Grouped TNM	1= stage I 2= stage II 3= stage III 4= stage IV	9	Summary stage, See definition of variables
*VAR24	Pathological T	alphanumeric	pTX	UICC, e.g. pT0, pTis, pT1a, pT2
*VAR25	Pathological N	alphanumeric	pNX	UICC, e.g. pN0, pN2b, pN3
*VAR26	Pathological M	alphanumeric	pMX, not allowed if VAR30=7	UICC, e.g. pM1, pM1a See definition of variables
*VAR27	Clinical T	alphanumeric	cTX	UICC, e.g. cT0, cTis, cT1a, cT2
*VAR28	Clinical N	alphanumeric	cNX	UICC, e.g. cN0, cN2b, cN3

Name	Variable	Format	Unknown/ Missing	Definition, notes
*VAR29	Clinical M	alphanumeric	cMX, not allowed if VAR30=7	UICC, e.g. cM0, cM1 See definition of variables
*VAR30	TNM reference	5= UICC 5 th edition 6= UICC 6 th edition 7= UICC 7 th edition	99	TNM edition used
*VAR31	Condensed T	1= localized 2= advanced	9= X	UICC 6 th edition/ENCR See definition of variables
*VAR32	Condensed N	1= N0 2= N+	9= NX	UICC 6 th edition/ENCR See definition of variables
*VAR33	Condensed M	1= M0 2= M+	9= MX	UICC 6 th edition/ENCR See definition of variables
VAR34	Dukes' stage	1= Dukes' stage A 2= Dukes' stage B 3= Dukes' stage C 4= Dukes' stage D	9	For cancers of the colon and rectum only, See definition of variables
VAR35	FIGO stage	1= FIGO stage I 2= FIGO stage II 3= FIGO stage III 4= FIGO stage IV	9	For cancers of the ovary only, See definition of variables
*VAR36	Tumor size	in mm (values 1-300)	999	e.g. 35 (for a tumor with diameter of 3.5 cm)
*VAR37a	No. of lymph nodes examined	Numeric, values 0-98	999	No. of lymph nodes examined (from pathological record)
*VAR37b	No. of lymph nodes involved	Numeric, values 0-98	999	UICC 7 th edition, no. of lymph nodes containing tumor cells (from pathological record)
VAR38	C-factor	Numeric, values 1-5	9	ENCR recommendation, See definition of variables
<p>DATA ON TREATMENT AND COMORBIDITY <i>The following variables are related to the first course of anticancer therapy after diagnosis. Purely symptomatic therapy (e.g. bypass surgery, pain relief) should not be included. Please provide as much data on the following variables as possible and as provided to your cancer registry. If you have any questions, please contact us before submitted the data.</i></p>				
VAR39a	Surgery	1= administered 2= not administered	9	Non-investigative surgery within 6 months of diagnosis
VAR39b	Radiotherapy	1= administered 2= not administered	9	Radiotherapy within 6 months of diagnosis, including adjuvant radiotherapy
VAR39c	Systemic therapy	1= administered 2= not administered	9	Systemic therapy (e.g. chemotherapy) within 6 months of diagnosis, including adjuvant systemic therapy
VAR39d	Hormone Therapy	1= administered 2= not administered	9	Hormone therapy within 6 months of diagnosis, including adjuvant hormonal therapy
VAR40	Date of first course of treatment	YYYY-MM-DD	9999-99-99	Date when first course of treatment was performed
VAR41	Comorbidity index	Numeric	999	Charlson comorbidity index, Elixhauser comorbidity score See definition of variables

Definition of variables

VAR4 Socio-economic group (optional)

If the registry data permits analysis by socio-economic group, the relevant categories should be appropriately coded in all four files using the same sub-populations: the Incidence, Population, Mortality and lifetable file. When information on socio-economic group is provided, a description of the codes used must also be submitted.

VAR5 Ethnic group (optional)

If the registry data permits analysis by ethnic group, the relevant categories should be appropriately coded in all four files using the same sub-populations: the Incidence, Population, Mortality and lifetable file. When information on ethnic group is provided, a description of the codes used must also be submitted.

VAR7 IARC flag

Please use this variable to indicate which records have already been checked, for example using [IARCcrgTools](#). This would greatly reduce the processing time and avoid unnecessary request for verifications to your registry.

Code	Description
0	Failed
1	Tumor record has not been checked with IARC CHECK
2	Tumor record has been checked with IARC CHECK; no error(s) or warning(s)
3	Tumor record has been checked with IARC CHECK; any error(s) or warning(s) has been corrected
4	Tumor record has been checked with IARC CHECK; no change was made because the registry has confirmed that the original record was correct
9	This variable will not be provided

VAR8a-f Date of incidence, by source

The date of incidence can be obtained from several sources and has been found to partly explain differences in 1-year survival estimates during the first phase of ICBP. In order to allow for valid comparisons and adjustments based on date of incidence, you are asked to provide as many of the following dates as possible:

VAR8a Date of 1st consultation at outpatient clinic because of this malignancy

VAR8b Date of 1st admission to hospital because of this malignancy

VAR8c Date of 1st diagnosis of cancer by a physician

VAR8d	Date of 1st pathology report (histological or cytological confirmation) of this malignancy (with the exception of histology or cytology at autopsy)
VAR8e	Date of death, when cancer is first ascertained from death certificate and trace-back was unsuccessful
VAR8f	Date of death, if the cancer is discovered at autopsy

VAR13 ICDO-3 Topography

Tumor site should be coded to ICDO-3. Please provide the full 4-character ICDO-3 code, but **without the decimal point**. The anatomic subsite of the **eight index cancers** will be coded as followed:

Oesophagus: C150-C155; C158-C159

Stomach: C160-C166; C168-C169

Colon: C180-C189; C199

Rectum: C209; C210-C212; C218 (includes anus and anal cancer)

Liver: C220-C221 (includes intrahepatic bile ducts)

Pancreas: C250-C254; C257-C259

Lung: C339; C340-C343; C348-C349 (includes trachea)

Ovary: C480-C482; C488; C569; C570-C574; C577-C579 (includes peritoneum and retroperitoneum, fallopian tubes and other and unspecified female genital organs)

VAR15 ICDO-3 Behavior

Please include records for all neoplasms (**behavior codes 0-3**) diagnosed at one of the index sites when submitting your data. Please do not select tumors for inclusion in your data files on the basis of tumor behavior.

If your data do include behavior codes **6** (malignant, metastatic site) and **9** (malignant, uncertain whether primary or metastatic site), please do not recode them before data submission. Instead, please provide us with a description of how the codes have been used in your data.

VAR16 Grade

Histological grade (or differentiation) is a major prognostic factor for several cancers. It is only applicable for malignant tumors. It should reflect the highest differentiation recorded in the diagnostic statement or pathological report, i.e. the one with the most adverse prognostic significance (Rule G in ICD-O-3).

If you do not collect data on histological grade or differentiation, please use the code 9 for this variable in all tumor records.

Code	Description
1	Grade I – Well differentiated, <i>or</i> Differentiated, NOS
2	Grade II – Moderately differentiated, <i>or</i> Moderately well differentiated, <i>or</i> Intermediate differentiation
3	Grade III – Poorly differentiated
4	Grade IV – Undifferentiated, <i>or</i> Anaplastic
9	Grade or differentiation not determined, <i>or</i> not stated, <i>or</i> not applicable, <i>or</i> no pathology was performed

VAR17 Most valid basis of diagnosis

This variable indicates the degree of certainty with which a diagnosis of cancer has been established, in the specific context of survival analyses. The IARC recommends the following coding:

Code	Description	Criteria
0	Death certificate only	Information provided is from a death certificate.
Non-microscopic		
1	Clinical	Diagnosis made before death, but without any of the following (codes 2-7).
2	Clinical investigation	All diagnostic techniques, including X-ray, endoscopy, imaging, ultrasound, exploratory surgery (such as laparotomy), and autopsy, without a tissue diagnosis.
3	Specific tumor markers	Including biochemical and/or immunologic markers that are specific for a tumor site.
Microscopic		
5	Cytology	Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.
6	Histology of a metastasis	Histologic examination of tissue from a metastasis, including autopsy specimens.
7	Histology of a primary tumor	Histologic examination of tissue from primary tumor, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumor.
9	Unknown	

VAR18 Last known vital status

This variable encodes the patient's last known vital status, to the extent that it is known to the cancer registry.

VAR19 Date of last known vital status

Date of last contact is the date when the patient was last confirmed to be either alive or dead. This is not the date when an attempt for contact was made, if the current vital status could not be confirmed.

If the patient is **dead**, the date of last known vital status should be the **date of death**. If the patient has been **lost to follow-up**, the date of last known vital status should be the **date of loss to follow-up**. If the patient is considered to be **alive**, but not emigrated or lost to follow-up, the date of last known vital status should be **31 December 2015** (last year for which follow-up of all patients is believed to be complete).

VAR20 Cause of Death

Should be obtained from linkage with vital statistics and should only be coded if the patient is dead. Please provide the ICD edition if other than ICD-10 has been used.

VAR22 SEER summary Stage 2000

SEER summary Stage 2000 is a simple categorization of stage, developed by the US National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) programme (for more information, please refer to <http://seer.cancer.gov/tools/ssm/>).

Code	Description
0	<i>In situ</i>
1	Localized only
2	Regional spread by direct extension only
3	Regional lymph nodes involved only
4	Regional spread by both direct extension and lymph node involvement
5	Regional, NOS (regional spread, but route of spread is unknown)
7	Distant site(s) or lymph node(s) are involved
9	Unknown if there is an extension or metastasis (or DCO case)

VAR23 Grouped TNM

If for some patients only grouped TNM stage values I-IV are available, this variable should be coded as outlined.

VAR26/29 Pathological and Clinical M

These variables encode information on the presence of absence of distant metastases. **Please note that the codes pMX and cMX have been deleted from the TNM 7th edition.** The use of MX may result in exclusion from staging due to not valid code.

VAR 26 (pathological M): According to the TNM 7th edition, the presence of a distant metastasis proven microscopically (e.g. needle biopsy) should be coded as pM1 (pM1a or pM1b for colon, rectum and lung cancer). If a clinically proven metastasis (cM1) is biopsied and is negative, it becomes **cM0** (VAR29), **not pM0**. Please note that the code pM0 and pMX are not valid in the TNM 7th edition.

VAR 29 (clinical M): In TNM 7th edition, cMX is inappropriate as the clinical assessment of metastasis can be based on physical examination alone. If the clinician does not record the

presence of metastases, it is assumed under the TNM 7th edition that no metastases are present (cM0) - such cases should be coded "0". The code cMX is no longer considered a valid code.

VAR31-33 Condensed TNM

Condensed TNM is based on the TNM 6th edition and reflects the best available information, clinical, instrumental or pathological. For T, the extent of the disease is classified as localized, regional or distant. For N and M, the presence (+) or absence (0) of spread to regional lymph nodes or metastatic deposits is classified.

For **VAR31 (Condensed T)**, the following coding should be used:

Code	Description
1	Localized disease, meaning: T1 and T2 for cancers of the oesophagus, stomach, colon, rectum, liver, pancreas and lung T1 for cancer of the ovary
2	Advanced disease, meaning: T3 and T4 for cancers of the oesophagus, stomach, colon, rectum, liver, pancreas and lung T2 and T3 for ovary
9	Cannot be assessed: no information on tumor size category

VAR34 Dukes' stage (for colon and rectal cancer only, optional variable)

Please only include data on Dukes' stage if your registry collects this information; do not recode data. If your registry collects Dukes' stage, please also provide the source of the data (pathology alone or clinical) used for its classification.

Dukes' stage is a specialized classification of tumor stage for cancers of the **colon and rectum only**. For all other index cancers, please assign the code 9 to every tumor record.

For cancers of the colon (C180-C189) and rectum (C199; C209; C210-C212; C218), the following codes should be used:

Code	Description
1	Dukes' stage A (equivalent to T1N0M0 or T2N0M0)
2	Dukes' stage B (equivalent to T3N0M0 or T4N0M0)
3	Dukes' stage C (equivalent to T(any)N1M0 or T(any)N2M0)
4	Dukes' stage D (equivalent to T(any)N(any)M1)
9	Dukes' stage missing , no information

VAR35 FIGO stage (for ovarian cancer only, optional variable)

Please only include data on FIGO stage if your registry collects this information; **do not recode data**. If your registry collects FIGO stage, please also provide the source of the data (pathology alone or clinical) used for its classification.

FIGO stage is a specialized classification of tumor stage for **ovarian** and other gynecological cancers **only**. For all other index cancers, please assign the code 9 to every tumor record.

For cancers of the ovary (C569) and Fallopian tube (C570), the following codes should be used:

Code	Description
1	FIGO stage I (A,B,C): tumor limited to one or both ovaries/fallopian tubes
2	FIGO stage II (A,B,C): tumor involves one or both ovaries/fallopian tubes with pelvic extension
3	FIGO stage III (A,B,C): tumor involves one or both ovaries/fallopian tubes with microscopically confirmed peritoneal metastasis outside the pelvis, and/or regional lymph node metastasis
4	FIGO stage IV : distant metastasis outside the peritoneal cavity
9	FIGO stage unknown

VAR38 C-factor (optional)

The C-factor, or certainty factor, reflects the validity of stage data for a given case, in relation to the diagnostic methods used to determine it. It refers to the diagnostic examinations carried out to detect or exclude local extension and distant metastases. The [ENCR recommendations](#) should be used for coding this variable:

Code	Description
1	C1 Evidence from standard diagnostic methods only
2	C2 Evidence obtained by special diagnostic means
3	C3 Evidence from surgical exploration, including biopsy and cytology
4	C4 Evidence following definitive surgery and pathological examination of the resected specimen
5	C5 Evidence from autopsy
9	Unknown

VAR39a-d First course of treatment (administered within 6 months of diagnosis) (optional)

VAR39a **Surgery**: includes any minor or major operation to remove all or part of the cancer, i.e. performed with therapeutic intent. Biopsy which is followed by definitive surgery should not be included; other biopsies, where the cancer is completely excised, can be included.

VAR39b **Radiotherapy**: includes any form of radiation administered pre-, intra- or post-operatively to treat or manage the patient's cancer. Any form of diagnostic imaging should **not** be included here.

VAR39c **Systemic therapy:** includes any form of systemic therapy that was administered pre- or post-operatively to treat or manage the patient's cancer, including treatment with cytotoxic chemotherapy, angiogenesis inhibitors and immunotherapy.

VAR39d **Hormone Therapy:** includes any form of hormone therapy that was administered pre- or post-operatively to treat or manage the patient's cancer

VAR41 **Comorbidity index** (*optional*)

If your registry collects data on comorbidity (e.g. the Charlson index or the Elixhauser comorbidity measure), please include the relevant score or index here and provide a description of the codes used in the coding file.

2. Population Dataset

The possible sources of population data are from official censuses, or from intercensal/postcensal estimates provided by Vital Statistics Departments or equivalent. Census data (with reference date) should be supplied for the period during, before and after the years covered in your dataset of cancer records (**1995-2015**). Any official estimates of the population made during the period should also be sent, preferably for each individual calendar year. If possible, population figures should give the mid-year (as of 1st July) estimates (or mid-period estimates) for each sub-category.

The population dataset, and the codes used in this file, should correspond to the cancer cases file with respect to ethnic and socio-economic groups, registration area, time period, sex and age.

Please also provide references to all sources of population data submitted.

Population data variables (mandatory variables are in bold and preceded by a *):

Name	Variable	Format	Unknown/ Missing	Definition, notes
*VAR1	Year	4 digits, YYYY	Not allowed	
*VAR2	Sex	1=Male 2=Female	Not allowed	
*VAR3	Age	numeric, year unit	Not allowed	
*VAR4	Number of residents	numeric	Not allowed	
VAR5	Ethnic group	numeric, same as incidence	99	See definition of variables
VAR6	Socio-economic group	numeric, same as incidence	99	See definition of variables

File format

Each line of the Population File should include the number of residents for a combination of calendar year, sex and age. Age should be provided as a single year if possible or as standard 18 age-groups otherwise, using the same age groups codes as for the incidence data (e.g. 1=0-4 years of age, 2=5-9 years of age, ... 17=80-84 years of age, 18=85+). The coding of the age groups should be appropriately adjusted and documented if there are less than 18 age groups available. Please provide the numbers of persons of unknown age if applicable.

3. Mortality Dataset

The mortality data should consist of all certified deaths from cancer among residents of the registration area during the same period as that covered by the incidence data, including follow-up (1995-2015).

Wherever possible, the mortality data should be the official cancer mortality data, as obtained from the Vital Statistics Department or equivalent and based on certificates/death records.

Mortality data variables (mandatory variables are in bold and preceded by a *):

Name	Variable	Format	Unknown/ Missing	Definition, notes
*VAR1	Year	4 digits, YYYY	Not allowed	
*VAR2	Sex	1=Male 2=Female	Not allowed	
*VAR3	Age	numeric, year unit	Not allowed	
*VAR4	Cause of death	3-character	Not allowed	Code of underlying cause of death, e.g. C61
*VAR5	ICD edition	6= ICD-6 7= ICD-7 8= ICD-8 9= ICD-9 10= ICD-10	Not allowed	Coding system used for cause of death
*VAR6	Number of deaths	numeric	Not allowed	
VAR7	Ethnic group	numeric, same as incidence	99	See definition of variables
VAR8	Socio-economic group	numeric, same as incidence	99	See definition of variables

File Format

Each line of the Mortality File should include number of deaths for a combination of calendar year, sex, age and cause of death (3 characters of the applicable ICD code, preferably ICD-10). Age should be provided as a single year if possible or as standard 18 age-groups otherwise, using the same age groups codes as for the incidence data (e.g. 1=0-4 years of age, 2=5-9 years of age, ... 17=80-84 years of age, 18=85+). The coding of the age groups should be appropriately adjusted and documented if there are less than 18 age groups available. The total number of deaths can be provided if no breakdown information by age-group is available.

4. Population life tables

The life table data should consist of all-cause mortality probabilities among residents of the registration area during the same period as that covered by the incidence data and follow-up years (1995-2015). The underlying mortality data should be obtained from the Vital Statistics Department or equivalent and based on certificates/death records.

Population life table data variables (all variables are mandatory):

Name	Variable	Format	Unknown/ Missing	Definition, notes
*VAR1	Year	4 digits, YYYY	Not allowed	Needs to be provided for all incidence and follow-up years (1995-2015)
*VAR2	Sex	1=Male 2=Female	Not allowed	
*VAR3	Age	Numeric, year unit	Not allowed	
*VAR4	Mortality probability	Numeric, 6 decimal places	Not allowed	

File Format

Each line of the Population life table file should include mortality probabilities for a combination of calendar year, sex and age. Age should be provided as a single year and if available, **additional lifetables** should be provided by **ethnic and socioeconomic group**, using the same coding as in the incidence dataset. Please also provide the **source for the life table data**.

5. Coding File

This file is to be used to supply details of any non-standard coding conventions used or to provide information on any unique codes specific to your registry. Examples of the possible contents:

- Changes in the registration coverage
- Local definition of incidence date
- Coding of basis of diagnosis that differs from the codes proposed in this document
- Coding of ethnic and/or socio-economic group
- Coding of comorbidity
- Description of the methodology used to derive population figures in the absence of published population data
- Any other information useful for processing the submitted dataset
- Any other information useful to evaluating the results

Downloads / Links

Software

- IARCcrgtools: [Download](#)

Websites

- International Association of Cancer Registries (IACR): [Access](#)
- International Agency for Research on Cancer (IARC): [Access](#)
- International Benchmarking Project (ICBP): [Access](#)
- Registries' portal: [Access](#)

Classifications and Coding

- International Classification of Diseases for Oncology (ICD-O-3): [Access](#)
- European Network of Cancer Registries (ENCR) Recommendations for Coding of Incidence Date: [Download](#)
- SEER Program Coding and Staging Manual: [Download](#)
- Multiple Primary rules: [IARC/IACR](#), [SEER](#)
- Rules for coding of "Basis of Diagnosis" (IARC): [Download](#)