Istituto Scientifico Prevenzione Oncologica
cspo

I tumori multipli

Dr Emanuele Crocetti

E’ prevista per il mese di dicembre la pubblicazione del ***Manuale di tecniche di registrazione dei tumori.*** Il volume è uno dei prodotti del progetto AIRTUM-CCM, e si colloca nel filone delle attività di standardizzazione e dei dati dei registri tumori italiani.

Banca dati AIRTum novembre 2007

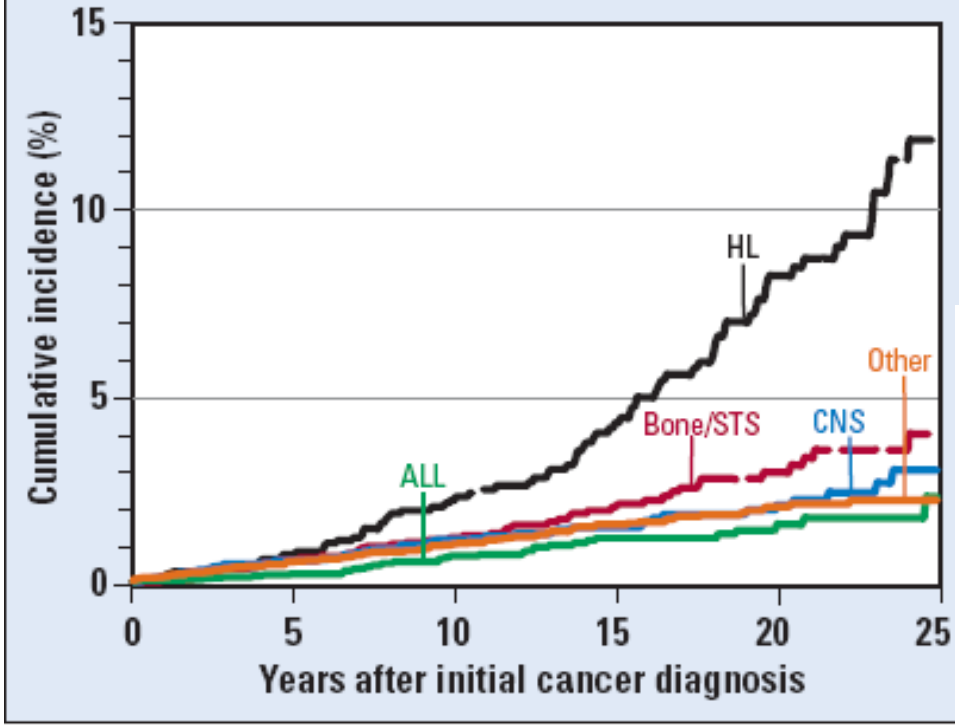
	N° casi	%
Totale casi	1.331.255	100.00
One primary only	1.156.566	86.9
1st of 2 or more primaries	84.250	6.3
2nd of 2 or more primaries	84.254	6.3
3rd of 3 or more primaries	5.789	0.4
4th of 4 or more primaries	379	0.03
5th of 5 or more primaries	17	0.001

Tumori multipli

- Condivisione fattori di rischio

- Organi diversi per necessità classificative
- Effetto dei trattamenti
- Sindromi eredo-familiari
- Anticipazione diagnostica e sovradiagnosi

Figure 18.2: Cumulative incidence of developing a second cancer among children with selected first primary cancers: Hodgkin lymphoma (HL), bone and soft tissue sarcomas (Bone/STS), brain and other central nervous system cancers (CNS), acute lymphocytic leukemia (ALL) and other cancer sites (Other).



New Malignancies Following Childhood Cancer

Peter D. Inskip, Lynn A. G. Ries, Randi J. Cohen, Rochelle E. Curtis

New Malignancies Among Cancer Survivors:

SEER Cancer Registries, 1973-2000

Edited by
Rochelle E. Curtis[1]
D. Michal Freedman[1]
Elaine Ron[2]
Lynn A. G. Ries[3]
David G. Hacker[1]
Brenda K. Edwards[3]
Margaret A. Tucker[1]
Joseph F. Fraumeni Jr.[1]

[1]Division of Cancer Epidemiology and Genetics, National Cancer Institute (NCI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
[2]Division of Cancer Control and Population Sciences, NCI, NIH, DHHS
[3]Information Management Services, Inc., Silver Spring, MD

Long term risk of invasive cancer after treatment for cervical intraepithelial neoplasia grade 3: population based cohort study

BMJ 2007;335;1077

Björn Strander, senior consultant,[1] Agneta Andersson-Ellström, senior consultant,[1] Ian Milsom, professor,[1] Pär Sparén, professor of medical epidemiology[2]

Table 1 | Risk of invasive cervical cancer and vaginal cancer among women with previous cervical intraepithelial neoplasia grade 3 (CIN 3)

	Cervical cancer					Vaginal cancer				
Variables	No of cases	Expec-ted No	Woman years	SIR (95% CI)	Change in incidence/ 100 000	No of cases	Expec-ted No	Woman years	SIR (95% CI)	Change in incidence/ 100 000
All cases	881	382	2 315 724	2.30 (2.15 to 2.46)	21.5	111	16.28	2 324 157	6.82 (5.61 to 8.21)	4.1

WHAT IS ALREADY KNOWN ON THIS TOPIC

The risk of invasive cervical cancer is more than double that of the general population at least 10 years after treatment for cervical intraepithelial neoplasia grade 3

Long term incidence of vaginal cancer after treatment for cervical intraepithelial neoplasia grade 3 is poorly documented

WHAT THIS STUDY ADDS

Women are at an increased risk of invasive cervical cancer more than 25 years after treatment for cervical intraepithelial neoplasia grade 3

The risk of invasive disease is noticeably increased in women aged more than 50 when treated

The risk of vaginal cancer is increased in women treated for cervical intraepithelial neoplasia grade 3

Table 1 Tuscany Cancer Registry. Malignant skin melanoma patients, 1985–1999. Observed metachronous second primary cancers, standardized incidence ratio (SIR=observed/expected) and 95% confidence intervals (95% CI) by sex and site of second cancer

Site	Males		Females		Males and females	
	Obs	SIR (95% CI)	Obs	SIR (95% CI)	Obs	SIR (95% CI)
Lip	0	–	1	33.3(0.87–75.7)	1	5.56(0.14–31.0)
Tongue	0	–	1	11.1(0.29–61.9)	1	4.55(0.12–25.3)
Stomach	3	0.84(0.17–2.45)	2	0.64(0.08–2.32)	5	0.75(0.24–1.74)
Small intestine	0	–	1	12.5(0.33–69.7)	1	5.55(0.14–31.0)
Colon	3	0.85(0.18–2.50)	1	0.25(0.01–1.39)	4	0.53(0.15–1.36)
Rectum*	1	0.51(0.01–2.83)	2	1.20(0.15–4.33)	3	0.82(0.17–2.41)
Liver	0	–	1	1.49(0.04–8.32)	1	0.59(0.02–3.28)
Pancreas	1	1.09(0.03–6.06)	1	0.93(0.02–5.16)	2	1(0.12–3.61)
Lung	2	0.29(0.04–1.04)	4	2.19(0.60–5.60)	6	0.68(0.25–1.49)
Mediastinum	1	20(0.52–111.4)	0	–	1	12.5(0.32–69.7)
Bone	1	20(0.52–111.4)	0	–	1	9.10(0.24–50.7)
Skin	18	4.31*(2.55–6.81)	7	2.0(0.80–4.12)	25	3.26*(2.11–4.81)
Female breast			14	1.47(0.80–2.47)	14	1.47(0.80–2.47)
Corpus uteri			2	1.04(0.13–3.76)	2	1.04(0.13–3.76)
Ovary			1	0.72(0.02–4.01)	1	0.72(0.02–4.01)
Prostate	8	1.63(0.71–3.22)			8	1.63(0.71–3.22)
Bladder	5	1.09(0.35–2.54)	0	–	5	0.85(0.28–1.98)
Kidney	1	0.72(0.02–4.01)	3	3.19(0.66–9.33)	4	1.72(0.47–3.40)
Thyroid	0	–	1	1.64(0.04–9.13)	1	1.28(0.03–7.14)
NHL	4	3.81*(1.04–9.75)	2	1.74(0.21–6.28)	6	2.74*(1.01–5.94)
LLC	0	–	1	3.85(0.10–21.4)	1	1.89(0.05–10.5)
Ill-defined	1	1.35(0.04–7.53)	0	–	1	0.47(0.01–2.63)
All	49	1.31(0.97–1.74)	45	1.23(0.90–1.65)	94	1.27*(1.03–1.56)

*$P<0.05$.

Il riscontro di più tumori nello stesso paziente può essere suddiviso in alcune casistiche:

- Due o più neoplasie in organi (sedi topografiche) diversi
- Due o più neoplasie a differente morfologia insorgenti nello stesso organo
- Due o più neoplasie con morfologia uguale o simile, ma con codice di comportamento diverso insorgenti nello stesso organo anche a distanza di tempo
- Due o più neoplasie con morfologia uguale o simile, e stesso codice di comportamento, insorgenti nello stesso organo anche a distanza di tempo
- Due neoplasie insorgenti in organi pari
- Una singola neoplasia coinvolgente siti multipli, la cui origine precisa non può essere determinata
- Malattie oncologiche sistemiche (linfomi, sarcoma di Kaposi) che spesso interessano più stazioni linfonodali e/o sedi differenti già al momento della prima diagnosi

Il registratore deve quindi compiere in tali casi alcune valutazioni:

- sull'esistenza effettiva di un secondo tumore. **Potrebbe trattarsi di un'estensione, metastasi o recidiva del primo tumore**
- sulla data di incidenza effettiva del primo tumore e di quelli successivi
- sul fatto che esso sia da registrare ed entri in incidenza
- sul terzo punto l'approccio ritenuto più corretto è quello di considerare come indipendenti i due aspetti.

Il registratore deve quindi compiere in tali casi alcune valutazioni:

- Compito del registratore è quello di registrare ed annotare, mentre la valutazione circa i casi che entrano veramente in incidenza dovrebbe appartenere alla sfera successiva della valutazione dei dati ed ad un sistema di *recording* che consenta di distinguere casi “veri” incidenti rispetto agli altri casi.

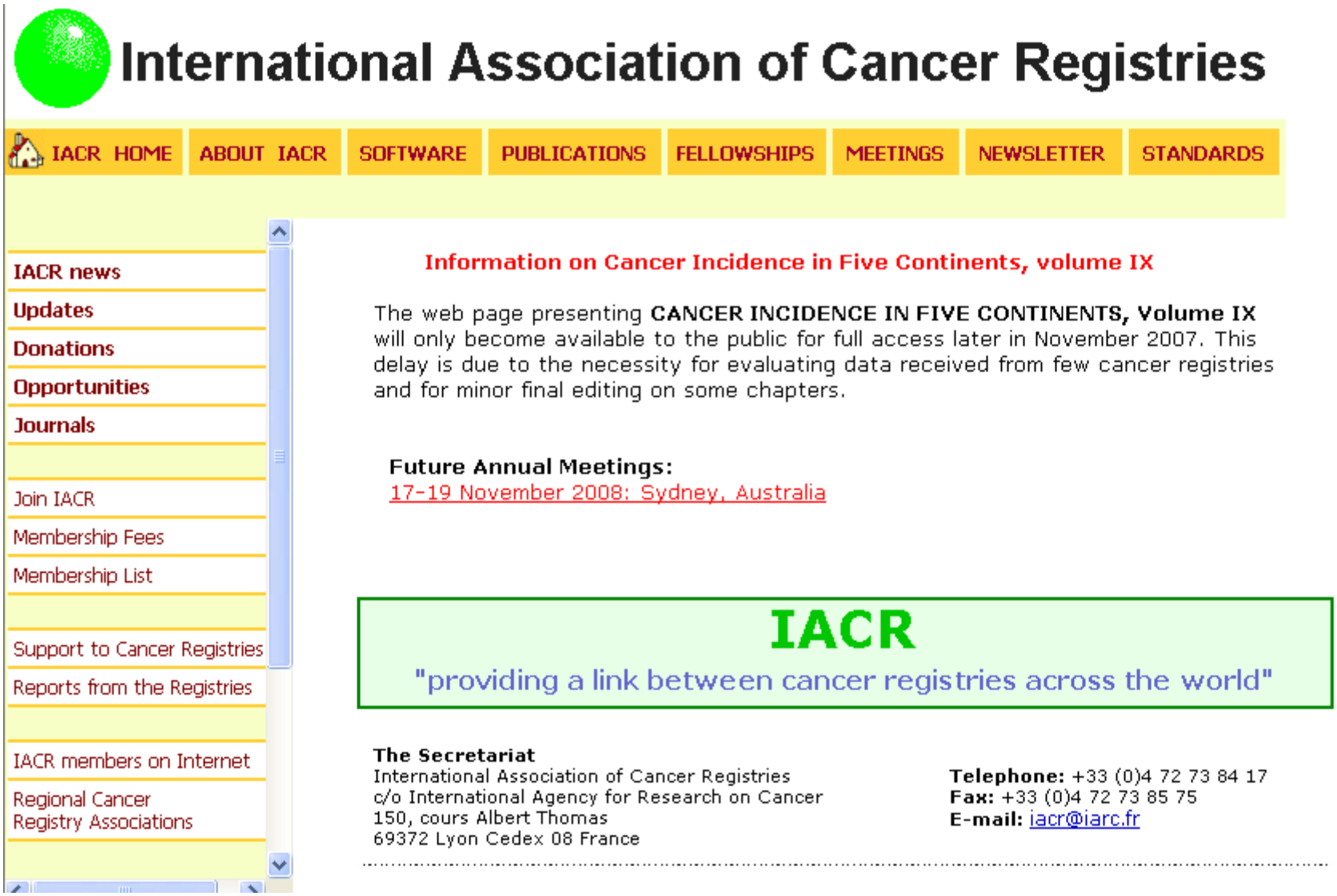
Valutazione per l'incidenza

- Occorre fare riferimento alle raccomandazioni della IARC:

Table 5.5. Percentage difference in incidence rates using multiple primary rules of SEER versus IARC/IACR: SEER registries, 1993–97

Site	Difference (SEER/IACR) (%)			
	Male		Female	
	Crude	ASR	Crude	ASR
Breast	–	–	+ 6.2	+ 5.7
Colon	+ 4.9	+ 4.6	+ 5.0	+ 4.5
Melanoma	+ 4.8	+ 5.2	+ 3.8	+ 4.0
Kidney	+ 1.7	+ 2.1	+ 0.0	+ 2.0
Testis	+ 1.8	+ 2.1	–	–
Lung	+ 1.5	+ 1.6	+ 1.6	+ 1.5
All	+ 0.9	+ 0.9	+ 2.0	+ 1.7

http://www.iacr.com.fr/



International Association of Cancer Registries

NEWS

- Multiple Primaries
  - ICD-O-3
  - ICD-O-2
- Basis of Diagnosis

Get Acrobat Reader

Please write your comments about this site!

IACR Standards

The information generated by cancer registries has a wide variety of uses, in epidemiological research, in planning and evaluation of cancer control measures, and in monitoring some standards of clinical care. So that comparisons between different registries, countries, and over time can be made with confidence, it is essential that certain definitions, for collecitng, coding and presenting data, are comparable between registries.

The encouragement of such comparative studies is one of the objectives of IACR. Thus, to aid this process, the IACR has developed classifications (the successive editions of the International Classification of Diseases for Oncology, published by WHO), guidelines for registry practices and standard definitions. As the guidelines available are produced or revised, they will be made available on this site.

IACR

IARC

International Agency for Research on Cancer
World Health Organization
International Association of Cancer Registries
European Network of Cancer Registries

INTERNATIONAL RULES FOR MULTIPLE PRIMARY CANCERS (ICD-O Third Edition)

IARC, Lyon, 2004

Internal Report No. 2004 / 02

MULTIPLE PRIMARY NEOPLASMS

Cancer registries use different rules for defining multiple primaries when registering cancer cases. The rules given here are for reporting data on cancer incidence and survival, so that cancer risk and outcome are comparable between different populations.

For collection, it is recommended that registries collect and register more detailed data and some suggestions are given in the Recommendations for Recording which follow. Such cases should be collapsed to conform to the international rules for analysis.

RULES FOR REPORTING INCIDENCE AND SURVIVAL

1. The recognition of the existence of two or more primary cancers does not depend on time.

2. A primary cancer is one that originates in a primary site or tissue and is not an extension, nor a recurrence, nor a metastasis.

3. Only one tumour shall be recognised as arising in an organ or pair of organs or tissue.
   Some groups of codes are considered to be a single organ for the purposes of defining multiple tumours. These topography code groups are shown in Table 1.

   Multifocal tumours – that is, discrete masses apparently not in continuity with other primary cancers originating in the *same* primary site or tissue, for example bladder – are counted as a single cancer.

4. Rule 3 does not apply in two circumstances:

   4.1 Systemic (or multicentric) cancers potentially involving many different organs are only counted once in any individual. These are Kaposi sarcoma (group 15 in Table 2) and tumours of the haematopoietic system (groups 8-14 in Table 2).

   4.2 Neoplasms of different morphology should be regarded as multiple cancers (even if they are diagnosed simultaneously in the same site).

   If the morphological diagnoses fall into one category in Table 2, and arise in the same primary site, they are considered to be the same morphology for the purpose of counting multiple primaries. If the morphological diagnoses fall into two or more of the categories in Table 2, even if they concern the same site, the morphology is considered to be different, and two or more cases should be counted.

   Single tumours containing several different histologies which fall into one histological group in Table 2 are registered as a single case, using the numerically highest ICD-O morphology code.

   If, however, one morphology is not specific (groups (5), (14) and (17)) and a specific morphology is available, the case should be reported with the specific histology and the non-specific diagnosis should be ignored.

Table 1: Groups of topography codes from ICD-O-2 and ICD-O-3 considered a single site in the definition of multiple cancers

ICD-O-2/3		ICD-O-1
C01	Base of tongue	
C02	Other and unspecified parts of tongue	141
C05	Palate	
C06	Other and unspecified parts of mouth	145
C07	Parotid gland	
C08	Other and unspecified major salivary glands	142
C09	Tonsil	
C10	Oropharynx	146
C12	Pyriform sinus	
C13	Hypopharynx	148
C19	Rectosigmoid junction	
C20	Rectum	154
C23	Gallbladder	
C24	Other and unspecified parts of biliary tract	156
C30	Nasal cavity and middle ear	
C31	Accessory sinus	160
C33	Trachea	
C34	Bronchus and lung	162
C37	Thymus	164
C38.0-3	Heart and mediastinum	164
C38.8	Overlapping lesion of heart, mediastinum and pleura	165.8
C40	Bones, joints and articular cartilage of limbs	
C41	Bones, joints and articular cartilage of other and unspec. sites	170
C51	Vulva	184.4
C52	Vagina	184.0
C57.7	Other specified female genital	184.9
C57.8-9	Overlapping lesion and female genital tract, NOS	184.8, 184.9
C60	Penis	
C63	Other and unspecified male genital organs	187
C64	Kidney	
C65	Renal pelvis	
C66	Ureter	
C68	Other and unspecified urinary organs	189
C74	Adrenal gland	
C75	Other endocrine glands and related structures	194

Table 1. Groups of topography codes considered a single site in the definition of multiple cancers

ICD-O-2/3 site code	Label	If diagnosed at different times, code first diagnosis If diagnosed at the same time use codes given below.
C01	Base of tongue	
C02	Other and unspecified parts of tongue	C02.9
C00	Lip	
C03	Gum	
C04	Floor of mouth	
C05	Palate	
C06	Other and unspecified parts of mouth	C06.9
C09	Tonsil	
C10	Oropharynx	
C12	Pyriform sinus	
C13	Hypopharynx	
C14	Other and ill-defined sites in lip, oral cavity and pharynx	C14.0
C19	Rectosigmoid junction	
C20	Rectum	C20.9
C23	Gallbladder	
C24	Other and unspecified parts of biliary tract	C24.9
C33	Trachea	
C34	Bronchus and lung	C34.9
C40	Bones, joints and articular cartilage of limbs	
C41	Bones, joints and articular cartilage of other and unspecified sites	C41.9
C65	Renal pelvis	
C66	Ureter	
C67	Bladder	
C68	Other and unspecified urinary organs	C68.9

RULES FOR REPORTING INCIDENCE AND SURVIVAL

1. The recognition of the existence of two or more primary cancers does not depend on time.

2. A primary cancer is one that originates in a primary site or tissue and is not an extension, nor a recurrence, nor a metastasis.

3. Only one tumour shall be recognised as arising in an organ or pair of organs or tissue.
   Some groups of codes are considered to be a single organ for the purposes of defining multiple tumours. These topography code groups are shown in Table 1.

   Multifocal tumours – that is, discrete masses apparently not in continuity with other primary cancers originating in the *same* primary site or tissue, for example bladder – are counted as a single cancer.

4. Rule 3 does not apply in two circumstances:

   4.1 Systemic (or multicentric) cancers potentially involving many different organs are only counted once in any individual. These are Kaposi sarcoma (group 15 in Table 2) and tumours of the haematopoietic system (groups 8-14 in Table 2).

   4.2 Neoplasms of different morphology should be regarded as multiple cancers (even if they are diagnosed simultaneously in the same site).

   If the morphological diagnoses fall into one category in Table 2, and arise in the same primary site, they are considered to be the same morphology for the purpose of counting multiple primaries. If the morphological diagnoses fall into two or more of the categories in Table 2, even if they concern the same site, the morphology is considered to be different, and two or more cases should be counted.

   Single tumours containing several different histologies which fall into one histological group in Table 2 are registered as a single case, using the numerically highest ICD-O morphology code.

   If, however, one morphology is not specific (groups (5), (14) and (17)) and a specific morphology is available, the case should be reported with the specific histology and the non-specific diagnosis should be ignored.

Table 2: Groups of malignant neoplasms considered to be histologically "different" for the purpose of defining multiple tumors (adapted from Berg, 1994)

Group		
	Carcinomas	
1.	Squamous carcinomas	M-805 - 808, M-812 - 813
2.	Basal cell carcinomas	M-809 - 811
3.	Adenocarcinomas	M-814, M-816, M-819 - 822, M-826 - 833, M-835 - 855, M-857, M-894
4.	Other specific carcinomas	M-803 - 804, M-815, M-817 - 818, M-823, M-824, M-825, M-834, M-856, M-858 - 867
(5.)	Unspecified carcinomas (NOS)	M-801, M-802
6.	**Sarcomas** and soft tissue tumors	M-868 - 871, M-880 - 892, M-899, M-904, M-912 - 913, M-915 - 925, M-937, M-954 - 958
7.	**Lymphomas**	M-959 - 972
8.	**Leukaemia**	M-980 - 994, M-995, M-996, M-998
9.	**Kaposi's sarcoma**	M-914
10.	**Mesothelioma**	M-905
11.	**Other specified** types of cancer	M-872 - 879, M-893, M-895 - 898, M-900 - 903, M-906 - 911, M-926 - 936, M-938 - 953, M-973 - 975, M-976
(12.)	**Unspecified** types of cancer	M-800, M-997

Table 2. **Groups of malignant neoplasms considered to be histologically 'different' for the purpose of defining multiple tumours (adapted from Berg JW. Morphologic classification of human cancer. In: Schottenfeld D & Fraumeni JF Jr. *Cancer Epidemiology and Prevention*, 2nd edition, Chapter 3 of Section 1: Basic Concepts. Oxford, New York, Oxford University Press, pp. 28-44, 1996).**

Group	
Carcinomas	
1. Squamous and transitional cell carcinoma	8051-8084, 8120-8131
2. Basal cell carcinomas	8090-8110
3. Adenocarcinomas	8140-8149, 8160-8162, 8190-8221, 8260-8337, 8350-8551, 8570-8576, 8940-8941
4. Other specific carcinomas	8030-8046, 8150-8157, 8170-8180, 8230-8255, 8340-8347, 8560-8562, 8580-8671
(5) Unspecified carcinomas (NOS)	8010-8015, 8020-8022, 8050
6. *Sarcomas* and soft tissue tumours	8680-8713, 8800-8921, 8990-8991, 9040-9044, 9120-9125, 9130-9136, 9141-9252, 9370-9373, 9540-9582
7. ***Mesothelioma***	9050-9055
Tumours of haematopoietic and lymphoid tissues	
8. Myeloid	9840, 9861-9931, 9945-9946, 9950, 9961-9964, 9980-9987
9. B-cell neoplasms	9670-9699, 9728, 9731-9734, 9761-9767, 9769, 9823-9826, 9833, 9836, 9940
10. T-cell and NK-cell neoplasms	9700-9719, 9729, 9768, 9827-9831, 9834, 9837, 9948
11. Hodgkin lymphoma	9650-9667
12. Mast-cell Tumours	9740-9742
13. Histiocytes and Accessory Lymphoid cells	9750-9758
(14) Unspecified types	9590-9591, 9596, 9727, 9760, 9800-9801, 9805, 9820, 9832, 9835, 9860, 9960, 9970, 9975, 9989
15. *Kaposi sarcoma*	9140
16. *Other specified* types of cancer	8720-8790, 8930-8936, 8950-8983, 9000-9030, 9060-9110, 9260-9365, 9380- 9539
(17) *Unspecified* types of cancer	8000-8005

RULES FOR REPORTING INCIDENCE AND SURVIVAL

1. The recognition of the existence of two or more primary cancers does not depend on time.

2. A primary cancer is one that originates in a primary site or tissue and is not an extension, nor a recurrence, nor a metastasis.

3. Only one tumour shall be recognised as arising in an organ or pair of organs or tissue.
   Some groups of codes are considered to be a single organ for the purposes of defining multiple tumours. These topography code groups are shown in Table 1.

   Multifocal tumours – that is, discrete masses apparently not in continuity with other primary cancers originating in the *same* primary site or tissue, for example bladder – are counted as a single cancer.

4. Rule 3 does not apply in two circumstances:

   4.1 Systemic (or multicentric) cancers potentially involving many different organs are only counted once in any individual. These are Kaposi sarcoma (group 15 in Table 2) and tumours of the haematopoietic system (groups 8-14 in Table 2).

   4.2 Neoplasms of different morphology should be regarded as multiple cancers (even if they are diagnosed simultaneously in the same site).

   If the morphological diagnoses fall into one category in Table 2, and arise in the same primary site, they are considered to be the same morphology for the purpose of counting multiple primaries. If the morphological diagnoses fall into two or more of the categories in Table 2, even if they concern the same site, the morphology is considered to be different, and two or more cases should be counted.

   Single tumours containing several different histologies which fall into one histological group in Table 2 are registered as a single case, using the numerically highest ICD-O morphology code.

   If, however, one morphology is not specific (groups (5), (14) and (17)) and a specific morphology is available, the case should be reported with the specific histology and the non-specific diagnosis should be ignored.

Ci può essere differenza fra i casi che vengono inseriti nel registro e quelli, tra questi,che poi saranno considerati per calcolare l’incidenza

RECOMMENDATIONS FOR RECORDING

1. Two tumours of different laterality, but of the same morphology, diagnosed in paired organs (e.g. breast) should be registered separately unless stated to have originated from a single primary.

   Exceptions to this rule are:

   a) Tumours of the ovary (of the same morphology)
   b) Wilm's tumour (nephroblastoma) of the kidney.
   c) Retinoblastoma

   which should be recorded as a single bilateral registration when they occur on both sides.

   Reminder: tumours in paired organs of completely different histology should be registered separately.

2. Cancers which occur in any 4th character subcategory of colon (C18) and skin (C44) should be registered as multiple primary cancers.

Tumori multipli - consigli

- Seguire le classificazioni di codifica dei tumori più recenti
- Seguire le regole di definizione dei TM più recenti (o esplicitare le proprie)
- Adottare regole interne più estensive per la registrazione dei tumori allo scopo di poter seguire in futuro nuove diverse regole di inclusione dei TM nell'incidenza.

Tumori multipli - consigli

- I casi che compaiono più frequentemente si risolvono facilmente seguendo le regole

TM registrazione e utilizzo in incidenza (1)

- Adenocarcinoma duttale della mammella (femminile) destra
- Carcinoma duttale della mammella sinistra
- Adenocarcinoma duttale della mammella destra
- Adenocarcinoma lobulare della mammella destra

TM registrazione e utilizzo in incidenza (2)

- Adenocarcinoma duttale della mammella destra
- Sarcoma della mammella destra
- Adenocarcinoma duttale (varietà tubulare) della mammella destra
- Tumore maligno della mammella destra

TM registrazione e utilizzo in incidenza (3)

- Cute naso carcinoma spinocellulare
- Cute orecchio carcinoma basocellulare
- Cute naso carcinoma spinocellulare
- Cute braccio carcinoma spinocellulare

TM registrazione e utilizzo in incidenza (4)

- Cute gamba Melanoma nodulare spinocellulare
- Cute gamba carcinoma basocellulare
- Cute naso carcinoma spinocellulare
- Cute orecchio carcinoma basocellulare
- Cute gamba sarcoma di Kaposi
- Cute gamba Micosi fungoide
- Cute tronco Linfoma cutaneo a cellule T
- Cute tronco Melanoma a diffusione superficiale
- Cute tronco Melanoma su lentigo maligna
- Cute braccio Siringoma maligno

TM registrazione e utilizzo in incidenza (5)

- Colon sinistro adenocarcinoma
- Retto adenocarcinoma mucinoso

- Biopsia: Colon sinistro adenocarcinoma
- PO: Retto adenocarcinoma mucinoso

1.o caso	2. caso dello stesso gruppo di istotipi			
Codice di comportamento	**Benigno /0* Incerto se Benigno/Mal /1**	**In-situ /2**	**Maligno /3**	**Metastatico**
Benigno 0* Incerto se Benigno/Mal. /1	1 registrazione	**2 registrazioni**	**2 registrazioni**	**2 registrazioni**
In-situ /2	1 registrazione	1 registrazione	**2 registrazioni**	**2 registrazioni**
Maligno /3	1 registrazione	1 registrazione	**2 registrazioni se metacroni e non ripresa di malattia**	1 registrazione
Metastatico	1 registrazione	1 registrazione	1 registrazione	1 registrazione

* solo intracranico-intraassiale

Diapositiva del Dr. A. Giacomin

Prima diagnosi	Seconda diagnosi	Raccomandazioni per la registrazione	Raccomandazione per l'incidenza come tumore multiplo
Leucemia mieloide cronica	**Leucemia mieloide acuta**	2 registrazioni se non si tratta di crisi blastica (per esempio per presenza di markers biomolecolari specifici)	Non tumore multiplo
Leucemia mieloide	**Sindrome mielodisplastica**	2 registrazioni se la sindrome mielodisplastica è considerata secondaria alla terapia	Non tumore multiplo
Leucemia mieloide mielomonocitica cronica	**Leucemia mieloide acuta**	2 registrazioni se non si tratta di crisi blastica (per esempio per presenza di markers biomolecolari specifici)	Non tumore multiplo
Sindrome mielodisplastica	**Leucemia mieloide acuta**	2 registrazioni, la leucemia mieloide viene codificata come 9895/3 (da non usare per singola leucemia) al fine di poter controllare i trend delle leucemie	Non tumore multiplo
Policitemia vera	**Leucemia mieloide acuta**	2 registrazioni, la leucemia mieloide viene codificata come 9895/3 (da non usare per singola leucemia) al fine di poter controllare i trend delle leucemie	Non tumore multiplo
Trombocitemia essenziale	**Leucemia mieloide acuta**	2 registrazioni, la leucemia mieloide viene codificata come 9895/3 (da non usare per singola leucemia) al fine di poter controllare i trend delle leucemie	Non tumore multiplo
Leucemia mielomonocitica cronica	**Sindrome mielodisplastica**	1 registrazione	Non tumore multiplo
Policitemia vera	**Mielofibrosi primaria** **Anemie refrattarie**	2 registrazioni	Non tumore multiplo
Trombocitemia essenziale	**Mielofibrosi primaria** **Anemie refrattarie**	2 registrazioni	Non tumore multiplo

Diapositiva del Dr. A. Giacomin

Prima diagnosi	Seconda diagnosi	Raccomandazioni per la registrazione	Raccomandazione per l'inciden come tumore multiplo
Linfoma nodale	**Linfoma extranodale**	2 registrazioni, tranne nel cas di localizzazione midollare di linfoma nodale	Tumori multipli solo se le linee cellulari sono diverse (B vs T vs N vs Null)
LNH a basso grado	**LNH ad alto grado**	2 registrazioni	Tumori multipli solo se le linee cellulari sono diverse (B vs T vs N vs Null)
LNH ad alto grado	**Fase leucemica acuta linfoblastica**	1 registrazione. Trattasi di evoluzione	Non tumore multiplo
Leucemia linfatica cronica	**LNH ad alto grado (sindrome di Richter)**	2 registrazioni	Tumori multipli solo se le linee cellulari sono diverse (B vs T vs N vs Null)
Leucemia linfatica cronica	**Linfoma di Hodgkin**	2 registrazioni (regola IARC)	Tumori multipli
LNH	**Linfoma di Hodgkin**	2 registrazioni (regola IARC)	Tumori multipli
Linfoma di Hodgkin	**LNH**	2 registrazioni (regola IARC)	Tumori multipli
Linfoma di Hodgkin	**Leucemia mieloide acuta**	2 registrazioni (regola IARC)	Tumori multipli
Linfoma di Hodgkin	**Sindrome mielodisplastica**	2 registrazioni (regola IARC)	Tumori multipli
Leucemia linfatica cronica	**Leucemia linfoblastica acuta**	1 registrazione, la leucemia acuta è in tal caso una dedifferenziazione della LLC	Non tumore multiplo
Leucemia linfatica **Linfomi**	**Sindrome mielodisplastica**	2 registrazioni se la sindrome mielodisplastica non è considerata secondaria alla malattia di base	Tumori multipli
Leucemia mieloide cronica	**Leucemia linfoblastica acuta**	2 registrazioni (regola IARC)	Tumori multipli

Diapositiva del Dr. A. Giacomin