

RESEARCH

Open Access



Rotterdam Oncology Documentation (RONCDOC) – a high-quality data warehouse and tissue collection for head and neck cancer

Arta Hoesseini^{1*}, Emilie A. C. Dronkers^{1,2}, Eveline Dieleman¹, Maria J. De Herdt³, Marjan. H. Wieringa⁴, Marie-Louise F. van Velthuisen³, Marinella P. J. Offerman¹, Aniel Sewnaik¹, Dominiek Monserez¹, Stijn Keereweert¹, Jose A. U. Hardillo¹ and Robert Jan Baatenburg de Jong¹

Abstract

Background Every year, almost 900.000 people are diagnosed with head and neck cancer (HNC) worldwide. HNC contains many different subsites and a large variability in tumor biology. This often results in small and/or heterogeneous study populations. Developing overarching databases is an efficient solution to collect and analyze data of these smaller subsets of patients and to facilitate data sharing among research groups. The few existing large databases often include only basic characteristics. In addition, hospital-based cohorts that include more variables are often not collected consecutively, resulting in selection bias. Therefore, we established a hospital-based cancer registry system “Rotterdam Oncology Documentation” (RONCDOC), a complete and consecutive data warehouse and tissue collection for HNC, directly registered at the source. The primary aim of this paper is to report on our data collection protocol in order to make the RONCDOC data accessible and reusable for other researchers, and to offer a blueprint to other consortia planning to establish their own data warehouse.

Methods Data collected in the Netherlands Cancer Registry (NCR) of patients with HNC were obtained from the Netherlands comprehensive cancer organization (IKNL) and merged with corresponding data from the electronic patient file (EPF). The data were manually verified using the EPF, and enriched with additional variables from the EPF according to an extensive data entry protocol. Furthermore, a comprehensive validation protocol was developed to guarantee the quality of the data. Tissue microarrays (TMAs) were constructed from resection specimens of patients with primary oral squamous cell carcinoma.

Conclusion With RONCDOC, we have established a consecutive and high-quality data warehouse for HNC. This paper outlines the essential steps for establishing such a data warehouse, offering a blueprint for other consortia.

Trial registration This study was approved by the ethics committee of the Erasmus Medical Center (MEC-2016–751).

Keywords Head and neck cancer, Oncology, Database, Cohort study

*Correspondence:

Arta Hoesseini
a.hoesseini@erasmusmc.nl

Full list of author information is available at the end of the article



© The Author(s) 2025. **Open Access** This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/4.0/>.

Background

Researchers often acquire similar data and store them in separate data sets making it difficult to reuse data for purposes other than the initial research question. This does not only occur among different centers but also within one clinical center, within different disciplines or even within a research group. It is valuable, cost-effective and more efficient for novel research projects, when researchers would be able to combine these datasets. This facilitates data sharing among research groups. In addition, an overarching database facilitates collaboration in multi center studies. Almost 900.000 people per year are diagnosed with HNC worldwide [1]. More than 90% of all HNCs are squamous cell carcinomas [2]. HNC represents a variety of (squamous cell) tumors originating from the lip, oral cavity, oropharynx, hypopharynx, larynx, (sino)nasal cavity, nasopharynx and salivary glands. In the Netherlands, around 3000 new patients are diagnosed with HNC annually [3]. A patchwork of different subsites with different biology disperses the already relatively small numbers of HNC patients per year. This often results in small and/or heterogeneous study populations. The few existing large population based cohorts in the world containing HNC include TNM classification, tumor location and survival data but often lack more patient and tumor specific variables such as smoking behavior, comorbidity, histopathology and/or molecular features [4–7]. Hospital based cohorts that do include these variables are often not collected consecutively resulting in selection bias. Therefore, we established the hospital-based cancer registry system “Rotterdam Oncology Documentation” (RONCDOC), a complete, high-quality and consecutive data warehouse including clinical, diagnostic and therapeutic data and tissue collection for HNC, directly registered at the source. The primary aim of this paper is to report on our data collection protocol in order to make the RONCDOC data accessible and reusable for other researchers, and to offer a blueprint to other consortia planning to establish their own data warehouse.

Construct and content

Design and setting

Data collected in the Netherlands Cancer Registry (NCR) of patients with HNC were obtained from the Netherlands comprehensive cancer organization (IKNL). Information on every patient with cancer in the Netherlands is recorded in the NCR. In general, data collected by the IKNL includes variables like sex, age, cTNM, pTNM, tumor morphology, tumor topography, and date of death. Data from the IKNL are retrospectively collected by trained data managers. In contrast, data in the Electronic Patient File (EPF) contains more specific patient

and tumor data and is directly registered at the source. Since 2016, our institution has implemented the use of an individual tumor board form for each new head and neck tumor that includes several mandatory variables beyond the TNM classification, such as comorbidities, height, weight, smoking status, WHO performance status, and alcohol consumption. This facilitates standardized data collection. All variables are initially registered in the EPF and subsequently in the tumor board form. Therefore, the EPF serves as the primary data source. In RONCDOC, the consecutive NCR data of patients with HNC were first merged with corresponding clinical data from the EPF of the Erasmus Medical Center Cancer Institute (see Fig. 1, validation step 1). These variables were manually verified by trained medical students using the EPF, and enriched with additional variables from the EPF according to an extensive data entry protocol. The data entry protocol provides descriptions of all variables listed in Table 1, along with examples. The complete data dictionary and data entry protocol are added as a supplementary file. All medical students were extensively trained by senior medical students, senior researchers, and medical doctors on how to use the data entry protocol. When data of the NCR did not correspond with the data in the EPF, the latter was considered superior. In case of doubt, selected cases were discussed in the research staff. During the second validation step, students verified data samples of each other (internal control). Around 10% of the total processed data by one student was checked by another student or by a senior researcher. If a variable showed deviating results, the matter was examined, and the data were manually adjusted where necessary. Hereafter, data were verified again using a cleaning algorithm (validation step 3): for each variable, a separate “cleaning syntax” was created in SPSS in order to review the data and adjust if necessary. Categorical values were first checked for correct entry. Some missing data were verified again in the EPF by a different student or senior researcher and adjusted if necessary. Any additional irregularities identified were addressed similarly. Finally, during the analyses of various research projects, any remaining data cleaning was performed if necessary (step 4). For example, when a variable initially considered missing was later identified in the EPF by a different researcher. All baseline variables were scored according to their outcome at the time of diagnosis, and a log was kept in which members of the research team entered the data. In addition, a log was kept of all changes made.

Study population

Inclusion started from the 1st of January 2006, in correspondence with the transition from paper charts to the EPF. Data of patients treated between the 1st of January

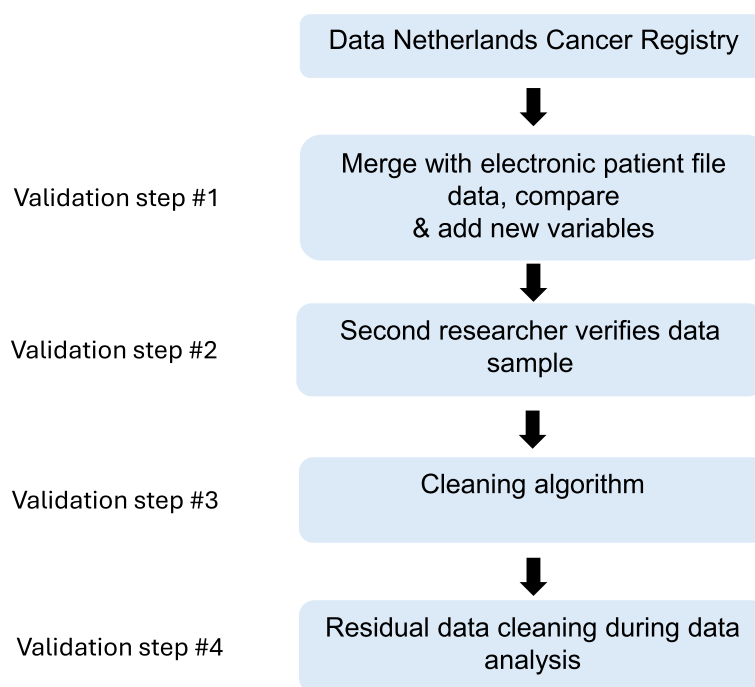


Fig. 1 RONCDOC design and validation steps

2006 and the 31st of December 2016 has been completed ($N = 3728$). Currently, we are gathering data from 2017 until present. Follow-up time has been repeatedly updated by consulting the Municipal Personal Records Database (MPRD). The final day of follow-up was defined as the final date that the patient was confirmed to be alive (last registered hospital contact) or the date of death.

Clinical, diagnostic and tumor tissue data collection

Clinical data, diagnostics and tumor tissue data were collected. Table 1 shows an overview of the variables included in RONCDOC. Number of alcohol units per week were scored according to a standardized list: one unit, or 10 g of alcohol is equivalent to 12.5 ml of pure ethanol [8]. The cumulative quantity of smoking was defined in pack-years in which one pack year was equal to one pack of 20 cigarettes smoked per day for one year. If a patient had stopped smoking for ≥ 3 months, he or she was considered as a *former smoker*. If a patient had stopped drinking for ≥ 6 months he or she was considered as a *former drinker*. Comorbidity was scored using the Adult Comorbidity Evaluation-27 (ACE- 27) which is a 27-item validated comorbidity index covering nine organ systems [9]. Weight loss in kilograms (kg) was defined as weight loss in the six months before diagnosis. The World Health Organization (WHO) performance status, also known as the

Eastern Cooperative Oncology Group (ECOG) score, was scored according to the classification published by Oken et al. [10] Marital status was defined as being married or having a durable relationship versus being single or widowed. TNM was staged according to the 7th American Joint Committee on Cancer (AJCC) edition of the TNM classification of malignant tumors [11]. Synchronous tumors were defined as tumors that were diagnosed ≤ 6 months after diagnosis of the index tumor and metachronous tumors > 6 months. In case of oropharyngeal tumors, immunohistochemical analysis was performed for tumor suppressor protein p16 (cyclin-dependent kinase 2A). p16 Positivity was defined as strong and diffuse nuclear and cytoplasmic immunostaining in $> 70\%$ of the tumor cells. p16 Positive tumors were considered human papilloma virus (HPV) positive according to the 8th AJCC TNM guideline [12, 13]. Histopathological characteristics were extracted from the pathology reports. Infiltration depth of oral squamous cell carcinoma was assessed according to the 7th edition of the AJCC [11]. The depth of invasion was revised – using scans of hematoxylin and eosin stained (HE) slides representative for the cancer resection specimen – according to the 8th AJCC edition of the TNM classification of malignant tumors [12, 13]. All revisions were performed in collaboration with a dedicated head and neck pathologist.

Table 1 Overview of the variables available in RONCDOC in 2025

Variable	Category
Sex	Female/male
Date of birth	Date
Deceased	Yes/no
Final date of follow-up/date of death	Date
Cause of death	Due to HNC/not due to HNC/unknown/not applicable
Smoking	Yes/no/former
Pack years	
Alcohol consumption	Yes/no/former
No. alcohol units per week	
Adult Comorbidity Evaluation 27	Subscales & total scale
Weight	Kilogram (1 kg = 2.20 pounds)
Weight loss in the past six months	Kilogram (1 kg = 2.20 pounds)
Height	Centimeter (1 cm = 0.39 inches)
Body Mass Index	
WHO performance status (Eastern Cooperative Oncology Group score)	0/1/2/3/4
Anemia	Yes/no, cutoff male < 8.5 mmol/L, cutoff female < 7.5 mmol/L (1 mmol/L = 1.61 g/dL)
Heart valve disease	Yes/no
Marital status	Married in a durable relationship or single/widowed
Prior malignancy	Yes/no
Localization prior malignancy	Lung/breast/bowel/prostate/hematologic/head and neck/other
Year of diagnosis of prior malignancy	Year
Treatment for prior malignancy?	Yes/no
Type of treatment for prior malignancy	None/radiotherapy/chemoradiation/surgery/surgery & radiotherapy/chemoradiation & surgery/chemotherapy/surgery & chemotherapy
Tumor	
Date of diagnosis	Date
Tumor no in chronologic order	1, 2, 3, 4, 5, etc
Primary or recurrent tumor	First primary/second primary/etc First recurrence/second recurrence/etc
Recurrence related to	First primary/second primary/etc
Synchronous/metachronous tumor	Not applicable/synchronous/metachronous
Tumor topography	Lip/oral cavity/oropharynx/hypopharynx/pharynx NOS ^a /glottic larynx/supraglottic larynx/subglottic larynx/larynx NOS ^a /nasopharynx/unknown primary/salivary glands/nasal cavity/middle ear/sinus/thyroid/skin
Site of tumor	Left/right/middle/bilateral
cTNM	According to the TNM- 7
pTNM	According to the TNM- 7
Tumor morphology	Squamous cell carcinoma/adenocarcinoma/etc
Treatment intention	Curative/palliative because of HNC/palliative because of another tumor/refusal of curative treatment/died before completing diagnostics/unknown
Retropharyngeal nodes	Yes/no
HPV-status (p16 immunoreactivity)	Yes/no
Treatment	
Treatment intention	Curative/palliative because of HNC/palliative because of another tumor/refusal of curative treatment/died before completing diagnostics/unknown
Did the patient receive treatment?	Yes/no (patient related)/no (physician related)/died before start treatment
Treatment according to protocol?	Yes/no (patient related)/no (physician related)/died before start treatment
Treatment type no. 1 ^b	None/radiotherapy/chemotherapy/surgery with lymph node dissection/surgery without lymph node dissection/lymph node dissection/other

Table 1 (continued)

Variable	Category
Start date of treatment no. 1	Date
End date of treatment no. 1	Date
Was treatment no. 1 completed?	Yes/no/not applicable/unknown
Pathology	
Pathology specimen ID	
Pathology specimen date	Date
Pathology specimen type	Biopsy/resection/etc
Pathology specimen characteristics	Tumor site & location/tumor diameter/no. pathological lymph nodes affected (side & level)/diameter of metastasis in mm (if RLNMs are present)/extranodal extension (if RLNMs are present)/depth of invasion (according to 8th ed AJCC)/resection margin status/WPOI (intended according to 8th ed AJCC)/invasion pattern/perineural invasion/lymphovascular invasion/histological grade/tumor infiltrating lymphocytes (intended according to 8th ed AJCC)

Several free text fields were added between variables (not included in this table). A complete overview of all variables can be found in the data dictionary and data entry protocol

^a Not Otherwise Specified

^b For each treatment type a separate column was completed on type, start date, end date and completion (no. 1, no. 2, etc.)

Tissue Microarray production and sample collection

Tissue microarrays (TMAs) were constructed from formalin-fixed paraffin-embedded (FFPE) resection specimens of patients with primary oral squamous cell carcinoma. Patients with simultaneous primary cancers in the head and neck region were excluded from sampling. Prior to the TMAs construction, hematoxylin and eosin (HE) sections – representing the selected cancers – and their corresponding FFPE tissue blocks were collected from the tissue archive of the pathology department. Subsequently, a dedicated head and neck pathologist examined all HE slides with special attention to the following pathological characteristics: cancer type, differentiation grade, depth of invasion, growth pattern, perineural invasion, vasoinvasive growth, extranodal growth and bone invasion and selected vital cancer regions that were properly fixated for coring. Three cores (1.0 mm diameter) were sampled for pT1 -2 cancers: one from the center and two from the periphery. For pT3 -4 cancers, four cores (1.0 mm diameter) were sampled: two from the center and two from the periphery. Tissue microarray cores were sampled from donor blocks and positioned in acceptor blocks using the TMA Grand Master (3DHISTECH Ltd.; Budapest; Hungary). Tissues were used according to the “The Code for Proper Secondary Use of Human Tissue” and “The Code of Conduct for the Use of Data in Health Research” as stated by the Federation of Dutch Medical Scientific Societies [14, 15].

Data storage & coding

Patient data were entered and stored in GEneric Medical Survey Tracker (Gemstracker) [16]. This software package allows data collection and is especially developed for clinical research and quality registrations in healthcare.

The software is published under an open-source license and allows coded data collection. RONCDOC data were coded by study ID. FFPE blocks representing the tissue microarray are stored at the department of pathology of the Erasmus MC.

Data and sample dissemination

The dissemination of RONCDOC data is regulated in the RONCDOC collaboration agreement. A request for data release can be sent to the RONCDOC consortium by submitting a research proposal in a standardized format. The consortium consists of the departments: Otorhinolaryngology and Head and Neck Surgery, Radiotherapy, Plastic and Reconstructive Surgery, Oral and Maxillofacial Surgery, Radiology and Nuclear Medicine, Pathology and Internal Oncology within the Erasmus Medical Center. During quarterly meetings the research proposals are evaluated and discussed. Researchers are encouraged to introduce themselves or a medical student as a new member of the research team when they submit a new research proposal. When additional data are collected in the course of new research projects, these are added to RONCDOC.

Utility and discussion

RONCDOC has been built to develop a consecutive and high-quality data warehouse and tissue collection for HNC. Extensive validation contributed to a high degree of accuracy and a low risk of bias. This combination of high-quality data with tumor tissue collection can be of high value for future research. The strength of RONCDOC is its completeness in collected variables like general socio-demographic information, detailed information on co-morbidity including ACE-27 scores,

detailed treatment information, data on health and lifestyle, follow-up and pathology data. The variables are registered directly at the source and at time of diagnosis of each new primary head and neck tumor. Aside from being comprehensive, RONCDOC is set up as a consecutive database. A consecutive registration has advantages over other registrations as a consecutive design does not have to take selection bias into account.

Overview of existing HNC databases

To date, there are few other large oncology databases including national registries and international studies

that include HNC. Most of these databases mainly cover other cancer types, yet some databases are specifically designed for HNC. Table 2 provides an overview of the various existing databases, including RONCDOC, to the best of our knowledge. Most of the databases were developed to get insight in national cancer care. Although there is a significant overlap in collected variables such as patient demographics, tumor staging and first course of treatment, important differences exist. The National Cancer Database (NCDB) [17, 18] provides data on comorbidities using the Charlson comorbidity index (CCI) while the Surveillance, Epidemiology, and End

Table 2 Overview and characteristics of existing head and neck cancer (HNC) databases

	(DAHANCA) [26]	NORDCAN [6, 7]	IKNL [24]	NET-QUBIQ [25]	DHNA [28]	HN5000 study [27, 29]	NCDB [17, 18]	SEER [4, 5]	RONCDOC
Country of origin	Denmark	Nordic countries	NL	NL	NL	UK	USA	USA	NL
Database characteristics									
Head and cancer specific	yes	no	no	yes	yes	yes	no	no	yes
Pro-/retrospective	pro	retro	retro	pro	pro	pro	retro	retro	both
Hospital (h) or population (p) based	p	p	p	h	p	p	h	p	p
Consecutive	yes	yes	yes	no	yes	no	no	yes	yes
Tumor characteristics									
Diagnosis/subsite	x	x	x	x	x	x	x	x	x
TNM classification	x	x	x	x	x	x	x	x	x
Treatment	x	x	x	x	x	x	x	x	x
Sociodemographic data									
Demographic data	x	x	x	x	x	x	x	x	x
Education/literacy		x		x		x	x		x
Occupation		x		x		x			x
Income				x		x	x		x
Health and lifestyle									
Co-morbidity	x			x	x	x	x		x
Smoking/alcohol	x		x	x	x	x			x
Quality of life	x			x	x	x			x
Follow-up									
Recurrence	x		x	x	x				x
Mortality	x	x	x	x	x	x	x	x	x
Biological samples									
Blood sample	x			x		x			x
Saliva sample				x		x			
Tissue sample	x			x		x			x

UK United Kingdom, USA United States of America, NL The Netherlands

x: variable included in database

Results SEER program (SEER) [4, 5] database does not [19]. The NCDB data are hospital based contrary to the population based data in the SEER database meaning that the NCDB only includes data from patients diagnosed or receiving treatment in hospitals accredited by the American College of Surgeons' Commission on Cancer [18, 19]. Currently, these hospitals represent approximately 30% of all hospitals in the U.S. covering about 70% of all patients newly diagnosed with cancer [17, 18]. The SEER program covers approximately 35% of the U.S. population including data from different geographic areas representative of the demographics of the complete U.S. population [4, 5]. To improve the latter national databases in the U.S., the National Program of Cancer Registries (NPCR) was founded supporting statewide, population based cancer registries in 1992 [20–22]. All these databases consist of a considerable large amount of data presuming to yield national coverage, but are formed retrospectively and in a non-consecutive manner. Another particular large database, NORDCAN, is an international database covering approximately 98% of all cancers diagnosed in the Nordic countries (Denmark, Finland, Iceland, Norway, Sweden, Faroe Islands and Greenland) [6, 7]. On the one hand NORDCAN describes both national and international incidence, prevalence and mortality, on the other hand detailed information about recurrence and co-morbidity is lacking [6, 7]. The Cancer Genome Atlas (TCGA) collected a comprehensive set of data to examine the molecular basis of cancer, including HNC [23]. In the Netherlands, the IKNL provides the NCR, a national cancer registration including many variables on patient and tumor characteristics [24]. In addition to the abovementioned databases, there are few databases that are prospective and specific to HNC. Recently, a Dutch multicenter research group conducted the NET-QUBIC study in patients with HNC [25]. While smaller in size than the previously mentioned databases, NET-QUBIC provides extensive data on patient and tumor characteristics complemented by a biobank. It also contains multiple patient reported outcome measures (PROMs) focusing on lifestyle and quality of life (QOL), and data on caregivers. In Denmark, the DAHANCA group was established to develop national guidelines targeting patients with HNC [26]. The DAHANCA database registers several basic variables such as symptoms, diagnostic evaluation and primary treatment, and also contains a biobank including tumor tissue, blood samples, and DNA [26]. In addition, a large UK-based clinical cohort study in head and neck cancer called Head and Neck 5000 was set up including data on QoL, blood samples and saliva samples [27]. To monitor and effectively improve high quality integrated care in the Netherlands, the Dutch Head and Neck Audit (DHNA) was set up

[28]. This multidisciplinary oncological quality registration includes primary head and neck tumors and aims to monitor, benchmark and find areas for improvement.

Current application of RONCDOC data

Physicians are often unable to give patients an accurate assessment of their prognosis [30–32], which may result in non-optimal patient counseling and over- or under-treatment [33, 34]. To improve this, more personalized and customized information about patients' prognosis is needed. Besides TNM-classification, a variety of covariables such as age, primary tumor site, and comorbidity are potential prognostic factors. Recently, our prognostic model OncologIQ [35], which predicts 1- to 10 year overall survival chances among patients with a primary head and neck tumor, was updated using RONDOC data [36–38]. RONCDOC data was also used in other publications reporting on survival rates [39–41].

Limitations

RONCDOC only includes patients treated at the Erasmus Medical Center Rotterdam. Despite the fact that the largest HNC care center of the Netherlands is located in Rotterdam, this single-center design can result in selection bias. Therefore, we recommend to extend the database nationally. RONCDOC is based on work executed voluntarily by a dedicated team of medical professionals, researchers and students. This team ensures that all data from the IKNL are compared to the data in the EPF. In case of errors, these are analyzed and corrected if applicable. Due to changing members of the RONCDOC study group, one could argue that the inter-rater-variability may increase. However, the interrater variability was constrained by the validation protocol. Establishing RONCDOC, i.e. analyzing paper patient files and all electronic patients documentaries was time consuming. This was inherent to the used methods to document patient data in the EPF. The majority of data are not structured and therefore not directly usable for database purposes. As such, a different future set up of the EPF may be necessary in order to automatically and efficiently collect data without error, preferably following FAIR guiding principles. The continuous updating and entry of new data remains time-consuming and requires adequate staffing including students and a dedicated senior team (with a data manager) that provides supervision and effectively addresses challenges. Another limitation is the incidence of missing data. However, when the missing (completely) at random assumption is plausible, multiple imputation can be applied to handle the missing data [42, 43].

Future perspectives

RONCDOC will continue to provide the data that is needed to realize robust and reliable prognostic models for HNC patients, like the recently updated OncologIQ and the development of a prognostic model for the palliative phase [38, 41]. These models could subsequently be used by physicians to improve decision making and optimize individual counseling and empower HNC patients. In order to further personalize counseling on treatment options and survival, a continuous update of RONCDOC including data on QoL is of high importance. In 2013 we developed the Healthcare Monitor (HM), an electronic patient reported outcome (ePRO) based clinical support system, which uses simple and internationally validated questionnaires regarding HNC, measuring physical and psychosocial functioning from day of diagnosis until 5 years after. The ePRO data collected within HM are a great source [44]. Since 2015, the HM is structurally embedded in our care for HNC patients. Repeated measurement data on QoL, psychosocial and physical symptoms from a consecutive cohort will enable valid and reliable predictions of QoL and morbidity in relation to survival.

At present, we are providing steps to connect the currently retrospective RONCDOC database with the prospective HM data and an automated input of clinical data from the EPF and the IKNL. Currently, data from 2017 are included working towards this prospective set-up of RONCDOC. The RONCDOC infrastructure will facilitate future fundamental and clinical studies, by bringing all data together instead of setting up data collection and processing for each project separately. This will also speed up translation of the results to the clinical practice. As for the tissue collection: future efforts will focus on expanding the inventory of histopathological characteristics and tissue sampling to more anatomical localizations within the head and neck region.

Conclusions

With RONCDOC, we have established a consecutive, high-quality data warehouse for HNC. This paper outlines the necessary steps to establish such a data warehouse, offering a blue print for other consortia. More accurate, valid and multidisciplinary data can make important contributions to future interdisciplinary research and patient care in the field of HNC.

Abbreviations

AJCC	American Joint Committee on Cancer
CCI	Charlson comorbidity index
DAHANCA	Danish Head and Neck Cancer
DHNA	Dutch Head and Neck Audit
ECOG	Eastern Cooperative Oncology Group
EPF	Electronic patient file

ePRO	Electronic patient reported outcome
FAIR	Findability, Accessibility, Interoperability and Reusability
FFPE	Formalin-fixed paraffin-embedded
Gemstracker	GEneric Medical Survey Tracker
HE	Hematoxylin and eosin stain
HM	Healthcare Monitor
HNC	Head and neck cancer
HPV	Human papilloma virus
IKNL	Netherlands Comprehensive Cancer Organization
NCDB	National Cancer Database
NCR	Netherlands Cancer Registry
NET-QUBIC	NETherlands Quality of Life and Biomedical Cohort study
NPCR	National Program of Cancer Registries
PROMs	Patient reported outcome measures
QoL	Quality of life
RONCDOC	Rotterdam Oncology Documentation
SEER	Surveillance, Epidemiology, and End Results
SPSS	Statistical Package for the Social Sciences
TMA	Tissue Microarrays
U.S.	United States
WHO	World Health Organization

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12885-025-14100-4>.

Supplementary Material 1.

Acknowledgements

We would like to thank all the students that joined the RONCDOC research team. We would also like to thank the members of the RONCDOC consortium, for their contribution to the project.

Authors' contributions

AH, EAD, JH, MH, MW, RBJ: design of the RONCDOC study. AH, EAD, MH collection of data. AH, ED and EAD took primary responsibility for writing the manuscript. All authors critically revised the manuscript and approved the final draft. AH is the corresponding author (a.hoesseini@erasmusmc.nl).

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Data availability

The data that support the findings of this study are available from the RONCDOC consortium but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the RONCDOC consortium.

Declarations

Ethics approval and consent to participate

This study was approved by the Erasmus MC Medical Ethics Review Committee (MEC- 2016–751). Informed consent was waived by the Erasmus MC Medical Ethics Review Committee considering the retrospective nature of the study. In the case of human tissue, only material of patients whom did not object to the use of their left over material is included (opt-out). All methods were performed in accordance with the relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

¹Department of Otorhinolaryngology and Head and Neck Surgery, Erasmus MC Cancer Institute, Erasmus University Medical Center, Dr. Molewaterplein 40, Rotterdam 3015 GD, The Netherlands. ²Department of Otorhinolaryngology and Head and Neck Surgery, Leiden University Medical Centre, Leiden, The Netherlands. ³Department of Pathology, Erasmus MC, Erasmus University Medical Center, Rotterdam, The Netherlands. ⁴Department of Education and Research, Elisabeth TweeSteden Hospital (ETZ), Tilburg, The Netherlands.

Received: 2 August 2024 Accepted: 7 April 2025

Published online: 25 April 2025

References

- Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin*. 2018;68(6):394–424.
- Gregoire V, Lefebvre JL, Licitra L, Felip E, Group E-E-EGW. Squamous cell carcinoma of the head and neck: EHNS-ESMO-ESTRO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2010;21 Suppl 5:v184–6.
- Hoofd-halskanker: Netherlands Comprehensive Cancer Organisation; 2018. updated 26–01–2018. Available from: <https://www.iknl.nl/oncologische-zorg/tumorteams/hoofd-halskanker>. Accessed 1st January 2024.
- Gloeckler R, Ries LA, Reichman ME, Lewis DR, Hankey BF, Edwards BK. Cancer survival and incidence from the Surveillance, Epidemiology, and End Results (SEER) program. *Oncologist*. 2003;8(6):541–52.
- Surveillance Epidemiology and End Results Program (SEER). Available from: <https://seer.cancer.gov/>. Accessed 1st January 2024.
- Engholm G, Ferlay J, Christensen N, Bray F, Gjerstorff ML, Klint A, et al. NORDCAN—a Nordic tool for cancer information, planning, quality control and research. *Acta Oncol*. 2010;49(5):725–36.
- Pukkala E, Engholm G, Hojsgaard Schmidt LK, Storm H, Khan S, Lambe M, et al. Nordic Cancer Registries - an overview of their procedures and data comparability. *Acta Oncol*. 2018;57(4):440–55.
- UK Parliament. House of Commons SaTC. Alcohol guidelines, Eleventh Report of Session 2010–12. London 2011. Online link to this document: Microsoft Word - S&T Ctte Virtual volume HC 1535.docx
- Piccirillo JF, Tierney RM, Costas I, Grove L, Spitznagel EL Jr. Prognostic importance of comorbidity in a hospital-based cancer registry. *JAMA*. 2004;291(20):2441–7.
- Oken MM, Creech RH, Tormey DC, Horton J, Davis TE, McFadden ET, Carbone PP. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol*. 1982;5(6):649–55.
- Edge SB, Compton CC. The American Joint Committee on Cancer: the 7th edition of the AJCC cancer staging manual and the future of TNM. *Ann Surg Oncol*. 2010;17(6):1471–4.
- Brierley JD, Gospodarowicz MK, Wittekind C. UICC TNM classification of malignant tumours. Eight Edition. Wiley Blackwell; 2017.
- Amin MB, Edge SB. AJCC cancer staging manual. 8th ed. New York: Springer; 2017.
- Federa F. Code for proper secondary use of human tissue in the Netherlands. 2002.
- Codes of Conduct. Available from: <https://www.federa.org/codes-conduct>. Accessed 1st January 2024.
- Gemstracker. Available from: <https://gemstracker.org/>. Accessed 1st January 2024.
- NCDB. Available from: <https://www.facs.org/quality-programs/cancer/ncdb>. Accessed 1st January 2024.
- Boffa DJ, Rosen JE, Mallin K, Loomis A, Gay G, Palis B, et al. Using the National Cancer Database for Outcomes Research: A Review. *JAMA Oncol*. 2017;3(12):1722–8.
- Janz TA, Graboyes EM, Nguyen SA, Ellis MA, Neskey DM, Harruff EE, Lentsch EJ. A Comparison of the NCDB and SEER Database for Research Involving Head and Neck Cancer. *Otolaryngol Head Neck Surg*. 2019;160(2):284–94.
- Wingo PA, Jamison PM, Hiatt RA, Weir HK, Gargiullo PM, Hutton M, et al. Building the infrastructure for nationwide cancer surveillance and control—a comparison between the National Program of Cancer Registries (NPCR) and the Surveillance, Epidemiology, and End Results (SEER) Program (United States). *Cancer Causes Control*. 2003;14(2):175–93.
- White MC, Babcock F, Hayes NS, Mariotto AB, Wong FL, Kohler BA, Weir HK. The history and use of cancer registry data by public health cancer control programs in the United States. *Cancer*. 2017;123(Suppl 24):4969–76.
- Hutton MD, Simpson LD, Miller DS, Weir HK, McDavid K, Hall HI. Progress toward nationwide cancer surveillance: an evaluation of the National Program of Cancer Registries, 1994–1999. *J Registry Manage*. 2001;28(3):113–20.
- Cancer Genome Atlas N. Comprehensive genomic characterization of head and neck squamous cell carcinomas. *Nature*. 2015;517(7536):576–82.
- Netherlands Cancer Registry (NCR). Available from: <https://www.iknl.nl/en/ncr>. Accessed 1st January 2024.
- Verdonck-de Leeuw IM, Jansen F, Brakenhoff RH, Langendijk JA, Takes R, Terhaard CHJ, et al. Advancing interdisciplinary research in head and neck cancer through a multicenter longitudinal prospective cohort study: the NETHERlands Quality of life and Biomedical Cohort (NET-QUBIC) data warehouse and biobank. *BMC Cancer*. 2019;19(1):765.
- Overgaard J, Jovanovic A, Godballe C, Grau EJ. The Danish Head and Neck Cancer database. *Clin Epidemiol*. 2016;8:491–6.
- Ness AR, Waylen A, Hurley K, Jeffreys M, Penfold C, Pring M, et al. Establishing a large prospective clinical cohort in people with head and neck cancer as a biomedical resource: head and neck 5000. *BMC Cancer*. 2014;14:973.
- van Overveld LFJ, Takes RP, Smeele LE. The Dutch Head and Neck Audit: The First Steps. *J Head Neck Surg*. 2018;1(1):1–8.
- Ness AR, Waylen A, Hurley K, Jeffreys M, Penfold C, Pring M, et al. Recruitment, response rates and characteristics of 5511 people enrolled in a prospective clinical cohort study: head and neck 5000. *Clin Otolaryngol*. 2016;41(6):804–9.
- Glare P, Virik K, Jones M, Hudson M, Eychmuller S, Simes J, Christakis N. A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ*. 2003;327(7408):195–8.
- White N, Reid F, Harris A, Harries P, Stone P. A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts? *PLoS ONE*. 2016;11(8): e0161407.
- Christakis NA, Lamont EB. Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. *BMJ*. 2000;320(7233):469–72.
- Mack JW, Cronin A, Keating NL, Taback N, Huskamp HA, Malin JL, et al. Associations between end-of-life discussion characteristics and care received near death: a prospective cohort study. *J Clin Oncol*. 2012;30(35):4387–95.
- Temel JS, Greer JA, Admane S, Gallagher ER, Jackson VA, Lynch TJ, et al. Longitudinal perceptions of prognosis and goals of therapy in patients with metastatic non-small-cell lung cancer: results of a randomized study of early palliative care. *J Clin Oncol*. 2011;29(17):2319–26.
- Hoesseini A. Updated 2019, October 1. Available from: <http://www.oncologiql.nl/>. Accessed 1st January 2024.
- Datema FR, Ferrier MB, van der Schroeff MP, Baatenburg de Jong RJ. Impact of comorbidity on short-term mortality and overall survival of head and neck cancer patients. *Head Neck*. 2010;32(6):728–36.
- Datema FR, Ferrier MB, Vergouwe Y, Moya A, Molenaar J, Piccirillo JF, Baatenburg de Jong RJ. Update and external validation of a head and neck cancer prognostic model. *Head Neck*. 2013;35(9):1232–7.
- Hoesseini A, van Leeuwen N, Offerman MPJ, Zhang J, Dronkers EAC, Sewnaik A, et al. Predicting survival in head and neck cancer: External validation and update of the prognostic model OncologIQ in 2189 patients. *Head Neck*. 2021. <https://pubmed.ncbi.nlm.nih.gov/33960553/>.
- Te Riele R, Dronkers EAC, Wieringa MH, De Herdt MJ, Sewnaik A, Hardillo JA, Baatenburg de Jong RJ. Influence of anemia and BMI on prognosis of laryngeal squamous cell carcinoma: Development of an updated prognostic model. *Oral Oncol*. 2018;78:25–30.
- Bugter O, van Iwaarden DLP, Dronkers EAC, de Herdt MJ, Wieringa MH, Verduijn GM, et al. Survival of patients with head and neck cancer with metachronous multiple primary tumors is surprisingly favorable. *Head Neck*. 2019;41(6):1648–55.

41. Hoesseini A, Sewnaik A, van den Besselaar BN, Zhang J, van Leeuwen N, Hardillo JA, et al. Prognostic model for overall survival of head and neck cancer patients in the palliative phase. *BMC Palliat Care*. 2024;23(1):54.
42. Rubin DB. Multiple imputation for survey nonresponse. New York: Wiley; 1987.
43. van Ginkel JR, Kroonenberg PM. Analysis of Variance of Multiply Imputed Data. *Multivariate Behav Res*. 2014;49(1):78–91.
44. Dronkers EAC, Baatenburg de Jong RJ, van der Poel EF, Sewnaik A, Offerman MPJ. Keys to successful implementation of routine symptom monitoring in head and neck oncology with Healthcare Monitor and patients' perspectives of quality of care. *Head Neck*. 2020;42(12):3590–600. <https://pubmed.ncbi.nlm.nih.gov/32808370/>.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.