

OHIO CANCER
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OCISS Newsletter

OCISS Updates

OCISS Data Evaluation, 1996-2014

OCISS submitted 1996-2014 data to CDC's National Program of Cancer Registries (NPCR) and to the North American Association of Central Cancer Registries (NAACCR) in late November 2015. All data, but especially data for diagnosis year 2013, were evaluated for completeness and data quality by both organizations. OCISS received the **Registry of Distinction Award from CDC's NPCR**, having met CDC's National Data Quality Standard. OCISS data were 98% complete (standard is 95%), had no unresolved duplicates (standard is less than 1%), had no missing or unknown age, sex, or county (standard is less than 2% for each), had 1.8% missing or unknown race and 2.8% death certificate only (standard is less than 3% for each), and all records passed core single and inter-field edits (standard is 99%). OCISS also received the **NAACCR Gold Certification**, having achieved the highest NAACCR standard for complete, accurate, and timely data to calculate standard incidence statistics. NAACCR data quality standards are similar to CDC NPCR with two exceptions. There must be fewer than 0.1% duplicate case records and all data variables used to create incidence statistics by cancer type, sex, race, age, and county must be 100% error-free. Thank you for all the work you do to report timely, complete, and accurate data to OCISS to allow us to achieve these recognitions.

NAACCR version 16 Conversion

OCISS recently shared that we were awaiting the new edits for NAACCR version 16 in order to upgrade Web Plus to accept files in the NAACCR version 16 format. The new edits were released after the Annual NAACCR Conference in mid-June. OCISS staff are reviewing to see which of the 175 new edits we need to add and whether there are any that we can remove. We will keep you posted via e-mail as to where we are in that process.

Death Clearance

OCISS recently let hospital reporters know that we were in the process of doing our annual death certificate review to identify potential cancer cases not previously reported to OCISS. Some of you may have since received notification of potential cancer cases for which we need your follow-up. These are persons who died in your facility and had a cancer cause of death but were not previously reported to OCISS. We sent out a short 'cheat sheet' and an updated manual – in which we tried to incorporate many of your comments and suggestions from last year's process. Please keep in mind that some of these cases may not have been reportable by your facility because their diagnosis and treatment were elsewhere. However, the hospital is our only source of information and we need your help to confirm the cancer diagnosis and estimate a date of diagnosis.

Close Out 2014

As part of last year's Close Out process, OCISS identified 23 hospitals that indicated they reported more cases than OCISS had received. As a result of this review and subsequent follow up, more than 4600 cancer cases were submitted to OCISS by these facilities. This demonstrates why the Close Out process is so important. Thank you to the hospitals that worked with us to identify and submit these cases. We will be starting Close Out for 2015 soon.

OCISS Professional Development Seminar

Many thanks to all who attended the OCISS Professional Development Seminar on June 7, 2016. If you have not yet done so, please remember to complete the evaluation at <https://www.surveymonkey.com/r/J79MR2S>.

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NAACCR Webinars are available in [Web Plus](#). Each provides 3 hours of continuing education (CE) credit. CEs are available for three years after the 'live session' was presented. The following are some abstracting tip highlights from recent NAACCR webinars. Refer to the specific webinars for more information.

Abstracting Tips: Bone & Soft Tissue (NAACCR Webinar January 2016)

- ⇒ Sternum (C41.3) and Sacrum, Coccyx, Symphysis Pubis (C41.4) are **NOT** paired sites [[FORDS 2016](#) pg 9].
- ⇒ Use "Other Sites" in the [MP/H rules](#) for bone and soft tissue:
 - * M2 single tumor = single primary will be used often.
 - * M5 **Kaposi sarcoma is always a single primary** regardless of site and timing, i.e. only one per life time.
- ⇒ Use Hematopoietic Coding Manual for multiple myeloma (9732/3).
 - * http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
- ⇒ Gastrointestinal stromal tumors (GIST) are reportable only when a physician or pathologist *states* it is *malignant* or there are multiple foci, metastasis or positive lymph nodes [[SEER Data Collection Answers & FORDS 2016](#) pg 124].
- ⇒ Code primary site for GIST to the location where the malignant GIST originated [SEER Program Coding & Staging Manual 2015 pg 76, <http://seer.cancer.gov/tools/codingmanuals/>].
- ⇒ Staging -
 - * Musculoskeletal tumor society (MSTS) staging should **NOT** be used for cancer reporting.
 - * AJCC Cancer Staging Manual 7th Ed chapter 27: Bone, applies to all primary of the bone **except** primary malignant lymphoma and myeloma.
 - * Bone and sarcoma is tumor size driven, and there is no T4 [AJCC Cancer Staging Manual 7th Ed chapters 27 and 28].
 - * Regional lymph node involvement from bone tumors is rare, so clinical N may be used for pathological staging. Any T, N1, Any M and Any G is stage IVB.
 - * Ewing's Sarcoma is always AJCC grade 4, and for soft tissue primary sites, CS SSF 1 grade for sarcomas is also 4.
- ⇒ Grade is required for bone and soft tissue because staging is grade-driven. For soft tissue sarcomas, see SEER instructions for coding grade and CS SSF1: <http://seer.cancer.gov/tools/grade/>.
- ⇒ Denosumab (aka Prolia, Xgeva) is considered ancillary and **NOT** coded as treatment **EXCEPT** in the case of unresectable giant cell tumors of the bone, where it IS CODED as BRM/Immunotherapy [[SEER*Rx](#)].

Abstracting Tips: Breast (NAACCR Webinar February 2016)

- ⇒ Coding primary site [[SEER Program Coding & Staging Manual 2015 Appendix C](#)]:
 - * When multiple invasive tumors are found in two or more quadrants, code to C50.9.
 - * When multi-focal tumors are found in one quadrant, code to that specific quadrant.
 - * Code C50.8
 - ◇ when there is a single tumor in two or more subsites *and* it is unknown where it originated
 - ◇ single tumor at 12, 3, 6, or 9 o'clock position
- ⇒ Inflammatory carcinoma, characterized by peau d'orange involving 1/3 or more of the skin of the breast is mainly a clinical diagnosis, with staging classified as T4d [AJCC Cancer Staging Manual 7th Ed pgs 354, 358].

Abstracting Tips: Ovary (NAACCR Webinar April 2016)

Regarding liver metastases—metastasis to the liver **CAPSULE** is T3/Stage III while metastasis to liver **PARENCHYMAL** is M1/Stage IV [AJCC Cancer Staging Manual 7th Ed pg 421].

Abstracting Tips: Kidney (NAACCR Webinar May 2016)

Important clarification about sarcomatoid/spindle cell [<http://www.cancerstaging.org/cstage/education/Pages/Kidney-SSF4-Sarcomatoid-Features.aspx>]:

- ⇒ The histology 8318 “Renal cell carcinoma, sarcomatoid (spindle cell)” is **ONLY** coded as such when it is stated in the final diagnosis, otherwise it is **NOT** considered a distinct histology.
- ⇒ Sarcomatoid/spindle cell is **ignored** as a specific histology type in [MP/H rules](#) H5 and H12.
- ⇒ Sarcomatid/spindle cell features are recorded in CS SSF4 of the kidney schema.

Abstracting Tips: Prostate (NAACCR Webinar June 2016)

- ⇒ Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma (MP/H Other Sites Rules H10 and H20). This is because **for prostate primaries ONLY**, “acinar adenocarcinoma” and “adenocarcinoma” are *equivalent* terms and “acinar adenocarcinoma” is not a specific histologic type for prostate primaries [[MP/H rules](#) pg 77].
- ⇒ Reminder: for cases diagnosed January 1, 2014 and later, Gleason score of **7** now corresponds to a grade code of **2** while Gleason score of **5 or 6** is grade code **1** [<http://seer.cancer.gov/tools/grade/>].
- ⇒ Rule of thumb: in the event of no disease progression, if a patient who initially chose active surveillance as first course of treatment changes his mind BEFORE his first follow up visit for active surveillance, then it is a change in first course of treatment. If it occurs after that first follow up visit, the switch to another treatment is second course [Kathleen Thoburn, Dr. Winchester, [Answer forum](#)].
- ⇒ There is no neoadjuvant therapy for prostate cancer outside of clinical trials. Be aware that not all drugs given prior to surgery are for treating the cancer [[AJCC Curriculum for Registrars Lesson 22](#), [Answer forum](#)].

Abstracting Resources

- ◇ **FORDS 2016** - FORDS 2016 is available from the American College of Surgeons. Please note the new data items and discontinued items for cases diagnosed January 1, 2016 and later.
 - ⇒ <https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual>
- ◇ **Text Fields** -The National Cancer Registrar Association (NCRA) has free site-specific informational abstracts that outline the pertinent information that should be included in the text fields when abstracting.
 - ⇒ Includes tips on where to find the information and examples.
 - ⇒ Sites available: bladder, breast, cervical, colon, endometrial, lung, melanoma, ovarian, prostate.
 - ⇒ <http://www.cancerregistryeducation.org/rr>
- ◇ **TNM Staging** - SEER launched the Registrar Staging Assistant (SEER*RSA) website earlier this year to help with assigning TNM stage and coding predictive and prognostic factors.
 - ⇒ Includes a staging calculator and full schema list that is searchable by term or site/histology, which can be particularly helpful when abstracting uncommon site/histology combinations.
 - ⇒ The notes section of each [TNM schema](#) include a link to the schema-corresponding chapter of SEER Summary Stage 2000 online manual to facilitate summary stage assignment.
 - ⇒ <https://staging.seer.cancer.gov/>
- ◇ **Systemic Treatment** - The interactive antineoplastic drugs database SEER*Rx provides information on whether a specific drug should be coded, its category classification, synonyms, detailed remarks, and information on drug regimens.
 - ⇒ <http://seer.cancer.gov/seertools/seerrx/>



OCISS

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Ask OCISS

Is polycythemia vera (9950/3) reportable to OCISS when the patient only had phlebotomy?

Yes, because phlebotomy is a valid treatment for control of polycythemia vera. To be reportable, the diagnosis must be polycythemia vera or one of the alternative names listed in the hematopoietic & lymphoid neoplasm database (see: <http://seer.cancer.gov/seertools/hemelymph/51f6cf57e3e27c3994bd538d/?q=9950/3>). Phlebotomy is recorded specifically **ONLY** for polycythemia vera [SEER Inquiry: <http://seer.cancer.gov/seerquery/index.php?page=view&id=20110067&type=q>].

Please send your questions to OCISS@odh.ohio.gov with **Ask OCISS** in the subject field.

Unknown Race

As OCISS prepares 2014 data for submission at the national level, 295 records with unknown race were sent out to 59 hospitals for review. This is because race is important for cancer data analysis. It also factors into the assessment of completeness of state cancer registry data.

OCISS is very appreciative of the hospital reporters who responded (85% responded within 4 weeks), resulting in 68% of the patient records getting updated with known race information.

Aside from the patient intake form, sources where race information may be found include the history and physical examination of the patient, consultation notes, physician progress notes, nurses' notes, discharge summary, and admission or ER physician notes. [SEER Program Coding and Staging Manual 2015 Appendix D](#) has a list of race and nationality descriptions that can be helpful for coding race.

Unknown Date of Diagnosis

OCISS has been reviewing records where date of diagnosis is unknown. Although 53% of the cases were assigned a Class of Case of 30 or above, 47% were analytic cases.

Per FORDS guidelines, if the year of diagnosis cannot be identified, it **must** be approximated, while month and day can be unknown [[FORDS 2016](#) pg 120]. If you have a case where you absolutely cannot estimate at least a year for the initial date of diagnosis, please call OCISS. We will work with you to try to estimate a diagnosis date.

Calendar of Events

September 29-30, 2016

OCRA Annual Meeting (hosted by NECRA)

Holiday Inn in Canton, Ohio

Detailed information will be posted on OCRA's website:

<http://www.ohio-ocra.org/ocracalendar/ocracalendar.html>