TEXAS CANCER REPORTING NEWS

Texas Cancer Registry

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From the Director

We are beginning the New Year with completion of submissions of Texas Cancer Registry (TCR) data in response to three Calls for Data, including those from the North American Association of Central Cancer Registries (NAACCR), the Centers for Disease Control and Prevention (CDC) and the Central Brain Tumor Registry of the U.S. (CBTRUS). Over 600,000 de-identified cancer records covering the years 1995 through 2002 were sent to NAACCR and CDC for inclusion in upcoming national cancer incidence publications (Cancer Incidence in North America and U.S. Cancer Statistics, 2002). We will learn later in the spring if our 2002 data met all criteria for achieving silver or gold certification from NAACCR. We continue to improve upon the completeness, timeliness and quality of the data thanks to the efforts of our cancer reporters, TCR staff and others.

We also are pleased to announce that several academic centers in the state are partnering with the TCR in providing assistance and piloting methods for further improving cancer registration processes and the completeness, timeliness and accuracy of the TCR's data. Some of these efforts are focused on statewide data improvements and others targeted for improvements in the Border area. The Texas A&M School of Rural Public Health (SRPH) has contracted with the Department of State Health Services for a 15-month period to pilot the operation of a sub-regional Border cancer registry to be located at the Texas A&M University System Health Science Center's South Texas Center in McAllen. This office will house two staff whose primary responsibilities will be to facilitate complete, timely and accurate cancer case reporting from hospitals and other health care providers in a 7 county regional area which includes Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy and Zapata counties. An evaluation of the effectiveness of the presence of a border area central cancer registry site and staff and the administration of the registry via an academic center will be made.

In addition to the SRPH efforts, the University of Texas Health Science Center at Houston- Brownsville campus will be assisting the TCR with securing electronic pathology laboratory reporting from Border area labs and will assist in identifying and collecting data on Texas residents who die in Mexico. They also will be collaborating with others in developing a university curriculum for increasing the CTR workforce in the state. The University of Texas Health Science Center at Houston and the San Antonio Cancer Institute are providing staff to be located at their Laredo campus for helping improve the quality of reported data for the Border area (e.g., missing or unknown data items) and reducing the number of cases identified solely by death certificates.

We also are receiving assistance from the University of Texas MD Anderson Cancer Center who is providing two certified tumor registrars (CTRs) for a year to process, review and code cancer records backlogged in the TCR. This will help us catch up and stay current on the processing of newly incoming cancer reports. The University of Texas Medical Branch at Galveston has provided a staff person housed in our Houston regional registry to assist with data collection efforts in a 16-county area in southeast Texas.

The support from these academic and health science centers is greatly appreciated and will result in more complete, timely and accurate cancer data for Texas, essential for better understanding the causes of cancer and implementing effective cancer prevention and control measures to reduce the cancer burden in our state.

We also have launched an initiative using one-time Preventive Health and Health Services Block Grant funding to pilot test the cost effectiveness of contracting for case finding and data collection services to secure cancer reporting from small caseload (<100 cases) hospitals across the state. Historically, these facilities

(Continued on page 2)

have insufficient or high turnover of staff performing cancer reporting duties, requiring frequent training. They also experience the most unreported cases and increased follow-back efforts to clarify missing or conflicting information. A total of 144 small caseload hospitals across the state agreed to participate in this pilot which focuses on identifying and collecting data on 2004 cancer cases. The project is to be completed by August 2005 and will include an evaluation component to assess if continuation is warranted, and if so, funds will be sought for its continuation.

- Nancy S. Weiss, Ph.D.

The New Face

Dr. Eduardo Sanches, M.D., M.P.H.
Department of State Health Services Commissioner

The Texas Department of Health and Cancer Registry Division both have new names. We are now the Department of State Health Services (DSHS) and the Cancer, Epidemiology and Surveillance Branch (CES), respectively. Eduardo Sanchez, M.D., M.P.H. is the new Commissioner of the DSHS and Nancy S. Weiss, Ph.D., M.P.H. has been selected as the Branch Manager of the CES. Housed within the CES Branch is the Texas Cancer Registry (TCR). Our branch has also experienced staffing changes over the last year. Patsy Long, Kimberly Kinney-Lara, Carolyn Hunter, Paul Betts and Shelley Jordan have accepted positions elsewhere.

Elaine Woods is the Regional Operations Supervisor for Arlington, Lubbock and Houston regional coverage. Velma Garza, Regional Operations Supervisor in the Central Office, is responsible for San Antonio, Region 7, and McAllen sub-regional registry operations. Susan Perez, the Quality Assurance Team Lead, is responsible for quality assurance, training and consolidation.

Regional Team Leads include Judy Spong and Nelda Gonzalez. Marie Longoria and Dora Rodriguez-Flores are Lead Workers. Our case-finding specialists are Diann Purvis, Cynthia Evans and Dwenda Smith. Regional trainers are Candace Bogard, Geri Knippen, Cindy DeAnda, Wanda Taylor, and Debra Anderson. Leticia Vargas and Henry Abimbola are the Quality Control Analysts, Beatriz Gutierrez is the Vital Statistics Specialist and Esmeralda Zavala is in Registry Operations. The data consolidation team is comprised of Jael Davis, Lead Worker, Robin Milner, and Hortencia Regalado. Judy Gonzales handles special projects and Dianna Watkins uploads and examines incoming electronic data. Melanie Williams is the Supervisor for the Epidemiology section. David Risser, and Brenda Mokry are epidemiologists and Stephanie Easterday and George Lara function as research specialists.

Contract staff include Jon Unnasch, business analyst, Randy Robisheaux, programmer, and Marilyn Stark, systems analyst. Contract CTR's include Judy Maynard, Mary Martinez, Pam Fortier and Cindy Dorsey.

The administrative staff includes Team Lead Debra Dale, Henrietta (Etta) Jimenez, Kathy Johnson and Jessica Castillo. Corbin Choate is the graphics designer. John Hopkins is the program specialist responsible for program planning, program development, contracting and liaison activities.

Texas Cancer Data Work Group (TCDWG)

The Texas Cancer Data Work Group (TCDWG) is a committee of twenty-four stakeholder organizations that supports and advises the TCR. The entire Work Group and three standing subcommittees meet three times each year. Subcommittee meetings are supplemented by periodic teleconferences as needed between regular meetings.

The TCDWG has revised its subcommittee structure to better meet the goals and objectives of both the Work Group and the TCR. Standing subcommittees now include Data Collection, Data Utilization and Funding/Rules. The Data Collection Subcommittee continued to assist in devising mechanisms to assure efficient and quality data collection and processing; support and create education initiatives; and identify methods for improving data completeness, timeliness and accuracy. The Data Utilization Subcommittee has been working to facilitate broad and appropriate use of TCR data to improve research, health planning and policy development. The Funding/Rules Subcommittee is providing support to secure adequate funding of the TCR, and seek and identify alternative funding sources. The Funding/Rules Subcommittee also has as its responsibility providing advice on laws, regulations and policies when needed.

This last year, important input was provided by the TCDWG to assist in implementing the Independent Pathology Laboratory Reporting Pilot Project, as well as the

physician follow-back process that results from obtaining pathology laboratory reports. Data issues addressed by the Work Group have included potential uses of TCR data, developing disclaimers so customers better understand data limitations, ensuring recognition for the TCR when its data are used and envisioning new products that use TCR data. The TCDWG has contributed its collective knowledge and skills to helping the TCR address certain challenges of change brought about by consolidation of the new Department of State Health Services under the Health and Human Services Commission. The Work Group has been involved in identifying additional funding options to help the TCR meet its goal of "Gold" certification by the North American Association of Central Cancer Registries.

- John Hopkins
Program Specialist

Case Ascertainment
(A Needle in a Haystack)

Case ascertainment is much like searching for a "needle in a haystack". The "needles" are the cancer cases being sought and the "haystacks" are all the case ascertainment sources listed in the Cancer Reporting Handbook, dated July 2004 (hereinafter referred to as "Handbook"). The two primary "haystacks" (sources) are a facility's disease index and pathology reports. The other sources listed in the Handbook should be cross-checked to assure all reportable cases are being captured.

A registrar will need to determine whether all services (inpatient and outpatient) are captured on one disease index. If they are not, separate reports should be created to capture each service not available in the main report.

The disease index is a useful tool formatted from the ICD-9-CM codes detailed on pages 17- 19 of the Handbook. These codes indicate which cases are to be reviewed for reportability. Do not expect every case with the specified ICD-9-CM codes to be reportable. Please refer to page 16 of the TCR handbook for a list of non-reportable neoplasms. The ICD-9-CM coder codes each chart based on ICD-9-CM billing rules, not the cancer reporting rules outlined in the Texas Cancer Incidence Reporting Act. Depending on the types of services provided at the facility, 100 cases may be reviewed and only 50 are reported.

Pathology reports review is another case ascertainment process for reportable diagnoses. If pathology is outsourced, the registrar should have a procedure in place to review the reports prior to placement in the medical record or make copies of all reports for further review.

These case ascertainment processes pull information from different areas. They are equally important and compliment rather than duplicate each other. Pathology ascertainment identifies pathologically diagnosed cancers. The Disease Index review will identify radiological and clinically diagnosed cancers, as well as patients with active cancer. Other case ascertainment sources include patient logs from surgical and outpatient departments, medical and diagnostic imaging, radiation and medical oncology, and emergency room reports. Additional sources are the facility monthly death report and the monthly quality assurance report on ICD-9-CM corrected codes.

Facilities utilizing an automated casefinding method (the facility's mainframe system uploads possible reportable cases based on ICD-9-CM codes into the cancer registry software's suspense file) should run a manual disease index at the completion of each reporting year. The intent of the automated method is to eliminate the need for monthly casefinding review of disease index and other sources that are specific to your facility. However, compare the manual disease index to the cancer registry database to ensure that all cases were reported or clearly documented as non-reportable.

A helpful step-by-step guide for case ascertainment is detailed in the TCR Handbook and an informative casefinding training module can be found on the web at http://training.seer.cancer.gov/. TCR casefinding specialists are available to help establish successful casefinding procedures, or evaluate existing procedures and provide input on the disease index to ensure it encompasses all the variables necessary to be an efficient tool. These staff or other TCR staff can work with your internal computer specialist or your medical software company to get the best possible report. Certain medical software companies have recognized this need and worked with the TCR

to get a report format for their customers. Please remember that once reporting is complete for a year, a copy of your disease index report, the Non-Reportable Listing (example on page 28 of the Handbook and in SCL) and the casefinding checklist as detailed on page 29 of the Handbook should be mailed to your TCR regional office.

- *TCR staff*

In 2004, TCR Audited by CDC

The tables are turned and we too have been audited! The Texas Cancer Registry's 2001 data were audited by the Centers for Disease Control and Prevention (CDC). First and foremost, we extend our sincere appreciation to the facilities that were selected to assist with this audit. While this was an audit of the TCR, reporting facilities were selected in order to verify that the TCR had accurate and complete data. The TCR is funded by the National Program of Cancer Registries (NPCR), the Division of Cancer Prevention and Control within the CDC. We must ensure compliance with NPCR program standards for completeness, timeliness, and the quality of data set for central cancer registries.

The TCR provided an extract file containing 33,000 eligible cases of all unduplicated in situ and invasive cancers of female breast, colon and rectum, lung and bronchus, and prostate that were diagnosed in 2001. While we often receive multiple records for the same primary from different facilities, the record that is received first makes it into our analytic file (unduplicated records) and this facility ID number is usually retained. As other records are received for the same primary, our analytic record gets updated to contain the best information of all records submitted for that primary. The CDC randomly selected cancer cases from our analytic file and any facility reporting at least 24 new cancer cases was eligible to be included in the audit, with the exception of military, VA hospitals and children's facilities. Nine facilities were selected to participate in the audit.

The audit was conducted by two auditors and consisted of two parts, casefinding and data quality review. During the casefinding process, all sources were reviewed to ensure completeness of data reporting. The purpose of the data quality review was to identify any problems in data collection and interpretation, to estimate rates of agreement, and to standardize interpretation of the medical record. All selected cases were re-abstracted and recoded using the information from the medical record, then the codes were compared to the TCR record to determine if the codes matched exactly. A total of 33 records were randomly selected from each facility audited for a total of 297 cases reviewed.

The TCR was given lists of unmatched cases and printed abstracts with those codes that did not match. Potentially missed cases were looked up in our database to determine if they were truly missed cases. Some cases were determined as not missed if they were non-Texas residents, diagnosed in years prior to 2001, or if they were non-reportable cancers. The printed abstracts with discrepancies were reviewed and many were resolved because we had multiple records submitted for some and the abstract the auditor reviewed was made up of several records.

We were very pleased with the results of the audit. Our case completeness from casefinding review shows that we are 98.7% complete. In comparison, the national standard rate for CDC is 95%, so we surpassed that rate. We only missed 20 cases total and we had no missed cases identified in three or more casefinding sources. The highest number of cases missed were from one source-pathology reports. Overall, prostate cancer cases were missed most often.

Our data quality review accuracy rate was 94.6%, with 208 data discrepancies identified. Of these, 46.2% (96 errors) were considered major errors and 53.8% (112 errors) considered minor. The major discrepancies consisted of eleven required reporting fields. The highest number of major discrepancies that were found in three of the eleven fields were histology, stage at diagnosis, and date of diagnosis. The two cancer sites with the most errors were female breast with 37.5% (78 errors) and lung and bronchus with 33.7% (70 errors). Prostate cancer was identified with the lowest amount of discrepancies, only 11.5% (24 errors). Our number one discrepancy was for the histology codes, and the cancer site with the most major discrepancies was lung and bronchus with 37.5% (36 errors).

(continued on next page)

Remember:
Do not cod e behavior as "in situ" (2) if there is a statement indicating invasion.

	Histology	Stage	DX Date (yy or mm/dd >30 days)
TCR Error rate (%)	12.5	7.1	5.1
NPCR Error Rate (1993-2000) Mean%	8.7	12.0	3.9

Audit conclusions and recommendations – no recommendations were made for case completeness because we did so well. Data quality recommendations were to provide a review of basic abstracting practices focusing on interpretation of breast clock diagrams, Gleason's scores, and coding multiple histology tumors with special focus on polyps and adenomas. Review of all reports to focus on proper information to use in determining date of diagnosis, using all reports to capture complete accurate data with attention to dates and diagnostic language, abstracting and anatomy of female breast and lung and bronchus were also recommended. Finally, it was recommended we strengthen our policy on text documentation necessary for quality control procedures and develop a policy outlining the hierarchy of sources for determining correct subsites.

2001 Audit - 1996 Data
Case Completeness - 81.8% (243 missed cases)
Data Accuracy Rate - 93.4%

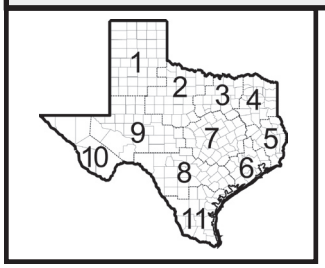
2004 Audit - 2001 Data
Case Completeness - 98.7% (20 missed cases)
Data Accuracy Rate - 94.6%

We have improved, thanks to all of you!

-Velma Garza, CTR
Regional Operations Supervisor

Case Completeness

HSR 1:	2001	100%	HSR 4:	2001	89%	HSR 7:	2001	94%	HSR 10:	2001	100%
	2002	97%		2002	87%		2002	94%		2002	100%
	2003	71%		2003	41%		2003	74%		2003	85%
	2004	23%		2004	4%		2004	26%		2004	19%
HSR 2:	2001	96%	HSR 5:	2001	92%	HSR 8:	2001	100%	HSR 11:	2001	93%
	2002	94%		2002	89%		2002	96%		2002	88%
	2003	55%		2003	58%		2003	65%		2003	54%
	2004	9%		2004	14%		2004	11%		2004	10%
HSR 3:	2001	96%	HSR 6:	2001	100%	HSR 9:	2001	99%	Statewide:	2001	97%
	2002	93%		2002	100%		2002	94%		2002	95%
	2003	60%		2003	80%		2003	64%		2003	66%
	2004	12%		2004	11%		2004	7%		2004	13%



As of: February 19, 2005

Technology Corner

SandCrab Lite (SCL):
In September 2004, the Texas Cancer Registry (TCR) released a new version of Sandcrab Lite (SCL) 8.0. This replaces the current version of SCL 6.0. SCL was upgraded to meet the new North American Association of Central Cancer Registries (NAACCR) version 10b standards and to add features that were recommended by our reporters. This new version of SCL 8.0 is used to submit cancer cases diagnosed for year 2004. Any cases diagnosed prior to 2004 can also be submitted with the new version.

The TCR is in the process of testing SCL 9.0. The new version is scheduled for release in June 2005.

Note: The CD version of SCL 8.0 sent to facilities had a missing .dll file. This is not a problem for previous SCL users, but it is a problem for new users. We are recommending that users install SCL from the TCR website: www.tdh.state.tx.us/tcr/sclite.html.

Some new or upgraded features in SCL 8.0 include:

- Login and password security has been added to address security issues related to compliance with Health Insurance Portability and Accountability Act (HIPAA) laws.
- Help Screens are new and allow the user the capability to view NAACCR 10.2 "Data Standards and Data Dictionary" item descriptions. Help screens can be accessed by left clicking the item name in the Data Entry screens.
- FTP Corrupted Files are new. When users have problems with their data (i.e., corrupted tables) and they are unable to resolve the issue, they can call the Texas Department of State Health Services (DSHS) Texas Cancer Registry (TCR) for Help Desk assistance. If the Help Desk advisor suspects that the files are corrupted, they will often request the user send the corrupted data using this new feature. To access this feature, the user will click on the Data Entry tab, move their mouse over the "Submit Cases" icon and click on the "FTP Corrupted Files."
- Collaborative Staging is another new feature within SCL 8.0. Users should be reminded that if they code their data, they will be required to do Collaborative Staging as well. To turn coding on, the user will click on the Maintenance/Setup tab, click the User Preferences icon, and select "Turn Coded Fields On."

As a reminder:

- SandCrab Lite (SCL) has the capability to submit data electronically via the Internet using the File Transfer Protocol (FTP) method and is highly recommended. This method ensures that your data is encrypted and password protected and eliminates the need for the added expense of diskettes or CD's.
- The Cancer Registry Electronic Submission System (CRESS) was developed to support web-based submissions of data files (generated by commercial registry software) in NAACCR format. This system will simplify and reduce the need for diskette-based submissions. The CRESS website is a secured site and cannot be accessed by anyone without a valid user id and password. With this system, all data submissions will become encrypted, password protected and sent to the DSHS secured server. Encryption is done within the CRESS system and is accomplished without any additional effort from the user. For more information about the CRESS application, please refer to Appendix M of the TCR Cancer Reporting Handbook, or contact the CRESS helpdesk at 1-800-252-8059 or at CRESS@dshs.state.tx.us.

SandCrab Lite for Pathlabs (Pilot – beta version):
In September 2004, the Texas Cancer Registry (TCR) began implementing the new SandCrab Lite for Pathlabs (SCL-P) v1.0 (beta) software to a limited number of pathology laboratories and physicians. The pilot project was implemented in order to satisfy SB 285 of the 77th Legislative session. The TCR is tasked with the responsibility of collecting and reporting missed "health practitioner only" cases. This project will add an electronic data linkage and matching capabilities to the Registry's SandCrab (SC) system. The primary method for collecting incoming data will be through the National Electronic Disease Surveillance System (NEDSS), SCL-P, or CRESS. The modified SC system will include a module to link pathology laboratory reports to cancer records stored in the SandCrab database to identify previously unreported cancer cases. The system will also consolidate pathology laboratory reports that have matching cases in the TCR database. Cases requiring additional information will be followed-back to the physician using SandCrab Lite for Pathlabs. This enhancement to the existing SC and SCL systems will result in an improvement in the timeliness of data received and will increase data completeness. The SCL-P software will be available to pathology laboratories and physicians "free of charge."

Vendor Software Pre-Edits
The Texas Cancer Registry (TCR) is in the process of developing a document that will assist facilities in performing pre-edits of their NAACCR formatted Cancer

Reports (data). The document will provide a step-by-step process for downloading and installing GenEdits and/or GenEdits Lite software from the CDC website and the TCR Edits (metafile) from the TCR website; setting the configuration; and, selecting the Cancer Report data file that will be submitted to TCR. Once the software is successfully installed, the Facility will be able to select their Cancer Report data file and run it against the TCR Edits to display any errors generated. The facility can correct the errors and re-run the pre-edits again until there are no errors. Once the data is error free, the facility can use CRESS to FTP the data directly to TCR or save the data to a floppy diskette/CD-R and mail it to TCR. The purpose of this process is to eliminate errors prior to sending data to the TCR.

- Jonathan Unnasch
Business Analyst

Coding Corner

Type of Reporting Source
The "Type of Reporting Source" identifies the source documents used to abstract the case being reported. This is not necessarily the original document that identified the case but rather, the source that provided the best information.

Codes and Definitions
Code '1', Hospital Inpatient/ Outpatient or Clinic
One of the source documents used to abstract the case was from a hospital admission as an inpatient or an outpatient. Includes outpatient services of HMO's and large multi-specialty physician group practices, such as oncology or radiation therapy, if the reports from multiple physicians and laboratories are stored in a single unit record.

Code '3', Laboratory Only (Hospital or Private)
Source documents from a laboratory were used to abstract the case. (There were no source documents from codes 1-Facility only, 4-Physician's Office, 5-Nursing Convalescent Home/Hospice.)

Code '4', Physician's Office/ Private Medical Practitioner
Source documents are from a physician's office that is NOT an HMO or large multi-specialty group practice. There were no source documents from code 1.

Code '5', Nursing/Convalescent Home/Hospice
Source documents are from a nursing or convalescent home or a hospice. There were no source documents from codes 1 or 4.

Code '6', Autopsy Only
The cancer was first diagnosed on autopsy. There are no source documents from codes 1-5.

Code '7', Death Certificate Only
Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1-6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1-6.

When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source:

1 Hospital/Clinic
4 Physician Office
5 Nursing home
3 Laboratory
6 Autopsy
7 Death Certificate only

- Leticia Vargas, CTR
Quality Control Analyst

New Publications and Statistical Data: Epi Update

The Cancer Epidemiology Team of the TCR has been busy analyzing and publishing the data that you work so hard to collect. Most recently, they completed the Texas Cancer Facts & Figures 2004, using 1997–2001 cancer incidence and mortality data. This report was co-authored with the American Cancer Society Texas Division, Texas Cancer Council, and University of Texas M.D. Anderson Cancer Center as part of the up-coming newly revised Texas Cancer Plan. The report is available upon request, as well as posted on the TCR web site.

The Epidemiology Team has also made some recent additions to the statistical information available on the website. The "Statistical Data" page now includes 1997-2001 statewide, county, and health service region (HSR) incidence and mortality tables by sex and primary cancer site. New county and HSR cancer fact sheets are now available and childhood cancer tables will be added very soon.

A new publication, Cancer in Texas, 1997-2001 is also in the works. This new report will provide detailed and comprehensive cancer incidence and mortality statistics for Texas and hopefully serve as a useful reference guide. Cancer data will be presented by sex, age, and race/ ethnicity for all primary cancer sites. When completed, the report will be available by request and added to the TCR website.

All of the work conducted by the TCR Epidemiology Team would not be possible without all of your hard work. And of course, their work can only be as good as the data that are

provided to them. For those reasons, thank you and please remember—the timeliness, completeness, and overall quality for your own data really matter. No number of cases is too few or insignificant!

- Melanie Williams, Ph.D.
Team Lead, Epidemiology Section

Coded vs Uncoded Submissions

All reporting facilities having trained staff in cancer registration or third party cancer reporting software should submit completely coded abstracts to the Texas Cancer Registry (TCR). This also includes facilities that have contract Certified Tumor Registrars abstracting their cancer cases. Reporting facilities that do not have trained staff abstracting their cancer cases and are reporting on SCL may leave the following fields blank: Morph/Behavior (NAACCR data items 420 and 430) or ICD-O 3 Morph/Behavior (NAACCR data items 522 and 523) depending on date of diagnosis; Primary Site (NAACCR data item 400); Summary Stage 1977 (NAACCR data item 760), Summary Stage 2000 (NACCR data item 759) or the Collaborative System data items (NAACCR data items 2800, 2810, 2830, 2850, 2880, and 2900) depending on diagnosis date.

Reporters must use the International Classification of Diseases for Oncology Second edition (ICDO 2) to code the morphology and behavior (NAACCR data items 420 and 430) for cases diagnosed prior to 2001. The International Classification of Disease for Oncology Third edition (ICDO 3) must be used for cases diagnosed 2001 and forward to code the morphology and behavior (NAACCR data items 522 and 523). If the date of diagnosis is unknown, the date of 1st contact should be used to determine the correct resource to use in coding the appropriate data items.

Cases diagnosed prior to 2001 should be coded using the SEER Summary 1977 Manual and cases diagnosed during the period 2001-2003 should be coded using the SEER Summary 2000 Manual.

The Collaborative Staging (CS) System should be implemented with cases diagnosed beginning January 1, 2004. The TCR is collecting six of the 15 CS data items in order for the algorithm to derive the SEER Summary Stage. Two of these six data items will be collected for pleura and prostate primaries only. The CS Site Specific Factor 1 is specific to pleura primaries and CS Site Specific Factor 3 is specific to prostate primaries. Facilities that are certified by the American College of Surgeons (ACoS) must collect all 15 CS data items. This enables the algorithm to derive TNM, EOD and SEER Summary Stage.

The Collaborative Staging System has undergone several revisions. Updated pages for the manual and tables for the algorithm should be used. These revisions can be found on http://www.cancerstaging.org/personnelinfo.html.

Remember that supporting documentation must be provided for all submissions to the TCR.

- Susan Perez, RHIT, CTR
Quality Asurance Team Lead

2004 Handbook Errata Sheet

Please replace the following pages in your copy of the Cancer Reporting Handbook July 2004. The corrected pages can be downloaded from our web site www.dshs.state.tx.us/tcr. We will be updating the errata sheet and adding the replacement pages quarterly as needed.

Page	Reason for change
Appendix A	
A-34	In the box **upper** is misspelled (has an extra r).
A-59	Under surgery code (70) the last two words in the paragraph are misspelled. Should be radical **cystectomy** (the s is missing) and **prostatectomy** (the a is missing).
A-64	In the box **regional** is misspelled twice (the o is missing).
Appendix D	The blank reporting form has **Example 1** on the top and it should not be there.
Appendix J	Replace pages 21-57 with pages 21-58. Added names that were missing.
70	On the last table, under Gleason's score 5, 6, 7 the **7** needs to be moved to the last row along with 8, 9, 10 per SEER Program manual 2004 page 96.
82	The codes changed in the table at the top. **96** is an invalid code for nodes positive.

- Leticia Vargas CTR
Quality Control Analyst

Collaborative Stage Technical Corner

Question:
CS Extension/CS Tumor Size--Brain and CNS: How should Collaborative Stage Extension and Tumor Size be coded for Benign CNS tumors?

Answer:
Code CS Extension as 05 [Benign or borderline brain tumors]. Code the size of the tumor if specified, otherwise code CS Tumor Size as 999 for benign CNS tumors.

-Reference:
CS Manual, Part II; pg 603 (Vers 1.0, Jan. 1, 2004)

Question:
CS extension--Bladder: How would extension be coded for a bladder case that states: papillary transitional cell carcinoma with no invasion into the submucosa or deep muscularis. There is focal extension of tumor into bladder diverticula.

Answer:
Assign extension code 01 [Papillary transitional cell carcinoma stated to be noninvasive]. Extension into bladder diverticula does not change the code. Diverticula are pouches in the mucosa (mucous membrane).

-Reference:
CS Manual, Part II; pgs 549-551 (Vers 1.0, Jan 1, 2004)

Question:
CS Extension--Prostate: What is the Collaborative Stage - Extent code for a prostate tumor that is clinically inapparent, but a biopsy from the prostatic apex is positive? Is this 15 or 34?

Answer:
Code CS Extension-Clinical Extension to 15 [Tumor identified by needle biopsy, e.g., for elevated PSA (clinically inapparent)] for clinically inapparent prostate cancer with positive apex biopsy.

-Reference:
CS Manual, Part II (Vers 1.0, Jan. 1, 2004)

Question:
CS Tumor Size/Ovary: We do not record the size of a cyst, but do we use the size of a cystic mass?

Answer:
If the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
Please note: Ovarian cancer stage is not based on tumor size.

-Reference:
CS Manual, Part I ;pg 26 (Vers 1.0, Jan. 1, 2004)

Question:
CS Lymph Nodes, Lung page 407 says, "If at mediastinoscopy/xray, the description is mass, adenopathy, or enlargement of any of these lymph nodes named in the regional lymph nodes, assume that at least regional lymph nodes are involved." Does this apply only to regional lymph nodes (codes 10 and 20) and not supraclavicular and scalene (code 60)?

Answer:
11/15/04 Response from the CS Steering Committee. CS Lymph Node Table Note 2 will be clarified to read: "If at mediastinscopy/x-ray, the description is 'mass,' 'adenopathy,' or 'enlargement' of the lymph nodes named in Regional Lymph Node codes 10 and 20, assume that at least regional lymph nodes are involved."

-Reference:
ACoS Inquiry and Response System Question: 13431

Question:
How is a PSA of 94.0 ng/ml recorded in Prostate Collaborative Staging SSF 1? There is no value code for 90.0 to 98.9 values.

Answer:
Prostate Site-Specific Factor 1 Prostatic Specific Antigen (PSA) Code 002-899 will be corrected to Code 002- 989. Changes, revisions to the Collaborative Staging Schemas will be announced via CoC Flash. In the meantime, make note of the change and code SSF 1 as 940: CS algorithm will allow this value.

-Reference:
ACoS Inquiry and Response System Question: 13109

Question:
A patient had diffuse large B-cell Non-Hodgkin's lymphoma involving the palate, pharynx, oropharynx and base of tongue. The topography code was C14.8. We abstracted the case but the the collaborative stage was not for a lymphoma histology. The AJCC stage group also shows "not applicable" instead of the lymphoma choices. Is this a program error?

Answer:
In the Collaborative Stage system, the data for all lymphomas are coded using criteria for lymphoma. This applies whether the lymphoma is sited to lymph nodes or a non-lymphatic primary such as C14.8. You will need to re-code the Collaborative Stage items for this case using the criteria for lymphoma.

-Reference:
ACoS Inquiry and Response System Question: 12657

New Rules for Coding Brain Related Tumor Laterality

REMINDERS

Come on admit it! For some of us, it can be difficult and confusing coding brain related tumors. This article may help.

As you may know, effective January 1, 2004 all United States cancer registries adopted a standard definition for the reporting of "brain related tumors" that includes benign and borderline tumors of the brain and central nervous system (CNS). The standard definition comes from U.S. Public Law 107-260 and defines "brain related tumors" as:

"a listed primary tumor (whether malignant or benign) occurring in any of the following sites: (I) The brain, meninges, spinal cord, caudia equina, a cranial nerve or nerves, or any other part of the central nervous system. (II) the pituitary gland, pineal gland, or craniopharyngeal duct."

Texas reporters are probably saying, " Whew, that is not new for us, we have always reported brain related tumors using this definition." But, did you remember that the bones of the skull (C41.0) and spine (C41.2) are not part of the central nervous system? In other words, non-malignant tumors arising in bone and extending into the CNS are not reportable! And, did you also know that there are new changes for coding brain related tumor laterality? Depending on the diagnosis date, certain brain related tumors are now considered paired organs.

WHAT ARE THE NEW LATERALITY CHANGES?

Laterality for any brain or other CNS tumor diagnosed prior to January 1, 2004 should be coded to 0. However, for cases newly diagnosed from January 1, 2004 forward, the following malignant and non-malignant brain and other CNS tumors must have a laterality code of 1–4 or 9. Midline tumors should be coded to 9 for these sites.

C70.0 Cerebral Meninges, NOS
C71.0 Cerebrum
C71.1 Frontal Lobe
C71.2 Temporal Lobe
C71.3 Parietal Lobe
C71.4 Occipital Lobe
C72.2. Olfactory Nerve
C72.3 Optic Nerve
C72.4 Acoustic Nerve
C72.5 Cranial Nerve, NOS

There remain a large number of brain and other CNS tumors that, regardless of the date of diagnosis, are not considered a paired organ, so these are coded to laterality 0. These sites include:

C70.1 Spinal Meninges
C70.9 Meninges, NOS
C71.5 Ventricle, NOS
C71.6 Cerebellum, NOS
C71.7 Brain Stem
C71.8 Overlapping Lesion of Brain
C71.9 Brain, NOS
C72.0 Spinal Cord
C72.1 Cauda Equina
C72.8 Overlapping Lesion of Brain and Central Nervous System
C75.1 Pituitary Gland
C75.2 Craniopharyngeal Duct
C75.3 Pineal Gland

HELPFUL TOOLS:

A number of helpful reference and training tools are available to assist you with coding brain related tumors, as well as other cancer reporting questions.

- The Texas Cancer Registry website www.dshs.state.tx.us/tcr is a wonderful source of information. It contains the latest information on Texas cancer reporting (including recent changes) and provides reporters with available training dates. Details on training sessions offered in your area can be found by visiting the TCR web site "Regions/Training" link and clicking on a particular region.

- You can refer to your July 2004 Cancer Reporting Handbook Laterality Section, pages 71-75. This section can also be reviewed online at http://www.tdh.state.tx.us/tcr/publications/2004crhb/2004hb-pdf/pgs69-80CancerInfo.pdf.

- The Surveillance, Epidemiology and End Results (SEER) website, www.seer.cancer.gov, includes training modules to help improve everybody's cancer reporting knowledge base. Be sure to review the "Benign Brain Tumor Reporting Module" that specifically discusses and includes exercises related to the reporting changes mentioned in this article. SEER training modules are located at http://training.seer.cancer.gov/.

- The SEER web site also has a list of publications that can be purchased for a very minimal price (if not for free). One of the publications that will be available soon is *The Brain Book*. This book will include additional helpful reference and coding instructions for coding primary brain sites.

One final thought, with all of the changes happening so quickly, you might think that you will never get it all straight. The Texas Cancer Registry staff promise that we will try and help without you suffering from a serious brain overload.

For any questions, contact your regional office staff. We will do everything we can to make all the new changes easier for you.

- Cindy DeAnda
Regional Trainer

Changes for 2005 Admissions

Beginning with admissions on January 1, 2005 and forward, reporters are no longer required to report a non-analytical case with a diagnosis date prior to 1995. For example, if a patient with active cancer which was diagnosed in 1994 is seen at a facility in 2005 but the facility provided no diagnostic procedures or first course treatment, this case is not reportable. Due to incomplete statewide cancer case ascertainment prior to 1995, the TCR has chosen to concentrate on statewide data for 1995 and forward. Cases with an unknown diagnosis year should be reported regardless of the class of case (i.e. analytical or non-analytical).

- TCR Staff

Remember:
"Undifferentiated" and "anaplastic" are coded to grade "4".

Remember:
Additional questions and answers on the Collaborative Staging System can be referenced on the Surveillance Epidemiology and End Results (SEER) and American College of Surgeons (ACoS) websites.

New CTRs

Congratulations to the new Certified Tumor Registrars in Texas!

The following successfully sat for their CTR exam in March 2004:

Cynthia C. Carlisle	USO, Dallas
Sylvia R. Dashkovitz	Covenant Medical Center-Lubbock
Susan E. Datz	Memorial Hermann Baptist-Beaumont West
Melinda L. Good	
Jeanine Harmon	Parkland Hospital, Dallas
Michael R. Peterson	K-Force

The following successfully sat for their CTR exam in September 2004:

Monte H. Bivens	South Texas Cancer Center, McAllen
Martina M. Boen	Valley Baptist-Harlingen
Michelle L. Cassity	St. Luke's Episcopal-Houston
Monica K. Conner	Brownwood Regional Medical Center, Brownwood
Karen C. Diver	Childrens Medical Center, Dallas
Tiffanee D. Farmer	Goldston Cancer Registry-Amarillo
Patricia H. Harrison	
Victoria E. Holmes	Arlington Memorial Hospital, Arlington
Joann Humphries	Park Plaza-Houston
Jennifer L. Janise	Memorial Hermann Baptist-Beaumont West
Cecilia Kennedy	STVHCS, Audie L. Murphy Division, San Antonio
Crystal D. McDaniel	AHEC, Texarkana
Sherry F. Norman	Medical Center Hospital-Odessa
Gloria A. Smith	Harris Methodist, Fort Worth
Monica Sullivan	M.D. Anderson, Houston
Charlotte A. Wammel	Houston Northwest Medical Center, Houston
Ann M. Worden	Baylor All Saints Health Systems, Fort Worth

Again congratulations for a job well done!

- Jael Davis, BS, CTR
Consolidation Lead Worker

Attention:
A complete edition of the 2004 Cancer Reporting handbook is now available online. It includes the 2003 files combined with the updates for 2004, corrected as per the errata. The errata is also available as a separate file.

www.dshs.state.tx.us/tcr/reporting.html

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Eduardo J. Sanchez, M.D., M.P.H.
Commissioner of Health

Questions regarding information found in this newsletter, or suggestions for future editions can be directed to Leticia Vargas in Austin.

Please let us know if you would like to receive a hard copy of this publication.

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Visit us online:
www.dshs.state.tx.us/tcr

Important Websites

www.dshs.state.tx.us/tcr
Training opportunities, Cancer Reporting handbooks, Statistical reports, Rules and Law

www.seer.cancer.gov
Training modules, SEER Books, Seer Program Manual, Statistical reports and information

www.ncra-usa.org
Training opportunities, Links to other helpful sites, Job postings

www.naaccr.org
Registry Standards, Training opportunities, Links to other helpful sites

www.txtra.org
Local Association, Education opportunities, Job postings

www.txhima.org
Educational opportunities, Job postings, Links to helpful sites

http://zip4.usps.com
Helpful in resolving address issues when abstracting

Additional Information

The TCR internet site is continually updated with new and important information. Please remember to visit the site often. The regional training sessions, times, and places are on the site under the "Regions" page. All new data publications are posted as well.

www.dshs.state.tx.us/tcr

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