Alabama Department of Public Health
Alabama Statewide Cancer Registry

ASCR NEWS

Volume 7 Issue 1 Spring 2010

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CENTRAL REGISTRY UPDATE

As we have known for a long time, 2010 means big changes for cancer registrars. This is also true for the ASCR.

Beginning January 1, the ASCR was placed under the Bureau of Family Health Services (FHS) to form a new cancer division, which includes the ASCR, Comprehensive Cancer Coalition, Alabama Colorectal Cancer Prevention Program, and the Alabama Breast and Cervical Cancer Early Detection Program. Ms. Nancy Wright is the division director. Ms. Janice Cook has taken a position in another bureau and Ms. Xuejun Shen is now the acting director for the ASCR and Mr. Justin George is the assistant director. The ASCR staff would like to congratulate XJ and Justin for taking on these very important roles.

With the changes in the ASCR, Justin will be the contact person for the online data transfer system and Web Plus.

Starting in February, the ASCR staff will have to use new email addresses to send and receive emails. Our email should be firstname.lastname@adph.state.al.us. Please look over the staff list to the left and update your address book. (Note – Mark Jackson's address has a "2" after the last name as there are 2 Mark Jackson's in the State email system.)

ASCR PLAN FOR 2010 DATA SUBMISSION

ASCR is working with vendors to get ready for 2010 data submissions. The new required data items will be available online in May. We strongly recommend facilities finish 2009 data before updating the software for 2010 data. If you abstract 2010 data in the current version of software (i.e. NAACCR V11.3), please update the cases accordingly when your software is updated. We will accept 2010 data at any time as long as it is abstracted in NAACCR V12 and we will still be able to accept your data in V11.3 after our software is updated to NAACCR V12.

DEATH CLEARANCE - WORDS FROM TARA FREEMAN

Thank you for your responses to the 2008 death clearance follow-back. Your timely responses are appreciated. We are still in the process of clearing up as many cases as possible in order to ensure the number of DCO cases in our state is below 3%. In order for us to do this, we need your help. If you receive a follow-back letter in reference to any cancer cases that were not diagnosed or treated in your facility, please provide the name of the primary physician that you have on file so additional follow-up attempts can be made. Remember, death clearance allows us to identify missed cases as well as identify additional sources to include in case reporting. If I can be of any assistance in this process, please give me a call at 334-206-7022 and continue to submit your 2008 responses to me.

How Many NAACCR Record Layouts Can You Name?

The NAACCR data exchange record layouts were designed to facilitate electronic transmission of cancer registry data among registries for multiple purposes. All data items that currently are standardized by NAACCR, SEER, or the Commission on Cancer have been included.

Although the ASCR requires all reporting facilities to submit full abstract (type A), there are several more layouts available for various purposes.

Incidence Record (record type I) (coded data without direct personal identifiers)

These records include all the coded fields for each case, including demographic, tumor, staging, treatment, and follow-up fields. The primary use of the incidence record is to transmit data for multi-registry research projects or surveillance.

Contents:	Demographic, Tumor and Staging, Treatment, and Follow-up (Optional)
Use:	Combined studies
Length:	3339 characters

Confidential Record (record type C) (incidence record plus personal identifiers)

These records include all the data items in the incidence record, plus items such as patient name and Social Security Number that identify the case. Also included are quasi-confidential data items such as referring hospital or primary physician, and items which some agencies are required to keep confidential**.**
This record type can be used to exchange cases between registries, whether central-based or hospital-based.

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, plus Patient Identifiers and Physicians
Use:	Case sharing between central registries
Length:	5564 characters

Full Case Abstract (record type A) (confidential record plus text; used for reporting to central registry)

These records contain all fields noted above, plus the supportive text required for the transmission of full case abstracts. The full case abstract allows the receiving registry to perform a higher degree of quality *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions Purpose and Use of Data Exchange Layouts* 6 control with each case report.

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, Patient Identifiers & Physicians, plus Text
Use:	Sending abstracts between registries
Length:	22824 characters

Pathology Laboratory Record (record type L)

The Pathology Laboratory record is designed for electronic transmission of reports from pathology laboratories to central registries. Health Level 7 (HL7) or a character delimited flat file is recommended as the data format for transmitting pathology laboratory reports. A standard pathology laboratory dataset, data dictionary, and HL7 transmission format and flat file were developed to enhance the completeness, timeliness, consistency, and efficiency with which tumor data are transmitted by pathology laboratories and received and processed by central cancer registries

Contents:	Demographic, Tumor, and partial Staging (content varies dependent on availability at pathology laboratories and agreement between pathology laboratory and central registry)
Use:	Electronic transmission of tumor reports from pathology laboratories to central registries
Length:	No standard length

Update/Correction (record type U) and Modified Records (record type M) for updating and correcting information.

EDUCATION CORNER

NAACCR Webinar – ASCR will host NAACCR webinars on the following dates from 1:00 – 4:00 pm in the Montgomery office

4/1/2010 - Collecting Cancer Data: Soft Tissue Sarcoma and Gastrointestinal Stromal Sarcoma
6/3/2010 - Collecting Cancer Data: Esophagus and Stomach
8/5/2010 - Collecting Cancer Data: Lip and Oral Cavity
9/2/2010 - Coding Pitfalls

A recorded webinar can be hosted at Cullman or Mobile office in two weeks after the above date if at least three registrars can attend.

Please contact Briana McCants as soon as possible if you plan to attend any webinar in any of our offices.

DCH in Tuscaloosa also hosts webinars at the above dates in the morning (8:00 – 11:00 am) with a small fee. You should contact Kay Cook a week in advance.

These webinars provide essential and up to date information on each primary site and current changes for 2010 data submission. The registrars, even in non approved CoC hospitals and physician offices, should attend some sessions.

ASCR/ACRA Educational Training Sessions

In a collaborative partnership with the Alabama Cancer Registrars Association, the ASCR and ACRA are working diligently to sponsor CE approved educational training sessions on 2010 CSv2 coding rules. These trainings have been tentatively scheduled for spring and summer 2010; more information regarding training will be sent via blast email. Training will consist of the following:

Overview of CSv2	Merkel	Gynecologic Sites
Colon, Rectum, Appendix	Breast	Hematopoietic Rules and Database
Head and Neck	GISTs	Liver Intrahepatic
Melanoma	Genitourinary	Lung

Commission on Cancer Inquiry and Response System (http://web.facs.org/coc/default.htm**)**

The I&R team, comprised of CoC, NCDB and AJCC technical staff, meet weekly to review questions submitted and provide consensus answers. The team also utilizes physician and other expert curators (for example, MP/H, AJCC physician curators, and NCDB analysts) who specialize in certain fields and provide additional input and support to the team. During 2009, the I&R team responded to 2,341 queries; the average turnaround time for a response was 7.4 days.

Number of Questions Asked Per Category (in 2009)

FORDS – 768 (33%)
Cancer Program Standards – 474 (20%)
AJCC – 223 (10%)
NCDB – 25 (1%)
Other – 26 (1%)
SEER MP/H – 527 (22%)
Collaborative Staging – 252 (11%)
ICDO-3 – 30 (1%)
NAPBC – 16 (1%)

- The Inquiry and Response System includes a large number of questions and answers submitted over the past few years.
- In most cases, questions similar to your inquiry may already have been submitted.
- The Search Database feature to seek an answer to your question is *now required*. If, after reviewing the results, you do not find your answer, use the Submit a Question feature that will appear at the end of the search results.
- Please note, additional information to assist the I & R team in answering your question will be required and appears when you submit a question.

Coding Clarifications for 2010 Data *from the NPCR winter Newsletter to Central Registries*

Laterality will have a rewording of code 4 to be implemented in 2010. **Code 4** will indicate either of the following:

- Bilateral involvement at time of diagnosis - lateral origin unknown for a single primary
- Both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors

New Laterality Code

Midline Tumor for Paired Sites

- **Code 5** has been added for paired organ tumors arising in midline (example: midline tumor of brain)

Laterality has been permitted by SEER for unpaired organ primaries that have been documented as left or right (e.g., left lobe of prostate). CoC will now permit laterality to be coded this way as well. Central registries can globally change the laterality to recode it as "not a paired organ".

Simple vs. modified radical mastectomy - Coding to MRM is dependent on whether other than sentinel nodes are included in the nodes from the axilla. If only sentinel nodes are removed the surgical code would be for **simple mastectomy.**

In the event that lymph nodes are found incidentally in a simple mastectomy the surgery is to be coded based on the surgeons description of the procedure.

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Clarification on whether to consider delayed reconstruction as first course breast treatment resulted in the following consensus: If the reconstruction is included in the treatment plan and/or a tissue expander is inserted at time of surgery this would validate coding the reconstruction as first course treatment.

Carcinoids of the appendix are to be reported if nodes and/or implants are metastatic with the pathologist reporting the histology as carcinoid arising in the appendix. The borderline/ benign behavior code of /0 should be recorded as /3.

If a carcinoid of the appendix is found on appendectomy and patient returns later with regional or widespread disease, the case is to be back coded to the date of the appendectomy and the first course of treatment date is the appendectomy date.

Schwannomas are reportable for intradural lesions only.

Coding watchful waiting:
A new Data Item has been created for 2010 and forward cases to summarize the status of all treatment modalities. Use of **RX Summ-Treatment Status** (NAACCR Item number 1285) will document a summary of the status of treatment modalities. It is used to indicate whether treatment was given or not or whether treatment status is unknown. It also allows for coding watchful waiting. It is used in conjunction with SEER (1260) Date of Initial RX and CoC (1270) Date of 1st Crs RX.

Codes used in this field:

0-No treatment given
1-Treatment given
2-Active Surveillance (watchful Waiting)
9-Unknown if treatment given

Which Year's Cases Use Which CS Version?

2004 – Collaborative Staging Manual and Coding Instructions, Version 1.0 and 1.1, Published August 2004

2005 – Collaborative Staging Manual and Coding Instructions, Version 01.02.00, Published May 2005

2007 – Collaborative Staging Manual and Coding Instructions, Version 01.03.00, Published September 2006

2008 – Collaborative Staging Manual and Coding Instructions, Version 01.04.00, Published October 2007

2009 - Version 01.04.01 software only, Published March 2008

2010 - Collaborative Stage Data Collection System, Version 02.00.01, Published October 2009

Choosing Correct Brain Surgery Codes.

Code: 20

Local excision (bx) of lesion/tumor/mass includes:
Subtotal resection (tumor/lesion/mass)
Partial resection (tumor/lesion/mass)
Debulking (tumor/lesion/mass)
Total resection (tumor/lesion/mass)
Gross resection (tumor/lesion/mass)

Code: 40

Partial resection (partial lobectomy) includes:
Partial lobe
Partial meninges
Partial nerve(s)

Code: 55

Gross total resection (lobectomy) includes:
Total lobectomy
Total lobectomy plus more
Radical lobectomy resection

It is rare for a patient to undergo a total lobectomy. Please be sure to review the Operative report when the physician states "gross resection" performed. Many times they are referring to the gross resection of tumor not the lobe.

Q & A:

Question: What is the time frame for a new primary of CLL diagnosed in 1998 which recurred in 2003, 2004 and 2007?
Answer: The hematopoietic rules have not changed. If this has remained a CLL, it is treated as a single primary that has gone into remission and then recurred. Curator (*I & R Team*)

Question: How is the histology of a breast primary with pleomorphic type of lobular carcinoma in situ coded?
Answer: Pleomorphic carcinoma is a specific type of duct carcinoma (see Table 2). That means that you have a duct and lobular carcinoma. Use rule H5 and code 8522. Curator (*I & R Team*)

Question: If a patient has a wide excision/re-excision of a site for melanoma and there is no residual disease, is it staged or abstracted? A biopsy was done in the physician's office and read at an outside lab, we never made the diagnosis of cancer.
Answer: If your facility participated in the first course of treatment by providing a surgical resection even if there is no residual disease, it would be abstracted. Curator (*I & R Team*)

Question: Patient had a biopsy of a lesion of the right eyelid that was positive for mucinous eccrine carcinoma. Is this case reportable? If so, how would we code it?
Answer: This would be reportable. The site code would be C44.1 and the histology would be 8480/3. Curator (I & R Team)

Question: Is Polycythemia, NOS reportable?
Answer: Not reportable. It must include one of the following terms - Proliferative, Rubra Vera or Vera to be reportable.

Question: Brain cases especially Meningioma that have been previously dx elsewhere and they are coming to our facility for follow up CT/MRI scans. Is this reportable?
Answer: This is not reportable by your facility, if there was no treatment given at your facility.

Question: Is melanoma in-situ cases reportable to ASCR?
Answer: Yes, all melanoma that originate in any site, invasive or in situ is reportable, while squamous cell and basal cell carcinoma primary tumors that originate in a mucous membrane are reportable in the following sites only:

Lip C00.1 - C00.9	Anus C21.0	Labia C51.0 - C51.1	Clitoris C51.2	Vulva C51.9
Vagina C52.9	Prepuce C60.0	Penis C60.1 - C60.9	Scrotum C63.2	

Alabama Statewide Cancer Registry to Begin Gold & Silver Certificate Program for Cancer Registrars

Just as the Alabama Statewide Cancer Registry (ASCR) is recognized each year by the North American Association of Central Cancer Registries (NAACCR), the ASCR would like to start a certificate process to recognize the great efforts cancer registrars make throughout the year. Without the hard work of cancer registrars throughout the state, the ASCR would never be able to achieve NAACCR Gold. The ASCR will present the first certificates for 2009 data at the Alabama Cancer Registrar Association annual meeting this October.

The qualifications for receiving a certificate will be based upon completeness, accuracy, and timeliness of reporting during the 2009 data transmission year. In the future, more criteria may be added which could include death clearance, pathology follow back, and missing data fields. In order to qualify for a Gold Certificate, a facility must have at least 95% completeness by July 8, 2010, must have at least 98% accuracy on all files submitted between July 1, 2009 and July 8, 2010, and must maintain compliant status in 10 out of 12 monthly submission reports. In order to qualify for a Silver Certificate, a facility must have at least 90% completeness by July 8, 2010, must have at least 95% accuracy on all files submitted between July 1, 2009 and July 8, 2010, and must maintain compliant status in 9 out of 12 monthly submission reports.

The ASCR would also like to recognize facilities going through the audit process that have achieved exemplary results with the Award of Excellence. For case-finding audits, an Award of Excellence will be presented if there are no missing cases found. For re-abstraction audits, an Award of Excellence will be presented if there are no unjustified coding errors.

Small hospitals, physician offices, free standing facilities, and laboratories will receive an Award of Excellence from the ASCR in October when facilities send the required information to the ASCR on time every month.

EVENT CALENDAR

NCRA's 36th Annual Education Conference
An Oasis of Information and Education for Cancer Registry Professionals
April 20-23, 2010
Palm Springs, California

NAACCR Annual Meeting
Renewed Collaboration: A Modern Paradigm for Cancer Surveillance
June 19-26, 2010
Québec City, QC, Canada

CTR Exam
September 11-25, 2010
Application due by **July 31, 2010**

ACRA Annual Meeting
Oct 7 - 8, 2010
Mobile, AL

CANCER REGISTRAR WEEK

National Cancer Registrar Week is April 12-16, 2010.

Cancer Registrars are Recording Artists

Capturing Data enabling Cancer Research and Control

ALABAMA DEPARTMENT OF PUBLIC HEALTH

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Capturing Cancer Data in Alabama
Find us on the web at
Http://www.adph.org/cancer_registry

ASCR News is published for those involved in cancer data collection in Alabama. Contact us to submit articles for publication.

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Diane Hadley, BS, RHIT, CTR, Editor

Editorial Reviewers: **Nancy Wright, MPH**

Daylight Saving Time and Ways to Save Energy

Although we still feel the chill every morning, the Spring is on the way, and the flowers are blooming. Please remember that daylight saving time is March 14, a mere days away.

In addition to this time change, there are a few easy ways to save energy:

1) You can turn off the computer monitor if you will not use it for an extend time
2) Print on both sides of paper
3) Turn off lights when you leave the office or cubicle for extend time.

ASCR COMPLETENESS SCHEDULE

Current Month	Completeness %	Cases Due
January 10	58	July 09
February 10	67	August 09
March 10	75	September 09
April 10	83	October 09
May 10	92	November 09
June 10	100	December 09
July 10	8	January 10
August 10	17	February 10
September 10	25	March 10
October 10	33	April 10
November 10	42	May 10
December 10	50	June 10

Financial assistance for Patients with Myeloma and Waldenström Macroglobulinemia Announced by The Leukemia & Lymphoma Society

The Leukemia & Lymphoma Society (LLS) is pleased to announce that effective February 1, 2010, patients with myeloma and Waldenström macroglobulinemia will now be able to receive up to $10,000 in support to help offset the costs of prescription drug co-pays and other insurance related expenses. This increase is retroactive for expenses incurred from July 1, 2009 and extends through June 30, 2010 and is available to new and currently approved patients. Patients, caregivers and healthcare professionals, may easily submit applications through the online system by accessing the established link on the Co-Pay webpage (click here). Applications may also be submitted via the toll free line (1-800-955-4572) with the assistance of a Co-Pay specialist. Eligibility will be determined by medical and financial need. (Source: FYI from the ICC - February 5)

News from Hospital - Princeton

The recognition of the cancer program at Princeton Baptist Medical Center for quality care continues with its latest Three-Year Accreditation with Commendation and winner of the ***Outstanding Achievement Award*** following its most recent survey by the American College of Surgeons/ Commission on Cancer.

"We are delighted with the description of our program by the physician surveyor", said the Cancer Center Director Lynn Morgan. The Surveyor described it as "one with 'good administrative support, active medical staff involvement, good nursing and ancillary service activities and good collaborative work among all groups.' We're very pleased to be awarded this highest level of accreditation and with what that means for our patients and staff."

This achievement marks more than 28 years of continuous accreditation by Princeton's cancer program.

By Judy Lang

(We would like to hear your story, please email it to ASCR).