



An Insight into the Alabama Statewide Cancer Registry

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Director's Corner

Xuejun Shen, PhD, MS

After a long cold winter, I am excited that summer is here! This also means we are going to close out 2013 data submission from the hospital registry and start 2014 data submission. This November, we will submit for 2012 data – the 24-month data submission to the North American Association of Central Registries (NAACCR) and the Centers for Disease Control and Prevention (CDC). Our completeness rate is significantly lower compared to previous years; there are around 1,600 cases fewer than we had for 2011.

Please assist the ASCR to reach a 95% completeness rate with 2012 data and a 90% completeness rate with 2013 data through implementing the following approaches:

1. Compare your facility's 2012 and 2013 completeness rate with previous years and identify whether some cases were missed during the regular reporting period. Facility Reports by Diagnosis Month are available through Regional Coordinator.
2. Respond to pathology and death certificate follow-back requests as soon as possible.

I have also received some inquiries about the ASCR death lists. I would like to take this opportunity to clarify the purpose and processes for the death list and death clearance reports.

Death List

In order to assist facilities with their follow-back processes on patients, we have provided a patient death list obtained from the Alabama Center for Health Statistics. The list with all deaths is posted in a password protected account in Web Plus. Lists from the last five years are also available in that account. Death lists from prior years are available upon request. The death reports matched with the patients submitted by facilities are posted to the Web Plus account of the applicable facilities. These reports will be removed after 6 months. So, please review the report as soon as it is posted to your account.

Death Clearance

The ASCR tries very hard to resolve the potential cancer cases from death certificates with the resources we have. However, we still need your assistance in resolving some incomplete cases. We need to know if these cases are reportable. Please respond to our requests as soon as possible indicating whether the cases are reportable. For reportable cases, please abstract and submit immediately. As our overall numbers are low in recent years, the cases identified through this process and through path reporting follow-back are crucial to reach our goal of 95% completeness.

I am glad to share with you that our *2011 data met NAACCR Gold Certificate standard!* Although we have a long way to get there again for the 2012 data, let's work hard together for another successful year. I look forward to seeing you at the ACRA meeting in October.

Information Systems CORNER

NAACCR Version 14.0 Conversion

The **ASCR** has converted its databases to NAACCR Version 14.0. The conversion is done to meet the data transmission standards set by the North American Association of Central Registries (NAACCR) and Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR).

- **Web Plus Upload**

NAACCR v14.0 for *Web Plus* has been updated. For reporting facilities using NAACCR v13.0 software for 2014 cases, please still choose NAACCR v13 file. Otherwise, select NAACCR v14.x file for 2014 cases.

- **Abstract Plus**

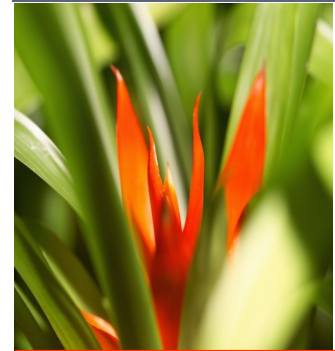
NAACCR v14.0 for *Abstract Plus* software has been updated. Users can utilize this current version for 2013 and 2014 cases. All users should immediately update their Abstract Plus (3.3.1.3) with the v14.0 metafile. We will no longer accept cases formatted in NAACCR v12.2.

- **GenEDITS**

GenEDITS Plus software for 2014 data is available on our website, including updated installation instructions. Please refer to the 'Hospital Resources' link on our website at www.adph.org/ascr.



Please check the **ASCR** website regularly for cancer registry updates.



ABSTRACT PLUS UPDATE

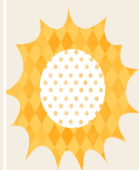
If any user is still using a version other than Abstract Plus 3.3.1.3, please contact the ASCR immediately.



Transmitting Patient Specific Data

If you have documents (e.g., path reports in Excel format or delimited text format) containing patient identifying information that you would like to transmit to the ASCR, please send those documents through our secure online database system called Web Plus.

For questions regarding file transmission, please feel free to contact Teresa Trailer at 334-206-5918 or email at teresa.trailer@adph.state.al.us.



Retention of Documents

If you are a healthcare provider who maintains paper records of pathology reports, imaging records, etc., please retain these records for a period of 5 years in the event the ASCR needs you to provide this information to our agency.

For questions regarding document retention, please feel free to contact Tara Freeman at 334-206-7035 or email at tara.freeman@adph.state.al.us.

ASCR Declaration of Readiness for Meaningful Use Stage 2

The ADPH is currently accepting cancer reporting from Eligible Providers (EPs) for Meaningful Use Stage 2. EPs are required to generate and transmit reports to the State of Alabama in a valid Health Level 7 Clinical Document Architecture, Release 2 (HL7 CDA R2) cancer event report. For more information, visit our website at www.adph.org/ascr or contact Teresa Trailer at 334-206-5918.

TNM Trivia

Which of the following sites only have III stages?

- Thyroid
- Testis
- Uvea

See answer on the bottom of page 9.

Education **corner**

Upcoming Webinars



Cullman County

The ASCR will host NAACCR webinars at the Cullman County Health Department. Exact dates and times to be announced.

August 2014 — *Collecting Cancer Data: Colon & Rectum*

September 2014 — *Collecting Cancer Data: Liver*

If you plan to attend, please contact Diane at (256) 775-8970 or by email at diane.hadley@adph.state.al.us.



Montgomery County

The ASCR will host live NAACCR webinars at the RSA Tower in Montgomery beginning at 1:00p.m. on the following dates:

August 7, 2014 — *Collecting Cancer Data: Lung*

September 11, 2014 — *Coding Pitfalls*

October 2, 2014— *Using the AJCC Cancer Staging Manual 7th Ed. & Summary Stage 2000*

November 6, 2014— *Hematopoietic & Lymphoid Neoplasms*

If you plan to attend, please contact Tara at (334) 206-7035 or by email at tara.freeman@adph.state.al.us.



Jefferson County

Princeton Baptist Medical Center will be hosting recorded NAACCR webinars. Exact dates and times to be announced.

For more information, please contact Judy Lang by email at judy.lang@bhsala.com.



Mobile County

The ASCR will host 2 recorded NAACCR webinars on **July 28, 2014, from 8:00 am to 3:30 pm** at Mobile Infirmary. The topics of the webinars are:

Boot Camp

Collecting Cancer Data: Ovary

If you plan to attend, please contact Mark at (251) 341-6247 or by email at mark.jackson2@adph.state.al.us.

Use of Resubmission Files

The purpose of the annual data resubmission process is to identify cases that may have been missed from the regular data submissions.

The ASCR is unable to update additional treatment data from the resubmission file.

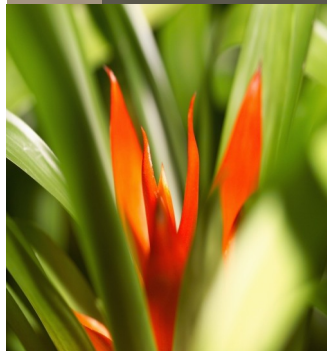
To provide updated patient treatment information after the regular data submission, please complete the **ASCR Online Data Revision Form** which can be found on our WebPlus login page at <https://webplus.adph.state.al.us/>.

RQRS and State Reporting

When fulfilling Standard 5.2 with Rapid Quality Reporting System (RQRS) participation, please keep in mind that you will not submit these cases to ASCR until 6 months from date of diagnosis or date of first contact. Continue to follow your ASCR data submission reporting schedule. This is done so we can capture the patient's first course of treatment when the abstract is submitted. Additionally, this will keep you from having to constantly submit online data revision forms to update patient treatment information.

Here is a link to the thread that addresses this in the CANSWER Forum: <http://cancerbulletin.facs.org/forums/showthread.php?q123-RQRS-cases&goto=newpost>.

Education **corner**



Coding Tidbits

- ◆ Please remember to include dates in your text. It is imperative for us to accurately code the treatment(s) the patient receives.
- ◆ Be sure to look up the specific code that should be used when coding adenocarcinoma arising in a colon polyp. The multiple primary book outlines specific guidelines on coding colon histology. See rule H4:
 - ⇒ Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma) when:
 - The final diagnosis is adenocarcinoma in a polyp.
 - The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
 - The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp, **or**
 - The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp, **or**
 - There is documentation that the patient had a polypectomy.
 - *Note 1:* It is important to know that the adenocarcinoma originated in a polyp.
 - *Note 2:* Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.
- ◆ Colonoscopies are not surgeries. Remember that 1st course of treatment is defined as procedures that affect, control, change, remove or destroy cancer tissue and is administered prior to disease progression or recurrence unless watchful waiting.

Remember

Date 1st CRS RX COC or the **Date 1st CRS RX COC Flag** field must be coded to pass edits.

Matching Trivia

Match the following AJCC staging classifications with the time frames.

- Clinical (c)
- Pathologic (p)
- y clinical (yc)
- y pathologic (yp)
- Retreatment (r)
- Autopsy (a)

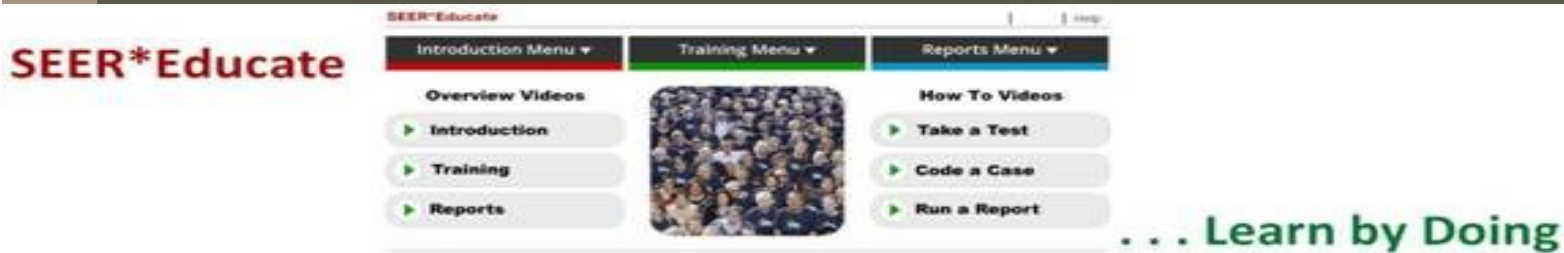
- ___ Recurrence after a disease-free interval
- ___ After systemic/radiation therapy of neoadjuvant and before surgery
- ___ After completion of definitive surgery
- ___ Incidental finding on a postmortem examination
- ___ At time of diagnosis, before treatment
- ___ After neoadjuvant therapy including surgical resection

See answers on the bottom of page 9.



Be sure to read the general rules of your AJCC manual. This sets the foundation for AJCC staging. If the site specific chapters differ from the general rules, the site specific chapters take precedence.

Education **corner**



A primary goal of SEER*Educate is to provide access to free practical application exercises to learn how to code and apply guidelines associated with various aspects of a registrar's responsibility. Over the next six weeks, TNM training modules will be released in SEER*Educate. Each of the following modules include 10 case scenarios with answers and rationales to help registrars learn how to assign TNM in vendor software packages.

- Bladder
- Cervix and Endometrium
- Esophagus, GE Junction and Stomach
- Kidney
- Lymphoma
- Ovary
- Prostate
- Breast
- Colorectal
- Head and Neck
- Lung
- Melanoma
- Pancreas and Biliary
- Testis

Sign up at [SEER*Educate](https://educate.fhcrc.org/) today by visiting <https://educate.fhcrc.org/> and [Learn by Doing!](#)

TEXT BOX/CODING TIPS

Provide detailed text information in the text box. Include any date of services, procedures performed, and staging information in the appropriate box. Below is a list of the most important text boxes and a description of the information needed.

Physical Examination: Include remarks about why the patient sought medical care. Include information about past history of cancer. This is also a good place to add the patient date of birth, gender, and race.

Primary Site: Include the origin of cancer; include laterality and any other relevant information. Example: right arm or upper outer quadrant of left breast.

Histology Title: Include name of the type of cell as described in the pathology report. Example: adenocarcinoma, melanoma, ductal cell carcinoma.

Pathology: Include tumor size, grade and number of lymph node(s) removed and positive. Make mention of any metastasis, spread of disease.

OP: Include the dates and names of any diagnostic procedure that helped to identify the cancer. Include a brief statement of the findings. You can also include any relative definitive surgery. Definitive surgery is a surgery that removes the cancer.

Staging: Include tumor size, extension of disease, lymph node involvement and metastatic involvement. Use of the T, N, M designations might be helpful. Example: T= tumor size,; N= no lymph node involvement; M=no metastatic involvement.

- Basal and Squamous cell carcinoma of the skin are not reportable, but tumors that originate in the mucous membrane are reportable. Be as specific as possible. For example: skin of the anus, c445 and anus, c210 are two different codes; skin of the anus is not considered reportable while anus is. Do not add or take away from the diagnosis.
- The vermilion border is considered a reportable cancer. The code for reportable lip cancers ranges from C000 – C009.

Alabama & United States Cancer Incidence Rates

For males and females combined, the all sites incidence rate for Alabama is slightly higher than the U.S. rate. However, after stratifying by race, the all sites incidence rates for both white males and females and black males and females are statistically significantly lower than the U.S. rate. For males, both white and black males in Alabama have significantly higher incidence rates for all sites, lung and bronchus, and colorectal cancers compared to the U.S. rates. White males in Alabama have significantly higher melanoma rates than their U.S. counterparts, and black males in Alabama have significantly higher prostate cancer rates than their U.S. comparison group.

For females, both white and black females have significantly lower incidence rates for all sites combined compared to the U.S. Additionally, white females in Alabama have significantly lower breast cancer incidence rates, and black females have significantly lower lung cancer incidence rates than the U.S. However, black females in Alabama have significantly higher incidence rates than both their U.S. counterparts and white females in Alabama. This is unique to Alabama as white females typically have significantly higher breast cancer incidence rates than black females.

Alabama and United States Cancer Incidence Rates, by Site, Race & Sex, 2006-2010*

	Males and Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	471.6	469.6	470.9	470.2	471.0	477.6
Lung and Bronchus	75.2	77.8	65.5	65.7	66.6	68.1
Colon and Rectum	47.9	46.0	56.0	44.7	43.7	53.1
Melanoma of the Skin	20.5	26.2	1.0	19.4	21.9	1.0

	Males					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	574.6	559.5	618.1	542.3	536.1	601.0
Lung and Bronchus	103.4	103.2	105.5	80.1	79.7	94.7
Colon and Rectum	57.2	54.9	68.0	51.7	50.5	62.5
Melanoma of the Skin	27.4	33.9	1.1	24.7	27.5	1.1
Prostate	158.4	135.1	236.0	146.6	136.6	220.1

	Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	397.5	404.5	374.6	418.8	424.9	395.9
Lung and Bronchus	54.3	58.5	39.3	55.1	56.8	50.4
Colon and Rectum	40.6	38.5	48.1	39.1	38.0	46.7
Melanoma of the Skin	15.7	20.7	1.0	15.6	18.0	1.0
Breast	119.4	117.7	122.2	122.2	123.5	118.4
Cervix	8.6	8.3	9.9	8.0	7.7	10.3

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.

* All rates are for malignant cases only except the rates for All Sites which includes bladder cancer *in situ*.

Source Alabama Data: Alabama Statewide Cancer Registry (ASCR), 2013. Data Years: 2006-2010

Source United States Data: NAACCR CINA+ Online, 2013. Data Years: 2006-2010

If you have any questions regarding the information provided, please contact Justin George at 334-206-3962 or by email at justin.george@adph.state.al.us.

Knowledge nook



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Clinical Research and the Cancer Registrar

Learning about the work of cancer registrars.

By Judith Keating, CTR

The most successful cancer registrars are always seeking new opportunities to increase their value to their facilities' cancer programs. It is no longer enough to abstract data from hospital medical records and submit it to a central or state registry. The data is being used to measure quality of care, assess outcomes, provide comparison data, and support administrative and financial decisions.

Cancer registrars have a unique opportunity to collaborate with the clinical research department. The Commission on Cancer, Standard 1.9, Clinical Trial Accrual, requires cancer programs to meet the clinical trial accrual percentage that is required for their specific accreditation category. According to the Cancer Program Standards 2012, patients who participate in clinical research trials have the opportunity to advance evidence-based medicine. Cancer Committees, including the required Clinical Research Coordinator, often look to the Cancer Registrar to be the expert in interpreting the finer points of the Clinical Research standard and how it applies to their particular program.

The first question often asked is what constitutes a clinical trial and when does a patient count? The clinical trial must have approval by an internal or external institutional review board (IRB). A signed consent is necessary unless the IRB has specifically allowed a verbal consent. Patients may sign an informed consent but do not meet the eligibility or screening requirements for participation in the study.

These patients cannot be counted as accruals. Count patients who are diagnosed or treated at your program, but are placed on a trial through another program or referral. It may be harder to collect this information so educating physicians and their office staff on the importance of notifying the registry of their patients' enrollment to outside trials is critical. The Commission on Cancer expects that all accredited programs, including National Cancer Institute (NCI)- designated Comprehensive Cancer Centers, provide enrollment data and assistance to all cancer programs that refer to clinical trials.

A patient who is seen at your facility for any reason and placed in a cancer prevention or cancer control trial can be counted toward accrual. Some examples of these types of trials are primary prevention of cancer, early detection of cancer, quality of life and economics of care related to cancer. Perhaps your program may have a high risk breast cancer program that refers to a primary prevention trial. The Commission on Cancer now allows programs to include patients who are enrolled in bio-registries or patient registries with an underlying cancer research focus.

The registry should be utilized when a program is assessing the feasibility of opening a particular trial. Registry data can tell if there are sufficient numbers of a particular type and/or stage cancer to justify the resources needed to perform that trial. A novel opportunity exists when the cancer registrar considers IRB membership. The U.S. Office for Human Research Protections empowers IRB's to approve, monitor and review biomedical research involving human subjects. Usually an online training course in human subject protections and an introduction to the IRB process is all the preparation required of a new member. The registrar who is an IRB member acquires firsthand, in-depth knowledge of the trials open in their program, interacts with the study team, and in turn, becomes a visible, valuable member of the clinical research program.

To learn more about the work of cancer registrars, visit the National Cancer Registrars Association's website at www.ncra-usa.org.

Knowledge **nook**

CDC Home



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Breast Cancer in Young Women

Most breast cancers are found in women who are 50 years old or older, but breast cancer also affects younger women. About 11% of all new cases of breast cancer in the United States are found in women younger than 45 years of age.

Who has a higher risk?

Some young women are at a higher risk for getting breast cancer at an early age compared with other women their age. If you are a woman under age 45, you may have a higher risk if—

- You have close relatives (parents, siblings, or children) who were diagnosed with breast or ovarian cancer when they were younger than 45, especially if more than one relative was diagnosed or if a male relative had breast cancer.
- You have changes in certain breast cancer genes (BRCA1 and BRCA2), or have close relatives with these changes.
- You have an Ashkenazi Jewish heritage.
- You were treated with radiation therapy to the breast or chest during childhood or early adulthood.
- You have had breast cancer or certain other breast health problems such as lobular carcinoma *in situ* (LCIS), ductal carcinoma *in situ* (DCIS), atypical ductal hyperplasia, or a typical lobular hyperplasia.
- You have been told that you have dense breasts on a mammogram.

For a complete review of this article and learn how to reduce your risk for breast cancer, check out the CDC website at http://www.cdc.gov/cancer/breast/young_women/index.htm.

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - [Contact CDC-INFO](#)



Around & **about**

Good Eatin' at NCRA meeting



Cancer Registrars at NCRA meeting in Nashville, TN



Around & about



Weddings, Weddings, Weddings



Congratulations Seth & Katty Hadley



Seth is the son of Diane Hadley, ASCR Data Completeness Manager

Congratulations J.C. & Crystal Jones



Crystal is the ASCR Non-Hospital Coordinator

Congratulations Justin & Koren George



Justin is the Director of Cancer Epidemiology

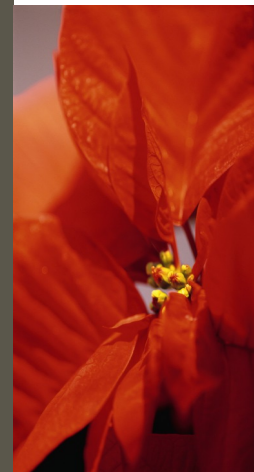


Food for thought...

Question: Is “early” melanoma reportable?

Answer:

- The following skin histologies **are not reportable**: Early melanoma; Evolving melanoma; and, Early/evolving melanoma.
- The following skin histologies **are reportable**: Melanoma, NOS; In situ melanoma; Early in situ melanoma; Evolving in situ melanoma; and, Early/evolving in situ melanoma.



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The ASCR was established in 1995 by the Alabama Department of Public Health in response to state law (Act 95-275) that made cancer a reportable condition. Data collection began in January 1, 1996.

The ASCR is a member of the North American Association of Central Cancer Registries (NAACCR) which sets standards for completeness, timeliness, and data quality. Registries that meet the highest standards receive NAACCR Gold Certification. Alabama has achieved the highest NAACCR standards and received the Gold Certification since data year 2004.



www.adph.org/ascr

SEER Training on TNM Staging

SEER Training Assessment for TNM Staging will take place on:

August 9, 2014 at 7:00am to 12:00noon

Participants will be using the new upgraded version of the SEER Reliability software and will need to create a new account to access the training. To create a new account, please follow the Create An Account link on the sign-in page

<https://reliability.seer.cancer.gov>.