Alabama Department of Public Health
Alabama Statewide Cancer Registry

ASCR NEWS

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Inside this issue:

ASCR Data Reporting

The staff of the Alabama Statewide Cancer Registry (ASCR) is excited about the 100% completion of Alabama's 2004 cancer cases and are eagerly anticipating the completion of the 2005 data which is currently at 76%. We are asking that you review your casefinding processes and databases to ensure that all 2005 cases have been reported. Complete and timely reporting by all data sources is crucial to a central registry's ability to meet its reporting timeframe.

The central registries are required to report annually to the North American Association of Central Caner Registries (NAACCR) and the National Program of Cancer Registries (NPCR). Reporting consists of twenty-four and twelve month data.

NPCR's twenty-four month (2004) data submission is required to be 95% complete and twelve month (2005) data must be 90% complete. Data is submitted in January of each year and is reviewed to ensure that NPCR's timeliness, completeness and quality standards are achieved. Because all central registries are partially or completely funded by NPCR; it should be noted that the lack or presence of these elements could impact program funding.

Similarly, NAACCR requires twenty-four and twelve month submissions, but review is only performed on the twenty-four month data which is required to be 95% complete. Review of this data determines if certification has been achieved. Currently, there are two levels of certification, gold and silver; the ASCR enjoys silver status with an eye clearly focused on gold.

The staff of the ASCR would like to thank you for your continued dedication and support. Only through our collaborative efforts can the complete and accurate details of cancer diagnosis and care in our great state of Alabama be reported nationally.

2006 ASCR Completeness s Schedule

Current Month	Completeness %	Timeliness
July 06	**8**	January
August 06	**17**	February
September 06	**25**	March
October 06	**33**	April
November 06	**42**	May
December 06	**50**	June

Total expected cases 23,207

Alabama Statewide Cancer Registry
&
Alabama Cancer Registrars Association

Host
NAACCR's Webinar

Abstracting Head and Neck Cancer Incidence and Treatment Data
October 12, 2006

Jefferson County Health Department
1600 6th Avenue South
Birmingham, Alabama 35233

Time To Be Announced

NEUROFIBROMATOSIS

What is Neurofibromatosis?

The neurofibromatoses are genetic disorders of the nervous system that primarily affect the development and growth of neural (nerve) cell tissues. These disorders cause tumors to grow on nerves and produce other abnormalities such as skin changes and bone deformities. Although many affected persons inherit the disorder, between 30 and 50 percent of new cases arise spontaneously through mutation (change) in an individual's genes. Once this change has taken place, the mutant gene can be passed on to succeeding generations. Scientists have classified the disorders as neurofibromatosis type 1 (NF1) and neurofibromatosis type 2 (NF2). NF1 is the more common type of the neurofibromatoses. In diagnosing NF1, a physician looks for changes in skin appearance, tumors, or bone abnormalities, and/or a parent, sibling, or child with NF1. Symptoms of NF1, particularly those on the skin, are often evident at birth or during infancy and almost always by the time a child is about 10 years old. NF2 is less common. NF2 is characterized by bilateral (occurring on both sides of the body) tumors on the eighth cranial nerve. The tumors cause pressure damage to neighboring nerves. To determine whether an individual has NF2, a physician looks for bilateral eighth nerve tumors and similar signs and symptoms in a parent, sibling, or child. Affected individuals may notice hearing loss as early as the teen years. Other early symptoms may include tinnitus (ringing noise in the ear) and poor balance. Headache, facial pain, or facial numbness, caused by pressure from the tumors, may also occur.

Question

Is neurofibromatosis of the leg reportable?

Answer

Neurofibromatosis, 9540/1 is reportable if it is of the CNS system. Please check with the physician to determine the site.

Further, according to April Fritz, Neurofibromatosis is not reportable to a cancer registry. The syndrome that includes neurofibromatosis can also cause benign and borderline tumors of the cranial nerves and other parts of the central nervous system, and those CNS tumors are reportable, not the NF.

CoC's New Online Education

The COC recently announced the release of its Online Education Center for cancer programs. This resource offers CoC and AJCC-related presentations with synchronized audio and slides, and a written transcript. From the comfort of your own home or office, the fee-based sessions can be viewed at your own pace, you may start and stop whenever you choose, and you may view them as often as you'd like. The National Cancer Registrar's Association has awarded 1.25 CE's for each Web cast, unless otherwise noted.

TNM and Collaborative Staging presentations are slated to be introduced in the Fall.

CoC Changes

The CoC recently made the following decisions affecting facility and NCDB data collection.

- This fall's NCDB Call for Data will request reports for data years 1985,1990, 1995, 2000 and 2005.
- This fall's Call for Data will open October 2, 2006.
- Several new data items that record facility and physician National Provider Identifiers will be requested for cases diagnosed in 2007 and will be required beginning in 2008. These items have all been added to the NAACCR standard transmission record, and software providers will implement them by 2007.
- The new histology and multiple primary rules developed largely by SEER were endorsed for use beginning in 2007, along with five new data items: Ambiguous Terminology Dx, Date of Conclusive Dx, Multiple Tumors Reported as One Primary date of Multiple Tumors, and Multiplicity Counter. These items are all available in the NAACCR transmission record, and software providers will be able to implement them in 2007 cases.

NEW ELIGIBILITY CRITERIA for the CTR EXAM
Implementation: Starting for the 2008 CTR Exams

Rationale for Changes

As cancer registrars move forward, it is apparent that obtaining college level education is becoming more critical as oncology physicians and researchers are becoming more sophisticated and complex in their approach to cancer care. Cancer registrars must know the natural disease process of cancer, all available treatment options (standard of care and research), and general prognostic indicators. To be successful in this profession, one must obtain a strong background in anatomy and physiology, medical terminology, medical record management, confidentiality rules and regulations, speech, computer applications and database management skills, statistics and business management.

Degree Requirement

Nearly uniform agreement by participants in an assembled workgroup decided that a minimum college degree should be a prerequisite to certification testing. They believe that a requirement of a minimum degree would improve the profession by increasing the public profile of cancer registration, improve the credibility of the job as a profession, and improve the quality of cancer data.

The focus of the changes will be to require a minimum of an Associate's degree in an allied health field by 2010. Based on information from candidates taking the CTR exam in the past 7 years, 40% do not currently have a minimum of an Associate's degree. It is unknown how much additional training would be needed by those candidates indicating that they have "some college".

In 2008:

NEW Eligibility Route 1:

Minimum two years full-time (24 months or 3,900 hours) or equivalent experience in the Cancer Registry field and two semesters/3 quarters of college-level courses in Human Anatomy and/or Physiology.

Identified change: The additional educational requirement of two semesters of college-level courses in Human Anatomy and/or Physiology.

In 2009:

NEW Eligibility Route 1:

Minimum two years full-time (24 months or 3,900 hours) or equivalent experience in the Cancer Registry field and the equivalent of one year (12 credits hours) of college education that includes two semesters/3 quarters of Human Anatomy and/or Physiology, one semester of Medical Science/Biology plus a college-level course in Medical Terminology.

Identified change: The educational requirement of the equivalent of one year (12 credits hours) of college education that, in addition to the required Anatomy and /or physiology requirements, includes the additional courses of one semester of Medical Science/Biology plus a college-level course in Medical Terminology.

NEW Eligibility Route 2:

Successful completion of an NCRA-approved Cancer Information Management Associate's degree; **OR** NCRA-approved college level curriculum in cancer data management/Cancer Registry **AND** successful completion of a minimum of an Associate's degree or equivalent (4 semesters/6 quarters).

Identified change: The educational requirement of a minimum of an Associate's degree or equivalent (4 semesters/6 quarters),

In 2010:

Eligibility Route 1 will be eliminated, meaning that all candidates must apply through another route and that they have a minimum of an Associate's degree in an allied health field.

CERTIFICATION EXAMINATION FOR CANCER REGISTRAS

Fall Testing Period
Application Deadline: July 31, 2006
Testing Begins: Saturday, September 16, 2006
Testing Ends: Saturday, September 30, 2006

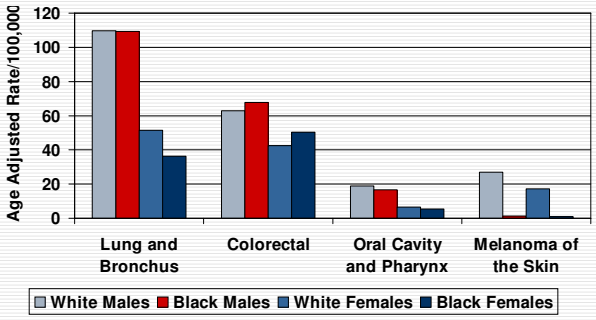
FEES

Current NCRA Members	**$225.00**
All Other candidates	**$325.00**

STATISTICALLY SPEAKING

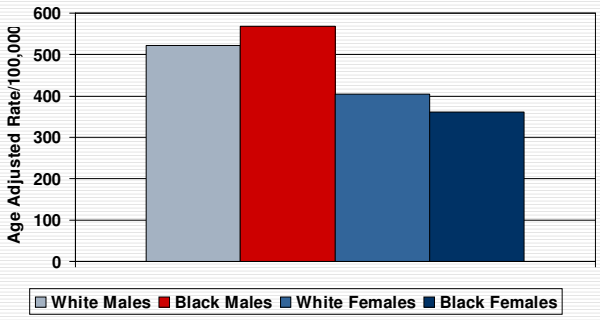
ASCR'S 1996 –2004 DATA

Incidence Rates 1996-2004 Selected Cancer Sites



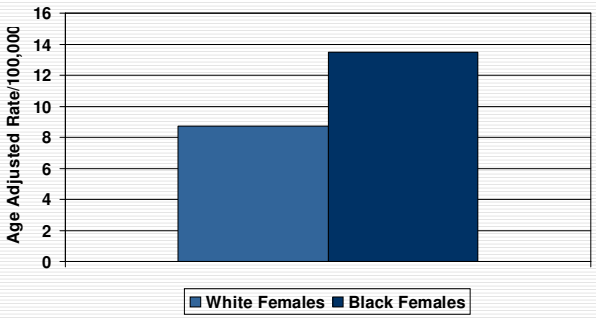
Source: ASCR 2006

Incidence Rates 1996-2004 All Cancer Sites Combined



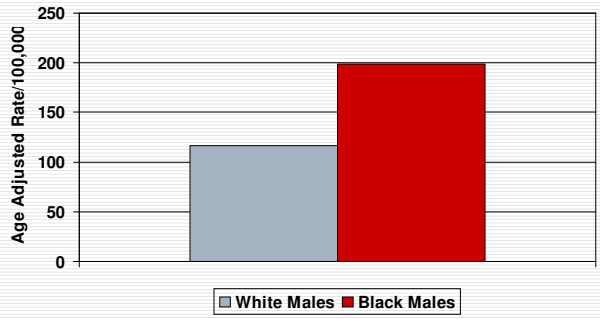
Source: ASCR 2006

Incidence Rates 1996-2004 Cervix Cancer



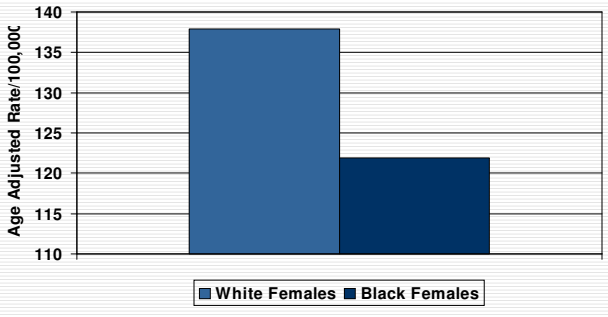
Source: ASCR 2006

Incidence Rates 1996-2004 Prostate Cancer



Source: ASCR 2006

Incidence Rates 1996-2004 Breast Cancer



Source: ASCR 2006

Alabama Incidence Rate Summary 1996-2004

	White Males	Black Males	White Females	Black Females
All Sites	522.2	568.2	403.8	361.1
Lung and Bronchus	109.6	109.2	51.6	36.3
Colorectal	62.9	67.6	42.5	50.0
Oral Cavity and Pharynx	18.9	16.8	6.6	5.4
Melanoma of the Skin	27.0	1.1	17.2	0.9
Breast	2.2	2.7	137.9	121.9
Cervix	^	^	8.7	13.5
Prostate	116.3	198.4	^	^

Source: ASCR 2006

WORLD HEALTH ORGANIZATION

10 Facts About Cancer

The World Health Organization (WHO) is the United Nations specialized agency for health. It was established on April 7, 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- There are more than 100 types of cancers; any part of the body can be affected.
- In 2005, 7.6 million people died of cancer 13% of the 58 million deaths worldwide.
- More than 70 % of all cancer deaths occur in low and middle income countries.
- World wide, the 5 most common types of cancer that kill men are (in order of frequency): lung, stomach, liver, colo-rectal and esophagus.
- World wide, the 5 most common types of cancer that kill women are (in order of frequency): breast, lung, stomach, colorectal and cervical.
- Tobacco use is the single largest preventable cause of cancer in the world.
- One fifth of all cancer world wide are caused by chronic infection, for example Human Papilloma Virus (HPV) causes cervical cancer and hepatitis B virus (HBV) causes liver cancer.
- A third of all cancers could be cured if detected early and treated adequately.
- All patients in need of pain relief could be helped if current knowledge about pain control and palliative care were applied.
- 40 % of cancer could be prevented, mainly by not using tobacco, having a healthy diet, being physically active and preventing infections that may cause cancer.

THE NAACCR WASHINGTON REPORT EXCEPRTS

BREAST CANCER LINKED TO WEIGHT GAIN--

Gaining 22 pounds increased a woman's risk of breast cancer by 18 percent, according to a study in the *Journal of the American Medical Association*. Women who lost the same amount lowered their risk by 57 percent, however.

The study tracked 87,000 women between the ages of 30 and 55 for 26 years. Researchers monitored how their weight changed after the age of 18, and from menopause onward.

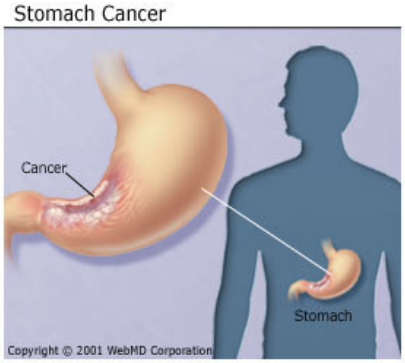
Women who gained 55 pounds or more after age 18 and kept the weight on had a 45 percent greater risk of developing breast cancer than those who maintained their weight. The study did count weight gained during pregnancy. Losing weight, even after menopause, significantly decreased the chance of breast cancer. But age was still the main risk factor for developing the disease, the study concluded.

The National Research Council report *Fulfilling the Potential for Cancer Prevention and Early Detection* examines several behaviors that increase the risk of cancer, including obesity, tobacco use, physical inactivity, poor diet, and alcohol use.

The Institute of Medicine and National Research Council report *Saving Women's Lives* looks at different screening methods and ways to diagnose breast cancer. It recommends increasing the access to mammography and broadening the pool of people who can properly read mammograms. It also recommends tracking and providing specialized screenings for women at high risk of developing the disease.

CANCER OF THE STOMACH

Stomach cancer (also called **gastric cancer**) can develop in any part of the stomach and may spread throughout the stomach and to other organs, particularly the esophagus, small intestine. It also may extend through the stomach wall and spread to nearby lymph nodes and to organs such as the liver, pancreas, and colon. Stomach cancer also may spread to distant organs, such as the lungs, the lymph nodes above the collar bone, and the ovaries. Metastasis to the ovary is called a **Krukenberg tumor**.



Epidemiology

Stomach cancer represents roughly 2% (21,500) cases of all new cancer cases yearly in the United States, but it is much more common in Japan, Great Britain, South America, and Iceland, possibly due to increased dietary consumption of nitrates. It is also associated with high salt in the diet, smoking, and low intake of fruits and vegetables. Infection with *H. pylori* is the main risk factor in about 80% or more of gastric cancers. It is more common in men.

Metastasis occurs in 80-90% of individuals with stomach cancer, with a five year survival rate of 75% in those diagnosed in early stages and less than 30% of those diagnosed in late stages. The death rate is 12,400 a year in the United States.

Symptoms

Endoscopic image of linitis plastica, a type of stomach cancer where the entire stomach is invaded, leading to a leather bottle like appearance.

Stomach cancer is often asymptomatic or causes only nonspecific symptoms in its early stages. By the time symptoms occur, the cancer has generally metastasized to other parts of the body, one of the main reasons for its poor prognosis. Stomach cancer can cause the following signs and symptoms:

Early

- Indigestion or a burning sensation (heartburn)
- Loss of appetite, especially for meat
- Abdominal pain or discomfort in the upper abdomen
- Nausea and vomiting
- Diarrhea or constipation
- Bloating of the stomach after meals
- Weight loss
- Weakness and fatigue
- Bleeding (vomiting blood or having blood in the stool), which can lead to anemia

These can be symptoms of other health problems, such as a stomach virus or gastric ulcer, and diagnosis should be done by a gastroenterologist or an oncologist

Diagnosis

To find the cause of symptoms, the doctor asks about the patient's medical history, does a physical exam, and may order laboratory studies. The patient may also have one or all of the following exams:

- Gastroscopic exam is the diagnostic method of choice
- Upper GI series (may be called barium roentgenogram)
- Fecal occult blood test is obsolete except possibly as a screening test; a negative test proves nothing and a positive result may result from a large number of other conditions beside gastric carcinoma.

Abnormal tissue seen in a gastroscope examination will be biopsied by the surgeon or gastroenterologist. This tissue is then sent to a pathologist for histological examination under a microscope to check for the presence of cancerous cells. A biopsy, with subsequent histological analysis, is the only sure way to confirm the presence of cancer cells.

Histopathology

Low differentiated Adenocarcinoma of the stomach.

- *Gastric adenocarcinoma* is a malignant epithelial tumor, originating from glandular epithelium of the gastric mucosa. It invades the gastric wall, infiltrating the muscularis mucosae, the submucosa and thence the muscularis propria. Histologically, there are two major types of gastric cancer (Lauren classification): intestinal type and diffuse type.
- ***Intestinal type adenocarcinoma*:** tumor cells describe irregular tubular structures, harboring pluristratification, multiple lumens, reduced stroma ("back to back" aspect). Often, it associates intestinal metaplasia in neighboring mucosa. Depending on glandular architecture, cellular pleomorphism and mucosecretion, adenocarcinoma may present 3 degrees of differentiation: well, moderate and poorly differentiate.
- ***Diffuse type adenocarcinoma*** *(mucinous, colloid):* Tumor cells are discohesive and secrete mucus which is delivered in the interstitium producing large pools of mucus/colloid (optically "empty" spaces). It is poorly differentiated. If the mucus remains inside the tumor cell, it pushes the nucleus at the periphery - "*signet-ring cell*".

Treatment

Like any cancer, treatment is adapted to fit each person's individual needs and depends on the size, location, and extent of the tumor, the stage of the disease, and general health. Cancer of the stomach is difficult to cure unless it is found in an early stage (before it has begun to spread). Unfortunately, because early stomach cancer causes few symptoms, the disease is usually advanced when the diagnosis is made. Treatment for stomach cancer may include surgery, chemotherapy, and/or radiation therapy. New treatment approaches such as biological therapy and improved ways of using current methods are being studied in clinical trials.

Source WIKIPEDIA

CoC's Inquiry & Response Review

Question	Answers
A GIST tumor was found on the outside serosa of stomach, did not invade the stomach wall. Is the site of the tumor, stomach or soft tissue? Can it be CS staged?	GIST tumor arising outside of the stomach serosa (wall) should be Collaborative Staged using the Retroperitoneum and Peritoneum CS Schema. The site would be soft tissue.
A patient was diagnosed elsewhere with MALT lymphoma of stomach. He was treated for H. pylori elsewhere, followed by repeat EGD that showed persistent lymphoma. Then came to our facility for cancer care, xrt, etc. Is treatment of the H. pylori considered cancer-directed treatment and if so, how is it coded? Since the patient presented here for persistent disease after H. pylori treatment is it a class 2 or class 3/non-reportable?	Antibiotic Therapy is not coded. The patient presenting to your facility for cancer care and treatment would be a Class of Case 2.
Are carcinoid tumors of the stomach AJCC staged ?	Carcinoid tumors of the stomach are not staged using the AJCC system.
For Kaposi sarcoma of the stomach?	The primary site would be stomach.
A primary gastric adenocarcinoma patient underwent gastric resection and splenectomy. There was invasion through the peritoneal surface without perforation and perigastric lymph nodes were involved. There was foci of gastric adenocarcinoma found in the perisplenic fat. Would the foci be M1 or fall into one of the T categories?	This would be M1
Do all margins need to be described on resection of stomach carcinomas to meet CAP protocols? The path report stated, "Margins uninvolved" but did not state distal, proximal or radial.	The checklist does specify distal, and circumferential margins. "Not accessed" is one of the selections for each of these margins.
If the pathology reports on stomach cancer includes Lauren and WHO classification, is the information used for coding the ICD-0-3 histology codes? If a final diagnosis was adenocarcinoma of the lesser curvature, Lauren classification intestinal type, WHO classification tubular adenocarcinoma, is coded 81403, 82113 or 81443?	Use the ICD-O-3 histology/behavior code of 8211/3
Stomach, antrum (ulcerated masses), biopsy: "Diffuse large B-cell lymphoma probably arising from a low-grade MALT lymphoma. We favor the dense lymphoid proliferation in the biopsies of the ulcerated antral masses ("B") is a diffuse large B-cell lymphoma arising from a low-grade MALT lymphoma. What code should be used for the histology?	Code the MALT lymphoma since it is more specific. Diffuse large B-cell lymphomas has about 25 synonyms, so we consider it an NOS term and our rules say to code to the more specific term.
A plasmacytoma was diagnosed by biopsy of the duodenum with the bone marrow negative. What is the primary site if the treating physician called it a bulky plasmacytoma of the head of the pancreas region?	Plasmacytomas are usually solitary and are sited to the organ of origin (head of pancreas). Staging would be based on the extent of disease for the site of origin.
Are gastrinomas stageable?	A malignant gastrinoma is a type of adenocarcinoma. The AJCC staging scheme for stomach applies to adenocarcinomas. Only malignant gastrinmas are reportable and stageable.

ALABAMA DEPARTMENT OF PUBLIC HEALTH
ALABAMA STATEWIDE CANCER REGISTRY

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Capturing Cancer Data in Alabama
Find us on the web

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

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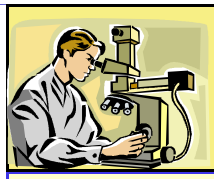

CASEFINDING

Include Autopsy Cases

Active casefinding: involves registry personnel retrieving all source documents (such as disease indices, pathology reports, etc.). These documents are then screened to identify reportable cases. The benefit of active casefinding procedures is that this method is more thorough and accurate than passive casefinding. **Autopsy cases should be included in the casefinding process. If a case is identified by autopsy it should be reported as a Class 5—Autopsy Only Case.**

A combination of active and passive casefinding is a commonly used system in registries today. The registrar must identify the critical casefinding sources that require active review by the registrar, decide the amount of passive case identification that should be performed, and determine which departments can provide high-quality casefinding information. An effective combination of active and passive reporting methods ensures more complete cases and reduces labor costs of the registry..

THE QA BOARD

Tumor Sequencing

- ASCR quality review recently revealed coding errors with sequencing of non-malignant tumors.
- Non-malignant tumors are coded in the 60 to 87 range. First non-malignant tumor will be coded 60.
- If a subsequent non-malignant tumor arises, it would be coded as 62 and the first non-malignant tumor changed to 61.