Alabama Department of Public Health
Alabama Statewide Cancer Registry

ASCR NEWS

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Central Update:

This time of year is like the calm after the storm at the ASCR. We have spent the last several months working feverishly to get your Alabama cancer data submitted to the national organizations—NPCR and NAACCR*. We're breathing a little easier knowing that goal has been accomplished and we are anticipating Gold certification once again for our 2005 data year. We have seen a huge improvement this past year in the timeliness of data submissions statewide and that has made the preparation of the data for these national submissions so much more efficient. We are looking forward to continuing that momentum this coming year by constant assessment of "old" processes, making improvements wherever necessary to make all our efforts as streamlined and efficient as possible. We thank you, once again, for all your support and cooperation in 2007!!!

*National Program of Cancer Registries and North American Association of Central Cancer Registries

WEB PLUS New To Alabama
Low Volume Data Collection Software

Web Plus has been implemented in Alabama. This is a web-based software application developed as a component of the CDC's Registry Plus Suite of computer products for cancer registry operations. It allows for collection of cancer data securely over the public Internet. It is for use by our low volume facilities, physicians' offices, and non-hospital reporting sources. The User display and edit configurations have been customized by the ASCR to simplify the data collection process for those with little or no former cancer registry experience. The software itself becomes an educational tool that equips the inexperienced cancer data collector with the knowledge necessary to capture quality "text only" data from the patient's medical record. That information is then saved in a database at the ASCR (the hosting registry), until the text information is converted into coded data by the ASCR staff. Web Plus is housed on a secure web server that has a digital certificate installed; all communication between the reporting source and the server is encrypted with Secure Socket Layer (SSL) technology, and cases entered by one facility are visible to that facility only via a private account known to that facility and the ASCR. This new option available to our non-registry facilities, physicians and free-standing cancer centers has provided them with several advantages over our prior processes. This software has proven to save these facilities the expense of excessive copying costs, as well as provided a much more efficient and secure method for transferring the data, eliminating the potential for lost records and confidentiality breaches. Two ASCR Casefinding Auditors continue to conduct casefinding procedures for these low-volume facilities by reviewing their pathology reports, disease indices, x-rays and scans, etc. according to a specified schedule. A list of reportable cases is then returned to each facility who, in turn, transfers specified software-driven information from that medical record chart via the ASCR's secure web-based data transfer system. There are currently 59 Web Plus users in Alabama with additional facilities being added regularly.

FACILITY AUDITS: Year One Review

The primary purpose of the audit process is to assess the level of data quality and case completeness of cancer reporting in population-based cancer registries throughout the state. An overview of the 2007 audit outcomes are as follows:

2007 Casefinding Audits – 5

85 Missed Cases Reported
150 Justifications

Casefinding Reviews include:
Pathology Reports
Disease Index

2007 ReAbstracting Audits— 4
44 Recodes
21 Miscodes
11 Justifications

Data Items Re-Abstracted — 9

DX Date	**DOB**
Sex	**Race**
Site	**Histology**
Grade	**Laterality**

Tumor Size

ALABAMA CANCER DATA RANKED NATIONALLY

Annually, the National Program of Cancer Registries ranks the data submitted by 45 funded state cancer registries from all across the U.S., based on a variety of quality indicators as noted in the table below. Our goal at the ASCR is to ensure that Alabama's data ranks lower than the NPCR average, which is indicative of higher quality data than the average state, based on these NPCR ratings. We have achieved that goal in many areas (as highlighted in blue below), and look forward, with your help, to accomplishing that goal in each and every area reviewed. You can help by avoiding the use of unknown and non-specific codes as much as possible, and by exhausting every plausible option to uncover and utilize valid codes. This is particularly important for coding laterality and diagnostic confirmation. There will always be occasions for the appropriate use of non-specific and/or unknown morphology codes as well as C76 for ill-defined sites...but limiting the use of those codes, only to those unavoidable situations, and refraining from using such codes when better information may be available with a little more pursuit... will improve Alabama's data quality ranking.

QUALITY INDICATOR	RANKING (1-45)	PERCENT ASCR CASELOAD	NPCR AVERAGE
Percentage of Unknown or Unspecified Laterality	29	2.91%	2.54%
Percentage of Non-specific Morphology (8000-8005)	28	2.96%	2.76%
Percentage of Unknown Diagnostic Confirmation or Not Microscopically Confirmed	26	4.95%	4.71%
Percentage of Other Ill-Defined and NOS Primary Site	34	2.41%	2.30%
Percentage of Unknown Race	12	0.48%	1.61%
Percentage of Death Certificate Only	15	1.68%	1.93%
Percentage of Unknown Derived SS2000 Colorectal Ca	15	4.56%	9.22%
Percentage of Unknown Derived SS2000 Breast Cancer	28	2.82%	5.52%
Percentage of Unknown Derived SS2000 Lung Cancer	25	7.68%	10.71%
Percentage of Unknown Derived SS2000 Prostate Cancer	34	5.20%	7.48%

EVENT CALENDAR

NATIONAL CANCER REGISTRARS WEEK
April 7-11, 2008
Theme:
"Cancer Registrars: "More Than Just Statistics"

Alabama Cancer Congress
The Village of Baytown Wharf—SanDestin, Florida
April 4-6, 2008

National Cancer Registrars Annual Conference
Minneapolis, Minnesota
April 28-May 1, 2008

ACRA Fall Meeting
Birmingham, Alabama
September 19, 2008

PUBLICATIONS OF INTEREST

Check out the following articles published during the last quarter of 2007 using NPCR data:

1) Larson T, Melnikova N, Davis S, **Jamison P**. Incidence and Descriptive Epidemiology of Mesothelioma in the United States, 1999–2002. *Int J Occup Environ Health* 2007; 13:398-403. http://www.ijoeh.com/pfds/IJOEH_1304_Larson.pdf

2) Wingo PA, Tucker TC, **Jamison PM**, Martin H, McLaughlin C, Bayakly R, Bolick-Aldrich S, Colsher P, Indian R, Knight K, Neloms S, Wilson R, Richards TB. Cancer in Appalachia, 2001–2003. *Cancer* 2008; 112:181-192.

3) **Stewart SL**, **Wike JM**, **Foster SL**, **Michaud F**. The incidence of primary fallopian tube cancer in the United

CODING POINTS:

The coding points listed below were drawn directly from routine edit reports on Alabama data and based on errors found in the originally submitted data.

- CS Extension of a colon/rectal adenocarcinoma in situ occurring in a tubillovillous polyp should be coded to 05, not 00, and the behavior should be coded to 02. Source: CS Manual and Coding Instructions Part II Colon/Rectal Extension
- Those brain sites C71.0-C71.4 and C72.2-C72.5 are considered paired, therefore, laterality should NOT be coded to 0. Source: FORDS Manual, Section One: Case Eligibility, Cancer Identification, and Overview of Coding Principles *List of Paired Organ Sites*
- CS tumor size for unknown primary site (C809) should be coded to 999, not 000. Source: CS Manual and Coding Instructions Part II Heme/Retic Tumor Size
- Diagnostic confirmation on leukemia cases with positive hematologic findings should be coded to 1, rather than 5. Source: FORDS page 99
- Laterality is frequently coded to '9' unknown, when the text information specifies right or left side. For example, x-ray text may state "5 cm. dense mass on the right side".
- A metastatic melanoma with an unidentified primary site should be coded to skin NOS (C44.9). Source: FORDS Revised, page 10
- Primary site for meninges should be coded to C70 Meninges, rather than C71 (Brain) or C72 (Other CNS). Source: NPCR CNS Coding Guidelines (See pages 6-7 of this newsletter)

CONGRATULATIONS

NEW CTRs

Kelly A. Evers
Yelonda NeShelle Prince
Rebecca B. Thomas
Shri Walker

MONTHLY DSRs: What You Need To Know!

The Monthly Data Submission Reports the ASCR uses to provide feedback to you each month confirming your data submissions, as well as your timeliness and completeness, have evolved significantly over the years. Revisions have been ongoing in an attempt to better reflect the reporting status of each of our reporting sources. Calculating timeliness and completeness is a very complex process, that we continue to improve upon, and simplify as much as possible. To further standardize and clarify this very complicated process, we have developed a software-based program that automates the calculation of your monthly case counts utilizing a formula based on categorization of cases by type. This new process takes away some of the potential for human error in the mathematical calculations. We are now able to classify cases according to current, late and non-analytic categories, which are reported separately on the DSR. Below is a simplified schematic of the formula used to categorize the case counts. Please remember that all data files should be received by the ASCR on or before the last day of each month. A five day grace period has been established to allow for unforeseen delays in file submission. Files received after the grace period will be counted as late and reflected accordingly on the DSR.

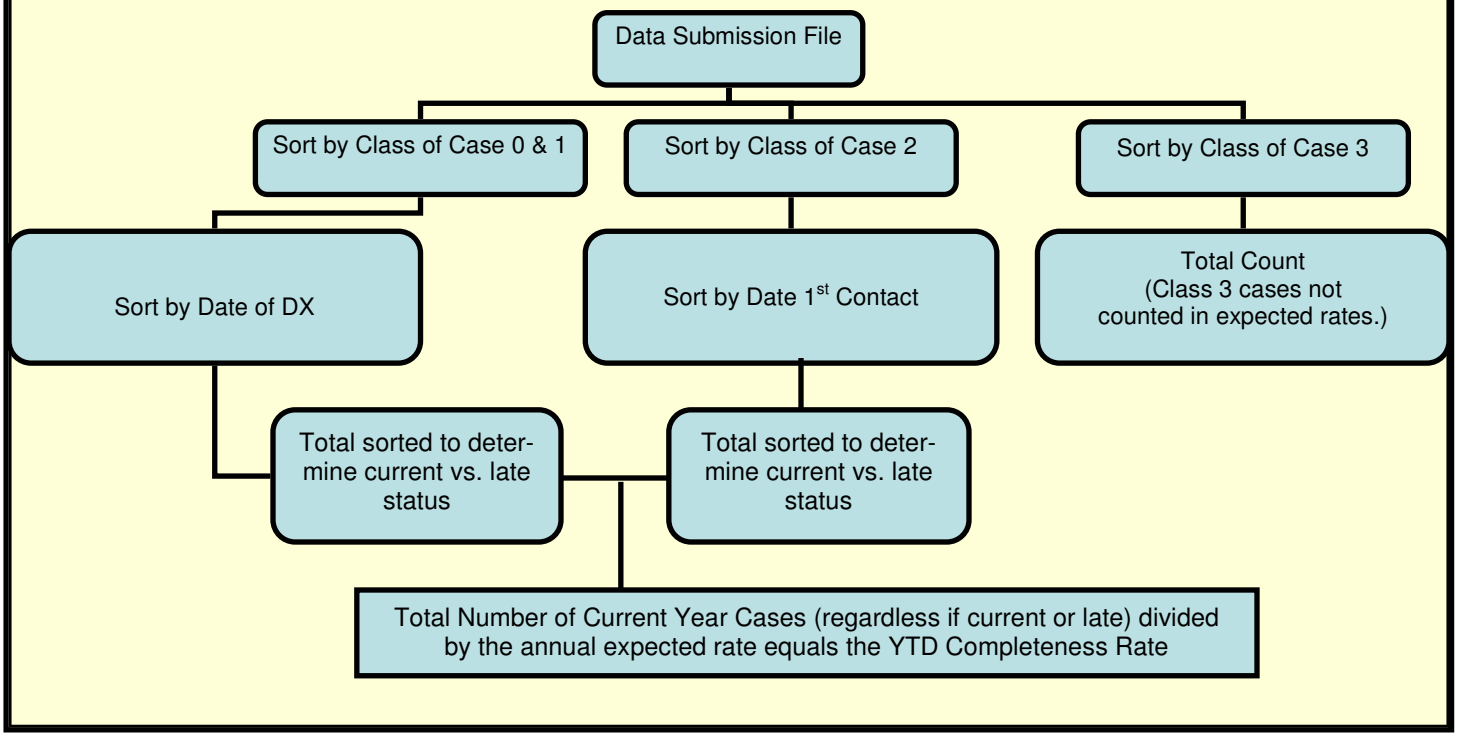
WELCOME ABOARD!!! Non-Registry Reporters

Non-Registry reporters are defined as those reporting facilities that do not have a cancer registry in place to report their cancer cases to the state, but rather have designated staff to report any cases they diagnose and/or treat. Such facilities might include low-volume hospitals, free-standing cancer centers, surgery centers, physician's offices or groups, clinics, etc. We are happy to have these reporters working with us. Their efforts improve our ability to understand and report the true incidence of cancer in Alabama. We will be providing increasing guidance and items of interest to our non-registry reporters in future publications of this newsletter. Be watching out for a new column !!! We also welcome Briana McCants, our Non-Hospital Reporting Source Coordinator.

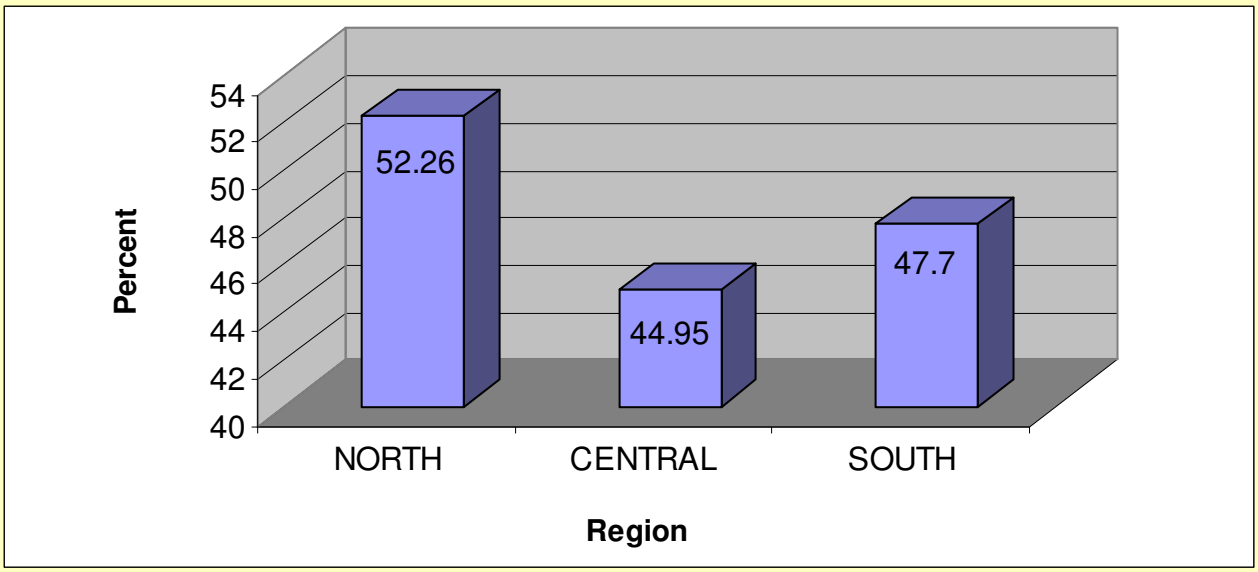
NEW ON THE ASCR WEBSITE

- Reportable List...Revised and Posted on the Downloads Page

CASE COUNTING ALGORITHM



DATA COMPLETENESS BY REGION IMPROVING



*As of January 15, 2008

REMINDERS AND TIPS

REMEMBER:

- To use the Multiple Primary and Histology rules in hierarchical order.
- DO NOT SKIP rules.
- For the bladder, Rule M5 states that if an invasive tumor occurs more than 60 days after a non-invasive or in-situ tumor it is a multiple primary.
- Rule M6 states that bladder tumor with any combination of papillary carcinoma(8050); transitional cell carcinoma (8120-8124) or papillary transitional cell carcinoma (8130-8131) are a single primary.
- You would never reach rule M7 for a papillary/transitional cell tumor of the bladder. Source: Multiple Primary and Histology Coding Rules, Urinary page 314 and SEER Inquiry System (SINQ) ID 20071016

REMEMBER:

- To use the correct site-specific surgery schema for extranodal lymphomas.
- Code the primary site and surgery using the site schema and code the stage using the lymphoma schema. Source: SEER Program Coding and Staging Manual 2007, note on page 117 and on page 177 under coding instructions #7

REMEMBER:

- A schwannoma (9560/0) stated to be an acoustic neuroma should be coded to C72.4. Source: http://www.cdc.gov/ cancer/npcr/training/btr/clarification.htm

REMEMBER:

- The 2007 Multiple Primary and Histology Coding Rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site
- OR to the reportable benign or borderline intracranial or CNS tumors. Source: Multiple Primary and Histology Coding Rules General Instructions, page 10

CNS CODING GUIDELINES

NPCR conducted a quality control review of all CNS data for 2004 with the first non-malignant CNS cases received in the 2007 call for data. The review identified the need for additional training regarding the coding of primary site and histology for both malignant and non-malignant CNS tumors. As a result of the review, NPCR developed the following CNS coding Guidelines.

- Always use the **behavior code** listed in the ICD-O-3 unless otherwise directed by a pathologist.

- **Meningiomas** are always coded to meninges (C70.-) unless specifically directed otherwise by a pathologist.
  Intraparenchymal meningiomas are exceedingly rare. Meningioma can also occur as a tumor of the **choroid plexus** in rare cases.

- **Solitary fibrous tumor** is a rare, usually dural based lesion of cranium or spinal canal; occasionally occurring in the lateral ventricle or spinal cord. They should be coded to meninges (70.-) unless specifically directed otherwise by a pathologist.

- **Nerve Sheath Tumors**
  Malignant: all tumors are reportable Always code to nerve of origin (**C47.**- or (**C72.-**).
  Nonmalignant: reportable for intracranial segment of cranial nerves only. Always code to the nerve of origin, (**C72.2, .3, .4, & .5)**
  Neurofibroma, neurilemmoma and neuroma are always peripheral nerve and thus can be either cranial nerve or nerve root.
  Pacinian tumor (M9507/0) is a non-malignant peripheral nerve tumor. The only reportable pacinian tumors are those arising intracranially.

- **Germ cell tumors:** Intracranially, these tumors are usually located in the **pineal gland (C75.3)** and suprasellar region (**C71.9** Brain, NOS)**,** and posterior 3rd ventricle (**C71.5)**. Code to site of origin.
  A **teratoma** (M908-) is always a germ cell tumor. It may be malignant or non-malignant. The only non malignant teratomas that are reportable are those occurring intracranially.

- **Vascular tumors** Malignant: all tumors are reportable; Nonmalignant: reportable for blood vessels of brain and spinal cord only. Code to CNS site of occurrence, not blood vessel.

Chordomas (9370-9372) are malignant tumors so ALL chordomas are reportable. These tumors usually start in the bone at the back of the skull (**C41.0** bones of skull) or at the lower end of the spinal column (**C41.2** vertebral column). 35% occur at the base of the skull. Intracranially, the tumors occur at the clivus (bones of skull: **C41.0**), and occasionally in the parasellar and sellar area (**C71.9** Brain, NOS). All chordomas should be **coded to the bone of origin** unless otherwise directed by a pathologist.

Chondrosarcoma is a malignant tumor of cartilage cells so ALL chondrosarcomas are reportable. When these tumors develop in the skull base, they usually arises in the parasellar area, cerebellopontine angle, or paranasal sinuses. These tumors may also arise in the clivus.

Clivus chordomas and chondrosarcomas may extend into the sella tursica, the clinoids, the nasopharynx, the posterior fossa, the foramen magnum, and may effect C1-2, the cranio-cervical junction. These tumors rarely may occur in the segmental spine arising from the vertebrae and commonly occur in the sacrum. These tumors should be coded to the bone of origin such as skull base/clivus (bones of skull: **C41.0**), spine: C3-L5 (**C41.2**), or sacrum (**C41.4**).

Chondromas (M9220/0 & M9221/0**)** are rare, slowly growing nonmalignant tumors which are only reportable if the primary tumor is in an intracranial site. In the cranial region, this includes the bones of the skull base and paranasal sinuses. These tumors should be coded to bones of skull **(C41.0)**. Reportablility of these tumors is an area of "Unresolved Issues". Expert neurosurgeons and neuropathologists believe that they should be reported and included in analysis of CNS tumors.

Paragangliomas are rare nonmalignant tumors. The only reportable paragangliomas are those arising intracranially. Paraganglia are located in several areas along the cervical nerves.

CUT AND SAVE

Carotid body tumors or **chemodectoma** comprise the majority of head and neck paragangliomas. These are coded to carotid body (**C75.4)**.

In the ICD-O, **aortic body** and **other praganglia** are in the same section as paragangliomas and are coded **C75.5.**

Glomus tumors arise from paraganglionic tissue in glomus bodies. These tumors are also coded to Aortic body and other paraganglia (**C75.5).**

Reportability of non-malignant intracranial paragangilomas is another are of "Unresolved Issues". Again, excpert neurosurgeons and neuropathologists believe that they should be collected and reported with CNS tumors.

HISTOLOGIES THAT ARE SITE-SPECIFIC

- **Choroid plexus tumors—**
  Located in the ventricular system.
  Code to ventricle **(C71.5)** unless otherwise directed by a pathologist.

- **Pituitary adenoma** (M8272/0) **& Pituitary carcinoma** (M8272/3**)**
  Always code to pituitary **(C75.1)** unless otherwise directed by a pathologist.

- **Craniopharyngiomas** (M9350/1)
  All craniopharyngiomas are non-malignant.
  Very few of these tumors actually arise in the craniopharyngeal duct. Most are either suprasellar (**C71.9** Brain, NOS)**,** or in the 3rd ventricle (**C71.5)**.

- **Pineal Parenchymal tumors**: Always code to Pineal gland **(C75.3)** unless otherwise directed by a pathologist. This includes:
  Pineocytomas (M9361/1)
  Pineoblastomas (M9362/3)
  Mixed pineocytoma-pineoblastoma (M9362/3)
  Pineal astrocytomas (M9400/3)

A **dermoid** (M9084) is usually a mal-developmental tumor that can be either malignant or non-malignant. The only nonmalignant dermoids that are reportable are those occurring intracranially.

A **desmoid tumor** is a nonmalignant fibrous tumor that does not occur intracranially, but is found on the neck. These tumors are not reportable.

A **myxoma (**M 9562**)**never occurs intracranially. However, something very similar to it does occur and is usually a scarred over meningioma.

THE FOLLOWING HISTOLOGIES SHOULD BE EXCLUDED FROM ALL BRAIN AND CNS SITES: C70.0-72.9 AND C75.1-75.3)

8041/3	SMALL CELL CARCINOMA	8070/3	SQUAMOUS CELL CARCINOMA, NOS
8130/3	PAPILLARY TRANSITIONAL CELL CARCINOMA	8360	MULTIPLE ENDOCRINE ADENOMAS
8370	ADRENAL CORTICAL ADENOMA (these are sometimes coded to C75.1 (pituitary) site, but should be coded to C74.0 Adrenal)		
8410	SEBACEOUS ADENOMA		
8700	PHEOCHROMOCYTOMA (these sometimes are coded to C71.x and C72.x sites, but should be coded to C74.1 Medulla of adrenal gland)		
8726	MAGNOCELLULAR NEVUS	8832/0, /3	DEMATOFIBROMA/SARCOMA
8891	EPITHELIAL LEIOMYOMA	8894	ANGIOMYOMA/MYOSARCOMA
8940/0	PLEOMORPHIC ADENOMA	9000	BRENNER TUMOR
9050	MESOTHELIOMA	9160	ANGIOFIBROMA, NOS
9520/3	OLFACTORY NEUROGENIC TUMOR		

Source: National Program of Cancer Registries

CUT AND SAVE

ALABAMA DEPARTMENT OF PUBLIC

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

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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Janice Cook, MBA,
Shri Walker, BS, CTR
Diane Hadley, BS, RHIT, CTR

COMING SOON!

- V11.2 Alabama EDITS Metafile to Vendors February 2008
- NAACCR Record Layout V11.2 May 2008
- CS Update May 2008

ASCR COMPLETENESS SCHEDULE

Current Month	Completeness %	Timeliness
Jul 07	8	January 07
Aug 07	17	February 07
Sep 07	25	March 07
Oct 07	33	April 07
Nov 07	42	May 07
Dec 07	50	June 07
Jan 08	58	July 07
Feb 08	67	August 07
Mar 08	75	November 07
Apr 08	83	October 07
May 08	92	November 07
Jun 08	100	December 07

EDUCATIONAL OPPORTUNITIES:

Web Plus Training

for Non-Registry Reporters

Montgomery

Wed., Mar 19

Birmingham

Thurs., Mar 20

For Further Details Contact

334-206-7068

INDEPENDENT CONTRACTORS

The Alabama Statewide Cancer Registry has recently updated its **Independent Contractors List.** The list is distributed to reporting facilities that inquire at the ASCR about registry contractors. To have your name included on this list, you must:

- Be a CTR with a minimum of two years experience, or possess a minimum of five years recent Cancer Registry experience
- Must contact the ASCR requesting that your name be included and provide complete contact information

The following disclaimer is included:

> **Disclaimer: The Alabama Statewide Cancer Registry does not endorse the work of persons whose names appear on the Independent Contractor's List. The sole purpose of compiling this list is to provide a useful resource for reporting facilities.**

Please help us keep this information current by contacting your Regional Coordinator with any changes in you information.