OHIO CANCER INCIDENCE SURVEILLANCE SYSTEM

July 2017 Quarterly

OCISS Newsletter

Inside this issue:

OCISS Updates	1
Abstracting Tips from NAACCR Webinars	2-3
Ask OCISS	4
ODH Cancer Publications Update	4
Calendar of Events / Save the Date	4

OCISS Updates

OCISS Data Evaluation, 1996-2015

As you know, OCISS submitted data for cancers diagnosed from 1996-2015 to both the Centers for Disease Control and Prevention (CDC) and the North American Association of Central Cancer Registries (NAACCR) in December 2016. We have since received notification from CDC that OCISS data met CDC's National Program of Cancer Registries (NPCR) National Data Completeness and Quality Standard. As a result, OCISS is recognized as a CDC NPCR Registry of Distinction! OCISS also received notification from NAACCR that OCISS data met NAACCR's Gold Standard for quality, completeness and timeliness.

Thank you for all the work you do to report timely, complete, and accurate data to OCISS to allow us to accomplish these goals and achieve these recognitions!

Web Plus

OCISS upgraded Web Plus software in mid-April. Cancer reporters can now abstract cases for diagnosis year 2017 in Web Plus. The upgrade also incorporated our newest edit set, NAACCR v16D. The edit set can be downloaded from the Web Plus log-in page or from the OCISS website at http://www.odh.ohio.gov/health/cancer/ocisshs/reporting1.aspx.

NAACCR recently released v16E edits; OCISS will be reviewing to determine what changes are needed. Most of the changes in the v16D edits pertained to TNM Staging; we anticipate the same with this newest edit set. OCISS will communicate information on the edits via email and will also post information to the Web Plus log-in page.

Social Security Numbers

OCISS has been hearing from cancer reporters that their facility is either not collecting social security number (SSN) from patients or only collecting the last 4 digits.

If your facility no longer collects SSN, please enter all 9s in the SSN field.

If your facility is only collecting the last 4 digits, enter five leading 1s followed by the last 4 digits of the SSN. If you try to enter leading 9s and then the last 4 digits of the SSN, you will get an edit error. Please do not enter all 9s if you have the last 4 digits of the SSN. When OCISS matches data with Vital Statistics and other data sources that collect SSN, having even the last 4 digits is helpful.

Training

OCISS is in the process of contracting with A. Fritz and Associates for a one-day training to be led by Denise Harrison, CTR on staging cancers according to the 8th Edition of the AJCC. The training will be held on September 22, 2017 in conjunction with this year's Annual Meeting of the Ohio Cancer Registrars Association. Stay tuned for more details.

Death Clearance

By now, all hospitals should have completed Death Clearance for 2015 cancer reports. If you have any follow-back requests outstanding, please bring those to completion as soon as possible.

Close Out 2016

We will soon be conducting Close Out for diagnosis year 2016. Although we realize there were delays in your being able to submit 2016 data to OCISS due to software conversions, we appreciate your efforts to get all 2016 cases reported.

Abstracting Tips from NAACCR Webinars

NAACCR Webinars are posted in Web Plus. Each provides three hours of continuing education (CE) credit. CEs are available for three years after the 'live session' is presented. NAACCR's ***site-specific*** webinars that cover Category A topics meet the Category A requirements for CTR continuing education (*source*: NCRA's "Category A FAQ" and email communication from NAACCR). This includes the Boot Camp and Coding Pitfalls webinars. The following are abstracting highlights from the last few months of NAACCR webinars. Please refer to the specific webinars for more information.

Tip: you can now stream some of the webinars directly in your internet browser instead of downloading the large WebEx recording file. After you click on the "Webinar" link for a specific webinar and see the list of webinar-related documents, click on the video thumbnail if available.

Abstracting and Coding Boot Camp (March 2017 Webinar)

- For cases diagnosed on or after Jan 1, 2017: *noninvasive* "encapsulated follicular variant of papillary thyroid carcinoma" (EFVPTC) should be reported as "noninvasive follicular thyroid neoplasm with papillary-like nuclear features" (NIFTP), with NIFTP a synonym for non-invasive EFVPTC, both to be reported as ICD-O-3 morphology code 8343/2. *Invasive* or NOS EFVPTC is to be reported as 8343/3. [https://www.naaccr.org/implementation-guidelines/ (revised March 2017) and SINQ20160040]
- Address at diagnosis: if there is both a street address and PO Box or Apartment number, record the PO Box or Apartment number in the *supplemental address* field. This field is also used to record the name of the building/facility (prison/jail, nursing home, etc.) where the patient resides, if applicable.
- SEER Summary Stage versus AJCC 7th Edition TNM Staging comparisons:
  - They may have different chapters/schema for staging.
    - *Example*: base of tongue and lingual tonsil have a specific schema in SEER Summary Stage but, in TNM staging, they are included in the oropharynx chapter.
  - They may have different definitions of regional versus distant lymph nodes.
    - *Example*: mediastinal (level VII) and supraclavicular (level IV or V) lymph nodes are considered *distant* for base of tongue and lingual tonsil in SEER Summary Stage but are considered *regional* in TNM Staging [SEER Summary Staging Manual 2000, page 31 and AJCC Cancer Staging Manual 7th Edition, Chapter 4].
  - Stage IV disease in TNM staging DOES NOT always equal distant disease (code 7) in SEER Summary Stage.
    - *Example*: any regional lymph node involvement in bladder cancer is stage IV in TNM Staging, but SEER Summary Stage is 3 or 4 (if there is also direct extension) [SEER Summary Staging Manual 2000, page 245 and AJCC Cancer Staging Manual 7th Edition, Chapter 45].
  - Distant disease in SEER Summary Stage DOES NOT always equal stage IV cancer in TNM staging.
    - *Example*: breast cancer with ipsilateral supraclavicular lymph node involvement is considered distant (code 7) in SEER Summary Stage, yet it is considered N3, stage IIIC if M0, in TNM staging [SEER Summary Staging Manual 2000, page 188 and AJCC Cancer Staging Manual 7th Edition, Chapter 32].
  - Some cancers do not have TNM Staging but do have SEER Summary Staging.
    - Example: malignant brain and other parts of CNS [SEER Summary Staging Manual 2000, pages 266-268]
    - SEER Summary Stage is coded to 8 for benign/borderline brain & CNS cancers [FORDS 2016, page 173] while there is no applicable schema in TNM staging.
  - ***Key point:*** **there are 2 staging systems, with different rules and you cannot and should not try to 'convert' one to the other.**

Lip and Oral Cavity (April 2017 Webinar)

- ◊ Lip and oral cavity are grouped differently for SEER Summary Staging and AJCC TNM Staging.
  - ⇒ *Example*: base of tongue, lingual tonsil, soft palate and uvula are all covered (except mucosal melanoma) in AJCC TNM Staging Chapter 4 [AJCC Cancer Staging Manual 7th Edition], but are covered separately in SEER Summary Staging (base of tongue & lingual tonsil; soft palate & uvula).
- ◊ When carcinoma is described as "confined to mucosa", it may be *in situ* or localized. To distinguish between them, if the tumor is confined to the epithelium, it is *in situ*; if the tumor has penetrated the basement membrane to invade the lamina propria, it is localized. ["Lip, oral cavity, and pharynx table of anatomic structures", SEER Summary Staging 2000 page 20]
- ◊ When primary side is lateral tongue with no mention of dorsal or ventral surface, code to C02.3 (anterior 2/3 of tongue, NOS) [SINQ20041032].
- ◊ When the only information is enlarged cervical lymph nodes with biopsy positive for squamous cell carcinoma, code to C14.8 (the note in ICD-O-3 underneath C14.8 indicates it should be used for "neoplasm of lip, oral cavity & pharynx whose point of origin cannot be assigned to any of the categories C00 to C14.2"). This is a more specific primary site code than C76.0 (Head, face or neck, NOS). According to ICD-O-3 rule B, ill-defined sites C76._ is used when topographic site is modified by a prefix (peri-, para-, etc) with an unclear primary site.
- ◊ In the rules for classification for pathologic staging [AJCC Cancer Staging Manual 7th Edition, Chapter 3, page 32], it states, "Complete resection of the primary site **and/or** regional node dissection… allows the use of the designation for pT **and/or** pN, respectively." Per CAnswer forum (http://cancerbulletin.facs.org/forums/node/71147), due to the importance of additional information from neck dissection, a partial pathologic staging using pTX (even without primary site surgery) allows documentation of pN for neck dissection. Please refer to the CAnswer forum thread for the full discussion and explanation.
- ◊ *Use of T0 scenario:* patient presents with mass in neck and biopsy positive for metastatic squamous cell carcinoma. The physician thinks the primary site is most likely floor of the mouth although inspection of floor of mouth is negative for tumor. Because the physician believes the primary site is the floor of the mouth but evaluation fails to reveal the primary tumor, the primary site is floor of mouth and T would be T0.

Multiple Primary and Histology (MP/H) Rules (May 2017 Webinar)

- ◊ <u>*NOTE:*</u> The Q&A document for this webinar includes extensive instructions on how to run a query in your cancer registry database to evaluate multiple primaries and to put together a quality improvement report.
- ◊ General instructions apply to ALL sites unless specifically excluded. [Multiple Primary and Histology Coding Rules, revised 8/24/2012, pages 7-11].
- ◊ MP/H rules are NOT used for reportability OR staging OR grade of tumor.
- ◊ Do <u>not</u> count metastatic lesions when determining which module (unknown if single or multiple, single, multiple tumor) to use.
- ◊ A physician may stage tumors separately even though according to the MP/H rules they are to be abstracted as a single primary. This is because the physician is staging to facilitate treatment decisions. This does not affect the use of the MP/H rules to determine the number of primaries to abstract. Report the staging for the largest and most extensive tumor, and use the "m" descriptor to indicate multiple tumors. [CAnswer Forum thread]
- ◊ Some of the changes in 2018 rules mentioned during the webinar:
  - ⇒ rules for tumor at the anastomotic site for colon cancer;
  - ⇒ clarification on "features" in histology terminology;
  - ⇒ not otherwise specified (NOS) and subtype of NOS rule for lung chapter; and
  - ⇒ correction to typo of "apocrine" (a ductal subtype) in Table 3 of breast terms & definitions.

OCISS
Bureau of Health Promotion
Office of the Medical Director
Ohio Department of Health

www.odh.ohio.gov

For issues with Web Plus uploads, contact:

Lily Tatham
Lilith.Tatham@odh.ohio.gov
Ph: 614-728-2304
OR
Ruth Li
Ruth.Li@odh.ohio.gov
Ph: 614-728-4162

Do Not Fax Issues.

Need Web Plus Password Reset? Contact:
Lily Tatham
Lilith.Tatham@odh.ohio.gov
614-728-2304
OR
Debbie Mercer
Deborah.Mercer@odh.ohio.gov
614-466-7220

Ohio
Department of Health

Ask OCISS

Q. I am getting errors stating TNM Clinical and Pathologic Stage Groups cannot be blank but when clicking on options for the two fields I get a message that TNM staging is not applicable on a 2016 acute leukemia case.

A. For cases where the primary site and histology combination do not have a corresponding AJCC staging schema, please enter "88" in the TNM fields. *TNM Clin Staged by, TNM Path Staged by,* and *TNM Edition Number* would also be "88" to indicate the case does not have an AJCC staging schema.

Please send your questions to OCISS@odh.ohio.gov with **Ask OCISS** in the subject field.

ODH Cancer Publications Update

The Ohio Department of Health has recently released several reports on its Cancer Data and Statistics website, available at: http://www.odh.ohio.gov/health/cancer/ocisshs/newrpts1.aspx.

1. *Poverty and Cancer in Ohio, 2010-2014: Cancer Disparities in Ohio's Poorest and Most Affluent Counties*. This report compares cancer outcomes and factors associated with cancer disparities between counties with the highest poverty rates (≥20%) and lowest poverty rates (<10%) in Ohio in 2010-2014. Among the key findings: Ohio's poorest counties had higher cancer incidence and mortality rates for cervical and tobacco-related cancers compared to Ohio's more affluent counties.
2. *Ohio Annual Cancer Report, 2017*. This report provides a summary of cancer incidence and mortality for 2014 and cancer trends for 2005-2014, using the most recent and complete OCISS cancer incidence data available.
3. *Brain and Other Central Nervous System Tumors in Ohio, 2009-2013*. Completed in collaboration with The Ohio State University, this report highlights primary brain and other central nervous system (CNS) tumors, including Ohio-specific information on malignant and benign/borderline brain and other CNS tumors, trends, histology, incidence by county of residence, risk factors, signs and symptoms, and relative survival statistics.

We would like to express our appreciation to cancer registrars and others reporting cancer cases in Ohio in making these reports possible.

Calendar of Events / Save the Date

September 8-9, 2017
ACS Cancer Programs Conference
Rosemont (Chicago), Illinois
https://www.facs.org/quality-programs/cancer/annual-conference

September 21-22, 2017
OCRA Education and Annual Meeting
West Chester, Ohio
http://www.ohio-ocra.org/annualmtg/annualmtg.html