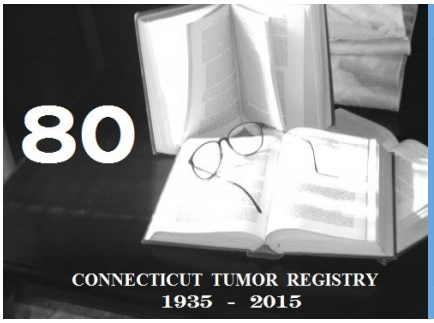


CONNECTICUT TUMOR REGISTRY

WINTER 2016 NEWSLETTER

CS Transition Update

The implementation of direct AJCC clinical and pathologic staging is effective with cases diagnosed January 1, 2016 forward. Although this is not a significant change for most hospital registrars in Connecticut, there are a few items to bear in mind.

First, all standard setters agreed in 2014 to continue collection of Site Specific Factors (SSFs) *at least through 2016.* A complete list of CoC and SEER required SSFs is available on the SEER website under the Cancer Statistics tab. SEER has also added the SEER*RSA (Registrar Staging Assistant) site, which is a terrific resource for TNM and CS staging (https://staging.seer.cancer.gov/)

Although the updated 2016 SEER Program Coding and Staging Manual (SPCM) has not been finalized as yet, Section V, Stage of Disease at Diagnosis, has been finalized and is available on the SEER website.

In Connecticut, hospital registries are *required* to continue collection and transmission of all CS v02.05.50 at least through diagnosis year 2016 cases. The continued collection is critical to the ongoing evaluation of data consistency and training needs.

NCI-SEER continues to work in partnership with NAACCR and NPCR to assess the various IT needs related to the CS transition. In addition to the SEER*RSA website, work has been completed for the SEER Staging REST API.

Diagnosis Year 2014 POC Update

Thanks to all of our hospital registrars and physician practices for your timely responses to the diagnosis year 2014 Patterns of Care study questionnaires for patients diagnosed with Stage IV colon cancer. We realise that the short turnaround time for this portion of the study was challenging. The response rate for hospitals was 100%, and all but one of the forms were received by the due date of 12th February. The physician response rate was 73%.

The second phase of the study will focus on chronic lymphocytic leukemia/small cell lymphocytic lymphoma (cll/sll) and multiple myeloma. Questionnaires will be distributed soon, with a requested return date of mid-April.

As you may know, POC data are collected under a Congressional Mandate to NCI. The goals of the POC studies are evaluate the dissemination of state-of-the-art cancer therapy into community practice; disseminate findings in scientific journals and professional meetings; and to work with professional organizations to develop educational or training opportunities to improve the use of state-of-the-art cancer therapy in community practice.

¤¤¤ CTR Staff Addition ¤¤¤

The CTR is pleased to announce the addition of a new Medical Records Technician 1 to our staff. Patricia Iaquinto joined CTR in January of this year.

Prior to joining CTR, Patricia has worked as a Medical Coder/Biller for physician's offices. She earned her coding certification from Branford Hall Career Institute and studied medical assisting at New England Technical Institute. She always finds the time to further her education. Patricia enjoys spending time outdoors with her family, camping, hiking and playing sports with her 7 and 6 year old daughters.

QA REMINDERS

Common Issues

Recently, a review of unedited NAACCR abstracts received from hospitals revealed some common errors. Since CTR staff visually review and edit 100% of submissions, these errors are corrected internally before data are released for research use. We would like to share our findings, since avoiding these errors will not only improve the CTR workflow, but also improve the quality of hospital registry data.

These are some common issues:

The diagnosis date is the date the cancer is first diagnosed, regardless of diagnostic confirmation. The date of a suspicious radiograph should be used as the diagnosis date if it precedes the biopsy date.

Radiation to brain and CNS should be coded to "9", unless prophylactic radiation was given for *lung and leukemia cases only diagnosed prior to 1998.*

Please refer to grade coding instructions; in a two-grade system, high grade is coded to "4", and low grade is coded to "2". Nottingham grade may be used to code histologic grade, just as Gleason's grade is. Detailed instructions are available on the SEER website, under "Grade Coding Instructions 2014+".

Palliative radiation should be coded as treatment. Treatment is defined as any intervention that destroys malignant cells.

Be mindful when coding laterality for paired organs. Right is coded to "1" and left to "2". These are miscoded fairly frequently, and make consolidating multiple reports difficult, as we may assume based on your codes that we have two primaries rather than one.

A reminder that sentinel lymph node biopsy has its own code (2). Please do not use code "4" for sentinel lymph node biopsies.

For melanomas, radical excision (45) can only be coded when the margins are <u>*stated*</u> to be 1 cm or greater. Per SEER, "If it is stated to be a wide excision or re-excision, but the margins are unknown, code to 30. "

Spring Undertaking

Resubmission Project

As mentioned in our Fall newsletter, the CTR will be asking hospitals to resubmit diagnosis year 2014 cases on 1st April of this year (NAACCR modified "M" records). Once received, the abstracts will be imported into the CTR database, and consolidated. The purpose of this project is to evaluate impact on completeness of treatment data. In addition, CTR epidemiologists will evaluate the effects on completeness and specificity of staging information and prognostic factors.

In preparation for the project, the CTR has contacted both C/Net Solutions and Elekta for assistance. We have provided the file specifications to both vendors, who have agreed to assist Connecticut hospital registrars with the extracts. The contact personnel are: Elekta/Metriq: Heidi Gianella; C/Net Solutions: Jean Roberts. Further information will be sent to registrars in mid-March.

Special Recognition

Congratulations to Danbury Hospital and Johnson Memorial Hospital for receiving the Outstanding Achievement Award from the Commission on Cancer. The amount of work involved in preparing for a Cancer Program survey is an enormous, and the outstanding achievement is difficult to attain. Hats off to all involved!

2016 SEER Program Manual Update

SEER Central has released the 2016 *SEER Program Coding and Staging Manual (SPCSM)* to the SEER regional registries for editing. Changes from the 2015 edition are fairly minimal, and primarily related to direct AJCC coding.

Summary of Changes

The changes and additions to the *2016 SEER Program Coding and Staging Manual* include

Reportability

Penile intraepithelial neoplasia III (PeIN III) is reportable

Section modified

Section V: Stage of Disease at Diagnosis

Data items added

Tumor Size - Clinical

Tumor Size - Pathologic

TNM Edition Number

Lymph Vascular Invasion

Mets at DX Bone

Mets at DX Brain

Mets at DX Liver

Mets at DX Lung

Mets at DX Distant Node(s)

Mets at DX Other

Tumor Size – Summary

Derived SEER Clinical Stage Group

Derived SEER Pathologic Stage Group

Derived SEER Combined T

Derived SEER Combined N

Derived SEER Combined M

Continued

Derived SEER Combined T Source (Clinical or Pathologic)

Derived SEER Combined N Source (Clinical or Pathologic)

Derived SEER Combined M Source (Clinical or Pathologic)

Derived SEER Combined Stage Group

Regional Nodes Positive

Regional Nodes Examined

Site-specific Factors 1-24

Site-specific Factor 25

Code(s) added/modified

Sex

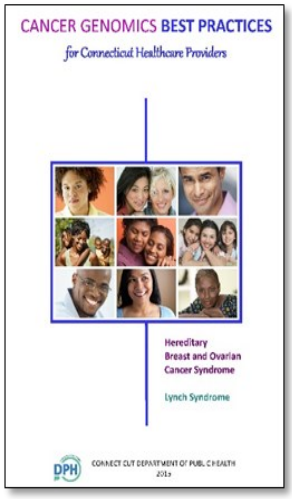
SEER Coding System – Current

SEER Coding System – Original

EPI CORNER

Fact Sheets

CTR epidemiologists are creating a series of fact sheets to promote increased awareness and understanding of the disease dynamics of common cancers within Connecticut. The fact sheets will address breast, ovarian, and colorectal cancers and will include sections on incidence, mortality and relative survival rates in Connecticut populations compared to earlier time periods, as well as national rates. The fact sheets will be available by mid-summer on the CTR webpage. Additional fact sheets in the series focusing on other common cancer sites are planned for future years.



News from the DPH Genomics Office

New Hereditary Cancer Genomics Resource

With the rise of personalized medicine, and rapid advances in genomic sequencing technology and diagnostic testing, healthcare providers and consumers have an increased need for accurate information about genetic testing, genomics, and heritable conditions. In response to these information needs, the Connecticut Department of Public Health Genomics Office (DPH-GO) has published a new version of *Cancer Genomics Best Practices for Connecticut Healthcare Providers.* In a concise format, the booklet provides information and resources for healthcare providers, patients, and patient family members about Hereditary Breast and Ovarian Cancer (HBOC) Syndrome and Lynch Syndrome (LS, formerly called Hereditary Non-Polyposis Colorectal Cancer Syndrome). Booklet contents include:

* Information sheets for patients and their families (Spanish versions available for download online);
* Information sheets for providers;
* Summaries of the current, evidence-based clinical practice guidelines on genetic susceptibility testing for HBOC syndrome and LS;
* State data on potential cases of hereditary cancer syndromes; and
* A list of cancer genetic counselors in Connecticut.
* Download *Cancer Genomics Best Practices for Connecticut Healthcare Providers* at www.ct.gov/dph/genomics.

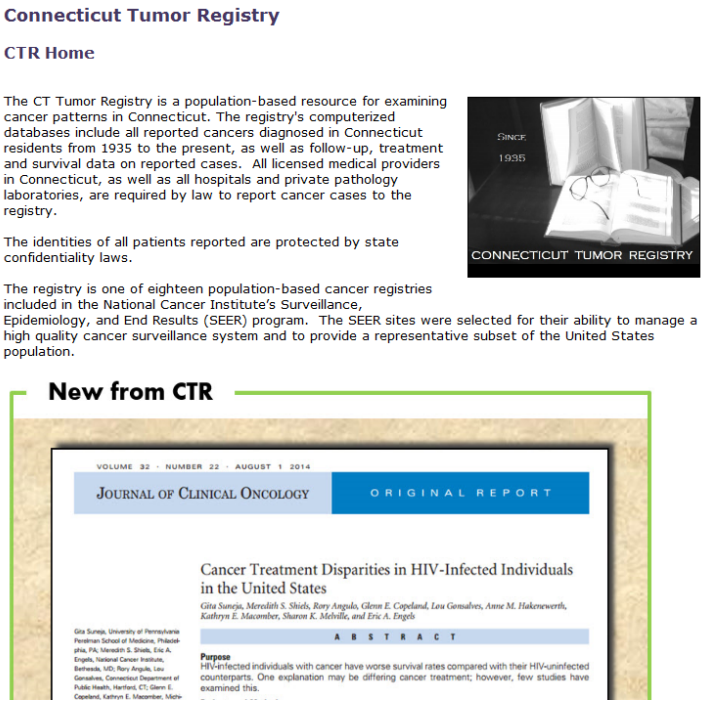
Hospital Reports

DPH Genomics Office staff will attend the April 2016 TRAC meeting to distribute *Cancer Genomics Best Practices for Connecticut Healthcare Providers* and individual hospital reports on the number of potential cases of hereditary breast and ovarian cancer (HBOC) syndrome and potential cases of Lynch syndrome. The reports are based on CTR data. The data tables contain the number of patients at a specific hospital who were diagnosed during 2010-2011 with specific cancers that are most likely to have a hereditary component.

CTR Web Page Update

CTR Epidemiologist Laura Hayes has been working hard on a much needed overhaul of the CTR web page. In addition to updating the main/home page, there will be separate sections with information on data and statistics; research; a registrars page; a page for information on reporting; as well as pages for other resources and updated CTR contact information.

Coming this summer, the revamped web pages will include updates to current information and resources; in addition, many new resources, reports, fact sheets and graphs have been added.



Connecticut Tumor Registry

CTR Home

The CT Tumor Registry is a population-based resource for examining cancer patterns in Connecticut. The registry's computerized databases include all reported cancers diagnosed in Connecticut residents from 1935 to the present, as well as follow-up, treatment and survival data on reported cases. All licensed medical providers in Connecticut, as well as all hospitals and private pathology laboratories, are required by law to report cancer cases to the registry.

The identities of all patients reported are protected by state confidentiality laws.

The registry is one of eighteen population-based cancer registries included in the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program. The SEER sites were selected for their ability to manage a high quality cancer surveillance system and to provide a representative subset of the United States population.

New from CTR