The Desert Sierra Exchange

1999
Desert Sierra Cancer Surveillance Program
Region 5 of the California Cancer Registry
Inyo, Mono, Riverside and San Bernardino
Loma University University Cancer Institute

Volume 2, Issue 2 June

Informational Packet for Visual Editing Standards Coming Soon

The Director's Digest

Becky Cassady, RRA, CTR

It was good to see most of you in April for our special Educational Program during National Cancer Registrar's Week and for the Comparison of Staging Systems' video teleconference. April Fritz, CTR did an excellent review of all the staging systems and the differences between them. Please let us know if you would like a copy of the handouts from the video conference and we will be glad to send them to you. We also have a copy of the video conference available that we can loan to you for viewing in your facility.

We have recently completed data collection for the Breast Cancer Treatment Study. As you may recall, this is a study funded by the Department of the Army to collect additional first course of treatment on breast cancer patients diagnosed 1995-1996 which are considered to be incomplete according to the PDQ guidelines. We received additional treatment on 598 patients of which, Tamoxifen was the most frequent treatment updated. Registrars need to be consistently proactive in collecting complete first course of treatment information after the patient is discharged from their hospital or treatment facility. Today's health care system is very dynamic with patients and physicians changing locations and medical groups. Valid physician license numbers should be entered into the physician fields consistently. Go to *www.docboard.org* on the Internet to access physician license numbers. I would encourage all registrars to increase their efforts in obtaining complete first course of treatment within the first six months of the patient's initial diagnosis. It is much easier to request this information during that time than years later. Having complete treatment information in your registry enhances the data usage and validity of treatment studies done for your facilities.

I am pleased that Region 5 C/NET users have been contacting Kathleen Horton, CTR for her assistance with C/NET problems and issues. Our phone number 558-6164 has been directly forwarded to her work number at (805) 933-8232. She is available Monday through Fridays from 8:00 am to 5:00 p.m. with a lunch break from 12:00 to 1:00 p.m. We anticipate that the C/NET Windows version will be released this fall.

An Informational Packet regarding the Visual Editing Standards is currently being drafted at this time by the Visual Editing Standards Taskforce for distribution to registrars for their feedback and suggestions. Thirteen data items have been identified which will be counted toward the accuracy rates per facility. These data items are in **bold** on your blue deficiency sheets which Crickett sends back to you with your corrections. I would encourage all of you to review the Informational Packet when it is distributed and let Crickett Dyke, CTR know of your concerns and questions. Once the computer programming has been completed for automatic visual editing for the CANDIS regions (Regions 2, 3, 4, 5 and 6), then we will be reporting the accuracy rates per facility.

Programming has also been in progress at the state level for shared follow-up processing which has been a goal for some time. We anticipate this will be a reality later this year and will be able to distribute listings of follow up dates on patients for reporting facilities.

During the past year, the regions have sent in their tape submissions one month later than the usual reporting months of January, April, July and October. This was at the request of the CCR as it allowed more time to process cases following the Christmas season. Now all the regions send their data in February, May, August and November. This does change the percentage expected rate for the previous year's cases: November is 33%, February is 58%, May is 83% and August should reflect 100% complete. All reporting facilities are encouraged to keep current with their casefinding and abstracting to avoid a backlog of delinquent cases.

I have recently returned from

In this issue...

Some QC TIPS for things you may not have known (or forgotten!)

QC QUIPS

Crickett Dyke, CTR

I have recently returned from attending the 25th Anniversary NCRA meting in Dallas, Texas and there were 777 registrars in attendance. Constance Percy, MSPH reported on the ICD-O-3 edition which is now in its field trial until early September. It will be published by the World Health Organization

World Health Organization with an anticipated availability date of 2001. one new code is being added: 9980/3 which will include refractory anemia, myelodysplastic syndrome and polycythemia vera. The variety of topics available for the attendees highlighted the progress registrars have made in increasing their responsibilities, recognition and contribution to cancer data management in the past 25 years.

There is an excellent article about the uses of cancer data and the role of the registrar in the next century in the Advance for Health Information Professionals. I will be glad to send you a copy of the article upon request.

There are many of us registrars that have been in the field for many, many years and have abstracted more cases than we care to think about! Have you ever noticed that the longer you do abstracting, the more real basic, fundamental rules we learned so very long ago just don't come to mind as we are all struggling with the new rules, and changes in coding structure? Well, I thought I would take this opportunity to bring up some of these basic fundamental concepts again just as a reminder to all of us. (*Thank you to Gloria Ross, CTR from Arrowhead Regional Medical Center for the idea.)*

So, here's Ten (or more) Things Maybe You Didn't Know (or Forgot!):

1) **Tumor Size:** When tumor size is stated as a *foci,* or *focal,* code 001 in tumor size field.

2) **Tumor Size for Breast Cases:** If the tumor size is less than 3 mm code 003. Code 001 for *'foci'.* Code 002 is reserved for a diagnosis made from mammography with no tumor size given (tumor not clinically palpable).

3) Seminoma: Did you know that the only two places in the body where a seminoma can arise are the testis (you knew that!) and the mediastinum (bet some of you didn't know that!). So be careful when coding primary site for a seminoma where the only noted involvement is in the chest. Don't automatically code these to testis!

4) **Tumor Grade:** The term *"low grade"* should code as a Grade II. The definition of a low grade tumor is Grade I to II. Our rules state to code to the highest (Grade II). Consequently, *"high grade"* tumors should code as Grade IV because it is defined as Grade III-IV. Remember to code the most specific term mentioned on the path report. For instance, one part may refer to a high grade tumor, but later in the report is stated to be Grade III, code Grade III rather than Grade IV.

5) **Foreign Addresses:** The zip code for foreign addresses should be recorded as 88888-8888. If it doesn't have the 'plus 4' numbers coded, it falls out as an error on our system. This would be a good edit for C/NET to include in their software, too.

6) **Clinical Extension codes for Prostate:** Remember that you need a TURP performed in order to use codes 10-14. If no TURP was performed, you will need to use code 15 if all the other criteria fit.

7) **Tumor Size Code 998:** Remember to use 998 when coding tumor size for 1) inflammatory carcinoma of the breast, or diffuse, widespread, 3/4 or more of breast involvement; 2) linitis plastica or diffuse carcinoma of the stomach; 3) a tumor involving the entire circumference of the esophagus; 4) Familial/multiple polyposis for colon; and 5) diffuse, entire lobe or lung for lung primaries.

8) **"Pleural-based lung mass":** Code extension as 40 when tumor is stated to be *pleural based,* unless you have specific path information stating that the pleura was not involved.

9) **Reconstructive Surgery Codes:** There are several sites where there are no reconstructive surgery codes. These should be coded to 9's and not 0. These sites include (but not limited to) pancreas, leukemia, lymphoma, unknown primaries, etc. Be sure to check your surgery code pages for accurate site-specific codes.

10) **Surgical Margins:** Margins for TURPs for prostate and TURBs for bladder should code to 7 (not evaluable).

11) **Bladder In Situ Extension Codes:** Beware when coding extension for in situ bladder cases that you don't use new codes 01, 03 or 06 for any cases that were diagnosed BEFORE January 1999! Use the old 00 and 05 codes for all your 1998 and earlier cases.

So, that's all. I know most of you are saying "I knew that!" I know most of us knew it at one time or another but we still need to take the time to code these correctly. Thanks for your cooperation.

I would like to call your attention to the May 1999 issue of the *Journal of Registry Management* as there is an article on "A Unified Cancer Stage Data Collection System: Preliminary Report from the Collaborative Stage Task Force". They have developed a uniform data set from which all staging systems could be derived from, thereby reducing workload and training needed for registrars. Call for copy of article.

4th Report of Cancer Incidence in Inyo, Mono, Riverside and San Bernardino Counties Published!

Epilogue

John W. Morgan, DrPH

The Desert Sierra Cancer Surveillance Program (DSCSP or Desert Sierra CSP) has just released the fourth report of cancer incidence in Inyo, Mono, Riverside and San Bernardino Counties and the first report of cancer mortality in the region. This report covers the years 1988 through 1996 and uses data for new cancer cases accessioned into the Desert Sierra CSP active data base prior to 5:00 p.m. on February 14, 1999 and cancer mortality data taken from the death certificate master files of the California Department of Health Services, Center for Health Statistics. This descriptive report contains 95 tables and 57 figures that depict cancer incidence and mortality in the Desert Sierra CSP population.

Other features of this report inlcude community resources, such as, listings of hospitals, surgery centers, radiation treatment facilities, laboratories and dermato-pathology practice groups in the Desert Sierra region; population counts by age, sex, race/ethnicity and year (1988-1996); summed population counts by county, sex and race/ethnicity for the most recent five-year time-period (1992-1996); names and addresses for population based central and regional cancer registries in California; addresses and telephone numbers for American Cancer Society region, units and branches within the Desert Sierra CSP; and County Health Departments within the Desert Sierra CSP. Aggregated presentations of data for the 95,906 invasive cancer cases, 40,093 cancer deaths and the 3,379 selected *in situ* cancer cases reported among Desert Sierra CSP residents between 1988 and 1996 are presented throughout this report. Data are presented for all cancer sites combined and for each of the 26 leading sites for cancer incidence. These 26 sites represent 93% of all invasive cancers diagnosed in the Desert Sierra CSP region for 1996 and 91% of the fatal cancers for 1996.

Summary of Findings

For all cancer types combined, there has been a gradual decline in the annual age-adjusted incidence (since 1993) and mortality rates (1988-1996) for cancer among male residents of the DSCSP region of California. This downturn appears to result from steady declines in incidence and mortality rates for lung and bronchus cancer and colon and rectum cancer since the DSCSP was formed in 1988 and declines in prostate cancer incidence since 1992. Age-adjusted incidence and mortality rates among women in the DSCSP region for all cancer sites combined have remained constant since 1988.

When compared to statewide rates, the DSCSP population exhibits higher incidence and mortality rates for tobacco-related cancers, with lower rates seen for HIV related cancers and for cancer types that predominate among Asians. Cancer of the colon and rectum, breast and prostate show higher incidence in the DSCSP population than the statewide average, identifying the need to enlarge the availability and utilization of cancer early detection and screening programs in the DSCSP region.

This report was prepared by John W. Morgan, Dr.P.H., Cancer Epidemiologist; Stephanie M. Woodward, Systems Analyst; Rebecca E. Cassady, R.R.A., C.T.R.,Program Director; Alan R. King, M.D., Medical Director; and Shilpa Jog, M.B.B.S., M. D., Loma Linda University School of Public Health with support from Pedro Bautista, C.T.R., Abstractor; Crickett Dyke, C.T.R., Quality Control Specialist; Liz Schoenwetter, Department Secretary and Nancy Snell, C.T.R., Abstractor. The findings on cancer incidence presented in this report are possible because of the dedication of cancer registrars and reporting facility staff throughout Inyo, Mono, Riverside and San Bernardino Counties. The development of this report was partly funded by a contract from the Public Health Institute and by grant number U75-CCU910677-01, that was awarded by the Centers for Disease Control and Prevention.

It won't be long until the year 2000 and for C/Net users that means C/Net for Windows! This is a major change

C/NET CORNER

Kathleen Horton, RTT, CTR

for C/Net and they have been working hard to give you a program that will be easy to use and familiar as well as opening up new vistas in abstracting and report writing.

One of the requirements for C/Net Windows is a working knowledge of Windows 95 or 98. Are you comfortable moving about in Windows 95 or 98? Are you able to copy a file to a diskette? Do you know how to rename a file? Have you used Windows Explorer? If you answered no to any of these questions, you should seriously consider taking a Windows course. There are many different learning options available. If your hospital offers classes on Windows, you should take the time to take an introduction or intermediate class, depending on your current experience. If this is not an option for you, there are courses available at community colleges and adult education centers which are low cost or free. If you are fearless and a self-learner, play around in Windows.

1997 DEATH CLEARANCE IS HERE!
Send Your Resolutions In Quickly.

It is unlikely that you will harm anything and it is likely that you will learn a great deal by exploring.

If you are planning to attend the California Cancer Registrars Annual Meeting in Long Beach, there will be a session given by Dan Curran , CTR on how to use the Windows version of C/Net with Excel, PowerPoint and Access. I am certain that this will be very exciting as he will show you how you can do impressive presentations with your C/Net data. Judy Knott will facilitate a session on C/Net Windows itself, giving you a view of what to expect. This may help you decide if your current Windows knowledge is sufficient or if it needs some enhancing.

The Path Finder

Nancy Snell, CTR

I hope you all have a wonderful summer. I would like to remind you to be sure to send copies of all the 1999 pathology reports that are read for doctors' offices by your hospital pathology department but were not admitted to your hospital for diagnosis or treatment.

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Mark Your Calendars

July 16, 1999
SCCRA Education Meeting
St. Jude Medical Center, Fullerton, CA
Topic to be announced
Contact: Meryl Leventhal (323) 442-2369

September 18, 1999
CTR Certification Examination
Contact Professional Testing Corp.
(212) 356-0660

September, 1999
Desert Sierra Cancer Surveillance Program-Region 5
Loma Linda University Medical Center
Topic: *Inside* the Regional Registry
Contact: Becky Cassady (909) 558-6170

October 7-8, 1999
CCRA Annual Meeting
Westin Hotel, Long Beach, CA
Contact: Louise Schuman (714) 962-1162

December 3, 1999
SCCRA Annual Meeting

DSCSP Transmission Date Deadlines for 1999

JULY 30, 1999

(100% complete for 1998 cases)

OCTOBER 29, 1999

(33% complete for 1999 cases)

DSCSP Exchange Contributors

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