The Registry Review

The Newsletter of the
South Carolina Central Cancer Registry
Fall 2004

Hospital Reporting

Thank you to all of the registry hospitals for submitting data to the South Carolina Central Cancer Registry in a timely manner. Registry Hospital Data Submissions are listed in the table below. If you have not submitted data in 2004, please contact Janice Shirley at the SCCCR as soon as possible.

HOSPITAL	Last Date Uploaded
Dorn VA Medical Center, Columbia	3/29/02
Mabry Ctr for Cancer Care @ TRutu8MC	3/19/03
Johnson VA Medl Center, Charleston	4/17/03
Naval Hospital-Beaufort	10/03/03
Naval Hospital-Charleston	10/03/03
Moncrief Army Community Hospital	10/09/03
Shaw Air Force Base Hospital	10/09/03
Aiken Regional Medical Centers, HCA	11/11/03
Lexington Medical Center	3/16/04
Trident Regional Medical Center, HCA	3/18/04
St. Francis Health System, Greenville	4/22/04

HOSPITAL	Last Date Uploaded
Palmetto Baptist Medical Center	5/17/04
Palmetto Richland Memorial Hospital	5/17/04
AnMed Health(Anderson)	5/17/04
MUSC-Medical Center	6/07/04
McLeod Regional Medical Center	6/08/04
Self Regional Healthcare	7/06/04
Roper Care Alliance	9/03/04
Greenville Hospital System	9/08/04
Mary Black Memorial Hospital, Inc.	10/04/04
Georgetown Memorial Hospital	10/04/04
Spartanburg Regional Medical Center	10/04/04
Grand Strand Regional Medical Ctr	10/04/04

Staff's Creative Writing Contributes to Health Education of South Carolina Citizens

Leasharn Hopkins joined the SCCCR in October, 2003. "Sharn" is the new Administrative Coordinator for the SCCCR. Her job with the registry includes coordination of all procurement, office organization, travel reimbursement and a myriad of other activities. Sharn came to us from DHEC Health Services. She has over 20 years of state government experience. She does a great job in keeping the registry operating and the staff happy.

But, her job in the SCCCR is not all she does to contribute to South Carolina's public health! Sharn is a professional playwright and emerging screenwriter in South Carolina. She works with organizations, schools, and public agencies in developing scripts and turning them into theatrical productions to acquaint the public about health and social issues. SC HIV/AIDS Council recently recognized and included one of her plays entitled ***To Touch God's Hands*** into an anti-stigma grant. The grant addressed harmful stigmas plaguing the African American community with HIV/AIDS. The grantors, the Ford Foundation and the Academy for Educational Development, chose five cities across the country for funding. Those cities included New York City, Washington, DC, San Francisco, Los Angeles, and Columbia. The play will be touring the state in the Fall of 2004 as part of the South Carolina initiative. Congratulations, Sharn, on this fine work.

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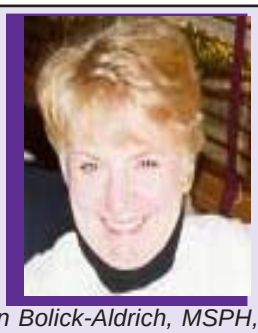
From The Director



Susan Bolick-Aldrich, MSPH, CTR

We have gotten off track with the Registry Review in recent months. Several reasons substantiate the delay. Number one being Laura Sanders' extended maternity leave and decision to be a full-time mom. Laura delivered Jay in February and has relocated with her family to Thomasville, Georgia. Husband Alan began his dental practice there in July. It's understated to say we miss her. Her contributions to the registry over the years are too many to list. Best wishes to Laura and family!

Natalie Scruggs, former Assistant Director of the SCCCR, will be the new editor of the Registry Review. Natalie currently resides in Indiana, but has managed to stay connected. Natalie will help us stay on track with our newsletter publication.

Publishing the newsletter on the web will speed up our turnaround time in getting news out to our data sources and other readers. In these tight financial times, we're all looking for ways to be more cost effective. We hope this distribution method of the newsletter will work for everyone. Of course your comments are welcomed.

The SCCCR seems to be a whirlwind of activity these days. Staff has and will continue to increase during the upcoming year. New hourly staff have joined the SCCCR since the last newsletter.

1. Ellen Kolender joined the SCCCR hourly in September, 2003. Ellen is a former Registry Manager at Roper Hospital, Charleston. She coordinates our follow back efforts to physicians for complete patient and cancer information needed to include cases in the SCCCR database. These primarily include cases identified through pathology labs or non-registry hospitals when only partial information is available. Ellen works out of our North Charleston office.

2. Catishia Mosley began with the registry as a Graduate Assistant back in the Fall of 2003. She prepared the Legislative District Cancer Profiles and has them ready for the web. She transferred to hourly status recently and will be with us a while longer. Catishia also works for the SC Cancer Alliance as Coordinator for the Research Task Force.

3. Michelle Ingham joined us in February 2004. Michelle has experience working in New Hampshire at a large hospital registry. She works 20 hours per week on database quality enhancement projects and abstracting.

4. Dr. Virginie Daguise was hired October 2004 as the SC Cancer Alliance Epidemiologist. She has a Ph.D. in Epidemiology from the Norman J. Arnold School of Public Health at USC. Dr. Daguise is working on specific projects related to the South Carolina Cancer Alliance and its task forces. She works out of the SCCCR office.

Make sure to read the feature on Leasharn Hopkins, the newest member of our fulltime SCCCR staff. It demonstrates her many talents in the public health arena.

The final staff item I will address is to recognize the retirement of Sharon Guest. Sharon was the Administrative Specialist for the SCCCR for many years. She is now enjoying time visiting with her children and grandchildren. We appreciate Sharon's work and her friendship through the years.

The remainder of the newsletter content focuses on reporting requirements. The final 2002 data are being collected by SCCCR staff at non-registry hospitals and non-hospital sources. The current reporting schedule for registry hospitals for 2003 data is included. This was provided to each reporting facility earlier this year. Greater strides are being made to maintain this schedule. This will assure complete and timely reporting.

I hope you gain valuable information from this issue of the Registry Review. We will see you all at the SCCRA Fall Educational Conference in October in Columbia.

Real Questions?...*Real Answers!*

The first three Q&A's are samples of some real questions that have been submitted to the SCCCR. They were forwarded to April Fritz, CTR, SEER Program for clarification (March & Sept. 2003, April 2002).
If you find an answer to an interesting question, whether new or unclear in our manuals, please send them to me so they may be shared with all. Also, please state reference and date.

Thanks,
Kathy Barnes, CTR
SCCCR Training Coordinator

(1) A colon bx showed "high grade dysplasia" which is not reportable. The patient went on to have a colectomy, which showed no disease. **In the AJCC/ TNM pg. 86 (5th ed.) & pg. 111 (6th ed.) states: Adenocarcinoma in situ***

***The terms "high grade dysplasia" or "severe dysplasia" may be used as synonyms for in situ adenocarcinoma or in situ carcinoma. The cases should be assigned pTis.

(Q) We have conflicting opinions by our local pathologists at registry hospitals. **Are these to be coded "in situ"** if and when the pathologist uses those terms (above)? This would be only if the pathologists and registrars have an understanding up front.

(A) The term is sometimes **referred to as a courtesy diagnosis**, since it avoids all of the attendant issues with a path report of carcinoma. **SEER's response is** that unless the diagnosis includes the words "in situ" the case is not reportable as "high grade dysplasia" or "severe dysplasia." (Neither of these terms is in ICD-O-3.) On the other hand, if the pathologist says "high grade dysplasia (carcinoma in situ)" the case is reportable. If you have statements from your pathologists that they ALWAYS mean carcinoma in situ by either of the other terms, then maybe you can consider including the cases in your central registry. BUT you'll never know how complete your CIS data is if it is called by another name.

(2) We know hypereosinophilic syndrome (9964/3) is a newly reportable hematopoietic disease. Referencing your hematopoietic presentation (pdf file), **Casefinding Codes Unique to NRHD slide**, it references / lists: Eosinophilia hypereosinophilic syndrome)

(Q) When our casefinding record states "eosinophilia" (by itself) falling under the 238.3 category, **do we code as reportable?** When we look up eosinophilia, there is no code in the ICD-O-3 book, but hypereosinophilic syndrome is listed. **Are these ambiguous / interchangeable?** Or does the diagnosis have to read hypereosinophilic syndrome to be considered reportable? These patients being seen maybe once or twice, not mentioning the hypereosinophilic syndrome. Are we to **accession with the diagnoses of "eosinophilia" only?**

(A) Hypereosinophilic syndrome is coded to 288.3 not 238.3. It's the only disease included in that code that is clonal and non-reversible. **Plain eosinophilia is not reportable.** Hypereosinophilic syndrome and eosinophilia, NOS **are not interchangeable.** Refer to page 34 of the Abstracting & Coding Guide for the Hematopoietic Diseases (the red heme book) for further information.

(3) We know that is states: All sites (including bladder & prostate) beginning with 1995 cases: Report as 2 primaries even if stated by a physician to be a recurrence.
-An in situ cancer followed by an invasive cancer in the same site more than 2 months apart.

(Q) With CIS, we would not have two primaries but: A patient has a history if CIS then invasion occurs (more than 2 months later). We **still accession the invasive cervical diagnosis with the data per invasive path report, correct?** It was asked to be clarified, due to CIS NOT being reportable to begin with. **Would this change reporting the invasive diagnosis for any reason?**

(A) For cervical cancer, the clock starts and the sequencing starts when an invasive tumor is diagnosed. Accession the invasive with the date of the invasive path report.

The following questions and answers were found on either the **NAACCR** (North American Association of Central Cancer Registries), **SEER** (Surveillance, Epidemiology and End Results) and **CoC** (Commission on Cancer) web sites. I encourage everyone to go to these sites for some interesting data to make our jobs easier. All inquiry systems are very user-friendly! We can learn from all of them. If you are reading and trying to follow the rules in all of our manuals…you will have questions. These sources have the answers :)
If you don't find an answer, submit it.

NAACCR = www.naaccr.org/ Standards/AskNAACCR
SEER = www.seer.cancer.gov/ seerinquiry
CoC = www.facs.org/dept/ cancer/coc/iandr

(Q) Is myelodysplastic disorder the same as myelodysplastic syndrome? SEER states (4/2004):

(A) Disorder, syndrome and disease are generally synonymous. Therefore, myelodysplastic disorder and myelodysplastic syndrome is synonymous.

(Q) Grade, Differentiation - Lymphoma: What code is used to represent this field when the only grade/ differentiation given is "low grade", "intermediate grade" or "high grade"? (SINQ)

(A) Code the Grade, Differentia-

Real Questions?

(continued from page 5)

tion field to **9** (cell type not determined, not stated or not applicable). For lymphomas, do not code the descriptions "high grade", "low grade", and "intermediate grade" in the Grade, Differentiation field. These terms refer to categories in the Working Formulation and not to histologic grade for lymphoma histologies.

*Generally, for histologies OTHER than Non-Hodgkin Lymphoma, the Grade, Differentiation field is coded to 2(low grade), 3(intermediate grade) and 4(high grade) for most cancers.

"TIDBITS" of Pertinent Information

· **Transitional Cell Carcinoma of the Prostate?**
Yes, we all have probably heard of it but was it coded correctly? Did you know TCC of the prostate should be classified as a **URETHRAL** tumor and coded as such?
See pg. 311, "Histopathologic Type" for this rule. It refers us to Chapter 39 in the AJCC / TNM Manual for better understanding.

· **Grading Lymphomas?**
It seems to be the least like category of us all, lymphoma. This came from the SINQ site. For lymphomas, you cannot code the descriptions "high grade", "low grade" and "intermediate grade", Differentiation (6th digit) field because these terms refer to the categories in the Working Formulation (cell type/histology) and not to histologic grade. However, you can code terms such as "well differentiated", "moderately differentiated" and "poorly differentiated" for lymphoma histologies. But remember, T-cell, B-cell or Null-cell take priority if they are stated also. All of this info would be great edit checks to run on your database. They are easy mistakes to make**!**
All of us benefit from new information, especially when it comes to collecting and using data to impact cancer in our state. Remember that the SCCCR annual report is your data!

· **Important SCCCR rule for ALL SC hospitals…**
If there is an *in situ* followed by an invasive cancer at the same site more than 2 months apart, report as two primaries even if stated to be a recurrence. The *invasive* primary should be reported with the date of the invasive diagnosis.
(Bladder will be the most common site)
*The purpose of this guideline is to ensure that the case is counted as an incident case (i.e. invasive) when incidence data are analyzed. SCCCR Manual, Appendix E, Exception 2.

· **New chemo drugs being used locally** but not in SEER Book 8 or on website yet…Erbitux, Iressa, Velcade

Don't forget…

The SCCCR wants each and every case for every patient in our state. **YOU** make everyone count **:)**

Upcoming Conferences and Events

SCCRA Fall Educational Conference
Dorn Veterans Administration Hospital, Columbia
October 28-29
Hosted
by
Dorn Veterans Administration Hospital
Moncrief Army Community Hospital
Shaw Air Force Base Clinic

SC Cancer Alliance Quarterly Meeting
Columbia Conference Center
Friday, October 22, 2004
12:00 noon - 4:00pm
Register at www.sccanceralliance.org

Reporting Requirements

In order for the SCCCR to meet standards for central registries regarding data collection, data from hospitals must be submitted in a uniform and timely manner. Kathy Barnes, SCCCR Training Coordinator presented Reporting Requirements at the SCCRA meeting held in Columbia in November 2003 and a letter followed in December 2003.

Hospital Registry staff should report cases to the SCCCR in two ways. All cases abstracted into the Hospital Cancer Registry Database should be submitted on a diskette in NAACCR Version 10 record layout. Cases that are not abstracted into the Hospital Cancer Registry Database, but are still reportable to the SCCCR, should be reported on the Hospital Registry Non-Reportable Case Form. We have taken this opportunity to reprint the letter for your convenience. If you have any questions please contact Linda Cope, SCCCR Data Acquisition / Quality Control Manager at (843) 740-1590.

Reporting Requirements

(continued from page 2)

Dear Hospital Registrar:

This letter is provided to clearly define the cancer reporting requirements of the SC Central Cancer Registry for the upcoming year. Beginning January 1, 2004 forward, the following new procedures will be implemented and monitored for all data submissions from SCCCR reporting facilities. The SCCCR Policy and Procedure Manual for Reporting Sources is currently being revised to reflect these changes and will be provided to each facility by January 1, 2004.

Quarterly submissions in the NAACCR Version 10 record layout will be required on the following timeline:

DUE TO SCCCR	**CASES REQUIRED**
January 1, 2004	Diagnosed/1st seen from January 1 - June 30, 2003
April 1, 2004	Diagnosed/1st seen from July 1 – September 30, 2003
July 1, 2004	Diagnosed/1st seen from October 1 – December 31, 2003
October 1, 2004	Diagnosed/1st seen from January 1 – March 31, 2004

In an effort the ensure that all incident cancer cases are identified correctly in SC, the following cases are required to be reported:
These cases may not be abstracted by each facility, but are reportable to the SCCCR by law:
Non-analytic cases: out of state residents, patients seen for subsequent treatment, patients with no evidence of active cancer, history of cancer with no treatment at present time
Consult cases: patients seen only for consultation or second opinion, pathology specimen only (Class of Case 7)

These cases will eliminate repetitive chart review during casefinding for SCCCR and hospitals:
Cases diagnosed prior to 1996: patients. diagnosed prior to the reference year of the SCCCR
Blood disorders prior to 2001: these conditions that became reportable in 2001 (238.4, 238.6, 238.7, 284.9, 285.0, 288.3, and 205.1 9963/3)

The **Hospital Registry Non-reportable Case Form** is provided for capture of these cases listed above. This form should be maintained electronically in Excel format. The information required should be entered as the registrar reviews charts during casefinding. A submission of these cases that are reviewed but not abstracted into the hospital registry is required along with the quarterly registry data submission according to the schedule above. A separate diskette must be used for the Hospital Registry Non-reportable Case Form. Maintenance of this patient listing electronically at each hospital will also enhance the efficiency of hospital registry casefinding procedures.

If hospital registry software allows these cases to be entered on an abbreviated abstract and categorized as “reportable to state only”, these cases must be submitted separately from the registry data submission to the SCCCR. The SCCCR staff can assist with these download procedures.

The South Carolina Central Cancer Registry is committed to preserving the confidentiality of cancer information reported to the SCCCR. Envelopes containing paper abstracts or diskettes should be carefully sealed and marked: “CONFIDENTIAL MEDICAL INFORMATION”.

The two submissions (the quarterly data submissions of abstracted cases and the Hospital Registry Non-Reportable Case Forms) should be submitted on separate diskettes and mailed to: Janice Shirley, Data Manager, SC Central Cancer Registry, SC DHEC/PHSIS, 2600 Bull Street, Columbia, SC 29201.

If there are any questions, please don’t hesitate to call Linda Cope, SCCCR Data Acquisition and Quality Control Manager at 843 740-1590 ext. 325, or Janice Shirley, Data Manager, at 803 898-3679.

Thank you all for your continued cooperation as we all strive for excellence in cancer registration in South Carolina.

Sincerely,
Susan Bolick-Aldrich, MSPH, CTR
Director
SC Central Cancer Registry
803 898-3626

Reportable Cases

The following is a summary of cases that are reportable to the SCCCR by either abstracting into the Hospital Cancer Registry Database or on the Hospital Registry Non-Reportable Case Form. For more detailed information, please refer to the SCCCR Manual.

- All cases with behavior code of 2 or 3 in the ICD-O-3
- Malignant neoplasm's known as: VIN III, VAIN III, or AIN III
- Patients diagnosed histologically or clinically
- Patients Receiving Cancer Directed Treatment at Your Facility
- Patients Receiving Non Cancer Directed Treatment at Your Facility (examples: Incisional biopsy, exploratory procedures; pain medications, oxygen, transfusions)
- Patients Diagnosed at Autopsy
- Patients Diagnosed Elsewhere
- Basal and Squamous Cell Carcinomas in mucoepidermoid sites. These include:
  - Lip (C00.0-C00.9
  - Anus (C21.0)
  - Vulva (C51.0-C51.9)
  - Vagina (C52.9)
  - Penis (C60.0-C60.9)
  - Scrotum (C63.2
  - Nasal cavity (C30.0)
  - Middle ear (C30.1)
- Class IV and Class V Cytology
- Pathology that states "No Residual Tumor" (the excision is considered cancer treatment)
- Private Outpatient Specimens (POP) (Path Only)
- Benign Brain and other CNS - Beginning with tumors diagnosed on or after January 1, 2004
- Consult Only Cases
- Slide Reviews
- Transient Care - Patients receiving care at the reporting institution to prevent interruption of the first course of treatment
- History of Cancer
- Ownership of the Medical Record - If the medical record is the property of the hospital/facility, the case must be reported by that hospital/facility. Anytime ownership of the medical record changes, the registrar must notify SCCCR to determine reportability. *Example:* The private oncology practice located in leased hospital space moves off-site and claims full ownership of the medical record.

The Registry Review newsletter is published by the South Carolina Central Cancer Registry, a Division of DHEC's Office of Public Health Statistics and Information Services.

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