

# OCCR NewsFlash

O K L A H O M A C E N T R A L C A N C E R R E G I S T R Y

O K L A H O M A S T A T E D E P A R T M E N T O F H E A L T H



## OKLAHOMA GOLD RUSH

The Oklahoma Central Cancer Registry proudly reports that we have received the highest certification for data quality, timeliness and completeness from both our funding source, The Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), and the North American Association of Central Cancer Registries (NAACCR). These two groups annually review data submitted by central registries across the U.S. and provide different levels of certification based on the quality of the data submitted. We want to share this exciting news with all of our reporters because our high quality data is not possible without all of you! We realize with the budget situation and staff shortages in many facilities across the state that completing all the necessary processing to submit high quality data can be challenging. With that said, we want to thank all of you for your dedication to providing the highest quality data possible. Your daily work and dedication to the field is reflected at not just the state level, but also the national and even global level. We have included the qualifications for the different certification levels from both NPCR and NAACCR.

### NPCR Data Evaluation Report, Report on Quality, Completeness and Timeliness, 2003-2007 Data

	Diagnosis Year	% Complete	Unresolved Duplicates	% Death Certificate Only	% Missing or Unknown Core Data Elements				% Passing Core Single and Inter-field Edits
					Age	Sex	Race	County	
OCCR Data by Year of Diagnosis	2007	>100	0.00	3.16	0.02	0.01	2.70	1.43	100
	2006	>100	0.01	2.02	0.01	0.00	0.30	0.04	100
	2005	>100	0.01	2.24	0.00	0.00	0.17	0.01	100
	2004	>100	0.01	2.32	0.00	0.00	0.19	0.00	100
	2003	>100	0.01	2.08	0.00	0.00	0.20	0.00	100
<b>NPCR Standard</b>		95%	≤1%	≤3%	≤2%	≤2%	≤3%	≤2%	99%

### NAACCR Registry Certification on Quality, Completeness and Timeliness of 2007 Data

	Diagnosis Year	% Complete	Unresolved Duplicates	% Death Certificate Only	% Missing or Unknown Core Data Elements				% Passing Core Single and Inter-field Edits
					Age	Sex	Race	County	
OCCR Data	2007	99.8	0.0	3.1	0.0	0.0	2.5	1.4	100
<b>U.S. Mean</b>	2007	>100	0.1	1.9	0.0	0.0	1.5	0.1	100
<b>NAACCR Standards</b>	Gold Standard	95%	≤1	≤3%	≤2%	≤2%	≤3%	≤2%	100%
	Silver Standard	90%	≤2	≤5%	≤3%	≤3%	≤5%	≤3%	97%

Each organization calculates the numbers slightly different, which is why there are some variations. You may also notice that our death certificate only percentage for 2007 cases does not meet the NPCR or NAACCR standards, however, they allow for some error which is why we still made the cut. For 2008 data we have focused on getting that percentage below 3 once again. Those states that meet the NPCR standards as seen above have their data published in the annual United States Cancer Statistics report published by CDC. This report can be accessed at <http://apps.nccd.cdc.gov/uscs/>.

**INSIDE THIS ISSUE:**

- Hematopoietic Changes In 2010 2
- Conversion Updates 2
- How Your Data Is Used 3
- Timeliness awards 3
- Question & Answer 4
- NAACCR Webinar Calendar 5
- OCRA Fall Conference 6



In the spirit of summer fun and family, the photos seen throughout this publication are of family faces that make the OCCR staff smile and represent our very reason to **“Work hard...and play harder!”**

## HEMATOPOIETIC CHANGES IN 2010

By Delores Greene, CTR

**Starting with cases diagnosed January 1, 2010 we are required to utilize the Hematopoietic Data Base and Manual (Rules).** If you have not done so you will need to go to <http://seer.cancer.gov/tools/heme/index.html> and download the database and manual to your desktop. **Prior to using either the manual or the Hematopoietic DB, please view the hematopoietic and lymphoid neoplasm Education Presentations.** These presentations cover: Disease presentation and diagnostic process, lineages of hematopoietic and lymphoid neoplasms, how to move through and use the rules and database, how to use the database to its fullest potential and how to use the electronic manual efficiently.



Anne Pate's nephew

Embedded in the Hematopoietic Database (Hematopoietic DB) is the Reportability and Coding Manual. The manual contains instructions and rules to determine the number of primaries, the primary site and histology, and the cell lineage or phenotype. The manual also includes several appendices. *Use the instructions and rules within the manual first.* The Hematopoietic DB is used when the rules specifically instruct the abstractor to refer to the DB or when the registrar has followed all the rules in the manual.

The Hematopoietic DB contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3 -9992/3). There are 33 new codes and terms with 3 newly reportable diseases (previously it was /1 and now it is /3). See Appendix in coding manual for details.

To navigate in the Hematopoietic DB there are "5 Steps:"

1. Provisional histology code: confirming histology/site combinations
2. Reportability Instructions
3. Multiple Primary Rules
4. Primary site and Histology (PH) Rules
5. Grade Rules (phenotype/lineage for hematopoietic neoplasms)

The Hematopoietic DB and Manual (Rules) are designed to help the registrar understand and interpret the information written by pathologists. The Hematopoietic DB will be updated periodically to ensure that the registrar has the most current information available to interpret and code a hematopoietic or lymphoid neoplasm. To receive notification of updates please register at <http://seer.cancer.gov>.

**In conclusion we will use only the Hematopoietic DB and Manual for cases diagnosed on or after January 1, 2010.**

**Starting with the 2010 data:**

- We will no longer use the ICD-O Third Edition for coding hematopoietic diseases.
- We will no longer use the Abstracting and Coding Guide for the Hematopoietic Diseases (Red Book).
- We will no longer use Appendix A: Definitions of Single and Subsequent Primaries for Hematologic Malignancies.

## CONVERSION UPDATES

By Paula Marshall, BBA, CTR

### RMCDs Conversion

All RMCDs users should have received an email from me that included a link to access a RMCDs document regarding specifics on converting your RMCDs software. If you did not receive this email, please let me know as soon as possible. Please keep me informed about your scheduled conversion date and completion thereof.



Sharon Hsieh's nieces

As stated in previous newsletters, it is strongly recommended that you complete all cases diagnosed prior to 2010 before you convert to NAACCR v12. If abstracting of 2010 cases begins prior to installation of the software update, it will be necessary to review those cases after the conversion to code the new items and make certain that converted items have the most specific codes assigned. OCCr will NOT accept any 2010 data that has not been coded with the new CSV2 codes.

*Continued on page 4*

## WHAT'S YOUR SUN SAFETY IQ?



Beth Watwood's nieces

Submitted by Beth Watwood, RHIA, CTR  
(Excerpt from the American Cancer Society-  
[www.cancer.org](http://www.cancer.org))

- 1.) I can't get skin cancer because my routine (work, drive to work, indoor hobbies and vacations) doesn't include any outdoor activities.  
a. True b. False
- 2.) If I'm wearing sunscreen, I can stay in the sun as long as I want.  
a. True b. False
- 3.) It's safe to let my children stay in the pool all day if they slip on a T-shirt after a couple of hours and reapply

sunscreen to their faces, arms and legs.  
a. True b. False

- 4.) How often do you need to reapply water-resistant sunscreen?  
a. Every 2 hours or sooner  
b. After sweating or swimming  
c. After you towel dry  
d. All of the above

- 5.) Getting a "base tan" at an indoor tanning salon is a good way to prevent sunburn when I go to the beach later this summer.  
a. True b. False

Answers on page 6

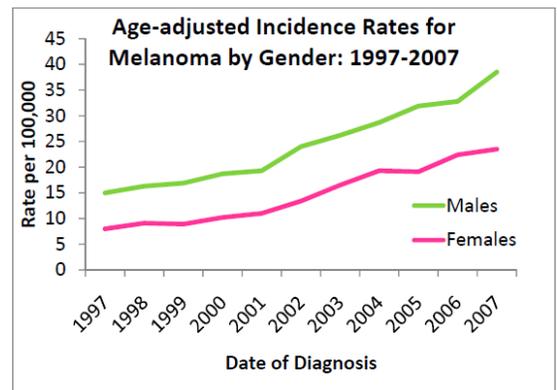


## HOW YOUR DATA IS USED

By Anne Pate, MPH

Oklahoma now has eleven years of high quality surveillance data available thanks to the efforts of both the central registry staff and all the facilities and individuals providing that data. Since we appreciate all the work that goes into achieving this, we wanted to share what happens to the data after it is collected, consolidated and cleaned. The graph to the right is a slide that was part of a presentation to the Oklahoma Comprehensive Cancer Network (OCCN) on melanoma incidence in the state.

Between 1997 and 2007 there was a 157% increase in incidence among males and a 194% increase incidence among females. While part of this increase may be due to improved collection of melanomas from dermatologists since 2006, it also reflects a lack of sun safety practices throughout the state that the OCCN is attempting to address.



## TIMELINESS AWARDS

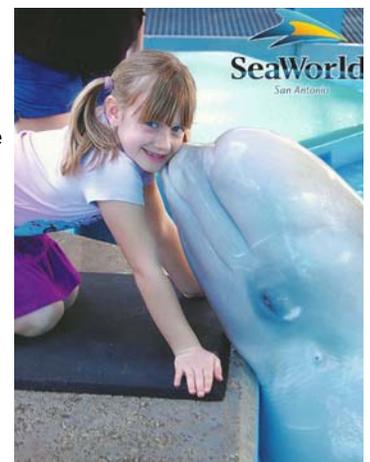
By Leslie Dill

OCCR would like to recognize the cancer registries of those hospitals who have met or exceeded the reporting timeline for data submission to the OCCR. The following hospitals will be receiving a certificate of achievement in recognition of this accomplishment: Jackson County Memorial Hospital,

Jane Phillips Medical Center, Logan Hospital & Medical Center, Mercy Health Center, Mercy Memorial Health Center, Oklahoma Surgical Hospital, Pauls Valley General Hospital, SouthCrest Hospital, St. John Medical Center, St. Anthony Hospital and Unity Health Center. Congratulations to these facilities! We truly appreciate your efforts. In our

next issue, OCCR will recognize the registrars in ambulatory surgery centers that are responsible for meeting or exceeding the reporting timeline.

**Great Job!**



Leslie Dill's daughter

## QUESTION AND ANSWER

Submitted by Delores Greene, CTR

Taken from SEER Inquiry System, <http://seer.cancer.gov/seer inquiry/>

### Question

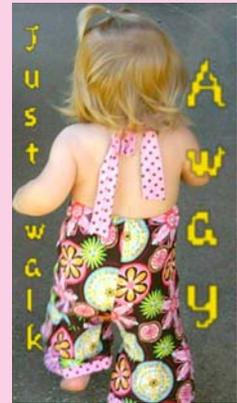
MP/H Rules/Histology--Breast: How are the following two examples coded? 1. Infiltrating ductal carcinoma, mucinous type 2. Infiltrating ductal carcinoma with features of tubular carcinoma.

### Discussion

We have a difference of opinion on which rule applies. Some registrars believe that the first rule that applies for both scenarios is Rule H12 (code the most specific histologic term) because "type" and "with features of" are used in the pathological diagnosis. They are coding 8480 and 8211 respectively for the above examples. Other registrars are stopping at Rule H17 because they do not believe these are examples of duct carcinomas since the histological code is not included in the Rule description nor are these histologies included in Table 2. They are coding to 8523 for both examples.

### Answer

Code 8523 for 1. Infiltrating ductal carcinoma, mucinous type AND 2. Infiltrating ductal carcinoma with features of tubular carcinoma. The infiltrating ductal types in Rule H12 are listed (8022, 8035, 8501-8508) and do not include mucinous nor tubular, therefore, we cannot use this rule. The first rule that applies to these single tumors is H17, so code to 8532. If you look up 8532 in the numerical morphology section of ICD-O-3, you will see similar examples included in the definition of this code.



Charlotte Murphy's  
granddaughter

### Question

MP/H Rules/Multiple primaries--Breast: When an in situ diagnosis is followed by an invasive diagnosis in the same breast 1.5 years later, is it a new primary?

### Discussion

Pt had a core bx 1/07 that showed DCIS. Pt refused resection, followed by chemo and/or XRT. A year and a half later (6/08) the pt returns for a MRM which shows infiltrating duct ca and positive LNS. The 6/08 information came in as a Correction Record. The comment in the Correction Record stated "Per MD, pt didn't see any urgency and delayed surgery 1.5 year after diagnosis. The patient did not have any rx in that time period. Not specifically stated that pt had progression - only info is that pt had no adenopathy 1/07 and then 6/08 had positive LNS. Is the 6/08 a new primary?"

### Answer

Abstract the 6/08 invasive diagnosis as a separate primary according to rule M8. Rule M8 applies whether or not the later diagnosis in this case is progression of disease.

If you have a question, please send it to [DeloresG@health.ok.gov](mailto:DeloresG@health.ok.gov).

## CONVERSION UPDATES

*Continued from page 2*

### OCCR Conversion

Due to the fact that a number of 2009 cases are currently outstanding from various reporters, the decision was made that OCCR will not convert until such time that the majority of 2009 cases have been submitted to the state. If you have completed abstracting all cases diagnosed prior to 2010 and converted your software to NAACCR v12, OCCR will accept your 2010 data. However, please make note that we will not process your data until we have converted our system. Date of receipt will be recorded and calculated for timeliness.

### Web Plus Update

Hopefully, the transition from OCROW to Web Plus will happen sometime before Christmas! As with all updates, changes, new systems, conversions, beta testing, and implementation, it takes time to get it just right. This application is provided by CDC and when they announce the release of the updated version, OCCR will be ready to start beta testing the system. Thank you for your patience.



Judy Hanna's son



NAACCR WEBINARS-ONE TO GO

By Leslie Dill

Only one NAACCR webinar remains in the 2009-2010 series. This webinar will be presented at Midwest Regional Medical Center in Midwest City and at St. John Medical Center in Tulsa. OCCR would like to thank the registrars at both facilities – Robin Morgan at MPMC and Carol Lane at SJMC –for graciously hosting.



**NAACCR**  
Webinars for ALL  
Oklahoma cancer  
registrars.  
Coming soon to a  
facility near you!

Date	Title	Hospital	Central
9/2/2010	Coding Pitfalls	X	X

OCCR has already purchased the NAACCR 2010-2011 webinar series for all Oklahoma registrars. With so many changes and conversions going on, be sure to mark your calendars monthly so that you can participate. As in the past, we will offer each webinar in OKC and in Tulsa. The hosting facilities will be Deaconess Hospital in OKC and St. John Medical Center in Tulsa. The webinars are free to everyone. We only ask that you register ahead of time. You may do so by emailing [LeslieD@health.ok.gov](mailto:LeslieD@health.ok.gov).

NAACCR 2010-2011 WEBINARS

Date/Time	Title	Hospital	Central
10/7/2010 8am-11am	Collecting Cancer Data: Endometrium	X	X
11/4/2010 8am-11am	Collecting Cancer Data: Hematopoietic Disease	X	X
12/2/2010 8am-11am	Collecting Cancer Data: Liver and Biliary Tract	X	X
1/6/2011 8am-11am	Collecting Tumor Data: Brain and Central Nervous System	X	X
2/3/2011 8am-11am	Collecting Cancer Data: Testis	X	X
3/3/2011 8am-11am	Collecting Cancer Data: Bladder	X	X
4/7/2011 8am-11am	Collecting Cancer Data: Breast	X	X
5/5/2011 8am-11am	Collecting Cancer Data: Prostate	X	X
6/2/2011 8am-11am	Best Practices for Developing and Working with Survival Data	X	X
7/7/2011 8am-11am	Complete Case Identification and Ascertainment	X	X
8/4/2011 8am-11am	NAACCR Interoperability Activities and the Electronic Health Record	X	X
10/7/2011 8am-11am	Coding Pitfalls	X	X



Delores Greene's grandson

## OKLAHOMA CENTRAL CANCER REGISTRY

Oklahoma State Department of Health  
1000 NE 10th St, Room 1205  
Oklahoma City, OK 73117  
Phone: 405-271-4072  
Fax: 405-271-6315



Paula Marshall and husband, Rick, with grandkids

## 2010 OCRA FALL CONFERENCE

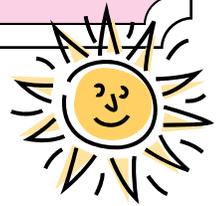


### SAVE THE DATE!

**September 23rd and 24th**  
**Muskogee Regional Hospital**

Registration is **FREE** to all OCRA Members. Non-member registration is \$60 and student registration is \$30 .

The focus of the conference will be colo-rectal cancer with an emphasis on diagnosis, treatment and staging (new changes to the AJCC 7th edition). Anne Pate, MPH, will open the conference with statistics from the OCCR database for colon and rectal malignancies in Oklahoma. Sameer Keole, MD, from the ProCure Center in Oklahoma City, will be speaking on the proton therapy treatment for colon malignancies. Muskogee Regional Hospital will share their tumor board conference with us during lunch time on Thursday, September 23rd, and Delores Greene, CTR, will present the new collaborative staging scheme for 2010 colon cancer.



## WHAT'S YOUR SUN SAFETY IQ? (ANSWERS)

*Continued from page 3*

1. **False**— Dermatologists say brief sun exposures all year round can add up to major damage for people with fair skin. The sun's ultraviolet (UV) rays do pass through car windows, so driving during peak sun hours, 10am-4pm, to lunch or on weekends, bathes your hands and arms in damaging UV rays. When added up, everyday exposures are linked to squamous cell cancer. Although not as dangerous as melanoma, squamous cell cancer is far more common and the number of cases has been going up every year.
2. **False**— It's not smart to broil in the sun for several hours, even if you are wearing sunscreen. These products don't provide total protection from UV rays. The American Cancer Society recommends that people seek shade and limit time in sun at midday. Also, cover up with a shirt, wear a wide-brimmed hat, wear sunglasses for eye protection, and use a sunscreen rated SPF 15 or higher, reapplying it about every 2 hours.
3. **False**— UV rays easily go through a white cotton T-shirt, especially if it's wet. Your children will get only about as much protection as an SPF 4 sunscreen—certainly not enough for all day and well below the minimum of SPF 15 recommended by the ACS. Better clothing choices include dark colors, fabrics with tight weaves, and specially treated garments and bathing suits. Sun-protective clothing is often found at sporting goods stores. Another choice is moving into the shade. For babies younger than 6 months, shade, sun-protective clothing and hats are best. As a last resort, pediatricians now say that very small amount of sunscreen can be used on small areas, such as the face and back of the hands.
4. **All of the above**— For best results, most sunscreens need to be reapplied about every 2 hours or sooner, but be sure to check the label. Sunscreens labeled "water resistant" are made to protect you when swimming or sweating, but may only last for 40 minutes. Also, remember that sunscreen usually rubs off when you towel dry.
5. **False**— Our experts say a "base tan" gives you very little protection against sunburn. That goes for indoor tans, too, which provide an SPF of about 4, much less than most sunscreens. A base tan may, in fact, increase the chance you will get a burn, because you're likely to stay out longer without properly protecting your skin. Also, tanning itself injures the skin. What you don't see is UV damage to deeper layers, where it builds up from every tan and burn you've ever had. There really is no such thing as a "safe tan."

We acknowledge the Centers for Disease Control and Prevention (CDC) and the National Program of Cancer Registries (NPCR) for its support and the distribution of this newsletter under cooperative agreement #U58/DP000834-03 awarded to Oklahoma. Its contents are solely the responsibility of the authors and do not represent the official view of CDC.

This publication was issued by the Oklahoma State Department of Health as authorized by Dr. Terry Cline, Commissioner of Health. 500 copies were printed by OSDH in July 2010 at a cost of \$290.00. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.