
RR Registrar Review

Vol. 5, No. 1 Quarterly Newsletter of the Virginia Cancer Registry Summer 2001

Welcome to the Summer 2001 edition of the REGISTRAR REVIEW (RR), the quarterly newsletter of the Virginia Cancer Registry (VCR). We remind all readers of our aim that the content of this newsletter address current and changing needs of persons interested in cancer control and prevention in Virginia. Therefore, we welcome any and all comments, criticisms, and suggestions on how the RR can continue to meet the dynamic needs of Virginia's cancer reporting system. If you have comments, please do not hesitate to let us know by contacting the VCR at:

Virginia Department of Health

Virginia Cancer Registry

P.O. Box 2448, Room 114

1500 East Main Street

Richmond, VA 23218

(804) 786-1668 phone

(804) 371-4061 fax

2001 Virginia Cancer Registry Annual Training Conference

Over 100 cancer information professionals came together April 12-13th for the annual training conference hosted by the Virginia Cancer Registry. Evaluations indicate that this meeting proved useful and relevant for those of you involved in cancer registration and surveillance in Virginia (see comments on page 2).

The overwhelming message in the evaluation comments was that the afternoon Quality Assurance breakout sessions were a beneficial and necessary change. Next year's meeting will certainly include this type of format but with improved logistics. Participants also enjoyed the hands-on training provided by Steven Roffers' presentations. The questions and answers to his ICD-O-3 exercises are provided on page 3 of this issue of RR. For the answers to the Lymphoma and Leukemia Histology/Behavior/Grade Coding Exercises, go to the ICD-O-3 on-line training module located at www.training.seer.cancer.gov and then click on "Quiz". The questions are identical although in a different order.

Continued on page 2



In this Issue:

2001 Virginia Cancer Registry Training Conference 1

VCR Changes 2

Overview of 1998 Cancer Incidence in Virginia 2

Hard Work is Paying Off 2

ICD-0-3 Exercise and Answer Sheet 3

Reporter's Corner

Regional Reports

Region 1 - Leona Rowe 4 Region 3 - Christine Flemming 4

Region 4 - Tonia Faro 4 Region 5 - Bonnie Perry 5

Patient Notification 6

Lost to Follow-up? 6

Hospital Lab Reporting 6

Reportable Case Definition 6

Mark Your Calendar 7

Quality Assurance Q & A 8

Graph of the Quarter 8



Registrar Review Vol. 5, No. 1

Many thanks again to our generous sponsors who helped us hold such a great meeting in a wonderful location. The extra room and convenience of our site this year made for a more conducive learning environment. We also were able to provide recognition awards for one person from each level of service to the field of cancer registration (0-4 years, 5-9 years, 10-14 years, 15-19 years, and 20+ years of service), although ALL of you deserve recognition!! Finally, a final round of applause for all of the VCR staff who worked hard to make this meeting a success.

Selected Evaluation Comments:

- This is the best meeting to date.
- Extremely well organized! VCR staff (were) very friendly and helpful.
- Accommodations couldn't get any better! It is so beneficial

Among males, prostate cancer was the predominant cancer (28.7% of males with cancer). Cancer of the lung and bronchus accounted for 17.1% of cancer in males and colorectal cancers accounted for 12.3%.

Breast cancer was the most commonly occurring cancer among females (34.1%). Colorectal and lung and bronchus cancers accounted for 12.7% and 12.3% of cancers among females, respectively.

The entire report, Cancer Incidence in Virginia _ 1998, which more completely describes cancer among Virginia residents, is available from the Virginia Cancer Registry. The report can also be downloaded from our web site at: <http://www.vdh.state.va.us/epi/cancer/vcrpub.htm> .

to have meeting in (the) same facility that we stay in.

- Very educational! Well presented!
- Excellent and informative.

VCR Changes

In April, the VCR welcomed back Dave Kuzminski. Dave worked with staff last December to develop the patient notification database now used to facilitate and monitor that activity. Dave now has primary responsibility for processing the notification correspondence as well as the death clearance activities to recommence this summer. We also have been fortunate to welcome back Jayne Arline, CTR, as well. Jayne has returned in a part-time position to assist in processing the pathology-only cases reported to the VCR. Unfortunately, the registry lost our Region 2 Cancer Surveillance Specialist, Dianne Collins, RHIT, CTR, who left in February. Meanwhile the region has been covered by existing staff. The VCR is currently recruiting to fill that position.

Overview of 1998 Cancer

Incidence in Virginia:

As of the publication date of our Cancer Incidence in Virginia - 1998 report, the Virginia Cancer Registry collected information on 25,438 cancers diagnosed among Virginia residents. This number includes invasive stages (local, regional or distant) except for the urinary bladder, which includes in situ cases.

Consistent with data reported for 1997 diagnoses, the most commonly occurring cancers were:

- § Female Breast
- § Lung and Bronchus
- § Prostate
- § Colorectal
- § Urinary Bladder.

Hard Work is Paying Off

The most recent evaluation by the North American Association of Central Cancer Registries (NAACCR) found that at 23 months past the close of the 1998 diagnosis year, the Virginia Cancer Registry included reports for 87.7% of expected, unduplicated incident cases. This ascertainment estimate is statistically derived by applying a national cancer incidence to mortality ratio to the Virginia observed 1998 cancer mortality.

To be almost 88% complete at 23 months is a great accomplishment for the VCR and reflects an almost 8% increase over the 1997 evaluation results. Such an achievement is due in large order to improved facility reporting and a great willingness to work with VCR staff preparing for the evaluation. Casefinding has improved in recent years, and the registry continues to support hospital registrars in improving access to critical casefinding sources. Likewise, reporting timeliness helps the VCR keep submissions manageable and still maintain the highest level of data quality (as certified again this year by the NAACCR evaluation).

National standards call for at least 90% (and preferably 95%) of all reportable cancers to be available for analysis by the central cancer registry no later than two years after the close of the diagnosis year. All of you have helped us come very close to reaching this level of completeness and timeliness, but we still have a way to go before we can rest and celebrate.

Which brings us to our current effort to close out the 1999 diagnosis year. Many great thanks need to go to all facilities that have finalized reporting for 1999 diagnoses. Submission of these cases has been much more timely than for 1998 cases, and we acknowledge all of the extra effort taken over the year to bring your reporting more up-to-date.

However, to date eight hospitals still have not finished sending these cases. According to Virginia reporting regulations, all cases diagnosed in 1999 should now be in house at the Virginia Cancer Registry. If you are having trouble meeting these requirements, please contact your regional Cancer Surveillance Specialist.

ICD-O-3 Exercise and Answer Sheet

Diagnosis	Topography	Morph/Beh/Gr	Report?*
1. PIN III (Prostatic intraepithelial neoplasia, Gr III)	C61.9	8148/29	N
2. Refractory anemia with sideroblasts	C42.1	9982/39	Y
3. Hodgkin lymphoma, nodular sclerosis, Gr 2, lymph nodes, NOS	C77.9	9667/39	Y
4. Papillary cystadenoma, borderline malignancy	C56.9	8451/19	N
5. Polycythemia vera	C42.1	9950/39	Y
6. Pilocytic astrocytoma	C71.9	9421/39	Y
7. Non-small cell carcinoma	C34.9	8046/39	Y
8. VIN III (vulvar intraepithelial neoplasia, grade III)	C51.9	8077/29	Y
9. Myelodysplastic syndrome, therapy related	C42.1	9987/39	Y
10. Waldenström macroglobulinemia	C42.0	9761/39	Y
11. Myelofibrosis with myeloid metaplasia	C42.1	9961/39	Y
12. Juvenile melanoma	C44.9	8770/09	N
13. Atypical carcinoid tumor, small intestine	C17.9	8249/39	Y
14. Papillary transitional cell neoplasm of low malignant potential	C67.9	8130/19	N
15. SETTLE of thymus	C37.9	8588/39	Y
16. Metaplastic meningioma	C70.9	9530/09	N
17. Squamous intraepithelial neoplasia, Gr III of vagina	C52.9	8077/29	Y
18. Gastrointestinal stromal sarcoma, poorly diff	C26.9	8936/33	Y
19. Infiltrating duct & colloid carcinoma, tail of breast	C50.6	8523/39	Y
20. AIN III	C21.1	8077/29	Y
21. FAB M5	C42.1	9891/39	Y

* Refer to Table 7 on page 17 of the *Guidelines for ICD-O-3 Implementation* produced by NAACCR, Inc., be aware of the reporting requirements by the CoC, SEER, and NPCR. Even though VIN III, VAIN III, and AIN III (notice that the "III" is missing from the NAACCR guidelines after "AIN"), they are indeed reportable by SEER and NPCR registries, so the hospitals must report these, too.

Reporter's Corner

Region 1 Leona Rowe

It was good to see you at the Virginia Cancer Registry's Conference in Richmond, and to address many of your concerns and questions. We had excellent representation from Region 1, and many felt we had a productive conference.

This field continues to present many challenges as we strive to collect complete and accurate data to assess the burden of cancer in Virginia. As a result, we are learning about new changes and additional requirements. In order to stay abreast of ever changing information, be sure to go online to find out the latest news, as this field continues to evolve. It is suggested that you visit the Virginia Cancer Registry's website (<http://www.vdh.state.va.us/epi/cancer/index.htm>) to access links to updates from professional cancer organizations. Updates can be an invaluable tool to assist you in performing your work as a cancer registrar.

By now, you should have received your 1999 accession listing. Please review the listing carefully and inform us of any discrepancies. Should you have any 1999 cases that were not reported, please submit them as soon as possible. This will aid us greatly in our case count as we prepare for the national call for data.

Here's wishing you a safe and enjoyable summer.

Region 3 Christine Flemming

Greetings!

It was wonderful to see so many of you at our conference in April. There are so many new and exciting things that are happening in the cancer registry field. With the implementation of ICD-0-3 and Seer Summary Stage 2000, we have many challenges ahead of us. No later than July, 2001, hospital software vendors should have upgrades for your systems. Please contact your vendor if you have any questions

regarding when this update will be available to your facility. A flow chart regarding submission of 2001 cases to the VCR was provided to each facility during the breakout session at our meeting. If you were unable to attend the meeting and would like a copy of this chart, please contact me.

We are still having some problems with facilities reporting to us by the 5th of the month. If you do not have any cases to submit to the VCR for that month, a submission form is still required to be sent into our office with a zero on the submission form. We are doing this to track the timeliness of each facility,

and will be recognizing those facilities who are consistent in

submitting their cases. In our region we have multiple facilities who report to a cancer registry coordinator. It is still important that each of these facilities complete a submission form so that the registrar at each individual facility can be recognized.

On a similar note, many of you have received an accession list from me for the cases that you have submitted to us for 1999. If you have not reviewed this list, please do a reconciliation and return it to me as soon as possible. Also, for those who still have outstanding 1999 cases, we need those cases to be submitted to us. We use your data to participate in a national call for data, and without those cases, our central registry cannot be accurately represented. Some of you have also received a telephone call from me regarding a low 1999 case count as compared to previous years. Please review your caseload count for 1999, and if it is low, please investigate and let us know why.

As a reminder, I will be setting up case finding reviews for facilities in our region. These will probably take place in the fall, and I will contact those of you who we will be visiting.

I know that all the changes can seem very overwhelming; however, I am available to discuss any questions or concerns you may have. You can reach me at (804) 786-0831; however, my e-mail has changed to cflemming@vdh.state.va.us.

You all are doing an excellent job. Keep up the good work!

Region 4 Tonia Faro

It was a pleasure to finally meet most of you at the conference. It was nice to put voices to all your beautiful faces. I hope that all of you felt that you benefited from the conference and the breakout sessions. We intend to continue the regional breakout sessions, but with better more organization. We appreciate any other suggestion you may have to help it to go smoothly.

Just to recap the topics we discussed. We went through some of the changes with ICD-0-3 and SEER Summary Stage 2000 (SSS2000). We handed out a flow chart that explains when and when not to submit cases diagnosed in 2001. We talked about monthly submission by the 5th of the month, and how if you have nothing to report, to send that month's submission form with a zero on it. This was implemented to help us track the timeliness of the facilities reporting and so that hopefully next year, facilities with the best efforts will be recognized. We discussed the need for complete demographic information, class of case and date of diagnosis issues, as per the ROADS manual. We also discussed some of the legal issues in reporting path only cases.

Reporter's Corner

Right now we are frantically trying to get the 1999 cases into the VCR for the NAACCR call for data. Just like a food chain, when you feed us your information we feed it to NAACCR. We would like each of you to review and compare your 1999 caseloads with prior years and if the case count is low, investigate and let us know why. Thank you for all your hard work.

Region 5 Bonnie Perry

Hats off to Region 5! Eastern Virginia's cancer registrars were well represented at VCR's April 12-13 training conference. With all of the registry staff turnover in our area (and the ensuing backlogs), we were very grateful for Region 5's attendance. During our regional breakout session, registrars participated in an hour of discussion on topics ranging from new reporting procedures (ICD-O-3 and Summary Stage 2000) to old procedures that needed to be reviewed.

A few highlights of our session were as follows:

- Regarding implementation guidelines for the new SEER Summary Staging and ICD-O-3 Manuals—all cases diagnosed on or after January 1, 2001, should be submitted according to the appropriate new manual. In order to report 2001 cases correctly, it is necessary to install NAACCR Version 9.0 software (including the changes from these new manuals). For registries that are still waiting for this software, cases affected by the ICD-O-3 changes should be held in suspense with detailed notes in the text fields so that when the software is in place, the case can easily be completed and submitted to VCR. Cases that are not affected by the ICD-3-O can be submitted as usual. Also, until the new software has been installed, new summary staging may be entered into the existing field (with notation regarding the scheme used for staging written in the text); and these cases may be submitted to VCR without any delay.

- The out-of-state county code for submission to VCR

is 998.

- Hospitals are reminded again that when they have determined who is legally responsible for reporting pathology-only cases, whether it is the pathology

- Cancer data must be submitted to the VCR by the 5th of each month for all cases abstracted during the month prior to the submission. For example, cases abstracted and completed in July (or months before that that have not previously been submitted to VCR) should be sent to us by August 5, accompanied by a Submission Form for August 2001.

- Registrars were reminded that text fields give VCR staff valuable assistance in their QA efforts. Text should be as clean and concise as possible and should relate only to the primary site being abstracted. The question to be answered when working through an abstract is always, "What picture do I want to give someone who reviews this patient's abstracted records?"

Those of you who were not able to attend this session may request a regional breakout folder by calling me at (804) 786-9511.

During this past year, almost every reporting hospital in the eastern region has had important staff changes. Rappahannock General has lost its registrar, Patricia Pawloski, and has not yet filled her vacancy. Chris Lee left Williamsburg Community Hospital very soon after he began working in the registry (greener pastures, Chris?), but he continues to help Williamsburg's new registrar, Debra Johnson. Betty Knapp, from Bon Secours Maryview, is mentoring another new registrar, Roxanne Womack, at Bon Secours DePaul Medical Center. Kathleen Marcia has left Sentara Norfolk General's registry and has begun working with Joan Chamberland at Sentara Virginia Beach General. Jane Duer has recently taken over the position of cancer registrar at Shore Memorial; and Chesapeake General's Crystal Brown, who is taking over the greatest part of the registry's operations, still considers herself one of the newer "kids on the block." Region 5 should be proud of its long tradition of supporting each other, experienced and novice alike. Keep it up! Some days it's all that keeps us going!

department or the registry, letters from such facilities stating their decision should be forwarded to the VCR.



Registrar Review Vol. 5, No. 1

Reporter's Corner

Patient Notification

In recent months over 1,200 recently diagnosed and reported cancer patients received notification letters from the VCR. Mailings include a letter of introduction, a copy of an excerpt of the Privacy Protection Act, and an informational flyer (soon to be revised). All materials were written carefully to be tactful and sensitive to patient concerns while still fulfilling the intent of § 32.1-71.02, which mandates this notification process.

Of the patients who have contacted the registry, the majority stated that they would not have been so shocked to receive our letter if their doctor had told them about the cancer registry and about cancer reporting. Feedback received during these calls has led us to revise the materials to improve their acceptability to patients and their families.

In the past we have encouraged reporting facilities to incorporate some type of advance notice to the patient that would minimize this type of surprise to the patient. To facilitate this, the VCR can provide you with copies of the notification flyer to incorporate into your own patient informational packet. Current limited production prevents us from doing this on a wide scale right now, but if you would like 50 copies or less, please contact the registry at (804) 786-1668. By late-summer we anticipate having mass quantities of the new flyer available for distribution on request.

Hospital Lab Reporting

Many of the hospitals across the state have been able to determine appropriate reporting procedures for the non-hospital, pathology-only cancer cases diagnosed through a hospital pathology laboratory. Currently two hospitals have initiated separate reporting for pathology-only cases, and one hospital identified the need to have separate reporting from its radiation treatment facility.

The VCR is leaving this legal matter to reporting facilities. However, if you would like our help in encouraging your hospital's management to reach a decision on this matter, please let your regional Cancer Surveillance Specialist know.

Reportable Case Definitions

The Virginia Cancer Registry participates in the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention. NPCR has certain requirements of its sponsored registries, much like the American College of Surgeons Commission on Cancer has for its accredited hospital programs. Sometimes our requirements differ.

One such difference is the collection of vulvar intra-epithelial neoplasia, grade 3; vaginal intra-epithelial neoplasia, grade 3; and anal intra-epithelial neoplasia, grade 3.

Note these three conditions (commonly known as VIN III, VAIN III, and AIN III) are in fact reportable to the Virginia Cancer Registry. As such, once reported these patients are

Lost to

Follow-up?



The VCR staff are in the process of updating deaths for 1996 _ 1999 to cancer patients across Virginia (year 2000 deaths will be available this Fall). Once these merges are complete, we will send out hospital-specific listings of these deaths to patients reported from your facility.

In the meantime, if you are having an ACoS survey this year and you have a list of cases for whom no contact has been made within 15 months after the date of last follow-up information, contact your regional Cancer Surveillance Specialist about processing these cases sooner.

included in our mandated patient notification process. Remember, however, the patient letter clearly states that not all conditions reported to us are cancerous. Hopefully this will minimize concern among this group of patients.

The College and NPCR are in agreement on the remainder of reportable conditions. The following are not reportable to either the National Cancer Data Base (NCDB) or to the VCR:

- CIS of the cervix and CIN III (non-reportable in Virginia as of 11/2000)
- PIN III
- Basal or squamous cell carcinoma of the skin (unless [1] localized and over 5 cm in size or [2] diagnosed at regional or distant stage _ then is reportable to VCR).

Registrar Review Vol. 5, No. 1



Mark Your Calendar

August 6-8, 2001 Advanced Cancer Registry Training Program "Principles and Practice of Cancer Registration, Surveillance, and Control." The registration fee is \$500 for the intensive three-day program. This training program is suitable for oncology program (hospital and central registry-based) employees

with a working knowledge of cancer, anatomy, physiology, and medical terminology. Cancer registrars with at least one year of experience or statistical and epidemiological staff who utilize cancer registry data would benefit most from this program. The program will specifically address: abstracting, staging, and coding difficult cancer cases; bizarre, rare, and unusual cancer cases; calculating incidence, prevalence, age -adjusted, survival, and other rates; using registry data and using the Internet to locate comparable data and useful cancer information and resources. Prerequisites: Participation in Principles and Practice training

program or at least one year of experience working in a cancer registry. For more information see their web site at <http://cancer.sph.emory.edu> or contact Steven Roffers, PA, CTR at (404) 727-4535.

August 1, 2001 CTR Exam Application Deadline

August 10-11, 2001 South Carolina Cancer Registrars Association CTR Exam Review Workshop. Registration fee is \$70.00. The workshop is intended to review and assess the basic cancer registrar's knowledge of cancer registry theory and practice in preparation for the National Cancer Registrars Association Certified Tumor Registrars (CTR) Certification Examination. At the end of the workshop, participants should be able to assess areas of strengths and weaknesses in cancer registry theory and practice and identify areas requiring concentrated study prior to the examination date. The workshop will be held at Trident Community Center in Charleston, South Carolina. For more information contact Linda Cope, CTR at 843-792-6672.

September 15, 2001 CTR Exam

October 4-5, 2001 VCRA Meeting, Airport Clarion Hotel, Roanoke, VA. Earlybird registration for members is \$65.00 (no earlybird discount for non-members); deadline date is August 31, 2001. After that date the fee for members is \$80.00, non-members \$95.00. Information packets will be mailed in early July 2001. Contact Jane Gladwell, CTR at 540-981-7843 or by email at jgladwell@carilion.com for more information.

November 5-9, 2001 Principles and Practice of Cancer Registration, Surveillance and Control, Atlanta, GA; registration fee \$800.00. Held at Emory University, this program is for all oncology healthcare personnel, especially oncology program (hospital and central registry-based) employees with mini-

mal knowledge of cancer anatomy, physiology and medical terminology. Cancer registrars, statistical staff and epidemiological staff who use cancer registry data would benefit most from this program. For more information see their web site at <http://cancer.sph.emory.edu> or contact Steven Roffers, PA, CTR at (404) 727-4535.

May 21, 2002 NCRA Annual Conference at the Opryland Hotel in Nashville, TN. Look for more information in future issues of the RR.

Quality Assurance Q & A

Q: What is the new "time rule" regarding summary stage?

A: Summary stage should include all information available through completion of surgery (ies) in the first course of treatment or within four months of the diagnosis in the absence of disease progression, whichever is longer. This new rule applies to all cases diagnosed on or after January 1, 2001.

Q: A patient came into the hospital emergency room on December 29, 2000, and has lab work done that was read and interpreted by a physician as refractory anemia on December 30, 2000. On January 3, 2001, the patient comes into the oncology unit for treatment. Should this case be accessioned by the registry as an analytic case for 2000 or 2001?

A: Neither. While refractory anemia has become a reportable disease with the new ICD-O-3 (9980/3_), in this case, the patient was diagnosed in the year 2000 with what was a non-reportable anemia at that time. For the implementation of the ICD-O-3 codes, only cases diagnosed on or after January 1, 2001, are accessioned. This case would, therefore, not be accessioned.

Q: A patient came into a hospital on April 4, 2001, and is treated for recurrence of refractory anemia which had been diagnosed two years earlier. Should the registrar accession and report this case as a non-analytic case?

A: No. Cases that were not reportable at the time of diagnosis should not be accessioned later as non-analytic. This is also true of other situations such as cases wherein the patients have a non-reportable localized squamous cell carcinoma of the skin that are readmitted for metastasis to bone two years later. As with the above example, these cases should not be reported.

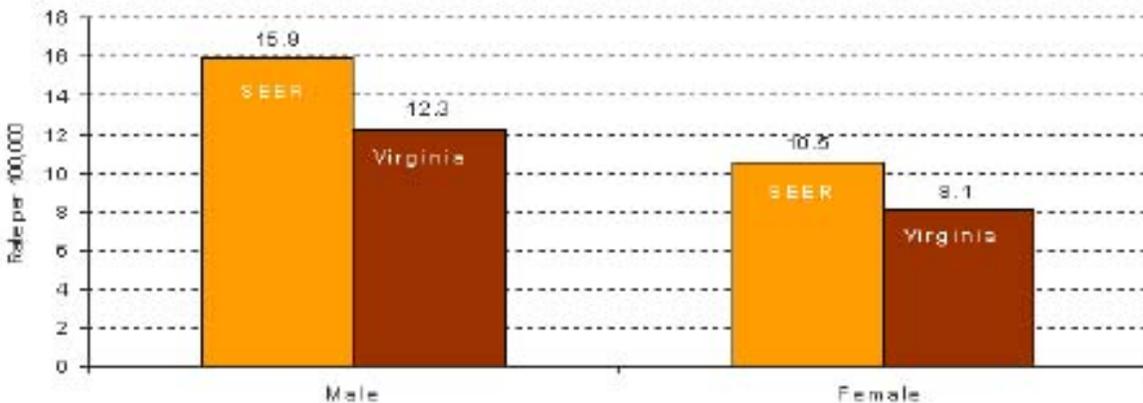
Q: Are non-analytic cases reportable to the Virginia Cancer Registry (VCR)?

A: Yes. Non-analytic cases with a diagnosis year after 1989 should be reported to the VCR. For the definition and clarification of analytic (class of case 0, 1, 2, and 6) and non-analytic (class of case 3, 4, and 5) class of case, please refer to pages 91-93 of the ROADS manual.

If you have questions you would like to see answered in this column, contact Bonita Bryant at 804-786-1669 or by email at bbryant@vdh.state.va.us.

Graph of the Quarter

Melanoma of the Skin
Age-Adjusted Incidence Rates by Sex
Virginia and SEER Registries, 1993-1997



Note. Data exclude in situ melanomas. Rates are per 100,000 persons and are age adjusted to the 1970 U.S. standard population. SEER Cancer Incidence Public-Use Database, 1992-1997, August 1999 Submission. Virginia Cancer Registry (VCR) Data, January 2001. Note that VCR data reflect a conservative description of cancer in Virginia.
