



**2010 Cancer Data Collection
Updates: Standards Volume II,
Version 12**

NAACCR 2009-2010
Webinar Series




Introduction



What's New for 2010

- Record length and record layout
- New/changed data items
- Multiple Primary and Histology Coding Rules
- Hematopoietic and Lymphoid Neoplasm Rules
- AJCC Cancer Staging Manual 7th Edition
- Collaborative Stage Data Collection System (CSv2)
 - CSv2 implementation guidelines being developed



**Implementation will be messy...
Pleeeeee be patient!**



Preparing for the Change

- Hospital registries
 - Finish your 2009 cases!
 - Keep in contact with your state registry, software vendor, and the CoC
 - Identify reporting requirements from CoC and from your state central registry
 - Review the new data items and discuss them with your cancer committee (especially CS V2)
 - Prepare for data item conversion
 - Be aware of educational opportunities



Preparing for the Changes

- Central registries
 - Create an implementation plan
 - Be aware of your standard setters reporting requirements
 - Notify your data submitters of your reporting requirements
 - Be aware of and plan for challenges due to increase in size of data exchange record
 - Make plans for revising your software
 - Make plans for educating data submitters



Change is Good!

- The new changes will...
 - Increase the value of the data
 - Allow for more interoperability
 - Accommodate future changes



Record Length and Record Layout

- NAACCR data exchange record layout
 - Expanded from character length of 6,694 to 22,824
 - Accommodates the many new data items, changes to existing variable lengths, expansion of text items and consideration for interoperability



New Data Items



Status and Date Flag Fields

- Non-date values no longer valid (codes 00000000, 88888888 and 99999999) into new status fields and date field flags
 - Code 10
 - No information whatsoever can be inferred from this exceptional value.
 - Code 12
 - A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., birth date).



Date Flag Fields

- Examples
 - Date of Diagnosis = 20100203; then, Date of Diagnosis Flag = blank
 - Date of Diagnosis = unknown (field will be blank); then, Date of Diagnosis Flag = 12 (proper value is applicable but not known)



Status and Date Flag Fields

- Inpatient status
 - Codes
 - 0 Patient was never an inpatient
 - 1 Patient was inpatient
 - 9 Unknown if patient was an inpatient (only used for consolidated cases)



RX Hosp--Surg App 2010

- Describes the surgical approach used for the most definitive surgery performed at the reporting facility among robotic, laparoscopic, and open approaches
- Monitors patterns and trends in adoption & utilization of minimally invasive surgical techniques



RX Hosp--Surg App 2010

- Codes
 - 0 No surgical procedure of primary site at this facility; diagnosed at autopsy
 - 1 Robotic assisted
 - 2 Robotic converted to open
 - 3 Laparoscopic
 - 4 Laparoscopic converted to open
 - 5 Open; approach, NOS
 - 9 Patient record does not state whether a surgical procedure of the primary site was performed and no information is available; death certificate only



Rx Summ--Treatment Status

- Provides a mechanism for recording active surveillance (watchful waiting) as a form of treatment
- Specifies whether or not the patient received any treatment
- Eliminates searching each treatment modality to determine whether treatment was given



Rx Summ--Treatment Status

- Codes
 - 0 No treatment given
 - 1 Treatment given
 - 2 Active surveillance (watchful waiting)
 - 9 Unknown if treatment was given



Treatment Dates

- Dates for the individual types of systemic therapy (chemo, hormone, and BRM) are once again required by the CoC
- Not a “new” data item
- If central registry decides to collect these dates they will need to revise software to begin collecting these date items again




Pathology Reporting

- Pathology reporting data items
 - Describe the origin of the pathology report contributing to the cancer report
 - 30 new pathology reporting data items




Changed Data Items




Expanded Text Fields

- Name fields
 - Expanded to 40 characters
- City and street address fields
 - Expanded to 50 for City and 60 for Street
- Occupation and industry fields
 - Expanded to 100 characters



Expanded Text Fields

- Primary site and histology text fields
 - Expanded to 100 characters
- Text fields
 - Expanded to **1000** characters!



Text Fields

- Text--Dx Proc--Lab Test
- Text--Dx Proc--OP
- Text--Dx Proc--Path
- Text--Dx Proc--PE
- Text--Dx Proc--Scope(s)
- Text--Dx Proc--X-ray/Scan
- Text--Remarks
- Text--Staging
- Rx Text--Surgery
- Rx Text--Radiation (Beam)
- Rx Text--Radiation (Other)
- Rx Text--Chemo
- Rx Text--Hormone
- Rx Text--BRM
- Rx Text--Other



Laterality

- Code 5 was added to this variable
- Use Code 5 for a midline tumor in a paired site
- Use code 9 only when the laterality is truly unknown



Laterality

- Revised and new codes
 - 4 Bilateral involvement *at time of diagnosis*, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastoma's; bilateral Wilm's tumors
 - 5 Paired site: midline tumor



Race

- Retired code 09 (Asian Indian, Pakistani)
- Replaced code 09 with codes 15-17
 - 15 Asian Indian or Pakistani, NOS
 - 16 Asian Indian
 - 17 Pakistani
- See the current *SEER Program Coding and Staging Manual* for coding instructions and race code history



Class of Case-Analytic

- 00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
- 10 Initial diagnosis AND part or all of first course treatment or a decision not to treat done at the reporting facility, NOS
- 11 Initial diagnosis by staff physician AND part of first course treatment was done at the reporting facility



Class of Case-Analytic

- 12 Initial diagnosis by staff physician AND all first course treatment or a decision not to treat was done at the reporting facility
- 13 Initial diagnosis AND part of first course treatment was done at the reporting facility
- 14 Initial diagnosis AND all first course treatment or a decision not to treat was done at the reporting facility



Class of Case-Analytic

- 20 Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
- 21 Initial diagnosis elsewhere AND part of treatment was done at the reporting facility
- 22 Initial diagnosis elsewhere AND all treatment was done at the reporting facility



Class of Case-Non Analytic

Patient appears in person at reporting facility

- 30 Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, staging workup after initial diagnosis elsewhere)
- 31 Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care



Class of Case-Non Analytic

Patient Appears in person at reporting facility

- 32 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence
- 33 Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only



Class of Case-Non Analytic

Patient Appears in person at reporting facility

- 34 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis AND part or all of first course treatment by reporting facility
- 35 Case diagnosed before program's Reference Date, having initial diagnosis AND part or all of first course treatment by reporting facility



Class of Case-Non Analytic

Patient appears in person at reporting facility

- 36 Type of case not required by CoC to be accessioned (for example, a benign colon tumor) having initial diagnosis elsewhere AND all or part of first course treatment by reporting facility



Class of Case-Non Analytic

Patient appears in person at reporting facility

- 37 Case diagnosed before program's Reference Date, having initial diagnosis elsewhere AND all or part of first course treatment by facility
- 38 Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death



Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 40 Diagnosis AND all first course treatment given at the same staff physician's office
- 41 Diagnosis and all first course treatment given in two or more different staff physician offices



Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 42 Non-staff physician or non-CoC approved clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)



Class of Case-Non Analytic

*Patient does **not** appear in person at reporting facility*

- 43 Pathology or other lab specimens only
- 49 Death certificate only
- 99 Case not required by CoC to be abstracted of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases)



Class of Case Conversion Table

Diagnosis Year ≤ 2009	Diagnosis Year 2010 +
0	00
1	10
2	20
3	32
4	37
5	38
6	40
7	43
8	49
9	99



Rad--No of Treatment Vol

- Records total number of radiation treatment session administered during 1st course treatment
- Expanded from 2 to 3 digits




Data Item Name Changes

Item #	Old Name	New Name
240	Birth Date	Date of Birth
2840	CS Reg Node Eval	CS Lymph Node Eval
2935	CS Version 1 st	CS Version Input Original
2936	CS Version Latest	CS Version Derived
2980	Derived AJCC M	Derived AJCC-6 M
2990	Derived AJCC M Descript	Derived AJCC-6 M Descript
2960	Derived AJCC N	Derived AJCC-6 N
2970	Derived AJCC N Descript	Derived AJCC-6 N Descript
3000	Derived AJCC Stage Grp	Derived AJCC-6 Stage Grp
2940	Derived AJCC T	Derived AJCC-6 T
2950	Derived AJCC T Descriptor	Derived AJCC-6 T Descript
193	Race--NAPIA	Race--NAPIA (derived API)




Retired Data Items




**Data Items Deleted from Version
12 Transmission Layout**

- Religion [260]
- Tobacco History [340]
- Alcohol History [350]
- Family History of Cancer [360]
- Screening Date [510]
- Screening Result [520]
- Date of 1st Positive BX [1080]
- Site of Distant Met 1 [1090]
- Site of Distant Met 2 [1100]
- Site of Distant Met 3 [1110]
- Recurrence Distant Site 1 [1871]
- Recurrence Distant Site 2 [1872]
- Recurrence Distant Site 3 [1873]
- Over-ride SS/DisMet1 [1984]



**Multiple Primary and Histology
Rules**



Multiple Primary and Histology Rules

- 2010 updates to Multiple Primary and Histology (MP/H) Coding Rules
 - Primarily clarifications and corrections
- Substantive changes to solid tumor MP/H rules
 - Deferred until 2011



Hematopoietic and Lymphoid Neoplasm Rules



Implementation

- New hematopoietic and lymphoid neoplasm rules
 - Effect cases diagnosed on or after January 1, 2010
 - Are based on *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissue, 2008* (WHO 2008)



Implementation

- Code cases diagnosed before 2010 using rules effective at the time of diagnosis
- Central registries
 - May need to update reportability statutes to include the newly reportable conditions



What's New and Different?

- Newly reportable conditions
 - New ICD-O histology terms and codes from WHO 2008
 - Changes to existing codes from non-reportable /1 to reportable /3
 - 3 codes/histologies
 - Transformations collected as new primary




2008 WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues

Newly Reportable Terms and Codes Numerical Order	ICD-O Code
Primary cutaneous follicle centre lymphoma	9597/3
T-cell/histiocyte rich large B-cell lymphoma	9688/3
Intravascular large B-cell lymphoma	9712/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood	9724/3




What's New and Different?

- *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB)*
 - Replace February 2001 “Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases” table for cases diagnosed January 1, 2010, and later
 - Replace casefinding and reportable neoplasm lists (ICD-9-CM & ICD-10)




What's New and Different?

- Hematopoietic and Lymphoid Neoplasm Rules
 - Include case reportability instructions with guidance on descriptive phrases and newly reportable conditions
 - Reinforce the instructions to abstract the acute and chronic phases of the same disease as separate primaries



What's New and Different?

- Hematopoietic and Lymphoid Neoplasm Rules
 - Guide the registrar in coding the correct primary site and the most appropriate and most specific histology rather than the histology as coded at diagnosis
 - Include grade coding rules that guide the registrar to code the cell line origins including the specific type when both null cell and a specific type such as T-cell are stated in the diagnosis



Conversion Considerations

- Consider that incidence counts for 2001-2009 will be different from other years because disease transformations were not collected
- Compare incidence over time by regrouping cases diagnosed prior to 2001 and diagnosed 2010 and later using the 2001 "Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" table



Education and Training

- Series of recorded webinars available on SEER website in Fall 2009



AJCC Cancer Staging Manual 7th Edition



AJCC Staging Manual

- *AJCC Cancer Staging Manual*
 - Edge, S.B.; Byrd, D.R.; Compton, C.C.; Fritz, A.G.; Greene, F.L.; Trotti, A. (Eds.)
7th ed., 2010, Approx. 655 p. 130 illus. With CD-ROM., Softcover
ISBN: 978-0-387-88440-0
- Available in October 2009
 - Order at www.cancerstaging.net, through Amazon, or Barnes and Noble



Chapter 1

- Clinical and pathologic stages are plainly delineated
- Correct uses of “mixed stage” are identified and explained
- MX has been removed entirely
 - If no distant metastases have been identified either clinically or pathologically, cM0 is assigned



Histologies

- Clear specification of stageable histologies for each chapter



Prognostic Indicators

- A number of “non-anatomic” prognostic indicators have been introduced



Staging Forms

- Revised to encourage recording of both clinical and pathologic T, N, M, and stage group, as well as prognostic indicators
- Working with College of American Pathologists (CAP) to update CAP checklists consistent with AJCC specifications



Expanded Fields

- AJCC Staging items expanded to 4 characters
 - TNM Clin T
 - TNM Clin N
 - TNM Clin M
 - TNM Clin Stage Group
 - TNM Path T
 - TNM Path N
 - TNM Path M
 - TNM Path Stage Group



New Chapters

- Gastrointestinal stromal tumors (GIST)
- Neuroendocrine tumors
- Merkel cell carcinoma
 - Previously coded with non-melanoma skin cancers
- Esophagogastric chapter
- Three separate chapters for perihilar, distal, and intrahepatic bile ducts



Questions?



Collaborative Stage Data Collection System (CS)

CS V2



CS V2 Conversion

- Once CSv2 is installed, it will be the only CS version used for all cases diagnosis year 2004 and forward, regardless of diagnosis year
- Existing CS data will need to be converted using the NAACCR 12 format
- Standard setters will not be releasing instructions for conversion until general instructions are released by the CS work group



Edits



EDITS

- Edits for new and modified Volume II Version 12 data items
 - Consistent with standard setters reporting requirements
 - Not yet available



EDITS

- CDC EDITS software tools
 - Available in fall 2009
 - Include Edit Engine 4.0, EditWriter 4.0, and GenEDITS Plus



Training

- Webinars
- Local workshops
- Annual meetings
- Self study!



Questions?



**Thank you for participating in
today's webinar!**

- The next webinar is scheduled for 11/5/09
Collecting Cancer Data: Colon/Rectum/Appendix
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