"The purpose of the registry shall be to provide information to design, target, monitor, facilitate, and evaluate efforts to determine the causes or sources of cancer among the residents of Oregon and to reduce the burden of cancer and benign brain tumors in Oregon."

OSCaR Update

State of Oregon

Volume 9, Quarter 4

Fall 2008

Manager's Update
Donald Shipley, MS

Getting a NAACCR Gold Certificate

It seems we just complete the Fall Workshop each year in time to dive head-long into preparation for the NAACCR annual call for data. The quality assurance team has been working tirelessly to prepare this year's submission. They checked high and low to scrape together every last 2006 case to get the numbers as high as possible so we can meet or surpass the 95% completeness goal.

When all the available cases have been completed and added to the final database, it is then time to struggle through death clearance. In this process, the cancer case database is linked with the Oregon death certificate file. Of course we want to update as many records as possible with death information, but the main objective is to identify any cancer cases that have not been reported. Once identified, hundreds of letters are sent in an all out effort to get complete information on these newly identified cancer cases. After all, we have to keep the death certificate only (DCO) cases under the 3% limit.

The file, which consists of over 207,000 cases, is run through the prescribed electronic edits. After starting with thousands of edits on the first run, today's run showed only 4 errors remaining (Claudia is breathing a sigh of relief)! Now its time to consider the inter-record edits to make sure information is consistent among multiple primary cases.

For us, the race field is always a challenge. NAACCR allows a maximum of 3% missing race, and we are currently somewhere much closer to five percent. How many sources can we check to get the missing rate down?

Many combinations of cases are also checked to identify possible duplicates. It takes a lot of work and a lot of time to check all those "possible dupes" and clear up the real duplicates. Just to make sure the job is complete, Claudia will print a listing of 4,500 cases to examine manually, just in case any duplicate cases have been missed. Oh, and then, she'll go through this same process again with a different set of 4,500 cases.

This should give you a very good idea of why we sit down to Thanksgiving dinner being very thankful that the call for data submission has been completed!

Happy Holidays to you all!

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Claudia's QA/Training Corner

Claudia Feight, RHIT, CTR

Greetings Registrars. I hope the recent Fall Workshop was beneficial and helpful to all who attended. Thank you for your politeness and tolerance for such a complicated subject as determining multiple primaries and histology of Malignant and Benign CNS Tumors.

We have some information that we would like to share with you. As you recall, OSCaR is funded by the Centers for Disease Control and Prevention (CDC), National Program of Cancer Registries (NPCR). Every five years, all NPCR-funded states are required to participate in an audit of compliance with NPCR standards on data quality and completeness. OSCaR was recently notified of our impending five-year audit. They have scheduled the audit for June 22 - July 3, 2009. Some of you may remember that you participated in our last audit five years ago when NPCR representatives came to your hospital. Before you panic though, please keep in mind that even though they will be coming to your hospital site, *OSCaR* is being audited not the hospitals.

On behalf of NPCR, Macro International, Inc. will perform the OSCaR audit. The Data Completeness and Quality Audit will evaluate the completeness of case reporting and data quality, including correctness and completeness of coding, for all reportable neoplasms for the 2006 reporting year. This will be accomplished by assessing the completeness and data quality in the central cancer registry, with an emphasis on the existence of appropriate policies and procedures for case ascertainment, data collection, and data quality assessment. This audit will be more inclusive than the previous five-year audit, with treatment data and the primary sites expanded to more than the five most common sites. Nine hospitals will be chosen through a random sampling process conducted by Macro International, Inc. using a master extract file provided to them by OSCaR. OSCaR will be notified of the chosen hospitals toward the end of April, 2009. We will then notify the chosen hospitals, and assist each hospital in preparation for the necessary reports and documents that will be required. There will be a reconciliation phase, with the final report sent back to OSCaR in November 2009. It is a very structured process, but Macro International, Inc. has indicated they want to cause the least amount of disruption to daily hospital routines during the audit process. The registrars that will be performing the audit are very knowledgeable and caring, and we look forward to their visit.

On another note, we are also working hard to prepare cancer data for submission for Tier 1 of the Coordinated Call for Data. This Coordinated Call for Data combines the NAACCR Call for Data for registry certification (1996-2006 cases) with the Tier 2, which is the NPCR Cancer Surveillance System Data Call (1996-2007 cases). This process is a change for us. The OSCaR CTR team has been working hard to complete path lab, physician office, death clearance, and mail-in cases in addition to visual review and editing. We always experience challenges in our attempts to obtain as many cases as possible from all hospitals to meet our case completeness guidelines. It is all possible though, due to the diligence of hospital registrars. You help make it all happen for OSCaR!

Have a great holiday season and stay safe!

Oregon Cancer Reporting Completeness

Diagnosis Year	Hospital cases	MD office cases	Path only cases	Death Cert only cases	Total Cases	% Complete
2006	19,798	2,041	92	577	22,508	100%
2007	15,895	770	104	pending	16,769	75.1%
2008	1,335	0	0	pending	1,335	6.0%

Note: These numbers reflect cases that have already gone through the QA review process and have been merged into our main database.

CTR News

Deborah Towell, CTR; Nancy Henderson, CTR; LeeLa Coleman, CTR;
Becky Gould, CTR; Joan Pliska, CTR

Kidney Multiple Primary Rules - C649 - Text

(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple tumors**, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

***Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note*:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for single tumors.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 **Wilms tumors** are a single primary. *

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are **different** at the second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries **

Rule M5 Tumors in **both** the **right kidney and** in the **left kidney** are multiple primaries. **
Note: Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.

Rule M6 Tumors diagnosed more than **three (3) years apart** are multiple primaries. **

Rule M7 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

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Rule M8 **One** tumor with a specific **renal** cell **type and** another tumor with a **different** specific renal cell **type** are multiple primaries (Table 1). **

Rule M9 Abstract as a single primary * when one tumor is
- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** the other is a **specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or**
- **Renal cell carcinoma, NOS** (8312) and the other is a **single renal cell type** (Table 1)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (**x**xxx), second (x**x**xx) or third (xx**x**x) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Kidney Histology Coding Rules – C649 - Text

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology**

SINGLE TUMOR

specimen or the pathology/cytology report is not available.
Note 1: Priority for using documents to code the histology
- Documentation medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H3 Code the **histology** when only one histologic type is identified.

Rule H4 Code the **invasive** histologic type when there are invasive and in situ components.

Rule H5 Code the **specific type** when the diagnosis is
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.
Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

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Continued from page 4

Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H6 Code 8255 (adenocarcinoma with mixed subtypes) when there are **two or more specific** renal cell carcinoma types.
Note: Use Table 1 to identify specific renal cell types.
Example: Renal cell carcinoma, papillary and clear cell types. Assign code 8255.

Rule H7 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H9 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.

Rule H11 Code the histology of the **most invasive** tumor.
Note 1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).
Note 2: See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.
- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
- If both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H12 Code the **specific type** when the diagnosis is
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.
Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H13 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Kidney Coding Tips

- *Transitional cell carcinoma rarely arises in the kidney parenchyma* (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C659). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.
- Rules are in hierarchical order. Use the first rule that applies and stop.
- Renal cell carcinoma, NOS (8312) is a non-specific term. If indicated, code the more specific histology even if it is a lower code.
- Do not confuse the histologies chromophil (8260) and chromophobe (8317). They are different histologies.
- The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
- The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. Do not use architecture, pattern, or variant to code invasive histology.

I&R #28151

Question:

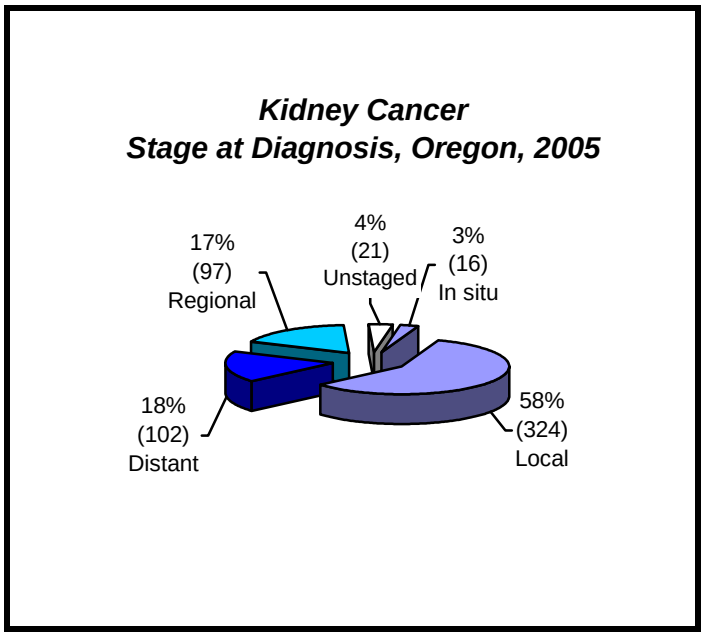
A path said lt kidney, nephrectomy renal cell carcinoma, clear cell type with sarcomatoid change. Is it coded 8310 clear cell or 8255?

In reply:

Follow Rule H6 to document both the clear cell and the sarcomatoid elements of the tumor and code 8255.
Curator

Analyst's Angle

Cathy Riddell; Joan Pliska, CTR; Alyssa Elting McGuire



In 2005, 560 cancers of the kidney were diagnosed among Oregonians and reported to Oregon's central registry. Median age at diagnosis was 65. During the same time period, 142 Oregonians died due to cancer of the kidney. Median age at death was 70. More than three in five (61 percent) were diagnosed at the local or in situ stage.