Texas Cancer Reporting News

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Texas Cancer Registry
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In this Issue

Want to stay on top of TCR's most recent publications?

Our publications page features a list of our latest publications, data use, and a link to our cancer statistics.

TCR Updates

Calls for Data Announcement

By Allison Vasquez, BS, CTR

Last fall, TCR completed the annual calls for cancer data. We submitted 3,025,430 Texas resident cancer cases diagnosed from 1995-2022 to the three national standard-setters: the National Cancer Institute Surveillance, Epidemiology, and End Results Program (NCI-SEER); the Centers for Disease Control and Prevention National Program of Cancer Registries (CDC-NPCR); and the North American Association of Central Cancer Registries (NAACCR).

The NCI-SEER submission data quality goal for Death Certificate Only (DCO) cases is very low: fewer than 1.5% of all cases. For the first time, TCR's DCO percentage (for 2021 diagnoses) fell under this target goal, at 1.47%!

The standard setters will release results from the data submissions later in 2024. TCR will then share this information in our subsequent newsletter.

TCR thanks you for your contributions to cancer prevention and control, to the lives of cancer patients and their families, and to the health of Texans.

Timely Reporting Calendars for 2023 and 2024

There have been no modifications to the 2023 or 2024 reporting calendars. Both the 2023 and 2024 reporting calendars follow TCR's standard policy of reporting cases within six months.

Timely Reporting Calendar 2023

Timely Reporting Calendar 2024

We acknowledge the Centers for Disease Control and Prevention for its financial support under Cooperative Agreement #1NU58DP007140. We acknowledge the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program for its financial support under Contract #75N91021D00011. TCR acknowledges support from the Cancer Prevention and Research Institute of Texas. This publication is solely the responsibility of the authors and does not necessarily represent the official views of the CDC, SEER, CPRIT, or U.S. Department of Health and Human Services.

Training Corner

SEER Summary Stage: Delving Into the Unknown

By Elizabeth Harvey, BS, CTR

Summary Stage 2018 is the staging system used by NPCR and NCI-SEER. This staging system aids in analyzing the burden of cancer on health services, evaluating the outcomes of screening programs, and providing an understanding of the differences in cancer outcomes and survival.

As an NCI-SEER- and NPCR-funded registry, TCR is required to collect *Summary Stage 2018* for cancer cases diagnosed in 2018 and forward.

In 2022 TCR received 6319 analytic cases where Summary Stage was coded to 9 for unknown. Of these, 3,672 cases were not C809, unknown primary site. Using the text documentation in the abstracts, our Quality Assurance Team recoded the analytic cases from unknown to a local, regional, or distant stage.

Examples of some analytic cases coded to unknown that were resolved using text include:

- Transverse resection, colon: invasive adenocarcinoma, md, pT2, 0/12 LN, invades into muscularis propria, margins neg. Resolution: Coded to 2, regional.
- TURBT: high-grade endophytic urothelial carcinoma, no invasive tumor identified, muscularis propria not identified. Resolution: Coded to 0, non-invasive.
- Lt breast lumpectomy: 2.2cm IDC, neg margins, 0/3 SLN. CT chest: neg. NM Bone scan: neg. Resolution: Coded to 1, local.

Pathological, operative, and clinical assessments form the basis for Summary Stage, collected for every site and/or histology combination. All the available information in the medical record takes precedence when determining the extent of disease for the patient and documenting it in the text fields.

Below are some helpful tips on coding Summary Stage:

- Always consult the Summary Stage manual and do not rely on the drop-down features of your software.
- If there is no information on the extent of tumor spread:
  - If it is known that there is regional lymph node involvement, assign code 3.
  - If it is known that there is metastatic spread, assign code 7.
- Negative regional lymph nodes can be determined if:
  - Workup is done (imaging, physical exam) and there is no mention of nodal involvement or there is a statement such as, “remainder of exam is negative.”
  - The tumor is local and standard treatment for local disease is administered.
- If there is no information on regional lymph node involvement:
  - Code based on the primary tumor or distant mets. Summary Stage algorithm treats unknown lymph node status as NONE.
- If *Regional Nodes Positive* data item equals 01-90, 95, or 97, this indicates that regional lymph nodes are involved. Summary Stage should be 3, 4, or 7, not 0, 1, 2 or 9.
- T, N, or M information may be used to assign Summary Stage when it is the only information available. Ensure to keep in mind the differences between the TNM and Summary Stage Staging systems.
- When coding EOD data items, you can use the SEER*RSA tables to help determine Summary Stage.

Summary Stage 2018 coding exercises are available for free in SEER*Educate, *Extent of Disease EOD 2018 General Instructions, SEER*RSA*, and *NCCN Clinical Practice Guidelines in Oncology*.

Please feel free to reach out to the TCR Training Team with any questions. We appreciate our Texas reporters and their continued efforts toward cancer reporting in Texas!

Have questions about TCR education and training opportunities?

Email us at TCR.training@dshs.texas.gov

Epidemiology Corner

A Continued Analysis: COVID-19's Lingering Impact on Cancer Data

By Adrianne Moreno, MPH

The COVID-19 pandemic left far-reaching impacts on health care services and the central cancer registry community. In our fall 2023 edition of this newsletter, we shared findings from analyses of 2020 incidence data in Texas. Overall, cancer incidence rates declined at the onset of the pandemic, followed by a recovery. However, rates did not return to pre-pandemic levels. We explained how these findings impacted the annual cancer statistics published by TCR. This edition's Epidemiology Corner provides an update on our ongoing evaluation of the impacts of COVID-19 on cancer incidence data.

Preliminary analyses of 2021 cancer incidence data show that cancer incidence rates increased in 2021 compared to 2020, without a rebound effect. This suggests missed cancer diagnoses because of the COVID-19 pandemic. To better understand these findings and trends, we compiled a table illustrating the 2019, 2020, and 2021 incidence rates per major cancer site (Table 1).

Overall, cancers persisted at lower-than-expected incidence rates in 2021 compared to pre-pandemic levels (2019 chosen as a baseline 'pre-pandemic' year). Almost all cancer sites shown in Table 1 still had statistically significantly lower incidence rates in 2021 compared with 2019. However, some cancer incidence rates, such as those for screening amenable cancers (breast, prostate, colon, and rectum) and melanoma experienced a statistically significant increase from 2020 to 2021. This indicates a possible recovery trend. Conversely, lung and bronchus, kidney and renal pelvis, and non-Hodgkin lymphoma cancer incidence rates remained as similarly low in 2021 as they did in 2020. Incidence rates at other sites remained unaffected, similar to trends noted in 2020. Examples include urinary bladder and pancreatic cancers, for which incidence rates in 2020 and 2021 were comparable to pre-pandemic levels (Table 1).

Table 1. Percent Change in Age-Standardized Incidence Rates from 2019 to 2021 by Cancer Site, Using the November 2023 Data Submission.

Rates are per 100,000 and age-adjusted to the 2000 US Std Population (19 age groups - Census P25-1130) standard.

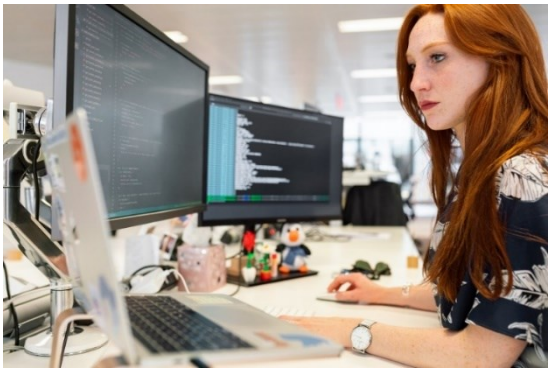
* Indicates the change in incidence rates between comparison years is significantly different ($p<0.05$).

SEER*Stat estimates of ratio = [rate (2020)/rate (2019)] are used. Percent change (PC) is calculated as (ratio − 1) × 100. See site recode definition for details on cancer site definitions.

Cancer Site	2019 Incidence Rates	2020 Incidence Rates	2021 Incidence Rates	Percent Change 2019-2020	Percent Change 2019-2021	Percent Change 2020-2021
All Sites	438.7	400.7	419.5	-8.66%*	-4.38%*	4.69%*
Breast (female)	127.9	114.1	124.3	-10.81%*	-2.77%*	9.01%*
Prostate (male)	114.7	97.5	105.8	-15.00%*	-7.83%*	8.43%*
Lung & Bronchus	47.5	42.4	42.0	-10.61%*	-11.53%*	-1.03%
Colon & Rectum	39.0	34.4	37.9	-11.77%*	-2.89%*	10.06%*
Kidney & Renal Pelvis	21.3	20.0	20.2	-6.02%*	-5.21%*	0.87%
Non-Hodgkin Lymphoma	18.1	16.8	16.9	-6.77%*	-6.30%*	0.50%
Melanoma of the Skin	16.6	13.7	15.7	-17.25%*	-5.55%*	14.14%*
Urinary Bladder	15.3	14.8	15.2	-3.50%	-0.95%	2.64%
Pancreas	13.5	13.1	13.4	-2.99%	-0.78%	2.28%
Thyroid*	12.3	10.6	11.0	-14.22%*	-10.93%*	3.84%

Data Source: Texas Cancer Registry (www.dshs.texas.gov/tcr) SEER*Stat Database, 1995-2021 Incidence, Texas Statewide 2023 Submission, cutoff 10/09/2023. Texas Department of State Health Services, Cancer Epidemiology and Surveillance Branch, created March 2024.

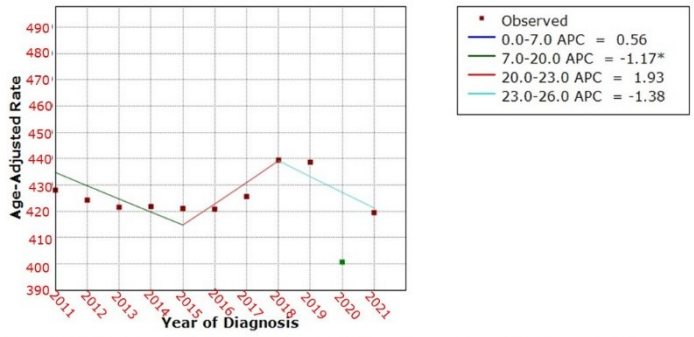
Prepared by Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, April 2024.



TCR's methods for analyzing cancer incidence data for 2020 and 2021 are aligned with SEER recommendations. After carefully evaluating the data, TCR plans to include 2021 incidence rates in trend analyses this year. For trend analyses, TCR uses SEER's Joinpoint Regression Program, which is a statistical software designed to analyze trends using joinpoint models. These models identify the best-fitting lines through multiple years of data. Each joinpoint, or inflection point, denotes a statistically significant change in trend. The figures below show the results from TCR's trend analysis of incidence rates for all cancer sites combined, as well as pancreatic cancer and female breast cancer, from 2010 through 2021. In these analyses, any significant differences in incidence rates between 2021 and pre-pandemic periods should not significantly impact the joinpoint model's results or the identification of joinpoints. We will continue excluding 2020 incidence data from these trend analyses. However, 2020 data will be included in survival statistics because the data provide valuable information on the cohort of patients diagnosed during that time. It is important to note that the most recent year of complete data has been intentionally excluded in survival statistics due to lacking a complete year of follow-up. As of April 2024, this would be diagnosis year 2021. By adhering to these guidelines, we aim to provide reliable and meaningful insights into cancer trends during this unique period.

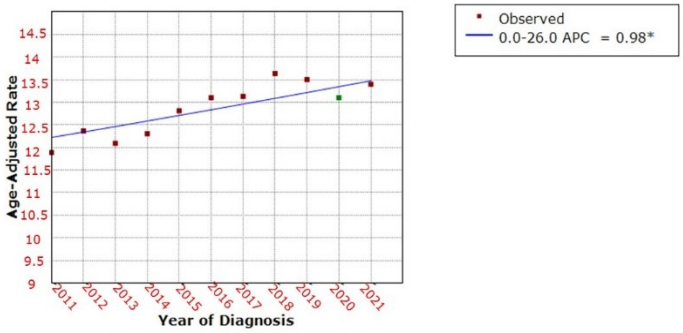
Our updated analysis reinforces the idea that COVID-19 caused a lasting impact on cancer incidence rates, albeit with varying effects across different cancer types. While incidence rates for some cancers seem to be recovering, others remain much lower than expected. It is crucial that we adapt our strategies to address potential delays or disruptions in cancer diagnosis and reporting during public health crises like the COVID-19 pandemic. As always, TCR remains dedicated to monitoring the lingering effects of the COVID-19 pandemic on Texas cancer data and adjusting our data products accordingly.

Figure 1. Percent in Age-Standardized Incidence Rates Changed from 2011-2021 for All Cancer Sites



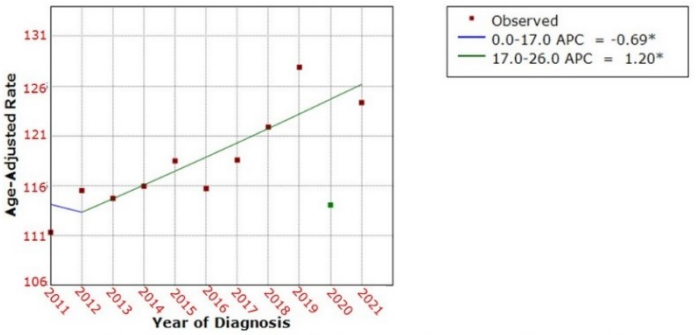
* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
# Observed Y Value 25 was excluded from the model fitting.
Final Selected Model: 3 Joinpoints.

Figure 2. Percent Changed from 2011-2021 for Pancreatic Cancer



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
# Observed Y Value 25 was excluded from the model fitting.
Final Selected Model: 0 Joinpoints.

Figure 3. Percent Changed from 2011-2021 for Breast Cancer



* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level.
# Observed Y Value 25 was excluded from the model fitting.
Final Selected Model: 1 Joinpoint.

Coding in Practice

By Alicia Smith, ODS

The frequency of cybersecurity threats to the U.S. health care industry seems to increase monthly. In response, health systems are developing more restrictive procedures for storing patient demographic data. This mitigates the potential exposure of confidential Personal Health Information (PHI) during ransomware events.

Due to these new measures, facility reporters can't code using complete PHI data sets like in the past. Therefore, accurate central cancer registry patient set consolidation depends wholly on the facility reporter's accurate coding of the following suite of incomplete patient demographic data basics:

First Name NAACCR #2240

Example: The patient's first name listed in the Electronic Health Record (EHR) is *Mike.* The face sheet and billing forms list his first name as *Michael*.

Code First Name as: Michael
Code Alias Name as: Mike

Middle Name NAACCR #2250

Example: The patient's middle name listed in the EHR is *M*. The face sheet and billing form lists her middle name as *Maria*.

Code Middle Name as: Maria

Example: The patient's middle name listed in the EHR is *blank*. The face sheet and billing form lists her middle name as *de la Garza*.

Code Middle Name as: Blank

Rationale: TCR provides a comprehensive Hispanic Surname list to determine that *de la Garza* is a not a middle name.

Last Name NAACCR #2230

Example: The patient's last name listed in the EHR is *Lopez-Smith*. The face sheet lists *Lopez* as her last name and the billing form lists her last name as *Smith*.

Code Last Name as: Lopez-Smith

Birth Surname NAACCR #2232

Example: The patient's birth surname (or maiden name) listed in the EHR is *blank*. The face sheet birth surname is *blank,* and the billing form lists the birth surname as *de la Gomez.*

Code Birth Surname as: de la Gomez

DO NOT code Birth Surname for male patients.

Social Security Number NAACCR #2320

Example: The patient's Social Security Number (SSN) is no longer listed in the EHR demographic data. The face sheet and billing form list the SSN as *XXX-XX-1234*.

Code SSN as: 777-77-1234

DO NOT code SSN as: 999-99-1234.

Example: The patient's SSN is no longer listed in the EHR demographic data. The face sheet and billing form list the SSN as XXX-XX-XXXX.

Code SSN as: 999-99-9999

DO NOT code SSN as: 777-77-7777.

DO NOT code SSN as: The patient's Medicare ID Number.

For further demographic data item coding resources click the following links:

NCI-SEER Program & Coding Manual
TCR Reporter Updates
Appendix - Spanish/Hispanic Surnames
ACS STORE Manual

You Asked, We Answered

Q: When the pathology for a liver biopsy states, "adenocarcinoma consistent with pancreaticobiliary origin" and the physician states "intrahepatic cholangiocarcinoma," what is the correct histology code?
A: Adenocarcinomas and liver are not a possible biological combination, so the adenocarcinoma would either be a primary of the intrahepatic bile duct or metastatic from another site. Additional documentation such as scans, lab tests, or definitive clinical diagnosis determine which. In your scenario, the physician states "intrahepatic cholangiocarcinoma." Therefore, we code it as 8160/3 and C221. Without the physician statement, we would code it as 8140/3.

Please note that prior to 2022, the pathology report took priority. This answer follows the new instructions per the *Guidelines for Assigning Primary Site for Liver and Intrahepatic Bile Duct* in Table 9a of the 2024 Solid Tumor Rules.

Q: The 2022 TCR Handbook Reportable List states that we are to report Pilocytic/Juvenile astrocytomas and code the histology and behavior as 9421/3 but the ICD-O-3.2 coding table lists it as 9421/1. Would you please clarify?

A: We can find the answer to this seeming contradiction in the history of coding this particular site. Pilocytic astrocytomas were originally assigned the code 9421/3 by WHO from 1976 to 2000. This included juvenile astrocytomas, pilocytic astrocytomas, or piloid astrocytomas.

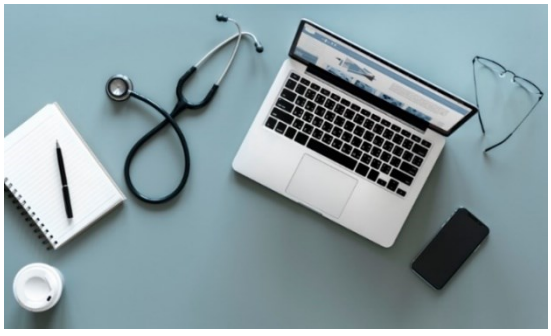
In 2001, during the conversion from ICD-O-2 to ICD-O-3, WHO changed the behavior from /3 to /1, assigning the histology code of 9421/1 and removed 9421/3 from ICD-O-3. Cancer standard setters opted to continue collecting pilocytic astrocytomas in CNS sites as 9421/3. The removal of juvenile or pilocytic astrocytomas as reportable would have dramatically affected data analysis in children and adolescents. The TCR handbook reflected the decision to continue collecting. For further background information on reporting astrocytoma as /3, click here.

In 2004, benign brain and Central Nervous System (CNS), behavior /0 and /1, became reportable. However, we continued to collect pilocytic astrocytomas in CNS sites as 9421/3 according to national guidelines.

In 2018, with updates to ICD-O-3.2 codes and the 2018 Solid Tumor Rules (STR), when the primary site is optic nerve C72.3 and the diagnosis is either optic glioma or pilocytic astrocytoma, the behavior is non-malignant and coded 9421/1. Hence, the exception to the rule allowing for two different coding options.

In 2023, the World Health Organization (WHO) added 9421/3 back to ICD-O-3.2 and assigned it to a new neoplasm of "high-grade astrocytoma with piloid features." Therefore, in cases diagnosed 2023 and forward, pilocytic astrocytoma will be coded as 9421/1. The 9421/3 code will be reserved for the new neoplasm.

This differentiation should provide more clarity on when to use which code. Furthermore, instructions regarding pilocytic astrocytomas can be found in Introduction Note 5 and Table 6 of the Non-Malignant CNS Solid Tumor Rules, and Introduction Note 6 of the Malignant CNS Solid Tumor Rules.



Educational and Training Opportunities

TCR offers various training opportunities throughout the year to assist Texas reporters with the changes of ever-evolving cancer reporting.

2024 Statewide Training

TCR is excited to sponsor the 2024 Statewide Training with Denise Harrison April 15, 2024 – May 28, 2024, for Texas reporters. Each webinar will last three hours and provides applicable CEs.

2023-2024 NAACCR Webinar Series

TCR sponsors the 2023-2024 NAACCR Webinar Series free for Texas reporters. NAACCR will present a webinar the beginning of each month from October 2023 through September 2024 covering different topics. Each webinar lasts three hours and provides applicable CEs.

NAACCR CTR Exam Preparation & Review Webinar Series

TCR offers a discounted price of $60 for the *NAACCR ODS Exam Preparation & Review Webinar Series* to Texas reporters planning to sit for the CTR certification exam. The eight-week webinar, offered three times a year, provides access to live presentations, recordings, quizzes, helpful study tools, and an active discussion board to share study tips and provide support. Be sure to check with the NAACCR website for the next session.

FLccSC

FlccSC is a free, web-based education platform available to cancer reporters. Through FLccSC, TCR can offer a variety of recorded webinars, handouts, and quizzes. It is a great source to increase your knowledge and sharpen your abstracting and coding skills. It is free and available 24/7 to all cancer reporters.

The following resources are available for more information on reportability:

- 2023 NCI-SEER Program Coding and Staging Manual, Appendix E- Reportable and Non-reportable Examples
- CAnswer Forum
- NCI-SEER Inquiry System

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