Texas Cancer Reporting News

August 2017
Vol. XIX, No. 2

TEXAS Health and Human Services

Texas Department of State Health Services

PUBLICATION NO. E10-10542

IN THIS ISSUE

Registry Accomplishments

by Maria Vega-Hedrick, MPA

Calls for Data Results

The Texas Cancer Registry (TCR) recently received results from the Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR) annual Calls for Data, that took place in Fall 2016 for 2014 incidence data. The data were evaluated on quality, completeness, and timeliness as demonstrated by meeting five key data quality criteria.

The TCR achieved NPCR "High Quality Data Standards" for diagnosis year 2014 and was recognized as a CDC-NPCR Registry of Distinction. For the eleventh time in its history, the TCR received NAACCR Gold Certification. Reaching this level of data quality and completeness is not possible without the efforts and dedication of Texas Cancer Reporters. The 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!

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Check out the TCR's Web Query Tool!

The TCR's Web Query Tool was recently updated to include data through diagnosis year 2014:

www.cancer-rates.info/tx/

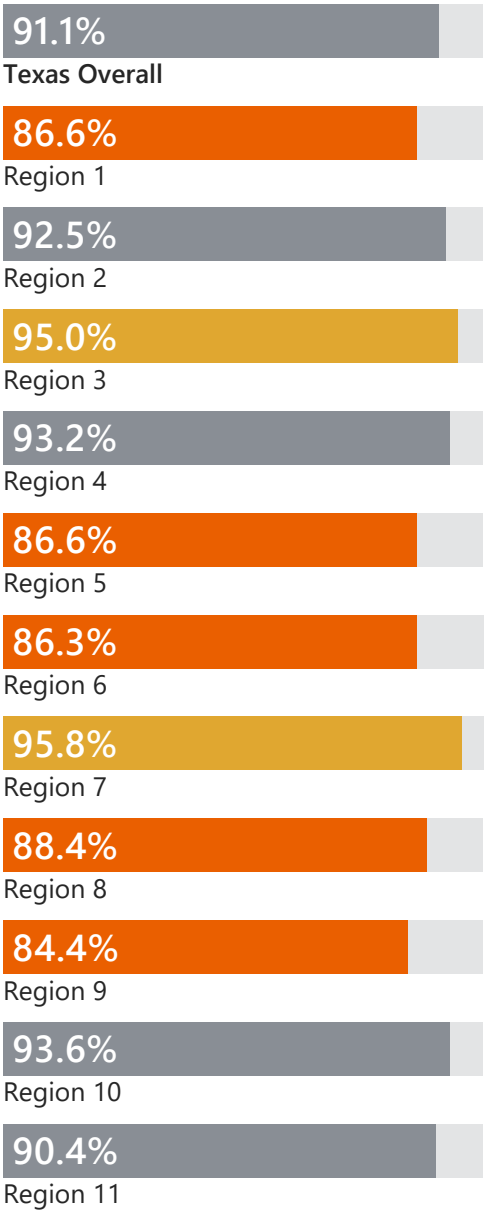
The Web Query tool allows users to generate customized maps, tables, and bar graphs of Texas cancer incidence and mortality rates by county, public health region, council of government, and metro/micro statistical areas. You can also select specific cancer sites, diagnosis years back to 1995, as well as sex and/or race/ethnicity.

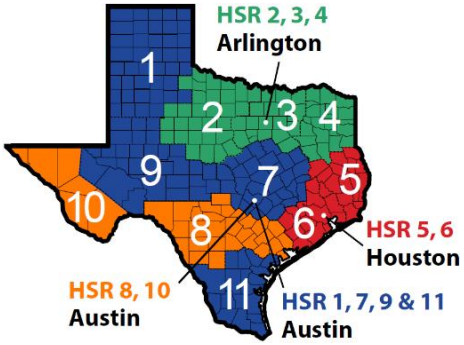
The Web Query Tool, as well as other statistical data tables and information are available on the 'Statistical Data' section of the TCR website: https://www.dshs.texas.gov/tcr/data.aspx.

COMPLETENESS BY REGION

Diagnosis Year 2015

As of August 16, 2017





FOR MORE INFORMATION:

See the TCR Completeness Dashboard: goo.gl/7bxGx1

Epidemiology Corner

by Angela Alexander, PhD, UT MD Anderson Cancer Center

Inflammatory Breast Cancer

Inflammatory breast cancer (IBC) is an aggressive but uncommon type of breast cancer in which cancer cells block lymph vessels in the skin of the breast, causing the breast to look swollen, red, and/or inflamed. Estimates from the literature suggest that IBC accounts for only 1 to 5% of all breast cancer cases in the United States. In Texas, 0.9% of all invasive breast cancer cases from 1995-2014 were classified as IBC, as defined by the International Classification of Diseases of Oncology (ICD-O-3) morphology code 8530/3 (Inflammatory Carcinoma C50.__).

Reporters: See the accompanying Coding IBC article on page 4 for information on how to code IBC.

IBC is different from other types of breast cancers in several ways; one is the unique presentation, which leads to a clinical diagnosis of IBC when a biopsy confirms invasive carcinoma along with one or more symptoms. IBC often presents as a swollen red breast, developing rapidly over a period of days to weeks. There are often nipple changes, and the skin can resemble an orange peel ("*peau d'orange*") due to tumor emboli that block breast lymphatics. Unlike traditional breast cancers that grow as a mass and gain invasive potential later in the progression of cancer outwards from the primary tumor, IBC masses are undetectable in 67% of mammograms and 22% of magnetic resonance imaging (MRI) scans. However, there are specific features that are seen particularly on MRI that support a clinical diagnosis of IBC. IBC typically spreads as small nests/clusters of cells throughout the skin of the breast (dermal emboli), and extensively invades lymphovascular vessels. Because of this skin invasion, by definition IBC is at least stage IIIB at diagnosis (T4d under the TNM system). Unfortunately, 30% of IBC patients have detectable cancer outside of the breast and regional lymph nodes at original diagnosis, due to both the highly metastatic nature of cancer as well as delayed diagnosis. Delays in diagnosis are common due to conditions such as mastitis that mimic IBC, in addition to the younger population considered not to be at high risk of breast cancer.

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Epidemiology Corner

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The median age at diagnosis for IBC (57 years) is significantly younger than other breast cancers (61.9 years), and potential IBC risk factors, including pregnancy and/or lactation and high BMI, may predispose younger women to develop this subtype of breast cancer. This disease remains a high priority for research in the United States as IBC may account for up to 10% of breast cancer deaths, owing to the intrinsic biological differences in responsiveness to therapy.

Texas leads battle to understand this rare and aggressive cancer subtype

Appropriate multidisciplinary IBC treatment, known as a tri-modal regimen, consists of neoadjuvant (pre-surgery) chemotherapy, mastectomy, and comprehensive radiation. This standard of care has been developed based on the leadership of Texas oncologists and decades of experience gained through clinical research performed in the state.

The State of Texas has supported a dedicated IBC research program and clinic based at the University of Texas MD Anderson Cancer Center. The Morgan Welch IBC Program, launched in 2006 and supported in 2007 by the $4M State of Texas Rare and Aggressive Breast Cancer Research Program grant, now sees 85-100 IBC patients per year and has the most IBC-focused clinical trials of any center in the world. In addition, MD Anderson leads the International IBC Registry, which is a central repository for IBC tissue, blood samples, and data gathered from patient surveys upon diagnosis. To date, approximately 500 patients have consented to participate in this registry, which has considerably accelerated the progress in target discovery and molecular profiling in IBC.

In February of 2017, the Morgan Welch IBC Program hosted an international conference, which brought researchers and clinicians together to discuss progress made in understanding the nature of IBC, brainstorm the path forward to translate these discoveries into measurable improvements in clinical outcomes, and define future research needs. One highlight of the conference was a presentation of work completed to characterize the immune profiles in IBC tissues, which serves as a rationale for the development of different avenues for novel immunotherapy (e.g., immune checkpoint and anti-macrophage therapy). Scientific proceedings from the conference are being prepared for publication and will be available on the MD Anderson Morgan Welch IBC Program website once accepted and in print. To learn more about IBC and the collaborative efforts in place to accelerate clinical trial development, please see https://www.mdanderson.org/research/departments-labs-institutes/programs-centers/inflammatory-breast-cancer-research-program.html.

Further Reading:

Anderson, WF et al. Epidemiology of inflammatory breast cancer (IBC). Breast Diseases 2005-2006;22:9-23.

Atkinson, RL et al. Epidemiological risk factors associated with inflammatory breast cancer subtypes. Cancer Causes & Control 2016 Mar;27(3):359-66.

Dawood, S et al. International expert panel on inflammatory breast cancer: consensus statement for standardized diagnosis and treatment. Annals of Oncology 2011 Mar;22(3):515-23.

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Coding Inflammatory Breast Cancer (IBC)

by Olivia Farley, CTR

Inflammatory breast cancer (IBC) is a rare and aggressive disease in which cancer cells block lymph vessels in the skin of the breast. It is called "inflammatory" because the breast looks swollen, red, or inflamed. Often there is no underlying mass or tumor, and most inflammatory breast cancers are invasive ductal carcinoma. The clinical description of inflammatory carcinoma is used in coding stage. It is important to document information based on the physician's physical exam, radiology and pathology reports showing spread of disease and the extent of skin involvement. Some descriptions of inflammatory breast cancer include terms such as edema, erythema, and ridges or pitting called *peau d'orange*.

With the national implementation of the Multiple Primary and Histology (MPH) Rules in 2007 the directions on coding inflammatory carcinoma were further clarified. Per rule M2 of the breast MPH rules if there is inflammatory carcinoma in one or both breasts it is considered a single primary. Per rule H13 in order to code histology 8530 (inflammatory carcinoma) it must be documented in the Final Diagnosis section of the pathology report. According to the AJCC Cancer Staging Manual 7th Edition, the term "inflammatory carcinoma" should be restricted to cases with typical skin changes involving a third or more of the skin of the breast. Please use the resources listed below to determine primary site and histology, number of primaries, and stage for IBC.

Resources: *Multiple Primary and Histology Rules 2007; Breast CS Extension on Note: 5 & 6, CS extension of 600, 710, 725, 730, or 750; AJCC Cancer Staging Manual 7th Edition, Chapter 32, page 354; SEER Summary Staging Manual 2000, page 185.*

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Texas Cancer Plan

by Alyssa Rubin

The Texas Cancer Plan (the Plan) aims to reduce the cancer burden across the state and improve the lives of Texans. As the statewide call to action for cancer research, prevention, and control, the Plan identifies the challenges and issues that affect our state and presents a set of goals, objectives, and strategies to help inform and guide communities in the fight against cancer. The intent of the Plan is to provide a coordinated, prioritized, and actionable framework that will help guide efforts to fight the human and economic burden of cancer in Texas. The Texas Cancer Plan is developed with input provided from organizations and institutions, community leaders, planners, coalition members, cancer survivors, and family and friends affected by cancer.

By state statute, the Cancer Prevention and Research Institute of Texas (CPRIT) is charged with the responsibility of facilitating the development of the Plan and supporting its implementation. However, the overall outcome and success of the Plan will depend on the cooperation, collaboration and resources of the many stakeholders that cover our great state. CPRIT's strategic direction and funding opportunities will align with the Plan but will, by necessity, be a subset of the Plan. CPRIT will publish an updated Plan in 2018.

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Training Corner

by Beatriz Gutierrez, MPH, CTR

Greetings, Texas Cancer Reporters! We hope everyone is having a great summer! The Training Group here at the TCR recently attended the 2017 National Cancer Registrars Association (NCRA) Conference in Washington D.C. and is feeling invigorated by the wealth of information received on AJCC TNM 8th edition updates along with many other great topics that were presented.

2017 Handbook Released

The TCR is pleased to announce that the *2017 Cancer Reporting Handbook* is now available to download on the following webpage: https://www.dshs.texas.gov/tcr/training/2017-handbook.aspx.

The *2017 Cancer Reporting Handbook* contains important updates pertaining to staging for cases diagnosed in 2017, coding and reporting requirements to the TCR, as well as other vital information. Additionally, the 2017 Handbook has enhanced table of contents and navigation features in the PDF document that allows users to easily navigate to different sections of the document. Please see the Handbook PDF Navigation Instructions for information on how to utilize these features.

NAACCR Webinars

The 2016 – 2017 NAACCR Webinar Series is coming to a close, with **one final webinar taking place on September 7th covering the topic Coding Pitfalls.** The 2017 – 2018 series will begin this fall, so be on the lookout for an announcement on the new NAACCR Webinar Series soon.

For a complete listing of NAACCR webinars, please visit the TCR Webinars page at www.dshs.texas.gov/tcr/training/webinars.aspx.

NAACCR CTR Exam Prep and Review Webinar Series

The TCR is making the NAACCR CTR Exam Preparation and Review Webinar Series available at no cost to active cancer reporters in Texas. The webinars series runs from August 22, 2017 through October 10, 2017, on Tuesdays at 12:00 PM – 2:00 PM (CT). The recorded sessions will be available to registrants through approximately two weeks after the CTR exam. For additional information, including registration for the webinar series, please see the CTR Prep webpage on the TCR website: www.dshs.texas.gov/tcr/training/CTR-prep.aspx.

Special Topics

Your attention to the following areas ensures high quality cancer data through your dedicated efforts.

- The 8th Edition of the AJCC staging manual was released and it was agreed by all standard setters to take effect for cases diagnosed as of January 1, 2018.
- Appropriate T, N, and M categories should be assigned based on AJCC rules for cases diagnosed on or after January 1, 2016 as defined in the AJCC 7th edition manual.
- AJCC is offering a series of free webinars to assist Registrars in the transition to directly assigning AJCC TNM stage. Please, visit AJCC 's website to register for free: https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx.
- The codes and instructions in the 2016 SEER Program Coding and Staging Manual remain in effect for 2017.
- Use the web-based SEER Hematopoietic and Lymphoid Neoplasm Database for coding all diagnosis years. You must now select a diagnosis year to be shown the correct information and the correct version of the manual.

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Training Corner

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Friendly Reminders

- Don't forget: DO NOT code CS for 2016 cases! AJCC TNM and Summary Stage 2000 should be used for all 2016 cases!
- Please DO NOT use CS tumor size to code 2016 cases! Please remember to use the "Tumor Size Summary" data field instead!
- If the patient does not meet the criteria for clinical staging (that is there is no hint of cancer prior to surgical treatment), the clinical TNM is to be left blank and group stage 99.
- If the patient has neoadjuvant therapy, the path staging is NOT a combo of clinical and path staging in that unique circumstance, there should be clinical staging already and the (y) path TNM should be based only on the pathologic resection.

Data Collection Requirements for 2017

CDC NPCR

Beginning with cases diagnosed January 1, 2017 and forward, CDC-NPCR will continue using the record layout and data collection requirements as published in NAACCR Standards Volume II, Version 16. There are no changes to CDC reporting requirements for 2017.

NCI SEER

The codes and instructions in the 2016 SEER Program Coding and Staging Manual remain in effect for 2017.

CoC

Beginning with cases diagnosed January 1, 2017 and forward, the CoC will continue using the record layout and data collection requirements as published in NAACCR Standards Volume II, Version 16. There are no changes to CoC reporting requirements for 2017.

Small updates will be released via FORDS: Revised for 2017—

1. The allowable values listed in the header for Sex [#220] were corrected to 1-6, 9 to reflect the addition of codes 5 and 6 in 2015.
2. For Mets at DX—Other [#1117] the following code has been added:

   2 Generalized metastases such as carcinomatosis.
3. Minor coding clarifications were made to Tumor Size Summary [#756].
4. Pagination was corrected for the First Course of Treatment section of the manual.
5. The coding clarification in APPENDIX B: Site-Specific Surgery Codes for SKIN was updated to state "1 cm or more."

ICD-O-3 Implementation and Reportability

For diagnosis year 2017, all standard setters have agreed to postpone these codes once again, and to use the alternate codes published in Table 2 of the NAACCR Guidelines for ICD-O-3 Update implementation (Appendix K in the 2017 Cancer Reporting Handbook). It is anticipated that these codes will be implemented in 2018 when the AJCC-TNM 8th Edition goes into effect.

Hospital registrars should look for use by their pathologists of the terms included in the **ICD-O-3 Histology Code Crosswalk** (Table 1.3 of the 2017 Handbook, page 9). Since these terms have not yet been officially adopted for cancer surveillance in North America, registrars should abstract cases using the acceptable codes listed in Table 1.3 to report them to central registries and to CoC.

For more information about ICD-O-3 new terms and codes, refer to the NAACCR Implementation Guidelines and Recommendations for 2017: https://www.dshs.texas.gov/tcr/training/resources/NAACCR-What-You-Need-to-Know-for-2017-(March-2017).pdf.

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Training Corner

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NPCR Site Specific Factors Required for Diagnosis Year 2017

Implementation of directly assigned SEER Summary Stage 2000 and AJCC-TNM Stage. The following SSF's are required and the existing SSFs in CSv2 will continue to be used to capture these data items.

SSFs Required for Directly Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Appendix	11	Histopathologic Grading
GIST Peritoneum	5, 10	Mitotic Count; Location of Primary Tumor
GIST Esophagus, GIST Small Intestine, GIST Stomach	6	Mitotic Count
GIST Appendix, GIST Colon, GIST Rectum	11	Mitotic Count
Mycosis Fungoides	1	Peripheral Blood Involvement
Placenta	1	Prognostic Scoring Index
Prostate	1, 8, 10	PSA Lab Value, Gleason Score
Testis	13, 15, 16	Post Orchiectomy AFP, hCG, and LDH Range
Bile Ducts Distal, Bile Ducts Perihilar, Cystic Duct, Esophagus GE Junction, Lacrimal Gland, Lacrimal Sac, Melanoma Ciliary Body, Melanoma Iris, Nasopharynx, Pharyngeal Tonsil, Stomach	25	*Schema Discriminator*

NOTE: NPCR will continue the requirement for Gleason Score data using SSF 8 and 10 in order to accurately determine the AJCC stage group for prostate cancer cases. This will also provide NPCR with comparable Gleason Score data to SEER and CoC for prostate cancer cases.

Site Specific Factors Required by NPCR (but not for AJCC staging)

Site (CS Schema)	SSF	Description
Brain, CNS Other, Intracranial Gland	1	WHO Grade
Breast	1	*ERA*
	2	*PRA*
	8	*HER2: IHC Value*
	9	*HER2: IHC Interpretation*
	11	*HER2: FISH Interpretation*
	13	*HER2: CISH Interpretation*
	14	*HER2: Result of other test*
	15	*HER2: Summary Result testing*
	16	*Combination of ERA, PRA, and HER2 Testing*

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Training Corner

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Recurrence Risk Stratification in GIST

GIST tumors stratification table that can help determine if the tumor is benign, borderline or malignant. (*Please note this is an updated table.*)

Group	Size (cm)	Mitotic Count (/50 HPF)	Stomach and Omentum	Jejunum/Ileum (incl esoph, mesentery, peritoneum)	Colon, Rectum
1	≤ 2	≤ 5/50 hpf	No risk of recur	None	None
2	> 2 ≤ 5	≤ 5/50 hpf	Very low	Low	Low
3a	> 5 ≤ 10	≤ 5/50 hpf	Low	Moderate	High
3b	> 10	≤ 5/50 hpf	Moderate	High	High
4	≤ 2	> 5/50 hpf	Unknown risk	Unknown risk	High
5	> 2 ≤ 5	> 5/50 hpf	Moderate	High	High
6a	> 5 ≤ 10	> 5/50 hpf	High	High	High
6b	> 10	> 5/50 hpf	High	High	High

No risk = /0 Benign Tumor
Low to moderate risk = /1 Borderline (uncertain behavior)
High = /3 Malignant

Training Requests

For training requests, please visit: www.dshs.texas.gov/tcr/Training-Request.aspx. TCR is your resource!

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New TCR Employees

by Ashley Dixon, MPH

Please join us in welcoming the following staff who recently joined the TCR.

Davica Decker joined the Core Business Operations Group Cancer Registry in June 2017 as the new administrative assistant. She has worked for the State of Texas since 2014 including positons with the Texas Department of Transportation, the Department of Aging and Disability Services, and of the Department of State Health Services (DSHS). She has also held positions with the City of Austin's Health and Human Services Department and the Austin Police Department. She most recently worked in the Environmental Epidemiology and Disease Registries Section Office here at DSHS.

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Texas Cancer Reporting News

August 2017
Vol. XIX, No. 2

Publication No. E10-10542

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TEXAS Health and Human Services

Texas Department of State Health Services

The mission of the Texas Cancer Registry is to collect, maintain, and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients.

Recognition of TCR Funding Sources

Maintaining a statewide cancer registry that meets Centers for Disease Control and Prevention (CDC) high quality data standards and North American Association of Central Cancer Registries (NAACCR) gold certification is accomplished through collaborative funding efforts.

The Texas Cancer Registry recognizes the following whose financial support is essential to accomplishing the Texas Cancer Registry mission for our State, and as the 4th largest cancer registry in the Nation.

Federal Grant Funding

We acknowledge the CDC for its financial support under Cooperative Agreement #1 NU58DP006308-01-00.

State Agency Funding

- Texas Department of State Health Services
- Texas Health and Human Services Commission
- Cancer Prevention and Research Institute of Texas

Questions regarding information found in this newsletter, or suggestions for future issues can be emailed to Ashley Dixon at ashley.dixon@dshs.texas.gov.

This publication is supported through a CDC Cooperative Agreement. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Texas Cancer Reporting News is published twice per year by the Texas Cancer Registry, Texas Department of State Health Services. For past newsletter issues, please visit: www.dshs.texas.gov/tcr/publications/newsletter.aspx.

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