NEVADA DIVISION OF PUBLIC AND BEHAVIOR HEALTH

OFFICE OF PUBLIC HEALTH INFORMATICS AND EPIDEMIOLOGY

NEVADA CENTRAL CANCER REGISTRY

NEVADA CENTRAL CANCER REGISTRY REPORTING MANUAL

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CHAPTER 1: INTRODUCTION

Mission statement

The primary purpose of the Nevada Central cancer registry (NCCR) is to collect complete, timely, and high-quality data that are available for use for cancer control and research. The multiple aspects of data collection that are specific to the population-based cancer registry require the program staff to evaluate all operational and procedural activities and then identify those activities that have the greatest impact on the timeliness, quality, and completeness of data collection.

Program statement

The goal of the NCCR is to gather comprehensive, timely, and accurate data on the incidences of cancer among Nevada residents.

Through the Office of Public Health Informatics and Epidemiology, NCCR provides statistical data for use by epidemiologists, health researchers and others in the medical and allied health professions. Information from the Registry is intended to identify cancer risk, evaluate cancer patient care, and characterize leading trends in cancer incidence, survival, and mortality among state residents.

History of the registry

The NCCR is a population-based registry that maintains data on all cancer patients within the State of Nevada. The Registry began collecting cancer incidence data in 1989. In 1995, the NCCR began receiving funding from the National Program of Cancer Registries (NPCR) through the Centers for Disease Control and Prevention (CDC).

The Registry receives data from hospitals, outpatient facilities and pathology laboratories throughout the State of Nevada. The number of reporting facilities increases each year as new reporting facilities open and the Registry develops new relationships. As a result of this and the state population growth, the number of reportable cancer cases also increase.

Services provided

The Nevada Central Cancer Registry provides the following services:

- Process cases and conducts quality control audits on cases abstracted by hospitals and out-patient facilities
- Receive and process reports from pathology laboratories
- Executes Data Exchange Agreements with other states
- Provide training to cancer registrars in the State
- Provides statistical cancer data for researchers, prevention programs, medical professionals and community partners

Contact and location information

The Nevada Central Cancer Registry is located at:

4126 Technology Way, suite 201
Carson City, NV 89706
Telephone: 775-684-3221
Fax: 775-684-5999.
Web site: http://health.nv.gov/VS_NVCancerRegistry.htm

Data Requests

Requests for research studies, reports, or information should be submitted to NCCR through http://health.nv.gov/PDFs/request_to_use_data_2013-05-14.pdf

CHAPTER 2: CONFIDENTIALITY

Cancer Reporting Laws

Public Law 102-515, the Cancer Registries Amendment Act, was enacted in 1992. Through this Congress established the National Program of Cancer Registries (NPCR) through the Centers for Disease Control and Prevention (CDC). Through this Act, the NPCR was established to fund and support the operation of population-based, statewide cancer registries in order to collect cancer data.

The Nevada Central Cancer Registry (NCCR) (also referred to as the Statewide Cancer Registry) is regulated by both Nevada Revised Statues (NRS) 457.230-457.280 and those regulations adopted by the State Board of Health. This statutemandates the reporting of cancer in the State of Nevada. The Nevada Administrative Codes (NAC) 457.045-457.150 provides authority requiring hospitals, pathology laboratories, free-standing cancer clinics, long-term care facilities, ambulatory surgery centers and physicians to report cancer cases diagnosed and treated in Nevada to the Statewide Cancer Registry.

The NCCR also operates under the Standards set by the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR).

State Registry Disclosure

According to NRS 457.065, 457.240, all documents in the possession of the registry which contain names of patients, physicians, hospitals, or medical laboratories are confidential except the list of names of hospitals which report information to the registry and the list of names of the medical laboratories which report information to the Registry.

In accordance with NRS 457.065, 457.240, the State Health Officer or person employed in the registry may provide confidential medical information in the registry concerning a patient's medical treatment for cancer with any health care facility, or the registry connected with the facility which has participated or is participating in treating that patient's illness if the person seeking the information:

1. Has been identified in the manner described in NAC 457.130;

2. Furnishes the employee of the registry with specific information, other than the patient's name, which is sufficient to identify the patient without using his/her name; and

3. Gives assurances to the employee of the registry that the confidentiality of the information will be maintained to the same extent as is required in NAC 457.010 to 457.150, inclusive

According to NRS 457.270, consent is required before the disclosure of the identity of a patient, physician, or health care facility. The Division of Public and Behavioral Health shall not reveal the identity of any patient, physician, or health care facility that is involved in the reporting required by NRS 457.250 unless the patient, physician, or health care facility gives prior written consent to such a disclosure. Information accumulated and maintained in the Nevada Central Cancer Registry shall not be divulged except as statistical information that does not identify individuals and for purposes of such research as approved by the State Board of Health. The rules and

regulations also state that all information reported to the Department of Health shall be confidential and shall not be disclosed under any circumstances except

1) To other State cancer registries with which the Department of Health has agreements that ensure confidentiality,

2) To other State health officials who are obligated to keep such information confidential, and

3) To approved cancer research centers under specific conditions in which the names and identities of the individuals are appropriately protected and when such research is conducted for the purpose of cancer prevention, control, and treatment.

HIPAA

The Nevada Central Cancer Registry is considered an exempt entity according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule 45 CFR 164.512 (a) because State law mandates cancer reporting. Therefore, HIPAA-covered entities, such as the health care providers described in section II.A of HIPAA Privacy Rule 45 CFR 164.512 (a), are permitted to disclose protected health information (PHI) to the Nevada Central Cancer Registry without patient (or their personal representative's) consent.

HIPAA Privacy Rule 45 CFR 164.5 permits covered entities to disclose PHI, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. Also, at the direction of a public health authority, covered entities may disclose PHI to a foreign government agency that is acting in collaboration with a public health authority. A covered entity that is also a public health authority may use, as well as disclose, PHI for these public health purposes.

Note: The Health Insurance Portability and Accountability Act known as HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the NCCR falls under the definition of a public health authority, HIPAA allows your facility to continue reporting cancer incidence data in compliance with state statutes NAC 457.070. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, hospitals must simply document that reporting has occurred.

CHAPTER 3: DETERMINING CASE REPORTABILITY

Basic Rules for Hospital and Laboratory State Reporting

All reportable cancer cases diagnosed and/or treated in your facility after January 1, 1995, must be abstracted and reported to the Nevada Central Cancer Registry.

Healthcare providers including, but not limited to, hospitals, ambulatory surgery centers, laboratories, radiation therapy facilities, oncology facilities and physician offices are required to report cancer cases to the NCCR. Hospitals need to abstract inpatient and outpatient cancer cases.

- Completed cases should be submitted to the NCCR within six months of the initial diagnosis for Class of Case 00 through 14 and within six months of the date of first contact for Class of Case 20 through 22.

- Classes of Case **00-22, 30, 31, 32, 34, 36, 38, and 43 must be reported** by all facilities if the case meets reporting requirements and **has not** been previously reported.

- Class of Case **34 and 36** would be used for cases of VIN III, VAIN III and AIN III which are not reportable to the CoC **but must be reported to the NCCR.**

- Cancer registries must also report Class of Case **40-42** if they collect these cases.

- New cancer programs should submit class of case **35 and 37** for cases diagnosed January 1, 1995 or later.

- DO NOT use Class of Case 99.

- Electronic reporting is highly encouraged for all facilities with an annual caseload greater than 25 cases. NCCR will provide free software (Web Plus) to facilities that have greater than 25 cases annually. If your facility meets this requirement, please contact the NCCR at 775-684-3221 to inquire about Web Plus.

- Solid tumors diagnosed on or after January 1, 2007, MUST be abstracted according to reportability and coding instructions set forth in *The Multiple Primary and Histology Coding Rules Manual* which can be downloaded from: seer.cancer.gov/tools/mphrules/download.html.

- The ICD-O-3 coding scheme must be used for site and histology of cases diagnosed on or after January 1, 2001. The ICD-O-2 coding scheme must be used for cases diagnosed prior to January 1, 2001 and may not be used for cases diagnosed on or after that date. http://seer.cancer.gov/icd-o-3/

- The Collaborative Staging Manual is to be used for cases diagnosed on or after January 1, 2001. The SEER Summary Staging Manual – 2000 is to be used for staging for cases diagnosed

between January 1, 2001 and December 31, 2001. The SEER Summary Staging Guide, 1986 reprint, is to be used for cases diagnosed prior to January 1, 2001. https://cancerstaging.org/cstage/Pages/default.aspx

- Hematopoietic malignancies are coded according to the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database* for cases diagnosed on or after January 1, 2010. http://seer.cancer.gov/tools/heme/

- All ACoS-accredited cancer facilities MUST include AJCC TNM staging data in abstract reports. To obtain the current edition of the AJCC Cancer Staging Manual or handbook, go to https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

- Inform the NCCR of ALL facility or contact personnel changes (e.g., mailing address, contact name, phone, email).

Casefinding Techniques

Reportable Cases may be identified from a variety of sources. The hospital pathology laboratory can provide cases diagnosed by histology, cytology, hematology, bone marrow, or autopsy. Other resources include daily discharges and daily coding logs, disease indices, inpatient and outpatient surgery logs, radiotherapy consults, treatment reports and logs, and oncology clinic treatment reports and logs. *Never rely solely on the pathology department to provide reportable cases.* Doing so could exclude cases for which the hospital has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radio-graphically or clinically only, without tissue confirmation would be missed during casefinding unless additional resources are employed.

It is essential to include review of the Medical Record Disease Index (usually provided by Health Information Management) and other tracking tools such as medical and radiation oncology clinic logs to ensure that all reportable cases are identified. You should form an alliance with staff from the aforementioned departments to establish and develop a systematic method to routinely receive necessary information from them.

Reportable List for Casefinding

A system should be established that would enable you to receive a copy of the disease index. A link to the SEER table listing reportable diagnoses for casefinding is posted on the SEER website at: http://www.seer.cancer.gov/tools/casefinding/index.html

Diagnoses are listed by ICD-9-CM and ICD-10-CM codes which can be used by facilities to identify which cases to include on their MRDI casefinding lists. The list is updated annually to ensure that any new applicable codes are added.

Cases That Must Be Reported

All patients first seen at the reporting facility after January 1, 1995—whether as an inpatient or outpatient or in an ambulatory care setting (including freestanding/ambulatory surgery centers and freestanding radiation therapy centers)—who meet one or more of the following criteria must be reported. If a patient has at least one primary reportable neoplasm that is active or under treatment, all other primary reportable neoplasms that the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately. Information about these previous (historical) primaries may be vague. Complete an abstract with as much information as is available in the medical record.

All cases should be reported regardless of the State/place of residence of the patient. The Nevada Central Cancer Registry has data sharing agreements with many central registries within the United States to exchange cancer incidence data. These agreements allow the registries to exchange data regarding patients diagnosed and/or treated in another State. If the registry has information on a patient diagnosed and/or treated in Nevada but is a resident of another State, the data are sent to that State if an agreement is in place.

The following diagnoses are required to be reported to the Nevada Central Cancer Registry per National Program of Cancer Registries (NPCR), even though they may not be required by the CoC and/or SEER.

General Rules for Reportable Cancers

1. All patients with an active, **malignant neoplasm** (in situ or invasive)

2. All patients with an active, **benign, or borderline brain or CNS tumor, diagnosed on or after January 1, 2004.**

3. **Adenocarcinoma** in situ of the cervix is reportable

4. Pilocytic/juvenile astrocytoma (9421) will continue to be collected as a /3 even though the behavior code changed to /1 in the ICD-O-3.

5. Gastrointestinal stromal tumors (GIST) and Thymomas are frequently non-malignant, however, they must be abstracted and assigned a behavior code 3 if they are noted to have multiple foci, metastasis, or positive lymph nodes.

6. All patients undergoing **palliative, prophylactic, or adjuvant therapy for malignancy.**

7. All patients **diagnosed at autopsy.**

8. All historical cases that meet the reportability guidelines that have not been previously reported.

Reportable Skin Cancers

Beginning with cases diagnosed on or after January 1, 2002, the following type of squamous neoplasia is reportable to the State (per NPCR requirement):

Squamous Intraepithelial Neoplasia, Grade III (8077/2)	**ICD-O-3 Site Code**
AIN III	C21.1
VIN III	C51._
VAIN III	C52._

Basal cell carcinomas and squamous cell cancers that originate in mucoepidermoid sites:

SITES	**ICD-O-3 SITE CODES**
Lip	C00.0-C00.9
Anus	C21.0
Vulva	C51.0-C51.9
Vagina	C52.9
Penis	C60.0- C60.9
Scrotum	C63.2

Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumors **must be** reported regardless of site. Any carcinoma arising in **a hemorrhoid is reportable** because hemorrhoids arise in mucosa, not in skin.

Diagnosis Prior to Birth

Reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable only when the pregnancy results in a live birth. If you have no indication in the record of still birth, abortion or fetal death, assume that there was a live birth. When a reportable condition is confirmed prior to birth and disease is not evident at birth due to regression, report the case based on the pre-birth diagnosis.

Multiple Primary Cancers

If a patient has at least one primary reportable neoplasm that is active or under treatment, all other primary reportable neoplasms that the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately. Information about these previous (historical) primaries may be vague. Complete an abstract with as much information as is available in the medical record.

Death Certificate Only Cases

Patients above who are not reportable for your facility, but who die at your facility with active cancer, although not required may be reported to NCCR. Cases not reported at the time of death may appear later on a **Death Certificate Only listing** (list of patients who died at your facility with cancer but not listed in the NCCR database), which requires additional follow-back by NCCR and research by the registrar. A minimal abstract prepared with documentation of any available information regarding date of diagnosis, primary site, histology or treatment is very useful.

Hematopoietic and Lymphoid Neoplasms

For cases diagnosed January 1, 2010 or later, see the Reportability Instructions in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database*.

Coding Manual: http://www.ctrexam.org/pdfs/resources/Hematopoietic_Instructions_and_Rules2014.pdf

Database: http://seer.cancer.gov/seertools/hemelymph/:

Positive Reportability Examples

1. Positive histology from a needle aspiration/biopsy followed by negative resection. This case is reportable based on the positive needle biopsy.

2. Carcinoid of the appendix found on appendectomy. Patient returns later with metastasis in regional lymph nodes. This case is reportable because of the metastatic lymph nodes. Code the diagnosis date to the date of the appendectomy and the first course of treatment date to the appendectomy date.

3. Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

4. Squamous cell carcinoma of the anus, NOS. Squamous cell carcinoma of the anus is reportable unless the primary site is confirmed to be the skin of the anus.

Cases Not Required to be Reported

Cases Not Required To Be Reported
1. Any skin cancer (site = C44.0 – C44.9) of the following types: malignant neoplasms, NOS; epithelial carcinomas, papillary and squamous cell carcinomas, basal cell carcinomas (histology codes of 8000-8110). EXCEPT GENITAL SITES.
2. Basal and squamous cell carcinoma (8070-8110) of skin of anus (C445)
3. Records, slides or patients seen only in consultation to confirm a diagnosis; no chart is created in your facility for this case. **(If a chart is created, it would be a reportable case.)**
4. Pathology cases that are consultative readings of slides submitted from outside facilities.
5. Patients with carcinoma *in situ* (non-invasive) of the cervix, cervical intraepithelial neoplasia, regardless of the histology (behavior of /2: C539)
6. (CIN) diagnosed on or after January 1, 2001 or prostatic intraepithelial neoplasia (PIN) diagnosed on or after January 1, 2003.
7. Metastatic sites or recurrences of a **previously reported** cancer.
8. Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are not collected as of January 1, 2001.
9. Benign and borderline tumors of the cranial bones (C410).
10. Cysts or lesions of the brain or central nervous system (CNS) diagnosed January 1, 2004, or later that have no ICD-O-3 morphology code.
***Your cancer committee may decide to require additional benign or borderline cases. Please do not submit these reportable-by-agreement cases to NCCR.

Not Reportable Examples

1. Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states ─ The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue. Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

2. Carcinoid of the appendix that extends into the mesoappendiceal adipose tissue. This case is not reportable. Extension does not make a carcinoid of the appendix reportable. Benign and borderline tumors can and do extend into surrounding tissue.

Ambiguous Terms at Diagnosis

Reportable cases are usually based on unequivocal statements made by recognized medical practitioners that the patient has a reportable diagnosis. However, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain. In instances where pathology or cytology findings cannot definitively confirm a cancer diagnosis or when imaging studies show inconclusive results, physicians often state the diagnosis in ambiguous terms. Reportability of such a diagnosis depends on the verbiage used.

For a cancer case to be reportable, the ambiguous term must always include a reference to the reportable diagnosis being described, e.g., favors carcinoma or suspicious for malignancy. When the diagnosis is stated in only ambiguous terms, use the following guidelines to determine whether a particular case should be reported. Note: Synonyms of these terms do not constitute diagnosis. Ambiguous terminology may originate in any source document, such as a pathology report, radiology report or clinical report.

Terms that constitute a diagnosis; case *should* be reported:		
Apparent(ly)	Favors	Suspect(ed)
Appears	Malignant appearing	Suspicious (for)
Comparable with	Most likely	Typical of
Compatible with	Presumed	
Consistent with	Probable	
Consistent with tumor (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–C75.3)		
Neoplasm or tumor (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–C75.3)		

Terms that *do not* constitute a diagnosis; case *should not* be reported:**		
Approaching	Potentially malignant	Suggests
Cannot be ruled out	Questionable	Very close to
Equivocal	Rule out	Worrisome
Possible		

****Without additional supporting information. Exception:** If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of How to Use Ambiguous Terminology for Case Ascertainment

1. If any of the reportable ambiguous terms precede a word that is synonymous with an in situ or invasive tumor, report the case.

    a. **Positive Example:** The pathology report says: Breast biopsy with abnormal cells consistent with ductal carcinoma. Report the case.

    b. **Negative Example:** The final diagnosis reads: Rule out lung cancer. Do not report this case.

2. For benign and borderline primary intracranial and CNS tumors, report the case if any reportable ambiguous term precedes either the word **Tumor or the word Neoplasm.**

3. Report the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record

    a. **Example:** Impression from a CT scan of the chest states probably malignant neoplasm of the lung. Discharge diagnosis states possible lung cancer. Report this case because probable lung cancer makes this case reportable.

4. When there is a single report, accept the reportable term and report the case when one section of a report uses a reportable term such as –apparently and another section of the same report uses a term that is not on the reportable list.

    a. **Example:** Abdominal CT reveals a 2cm liver lesion. The lesion is consistent with hepatocellular carcinoma, and appears in the discussion section of the report. The final diagnosis is 1cm liver lesion, possibly hepatocellular carcinoma. Report this case. It is consistent with being reportable.

    b. **Exception:** Do not accession a case based ONLY on suspicious cytology.

5. Use these terms when screening diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

    a. Do not report a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable**. There are two exceptions to this rule.**
        i. Exception 1 is if the physician treats a patient for cancer despite the negative biopsy, accession the case.
        ii. Exception 2 is if enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, accession the case.

    b. **Example:** Stereotactic biopsy of the left breast is focally suspicious for DCIS and is followed by a negative needle localization excisional biopsy. Do not report the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Cases Diagnosed Clinically are Reportable

In the absence of histologic or cytologic confirmation of a reportable cancer, accession a case based on the clinical diagnosis (when a recognized medical practitioner says the patient has cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis, on the face sheet or other parts of the medical record.

A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exception 1: If the physician treats a patient for cancer in spite of the negative biopsy, report the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, report the case. A reasonable amount of time would be equal to or greater than 6 months.

Brain or CNS Neoplasms

A brain or CNS neoplasm identified by diagnostic imaging is reportable even when no other information is available (from biopsy or resection, for example).

CHAPTER 4: REPORTING REQUIREMENTS FOR HOSPITALS AND MEDICAL CENTERS

Timeline and Frequency for Case Reporting

The primary source for obtaining epidemiological information is the hospital cancer registry. A registry is responsible for providing a listing of cancer patients and pertinent information regarding their diagnoses. A registry may be small or large, and the extent of information submitted varies, depending on hospital size and the reporting methods for each facility. Some hospitals have had their own registries for years in accordance with the American College of Surgeons-Commission on Cancer (ACoS-CoC) requirements, while others have limited registries and collect or provide only the state mandated reporting requirements. Hospitals, medical laboratories, and other facilities that provide patients with screening, diagnostic, or therapeutic services related to cancer shall report information on cases of cancer to the system.

All analytic cases must be submitted to NCCR within **180 days from the date of first contact.** Non-analytic cases that receive any care or treatment (to include palliation/hospice) related to a reportable diagnosis must be reported to the NCCR within 180 days of the initiation of the care or treatment.

Abstract Submission Schedule for Diagnosed Cases	
Month of Diagnosis…	**Submitted Abstract to NCCR no later than…**
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Table 1. Cancer Reporting Frequency based on Caseload.

Hospitals	*Submission Frequency Based on Caseload (below)*
Annual Caseload >500	*Monthly*
Annual Caseload 300-500	*Monthly*
Annual Caseload <300	*Monthly*
Nonanalytic and "History Of" cases	*Minimum, on a quarterly basis or with regularly scheduled transmission.*
Reporting facilities with **25 or less** confirmed cases may elect to report their cases on paper.	These records need to be submitted on a monthly basis. It is recommended that the facility keep a copy of what is submitted to prevent duplicate case reporting.
Copies of the following from the medical record need to be sent in for each identified cancer case: • Face Sheet • History and Physical • Operation Reports • Scans, X-Rays • Pathology • Chemotherapy • Radiation • Name of Referring Physician.	The submissions should be faxed to 775-684-5999. The fax machine is the property of the Nevada Cancer Registry, so the data will not be received or viewed by anyone other than our staff. Cancer Reporting Form: http://www.health.nv.gov/PDFs/CancerRegistryForm.pdf If you cannot fax the information, you may mail it to the following address: **Nevada Central Cancer Registry** **4126 Technology Way, 2nd Floor** **Carson City, NV 89706**
Facilities with no cases for a given month need to send a letter to the NCCR stating that there were no cases to report.	For facilities that frequently have no cases, quarterly reporting is acceptable.

Required Data Items for Hospital/Medical Center Reporting

The Nevada Central Cancer Registry recognizes the NPCR and the NAACCR as the primary regulatory bodies for reporting cancer, benign neoplasms, and hematopoietic diseases. (http://www.cdc.gov/cancer/npcr/registry/ and http://www.naaccr.org/)

The NCCR requires all hospitals to use the applicable version of the required instructions/guidelines and/or standards as defined by the date of first contact for each analytic case. The ***Facility Oncology Registry Data Standards (FORDS) manual*** is the primary resource for data collection and reporting recognized by NCCR. It specifies standards for cases to be included in the registry, data items to be collected, and the codes and coding rules for those items.

All hospitals are advised to consult the NAACCR Standards for Cancer Registries, Volume I: Data Exchange Standards and Record Descriptions, Appendix C, for data item reporting requirements. All hospitals/medical centers are required to report data items as indicated in the column labeled "Hosp -> Central" in addition to data items requested by the FORDS manual.

While the NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary is intended for central registries, the NCCR Cancer Reporting Manual provides detailed specifications and codes for each data item in the data exchange record layout that is required by reporting hospitals. All hospital reporters should note that NCCR also recognizes the standardized abbreviations and acronyms as defined in Appendix C of the NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary as the list of acceptable abbreviations to be used in abstracting.

OTHER REGISTRY STANDARD REFERENCES ARE IDENTIFIED AS:	
AJCC	***American Joint Committee on Cancer***
ICD-O-3	***International Classification of Diseases for Oncology, Third Edition, 2000***
NAACCR	***North American Association of Central Cancer Registries***
SEER	***Surveillance, Epidemiology, and End Results (National Cancer Institute program)***
CDC	***Centers for Disease Control and Prevention***
ACoS	***American College of Surgeons***
CoC	***Commission on Cancer***

Reporting Requirements by Item and Facility Type

Specific reporting requirements for hospitals operating a cancer registry, hospitals with no cancer registry, and independent laboratories are summarized in the table below. The need to report an item has been assigned to the levels of required, reportable, and not required. These requirements are patterned after the American College of Surgeons (ACoS) levels for inclusion of information within a hospital registry. The practical definitions of these levels of reportability are best termed as levels of effort associated with collecting and providing the information.

If there is no information available, and inquiries have been made, DO NOT leave the item blank unless specifically noted in the individual data item instructions, for example, Family History of Cancer. Instead, record the appropriate NOS or default code.

Acronym	Field Status	Explanation
[**REQ**]	Required	The facility **MUST** collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient records or other available records, as well as making inquiries with other facilities or the physician on record as is necessary to obtain the information.
[**REP**]	Reportable	The facility **MUST** report the information if it can be located within the patient's chart, outpatient records or other available records, but need not make inquiries of other facilities of physician's offices.
[**N/R**]	Not Required	Item considered generally not available to the facility and/or not considered as reliably available. Data for these items are not required, but may be report is available to the facility.
[**SSF**]	Special Site Specific Factor Field Requirements	The site specific factor field requirements are modeled after the requirements set forth by the American College of Surgeons. Refer to file "CoC and SEER Combined Site Specific Factors List" located at http://seer.cancer.gov/tools/ssf/ for a complete listing of the SSF fields.

Once you have determined your facility type, use the table on the following pages to determine the level of reporting requirement for each data item. The definitions for the three facility types are as follows.

- **Hospital with a Registry** - an entity that has an approved cancer program by the American College of Surgeons (ACoS) or *working* towards ACoS approval *or* a regional registry that houses data for surrounding facilities.
  - The SSF fields are REQUIRED for hospitals with a registry including all ACoS-accredited facilities. In other words, if the information is not available in the medical record, you are required to make inquiries to find the information. If the SSF field is NOT highlighted in orange, then the item is REPORTABLE for a hospital with a registry. That is, if the information is in the medical record, you are required to report it; however, if the information is not in the medical record, you DO NOT need to make inquiries to locate the information. If there is no information available, and inquires have been made, DO NOT leave the item blank. Refer to the applicable Collaborative Staging (CS) manual (based on diagnosis year) for the correct default codes.

- **Hospital without a Registry** - geared towards smaller entities that do not have an approved cancer program *or* have limited resources to diagnosis and treat cancer patients.
  - ALL of the SSF fields are REPORTABLE for a hospital without a registry. That is, if the information is in the medical record, you are required to report it; however, if the information is not in the medical record, you do not need to make inquiries to locate the information. If there is no information available, DO NOT leave the item blank. Refer to the applicable Collaborative Stage manual (based on diagnosis year) for the correct default codes.

- **Independent Laboratories** – a separate laboratory from a hospital that reads specimens for either a hospital or physician's office.
  - The SSF fields are NOT required, or reportable for laboratories. However, DO NOT leave the item blank. Refer to the applicable Collaborative Stage manual (based on diagnosis year) for the correct default codes.

More information can be found at http://www.cancerstaging.org/cstage/.

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
Last Name of Patient	REQ	REQ	REQ
First Name of Patient	REQ	REQ	REQ
Middle Name of Patient	REQ	REQ	REQ
Maiden Name	REP	REP	N/R
Alias Name	REP	REP	N/R
Social Security Number	REQ	REQ	REQ
Patient Address at Time of Diagnosis	REQ	REQ	REQ
City/Town at Diagnosis	REQ	REQ	REQ
Supplemental Address at	REQ	REQ	REQ
State at Diagnosis	REQ	REQ	REQ
Zip Code at Diagnosis	REQ	REQ	REQ
County at Diagnosis	REQ	REQ	REQ
Country at Diagnosis	REQ	REQ	REQ
Current Address	REQ	REQ	REQ
Date of Birth	REQ	REQ	REQ
Birthplace - State	REP	REP	N/R
Birthplace - Country	REP	REP	N/R
Sex	REQ	REQ	REQ
Spanish/Hispanic Origin	REQ	REQ	REP
Race (1-5)	REQ	REQ	REQ
Marital Status at Diagnosis	REP	REP	REP

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
Primary Payer at Diagnosis	REQ	REQ	REP
Comorbidities/Complications	REQ	REQ	N/R
Secondary Diagnoses (1-10)	REQ	REQ	N/R
Usual Occupation Prior to	REP	REP	N/R
Usual Industry Prior to	REP	REP	N/R
Family History of Cancer	REP	REP	N/R
Medical Record Number	REQ	REQ	N/R
Laboratory Report Number	REP	REP	REQ
Accession Number	REQ	N/R	N/R
Sequence Number	REQ	REQ	N/R
Type of Reporting Source	REQ	REQ	REQ
Case Finding Source	REQ	REQ	REQ
Reporting Facility Number	REQ	REQ	REQ
Class of Case	REQ	REQ	REQ
Date of Inpatient Admission	REQ	REQ	N/R
Date of Inpatient Admission	REQ	REQ	N/R
Date of Inpatient Discharge	REQ	REQ	N/R
Date of Inpatient Discharge	REQ	REQ	N/R
Date of First Contact	REQ	REQ	N/R
Date of (Initial) Diagnosis	REQ	REQ	REQ
Primary Site (Code/Text)	REQ	REQ	REQ

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
Laterality (Paired Organ)	REQ	REQ	REQ
Histology (Code/Text)	REQ	REQ	REQ
Behavior Code	REQ	REQ	REQ
Grade/Differentiation	REQ	REQ	REQ
Lymph Vascular Invasion	REQ	REQ	REP
Diagnostic Confirmation	REQ	REQ	REQ
SEER Summary Staging 2000	REQ	REQ	REQ
AJCC Stage: Clinical T	REQ	REP	N/R
AJCC Stage: Clinical N	REQ	REP	N/R
AJCC Stage: Clinical M	REQ	REP	N/R
AJCC Clinical TNM Stage	REQ	REP	N/R
AJCC Clinical TNM	REQ	REP	N/R
AJCC Stage: Pathological T	REQ	REP	N/R
AJCC Stage: Pathological N	REQ	REP	N/R
AJCC Stage: Pathological M	REQ	REP	N/R
AJCC Pathological TNM	REQ	REP	N/R
AJCC Pathological TNM	REQ	REP	N/R
CS Tumor Size	REQ	REQ	REP
CS Extension	REQ	REQ	N/R
CS Tumor Size/Ext Eval	REQ	REQ	N/R
CS Lymph Nodes	REQ	REQ	N/R

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
CS Lymph Nodes Eval	REQ	REQ	N/R
Regional Lymph Nodes	REQ	REQ	N/R
CS Metastasis at Diagnosis	REQ	REQ	N/R
CS Mets at DX - Bone	REQ	REQ	N/R
CS Mets at DX - Brain	REQ	REQ	N/R
CS Mets at DX - Liver	REQ	REQ	N/R
CS Mets at DX - Lung	REQ	REQ	N/R
CS Mets Eval	REQ	REQ	N/R
Site-Specific Factor (SSF) 1	Refer to special SSF requirements listed above		N/R
SSF2	Refer to special SSF requirements listed above		N/R
SSF3	Refer to special SSF requirements listed above		N/R
SSF4	Refer to special SSF requirements listed above		N/R
SSF5	Refer to special SSF requirements listed above		N/R
SSF6	Refer to special SSF requirements listed above		N/R
SSF7	Refer to special SSF requirements listed above		N/R
SSF8	Refer to special SSF requirements listed above		N/R
SSF9	Refer to special SSF requirements listed above		N/R
SSF10	Refer to special SSF requirements listed above		N/R
SSF11	Refer to special SSF requirements listed above		N/R
SSF12	Refer to special SSF requirements listed above		N/R
SSF13	Refer to special SSF requirements listed above		N/R

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
SSF14	Refer to special SSF requirements listed above		N/R
SSF15	Refer to special SSF requirements listed above		N/R
SSF16	Refer to special SSF requirements listed above		N/R
SSF17	Refer to special SSF requirements listed above		N/R
SSF18	Refer to special SSF requirements listed above		N/R
SSF19	Refer to special SSF requirements listed above		N/R
SSF20	Refer to special SSF requirements listed above		N/R
SSF21	Refer to special SSF requirements listed above		N/R
SSF22	Refer to special SSF requirements listed above		N/R
SSF23	Refer to special SSF requirements listed above		N/R
SSF24	Refer to special SSF requirements listed above		N/R
SSF25	Refer to special SSF requirements listed above		N/R
RX Summ – RX Status	REQ	REQ	N/R
Date First Course of Treatment	REQ	REQ	N/R
Date First Course of Treatment	REQ	REQ	N/R
Systemic/Surgery Sequence	REQ	REQ	N/R
Reason for No Surgery of Primary	REQ	REQ	N/R
Date First Surgical Procedure	REQ	REQ	N/R
Surgical Procedure of Primary Site	REQ	REQ	N/R
Surgical Procedure/Other Site	REQ	REQ	N/R
Scope of Regional Lymph Node	REQ	REQ	N/R

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
Radiation/Surgery Sequence	REQ	REQ	N/R
Date Radiation Started	REQ	REQ	N/R
Date Radiation Started Flag	REQ	REQ	N/R
Reason For No Radiation	REQ	REQ	N/R
Radiation Treatment Modality	REQ	REQ	N/R
Date Chemotherapy Started	REQ	REQ	N/R
Date Chemotherapy Flag	REQ	REQ	N/R
Chemotherapy	REQ	REQ	N/R
Hematologic Transplant and Endocrine Procedures	REQ	REQ	N/R
Date Hormone Therapy Started	REQ	REQ	N/R
Date Hormone Started Flag	REQ	REQ	N/R
Hormone Therapy	REQ	REQ	N/R
Date Immunotherapy Started	REQ	REQ	N/R
Date Immunotherapy Started	REQ	REQ	N/R
Immunotherapy	REQ	REQ	N/R
Date Other Therapy Started	REQ	REQ	N/R
Date Other Therapy Started	REQ	REQ	N/R
Other Treatment	REQ	REQ	N/R
Date of Last Contact	REQ	REQ	N/R
Date of Last Contact Flag	REQ	REQ	N/R
Text – Physical Exam/Signs & Symptoms/Lab Results	REQ	REQ	REQ

NCCR Item Name	Hospital w/ Registry	Hosp w/o Registry	Independent Laboratory
Text − X-rays/Scans	REQ	REQ	N/R
Text −	REQ	REQ	REQ
Text − Chemo/Hormone/ Immunotherapy/Other	REQ	REQ	N/R
Text − Radiation Therapy/ Miscellaneous	REQ	REQ	REQ
Abstractor Name and Contact	REQ	REQ	REQ
Vital Status	REQ	REQ	REQ
Date of Death	REQ	REP	N/R
Cause of Death	REQ	REP	N/R
Place of Death - State	REQ	REP	N/R
Place of Death - Country	REQ	REP	N/R
Date Abstracted	REQ	REQ	REQ

Text Requirements

Text is a key component in every abstract. A complete text will not only provide all the information necessary to properly code each data item, but also provide rationale for deviations in the standard of care and treatment and provide supplemental information that may not be reflected within the standardized coding items.

NCCR frequently receives abstracts from multiple facilities that must be consolidated into one case. Thus, abstracts must contain corroborating text in order for NCCR to assure that what is entered into the NCCR database is the most accurate information for each case reported. The operative concept here is "corroborating." That is, text must provide the rationale for selecting the codes assigned to primary site, histology, extent of disease and treatment fields. It's not necessary to strive for great literary expression. Brief, meaningful comments are all it takes to tell us what we need to know. Text is also evaluated in some data quality audits to ensure coding accuracy and completeness. Missing or inadequate text to support the coded fields results in unnecessary errors affecting final statistical results of an audit.

Because many software products do not allow a large space for text, it is important to do the following:

- Summarize applicable text with corresponding dates to validate stage of disease at diagnosis.
- Summarize FIRST COURSE diagnostics and treatment to support coding
- Be specific
- Record the sub site of the primary site (e.g., UOQ Right Breast)
- Use standardized abbreviations and acronyms as defined in Appendix C of the NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary.
- Document source data when consolidating information from multiple source documents.
- Use information directly from primary source documents such as pathology, imaging, laboratory, and procedure reports whenever possible.
- Always provide dates for diagnostic tests/treatment.
- Always record the type of diagnostic tests/treatment.
- Always record any pertinent positive or negative results of diagnostic tests/treatment.
  Example: Liver BX (-) for mets, CT brain (-), bone scan (+)
- Always record the location of the diagnostic test/treatment.
  Example: 1/2/10 CT Brain Nevada Hosp. positive one mass 1cm suspect meningioma

**When recording treatment, document the stated plan of care as noted in the medical record, not the Tumor Board/Cancer Conference notes or minutes.

CHAPTER 5: REPORTING REQUIREMENTS FOR NON-HOSPITALS

All health care providers who diagnose or treat cancer patients must report confirmed cases of cancer to the Nevada Central Cancer Registry. The types of providers listed below are included in this requirement.

Physician Offices

All physicians who diagnose or provide treatment for cancer are required to report cases as applicable to the Nevada Central Cancer Registry. This includes any facility for microbiological, serological, immunohematological (blood banking), cytological, histological, chemical, hematological, biophysical, toxicological, or other methods of the examination of tissues, secretions, or excretions of the human body; the term does not include a forensic laboratory operated by a law enforcement agency. Physicians must report all required cancer cases directly to the Nevada Central Cancer Registry **within 10 working days after the date of diagnosis. This includes the following cases:**

- Patients who are clinically diagnosed and receive no further workup or treatment
- Patients who are newly diagnosed in the physician's own laboratory facility or by sending a specimen from the office to an outside laboratory, whether hospital-based or independent
- Patients whose first course treatment is initiated in the physician's office or clinic. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones

Freestanding Radiation or Medical Oncology Clinics

Freestanding radiation or medical oncology clinics must report any patient initially diagnosed with reportable cancer, upon completion of first course treatment to include subsequent reporting of treatment summary information. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.

Dentists/Dermatologists

Dentists and Dermatologists must report all required cancer cases. This includes patients who are diagnosed or treated by a dentist and dermatologists who performs a biopsy and/or receives a pathology report of a malignant diagnosis. Please see further skin cancer reporting rules in General Rules for Reportable Cancers and Reportable Skin Cancers on pages 11 and 12, respectively.

Laboratories

Medical laboratories (defined as any facility for microbiological, serological, immunohematological (blood banking), cytological, histological, chemical, hematological, biophysical, toxicological, or other methods of examination of tissues, secretions, or excretions of the human body) are required to report directly to the Nevada Central Cancer Registry within 10 working days of the final report regardless of any affiliation with another reporting entity.

Surgery Centers

Freestanding surgery centers (independent centers not affiliated with any hospital) must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer. This includes cases also reported by either hospital-based or private/independent medical laboratories, as described above.

Surgery centers affiliated with a hospital must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer. This includes cases also reported by either hospital-based or private/independent medical laboratories, as described above.

Timeline for Non-Hospital Reporting

Table 2. Timeline for Non-Hospital Based Facilities

Facility Type	*Reporting Requirements*
Physician Offices	Within 10 working days after diagnosis or treatment
Medical Laboratories	Within 10 working days of final report
Radiation or Medical Oncology Clinics	Upon completion of first course of treatment
Surgery Center	Upon completion of first course of treatment
Copies of the following from the medical record need to be sent in for each identified cancer case: • Face Sheet • History and Physical • Operation Reports • Scans, X-Rays • Pathology • Chemotherapy • Radiation • Name of Referring Physician	If electronic submission is down, the submissions should be faxed to 775-684-5999. The fax machine is the property of the Nevada Cancer Registry, so the data will not be received or viewed by anyone other than our staff. Cancer Reporting Form: http://www.health.nv.gov/PDFs/CancerRegistryForm.pdf If you cannot fax the information, you may mail it to the following address: **Nevada Central Cancer Registry** **4126 Technology Way, 2nd Floor** **Carson City, NV 89706**
Facilities with no cases for a given month need to send a letter to the NCCR stating that there were no cases to report.	For facilities that frequently have no cases, quarterly reporting is acceptable.

CHAPTER 6: DATA SUBMISSION PROCEDURES FOR HOSPITALS AND MEDICAL CENTERS

Submission Requirements

- The **NCCR requires that all data be submitted via a secure electronic method. Diskettes and CDs are no longer accepted.**
- Electronic data are to be transmitted using the **Web Plus upload**. Instructions for the use of Web Plus can be found on the NCCR website. If your facility has other required methods of data transmission, please contact the NCCR staff.
- **Facilities with their own cancer registry software** should submit a file of cases in the appropriate NAACCR layout to the secure website, https://pbhwebplus.nv.gov:4432/logonen.aspx.
- **Facilities using Web Plus for direct data** entry will abstract their cases and correct edit errors. Once the cases are complete and free of edits, the facility will release the abstracts to NCCR.
- Protected Health Information (PHI) and other confidential data **MUST NOT** be included in emails to NCCR. Do not include information either in the text of the email or as an attachment. If this happens, NCCR staff will alert the registrar, so that the information can be deleted from all emails.

NOTE: A NCCR is transitioning to Registry Plus application; more information will be available as soon as we transition to the new environment.

Changes to Abstracted Information and Resubmission of Case to NCCR

It is possible that after a cancer case has been abstracted and submitted to NCCR, additional information was clarified or added to the patient's chart, which may lead to changes in specific data items submitted on the initial abstract. **The information in an abstract should be changed for the following circumstances and should be reported to the NCCR. When uploading a re-submission file, please indicate by writing a note that your submission is for "update cases."**

1. To correct Abstracting errors.
2. When clarifications or rule changes retroactively affect data item codes.
3. When better information is available later.
4. If after a case is reported to the NCCR, additional information on treatment is added to an abstract, the additional treatment should be reported to the NCCR by resubmitting the abstract.

Items for which updates may be required:

1. Last name	**9. Birthdate**
2. First name	**10. Social Security Number**
3. Middle name	**11. Date of Diagnosis**
4. Maiden name	**12. Primary Site**
5. Address at diagnosis, includes city, county, state, and zip code	**13. Morphology type, behavior, and grade**
6. Race	**14. Laterality**
7. Spanish/Hispanic origin	**15. Diagnostic Confirmation**
8. Sex	**16. Collaborative Stage (all required fields)**
17. Type and date of first course definitive treatment	

Example 1: Consults from specialty labs, pathology report addendums or comments or other information have been added to the chart after the registrar abstracted the case. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information. Make sure these changes are reported to the NCCR.

Example 2: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis. Update all other fields affected by the change in primary site. Make sure these changes are reported to the NCCR.

Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim. Make sure these changes are reported to the NCCR.

Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Make sure to enter supporting documentation in the text.

Visual Review of Incoming Cases

All cases submitted to the NCCR will be subject to a visual review of key data items. Text is a key component in every abstract. A complete text will not only provide all the information necessary to properly code each data item, but also provide rationale for deviations in the standard of care and treatment and provide supplemental information that may not be reflected within the standardized coding items.

NCCR frequently receives abstracts from multiple facilities that must be consolidated into one case. Thus, abstracts must contain corroborating text in order for NCCR to assure that what is entered into the NCCR database is the most accurate information for each case reported. The operative concept here is "corroborating." That is, text must provide the rationale for selecting the codes assigned to primary site, histology, extent of disease and treatment fields. It's not necessary to strive for great

literary expression. Brief, meaningful comments are all it takes to tell us what we need to know. Text is also evaluated in some data quality audits to ensure coding accuracy and completeness. Missing or inadequate text to support the coded fields results in unnecessary errors affecting final statistical results of an audit.

An effective data quality practice requires review **of relational data errors, questionable codes, and text inconsistencies.** The key monitoring field level indicators include:

- County at Diagnosis
- Primary Site/Gender
- Race Fields
- Spanish/Hispanic Origin
- Date of Diagnosis
- Laterality
- Histology/Topography
- Grade
- Collaborative Staging Fields
- Date of First Contact/Date of Diagnosis/Class of Case
- Date of First Course Treatment and Treatment Data Fields

*Other items may be included as time and resources permit

The items will be compared to the text submitted, so good text is important to this process. If problems are identified or codes are not justified in text, the facility will be contacted and issue discussed with the registrar to address training needs. This process serves to ensure the registry has high quality data.

CHAPTER 7: DATA SUBMISSION PROCEDURES FOR NON-HOSPITALS

Physician Offices and Outpatient Facilities

All health care providers are encouraged to use the NCCR Web Plus secure electronic reporting. This program was developed by the CDC for all health care providers for case abstraction and reporting. Web Plus software is an abstracting tool used to summarize the medical record as an electronic report of cancer diagnosis and treatment by abstractors and other individuals or groups who work with cancer data. This software was developed at CDC's Division of Cancer Prevention and Control in support of NPCR. All data items in national standard datasets, including text, are supported.

If electronic data submission is not possible, nonhospital case reporting forms are available at http://www.health.nv.gov/PDFs/CancerRegistryForm.pdf

Copies of the following from the medical record need to be sent in for each identified cancer case: • Face Sheet • History and Physical • Operation Reports • Scans, X-Rays • Pathology • Chemotherapy • Radiation • Name of Referring Physician.	These records need to be submitted on a monthly basis. It is recommended that the facility keep a copy of what is submitted to prevent duplicate case reporting. The submissions should be faxed to 775-684-5999. The fax machine is the property of the Nevada Cancer Registry, so the data will not be received or viewed by anyone other than our staff. If you cannot fax the information, you may mail it to the following address: **Nevada Central Cancer Registry** **4126 Technology Way, 2nd Floor** **Carson City, NV 89706**

Pathology Laboratories

NOTE: NCCR is transitioning to Registry Plus application; more information will be available as soon as we transition to the new environment.

CHAPTER 8: QUALITY ASSURANCE AUDITS

Quality Assurance Audits

NCCR periodically conducts case completeness and data quality audits through an NCCR Certified Tumor Registrar (CTR) as required by the NPCR. The intent of the audits is to assist facilities with casefinding and abstracting issues to ensure complete, high quality data is submitted to NCCR. Each Nevada hospital is audited every five years while each facility is audited periodically. All electronic reporting hospitals are subject to case completeness and data quality audits, including some low volume facilities, while only case completeness audits are performed at other low volume hospitals that do not perform abstracting. Standard audits include casefinding and re-abstraction of data for a specific year. Alternatively, audits other than the standard method may also be performed periodically such as case completeness review based on hospital accession register matches with NCCR's database, data quality re-coding audits to evaluate data quality and text, and other site specific or tumor specific data quality reviews. After completion of the audits, detailed summary reports are prepared and shared with the hospital registrar and other related hospital staff. **Per NPCR guidelines, the acceptable accuracy rate for all audits is 95 – 100%.**

Casefinding Audit

Inpatient/Outpatient hospital disease indices, pathology reports and other pertinent casefinding documents are reviewed and matched to the NCCR database. Any non-matched cases are returned to the registrar or hospital contact person for resolution. During routine case finding, registrars can assist themselves and NCCR by maintaining a non-reportable list (patient name, date of birth or social security number, ICD-9- CM code of the non-reportable malignancy, date seen and reason not reported). Another method is to note the reason a case is non-reportable on the registrar's casefinding source, such as the Medical Records Disease Index (MRDI). The listing or notations will help registrars avoid duplication of efforts related to casefinding and identification of non-reportable cases in the audit process.

Re-Abstraction Audits

The re-abstracting audit consists of review and re-abstraction of specific NCCR required fields from the original hospital record with comparison to the original abstracted data. During resolution, registrars are given the opportunity to provide any additional information not available to the auditor that may justify the original coding. Discrepancies are discussed with the hospital registrar. Abstracting and coding guidelines are reviewed and reinforced. Further training may be recommended and, if warranted, NCCR can provide assistance to individual registrars through conferencing and/or site visits.

NPCR Audits

Case Completeness and data quality audits are periodically conducted by NPCR on the Nevada Central Cancer Registry. While a few hospitals are requested to provide the data, the audits are conducted on NCCR, not on the individual facilities.

NCCR Death Clearance Audits NCCR Quality Control staff will perform annual matching of the NCCR Master File to the Nevada Office of Vital Records death files. NCCR will provide the reporting facility with a list of unmatched Vital Records cases (deaths) that show the place of death as the reporting facility. The facility abstractor will need to research these cases to determine whether the patient did expire at the facility and whether the case meets the cancer reporting requirements. If any case is found to meet reporting requirements, the case must be abstracted and reported to NCCR. For each case that will not be reported to NCCR or did not expire at the reporting facility, NCCR requires that a brief statement be submitted that provides a complete explanation for why the case will not be reported.

APPENDICES

Appendix A: Nevada State Cancer Reporting Law

NRS 457.230 Establishment and maintenance of system for reporting information; objectives; persons required to report information.

1. The State Health Officer shall, pursuant to the regulations of the State Board of Health, establish and maintain a system for the reporting of information on cancer.

2. The system must include a record of the cases of cancer which occur in this state along with such information concerning the cases as may be appropriate to form the basis for:

   (a) The conducting of comprehensive epidemiologic surveys of cancer and cancer-related diseases in this state; and

   (b) The evaluation of the appropriateness of measures for the prevention and control of cancer.

3. Hospitals, medical laboratories and other facilities that provide screening, diagnostic or therapeutic services to patients with respect to cancer shall report information on cases of cancer to the system.

4. Physicians who diagnose or provide treatment for cancer, except for cases directly referred or previously admitted to a hospital, medical laboratory or other facility described in subsection 3, shall report information on cases of cancer to the system.

5. As used in this section, "medical laboratory" has the meaning ascribed to it in NRS 652.060. (Added to NRS by 1983, 1677; A 1997, 1309)

NRS 457.240 Regulations of State Board of Health. The State Board of Health shall by regulation:

1. Prescribe the form and manner in which the information on cases of cancer must be reported;

2. Specify the malignant neoplasms which must be reported;

3. Prescribe other information to be included in each such report, for example, the patient's name and address, the pathological findings, the stage of the disease, the environmental and occupational factors, the methods of treatment, the incidence of cancer in the patient's family, and the places where the patient has resided; and

4. Establish a protocol for obtaining access to and preserving the confidentiality of the patients' records needed for research into cancer. (Added to NRS by 1983, 1677)

NRS 457.250 Records of health care facility: Availability to State Health Officer; abstracting of information; fees; penalty.

1. The chief administrative officer of each health care facility in this state shall make available to the State Health Officer or the State Health Officer's representative the records of the health care facility for every case of malignant neoplasms which are specified by the State Board of Health as subject to reporting.

2. The Health Division shall abstract from the records of the health care facility or shall require the health care facility to abstract from their own records such information as is required by the State Board of Health. The Health Division shall compile the information timely and not later than 6 months after it abstracts the information or receives the abstracted information from the health care facility.

3. The Board shall by regulation adopt a schedule of fees which must be assessed to the health care facility for each case from which information is abstracted by the Health Division or by the health care facility pursuant to subsection 2. The fee assessed to a facility which abstracts information from its own records must not exceed one-third of the amount assessed to facilities for which the Health Division abstracts.

4. Any person who violates this section is guilty of a misdemeanor and shall be punished by a fine of $1,000, and may be further punished by imprisonment in the county jail for not more than 6 months. (Added to NRS by 1983, 1677, 1678; A 1993, 174; 2001, 2257)

NRS 457.260 Publication of reports; provision of data.

1. The Health Division shall publish reports based upon the material obtained pursuant to NRS 457.230, 457.240 and 457.250 and shall make other appropriate uses of the material to identify trends in the incidence of cancer in a particular area or population, advance research and education concerning cancer and improve treatment of the disease.

2. The Health Division shall provide any qualified researcher with data from the reported information upon the researcher's:

   (a) Compliance with appropriate conditions as established under the Board's regulations; and

   (b) Payment of a fee to cover the cost of providing the data. (Added to NRS by 1983, 1677; A 2003, 1248)

NRS 457.265 Analysis of information, records and reports; investigation of trends.

1. The State Health Officer or a qualified person designated by the Administrator of the Health Division shall analyze the material obtained pursuant to NRS 457.230, 457.240 and 457.250 and the reports published pursuant to NRS 457.260 to determine whether any trends exist in the incidence of cancer in a particular area or population.

2. If the State Health Officer or the person designated pursuant to subsection 1 determines that a trend exists in the incidence of cancer in a particular area or population, the State Health Officer or the person designated pursuant to subsection 1 shall work with appropriate governmental, educational and research entities to investigate the trend, advance research into the trend and the cancer identified in the trend, and facilitate the prevention and control of the cancer. (Added to NRS by 2003, 1248)

NRS 457.270 Consent required before disclosure of identity of patient, physician or health care facility. The Health Division shall not reveal the identity of any patient, physician or health care facility which is involved in the reporting required by NRS 457.250 unless the patient, physician or health care facility gives prior written consent to such a disclosure. (Added to NRS by 1983, 1678; A 1993, 174)

NRS 457.280 Limitation on civil and criminal liability. No person or organization providing information to the Health Division in accordance with NRS 457.230, 457.240 and 457.250 may be held

liable in a civil or criminal action for divulging confidential information unless the person or organization has done so in bad faith or with malicious purpose. (Added to NRS by 1983, 1678)

REPORTING INFORMATION ON CANCER

NAC 457.010 Definitions. (NRS 457.065**,** 457.240**)** As used in NAC 457.010 to 457.150, inclusive, unless the context otherwise requires:

1. "Cancer" has the meaning ascribed to it in NRS 457.020.

2. "Health care facility" has the meaning ascribed to it in NRS 457.020.

3. "Health Division" means the Health Division of the Department of Health and Human Services.

4. "Malignant neoplasm" means a virulent or potentially virulent tumor, regardless of the tissue of origin.

5. "Medical laboratory" has the meaning ascribed to it in NRS 652.060.

6. "Physician" means a physician licensed pursuant to chapter 630 or 633 of NRS.

7. "Registry" means the office in which the State Health Officer conducts the program for reporting information on cancer and maintains records containing that information.

[Bd. of Health, Malignant Neoplasms Reg. § 1, eff. 3-19-70]—(NAC A 12-3-84; 1-24-92; 10-22-93; R075-98, 11-18-98)

NAC 457.030 Severability. (NRS 457.065**,** 457.240**)** If any of the provisions of NAC 457.010 to 457.150, inclusive, or any application thereof to any person, thing or circumstance is held invalid, the State Board of Health intends that such invalidity not affect the remaining provisions or applications to the extent that they can be given effect.

NAC 457.050 Abstracting of information by health care facility; standards for abstracting information. (NRS 457.065**,** 457.240**)**

1. Each health care facility shall provide to the State Health Officer information concerning malignant neoplasms by abstracting information on a form prescribed by the State Health Officer or his designee.

2. Except as otherwise provided in subsection 3, each health care facility shall abstract information in conformance with the standards for abstracting information concerning malignant neoplasms of the Commission on Cancer of the American College of Surgeons as set forth in the *Registry Operations and Data Standards (ROADS) Manual*, 1996 edition, which is hereby adopted by reference, and any subsequent revision or amendment to the standards established by the Commission on Cancer of the American College of Surgeons. A copy of the manual may be obtained from the American College of Surgeons, 633 North Saint Clair Street, Chicago, Illinois 60611-3211, for the price of $25.

3. The State Health Officer shall review any revision or amendment to the standards specified in subsection 2 to determine whether the revision or amendment is appropriate for this State. Ten days after the standards specified in subsection 2 are revised or amended, a health care facility shall abstract information in conformance with the revision or amendment unless the State Health

Officer files an objection to the amendment or revision with the State Board of Health within 10 days after the standards are revised or amended.

4. A health care facility which does not use the staff of the Health Division to abstract information from its records shall cause to have abstracted and reported to the Health Division the malignant neoplasms listed in NAC 457.040 in the manner required by this section.

5. If a health care facility with 100 beds or more does not use the staff of the Health Division to abstract information from its records concerning malignant neoplasms, it shall cause to have abstracted and reported to the Health Division, pursuant to subsection 4, the malignant neoplasms listed in NAC 457.040 using an electronic means approved by the State Health Officer or his designee, unless an exemption from this requirement is granted by the State Health Officer. (Added to NAC by Bd. of Health, eff. 12-3-84; A 10-22-93; R075-98, 11-18-98)

NAC 457.053 Reporting of information by medical laboratory. (NRS 457.065, 457.240)

1. A medical laboratory that obtains a specimen of human tissue which, upon examination, shows evidence of cancer shall, within 10 working days after the date that the pathology report is completed, provide information concerning its findings to the State Health Officer using an electronic means approved by the State Health Officer or his designee.

2. The information provided by a medical laboratory pursuant to subsection 1 must include, without limitation:

   (a) The name, address, date of birth, gender and social security number of the person from whom the specimen was obtained;

   (b) The name and the address or telephone number of the physician who ordered the examination of the specimen;

   (c) The name and the address or telephone number of the medical laboratory that examined the specimen;

   (d) The final diagnosis from the pathology report; and

   (e) Any other relevant information from the pathology report, including, without limitation:

      (1) The anatomical site of the lesion;

      (2) The size of the lesion;

      (3) The stage of the disease and the grade of tumor;

      (4) The lesion margin status, if available; and

      (5) Lymphatic involvement, if available.

      (Added to NAC by Bd. of Health by R075-98, eff. 11-18-98)

NAC 457.057 Reporting of information by physician. (NRS 457.065, 457.240)

1. Except as otherwise provided in subsection 3, a physician who has a case in which he diagnoses a patient as having cancer or provides treatment to a patient with cancer shall, within 10 working days after the date of the diagnosis or the date of the first treatment, provide information to the

State Health Officer concerning the case on a form prescribed by the State Health Officer or his designee, or by an electronic means approved by the State Health Officer or his designee.

2. Information provided by a physician pursuant to subsection 1 must include, without limitation:

   (a) The name, address, date of birth, gender, race or ethnicity, and social security number of the patient;

   (b) The name and the address or telephone number of the physician making the report;

   (c) The final diagnosis from the pathology report; and

   (d) Any other relevant information from the pathology report, including, without limitation:

      (1) The anatomical site of the lesion;

      (2) The size of the lesion;

      (3) The stage of the disease and the grade of tumor;

      (4) The lesion margin status, if available; and

      (5) Lymphatic involvement, if available.

3. A physician is not required to provide information pursuant to this section if the patient is directly referred to or has been previously admitted to a hospital, medical laboratory or other facility which is required to report similar information pursuant to this chapter. (Added to NAC by Bd. of Health by R075-98, eff. 11-18-98)

NAC 457.060 Confidentiality of information. (NRS 457.065**,** 457.240**)** All documents in the possession of the registry which contain names of patients, physicians, hospitals or medical laboratories are confidential except the list of names of hospitals which report information to the registry and the list of names of medical laboratories which report information to the registry. (Added to NAC by Bd. of Health, eff. 12-3-84; A by R075-98, 11-18-98) (Added to NAC by Bd. of Health, eff. 12-3-84; A 1-24-92)

NRS 457.070 Duties of Health Division. The Health Division shall:

1. Investigate violations of this chapter.
2. Investigate and test the content, method of preparation and use of any drug, medicine, compound, or device proposed to be used or used by any person or association in the State for the diagnosis, treatment of cancer.
3. Make findings of fact upon completion of any testing or investigation authorized by this chapter.
4. Hold hearings for the purpose of determining whether any of the provisions of this chapter have been violated
5. Contract with independent scientific consultants for specialized services and advice

(Added to NRS by 1960, 63; A 1963, 965; 1977, 1221; 1983, 1678; 1985, 114)

NRS 457.090 Statement concerning nature and content of drug, medicine or device to be furnished person before treatment; Health Division may require statement to be posted in office or room for treatment. After an investigation by the Health Division of the content or composition of any drug, medicine, compound or device used by any person or association in the diagnosis, treatment or cure of cancer, the Health Division shall direct that any such person or association shall, prior to prescribing,

recommending or making use of any such drug, medicine, compound or device in the treatment of any person, furnish such person with a statement as to the nature and content of such drug, medicine, compound or device. The Health Division may also require that such person or association post in a conspicuous place in the office or treatment rooms of the person or association a like statement as to the nature and content of such drug, medicine, compound or device in the form and size prescribed by the Health Division. (Added to NRS by 1960, 63; A 1977, 1222)

NRS 457.100 Investigation or testing of product is not endorsement of product; representation of endorsement by Health Division prohibited. The investigation or testing of any product by the Health Division is not an endorsement of the qualifications or value of such product, and a person shall not make any representation that investigation or testing constitutes an approval or endorsement of the person's activities by the Health Division. (Added to NRS by 1960, 64; A 1977, 1222)

NAC 457.150 Fees. (NRS 457.065**,** 457.250**,** 457.260**)** The State Health Officer shall charge and collect from:

1. A health care facility, a fee of $32 for each abstract prepared by the Health Division from the records of the health care facility and a fee of $8 for each abstract prepared by the health care facility from its own records.
2. A medical researcher or other person who obtains information from the registry, a fee of $35 or the actual cost of furnishing the information, whichever is larger.

(Added to NAC by Bd. of Health, eff. 12-3-84; A 8-31-89; 10-22-93; R075-98, 11-18-98)

Appendix B: Nevada City/County Codes List

City/Town	County	FIPS Code
Alamo	Lincoln	017
Amargosa Valley	Nye	023
Arden	Clark	003
Ash Springs	Lincoln	017
Austin	Lander	015
Baker	White Pine	033
Battle Mountain	Lander	015
Beatty	Nye	023
Beowawe	Eureka	011
Blue Diamond	Clark	003
Boulder City	Clark	003
Bunkerville	Clark	003
Cal-Nev-Ari	Clark	003
Caliente	Lincoln	017
Carlin	Elko	007
Carson City	Carson City	510
Cold Springs	Washoe	031
Crescent Valley	Eureka	011
Crystal	Nye	023
Crystal Bay	Washoe	031

City/Town	County	FIPS Code
Dayton	Lyon	019
Delamar Ghost Town	Lincoln	017
Denio	Humboldt	013
Duckwater	Nye	023
Dyer	Nye	023
Ely	White Pine	033
Elko	Elko	007
Empire	Washoe	031
Enterprise	Clark	003
Eureka	Eureka	011
Fallon	Churchill	001
Fernley	Lyon	019
Gabbs	Nye	023
Gardnervillle	Douglas	005
Gardnerville Ranchos	Douglas	005
Genoa	Douglas	005
Gerlach	Washoe	031
Glenbrook	Douglas	005
Glendale	Clark	003
Golden Valley	Washoe	031
Goldfield	Esmerelda	009

City/Town	County	FIPS Code
Goodsprings	Clark	003
Hawthorne	Mineral	021
Henderson	Clark	003
Hiko	Lincoln	017
Imlay	Pershing	027
Incline Village	Washoe	031
Indian Hills	Douglas	005
Indian Springs	Clark	003
Jackpot	Elko	007
Jarbidge	Elko	007
Jean	Clark	003
Jiggs	Elko	007
Johnson Lane	Douglas	005
Kingsbury	Douglas	005
Las Vegas	Clark	003
Lamoille	Elko	007
Laughlin	Clark	003
Lemmon Valley	Washoe	031
Logandale	Clark	003
Lovelock	Pershing	027
Lund	White Pine	033

City/Town	County	FIPS Code
McDermitt	Humboldt	013
McGill	White Pine	033
Mesquite	Clark	003
Minden	Douglas	005
Moapa Town	Clark	003
Moapa Valley	Clark	003
Montello	Elko	007
Mount Charleston	Clark	003
Nixon	Washoe	031
North Las Vegas	Clark	003
Orovada	Humboldt	013
Overton	Clark	003
Owyhee	Elko	007
Pahrump	Nye	023
Panaca	Lincoln	017
Paradise	Clark	003
Paradise Valley	Humboldt	013
Pioche	Lincoln	017
Primm	Clark	003
Rachel	Lincoln	017
Reno	Washoe	031

City/Town	County	FIPS Code
Round Hill Village	Douglas	005
Round Mountain	Nye	023
Sandy Valley	Clark	003
Schurz	Mineral	021
Searchlight	Clark	003
Silver City	Lyon	019
Silver Springs	Lyon	019
Sloan	Clark	003
Smith	Lyon	019
Spanish Springs	Washoe	031
Sparks	Washoe	031
Spring Valley	Clark	003
Stateline	Douglas	005
Summerlin South	Clark	003
Sun Valley	Washoe	031
Sunrise Manor	Clark	003
Sutcliffe	Washoe	031
Tonopah	Nye	023
Tuscarora	Elko	007
Verdi	Washoe	031
Virginia City	Storey	029

City/Town	County	FIPS Code
Wadsworth	Washoe	031
Wellington	Lyon	019
Wells	Elko	007
West Wendover	Elko	007
Winnemucca	Humboldt	013
Whitney	Clark	003
Winchester	Clark	003
Yerington	Lyon	019
Zephyr Cove	Douglas	005

Appendix C: NAACCR Version 13, Comparison of Reportable Cancers—Coc/NCCR, NPCR, and SEER-Nevada Applies NPCR Rules

	CoC	NPCR/NCCR	SEER
Reportable Diagnoses	1. Behavior code of 2 or 3 in ICD-O-3 2. Nonmalignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in table 3	1. Behavior code of 2 or 3 in ICD-O-3 2. Nonmalignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in table 3	1. Behavior code of 2 or 3 in ICD-O-3 (includes VIN III, VAIN III, AIN III) 2. Nonmalignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in table 3
Exceptions **(not reportable)**	1. Skin cancers (C44._) with histology 8000-8110 (after 1/1/2003); prior to that date, AJCC stage groups 2-4 in this group were reportable 2. CIS of the cervix and CIN III (after 1/1/96) 3. PIN III (after 1/1/96) 4. VIN III (after 1/1/96) 5. VAIN III (after 1/1/96) 6. AIN (after 1/1/96)	1. Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 2. CIS of the cervix and CIN III (after 1/1/96) 3. PIN III (after 1/1/2001)	1. Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 2. CIS of the cervix and CIN III 3. PIN III (after 1/1/2001)
Multiple Primary Rules	2007 Multiple Primary and Histology Coding Rules	2007 Multiple Primary and Histology Coding Rules	2007 Multiple Primary and Histology Coding Rules

	CoC	NPCR/NCCR	SEER
Ambiguous Terminology Considered as Diagnostic of Cancer	• apparent(ly) • appears • comparable with • compatible with • consistent with • favors • malignant appearing • most likely • presumed • probable • suspect(ed)	• apparent(ly) • appears • comparable with • compatible with • consistent with • favors • malignant appearing • most likely • presumed • probable • suspect(ed)	• apparent(ly) • appears • comparable with • compatible with • consistent with • favors • malignant appearing • most likely • presumed • probable • suspect(ed)
	• Suspicious (for) typical of exception: if the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.		
Ambiguous Terminology NOT Considered as Diagnostic of Cancer	• cannot be ruled out • equivocal possible potentially malignant • questionable rule out • suggests worrisome	• cannot be ruled out • equivocal possible potentially malignant • questionable rule out • suggests worrisome	• cannot be ruled out • equivocal possible potentially malignant • questionable rule out • suggests worrisome

Appendix D: Acronyms of Cancer Organizations for the United States

NCRA	National Cancer Registrars Association
NAACCR	North American Assoc. of Central Cancer Registries
NCI	National Cancer Institute
NABCO	National Alliance of Breast Cancer Org.
NCCF	National Childhood Cancer Foundation
NKCA	National Kidney Cancer Association
NNFF	National Neurofibromatosis Foundation
NORD	National Organization of Rare Disorders
NPCR	National Program of Cancer Registries
ONS	Oncology Nursing Society
AACR	American Association for Cancer Research
ABTA	American Brain Tumor Association
ACDM	Association for Clinical Data Management
ACRPI	Association of Clinical Research for the Pharmaceutical Industry
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
ASCO	American Society of Clinical Oncology
ASH	American Society for Hematology
ASTRO	American Society for Therapeutic Radiology and Oncology
ACR	American College of Radiology

ACRO	American College of Radiation Oncology
AAPM	American Assoc. of Physicists in Medicine
CALGB	Cancer and Leukemia Group B
CCG	Children's Cancer Group
COG	Cooperative Oncology Group
ECOG	Eastern Cooperative Group
FDA	Food and Drug Administration
IESS	Intergroup Ewing's Sarcoma Study
LRFA	Lymphoma Research Foundation of America
POG	Pediatric Oncology Group
SEER	Surveillance, Epidemiology, and End Results
SGO	Society of Gynecologic Oncologists
SWOG	Southwest Oncology Group
WHO	World Health Organization
COC	Commission on Cancer
CBTRUS	Central Brain Tumor Registry of the United States

Appendix E: Approved Abstracting Abbreviations List

Section 1. Demographics

DOB	Date of birth
POB	Place of birth
DOD	Date of Death
DC	Discontinue or Discharge
ETOH	Ethyl alcohol use/intoxicated
FH	Family History
Adm	Admission
SSN	Social Security Number

Section 2. Diagnostics

DX	Diagnosis
CC	Chief Complaint
BX	Biopsy
FNA	Fine needle Aspiration
S&S	Signs and Symptoms
Sx	Symptoms
CT	Computer Tomography
CAT	Computerized Axial Tomography
PET	Positron Emission Tomography

CXR	Chest X Ray
MRI	Magnetic Resonance Imagery
US	Ultrasound
KUB	Kidney,Ureter,Bladder
Exp	Exploratory
Fx	Fracture
GI	Gastrointestinal
GU	Genitourinary
GYN	Gynecology
OB	Obstetrics
ORTH	Orothpedics
CBC	Complete Blood Count
H&H	Hemaglobin and Hematocrit
Hgb	Hematglobin
HCT	Hematocrit
RBC	Red Blood Cell Count
WBC	White Blood Cell Count
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
WNL	Within Normal Limits
WT	Weight
Y/O	Years Old

Section 3. Physical Exam

PX	Physical Exam
H&P	History and Physical
Ax	Axillary
Ing	Inguinal
Abd	Abdominal
PALP	Palpation
Bil	Bilateral
Ant	Anterior
Post	Posterior
LUQ	Left upper quadrant (abdomen)
LLQ	Left lower quadrant (abdomen)
RLQ	Right lower quadrant (abdomen)
RUQ	Right upper quadrant (abdomen)
RUL	Right upper lobe (lung)
RML	Right middle lobe (lung)
RLL	Right lower lobe (lung)
LUL	Left upper lobe (lung)
LLL	Left lower lobe (lung)
SOB	Shortness of Breath
NVD	Nausea,vomiting, diarrhea
CNS	Central Nervous System

LMP	Last Mentural Period
SL	Sublingual
SQ or Sub Q	Subcutaneous

Section 4. Tumor Markers

AFP	Alpha Feta Protein
CEA	Carcinoembryonic antigen
PSA	Prostate specific antigen
HCG	Human chronic gonadotropin
LDH	Lactate deyhdrogenase
FIGO	Federation Internet Gyn. Obst. GYN staging system
FISH	Flourescence in situ Hybridisation

Section 5. Surgical Treatments

APPY	Appendectomy
D&C	Dilation and curettage
BSO	Bilateral Salpingo-oopherectomy
Hyst	Hysterectomy
TAH	Total Abdominal Hysterectomy
TVH	Total Vaginal Hysterectom
T&A	Tonsillectomy and Adenoidectomy
TUR	Transurethral Resection

TRUSP	Trans-rectal ultrasound (prostate)
TURP	Trans Urethral Resection (prostate)
I&D	Incision and drainage

Section 6. Radiation Therapy

RT	Radiotherapy
XRT	Radiotherapy(external)
TBI	Total Body Irradiation
mIBG	Radioactive Iodine Metaidobenzoguanidine
1MBq	27 microcuries
1GBq	27 millicuries
37 GBq	1curie
1TBq	27 curies
Ci	Curie
Bq	Becquerel
Gy	Gray
Sv	Sievert
C/kg	Coulomb/kilogram
mCi	Milicuries
Mrad	Millirads
MREM	Millirems
mR	Milliroentgens

I	iodine

Section 7. Chemotherapy

5-fu	5-Flurouracil
6-MP	6-mercaptopurine
6-TG	6 thioguanine
MTX	Methotrexate
VP-16	Etoposide
CAP	Cyclophosphamide, adriamycin,platinol
SWOG	Cyclophosphamide,methotrexate, 5 fluorouracil, vincristine, prednisone(hormone)
AC	Doxorubicin, cyclophosphamide
ECOG	Gemcitabine and Radiation
RCHOP	Rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone
CTX-Plat	Cyclophosphamide, platinol
FOLFOX4	Oxaliplatin, fluorouracil, leucovorin
COMP	Cyclophosphamide, Oncovin,Methotrexate, Prednisone
AP	Adriamycin, Cisplatin
AD	Adriamycin, dacarbazine
AF	Adriamycin, Fluorouracil
FLAG	Fludarabine, Ara-c, G-CSF
AID	Adriamycin,ifosfamide,dacarbazine,mesna

MAID	Mesna,Adriamycin,Ifosfamide,Dacarbazine
TAC	Docetaxel, doxorubicin, cyclophosphamide
MC	Mitoxantrone, cytarabine
MAC	Methotrexate, Dactinomycin, Chlorambucil
ABDIC	Adriamycin, bleomycin, dacarbazine,CCNU, prednisone
ABC	Adriamycin,BCNU, cyclophosphamide
ABCD	Adriamycin,Bleomycin, Dacarbazine
CAMP	Cyclophosphamide, adriamycin, methotrexate, procarbazine
CMP	CCNU, methotrexate, procarbazine
CARBOPEC	Carboplatin, Etoposide, cyclophosphamide
ICE	Ifosfamide, carboplatin, etoposide, mesna
MICE	Mesna rescue (ancillary agent), ifosfamide, carboplatin, etoposide.
COP	Cyclophosphamide, oncovin, prednisone
MOP	Mechlorethamine, Oncovin, Prednisone
CROP	Cyclophosphmide, Rubidazone,Oncovin, Prednisone
MAP	Melphalan,Adriamycin, prednisone
TAC	Docetaxel, Doxorubicin, Cyclophosphamide
PAC	Platinol,Adriamycin, Cyclophosphamide
FAC	5-flurouracil, adriamycin and cyclophosphamide
TIC	Paclitaxel,ifosfamide,carboplatin, mesna
TEC	Pacitaxel,estramustine,carboplatin

FLAG	Fludarabine, ARA-C, G-CSF
MAD	MeCCNU, adriamycin

Appendix F: Effective Dates for Cancer Registry Standard References

(Officially Updated January 25, 2010) **Updates by NCCR October 1, 2011**

These are the official dates of implementation for various coding references. Remember that your registry may have varied from these dates.

STAGING AND CODING

International Classification of Diseases for Oncology

First edition	1976–1991
Second edition [U]	1992–2000
Third edition [U]	2001–

American Joint Committee on Cancer TNM Staging System

Second edition	1983 (breast only**)–1988
Third edition	1989–1992 (all sites***)
Fourth edition	1993–1997
Fifth edition [U]	1998–2002
Sixth edition [U]	2003–2009
Seventh edition	2010–

SEER Extent of Disease Manual

First edition	1988–1991
Second edition	1992–1997
Third edition [U]	1998–2003

Summary Staging

Summary Staging Guide	1977–2000
SEER Summary Staging Manual 2000 [U]	2001–2003

Collaborative Stage Data Collection System [U]	2004–
version 1.00	2004–
version 1.01 issued 8-12-04	2004–
version 1.02 issued 4-25-2005	2005–
version 1.03 issued 9-8-2006	2007–
version 1.04 issued 10-31-2007	2008–
version 2.00.issued 1-13-2010	2010–
version 02.03.02	2011–

http://www.cancerstaging.org/cstage/

CSv2 version 02.03.02 must be used to code all cases diagnosed on or after January 1, 2011. Once version 02.03.02 is implemented in a registry, it should be used to code all newly abstracted cases diagnosed from 2004 forward. (2004 was the first year for which Collaborative Stage was collected.) Therefore, the item CS Version Input Original [NAACCR item number 2935] must be 020302 or greater for cases diagnosed in 2011 or

abstracted using version 02.03.02. Once version 02.03.02 is implemented in a registry, and existing CS data have been converted according to specifications provided, all cases with CS data coded in prior versions should have all output stage fields re-derived using the algorithm of the new version 02.03.02. Therefore, all cases with CS data will be expected to have CS Version Derived [NAACCR item number 2936] of 020302 after implementation and conversion.

DATA COLLECTION

Data Acquisition Manual	1988–1994
1st revision 10/89	
2nd revision 10/90	
Data Acquisition Manual, revised	1994–1995
Registry Operations and Data Standards (ROADS Manual)	1996–2002
2 digit surgery codes	1988–1997
Anew@ surgery codes [U]	1998–2002
Facility Oncology Registry Data Standards (FORDS) [U]	2003
FORDS Revised [U]	2004–2006
FORDS Revised for 2007 [U]	2007–2008
FORDS Revised for 2009	2009–2009
FORDS Revised for 2010	2010–2013
FORDS Revised for 2013	2013—
SEER Program Code Manual	
First edition	1988–1991
Second edition	1992–1997
Third edition [U]	1998–2003 [H]
Third edition revision 1 (treatment codes only) [U]	2003–2004
SEER Program Coding and Staging Manual 2004 [U]	2004–2006
SEER Program Coding and Staging Manual 2007 [U]	2007–2010
Log of changes (September 2008)	2007–2010
Updated Manual (December 22, 2008)	2007–2010
SEER Program Coding and Staging Manual 2011	2011–
Updated Manual (September 27, 2011)	
Benign and Borderline Central Nervous System reporting	2004–
Multiple Primaries and Histology Coding Rules [U]	2007–
Multiple Primaries and Histology Coding Rules—	
Revised September 27, 2011	
Hematopoietic	2010–
Hematopoietic Database	2010–

Version 1.6.2 released January 4, 2011

CODING SYSTEMIC THERAPY

SEER Self-instructional Manuals for Cancer Registrars,	
Book 8: Antineoplastic Agents, third edition [U]	1993–2004
SEER*Rx Interactive Antineoplastic Database,	
version 1.0.0 (7-1-2005)	2005–2006
Update version 1.1.0 (8-15-2006)	2006–
Update version 1.2.0 (9-14-2007)	2007–
Update version 1.3.0 (5-1-2009)	2008–
Update version 1.4.1 (1-11-2010)	2010–
Update version 1.5.0 (9-27-2010)	2010–

CANCER PROGRAM STANDARDS

Cancer Program Manual 1986	1986–1990
Cancer Program Manual 1991	1991–1995
Cancer Program Standards (Volume I)	1996–2003
Cancer Program Standards revised for 2004 (Volume I) [U]	2004–2008
Cancer Program Standards 2009 Revised Edition (Volume I)	2009–

Cancer Program Standards 2012: Ensuring Patient-Centered Care 2012–

* Effective with cases diagnosed on or after January 1 of the initial stated year and ending with cases diagnosed on December 31 of the closing year

** TNM staging of breast cancer was required as of 1982, prior to the second edition

*** The Commission on Cancer urged implementation of TNM staging of all sites as of 1989 but did not require it until 1991.

[H] SEER permitted treatment codes for cases diagnosed in 2003 to be submitted in either Third Edition or Third Edition Revision 1 format. Contact SEER or your SEER central registry for further information.

[U] Updated pages/errata were released after publication. See the following list for internet sources for these documents, or contact the publishing organization=s web site for a copy.

Appendix G: References for Tumor Registrars or Tumor Reporting Personnel

There are certain advantages to using online or electronic versions of reference manuals over printed versions. Online versions are always current, often use embedded hyperlinks for easy navigation to required information, as well as allow for real time searches by text string. Online or electronic versions save paper and ink resources and reduce the need for hard copy storage and manual updating of outdated material.

- **Collaborative Stage Data Collection System Manual at** https://cancerstaging.org/cstage/Pages/default.aspx

- **SEER Multiple Primary and Histology Coding Rules at** http://seer.cancer.gov/tools/mphrules/download.html

- **SEER Summary Staging Manual at** http://seer.cancer.gov/tools/ssm/

- **ICD-O-3 SEER Primary Site/Histology Validation List at** http://seer.cancer.gov/icd-o-3/

- **Facility Oncology Registry Data Standards (FORDS) at** http://www.facs.org/cancer/coc/fordsmanual.html

- **Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at** http://seer.cancer.gov/tools/heme/

- **SEER*Rx - Interactive Antineoplastic Drugs Database at** http://www.seer.cancer.gov/tools/seerrx/

- **International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3).** This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization at http://www.who.int/classifications/icd/adaptations/oncology/en/

- **For ICD-O-3 errata and clarifications go to:** http://seer.cancer.gov/icd-o-3

CITATIONS

- Thornton, M. "Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 13." North American Association of Central Cancer Registries, Mar. 2013. Web. http://www.naaccr.org/ StandardsandRegistryOperations/VolumeII.aspx

- "SEER Program Coding and Staging Manual." Web. http://seer.cancer.gov/tools/codingmanuals/ index.html

- "Facility Oncology Registry Data Standards, Revised for 2013." Commission on Cancer. Web. http://www.facs.org/cancer/coc/fordsmanual.html

- "Collaborative Stage Data Collection System Coding Instructions, Version 02.04." • Collaborative Stage Work Group of the American Joint Committee on Cancer., n.d. Web. http://www.cancerstaging.org/ cstage/manuals/coding0204.html

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