

Michigan Cancer Surveillance Program

July 2011 Update

Labeling Your Electronic Submission File ~

Facilities having tumor registries that utilize computer software submit their cancer data electronically. A CD or FTP site is used to transmit reports to the Michigan Cancer Surveillance Program. Once the export file has been created, enter a file name which begins with MI (Michigan) followed by your 5-digit facility number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 created an export file on April 28, 2011. The file will be named MI9876520110428, plus the extension assigned by their software. The extension for Metriq is either **.xva** (new case) or **.xvm** (updated case) and will automatically be assigned. The extension assigned by Abstract Plus is always **.txt**.

If you are sending more than one file at a time, please make sure that EACH file is numbered appropriately by adding -1, -2, -3, etc. to the file name. For example, the same facility could have two files MI9876520110428-1of2.txt and MI9876520110428-2of2.txt.

Even if you use the FTP site and save your file under your specific folder, you **MUST** accurately label your file. Please note that if your file is not accurately labeled, we cannot load it into the registry.

Submission of Data ~

The MCSP began accepting submission of data for 2010 cases in NAACCR Version 12.0 format in October 2010. Please submit your 2010 cases (and prior years if necessary) **BEFORE** upgrading your software to CSv02.03 or NAACCR v12.1. After you upgrade to NAACCR 12.1 you will no longer be able to report ANY cases to us in NAACCR 12.0 layout. Keep in mind, we are not ready to receive NAACCR 12.1 layout.

Due to the delay of our in-house software conversion and loading of the data, you will **NOT** be penalized for timeliness.

Cases Due ~

We are requiring all 2010 diagnoses be submitted by August 31, 2011. We realize this is an aggressive schedule, but it is imperative that we have the 2010 cases submitted for in-house processing prior to the NAACCR call for data in November. Your cooperation is much appreciated! Please make sure to send data regularly instead of waiting for the last moment to extract/export. In addition, abstract cases in chronological order. If you are unable to meet this deadline please contact Won Silva at 517.335.9391 or silvaw@michigan.gov.

A Cancer Registrar's Guide to Collecting Industry and Occupation ~

The usual (longest-held) occupation and industry of workers can reveal the national cancer burden by industry and occupation. Such information can also be used to help discover jobs that may have a high risk for cancer or other diseases and for which prevention efforts can be focused. A Cancer Registrar's Guide to Collecting Industry and Occupation has been provided by the CDC and can be downloaded at <http://www.cdc.gov/niosh/docs/2011-173/>.

Official Documentation ~

The Michigan Cancer Surveillance Program Update is deemed as the official documentation and communication of rules set forth by the Michigan Cancer Surveillance Program. The Update is to be used as an errata and addendum and takes precedence over the Cancer Program Manual when new rules are implemented. If you are uncertain of a rule, please contact your field representative for clarification.

Occupational and Industry Data Fields ~

During the in-house edit checks, we have noticed that several facilities are putting a period (.) in the occupational and industry field. This is NOT an acceptable value. If there is no information available, then you must record 'unknown.' These two data items are required by the Michigan Cancer Surveillance Program and must be completed with valid values.

Congratulations! ~

This year marks the 14th anniversary of NAACCR Certification. A total of 68 population-based cancer registries submitted their 2008 incidence data for evaluation and confidential feedback as part of the NAACCR Registry Certification process. There are two primary reasons for evaluating central cancer registry incidence data. First is to recognize population-based cancer registries that have achieved excellence in the areas of completeness of case ascertainment, data quality, and timeliness. Second is to provide confidential feedback, which individual registries can use to identify current and future resource and training needs.

The Michigan Cancer Surveillance Program received GOLD certification for their 2008 incidence data from NAACCR! A big THANK YOU to everyone for submitting their data timely and making it possible for us to achieve the highest recognition. We could not have done it without you!

The following table is a report detailing the evaluation results of Michigan's 2008 data.

<i>Registry Element</i>	<i>Gold Standard</i>	<i>Actual Measurement</i>	<i>Standard Achieved</i>
Completeness of case ascertainment	95%	97.9%	<i>Gold</i>
Missing/unknown age at diagnosis	<=2%	0.0%	<i>Gold</i>
Missing/unknown sex	<=2%	0.1%	<i>Gold</i>
Missing/unknown race	<=3%	2.4%	<i>Gold</i>
Missing/unknown state/county	<=2%	1.3%	<i>Gold</i>
Death certificate only cases	<=3%	1.7%	<i>Gold</i>
Duplicate primary cases	<=1 per 1000	0.7 per 1000	<i>Gold</i>
Passing EDITS	100%	100%	<i>Gold</i>
Timeliness	Data submitted within 23 months of close of accession year.		<i>Gold</i>

Collaborative Stage Clarification ~

Q#1: A nephrectomy is performed for a renal cell carcinoma. There is no mention of tumor necrosis in the pathology report. How do you code SSF5?

A#1: Code 000 (Histologic tumor necrosis not present/not identified.)

Q#2: A pathology report from a TURB for a papillary transitional cell bladder carcinoma states the tumor is grade 2. How would you code SSF1 for WHO/ISUP grade?

A#2: 999 (Unknown WHO/ISUP grade.)

Q#3: Patient diagnosed with adenocarcinoma of the rectum is treated with neoadjuvant chemotherapy followed by low anterior resection. Surgical pathology diagnosis is no residual tumor. What is the code for SSF5 Tumor Regression Grade?

A#3: 000

Q#4: Pathology report of a primary endometrial adenocarcinoma reads as histologic grade; FIGO grade 1 of 3. Where is the information coded, and what is the correct code?

A#4: Code in SSF7 should be 999.

Q#5: A biopsy of the breast showed a Nottingham score of 6. The lumpectomy specimen showed a Nottingham score of 4. Do you take the higher score, or the score where the most tissue was resected?

A#5: The highest score; code 060.

Q#6: Prostate case has two needle core biopsies taken. The first needle core biopsy shows a Gleason score of 2+5=7. The second needle core biopsy shows a Gleason score of 4+4=8. How do you code SSF7?

A#6: 044

Q#7: What is Microsatellite Instability (MSI) and where can the information be found in the medical record?

A#7: MSI is a molecular marker performed on tumor tissue. Identifies differences in length of section of nonfunctioning DNA (caused by problems with genes that repair DNA.) High positive results equal possible hereditary condition. May predict response to chemo and prognosis. Results can be found on the pathology report or reference lab report.

Q#8: What is tumor regression grade?

A#8: Indicates patient's response to neoadjuvant treatment. May be called treatment effect. Code the description from primary tumor specimen. Low tumor regression grade associated with better prognosis. Results can be found on the pathology report.

Q#9: What is the circumferential resection margin (CRM)?

A#9: Measurement of distance from deepest invasion of tumor to closest soft tissue margin of specimen. Prognostic factor for recurrences and survival. May be called circumferential radial margin, radial margin or mesenteric margin. Not the same as distance to proximal and distal margins. Information can be found on the pathology report.

Q#10: If both Mamma Print and Oncotype DX are performed, which should be coded in SSF22 (Multigene Signature Method)?

A#10: 010 Oncotype DX

Bladder Primary ~

Remember to follow the Multiple Primary and Histology Rules for a bladder primary. Many of you are creating a second bladder primary when according to the rules it is not a second primary.

M3: Right and left renal pelvis, multiple primaries.

M4: Right and left ureters, multiple primaries.

M5: Invasive following a non-invasive more than 60 days apart, multiple primary.

M6: Bladder tumors w/ any combinations of the following histologies: papillary carcinoma (8050), transitional cell carcinoma (8120-8124) or papillary transitional cell carcinoma (8130-8131), **are a single primary.**

M7: Tumors diagnosed more than three (3) years apart are a multiple primaries.

Remember! You must apply the rules in order, and the first rule that applies to your case, STOP.

The M6 rule applies to 90% of the bladder primaries. What we are finding is that facilities are automatically assigning a second primary when the M6 rule applies to the case. Do NOT automatically assign a new primary just because the two cases are more than three years apart. You must look at the histologies; if they fall in the range listed in M6, it is a single primary.

E-mail from Carol Johnson, Chair of MPH Revisions, June 14, 2011 ~

SEER would like to take this time to report on the current status of the MPH revisions and future activities.

Current status: The revisions to the 2007 MPH rules are well underway. Since the committee began meeting in 2009, we have revised and greatly improved the rules for the following sites: benign brain/CNS; malignant brain/CNS; kidney; urinary sites; head & neck; colon; lung, and cutaneous melanoma. The revision process incorporates many steps prior to presenting to the committee as well as after the many steps post-presentation. To date the benign brain/CNS rules have been completed in all three formats. The remaining sites are being edited and additional issues are being addressed by the SME's. The next step will be putting them into the matrix and flowchart formats. Finally, they will be sent to the contractor to make them 508 compliant and to program the links before adding to the manual.

The remaining sites to be revised include breast and other sites. During our review of the questions we received for MPH since 2007, it became clear that the "Other sites" would require a major revision. We have broken out the other sites into the following sections: GYN, GI, soft tissue, thyroid, prostate, and male genital. The breast rules will also undergo major revisions. The Site Team Leaders will continue working on these issues with the SME's. These sites will be presented at future MPH meetings.

Future activities: It has become apparent that the new rules will need to be beta tested prior to the release of the new manual. This will involve beta testing of the rules via the reliability study method. The new rules will be revised as needed based on the results from the beta testing. Adding this activity will require delaying the deployment of the MPH revised rules to 2013. Education and training will also be included when the revised rules are implemented. On-line training modules will again be developed as well as training at workshops and conferences.

Our goal is to revise the MPH manual in such a way that it can in turn become the MPH Database and Manual equivalent of the Hematopoietic and Lymphoid Database.

Revised schedule of activities: We have identified the need to focus on the sites which have been reviewed by the committee to complete all edits and corrections before presenting the remaining sites. Hence, the two remaining meetings scheduled for June 2011 will be cancelled. We will continue to work on the outstanding sites during this time so that they are ready for the committee when meetings resume in the Fall of 2011.

2011 CTR Exam ~

Exam Dates September 10-24, 2011. Application due by August 1, 2011. For further information visit <http://www.ctrexam.org/>.

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

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