Ohio Department of Health

September 2024

OCISS Quarterly Newsletter

Ohio Cancer Incidence Surveillance System

Awareness Months

- **July** – *Sarcoma and Bone Cancer*
- **September** – *Prostate Cancer*
- **August** – *Appendix Cancer*
- **September** – *Thyroid Cancer*
- **September** – *Childhood Cancer*
- **October** – *Breast Cancer*
- **September** – *Uterine Cancer*
- **November** – *Pancreatic Cancer*
- **September** – *Leukemia*
- **November** – *Lung Cancer*
- **September** – *Lymphoma*
- **November** – *Stomach Cancer*
- **September** – *Ovarian Cancer*

OCISS Updates

OCISS Data Evaluation

OCISS submitted data for cancers diagnosed from 1996-2021 to both the Centers for Disease Control and Prevention (CDC) and the North American Association of Central Cancer Registries (NAACCR). OCISS data met CDC's National Program of Cancer Registries (NPCR) National Data Completeness and Quality Standard and, as a result, OCISS is recognized as a CDC NPCR Registry of Distinction. OCISS data also met NAACCR's criteria for Gold Certification. The CDC and NAACCR evaluations assess data quality metrics for completeness, quality, and timeliness. Thank you for all the work you do to report timely, complete, and accurate data to OCISS to allow us to accomplish these goals and achieve these recognitions!

Cancer Reporting Timelines

OCISS is beginning to prepare for its annual data submissions to the CDC and NAACCR in late November. Any outstanding case reports for diagnosis year 2022 need to be reported as soon as possible, as 2022 data need to be 95% complete. Please also do your best to complete reporting of 2023 cases as we aim for 90% completion with our 12-month data.

Web Plus Version 24

OCISS updated Web Plus to the North American Association of Central Cancer Registries (NAACCR) v24 in July 2024. We are now accepting 2024 cases and v24 XML files. Many thanks for your patience during the update. Please see important reporting changes in the Web Plus v24 Release Notes. Please contact Kaitlin Kruger (Kaitlin.Kruger@odh.ohio.gov) with any questions.

Unknown Race and Unknown Stage

OCISS recently followed up with facilities that reported cases with unknown race and/or unknown SEER summary stage. If you have not already done so, please complete and return these reports in Web Plus. Thank you for your review and follow-up.

Modified Record Reporting

Thank you to all of our hospitals who have submitted their annual modified (M) records. **If you have not yet done so, please submit your annual M records as soon as possible.** If you have any questions on M record reporting, please contact Kaitlin Kruger (Kaitlin.kruger@odh.ohio.gov).

Death Clearance

OCISS is finishing up Death Certificate follow-back for diagnosis year 2022. Follow-back information was sent to hospitals (via Web Plus) in July. If you have not done so already, please review the follow-back cases sent to your facility and return as soon as possible. Please contact Bill Ruisinger (william.ruisinger@odh.ohio.gov) with any questions.

OCISS Staff Update

OCISS is pleased to welcome two new cancer registrars: Sarah Davis and Stephanie Haders. Sarah and Stephanie joined our team in July 2024. Their contact information is listed on the last page of this newsletter. Welcome to Sarah and Stephanie!

OCISS Presentations at NAACCR Annual Conference

Kaitlin Kruger, OCISS Data Administration Manager, presented at the North American Association of Central Cancer Registries (NAACCR) Annual Conference held in Boise, Idaho June 25-27. She presented on lessons learned after one year of implementing modified record reporting, as well as on evaluating, monitoring, and improving hospital reporting timeliness in Ohio. Both presentations were very well-received, generating several questions and engagement with other central cancer registries. As a result of the presentations, Kaitlin has been invited to participate in a national workgroup for modified record reporting. Congratulations, Kaitlin!

New Cancer Publications

Ohio Department of Health (ODH) has recently posted new reports to the **OCISS Data and Statistics page**.

Ohio Annual Cancer Report 2024:

This new report provides a summary of cancer incidence for 2021, the latest year of OCISS data publicly available, including data by sex, age group, race, ethnicity, along with cancer stage and survival statistics for selected cancers. The report also includes overall cancer trends and county incidence and mortality rates for all cancers combined. It can be found under the Ohio Cancer Profiles tab.

Child and Adolescent Cancer in Ohio 2024:

This report provides data and information about child and adolescent cancer incidence and mortality in Ohio. It can be found under the Ohio Cancer Profiles tab.

New Site-Specific Cancer Profiles:

Each report provides detailed information about a specific type of cancer, with Ohio-specific information on cancer incidence and mortality (by age group, sex, and race), trends, histology, survival, risk factors, and signs and symptoms. The new profiles include:

- **Bladder Cancer in Ohio 2024.**
- **Leukemia in Ohio 2024.**
- **Non-Hodgkin Lymphoma in Ohio 2024.**
- **Multiple Myeloma in Ohio 2024.**
- **Stomach Cancer in Ohio 2024.**

They can be found under the Site-Specific Cancer Profiles tab.

OCISS Data Use by Researchers

OCISS data are requested by many researchers each year. To obtain access, researchers must submit an application to the ODH Institutional Review Board (IRB). The ODH IRB is a group of individuals from various State of Ohio agencies who review any research involving human subjects that uses any State of Ohio data. This information can be found at **here**.

Since the last OCISS newsletter, there have been two new IRB-approved studies using OCISS data.

- **Atherosclerosis Risk in Communities (ARIC).** The Primary Investigator (PI) is Elizabeth Platz, ScD, MPH from the Johns Hopkins Bloomberg School of Public Health. This study, the Atherosclerosis Risk in Communities (ARIC) study, is a prospective cohort of 15,792 men and women (55%) participants, mostly White and Black (27%), recruited in 1987-1989 from four U.S. communities: Forsyth County, North Carolina; Jackson, Mississippi; suburban Minneapolis, Minnesota; and Washington County, Maryland. The participants were middle-aged and older at recruitment. The four catchment areas were selected to make Black/White, female/male, and geographic risk factor comparisons. At the current stage of the study, the researchers are linking to various central cancer registries, including OCISS, to look at cancer rates in their cohort.
- **The Sister Study.** The PI is Dale Sandler, PhD, MPH from The National Institute of Environmental Health Sciences (NIEHS) at the National Institutes of Health (NIH). The purpose of this study is to study the independent and joint effects of genetic susceptibility and environmental, biological, and lifestyle factors on risk for breast cancer and other diseases in a high-risk, motivated cohort. The study cohort is 50,000 sisters of women who have had breast cancer.

Cancer Registrar Training & Education

Ohio Cancer Registrars Association (OCRA)

54th Annual Educational Conference
Sept 29-20, 2024
West Chester, Ohio
More information can be found at:
https://ohio-ocra.org/annual-education-meeting/

The Ohio Cancer Registrars Association is offering a two-day in person educational conference including topics revolving around cancer care, treatments, and staging. The program has been approved by the National Cancer Registrars Association (NCRA) for 11.75 Continuing Education (CE) credits and also for 11 Continuing Education Units (CEUs) by the American Health Information Management Association (AHIMA.)

2024 SEER (Surveillance, Epidemiology, and End Results Program) Advanced Topics for Registry Professionals Workshop

Sept 24-26, 2024
Virtual training open to all cancer registrars.

The workshop will expand registrars' knowledge of several important topics: in-depth coding for mixed histologies, neoadjuvant treatment for breast, esophageal, and rectal cases, and more. There will be presentations from subject matter experts, surgeons, pathologists, and oncologists.

Participants will complete assigned cases in SEER*Educate before the workshop. For more information about the SEER*Educate cases, sign in or sign up (it's free), select the Training tab, and click on SEER Educational Workshop. In-depth coding and abstracting training during the SEER Workshop will be based on coding of the assigned cases. You are welcome to complete the SEER*Educate cases even if you cannot attend the workshop. CEs are pending.

Note: The workshop is complimentary, but registration is required. The workshop is open to all registrars, not just those in SEER states. Please visit NCRA's website to register for the workshop before Sept. 9, 2024. The agenda is also hosted on NCRA's website.

Special NCRA Offer for Non-Credentialed Cancer Registrars Working in a Commission on Cancer (CoC)-Accredited Hospital

Virtual training

Non-Oncology Data Specialist (ODS) credentialed staff who join NCRA as a new Associate Member may be eligible for a special complimentary package of education. This training is for non-ODS credentialed cancer registry staff who work in CoC-accredited facilities and need training to address CoC Standard 4.3. NCRA has developed special training for this staffing cohort.

The special training package includes three free hours of education on casefinding, follow-up, and advances in cancer diagnosis and treatment. New Associate Members who successfully complete the training will receive a formal Certificate of Completion to document the three hours of cancer-related training. This special offer is for non-ODS credentialed cancer registry staff only. More information and registration can be found on the NCRA's Center for Cancer Registry Education website.

NAACCR Webinar Summaries

NAACCR hosts monthly webinars that provide three continuing education credits approved by NCRA. OCISS makes these available free for cancer reporters via Web Plus and the Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC) platform. For Web Plus access, contact Kaitlin Kruger (Kaitlin.Kruger@odh.ohio.gov, 614-728-2304). To create an account in FLccSC, visit the **FLccSC student page,** click "New Users-Register here," and complete the registration form. Under "How do you categorize yourself?" please select "Ohio Student." For FLccSC questions please contact Emily Stewart (Emily.Stewart@odh.ohio.gov, 380-218-2242.)

The following are abstracting highlights and tips from recent NAACCR webinars. Note: Some webinars cover topics in more depth than may be needed for all cancer reporters and may include data not collected by OCISS.

Boot Camp 2 (April 2024 Webinar)

Guest Speaker: Nancy Etzold

This is part two of the two boot camps offered this year! Topics covered in this boot camp include terminologies, hematopoietics, primary site, unknown primaries, casefinding, class of case and text.

Lymphoma Multiple Primaries Q&A:

Quiz 1, Question 6: Scenario - A fine needle aspiration of a cervical lymph node is positive for lymphocyte-rich classic Hodgkin lymphoma (9651/3). Slides also show evidence of mature T-cell lymphoma (9702/3). How many primaries does the patient have?

Answer - Single primary.

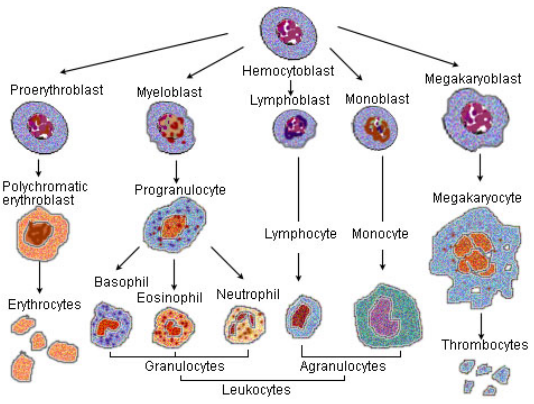
M5 states that if Hodgkin's and Non-Hodgkin lymphomas are present in the same anatomic location simultaneously, it is one primary.

Terms and Definitions:

- **Plasma:** The watery component of blood (which is 90% water). Transports nutrients and waste through the body.
- **Formed Elements:** Cells/cell fragments suspended in plasma.
- **Erythrocytes (Red Blood Cells):** Most numerous. Transports oxygen and carbon dioxide.
- **Leukocytes (White Blood Cells):** Generally larger in size than erythrocytes but fewer in number. Kills microorganisms (phagocytosis), produces antibodies, secretes heparin, and secretes and neutralizes histamines.
- **Thrombocytes (Platelets):** Fragments of megakaryocytes. Clump together to close breaks and tears in blood vessels. Initiates blood clot formation.

SEER Hematopoietic and Lymphoid Neoplasm Database Reportablity Guidelines:

- Consult the **Database** to determine reportablity.
- Report all cases with morphology codes 9590-9993 and a /3 behavior code.
- Report hematopoietic and lymphoid neoplasms with morphology codes 9590-9993 and /1 behavior codes when a provider describes them as "malignant". The behavior code should be changed to /3.
- Report hematopoietic neoplasms preceded by ambiguous terms described in the **SEER Hematopoietic & Lymphoid Neoplasm Coding Manual.**
- Report the case when the patient is treated for a reportable neoplasm.
- Report the case when there is a clinical diagnosis (physician's statement) of reportable neoplasms.
- Report the case when a reportable diagnosis appears in the text of a report described as a definitive diagnostic method.



Ovary (May 2024 Webinar)

Guest Speaker: Connie Boone

This webinar covered anatomy, solid tumor rules, staging and treatment of ovarian primary malignancies. Several examples, quizzes, and case scenarios were included. There is an "Ovary Abstracting Tips 2023 and Beyond" document provided by NAACCR among the supporting documents which is available in FLccSC (supporting documents including Q&A are only available through FLccSC and not in WebPlus.)

Ovarian cancer is primarily surgically or pathologically staged. A biopsy is rarely done due to the risk of rupture.

Serous Carcinoma:

Starting with cases diagnosed 2024 and forward, using code C56.9 with 8441/3 will trigger an edit stating that it is an "unlikely" combination. The edit can be overridden.

Assigning Primary Site:

- Rely on the physician/surgeon/pathologist's statement of primary site.
- See page 105 of the **SEER Program and Staging Manual** (Note 15) for additional instructions on assigning the correct site.

Note – Involvement of peritoneal metastasis (i.e., the peritoneal surface of the fallopian tubes) is not a factor when assigning primary site.

Tubal Primary:

When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, **any indication of fallopian tube involvement indicates the primary tumor is a tubal primary.** Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or mucosal invasive serous carcinoma.

Solid Tumor Manual:

Rule M9 states that bilateral epithelial tumors (8000 – 8799), of the ovary within 60 days are a *single primary*.

- Tumors must be the same histology or be an NOS and subtype/variant.
- Tumors listed in the same row means the tumors are one of the following:
  - The same histology (same four-digit ICD-O code).
  - One is the preferred term, and the other is a synonym for the preferred term.
  - An NOS and the other is a subtype/variant of that NOS.

Rule M10 states that tumors on both right and left sides of a site listed in **Table 1** are considered multiple primaries.

Rule H7:

Use a combination code when there are multiple specific in situ histologies AND the combination is listed on **Table 2** in Equivalent Terms and Definitions. Rules are hierarchical and this is only application when previous rules do not apply.

Example – GYN malignancies with two or more of the following:

- Clear cell.
- Endometrioid.
- Mucinous.
- Papillary.
- Serous.
- Squamous.

This histology would be Mixed cell adenocarcinoma 8323.

There is a similar rule (H21) for invasive histologies. Again, rules are hierarchical, and it is only applicable when previous rules do not apply.

Thyroid (June 2024 Webinar)

Guest Speakers: Amy Bamburg, Gillian Howell and Recinda Sherman

This webinar covered anatomy, solid tumor rules, staging and treatment of thyroid primary malignancies. Several examples, quizzes, and case scenarios were included.

Risk factors for developing thyroid cancer may include:

- Prior exposure to high dose ionizing radiation.
- Diabetes medications. (Certain medications may cause medullary thyroid carcinoma, or MTC.)
- Low iodine diet.
- Benign thyroid or breast conditions.
- Hereditary conditions.
- Obesity.
- Gender.
    - Women have three times the risk compared to men in developing thyroid cancer.
- Substance abuse.
- Exposure to flame retardants.
- Elevated thyroid-stimulating hormone (TSH) levels

The major histologies of thyroid cancer:

1. Papillary (85%), generally asymptomatic.
2. Follicular (10%), usually with symptoms.
3. Medullary (4%), aggressive and less differentiated than the common types.
4. Oncocytic (<2%), aggressive, includes Hürthle cell.
5. Anaplastic (<1%), aggressive.
6. Lymphoma (<0.5%) very rare, Hashimoto's disease is a risk factor.

Encapsulated follicular variant of papillary thyroid carcinoma (EFVPTC) has been re-classed to a non-malignant condition as of 2021+.

Fewer than 5% of newly diagnosed patients present with distant metastases. The most common sites of distant metastases include the lung and bone. Less common sites of distant metastases include the liver, kidney, adrenal and pituitary glands, and the skin.

Initial workup for a thyroid nodule should include obtaining a TSH level, followed by a thyroid ultrasound, and a fine needle aspiration.

Solid Tumor Rules:

- Use Other Sites Chapter.
- Check Table 12 of the Other Sites chapter for thyroid histologies.
- Multiple Primary Rules M7, M8, and M12 apply directly to thyroid cases.
- Histology rules H27, H30, and H31 apply directly to thyroid cases.
- DO NOT use histology 8050/3 for thyroid cases.

Grade:

- Grade clinical tumor before any treatment, it cannot be blank.
- Use the highest grade during clinical timeframe.
- Only use grade 9 when grade is not documented, a clinical workup is not done, or the grade cannot be determined.
- Clinical and pathological grade codes include: A, B, C, D, and 9.
- Pathological grade is used when there is a resection without neoadjuvant therapy. Pathological grade cannot be blank.
- Highest grade: if clinical grade is higher than pathological grade, then use clinical grade.
- Use grade 9 when: grade is not documented; there is no resection; the patient had neoadjuvant therapy followed by resection; cannot determine if grade is clinical, pathological or post therapy.

Summary Stage 2018:

- Differentiated & anaplastic schema
- Medullary schema
- Treatment with active surveillance, radioiodine or systemic hormone therapy
- Treatment with surgery

OCISS Abstracting Tips

Skin Multiple Primary Scenario

A patient has two lesions on their right arm with two biopsies on the same day. One biopsy site is the right proximal forearm with evolving malignant melanoma in situ (MMIS), and the other site is the right distal forearm with definitive MMIS.

Answer: Cases diagnosed Jan. 1, 2021, and later with the same histology would be reported as a single primary (even having different behaviors).

Note: Abstract a single primary when multiple tumors are:

- Simultaneous and abstracted as a single primary.
- Subsequent tumor(s) which are a recurrence rather than a multiple primary.

Ovarian Serous Borderline Tumors

Is an ovarian serous borderline tumor reportable? If a case is a 2018 or later, the answer is NO it is not reportable to OCISS.

> *Do not report serous borderline tumor – micropapillary variant of the ovary (8460/2, C569), as borderline ovarian tumors are not reportable. This applies to cases 2018 and later.*
>
> *Please see the SEER inquiry response for specifics.*

Coding Race and Ethnicity

OCISS staff performs routine quality reviews and audits on abstracts submitted from hospital facilities as a requirement of our NPCR grant. One of the reviews we are currently performing is a Text to Code review that ensures the numerically coded data is supported and confirmed by text documentation. While text documentation was discussed in a previous newsletter, data items such as race and ethnicity were notably inconsistent, confused with nationality, and many times absent in the reviews we have performed.

Race: The physical exam text should include and describe the race of the patient that corresponds to the numerically coded race data field. If a patient's race is not stated in the medical record but other information is provided (such as country of birth) then Appendix D of the SEER Program Coding and Staging Manual can be utilized. Race is analyzed along with a separate data item for ethnicity, Spanish/Hispanic Origin, another required data field.

If a person is multiracial and one of the races is White, code the other race(s) first with White in the next race field. Similarly, if the patient is Hawaiian, code Hawaiian as Race 1 followed by the other race(s) per the STORE Manual. A patient's name should never be used as a basis for coding race. Per the SEER Coding and Staging Manual, if the patient is described as Hispanic or Latino(a) and no further information is available, they can be coded to 01, or White, as a last resort instead of coding to unknown race.

Ethnicity: The ethnicity of a patient should be documented in the physical exam text and used to identify if the patient should be classified as Hispanic for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence than other populations that may be included in the 01 category (White) of Race.

Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names. If a person has a Hispanic name, but there is evidence that they are not Hispanic (the patient is Filipino or a White woman known to be non-Hispanic but has a Hispanic married name), the code in this field should be 0 for non-Hispanic. Persons that are Portuguese or Brazilian should be coded as non-Hispanic. If the only evidence of a person's Hispanic origin is a surname or maiden name, using code 7 (Spanish surname only) is appropriate.

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