

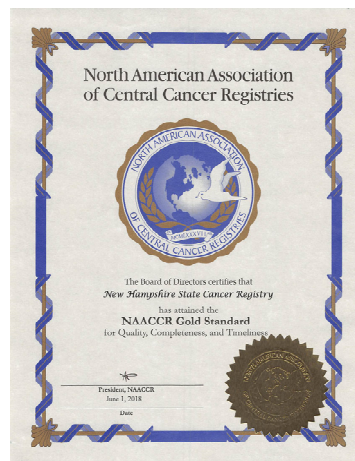
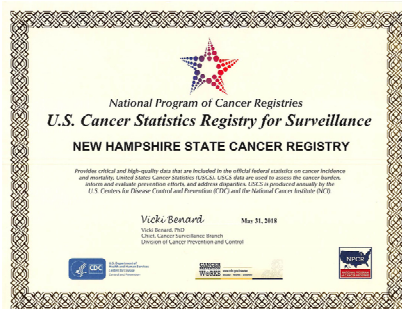
# NHSCR Registry Report



VOLUME 18, ISSUE 2  
AUGUST 2018

## NHSCR Achieves High Data Quality!

We continue to receive NAACCR gold certification for data quality, and were again awarded “Registry of Excellence” by the CDC. Thanks to everyone for your contributions to these awards – we couldn’t do it without you!



## 2018 Cancer Reporting

NHSCR continues to advocate for accommodations that will help reporters with the latest changes in standards, and will keep you posted of news from national standard setters when we get it. As noted in our Jan 2018 special newsletter, cases diagnosed January 1, 2018 and later, should be started in NAACCR Version 16 (v16) but **must be completed after** their v18-based software is installed. If you start to abstract cases diagnosed in 2018 using current v16 software, we recommend that **the following not be completed**, as new 2018 data items will be required once the standards are set (requirements will vary by standard setter): grade, stage, site-specific data items 1-25, and radiation treatment.

We recommend hospital registrars regularly check the NAACCR 2018 Implementation website: <https://www.naacr.org/2018-implementation/>

The website provides current information on all reporting standards related to v18, including:

- New Data Items
- Changes to existing data items
- Cancer Staging Requirements for 2018-2019
- 2018 Grade Coding Manual
- 2018 Site-Specific Data Items (SSDI) Manual
- ICD-O-3 changes and updates
- 2018 Solid Tumor Coding Rules
- 2018 SEER Hematopoietic and Lymphoid Neoplasm Database
- CoC STORE Manual

## NHSCR Updates

### NHSCR Data Collection Manual

With the release of the CoC STORE Manual to replace FORDS, NHSCR will again request permission from the CoC to use the STORE manual as the basis for the NHSCR Data Collection Manual. As soon as we are given the go-ahead, we will update it to include NHSCR specific-requirements where they differ from CoC. A blast email will be sent when it is available on our website.

### 2016-2017 Completeness of Cancer Reporting

As of July 31, 2018, we are at least 95% complete with year 2016 reporting from registry hospitals. We are now working on non-hospital and other reporting sources to close out the year. We are also 85% complete with diagnosis year 2017 reporting from registry hospitals. To ensure full capture of 2016-2017 cases, we are working on a number of follow-back requests:

- 2016 Path Reviews – done; went out with last quarterly upload
- 2017 Path Reviews – under review; follow-back to be sent with next quarterly upload
- 2016 MDI – done; went out with last quarterly upload
- 2017 MDI – request for the 2017 MDI will be going out mid-Sept 2018
- 2016 and 2017 Death Clearance – requests went out with last quarterly upload
- 2016-2017 Missing Values (I/O, smoking, ht/wt) – under review; follow-back to be sent with next quarterly upload
- 2016 and 2017 Rapid/Definitive Matching – under review; follow-back to be sent with next quarterly upload

### Non-registry Hospital Reporting

NHSCR staff are in the process of closing out 2016 and will be starting 2017 within the next month. Thanks to all facilities for completing the 2016 Medical Disease Index (MDI) follow-back requests, and to those who have sent in the 2017 MDI report. We are hoping to have the 2017 MDI follow-back out for review by the end of September.

Non-registry hospital reporters may have noticed that the layout of Web Plus for entering rapid abstracts changed at the beginning of 2016 MDI reporting. Please let us know how this is working out and if there are any changes we can do to make this more helpful.

Gentle reminder: When coding the primary site of a cancer, please remember to use to ICD-O-3 topography code rather than the ICD-10 code.

Lastly, a special thanks to all facilities for accommodating NHSCR staff and for granting us remote access. This has been very helpful in allowing the data collection process run more smoothly.



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### DHHS Update

NH DHHS is communicating with/working with other organizations including Dartmouth and UNH to talk about potential projects that could involve linking registry data to other datasets; just one more reason that data quality is so important!

When we link datasets together, we use all the identifiers to make sure the linkage is done correctly. For example, we may find a possible match between John Doe in the registry and Jonathan Doe in the death certificate data. If we know middle names and initials, that helps a lot. For example, John Eugene Doe is probably not the same person as Jonathan Eric Doe or Jonathan W. Doe.

## NHSCR Updates, cont.

### Quality Control

As we process data each month and clear edits, we come across data quality issues that are common among reporting facilities.

- As mentioned in the DHHS update, middle names and middle initials are **VERY important** to us for record linkages. Please be sure to record them to ensure accurate matching of cases.
- Do not include the middle initial or middle name in the *First Name* field. Use the *Middle Name* text field.
- Do not include titles such as Sr, Jr, Dr, or III in the *Last Name* or *First Name* fields. Use the *Name-Suffix* or *Name-Prefix* text fields.
- Do not enter “No Physical Address” or “USA” in the *Address at DX-No + Street* field. Nor is it used in the *Supplemental Address* field. Use the term “Unknown” in these fields when the patient’s street address is unknown or not available.
- Record apartment, unit, etc in the *Supplemental Address* field. Do not record it as part of the *Addr at DX-No + Street* field.
- We are seeing many cases with *Type of Reporting Source* left blank. Please complete this field. Most cases from hospitals will have *Reporting Source* coded to 1-Hospital.
- When using multiple *Alias Name*, do not use a comma to separate the different names. Use a space only.
- Males do not have “maiden names”. Please leave that field blank.
- Meningiomas arising in the brain should be coded to C70.0 with *Laterality* coded. Those arising in the spinal meninges are coded to C70.1. Do not use code C70.9 when information is available to assign a more specific site code.
- If a benign meningioma is followed by an invasive cancer, the meningioma is sequence 60. The invasive primary is sequence 00, not 02.
- Multiple breast cancers that are ductal and lobular arising in different quadrants of the same breast at the same time are the same primary. (See MP/H Rules M9-M11)
- Any combination of papillary or transitional cell carcinoma of the bladder: in situ followed by invasive after 60 days is a new primary (MP/H Rule M5). Invasive followed by either in situ or invasive, regardless of time span between diagnosis, is considered the same primary (MP/H Rule 6). Rule M7 does not apply; per MP/H instructions, stop at the first rule that applies. In this case, Rule M6 precedes Rule M7.
- VIN III is vulvar intraepithelial neoplasia, grade III. These are coded in situ with a grade 3.
- Many cases have the data items *Smoking*, *Height*, and *Weight* either missing, blank or coded as 9’s. Please try and find the information for these.
- Effective with diagnosis year 2015, AJCC and SEER Summary Stage must be manually staged.
- We are still receiving cases with *Summary Stage* coded as 9-unknown when definite information is available per text provided in the abstract. Please code the TNM and Seer Summary Stage fields when there is information available.
- Do not code death information when the patient is still alive at the time of last contact. *Cause of Death*, *Place of Death-State*, and *Place of Death-Country* are completed only when a patient has expired.
- If there is a blockage during planned surgical resection, and the surgeon could not go any farther, the aborted surgery should not be coded. However, the aborted surgical procedure could be coded as exploratory if surgeon looked around. And if a BX was taken during the aborted surgery, it should be coded as incisional BX of either primary or other site. If a resection was done of a mets site during the aborted surgery, it can be coded to surgery of distant mets. Still, there would be no surgery coded for the primary site.
- Radiation treatment: VMAT or RapidArc is a form of IMRT and should be coded 31. (See CANSWER Forum: “Vmat”, 06-08-11, 12:21 PM and “Appropriate rt code for vmat”, 01-21-12, 04:50 PM)

## Updates from National Standard Setters

### CDC NPCR

As you may know from an email sent earlier this month, NPCR is not requiring state registries to collect EOD or TNM staging for cases diagnosed in 2018 and 2019; states are only required to collect SS2018 and SSDIs. However, state registries can - and often do - require items not necessarily required by NPCR. We have yet to decide what NH will require, especially since we have not heard from CoC how, or if, this will affect the CoC-approved hospitals. For now, please continue abstracting all your cases as you have been doing. Remember that only cases prior to 2018 are to be marked as complete and transmitted. Year 2018 cases are not to be marked complete until after conversion to v18.

### NCI SEER

The final 2018 Solid Tumor Rules have been posted and now may be used for cases diagnosed 1/1/2018 forward. The rules can be accessed at <https://seer.cancer.gov/tools/solidtumor/>

The current casefinding list to be used for cases diagnosed 10/1/17-09/30/2018 is available on the SEER website. Please review the summary of changes to ensure they are included in your monthly Medical Disease Index reviews during your casefinding process. <https://seer.cancer.gov/tools/casefinding/>

The SEER Summary Stage 2018 manual is now available. As you begin abstracting year 2018 cases, please be sure to review the General Coding Instructions to ensure accurate coding of Summary Stage. <https://seer.cancer.gov/tools/ssm/>

### NAACCR

As mentioned on page 1, hospital registrars should regularly check the NAACCR 2018 Implementation website: <https://www.naacr.org/2018-implementation/>

### NCRA

The deadline to submit oral and poster abstracts for presentations at the next NCRA Annual Educational Conference in 2019 was August 17, 2018. While this deadline has passed, we would like to encourage hospital registries to submit for poster presentations at the 2020 meeting. You have a year to prepare for this. NHSCR recognizes the hard, valuable work that you do and would like for our NH hospitals to make a presence at the national level. Please consider showcasing your work!

### AJCC

A number of updates have been announced this year, including errata, staging forms, Histology and Topography Supplements, and information regarding the corrected 3rd printing of AJCC Cancer Staging Manual 8th Ed. Please visit the AJCC website for up-to-date information: [www.cancerstaging.org](http://www.cancerstaging.org)

### CoC

The Facility Oncology Registry Data Standards (FORDS) has been replaced by an entirely new and updated coding manual, the Standards for Oncology Registry Entry (STORE) manual. STORE is now available on the CoC website: <https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals>



## Education and Training

### SAVE THE DATE!!

The next NHSCR Annual Meeting is scheduled for Friday, Sept 21st at Elliot Hospital in Manchester, NH. Our keynote speaker will be Dr Roshani Patel. For other presentations, please let us know if there are topics you would like to hear about during the meeting or if you would like to present on a topic that other registries might find useful – either as a panel presentation or part of a round-table discussion. Please contact Maria Celaya with your suggestions by Sept 7, 2018.

### CRANE Annual Meeting

The CRANE Annual Meeting is scheduled to be held on October 22-23, 2018 in Burlington, MA. Please visit the CRANE website for information: <https://www.craneweb.org/annual-meeting/>

### NAACCR v18 Training

National standard setters (NAACCR, NCRA, SEER, NPCR, AJCC, and CoC) are working together to provide information, education, and training for.... Here we provide links and information to resources available to all registrars. Most of these links are included in the NAACCR 2018 Implementation website. It is your responsibility to register for, attend and learn from training provided by local, regional and national sources to ensure you are prepared for the 2018 changes when they go into effect. NHSCR will continue to provide information on training opportunities as they become available.

- NAACCR Education and Training Calendar <https://www.naaccr.org/education-training-calendar/>
- AJCC 8th Edition Cancer Staging Webinars for Registrars <https://cancerstaging.org/CSE/Registrar/Pages/default.aspx>
- NCRA: be sure you are registered to receive their emails and updates. Let us know if you are not a NCRA member and would like this information forwarded to you.

### NAACCR Webinars

NHSCR continues to provide the NAACCR Webinars to our NH registrars. Please consider hosting one of the upcoming sessions. If you cannot make it to the webinars but would still like to view them, email [Maria.O.Celaya@Dartmouth.EDU](mailto:Maria.O.Celaya@Dartmouth.EDU) for information on access to the recording.

09/06/18	Coding Pitfalls (hosted by WDH in Dover, NH)
10/04/18	Collecting Cancer Data: Lung
11/01/18	Collecting Cancer Data: Pharynx
12/06/18	Collecting Cancer Data: Breast
01/10/19	Collecting Cancer Data: Testis
02/07/19	Collecting Cancer Data: Colon
03/07/19	Boot Camp
04/04/19	Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasms
05/02/19	Collecting Cancer Data: Neuroendocrine Tumors
06/06/19	Collecting Cancer Data: Ovary
07/11/19	Hospital Cancer Registry Operations – Topic TBD
08/01/19	Solid Tumor Rules
09/05/19	Coding Pitfalls

### SEER\*Educate

If you visit the SEER\*Educate website, you will see that there is new material available to help with training for diagnosis year 2018 cases - AJCC TNM 8th Edition coding Modules, Summary Stage 2018, and Extent on Disease (EOD). <https://educate.fredhutch.org>

## NHSCR Data Use

### NHSCR Success Story

Every year, NHSCR is required to submit at least one success story to NPCR. These are presented as posters at national meetings. This year, our NHSCR success story poster was displayed at the NCRA Annual Conference in New Orleans, LA in May 2018.

### Increasing Human Papilloma Virus Vaccination in New Hampshire

#### SUMMARY:

Using New Hampshire State Cancer Registry data, staff of multiple public health programs wrote a data brief entitled "HPV-Associated Cancers in New Hampshire, 1999-2013". Published in 2016, this was used in publicity campaigns to increase HPV vaccination uptake.

#### CHALLENGE:

Several HPV subtypes are associated with a high risk of several types of cancer. Many of the 14 million new HPV infections that occur annually could be prevented by HPV vaccination.

#### SOLUTION:

Analysis of the HPV data showed that, on average, ~120 cases of HPV-attributed cancers were reported in NH each year. When restricting to anal and oropharyngeal cancer, the two types of cancer that affect both sexes, the number of cases attributable to HPV was almost twice as high in males as females, but only 50% of girls and 33% of boys aged 13-17 had completed a course of HPV vaccine in 2014. The HPV vaccination issue was publicized, and the data brief was disseminated to key stakeholders, clinicians, and is available online to the public.

#### RESULTS:

The State's HPV Vaccine Working Group used the data to justify the need for grant funding and to focus their outreach efforts. The group conducted four film screenings and panel discussions of *Someone You Love: The HPV Epidemic*, and two healthcare provider trainings—all with the key message that healthcare providers should strongly recommend HPV vaccination for both boys and girls 11-12 years old. The group also provided public education through newspaper, online, and social media to increase parental demand for the HPV vaccine. Public health officials and clinicians are also important target audiences. Bobby Kelly, a family physician in Exeter, NH, commented, "Clinical teams are often surprised by the increasing rates of oropharyngeal cancer in New Hampshire, as well as the fact that males still lag behind in getting vaccinated against HPV. Hopefully, this information will energize our providers and clinical staff to strongly recommend HPV vaccination to our youth."

#### SUSTAINING SUCCESS:

NH is working to promote the use of standing orders for HPV vaccination and to develop opportunities to receive HPV vaccination in community settings such as pharmacies and schools.

#### CONTACT INFORMATION:

Whitney Hammond, Bureau of Population Health & Community Services. [whitney.hammond@dhhs.nh.gov](mailto:whitney.hammond@dhhs.nh.gov)

<sup>1</sup><https://www.cdc.gov/std/hpv/stdfact-hpv.htm>

<sup>2</sup><https://www.dhhs.nh.gov/dphs/hsdm/cancer/documents/hpv-nh-1999-2013.pdf>



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## NHSCR Data Use, cont.

### Poster Presentations at NCRA and NAACCR

NHSCR staff presented posters at NCRA in New Orleans, LA in May 2018 and at the NAACCR 2018 Annual Conference in Pittsburgh, PA in June 2018:

Celaya MO, McGinn PM, Pollack LA, Celaya V, Riddle BL, Rees JR. *Collection of active follow-up data in a NPCR registry: A review of the Patient-Centered Outcomes project at the New Hampshire State Cancer Registry.*

Bernhardt EB, Caffrey AG, Celaya MO, Celaya V, Thompson T, Pollack LA, Chamberlin MD, Rees JR. Prognostic Multigene Testing in Breast Cancer: patterns, disparities, and opportunities for advancing standardized patient care-Findings from seven CDC National Program of Cancer Registries states. Presented at NCRA May 2018 and NAACCR June 2018

View the posters at <https://www.naacccr.org/2018-annual-conference-oral-and-poster-presentations/#PosterListing>

### Recent Publications Using NHSCR Data

New Hampshire participated in these papers, which will be discussed at the Fall training meeting.

- Siegel DA, et al; Enhancement of NPCR for Comparative Effectiveness Research Team. Capture of tobacco use among population-based registries: Findings from 10 National Program of Cancer Registries states. *Cancer*. 2018 Jun 1;124(11):2381-2389. doi: 10.1002/cncr.31326. Epub 2018 Mar 26.
- Allemani C, et al; CONCORD Working Group. Global surveillance of trends in cancer survival 2000-14 (CONCORD-3): analysis of individual records for 37 513 025 patients diagnosed with one of 18 cancers from 322 population-based registries in 71 countries. *Lancet*. 2018 Mar 17;391(10125):1023-1075. doi: 10.1016/S0140-6736(17)33326-3. Epub 2018 Jan 31.
- Freeman MB, et al; enhancement of NPCR for comparative effectiveness research team. Capture and coding of industry and occupation measures: Findings from eight National Program of Cancer Registries states. *Am J Ind Med*. 2017 Aug;60(8):689-695. doi: 10.1002/ajim.22739.

## NHSCR 2018 Calendar

09/03/18	Labor Day Holiday NHSCR office closed
09/06/18	NAACCR Webinar: Coding Pitfalls WDH; Dover, NH
09/21/18	NHSCR Fall 2018 Meeting Elliot Hospital; Manchester, NH
10/3-10/5	RMCDs Annual Meeting Scottsdale, AZ
10/04/18	Collecting Cancer Data: Lung (host needed!)
10/22-23	CRANE Annual Meeting Burlington, MA
11/01/18	Collecting Cancer Data: Pharynx (host needed!)
11/22-23	Thanksgiving Day Holiday NHSCR office closed
12/01/18	NPCR and NAACCR Call-for-Data due!
12/06/18	Collecting Cancer Data: Breast (host needed!)
12/24-25	Christmas Holiday NHSCR office closed
12/26-31	Winter Break NHSCR office closed
01/01/19	New Year's Day Holiday NHSCR office closed

## Claire's Corner



*Enjoy the last days of summer!*



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**NHSCR on the Web**

Please visit at: <http://geiselmed.dartmouth.edu/nhscr/>  
*We continuously aim to improve the NHSCR website. Suggestions are welcome!*

The state website for New Hampshire cancer data is:

<https://www.dhhs.nh.gov/dphs/hsdm/cancer/index.htm>

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***WE NEED RAPIDS AND DEFINITIVES EACH AND EVERY MONTH!***

Data transmissions should be made at least once a month. The simplest way to transmit is via the website. There's no zipping and it's secure. If you need help, please contact Bruce Riddle at 603-653-6620. He's always happy to help with sending your cases in!

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