



Texas Cancer Reporting News

Volume XIII, No. 1 Summer 2011 Publication No. E10-10542



Texas Cancer Registry



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

Recognition of TCR Funding Sources:

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

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

Federal Grant Funding

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State Agency Funding

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

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Appreciation is also extended to the following academic institutions for their past funding of the Texas Cancer Registry:

Through the Texas Higher Education Coordinating Board:

- University of Texas M.D. Anderson Cancer Center
- Baylor College of Medicine
- University of Texas Southwestern Medical Center at Dallas

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- Texas Tech University Health Sciences Center
- University of Texas at Austin
- University of Houston
- University of North Texas Health Science Center at Fort Worth
- Texas Tech University
- University of Texas at Arlington
- Texas State University - San Marcos
- University of Texas at Brownsville
- Texas Woman's University
- Texas Southern University
- University of Texas - Pan American
- University of Texas at El Paso
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- University of Texas at Dallas

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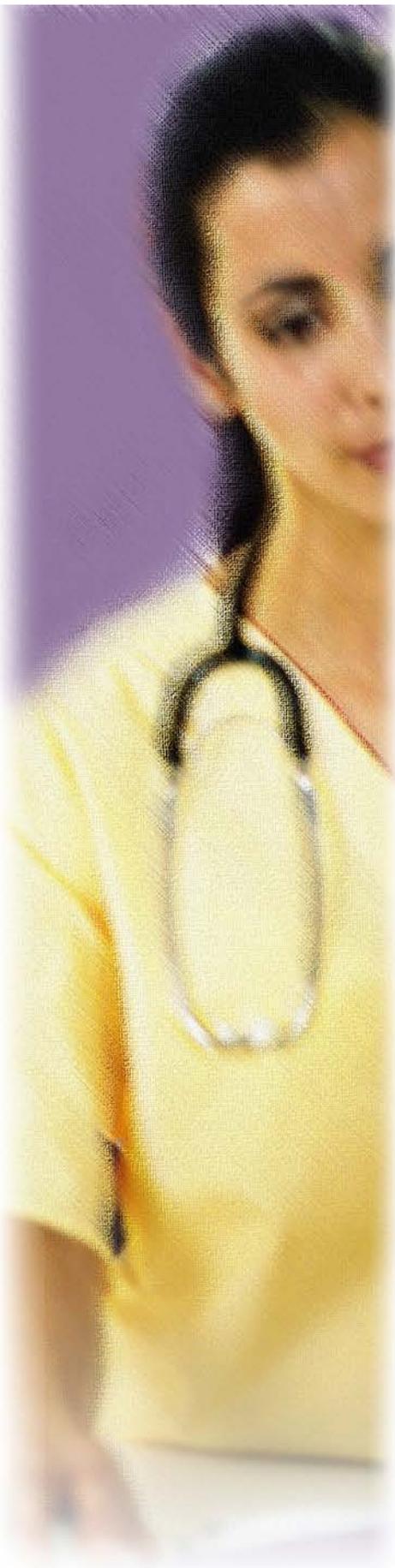
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Questions regarding information found in this newsletter, or suggestions for future editions can be directed to Alison Little, in Austin at (512) 458-7523, (800) 252-8059 (in Texas), or email at Alison.Little@dshs.state.tx.us.

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http://www.dshs.state.tx.us/tcr/news_tcrn.shtm

Visit us online: www.dshs.state.tx.us/tcr

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Change to Collaborative Stage Guideline, Effective Immediately

The table shown below is on the Collaborative Stage Melanoma Schema tab developed with the implementation of CS V 01.00.00, and reflects a conversion of the Breslow Depth of invasion and Clark's Level. Effective immediately, do not use this conversion to code these data fields (CS Ext and SSF 1). These data fields should be coded appropriately to unknown if no other information is provided. This conversion table changed with the 7th Edition of the AJCC manual. Additional tabs will be reviewed to ensure the information provided is still accurate. If you have any questions, please contact your regional representative.

NOTES

- This schema includes only malignant melanoma (morphology codes 8720-8790) of skin, vulva, penis, and scrotum, which comprise TNM chapter 24, Melanoma of Skin. All other histologies for these sites are coded with other schema.
- Regional lymph nodes for malignant melanoma of these sites are defined as those in the vicinity of the primary tumor. See figure 2 for lymph node chains of the head and neck and figure 157 for other lymph node chains.
- Anatomic illustrations for vulva are shown in figures 95 and 96; for penis in figures 112-114; and for scrotum in figure 120.
- This schema uses four site-specific factors.

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ANATOMIC DRAWINGS FOR MALIGNANT MELANOMA OF SKIN, VULVA, PENIS, SCROTUM

Adapted from: www.med-ars.it/galleries/various_2.htm

FIGURE 86. LAYERS OF SKIN, CLARK'S LEVELS AND DEPTH OF INVASION

FIGURE 88. SATELLITE AND IN-TRANSIT METASTASES

FIGURE 87. RELATIONSHIP BETWEEN THICKNESS, BRESLOW DEPTH OF INVASION AND CLARK'S LEVEL
(Use only for melanoma of skin, vulva, penis and scrotum)

Thickness/Depth	Clark's Level and Definition
In situ; noninvasive Up to 0.75 mm	I Involving only the epidermis
0.76 to 1.5 mm	II Invading papillary dermis but not to papillary-reticular dermal interface
> 1.5 mm	III Invades and expands papillary dermis but no penetration of reticular dermis
Through entire dermis	IV Into reticular dermis but not into subcutaneous tissue
Further extension	V Through reticular dermis into subcutaneous tissue
	-- Underlying cartilage, bone, skeletal muscle

Anatomy Charts for the Collaborative Staging System © 2004 Abstractor Artworks

Melanoma of Skin,
Vulva, Penis, Scrotum
C44, C51, C60, C63.2

Elena Torres, CTR
Quality Assurance/Training Group
Austin



Updates to Collaborative Staging Data Collection System

Conversion Specifications and Release Materials for CS Version 02.03.02

The conversion specifications and release notes for CS Version 02.03.02 have been updated to address known issues and are dated June 15, 2011. Specifications are available for download from the CS webpage of the American Joint Committee on Cancer's (AJCC) web site at <http://cancerstaging.org/cstage/index.html>, along with other programming and documentation files for this release.

The conversion specifications consist of two files: An MS Word file containing the textual instructions, and an MS Excel file containing the conversion specifications. These two documents comprise the guide for release 02.03.02. No other implementation guides are required for this release.

Implementing CS Version 02.03.02

NPCR requires conversion to CS Version 02.03.02 before cases diagnosed January 1, 2011 can be accepted.

If you have already implemented CS version 02.0x, then you can implement CS version 02.03 at any time. CDC will be providing Northcon12 and a DLL that will perform the conversions and derivations from CS version 02.0x to CS version 02.03.

You must implement 02.0x.xx before implementing this new release. A conversion program from CS version 1 to CS version 2 is available on the AJCC web site at <http://cancerstaging.org/cstage/index.html> along with the implementation guide.

For More Information

Vendor and general questions regarding the CS release can be submitted to CSv2@facs.org. All medical,

abstracting, coding, and staging questions should be submitted to the CANSWER Forum at <http://cancerbulletin.facs.org/forums/>.

Susana Perez, CTR

*Quality Assurance/Training Group Manager
Austin*



Congratulations to the Texas Facilities Newly Accredited by the Commission on Cancer in 2010:

- Texas Health Resources Harris Methodist Hospital Hurst-Euless-Bedford, Bedford
- Baylor All Saints Medical Center, Ft. Worth
- Baylor Regional Medical Center, Plano
- Wise Regional Health System, Decatur
- Hillcrest Baptist Memorial Hospital, Waco

Elaine Woods, CTR

*Northeast Texas Registry Operations Group Manager
Arlington*



Remember:

The Texas Cancer Registry is the 4th largest cancer registry in the United States.

Approximately 240,000 reports of cancer are received annually from over 500 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state.

The Return of the QA Flyers



The Texas Cancer Registry is proud to announce the return of our Quality Assurance (QA) Flyers. These flyers provide helpful tips on cancer reporting rules and guidelines and provide another form of education for cancer reporters. Every two to three months, a new QA Flyer is released, each with its own topic and theme. The QA flyer for January 2011 was on “Treatment – Coding Surgical Procedures,” and in April 2011, “Treatment – Radiation Therapy.” The information contained comes from different sources and standard setters such as SEER (Surveillance, Epidemiology and End Results), NCI (National Cancer Institute), CoC (Commission on Cancer), as well as our own Cancer Reporting Handbook, 2010. We will continue to periodically release these QA flyers with different topics using the most current information available.

Each flyer has detailed background information on a specific topic as well as corrected coding mistakes/misconceptions and explanations for these. Our goal is to reduce coding mistakes we most commonly see when performing data quality review on data submitted from different facilities. Areas of concern may not always trigger an edit, but are still coded incorrectly.

The QA flyers are similar to the “Coding Corner” of the newsletter in that the purpose of both is to help reporters avoid coding errors. QA flyers will have more background information on a particular cancer registry topic (e.g. treatment, surgery, etc), while “Coding Corner” articles are set up in a Question and Answer format. Also, QA flyers are published separately from the newsletter. Please watch for both types of resources on our website.

To view these flyers, please visit our website at http://www.dshs.state.tx.us/tcr/flyer_QA.shtm. If you have any suggestions for future QA Flyer topics or there is a particular topic you would like more information on, please contact us at 210-949-2165 or e-mail at edith.zambrano@dshs.state.tx.us.

Edith Zambrano, CTR

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Coding Corner

Multiple Primary and Histology Rules: Urinary Primaries

Question:

A patient had invasive papillary urothelial carcinoma of the renal pelvis (C659) diagnosed in December 2010. In July 2011 the same patient was diagnosed with Papillary transitional cell carcinoma in the bladder (C67). Would this be considered two primaries?

Answer:

Based on rule M7 of the Multiple Primary and Histology Rules this is one primary since they were diagnosed less than 3 years apart.

Resource:

2007 Multiple Primary and Histology Rules, page 314
http://seer.cancer.gov/tools/mphrules/mphrules_text.pdf

Question:

A patient has a history of transitional cell carcinoma of the bladder diagnosed in January of 2007. On April 11, 2011 the patient is diagnosed with a papillary urothelial cell carcinoma of the left ureter. Is this one or two primaries?

Answer:

Since the diagnoses were more than three years apart, this would be considered two primaries based on rule M7 of the Multiple Primary and Histology Rules.

Resource:

2007 Multiple Primary and Histology Rules, page 314
http://seer.cancer.gov/tools/mphrules/mphrules_text.pdf

Question:

Patient was diagnosed with biopsy proven invasive papillary transitional cell carcinoma. Diagnosis at TURBT was extensive invasive papillary transitional

cell carcinoma. A cystectomy was done and the patient had bladder and ureter transitional cell carcinoma insitu. Would the primary site code be C689 even though the most invasive disease is in the bladder?

Answer:

Per Urinary rule M8 this is a single primary. Code the invasive histology (Rule H6). The bladder has extensive invasive disease. The ureter only has in situ disease. Most registrars are documenting the organ with the most invasive tumor when there is invasive disease in one organ and in situ in one or more other organs. Physicians will be treating the patient according to the most extensive tumor. Choose bladder as the primary site.

Resource:

<http://cancerbulletin.facs.org/forums/content.php> I&R archives Transaction ID 47155

Note: To access I&R archives, go to CAnswer Forum at <http://cancerbulletin.facs.org/forums/> and register.

Question:

A patient was diagnosed with bladder cancer in 1997 and 2000 but no histology information is known. The patient had a positive biopsy with transitional cell carcinoma at our facility in 2011. Would this be recurrence or new primary?

Answer:

Per Urinary Rule M1, when it is not possible to tell if there is a single or multiple tumors, it should be treated as a single primary.

Resource:

<http://cancerbulletin.facs.org/forums/content.php> I&R archives Transaction ID 45051

continued on page 6...

Coding Corner *continued...*

Question:

What ICD-O-3 histology code and MP/H rules are used for a bladder cancer when the path report showed high grade carcinoma with both urothelial and keratinizing squamous differentiation?

Answer:

Per Urinary Rule H3, code to the urothelial differentiation, 8120. Do not code squamous carcinoma unless the tumor is pure squamous cell carcinoma.

Resource:

<http://cancerbulletin.facs.org/forums/content.php> I&R archives Transaction ID 45830

Cindy Dorsey, CTR

*Program Specialist, Quality Assurance/Training Group
Austin*

Outstanding Achievement Award

The Commission on Cancer (CoC) of the American College of Surgeons has granted its Outstanding Achievement Award to a select group of 90 currently accredited and newly accredited cancer programs across the United States for 2010. Scott and White Memorial Hospital in Temple, Texas is one of the facilities to receive this award.

The CoC Outstanding Achievement Award recognizes cancer programs that strive for excellence in providing quality care to cancer patients. This award is granted to facilities that demonstrate a Commendation level of compliance with seven standards that represent six areas of cancer program activity: cancer committee leadership, cancer data management, clinical management, research, community outreach, and quality improvement. In addition, facilities must receive a compliance rating for the remaining 29 cancer program standards.

Congratulations to Scott and White!

Susana Perez, CTR

*Quality Assurance/Training Group Manager
Austin*



(Left to right) Karen Torges, American Cancer Society; Dr. Melanie Williams; Dr. Brad Pollock, U.T. Health Science Center at San Antonio

New ACTCR Chairs

Dr. Melanie Williams expressed gratitude on behalf of the TCR and DSHS to **Dr. Brad Pollock** of the University of Texas Health Science Center at San Antonio and **Karen Torges** of the American Cancer Society for serving as volunteer Chair and Vice-Chair, respectively, of the Advisory Committee to the Texas Cancer Registry (ACTCR) for the past two years. At the June meeting of the group, **Ms. Torges** became the new Chair of the group and **Dr. Keith Argenbright** of the University of Texas Southwestern Medical Center and Moncrief Cancer Institute was elected the new Vice-Chair. Many thanks to all members of the ACTCR!

National Cancer Registrars Week

From NAACCR:

“In recognition of National Cancer Registrars Week and on behalf of the North American Association of Central Cancer Registries (NAACCR), we would like to express our deep appreciation for the dedication and commitment of cancer registrars all across North America.

Cancer registrars play a vital role in all of NAACCR’s priority areas. Central cancer registries rely on the expertise and dedication of cancer registrars to collect and process data on thousands of cases a day, contributing to our understanding of cancer and working toward our goal of reducing the cancer burden.

Cancer registrars pave the way towards a cure by serving as a bridge from clinical care to surveillance and cancer research. The rapid advancement of medical, genetic, and information technologies has altered the scope of cancer registration. Cancer registrars have answered the call bringing experience, talent, and passion to meet their goals. Congratulations!”

Sincerely, NAACCR Board of Directors

What some registrars in the state did to celebrate:

Vicki Holmes, CTR, and **Sandy Lowrey**, Texas Health Resources, Arlington Memorial Hospital gave NCRA postcards with a bowl of tulips to their Manager and Managing VP/CFO thanking them for their support of the registry. In their words: “The HIM department gave us a luncheon to help us celebrate our week. We presented a summary of what the Cancer Registry is all about and the information we collect. We talked about the cancer program and our pursuit of accreditation. We discussed the impact on HIM and how they can assist us with our data collection.”

Dianne Ketchum, CTR, Director, Texarkana Cancer Registry created two very nice large posters for CHRISTUS St. Michael Health System and Wadley Regional Medical Center to be displayed in the Wadley doctors’ dining room and CHRISTUS entry lobby during the week of April 11-15th. She says, “I create these by using the NCRA poster and our most recent annual report graphs and primary site tables. These posters were designed to feature each facility’s own information. I also included a photo of our cancer registry staff on both posters as a way to recognize the staff and the important work our cancer registrars do for each facility. I submitted an article for our UAMS AHEC-SW Newsletter highlighting this week.”

Dianna Miller, RHIT, CTR, Supervisor, Cancer Registry, Texas Health Harris Methodist Fort Worth really tries to make her staff feel special during NCRA week. “I give each of them a little gift each day, then we go out as a group to do something fun on the town. They are a very special group and deserve very special recognition.”

Dee Rodriguez, BA, CTR, Cancer Program Coordinator, Abilene Regional Medical Center, posted Governor Rick Perry’s NCRW proclamation on her office door. She received a signed card saying “Happy CTR week” along with flowers and candy from the HIM department.

Deidre Watson, CTR, State Administrator, Cancer Registry, Texas Oncology forwarded NCRA’s proclamation to their new Executive Director. He sent an email to all the staff thanking them for their hard work.

Elaine Woods, CTR

*Northeast Texas Registry Operations Group Manager
Arlington*



Technology Corner

NAACCR version 12 (2010 Changes):

The Texas Cancer Registry (TCR) has implemented the latest NAACCR v12D edits for Texas (TCRCRV12D.RMF). For facilities that use commercial software to submit their data to the TCR, the edits are available via our TCR website (<http://www.dshs.state.tx.us/tcr/vendors.shtm>). For facilities that use SandCrab Lite (SCLv10), the edits and updated SCL software should automatically download and install when you access the application.

New System Registry Software Planned for the Texas Cancer Registry:

As you may be aware, the Texas Cancer Registry (TCR) has received approval to replace the current SandCrab cancer reporting system with free software programs from the Centers for Disease Control and Prevention (CDC) – National Program of Cancer Registries (NPCR). Web Plus, designed for cancer reporter submissions, will replace the TCR-developed SandCrab Lite (SCL) and SandCrab Lite for Pathlabs (SCL-P). Registry Plus, designed for the central cancer registry, will replace the TCR-developed SandCrab system.

The first software change that TCR plans to implement is migrating to Web Plus, which is scheduled to happen in the summer of 2011. The change in software from SandCrab Lite to Web Plus will primarily impact cancer reporters (facilities) and will require training on use. For additional details about Web Plus, please view the CDC hyperlink: <http://www.cdc.gov/cancer/npcr/tools/registryplus/wp.htm>.

The other component of the new CDC software, Registry Plus (for the TCR Central Registry), is scheduled to be implemented (some or all components) by August 2011. The major tasks ahead are connectivity with the procured hardware, data migration, business process re-engineering, testing, training, and implementation. The change in software from SandCrab to Registry Plus will impact both TCR staff and cancer reporters (facilities).

Jonathan Unnasch

*Business Analyst, Data Management Group
Austin*

What Do You Want to See in the Texas Cancer Reporting News?

We would love to hear your suggestions for the Texas Cancer Reporting News! Please take a minute to share your thoughts at this link: <http://www.surveymonkey.com/s/3LKYHWS>. Thank you!

Remember:

The effectiveness of the Texas Cancer Registry is dependent on complete, timely and accurate reporting. To assure timely and complete cancer reporting, the TCR monitors compliance routinely in accordance with the Texas Cancer Incidence Reporting Act.

Training Corner

NAACCR Webinars

The Texas Cancer Registry (TCR) will continue to host North American Association of Central Cancer Registries (NAACCR) and National Cancer Registrars Association (NCRA) training opportunities. We will broadcast the 2011 NAACCR webinar series which can be viewed in Austin, Beaumont, Dallas, El Paso, Fort Worth, Houston, Laredo, Lubbock, McAllen, San Antonio and Tyler. Each webinar is three hours in length. Please check our website for specific location information at <http://www.dshs.state.tx.us/tcr/webinars.shtm>. Certificates will be emailed to you. If you prefer a hard copy, please email your request to Judy.Gonzales@dshs.state.tx.us.

Upcoming NAACCR Schedule for 2011:

- 08/04/11 NAACCR Interoperability Activities and the Electronic Health Record
- 09/01/11 Coding Pitfalls

NCRA Webinars

The NCRA offered a six-part Advance Quality Abstracting Webinar Series. According to the NCRA website, this was an “exciting webinar series aimed at understanding and addressing complex abstracting coding issues. This is an advanced series based on data compiled from registries’ most frequent abstracting data edit discrepancies. Each webinar included a 5-8 minute topic overview and will conclude with a question and answer session. The objective was to provide a program that is focused on addressing complex issues that go well beyond the basics.” The webinars were viewed in Amarillo, Austin, Arlington, Houston, Edinburg, El Paso, Laredo,

Lubbock, San Antonio, Temple and Tyler. Check our website for information and at <http://www.dshs.state.tx.us/tcr/webinars.shtm>.

Be sure to visit our website (<http://www.dshs.state.tx.us/tcr/training.shtm>) for additional training opportunities.

Dwenda Smith, CTR

*Training Specialist, Quality Assurance/Training Group
Austin*



Texas Cancer Registry Accomplishments

The TCR has achieved CDC-National Program of Cancer Registries “High Quality Data Standards” and Gold Certification by the North American Association of Central Cancer Registries (NAACCR) for diagnosis year 2008. Thank you for everything you do to make sure that cancer data is complete, timely, and high-quality in Texas!



Remember:

When submitting your file to the TCR you must place it in the submission folder for your facility on the WS_FTP server. To ensure your file gets uploaded, double-click on “Submissions” and open the file, then click on “Upload file.”



What is Comparative Effectiveness Research (CER)?

I received a letter a few months ago advising me of new requirements I need to adhere to when abstracting cases related to a Comparative Effectiveness Research project. What is this research, and how does it relate to cancer?

The Agency on Healthcare Research and Quality, which is part of the U.S. Department of Health and Human Services, says:

“Comparative effectiveness research is designed to inform health-care decisions by providing evidence of effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, surgeries, or ways to deliver healthcare.”ⁱ

Another, shorter definition is this:

“Comparative effectiveness research (CER) is the study of two or more approaches to a health problem to determine which one results in better health outcomes.”ⁱⁱ

One way CER is being used is to find better ways to screen for, prevent, and treat cancer.

Ok, but research on whether treatments work is nothing new, and I've only started hearing about CER recently. What is new or different about CER?

The short answer about why we have all started hearing more about CER lately is that there has been increased federal funding for it through the American Recovery Reinvestment Act (ARRA) and the Affordable Care Act (ACA). The funding that the Texas Cancer Registry and nine other central cancer registries in the country are receiving to participate in the 18-month CER project comes from ARRA.

However, the question remains of what makes CER different from research related to health outcomes with which we are all familiar. There are some recognized limitations of the body of existing research used to inform health decisions, such as that:

- Studies frequently compare a treatment with a placebo—essentially, with no treatment. Outcomes of these studies can lend evidence that a treatment works compared to nothing, but there are fewer studies that show whether one treatment is more effective than another one;ⁱⁱⁱ
- Studies may happen for too short of a time period to capture results of interest, like negative side effects of a treatment;
- In experiments, people may be in situations that are very controlled—e.g., someone makes sure that they take all of their pills and doctors check on them every week—which means it's not clear how people in regular settings respond;
- Researchers may pick homogenous groups to study, like people with cancer but no other health problems. This means it's hard to tell how the treatment works for the people who got excluded from these kinds of studies.^{iv}

The support and funding of CER is a targeted effort to improve the information available to policymakers and clinicians to make decisions related to health. Some of the defining characteristics of CER are:

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What is Comparative Effectiveness Research (CER)? *continued...*

- “direct comparison of effective interventions,
- the study of patients in typical day-to-day clinical care, and
- the aim of tailoring decisions to the needs of individual patients.”^v

CER includes studies and analyses that directly compare alternatives, analyze outcomes of patients in regular (non-laboratory) settings, and examine effects of interventions on subpopulations. Additionally, CER includes an emphasis on including different types of studies besides randomized controlled trials,^{vi vii} which is a shift in norms compared to evidence-based medicine as it has previously prevailed.^{viii} In practice, this may mean increased analysis of the data that we collect for other purposes, like disease surveillance or billing.

So, we’re collecting the extra data items and TNM staging in order to bring to light evidence that exists in the medical records about the comparative effectiveness of certain types of cancer treatment?

Yes. Data are being collected in 10 states, including ours, on several research questions, like whether colorectal cancer patients are tested for KRAS and whether that information is used in treatment decisions, along with their health outcomes. The goal is for researchers to analyze these data from the 10 specialized central cancer registries across the country and for doctors and patients to have access to the best information possible to make treatment decisions.

Alison Little, MPP

*Program Specialist, Core Business Operations Group
Austin*

ⁱ “What is Comparative Effectiveness Research.” *AHRQ Effective Health Care Program*. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Accessed online 10 May 2011.

< <http://www.effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/>>.

ⁱⁱ Tanenbaum, Sandra J. “Comparative Effectiveness Research: Evidence-Based Medicine Meets Health Care Reform in the USA.” *Journal of Evaluation in Clinical Practice* 15 (2009) 976.

ⁱⁱⁱ Greene, Jeremy A. “Swimming Upstream: Comparative Effectiveness Research in the U.S.” *Pharmacoeconomics* 27.12 (2009): 980.

^{iv} *Ibid* Tanenbaum 977.

^v Note: bullets have been added. “Initial National Priorities for Comparative Effectiveness Research.” Report Brief. Institute of Medicine of the National Academies. June 2009.

^{vi} *Ibid* “What is Comparative Effectiveness Research.” Also see “How are Comparative Effectiveness Reviews Conducted?” *AHRQ Effective Health Care Program*. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Accessed online 10 May 2011. < <http://www.effectivehealthcare.ahrq.gov/index.cfm/what-is-comparative-effectiveness-research1/how-are-comparative-effectiveness-reviews-conducted/>>.

^{vii} *Ibid* “Initial National Priorities for Comparative Effectiveness Research,” 1-2.

^{viii} *Ibid* Tanenbaum, 976 and 977.



Epidemiology Corner

Texas Cancer Registry Data Continues to Improve

The Texas Cancer Registry continuously assesses the quality of data. These data quality assessments are provided to researchers upon request for their use in documenting the significance of any findings utilizing our data.

The table below is an example of an assessment of several important data quality measures for the data we have now from a variety of diagnosis years: estimated completeness of the data, percentage of cases that are death certificate only (DCO), are microscopically confirmed, or have unknown stage at diagnosis or unknown race.

Year of Diagnosis	Complete %	Death Certificate Only (DCO%)	Microscopic Confirmation%	Unknown Diagnosis Stage %	Unknown Race %
1995-2008	99.1	3.0	91.4	17.0	0.7
2008	96.5	2.8	90.6	14.2	1.6
2007	100.3	2.2	91.6	13.4	1.4
2006	99.5	2.3	91.5	14.3	1.0
2005	98.7	2.6	91.5	13.7	0.9
2004	100.2	2.7	91.4	14.9	0.9
2003	98.8	2.6	91.4	16.5	0.8
2002	99.6	2.9	91.1	17.7	0.7
2001	100.8	3.0	91.1	17.8	0.5
2000	97.4	3.3	91.6	18.9	0.4
1999	98.5	3.3	91.6	19.2	0.3
1998	101.9	3.9	91.3	19.8	0.2
1997	99.1	3.5	91.4	20.6	0.2
1996	98.6	3.4	91.8	20.0	0.1
1995	98.1	3.7	91.3	20.0	0.1

Since 1995, other data quality items such as missing age, missing sex and missing county have remained so low as to be negligible, which is great news in terms of data quality.

Since the TCR continues to accept data even after the year of diagnosis when they are requested, the characteristics of the data file on a particular diagnosis year may change over time. For instance, there are fairly low rates of unknown race overall—0.7% for all diagnosis years taken together—and the percentage unknown are even lower for early diagnosis years than for the past couple of years. The improvement of the quality of data for earlier diagnosis years compared to more recent years is reflected in the data in the table above: 0.1% for diagnosis year 1995 compared to 1.6% unknown for diagnosis year 2008. One possible reason for this trend is that TCR may have data about a patient with an unknown race, but receive information about that individual’s race later. This frequently happens when someone whose race is unknown to the registry dies, and the information becomes available through that person’s death certificate.

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Epidemiology Corner *continued...*

The data trend in the opposite direction for two other quality measures—death certificate only and unknown diagnosis stage. As with unknown race, having smaller numbers is more desirable in terms of data quality. For both of these, the percentages are higher for early diagnosis years than for recent diagnosis years currently in the TCR's data file. Some possible explanations are that: available medical information has improved in recent years, registrars have improved in identifying cases before death and in identifying the stage of diagnosis in recent years, and TCR has had more staff-power to resolve DCO cases in recent years than in previous years. Whatever the explanation may be, the lower percentage rates of DCOs and unknown stage in recent diagnosis years are positive in terms of data quality.

Another characteristic, microscopic confirmation, has a very steady rate across all diagnosis years. Microscopic confirmation reflects the certainty of the diagnosis, but for some types of cancer and in some situations microscopic confirmation may not even be done. The steady rate simply reflects a characteristic of the overall cancer data, since this information is collected whenever it is available, and has been very consistent over time.

Completeness rates show no clear upward or downward trend before year 2008, and range from 97.4% to 101.9% for all diagnosis years, excluding the most recent one. Completeness was lower in earlier years before we had implemented all of our current case-finding improvements. Also, the latest year (2008 in our current file) will usually have a slightly lower completeness when the file is first produced, but this will improve in subsequent years, as late cases are added.

David Risser, PhD, MPH and Cheryl Bowcock, MPH

Epidemiologists, Epidemiology Group

Austin

Texas Cancer Registry Publishes Two Site-Specific Reports in 2010

The Texas Cancer Registry, in collaboration with the Cancer Prevention and Research Institute of Texas, published two new site-specific reports, *Colorectal Cancer in Texas, 2010* and *Cervical Cancer in Texas, 2010*. Both of these reports are published in a newer, more user-friendly format than previous reports, including fewer data tables and more descriptive information about the cancer types and trends in Texas populations. The reports provide information about differences in cancer incidence and mortality rates by different geographic areas of Texas, as well as make comparisons by the stage of disease at diagnosis. In addition to having colorful, bound versions of these reports available at the central and regional TCR offices, we also have each of these reports available for downloading from our web page: <http://www.dshs.state.tx.us/tcr/publications.shtm>.

David Risser, PhD, MPH and Cheryl Bowcock, MPH

Epidemiologists, Epidemiology Group

Austin



Legislative Update - 82nd Session

The regular session of the 82nd Texas Legislature ended on May 30, 2011. The legislature was immediately called back into special session to consider additional legislation, which ended June 29, 2011.

During the regular session, SB 156 by Senator Joan Huffman and sponsored by Representative Veronica Gonzalez passed. This bill would allow hospital discharge data, which is collected by another program in the Department of State Health Services, to be shared with the Texas Cancer Registry. The barrier to linking this data stemmed from a period of time when hospital discharge data was collected by an entity outside the Department of Health, and was not updated at the time of the consolidation of health-related agencies in 2003. Although bills to allow this linkage have been introduced in three previous legislative sessions, none have been successful until this session.

Going forward, we hope that the ability of the Department of State Health Services to link Texas Cancer Registry and hospital discharge data improves data available for research and should assist registrars in casefinding and other ways that may reduce the reporting burden to the state.

Alison Little, MPP

*Program Specialist, Core Business Operations Group
Austin*



TxTRA



The Texas Tumor Registrars Association, a volunteer organization dedicated to the support of cancer data management professionals, promotes education and guidance in the areas of cancer registry and cancer program administration.

Please visit their website www.txtra.org to view their newsletter and learn more about their organization and upcoming annual educational conference September 21-23.



Employee Update

TCR Staff's Years of State Service

The TCR would like to congratulate the following staff members who received awards for their years of service to the State of Texas:

Leticia Vargas – 30 years

Lee Cantrell – 20 years

Esmeralda Zavala – 20 years

George Lara – 10 years

Yolanda Conde – 5 years

Cindy Dorsey – 5 years

Kris Puramsetti – 5 years

New Employees

Jael Anaya

Welcome back to **Jael Anaya**, who has been selected as our new Death Clearance Coordinator/ Public Health Technician III. Jael's start date was April 18, 2011. She is a CTR and has a BS degree. Jael has an abundance of cancer registry experience, both at the hospital and central registry levels. She was also a TCR employee from 2003 to July of 2010. Prior to coming to us in 2003, she worked at Emory University and the Georgia Center for Cancer Statistics. We are excited to have her back!

Priscilla Ramos

The Texas Cancer Registry has a new addition to the Quality Assurance and Training team as of March 1, 2011. **Priscilla** comes to us from Christus Spohn Health in Corpus Christi where she performed medical record analysis since 2009 and has worked in health information and health care settings for over 9 years. She holds an Associate's Degree in Health Information Technology and is a Registered Health Information Technician (RHIT).

Promotion

Beatriz Gutierrez

Please congratulate **Beatriz Gutierrez** on her promotion in the Quality Assurance section as Program Specialist III, effective March 1, 2011. Beatriz has been with the Texas Cancer Registry since January 2005 and is our death clearance specialist. Beatriz is licensed to practice medicine in South America and is currently pursuing a Master in Public Health degree at The University of Texas Health Science Center. Beatriz came to the TCR from Florida, where she worked in medical records in a nursing home. She was recognized as one of the "Top 10 in Health Information Management" by Advance Magazine for Health Information Professionals in 2010.

Retirement

Lee Cantrell

After 20 years of service to the state of Texas, and five with the Texas Cancer Registry, **Lee Cantrell** of the central Austin office is retiring.

Lee is currently the Staff Services Officer of the TCR, which means that he handles purchasing, tracking, and administration for the Branch. His position offers great support to the program, and we appreciate his expertise and competence.

Lee started life with the State working as an accountant for Long Term Care in the Texas Department of Health. Immediately before coming to the TCR, Lee was the Chief of Staff for the Division of Family and Community Health.

Lee may be found spending some of his retirement days flying down the road on his Harley-Davidson motorcycle. He will be greatly missed, and we also wish him well.

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Employee Update *continued...*

Elaine Woods

It is with mixed emotions that we announce the retirement of our Northeast Texas Registry Operations Manager, **Elaine Woods**.

Elaine has worked with various state agencies throughout her 32 years of service with the State of Texas, including 21 years with the Texas Cancer Registry. She obtained her Certified Tumor Registrar (CTR) accreditation in 1983, the first year the exam was given. Since then, she has been an active member in the Texas Tumor Registrars Association.

Elaine plans to take pleasure in her newfound freedom by volunteering with the American Cancer Society, being on “her own schedule” and traveling. Please join the Texas Cancer Registry in wishing Elaine all the best in her retirement.

Diann Purvis

After working for DSHS for 19 years, **Diann Purvis** of our Houston office announced her retirement. Diann began her career with the legacy Texas Department of Health in the HIV/STD Program in 1992. She joined the Texas Cancer Registry in 1996 as a trainer. Diann was later promoted to the Casefinding Specialist position and she successfully sat for her CTR certification exam in 2006. She has been instrumental in providing guidance and technical assistance to facilities for accurate and complete reporting.

Diann’s last day on the job was May 10th. She and her husband have planned a long awaited trip back to Italy after retirement. We all appreciate Diann’s dedication and commitment to the Texas Cancer Registry. We wish her the best!

Marie Longoria, CTR

*Program Specialist, Northeast Texas Registry Operations Group
Houston*

Elaine Woods, CTR

*Northeast Texas Registry Operations Group Manager
Arlington, and*

Dora Rodriguez-Flores, CTR

*Program Specialist IV, Northeast Texas Registry Operations Group
Arlington*



New Certified Tumor Registrars in Texas

Congratulations to the new Certified Tumor Registrars in Texas!

The following individuals passed their CTR exam in March 2010:

Christy L. Hale, Hillcrest Baptist Medical Center, Waco, TX

Jo C. Parshall, Michael E. DeBakey Veterans Affairs Medical Center, Houston TX

Davina T. Rodriguez, Abilene Regional Medical Center, Abilene, TX

Leticia Vargas, CTR

*Public Health Technician, Quality Assurance/ Training Group
Austin*



Remember:

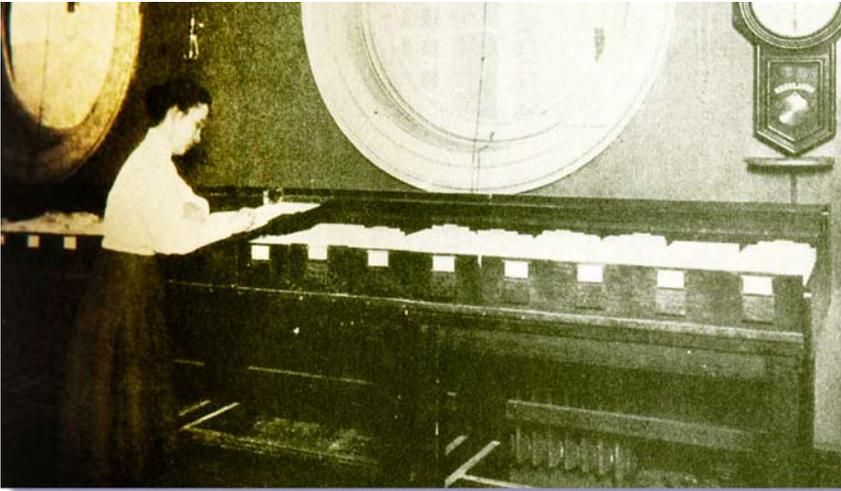
The Texas Cancer Registry is encouraging reporting facilities to keep track of your submission upload emails in an electronic file folder for the year. If your facility hires a contractor, it would be beneficial for an e-file to be maintained for the contractor as well.

Texas Cancer Registry Contract with UT Tyler Ending

The Texas Cancer Registry sadly announces ending its contract with UT Health Science Center Tyler at the end of September 2011. We greatly appreciate Dr. Deborah Cherry, Dr. Sharon Huff, Teresa Ball, Stephanie Fenter, and all of the other UT-Tyler faculty and staff who have worked so hard to support the TCR over the years. As of Oct. 1, 2011 the Houston regional office will be responsible for cancer reporting in Reg. 4. Reporters in Reg. 4 will receive their new TCR personnel contact information prior to Oct. 1.

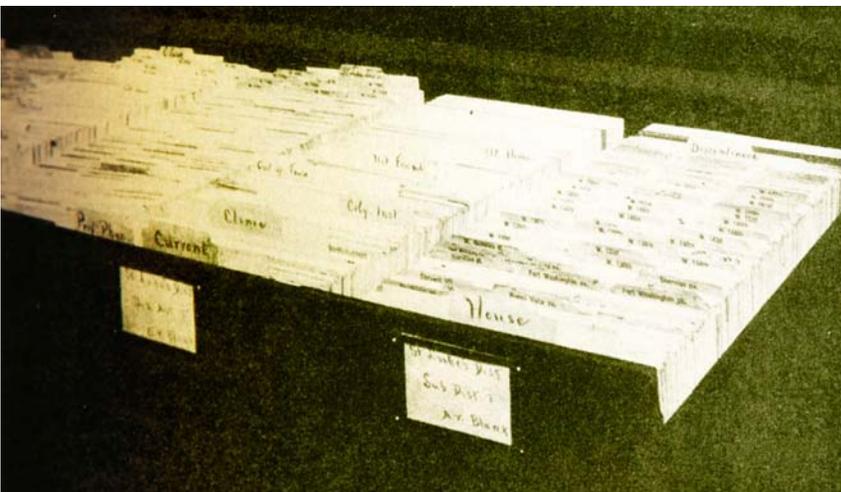


Vintage Registry Photos



The New York City tuberculosis registry. John Shaw Billings, "The Registration and Sanitary Supervision of Pulmonary Tuberculosis in New York City," Department of Health of the City of New York Monograph Series 1. New York, 1912. Used with permission of the New York Academy of Medicine.

Wanting to avoid and cure disease is surely at least as old as humankind—but using disease surveillance to do that is a relatively young effort. It is also one that has radically changed in the short time that it has been around. This photograph shows a registrar keeping records on people with tuberculosis in New York City in 1912, long before the invention of computers allowed for automatic checks on record accuracy or high-volume data analysis.



New Cancer Reporting Handbook

In July 2011 the Texas Cancer Registry will be distributing the *2011 Cancer Reporting Handbook* on CD. The new handbook includes the revisions for **Appendix A** as well as all the changes made by the national standard setters. Please verify that you are using the correct information by visiting all of the revision/errata pages, which can be downloaded at the following websites:

Multiple Primary & Histology Rules

<http://seer.cancer.gov/tools/mphrules/download.html>

Collaborative Staging System V02.03.02

<http://www.cancerstaging.org/cstage/manuals/index.html>

SEER Manual

<http://seer.cancer.gov/tools/codingmanuals/index.html>

FORDS

<http://www.facs.org/cancer/coc/fordsmanual.html>

AJCC 7th Edition Staging Manual

<http://www.cancerstaging.org/products/errata.html>

Yolanda Conde

*Program Specialist, Quality Assurance/Training Group
Austin*

Remember:

Contact the appropriate TCR representative (<http://www.dshs.state.tx.us/tcr/contact-tcr.shtm>) if you have additional information or corrections to data already submitted to the TCR. He or she will provide direction on the best way to provide this information to us.

Case Completeness by Dx Year

As of: July 11, 2011

HSR 1: 2006 96%	HSR 7: 2006 100%
2007 96%	2007 100%
2008 95%	2008 97%
2009 89%	2009 90%
2010 59%	2010 58%

HSR 2: 2006 91%	HSR 8: 2006 100%
2007 89%	2007 100%
2008 92%	2008 100%
2009 92%	2009 93%
2010 58%	2010 54%

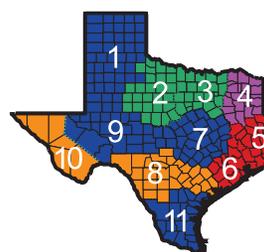
HSR 3: 2006 99%	HSR 9: 2006 94%
2007 100%	2007 95%
2008 96%	2008 93%
2009 93%	2009 91%
2010 65%	2010 65%

HSR 4: 2006 93%	HSR 10: 2006 100%
2007 96%	2007 100%
2008 90%	2008 100%
2009 85%	2009 95%
2010 55%	2010 73%

HSR 5: 2006 100%	HSR 11: 2006 96%
2007 100%	2007 98%
2008 96%	2008 100%
2009 97%	2009 93%
2010 59%	2010 54%

HSR 6: 2006 100%	State: 2006 100%
2007 100%	2007 100%
2008 100%	2008 97%
2009 98%	2009 93%
2010 57%	2010 59%

Texas Health Service Regions



Texas Cancer Registry Regional Offices	
●	HSR 1, 7, 9, 11 - Austin
●	HSR 2, 3 - Arlington
●	HSR 4 - Tyler
●	HSR 5, 6 - Houston
●	HSR 8, 10 - San Antonio