Texas Cancer Reporting News

Spring 2026
Volume XXX | Issue 1

Texas Cancer Registry
Texas Department of State Health Services
dshs.texas.gov/tcr cancerdata@dshs.texas.gov

In This Issue

TCR Updates

Calls for Data

By Allison Vasquez, BS, ODS-C

This past fall, the Texas Cancer Registry (TCR) completed our annual calls for data. We submitted 3,397,836 Texas resident cancer cases diagnosed from 1995-2024 to three national standard setters: the National Cancer Institute Surveillance, Epidemiology, and End Results Program (NCI SEER), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the North American Association of Central Cancer Registries (NAACCR).

These standard setters will release results from the data submissions later in 2026. Information on these results will be published in the next TCR newsletter.

We thank you for your contributions to cancer prevention and control, to the lives of cancer patients and their families, and to the health of Texans.

Timely Reporting Calendar for 2025

By Allison Vasquez, BS, ODS-C

There have been no modifications to the 2025 reporting calendar. It follows TCR's standard policy of reporting cases within six months.

2025 Timely Reporting Calendar

TEXAS Health and Human Services | Texas Department of State Health Services

COMPLETENESS BY REGION

Diagnosis year 2024
As of March 31, 2026

96%	Texas Overall
98%	Region 1
100%	Region 2
100%	Region 3
100%	Region 4
94%	Region 5
98%	Region 6
99%	Region 7
100%	Region 8
94%	Region 9
79%	Region 10
100%	Region 11

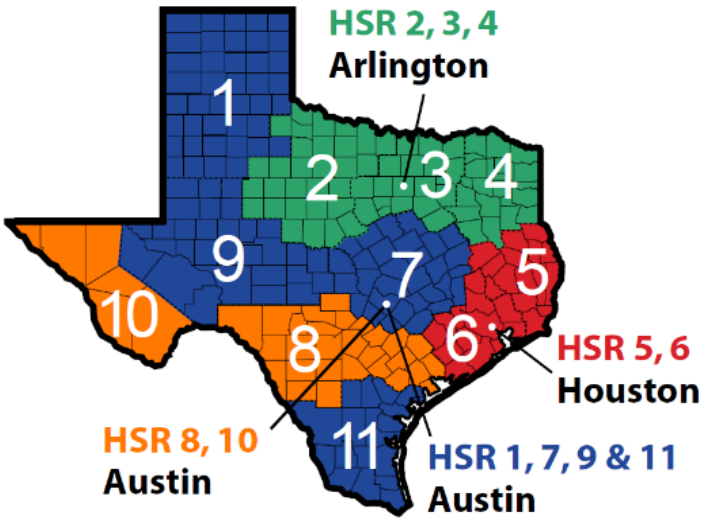
Calls for Earlier Case Submission

By Allison Vasquez, BS, ODS-C

NPCR, NAACCR, and SEER require TCR to submit annual data for case completeness evaluations. In February 2026, we submitted our state's interim Call for Data submission to SEER. Texas met SEER's goal of 95% interim case completeness for diagnosis year 2024. Looking ahead to our November 2026 Call for Data submission, our goal is to continue working to achieve 98% or greater case completeness for diagnosis year 2024.

To accomplish this, TCR aims to have all 2024 cases submitted no later than the end of August 2026. Doing so will allow us to meet our submission requirements by November 2026. This newsletter includes our compliance measures for each region as of March 31, 2026, found in the table labeled 'Completeness by Region'. Please review our newsletter for regional compliance status moving forward. For questions regarding the report featured in this newsletter, contact your regional representative.

Thank you to the reporting facilities who have been diligent in providing quality and timely data. Without you, we wouldn't be able to meet SEER's goals for interim and final case submissions, requiring cases to be submitted earlier in the year.



Training Corner

By Jessica Alvarez, AAS, RHIT, ODS-C

Unlike other solid tumors where grade reflects only the degree of cellular differentiation, the World Health Organization (WHO) grade for central nervous system (CNS) neoplasms represents a malignancy scale that reflects histological features, molecular alterations, growth patterns, and survival outcomes. Another key difference for this data item is that it can be assigned from imaging alone if the wording is conclusive.

The cancer grade governs treatment planning, predicting recurrence potential, progression, and overall survival. It is also a crucial factor in distinguishing indolent from aggressive disease. For cancer registries, accuracy in assigning grade directly affects histology coding for several tumor types. For example, grade and molecular status determine the final ICD-O-3 code for diffuse gliomas, thereby influencing incidence, survival statistics, and research validity. Grade also supports the correct interpretation of behavior (benign, borderline, or malignant) when terminology is ambiguous. Finally, the grade value allows for meaningful comparison of outcomes across populations and with time.

The recent Solid Tumor Rules (STR) update for coding grade involved a notable modification: all the grade tables were removed. The STR manual now directs us to the College of American Pathologists (CAP) Protocol webpage, which features WHO grading for some of the most common CNS tumors. Please note that the default WHO grade is still 1 for all benign CNS tumors as confirmed by the CAP Cancer Committee.

Core Rules (All Diagnosis Years)

Benign Tumors (/0) CNS Only:

- Code WHO Grade 1 by default (CAP Cancer Committee confirmation)

Grade Clinical (cGrade):

- Must not be blank
- Assign the highest grade from the clinical timeframe
- For CNS schemas only, grade may be assigned without histologic confirmation when the diagnosis is based on imaging
- Codes 1–4 take priority over A–D, L, H
- If only one grade is available and timing is unknown, code as clinical grade and:
    - Path grade = 9
    - yc / yp = blank

Grade Pathological (pGrade):

- Must not be blank
- Assign the highest grade from the primary tumor
- If multiple tumors are abstracted as one primary, code the highest grade

Code 9 (Unknown) when:

- Grade is not documented
- CAP states “not applicable” and no other information is available
- No resection and no qualifying exception
- Only one grade exists and timing cannot be determined

When Clinical Grade can be Used for Pathological Grade

Use the clinical grade when no pathologic grade is available and one of the following applies:

Behavior Scenarios

- Clinical and pathological behavior are the same and clinical grade is highest
- Clinical diagnosis is invasive and pathological diagnosis is in situ

Surgical Resection Scenarios

- Resection performed but no grade documented
- Resection performed with no residual tumor

No Resection Scenario

- No primary resection but distant metastasis microscopically confirmed during the clinical timeframe (2023+ wording clarified this requirement)

Why TNM Does Not Apply to CNS Tumors

- Tumor size is less important than location
- Nodal involvement generally not applicable
- Metastases uncommon at diagnosis
- Prognosis driven by:
  - Histology
  - Grade
  - Molecular profile
  - Resectability

<u>Do NOT assign a default grade without specific terminology.</u>

Example:

- ✓ Atypical meningioma → WHO Grade 2 (terminology provided)
- ✗ Meningioma NOS (not stated as benign) → No default grade

<u>For some tumors, grade determines the histology code.</u>

Astrocytoma, IDH-mutant

WHO Grade Histology

- Grade 1 9400/3
- Grade 2 9401/3
- Grade 3 9445/3

Astrocytoma, IDH-wildtype

- Typically, WHO Grade 4
- May be called Glioblastoma, IDH-wildtype
- Histology: 9449/3
- Worse prognosis than IDH-mutant tumor

Grade is one of the most clinically and analytically significant data elements for brain and CNS tumors. It functions as a biologic indicator of tumor behavior, prognosis, and expected clinical course. The ability to assign grade from imaging or clinical workup ensures population-based data reflect real world management because many CNS tumors are diagnosed via imaging and are not completely resected. Precise grading affects many aspects of cancer research. This precision is essential for high quality registry data, accurate prognostic modeling, appropriate resource allocation, and the advancement of molecularly driven CNS tumor research.

Education and Opportunities

By Jessica Alvarez, AAS, RHIT, ODS-C

TCR offers various training opportunities throughout the year to assist Texas reporters. TCR sponsors live and recorded training sessions. These sessions include NAACCR webinars, Oncology Data Specialist-Certified (ODS-C) exam prep courses, basic and advanced webinars, and Web Plus training. Read below for more details about these online training opportunities.

TCR also publishes a yearly cancer reporting guide for use with the SEER Program and Coding Manual, providing guidance to registrars reporting cancer cases in Texas. You can find the most recent version, the 2025 Cancer Reporting Guide, on TCR's Cancer Reporting Guides webpage.

2026 NAACCR Webinar Series

TCR sponsors the 2026 NAACCR Webinar Series at no cost to Texas reporters. NAACCR presents a webinar covering a new topic at the beginning of each month, January to March 2026. Each webinar lasts three hours and provides applicable continuing education (CEs) credits. If you did not register for the live versions, you may view the recorded webinars on the Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC) web based educational platform and still earn the CEs for a limited time afterwards.

NAACCR ODS-C Exam Preparation & Review Webinar Series

For Texas reporters planning to sit for the ODS-C certification exam, TCR offers a discounted price of $68 for the NAACCR ODS Exam Preparation & Review Webinar Series. The eight-week webinar series is available three times a year. It includes live presentations, recordings, quizzes, helpful study tools, and an active discussion board to share study tips and provide support. Check the NAACCR website for information about the next webinar series.

FLccSC

FlccSC is a free, web-based education platform available to cancer reporters. Through FLccSC, TCR provides a variety of recorded webinars, handouts, and quizzes. Use this resource to increase your knowledge and sharpen your abstracting and coding skills. It is accessible for all cancer reporters 24/7 at no cost.

If you have any questions or training requests, please reach out to the Training Team at tcr.training@dshs.texas.gov

Have questions about TCR education training opportunities?

Email us at tcr.training@dshs.texas.gov

Epidemiology Corner

Early Onset Cancers Among Women in Texas

By Keisha Musonda, MPH and Paige Miller, PhD, MPH

In the U.S., rising incidence rates of early-onset cancers—defined as those diagnosed among people under age 50—have captured significant media and public attention. Because early-onset cancers are diagnosed earlier in life, individuals often face different challenges compared to older adults, including additional long-term health challenges. The reasons behind the rising incidence of early-onset cancers remain unclear, especially among women. Texas is the fastest-growing and second-most populous state in the nation with an increasingly diverse population. This offers distinct opportunities to examine cancer incidence trends and disparities that can inform targeted public health prevention strategies. Therefore, we aimed to characterize early-onset cancer incidence trends among Texas women to inform public health practice and policy.

Analyzing High-Quality Texas Cancer Incidence Data

TCR analyzed the most recent 10 years of complete, high-quality TCR incidence data to better understand early-onset cancer incidence trends among Texas women ages 20-49. We included the following most common cancers in women as well as cancers with increasing incidence rates nationally: breast, cervical, ovarian, thyroid, and uterine cancers and melanoma. Each cancer type was examined separately and stratified by 10-year age groups (20-29, 30-39, and 40-49) and race/ethnicity (Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Asian/Pacific Islander, Non-Hispanic American Indian, and Hispanic). Diagnosis year 2020 was excluded from trends estimation to prevent calculations being skewed by the drop in cancer diagnoses during the COVID-19 pandemic.

Characterizing Trends

First, we used SEER*Stat software to calculate age-adjusted incidence rates. Then, Joinpoint was used to analyze trends (Annual Percent Change or APC) in these rates over time. TCR used the National Cancer Institute (NCI) definitions to characterize trends into one of four categories:

- **RISING** - Changing with a statistically significant APC > 0
- **FALLING** - Changing with a statistically significant APC < 0
- **NON-SIGNIFICANT CHANGE** - Changing more than 0.5% per year (APC < -0.5 or APC > 0.5), and the APC is not statistically significant
- **STABLE** - Changing less than or equal to 0.5% per year (-0.5 ≤ APC ≤ 0.5), and the APC is not statistically significant

How to Interpret an APC

APC measures how quickly or slowly a cancer rate has increased, decreased, or remained the same over a period of time. A statistically significant APC of +2.0 can be interpreted as a cancer rate rising by 2% per year.

Summary of Key Findings

The tables below show early onset cancer incidence among Texas women by type and age group based on our analyses.

Table 1. Early-Onset Incidence Rate Trends by Cancer Site, Texas Women Ages 20-49, 2014-2023

Cancer	APC (%)	Trend
Breast	+1.5*	Rising
Cervix	-0.5	Stable
Melanoma of the Skin	+1.4	Non-sig. increase
Ovary	+2.1*	Rising
Thyroid	-0.6	Non-sig. decrease
Uterine (endometrial)	+2.3*	Rising

Table 2. Early-Onset Incidence Rate Trends by Cancer Site and Age Group

Breast Cancer		
Age Group	**APC (%)**	**Trend**
20-29	+1.3	Non-sig. increase
30-39	+1.2	Non-sig. increase
40-49	+1.6*	Rising

Cervical Cancer		
Age Group	**APC (%)**	**Trend**
20-29	-7.9*	Falling
30-39	-0.5	Stable
40-49	+0.7	Non-sig. increase

*Abbreviations and definitions: APC = Annual Percent Change; * = statistically significant change; Non-sig = not statistically significant*

Discussion

Overall, cancer incidence rates have risen among younger Texas women (ages 20-49) in the past 10 years (2014-2023). However, early-onset incidence rate trends vary by cancer type and age group. For example, cervical cancer incidence rates are rising among women ages 40-49, whereas they are falling among younger women ages 20-29. This difference between age groups for cervical cancer incidence rates likely reflects the impact of HPV vaccination on cervical cancer prevention among the younger cohort of women compared to older women.

Our work at TCR indicates that more research is needed into the underlying causes of the rising early-onset cancer incidence rates among Texas women, including modifiable and genetic factors. Furthermore, the recommendations for the age at which to begin routine cancer screenings require ongoing evaluation. More information on early-onset cancers, as well as other relevant topics, can be found on the TCR website or by sending a data request to cancerdata@dshs.texas.gov.

Coding in Practice

By Alicia Smith, ODS-C

Greetings to the Texas cancer community! This edition of Coding in Practice focuses on a few of the v26 changes that could potentially impact coding quality. Below are examples of these changes highlighting the newly updated rules:

STR Multiple Primary Rules

- 06/01/2024 Right breast 4:00 biopsy positive for IDC gr 1; 07/15/2024 Right Breast lumpectomy with negative margins; Patient refused all adjuvant treatment
- 02/15/2026 Right breast 12:00 biopsy positive for ILC gr 2; Planned for surgery and adjuvant treatment

Is the 2026 incidence a new primary?

Yes, the updated STR 2026, Breast Multiple Primary Rule M13 for two separate/non-contiguous tumors, states the following: Regardless of whether the tumors are synchronous or non-synchronous, if they are in different rows of Breast Table 3 (8500 Ductal ca NST & 8520 Lobular ca) they are multiple primaries.

If the 2025 STR Update is referenced, the 2026 incidence would be abstracted as a single primary per the guidance in Breast Multiple Primary Rule 10. We recommend that reporters always link to the most current version of the STR via the SEER website for accuracy.

STR Histology Ambiguous Terminology

- 08/15/2025 Colonoscopy positive for partially obstructing likely malignant mass in the sigmoid colon with no biopsy taken
- 09/25/2025 Colonoscopy positive for partially obstructing mass in the sigmoid colon with biopsy taken indicating patient has adenocarcinoma

What is the diagnosis date for this primary?

The correct diagnosis date is 09/25/2025. Even though the STR Histology Ambiguous Terms have been updated to include “likely” for the purposes of assigning the correct histology code, the SEER Reportable Ambiguous Terms do not include “likely” for purposes of reportability. We recommend referencing slide 13 in the recent NAACCR v26 Updates webinar when attempting to determine the proper use of each coding resource’s Ambiguous Terms lists.

Histology Coding After Neoadjuvant Treatment

- 02/16/2026 Right breast 5:00 biopsy positive for IDC Gr 3, Right axillary lymph node biopsy positive for metastatic IDC
- 03/05/2026 – 04/13/2026 Neoadjuvant systemic treatment completed
- 05/05/2026 Right breast total mastectomy positive for cribriform carcinoma grade UNK, Right axillary lymph nodes neg for metastatic carcinoma

What is the correct histology code for this breast primary?

The correct histology code is 8201 Cribriform carcinoma. Per the updated 2026 STR Histology coding guidance language, when the initial histology code is based on a biopsy from the primary or a metastatic site, if the patient then has neoadjuvant treatment and the histology of the resected primary tumor differs, the histology is coded for the primary from the resected tumor

These are just a few examples of the changes to coding correctness caused by updates, so please continue to keep up with the standard setters. As always, feel free to reach out with any coding questions. Happy coding out there, y’all!