Missouri Cancer Registry

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NCRA News

32nd Annual Conference: Jeannette, Sue, Brenda, Lisa, and Deb attended the NCRA's 32nd Annual Educational Conference on May 5-8, 2006 in the Washington, DC area. We were glad to see all the Missouri registrars take advantage of this outstanding opportunity for education.

NCRA Elections: Congratulations to two Missouri registrars elected to positions on the NCRA Board: Carlene Anderson, Lake Regional Hospital, will be one of two Midwest representatives for the Nominating Committee. Sue Vest, MCR, was elected to the Council on Certification.

For the latest news and information, please go to the NCRA website:

http://www.ncra-usa. org/

Updates—NAACCR

Version 11: All 2006 cases must be submitted in NAACCR Version 11. Earlier versions will not accept the new Primary Payer or Reporting Source codes. Some vendors are already providing this update. This update will also involve a conversion of the Primary Payer codes.

MCR will accept cases in the V.11 layout.

Data Standards for 2007 Released: The North American Association of Central Cancer Registries (NAACCR) just recently released the Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary (version 11.1). The membership of this work group includes staff from all cancer registration standard setters, including the American College of Surgeons (ACoS), SEER, the CDC, representatives from various software vendors as well as central registries. To see a copy of the standards, which will be effective beginning in 2007, go to:

http://www.naacr.org/filesystem/pdf/Volume%20II%20Version%2011.1pdf

Online—Risk Calculator for Prostate Cancer

Researchers have developed an online statistical tool for estimating an individual's risk of developing prostate cancer. The risk calculator is designed to help certain men and their physicians evaluate the potential risks and benefits of being screened for prostate cancer. It is available at *http://www.compass.fhcrc.org/edrnnci/bin/calculator/main.asp*.

The calculator takes into account prostate-specific antigen (PSA) testing, family history, rectal examinations, and history of a prior negative prostate biopsy. Though PSA testing is widely used to assess prostate cancer risk, it does have limitations. Men with normal PSA levels can develop prostate cancer, while some men without prostate cancer can have abnormal levels.

"This risk calculator model uses variables that go beyond only PSA level to help patients and physicians decide whether a prostate biopsy should be performed," write Dr. Ian Thompson, of the University of Texas Health Science Center at San Antonio, and his colleagues in the April 19 *Journal of the National Cancer Institute* (*JNCI*).

The calculator was developed using data from 5,500 men in the placebo group of the Prostate Cancer Prevention Trial; it is appropriate for men age 55 or older who have had recent PSA testing and rectal exams but no history of prostate cancer. Researchers say that the calculator improves the accuracy of PSA testing, but the use of PSA testing alone in prostate cancer screening has yet to be shown to save lives.

"The hope is that the risk calculator helps us do a better job selecting patients for biopsy," says co-author Dr. Howard Parnes of NCI, adding, "We need to be careful about how we apply the test." He raises the possibility that the calculator could lead to a large increase in the overall number of biopsies. This, in turn, could increase the overdiagnosis and overtreatment of the disease by detecting and treating cancers that would never have come to clinical attention were it not for screening.

Novel Device Shows Potential in Detecting Oral Cancer

Researchers supported by the National Institute of Dental and Craniofacial Research, report their initial success using a customized optical device that allows dentists to visualize whether a patient might have a developing oral cancer.

Called a Visually Enhanced Lesion Scope (VELScope), this simple, hand-held device emits a cone of blue light into the mouth that excites various molecules within our cells, causing them to absorb the light energy and re-emit it as visible fluorescence. Because developing tumors in the mouth are often easily visible, public health officials have long advocated early detection of oral cancer. But determining whether a suspicious sore is benign or potentially cancerous has remained scientifically problematic. "A major reason is looks alone can be deceiving," said Rosin. "What's been badly needed in screening for oral cancer is a way to visualize the biological information within and let it tell you whether or not a lesion is likely to become cancerous."

In their study, the scientists evaluated 50 tissue sites from 44 people. Reading the fluorescence patterns of the 50 sites, the group correctly identified all of the normal biopsies, 10 of the severe dysplasias, and all of the cancers. These numbers translated to 100 percent specificity and 98 percent sensitivity. Specificity refers to how well a test correctly identifies people who have a disease, while sensitivity characterizes the ability of a test to correctly identify those who are well.

Management of Adnexal Mass

The Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, announced the release of the evidence report on the management of adnexal masses — enlargements in the area of the ovaries and fallopian tubes that are sometimes a sign of ovarian cancer. The report (PDF-3.4MB) was requested and funded by Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC). It concludes that based on current evidence it is not possible to estimate the effectiveness of different diagnostic strategies. In particular, the common bimanual pelvic exam does not succeed very well in detecting adnexal masses or distinguishing benign from malignant masses. These results raise doubts about the value of the bimanual pelvic exam in routine screening.

New Targets for Cancer Therapies

Researchers at the National Cancer Institute (NCI), part of the National Institutes of Health, have developed a new method to identify genes that keep cancer cells active and that could be potential targets of anticancer therapies. The method uses RNA interference (RNAi), a technology for silencing genes, to screen cancer cells for genes that, when silenced, cause cancer cells to die or stop dividing. These genes are essential for the survival of cancer cells and represent potential therapeutic targets, but they might not contain mutations or other alterations typically associated with the disease. Additional details are provided in the *Washington Report*, V*ol. 7, No. 8.*

Cancer Bill Introduced

Bipartisan legislation addressing childhood cancer was introduced in March by Sen. Coleman (R-MN), Sen. Reed (D-RI), and Rep. Pryce (R-OH). The Conquer Childhood Cancer Act (S. 2393/H.R. 4927) includes provisions creating a national childhood cancer registry to be operated by the Childhood Cancer Research Network of the Children's Oncology Group under an NIH grant. In introducing the Senate bill, Senator Reed stated: "This bipartisan legislation seeks to achieve several important goals in our battle against childhood cancer. Specifically, it will expand support for pediatric cancer research, foster the career development of more pediatric oncologists, and provide essential information and support to help families deal with this devastating disease. Childhood cancer impacts thousands of children and their families each year. While we have made great steps in treating cancer, we have made relatively little progress in advancing our understanding of the most common forms of pediatric cancer. This legislation will help to provide resources to hopefully one day find a cure."

Collaborative Staging Table Now Available

Some collaborative stage users have requested that the Collaborative Staging Task Force develop a table of the values for all CS tables that indicate "unknown" or "not applicable." As the codes are site-specific, the use of incorrect default codes has lead to edit errors. Therefore, the CS Steering Committee has prepared the following table as a convenience to users. The table can be used to populate CS items for cases with no information about staging and can be found at: ***http://www.cancerstaging.org/cstage/valid_dco_jes_032206.xls***

DCO Process

Normally, we have already started the DCO process by now. We are not exactly sure when we will be receiving the data from vital statistics, but the process will probably not begin for several weeks. ***What does this mean for hospital registries?*** It means that the turnaround time for responding to the request for information on these cases will probably be shorter. We will try to give everyone as much time as possible but we have certain deadlines that we have to meet. Thanks in advance for your assistance.

Non-hospital Update

Cancer reporting by non-hospital facilities and physicians continues to improve. During 2005, MCR received approximately 950 non-hospital cases with 2004 diagnosis dates: 350 invasive melanoma cases from physicians, 155 prostate cases from RT centers, and 450 surgery center cases, mostly breast cancer. For some of these cases the non-hospital facility will be the only source, for others it may be the first and timeliest of several sources.

We've been testing the use of Web Plus for urologists to report prostate cancers and will begin testing it for the reporting of melanoma cases. Anyone who wishes to see the program may access it at:

https://webplus.umh.edu/webplus/

The test user id is "johndoe."

The password is "test."

Coding Issues—Avodart

Recently, Bec Francis sent the following question to the I&R department of ACOS: 'When Avodart is used to for down-sizing the prostate prior to radical resection, how is the treatment coded? It is listed as a chemotherapy drug when used for pancreatic cancer but for prostate cancer, some physicians call it hormone therapy. '

In Reply from ACOS: As per SEER Rx, Avodart is used to treat an enlarging prostate and not considered treatment for prostate cancer. SEER Rx page(s) was used as the resolution source.

Précis Progress

The MCR QA staff are working diligently to clean up the 2004 cases while trying to keep up with new submissions. When the new software was implemented, there were more than 28,000 cases requiring disposition. Now there are less than 8000 cases remaining. We are still working out some issues with the software. Précis Central staff will be doing a site visit the week of May 15th to provide more assistance and training. We appreciate your patience during this transition period.

Survey

As mentioned in an earlier email, there is a "voluntary" survey on our website. This survey involves the use of 8000-8005 vs. 8010. If you have the opportunity, we would really appreciate your participation. We have already received some responses and they have been very interesting.

Please contact us if you have questions.

Text Comments

MCR staff see all kinds of comments in the text fields. Some are very good and very relevant. Others are very brief and sometimes not very useful. For example, while reviewing cases for info to update Collaborative Stage, we found statements = "In chart per MD" or "Dr. So and So". We cannot verify stage with this type of text. The text should be sufficient for someone to re-abstract the important fields, such as stage, site, histology, diagnostic confirmation, date of diagnosis. MoSTRA attendees will have a chance to see the text we receive and re-abstract certain fields based on the text. Sound like fun??