

***WebPlus* User's Manual**

Cancer Abstract Reporting



SOUTH DAKOTA CANCER REGISTRY

***WebPlus* URL: <https://apps.sd.gov/applications/dohwebplus/>**

2006

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PREFACE

The purpose of the South Dakota Cancer Registry (SDCR) *WebPlus Manual* is to assist health care providers and entities without tumor registries in reporting cancer cases. *WebPlus* is a software developed by the Centers for Disease Control and Prevention (CDC) for collection of cancer information.

This manual includes recent changes in coding structures and requirements from the National Program of Cancer Registries (NPCR), the North American Association of Central Cancer Registries (NAACCR) and the Commission on Cancer (CoC) Facility Oncology Required Data Standards (FORDS).

Since the passage of Public Law 102-515, entitled the *Cancer Registries Amendment Act*, by the 102nd Congress in October 1992, there has been a tremendous effort by all agencies collecting cancer data to unify and standardize data sets. With the establishment of NPCR in 1994, all central registries funded by the CDC through NPCR are required to follow stringent data management procedures; provide training for state personnel and all reporting facility staff; publish an annual report; and conduct case-finding/re-abstracting audits at selected facilities.

Although SDCR began receiving CDC/NPCR funding in 2000, our reference year is 2001. Thus the SDCR collects data that: 1) is compliant with required NPCR data elements; 2) meets standard requirements designated by NAACCR for incidence reporting and endorsed by CDC; and 3) assists in determining data quality. Data collected also provides useful feedback to submitting facilities that can be used for QA activities and administrative purposes. Data collected is submitted annually to:

a. NAACCR for Registry Certification and publication in *Cancer in North America (CINA)*. Registries whose data meet established criteria, including criteria for timeliness, accuracy and completeness, are recognized annually as Silver Certified or Gold Certified registries. Certification criteria are as follows:

Criteria	Silver	Gold
Completeness	90%	95%
% passing EDITS	97%	100%
Death Certificate Only cases	≤ 5%	≤3%
Duplicate reports	≤ 2/1000	≤ 1/1000
Missing Sex, Age, County	≤ 3%	≤ 2%
Missing Race	≤5%	≤3%

b. NPCR for data evaluation and inclusion in the *United States Cancer Statistics (USCS)* which is published in November of each year. Data must meet the following criteria for this publication:

- ✓ Case ascertainment is 90% of expected, unduplicated cases
- ✓ No more than 5% are ascertained by death certificates
- ✓ No more than 3% are missing information on sex.
- ✓ No more than 3% are missing information on age.
- ✓ No more than 5% are missing information on race.
- ✓ At least 97% must pass a single field and inter-field computerized EDIT set.

SDCR staff members are available to answer registry-related questions and to provide workshops,

educational presentations and one-on-one training.

For additional information and contact information, please refer to the SDCR website:

<http://www.state.sd.us/doh/sdcr/>

or

call the SDCR directly at

Cancer Registry Coordinator: 605-773-5740

Certified Tumor Registrar: 605-773-6345

The primary sources for obtaining information for some cancer cases, which are generally treated outside of hospital cancer treatment centers, may be other hospitals, physician offices and freestanding treatment centers such as radiation facilities. The SDCR, in conjunction with the CDC, has set up an internet based software program, *WebPlus* to report cancers diagnosed in their offices. Offices with more than 30 cases per year will be trained to complete abstracts. Others who have more than ten cases might also like to report complete abstracts. *WebPlus* is accessible through a secure site: <https://apps.sd.gov/applications/doh/webplus>

Facilities may be large or small, and the extent of information submitted varies, depending on size and reporting methods. Each reporting facility is however responsible for providing pertinent information regarding the patient's disease.

The manual's focus is using the software and not on developing expertise on abstracting the numerous types of cancers. The SDCR is distributing training materials to individuals who are learning to submit complete abstracts. Prostate cancer is used as an example in this manual as it is one of the cancers frequently seen only in urology offices instead of cancer centers as well as one of the cancers that is presently under-reported to the SDCR.

SECTION I: LAWS AND REGULATIONS

South Dakota Codified Laws (SDCL) 1-43-11 to 1-43-18

1-43-11. Cancer data collection system. The department of health shall establish and maintain a central cancer data collection system for cancer cases in South Dakota in accordance with the confidentiality provisions of § 34-14-1 and the terms of § § 1-43-11 to 1-43-17, inclusive.

1-43-12. Authority to contract for implementation and maintenance of cancer data collection system. In establishing a cancer data collection system pursuant to § 1-43-11, the department of health may by contract or agreement authorize any person or any public or private entity or any combination of persons or entities to implement and maintain any portion of the cancer data collection system.

1-43-13. Rules for establishment, maintenance and use of cancer data collection system. The department of health shall promulgate rules pursuant to chapter 1-26 to provide for the establishment, maintenance and use of a cancer data collection system pursuant to § § 1-43-11 and 1-43-12. The rules shall include:

(1) Provisions requiring the reporting of cancer cases or specifying circumstances under which cancer cases shall be reported;

(2) Criteria for authorizing persons or entities to undertake cancer data collection;

(3) Criteria and procedures for maintaining confidentiality as required in § 1-43-11; and

(4) Procedures and requirements governing the structure and objectives of the cancer data collection system and the reporting, collection, analysis and dissemination of data and information related to the cancer data collection system.

1-43-14. Meeting reporting requirements. Any hospital licensed pursuant to chapter 34-12, physician licensed pursuant to chapter 36-4, physician assistant licensed pursuant to chapter 36-4A, nurse practitioner or nurse midwife licensed pursuant to chapter 36-9A, pathology laboratory, or free-standing radiology center that detects, diagnoses, or treats a cancer case in South Dakota shall submit a report to the department of health as required by § § 1-43-11 to 1-43-17, inclusive.

1-43-16. Data collection -- Availability to public. Any statistical summary of data collected under the provisions of § § 1-43-11 to 1-43-17, inclusive, shall be available to the public, but may not be sold by the department of health or any agent under contract or agreement with the department pursuant to § 1-43-12. Any data released shall be presented in such a statistical manner that no person, who represents a case contained in the cancer data collection system, may be identified.

1-43-17. Good faith reporting -- Immunity from liability. Good faith reporting or disclosure pursuant to § § 1-43-11 to 1-43-16, inclusive, does not constitute a libel or slander or violation of the right of privacy or privileged communication. Any person who in good faith complies with the reporting requirements of § § 1-43-11 to 1-43-16, inclusive, or any request that may be made by the department of health pursuant to § § 1-43-11 to 1-43-16, inclusive, is immune from civil and criminal liability for such action taken in compliance with the provisions of § § 1-43-11 to 1-43-16, inclusive.

1-43-18. Transmittal of nonresident cancer diagnoses to national cancer registries. The department of health, by agreement, may transmit transcripts or copies of reports of cancer diagnoses to state or national cancer registries if the reports relate to residents of other states or countries. The agreement shall require that the transcripts or records be used under the terms provided in § § 1-43-11 to 1-43-17, inclusive.

Administrative Rules of South Dakota (ARSD)

ARTICLE 44:22 CANCER DATA COLLECTION

CHAPTER 44:22:01 RULES OF GENERAL APPLICABILITY

Section

- 44:22:01:01 Definitions.
- 44:22:01:02 Organization and structure.
- 44:22:01:03 Functions of central cancer registry.

44:22:01:01. Definitions. Terms used in this article mean:

(1) "Abstract," a summary from the medical record of pertinent cancer information about the patient, the disease, the cancer-directed treatment, and the disease process from the time of diagnosis until the patient's death;

(2) "Cancer," includes:

(a) Any malignant and in situ neoplasm of any site, excluding any basal and squamous cell carcinoma of the skin;

(b) Any basal and squamous cell carcinoma of any mucoepidermoid site; and

(c) Any brain and central nervous system neoplasm regardless of malignancy;

(3) "Central cancer registry," "SDCR," the South Dakota Cancer Registry, the central database of cancer cases in South Dakota maintained by the department;

(4) "Department," the South Dakota Department of Health;

(5) "Disease index," a listing of patients from a reporting entity organized by a disease or diagnosis code;

(6) "Free-standing radiology center," a radiology center operating independently of a hospital system;

(7) "Hospital," an establishment licensed pursuant to SDCL chapter 34-12;

(8) "NAACCR," the North American Association of Central Cancer Registries;

(9) "NPCR," the National Program of Cancer Registries;

(10) "Nurse midwife," a person licensed pursuant to SDCL chapter 36-9A;

(11) "Nurse practitioner," a person licensed pursuant to SDCL chapter 36-9A;

(12) "Pathology laboratory," a health care facility responsible for the microscopic analysis of tissues and body fluids;

- (13) "Physician," a person licensed pursuant to SDCL chapter 36-4;
- (14) "Physician assistant," a person licensed pursuant to SDCL chapter 36-4A;
- (15) "Primary cancer site," the site where a cancer originates;
- (16) "Record," any section of a patient's health information file that is needed for a complete cancer abstract;
- (17) "Research," any systematic investigation designed to answer a defined scientific question that requires collection and analysis of data in order to develop or contribute to generalizable knowledge;
- (18) "Researcher," the primary investigator or project director of a study; and
- (19) "Tumor registry," a data collection management system with complete cancer abstracts in a NAACCR layout.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:01:02. Organization and structure. The department is the custodian of the central cancer registry and is responsible for the overall collection, validation, analysis, and dissemination of data and information related to the system. The department may enter into agreements or contracts with other public or private entities in performing these functions.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-12, 1-43-13.

44:22:01:03. Functions of central cancer registry. The central cancer registry is a surveillance system and shall be used to:

- (1) Monitor the incidence and mortality of cancer in the state to detect potential public health problems;
- (2) Inform and educate by providing descriptive data on cancer incidence and mortality to health professionals and the general public about risks, prevention, and early detection of cancers known to be elevated in their communities;
- (3) Guide decisions about how to use public-funded cancer control resources by more accurately targeting intervention resources for communities and patients and their families; and
- (4) Respond to public concerns.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

CHAPTER 44:22:02 REPORTING REQUIREMENTS

Section

44:22:02:01	Entities required to provide report.
44:22:02:02	Reportable conditions -- General criteria.
44:22:02:03 to 44:22:02:05	Repealed.
44:22:02:06	Reportable data elements for tumor registries.
44:22:02:07	Method of reporting for tumor registries.
44:22:02:08	Repealed.
44:22:02:09	Method of reporting for pathology laboratories.
44:22:02:09.01	Method of reporting for hospitals without tumor registries, physicians, physician assistants, nurse practitioners, nurse midwives, and free-standing radiology centers.
44:22:02:10	Reporting for other entities.

44:22:02:01. Entities required to provide report. Any hospital, physician, physician assistant, nurse practitioner, or nurse midwife, pathology laboratory, or free-standing radiology center that detects, diagnoses, or treats a cancer case in South Dakota shall submit the information needed on a cancer case to the department or its representative as required by §§ 1-43-11 to 1-43-17, inclusive.

A federal tumor registry may participate in the central cancer registry if the registry submits reports in conformance with the same standards. Any other entity may voluntarily submit any cancer case to the central cancer registry.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-13, 1-43-15.

44:22:02:02. Reportable conditions -- General criteria. The following conditions are reportable:

(1) Any neoplasm listed in the **International Classification of Diseases for Oncology**, Third Edition, 2000, with a behavior code of "2", in situ, or "3", malignant, with the exception of:

- (a) Carcinoma *in situ* of the cervix;
- (b) Intraepithelial neoplasia of the cervix (CIN) and prostate (PIN); and
- (c) Basal or squamous cell carcinoma of the non-mucoepidermoid sites of the skin (C44.0-C44.9):

- (i) 8000-8005 Neoplasms malignant (NOS) (C44.0-C44.9);
- (ii) 8000-8046 Epithelial carcinomas of the skin (C44.0-44.9);
- (iii) 8050-8084 Papillary and squamous cell carcinomas of the skin (C44.0-C44.9);
and
- (iv) 8090-8110 Basal cell carcinomas of the skin (C44.0-C44.9);

(2) Any basal and squamous cell carcinoma originating in mucoepidermoid sites: such as the lips (C00.0-C00.9), anus (C21.0), vagina (C52.9), clitoris, labia, vulva (C51.0-C51.9), scrotum (C63.2), or penis (C60.0-C60.9);

(3) Any vulvar (VIN III), vaginal (VAIN III), and anal (AIN III) intraepithelial neoplasia;

(4) Any brain and central nervous system tumor, benign or malignant; or

(5) Any tumor that is not histologically confirmed but with any record that contains any of the following words:

apparently	favor	probable	typical of
appears to	favours	suspect	
comparable with	malignant appearing	suspected	
compatible with	most likely	suspicious	
consistent with	presumed	suspicious for	

However, if the record contains the word "suspicious" and there is no positive biopsy or physician's clinical impression to support the cytology findings, the condition is not reportable.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

Reference: International Classification of Diseases for Oncology, Third Edition, 2000, World Health Organization. Copies may be obtained from the World Health Organization Publications Center, USDA, 49 Sheridan Avenue, Albany, NY 12210. Cost: \$54.

44:22:02:03. Reporting inconclusive diagnoses. Repealed.

Source: 18 SDR 142, effective March 9, 1992; repealed, 29 SDR 21, effective August 27, 2002.

44:22:02:04. Reporting of basal and squamous cell carcinomas of the skin. Repealed.

Source: 18 SDR 142, effective March 9, 1992; repealed, 29 SDR 21, effective August 27, 2002.

44:22:02:05. Standards for determining single and multiple primary tumors. Repealed.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; repealed, 32 SDR 69, effective November 7, 2005.

44:22:02:06. Reportable data elements for tumor registries. A tumor registry shall report the minimal data elements in the required status table in **NAACCR Standards for Cancer Registries**, Volume II, for each case which meets the criteria established in §§ 44:22:02:02 to 44:22:02:05, inclusive. These must be reported in the designated NAACCR record layout in **NAACCR's Standards for Cancer Registries**, Volume II.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-13, 1-43-14.

Reference: **Standards for Cancer Registries**, Volume II, Data Standards and Data Dictionary, North Association of Central Cancer Registries, NAACCR, 2121 W. White Oaks Drive, Suite C, Springfield, IL 62704. Free.

44:22:02:07. Method of reporting for tumor registries. Each facility with a tumor registry shall provide to the department the data elements described in § 44:22:02:06 for all cases which meet the reporting criteria established in §§ 44:22:02:02 to 44:22:02:05, inclusive. Abstracts must be completed within six months from the date of initial diagnosis. Data must be transmitted to the central cancer registry at least on a quarterly basis, by the following dates:

First Quarter (January-March)	September 30 of the same year
Second Quarter (April-June)	December 31 of the same year
Third Quarter (July-September)	March 31 of the next year
Fourth Quarter (October-December)	June 30 of the next year

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-13, 1-43-14.

44:22:02:08. Method of reporting for manual tumor registries. Repealed.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; repealed, 32 SDR 69, effective November 7, 2005.

44:22:02:09. Method of reporting for pathology laboratories. Each pathology laboratory shall submit pathology reports at least on a quarterly basis.

Source: 29 SDR 21, effective August 27, 2002.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:02:09.01. Method of reporting for hospitals without tumor registries, physicians, physician assistants, nurse practitioners, nurse midwives, and free-standing radiology centers. Each provider shall complete a form prescribed by the department if a cancer case is found by the department through case finding mechanisms. The provider shall complete the form and return it to the department within 30 days. If the hospital, physician, physician assistant, nurse

practitioner, nurse midwife, or free-standing radiology center is unable to complete the form, they can provide a copy of that portion of the patient's medical record that contains the minimum information necessary for the department to complete the form. The department may request disease indices from hospitals without tumor registries, physicians, physician assistants, nurse practitioners, nurse midwives, or free-standing radiology centers to assist in case finding. The disease indices shall be provided to the department within 30 days of the request.

Source: 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:02:10. Reporting for other entities. The central cancer registry may develop an individual agreement with any entity. The central cancer registry and administration of the entity shall mutually decide how cancer cases will be made available to the central cancer registry.

Source: 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

CHAPTER 44:22:03 QUALITY ASSURANCE

Section

44:22:03:01 Correcting submitted data.

44:22:03:02 Validation of information.

44:22:03:03 Performance of quality assurance edits.

44:22:03:01. Correcting submitted data. Upon discovering an error in a report or upon the request of the department, a reporting entity shall supply corrected or missing information.

Source: 18 SDR 142, effective March 9, 1992; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:03:02. Validation of information. For the purpose of assuring the quality of submitted data, each reporting entity shall allow the department to inspect such parts of a patient's medical records as are necessary to verify the accuracy and completeness of submitted data. The SDCR shall make arrangements with facility or provider for these audits with no fewer than 15 working days notice.

Source: 18 SDR 142, effective March 9, 1992; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:03:03. Performance of quality assurance edits. The department shall perform quality

assurance edits on data entered into the central cancer registry to ensure that all data is completely and accurately recorded.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13

CHAPTER 44:22:04 CONFIDENTIALITY OF REPORTS AND DATA

Section

44:22:04:01 Duty to maintain confidentiality.

44:22:04:02 Publication of data.

44:22:04:03 Data for research.

44:22:04:01. Duty to maintain confidentiality. Information contained in the central cancer registry constitutes medical research. Confidentiality of identifying data shall be maintained in accordance with SDCL 34-14-1.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13, 34-14-1.

44:22:04:02. Publication of data. Published information may not contain the name of an individual who is or was the subject of a report of cancer submitted to the department and may not contain an identifying number, mark, or description which can be readily associated with an individual who is or was the subject of a report of cancer submitted to the department. All published data must be presented in such a statistical manner that no person can be identified. Data existing in cells with zero counts shall be published as "0" and cells with data counts of "1" or "2" shall be published as less than three individuals except on a statewide basis. Except as provided in § 44:22:05:01, published information may not identify reporting entities in relation to cancer data or statistics.

Source: 18 SDR 142, effective March 9, 1992; 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

44:22:04:03. Data for research. The department may approve any applicant who submits written application to obtain access to case-specific data or case-specific and patient-identifying data to assist in the applicant's research for cancer prevention, control, and treatment in order to reduce morbidity and mortality as described in SDCL 34-14-1. The applicant shall certify that (1) The applicant is a qualified researcher sponsored by a public or private college or university, governmental entity, non-profit medical, sociological or psychological association, or pharmaceutical industry;

(2) The data requested will be used for scientific or medical research for the prevention, cure, or control of cancer only;

(3) Disclosure of the information is necessary to accomplish the purposes of the research;

(4) The research project has been reviewed and approved by an institutional review board on the lists of registered Institutional Review Boards or Independent Ethics Committees and approved Assurances of the Office for Human Research Protections, U.S. Department of Health and Human Services;

(5) No patient, or patient's relatives or friends, will be contacted without prior approval of the patient's physician in accordance with SDCL 34-14-5;

(6) The applicant will maintain the confidentiality and security of the data obtained by establishing adequate safeguards;

(7) The applicant will comply with all federal and state laws, and department guidelines regarding release of data with identifying information and with de-identified information;

(8) The applicant agrees to pay the department reasonable costs of data retrieval and data processing as determined and billed by the department; and

(9) The applicant will provide the results of the research to the department at no cost and not publish the results until two months after submission to the department and that any publication will acknowledge the department and its central cancer registry.

Source: 32 SDR 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13, 34-14-1.

CHAPTER 44:02:05 INFORMATION EXCHANGE

Section

44:22:05:01 Requirement to prepare annual statistical summary.

44:22:05:01. Requirement to prepare annual statistical summary. The department shall publish annual statistical summaries of information contained in the central cancer registry. Annual summaries of data may also be provided to any reporting entity, based on the data submitted by the entities, upon request of the reporting entity. A reporting entity may not be provided source-specific reports for data other than the entity's own.

Source: 18 SDR 142, effective March 9, 1992; 29 SDR 21, effective August 27, 2002; 32 S D R 69, effective November 7, 2005.

General Authority: SDCL 1-43-13.

Law Implemented: SDCL 1-43-11, 1-43-13.

CONFIDENTIALITY

HIPAA and Cancer Reporting

HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the reporting of identifiable cancer data to public health entities. Because the South Dakota Cancer Registry falls under the definition of a public health authority, HIPAA allows your facility to report cancer incidence data in compliance with state statutes. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, reporting facilities must simply document that reporting has occurred.

Definition of Confidential Data

The Registry considers as confidential any information that relates to the past, present, or future physical or mental health or condition of an individual or the past, present, or future health care of an individual: and that 1) identifies an individual; or 2) with respect to which there is a reasonable basis to believe that the information can identify an individual. Confidential or protected health information refers to any information as defined in SDCL 34-14-1. Information that characterizes the caseload of a specific institution or health care provider is also considered confidential.

Responsibilities of Registry Staff

The Registry staff is responsible for protecting the database from unauthorized access and release. The Registry will maintain the same standards of confidentiality as is customary between physician and patient and with medical records. Inappropriate release of data could not only damage an individual whose diagnosis of cancer is made public, but also severely compromise the support and cooperation of individuals and facilities providing data to the Registry.

Security

Each staff member reads the confidentiality policy and signs a pledge that confidential information will not be released to unauthorized persons. This will be done annually and during orientation of a new hire. Any non-registry staff who needs access to the database must ask in writing, and if permission is granted, must sign a confidentiality statement.

All signed statements will be kept in the Registry Coordinator's office.

Consequence

The confidentiality pledge is made with the understanding that any failure to keep the agreement will be reviewed on an individual basis by the Administrators of the SDCR and Executive Management of the Department of Health, who will determine the consequences. SCDL 34-14-3 addresses this area.

SECTION II: CANCER REPORTING

NOTES ON CANCER REPORTING

- ✓ Physicians' offices are required by SDCL 1-43-14 to submit requested information on patients not diagnosed or treated for the cancer at another healthcare facility (i.e. hospital, free-standing cancer treatment center, freestanding ambulatory surgery center, etc.). The inclusion of these cases was effective with patients diagnosed July 1, 2005 and later.
- ✓ *WebPlus* is available to the physician at no charge. The hardware and software are maintained by the SDCR with the assistance and support of the CDC.
- ✓ Abstracting includes a list of the required data elements. This list is based on South Dakota laws, NPCR and NAACCR requirements and data quality requirements.
- ✓ Completed cases ***should be submitted quarterly*** to the SDCR within six months of diagnosis. You may choose to submit cases monthly.

Reportable cancers

1. All in situ and invasive cancers except prostate intraepithelial neoplasia (PIN).
2. Cancers diagnosed and/or treated in your facility that have not been referred to a cancer center within South Dakota.
3. Newly diagnosed cases.
4. Patients with continuing hormonal therapy who have never had radiation therapy or surgery for this diagnosis.
5. Patients who are ***not*** going to be treated at a hospital with surgery or brachytherapy.
6. Patients who are ***not*** going to be treated at a freestanding treatment center with external beam radiation.
7. Cases where planned treatment is:
Hormonal therapy; Chemotherapy; Observation only (also known as watchful waiting); or No treatment (due to other health conditions, patient refusal, etc).
8. Clinical diagnosis.

Note:

1. All in-patient or out-patient settings, including those who have passed away, must be reported to SDCR.

CASEFINDING

SDCR collects all cases regardless of residency.

3. SDCR reference year is 2001, which means that the central registry must report all cancer cases diagnosed and treated from 1 January 2001. The SDCR will work with you to collect any cases found from 1 January 2001 to 1 December 2005.

However you are required to submit all cases diagnosed and / or treated from 1 January 2006.

Some casefinding sources are as follows:

1. Pathology Reports

Flag each chart when a cancer is diagnosed with a visible reminder that chart needs to be reviewed to determine case eligibility/reportability. A separate box for copies of the pathology reports is helpful for case finding.

Any tumor that is not histological confirmed but has any record that contains any of the following terms **IS** reportable.

Apparently	Favor(s)	Probable	Typical of
Appears to	Suspect(ed)	Suspicious (for)	Most likely
Comparable with	Malignant appearing	Presumed	Consistent with
Compatible with			

The following terms **DO NOT** constitute case reportability:

Cannot be ruled out	Equivocal	Possible	Worrisome
Potentially malignant	Questionable	Suggests	

2. Office reports

Used to 'rule out' reportable cancers, for example for urology cancers:

- a. ICD-9: 185.9
- b. CPT procedure codes (e.g. radical prostatectomy, brachytherapy for prostate cancers)
- c. Place of service code such as hospital in patients and outpatients.

Exception—patients referred for external beam radiation

3. Central registry follow-back based on path reports submitted directly to SDCR from the path lab

a. Pathology reports collected by the SDCR are intended as a means of case finding and do not include the details needed to adequately report cancer cases (as in race, social security number, patient address, etc.). Thus, the SDCR is currently developing a method to notify physicians when cases have been identified through pathology reports so that completeness (of cancer reporting) may be met by both parties.

b. The SDCR would only follow-back on patients that have **not** been reported by other facilities.

SDCR follow-back means delay of 12-15 months from date of diagnosis and does not meet timeliness requirements.

A list of reportable cancers is at URL: www.state.sd.doh/sdcr/reportable_list.htm

Remember: Physicians' offices are only required to report patients who are/have not been treated elsewhere for the current cancer diagnosis. Please determine the most efficient and least time consuming method for your clinic that will help the SDCR meet data reporting requirements of completeness, timeliness and quality.

CASEFINDING LIST: ICD-9-CM CODES

The following list is to be used to identify potentially reportable neoplasms using ICD-9-CM** codes to identify cancer diagnoses. Some ICD-9-CM** codes contain conditions that are not considered reportable as well as conditions that are considered reportable. These records will need to be reviewed and assessed individually to verify whether or not they are reportable to SDCR. Only reportable conditions are included on this list. Casefinding must include both primary diagnoses and any subsequent or secondary diagnoses.

ICD-9-CM Code(s) Diagnosis (in preferred ICD-O-3 terminology)

- 042 AIDS (review cases for AIDS-related malignancies)
- 140.0 - 208.9 Malignant neoplasms
- 225.0 Benign: Brain, NOS, Brain stem, Cerebellum, Cerebrum, Frontal lobe, Occipital lobe, Overlapping lesion, Parietal lobe, Temporal lobe, Ventricle
- 225.2 Benign: Cerebral meninges, Meninges, NOS
- 225.3 Benign: Cauda equina, Spinal cord
- 225.4 Benign: Spinal meninges
- 225.8 Benign neoplasm of other specified sites of nervous system
- 225.9 Benign: CNS, NOS, Overlapping lesion,
- 227.3 Benign: Craniopharyngeal duct (suprasellar region) Pituitary gland
- 227.4 Benign: Pineal gland,
- 230.0 - 234.9 Carcinoma in situ – all sites (exclude cervix – 233.1)
- 235.0 - 238.9 Neoplasms of uncertain behavior
- 236.0 Endometrial stroma, low grade (M8931/3), Endolymphatic stromal myosis, (M8931/3), Endometrial stromatosis, (M8931/3), Stromal Endometriosis, (M8931/3), Stromal myosis, NOS (M8931/3), (236.0)
- 237.5 Ependymoma (epithelial) (malignant) (M9391/3) papillary, (237.5)
- 237.6 Papillary Meningioma (M9538/3), (237.6) DX ≥ 2001
- 238.4 Polycythemia (primary) (rubra) (vera) (M9950/3), (238.4)
- 238.6 Solitary plasmacytoma (M9731/3), Extramedullary plasmacytoma (M9734/3)
- 238.7 Chronic myeloproliferative disease (M9960/3), Myelofibrosis with myeloid metaplasia (M9961/3), Essential thrombocythemia (M9962/3), Refractory cytopenia with multilineage dysplasia (M9985/3); Myelodysplastic syndrome with 5q- syndrome (M9986/3), Therapy related myelodysplastic syndrome
- 239.0 - 239.9 Neoplasms of unspecified behavior
- 259.2 Carcinoid Syndrome
- 273.2 Gamma heavy chain disease; Franklin's disease (M9763/3)

- 273.3 Waldenstrom's macroglobulinemia (M9761/3)
- 273.9 Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
- 284.9 Refractory anemia (M9980/3)

- 285.0 Refractory anemia with ringed sideroblasts (M9982/3), Refractory anemia with excess blasts (M9983/3) Refractory anemia with excess blasts in transformation (M9984/3)
- 289.8 Acute myelofibrosis (M9932/3)
- 288.3 Hypereosinophilic syndrome (M9964/3)

Review these ICD-9-CM codes for recurrences, subsequent primaries, and/or subsequent Rx)

- V07.3 Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
- V07.8 Other specified prophylactic measure
- V10.0 - V10.9 Personal history of malignancy
- V58.) Admission for radiotherapy
- V58.1 Admission for chemotherapy
- V66.1 Convalescence following radiotherapy
- V66.2 Convalescence following chemotherapy
- V67.1 Radiation therapy follow-up
- V67.2 Chemotherapy follow-up
- V71.1 Observation for suspected malignant neoplasm
- V76.0 - V76.9 Special screening for malignant neoplasm

SDCR ABSTRACT DATA DESCRIPTOR TABLE

Field	Label	Length of Key space	NAACCR Item
---PHYSICIAN/FACILITY SPECIFIC ---			
Reporting Hospital	Reporting Facility/ Physician	10	540
Abstracted By	Abstractor	2	570
Sequence Number--Hospital	SeqNumHosp	2	380
Class Of Case	ClassCase	1	610
Date Case Completed	Date Case Completed	8	2090
Type Of Reporting Source	TypeRepSrc	4	500
---PHYSICIAN-CONFIDENTIAL			
Name--Last	Last Name	25	2230
Name--First	First Name	14	2240
Name--Middle	Middle Name	14	2250
Name--Maiden	Maiden name	14	2390
Name--Alias	Alias	15	2280
Name--Spouse/Parent	Spouse Name	50	2290
Social Security Number	SSN	9	2320
Sex	Sex	1	220
---PATIENT DEMOGRAPHICS			
Birthplace	Birthplace code	3	250
Age at Diagnosis	Age at Diagnosis	3	230
Marital Status at DX	Marital	1	150
Addr at DX--No & Street	Street Address	40	2330
Addr at DX--Supplementl	Supplemental Address	40	2335
Addr at DX--City	City	20	70
Addr at DX--State	State	2	80
Addr at DX--Postal Code	ZipCode	9	100
County at DX	County	3	90
Addr Current--No & Street	Curr Street Address	40	2350
Addr Current--City	Curr City	20	1810

Addr Current--Postal Code	Curr ZipCode	9	1830
Addr Current--State	Curr State	2	1820
Tobacco History	Tobacco History	1row	340
Alcohol History	Alcohol History	1row	350
Race 1	Race 1	2	160
Race 2	Race 2	2	161
Race 3	Race 3	2	162
Race 4	Race 4	2	163
Race 5	Race 5	2	164
Spanish/Hispanic Origin	Hispanic	1	190
Birthplace	Birthplace	3	250
Primary Payer at DX	Primary Payer at Dx	2	630
Text--Usual Occupation	Occupation	40	310
Text--Usual Industry	Industry	40	320
Family History of Cancer	FamHxCA	1	35
---COMORBIDITY			
Comorbid/Complication 1	ComorbidComp1	5	3110
Comorbid/Complication 2	ComorbidComp2	5	3120
Comorbid/Complication 3	ComorbidComp3	5	3130
Comorbid/Complication 4	ComorbidComp4	5	3140
Comorbid/Complication 5	ComorbidComp5	5	3150
Comorbid/Complication 6	ComorbidComp6	5	3160
---CANCER IDENTIFICATION			
Date of 1st Contact	Date of First Contact	8	580
Date Of Diagnosis	Diagnosis Date	8	390
Age at Diagnosis	Age at Diagnosis	3	230
Primary Site	Primary Site	4	400
Laterality	Laterality	1	410
Histologic Type ICD-O-3	Histology ICD-0-3	4	522
Behavior Code ICD-O-3	Behavior ICD-O-3	1	523
Grade	Grade	1	440

Diagnostic Confirmation	Dx confirmation	1	490
STAGE/PROGNOSTIC FACTORS			
CS Tumor Size	CS Tumor Size	3	2800
CS Extension	CS Extension	2	2810
CS Tumor Size/Ext Eval	CS TS evaluation	1	2820
CS Lymph Nodes	CS Lymph Node	2	2830
CS Reg Nodes Eval	CS Reg Nodes Eval	1	2840
CS Mets at DX	CS Mets at diagnosis	2	2850
CS Mets Eval	CS How Mets Evaluated	1	2860
Regional Nodes Examined	Reg Nodes Examined	1	830
Regional Nodes Positive	Reg Nodes Pos	2	820
CS Site-Specific Factor 1	Site Spec Fact 1	3	2880
CS Site-Specific Factor 2	Site Spec Fact 2	3	2890
CS Site-Specific Factor 3	Site Spec Fact 3	3	2900
CS Site-Specific Factor 4	Site Spec Fact 4	3	2910
CS Site-Specific Factor 5	Site Spec Fact 5	3	2920
CS Site-Specific Factor 6	Site Spec Fact 6	3	2930
Derived AJCC Stage Group	DerivedStageGroup	2	3000
Derived AJCC T Descriptor	DerivedTDescrip	1	2950
Derived AJCC T	DerivedT	2	2940
Derived AJCC N Descriptor	DerivedNDescrip	1	2970
Derived AJCC N	DerivedN	2	2960
Derived AJCC M Descriptor	DerivedMDescrip	1	2990
Derived AJCC M	DerivedM	2	2980
Derived AJCC--Flag	DerivedTNMFlag	1	3030
Derived SS2000	DerivedSS2000	1	3020
Derived SS2000--Flag	DerivedSS2000Flag	1	3050
CS Version 1st	CSVer1st	6	2935
CS Version Latest	CSVerLatest	6	2936

---TREATMENT-1ST COURSE

RX Date--Surgery	RxDateSurg	8	1200
RX Summ--Surg Prim Site	RxSumSurgPSite	2	670
RX Summ--Scope Reg LN Sur	RxSumScopeRegLN	1	1292
RX Summ--Reg LN Examined	RxSumRegLNExam	2	1296
RX Summ--Surg Oth Reg/Dis	RxSumSurgOthReg	1	
RX Date--Radiation	RxDateRad	8	1210
RX Summ--Radiation	RxSumRad	1	1360
Rad--Regional RX Modality	RadRegModal	2	1570
RX Summ--Surg/Rad Seq	RxSumSurgRadSeq	1	1380
RX Summ--Hormone	Hormone Therapy	2	1400
RX Date--Hormone	Hormone Therapy Date	8	1230
RX Summ--Chemo	RxSumChemo	2	1390
RX Date--Chemo	Rx Chemo	8	1220
RX Summ--BRM	RxSumBRM	2	1410
RX Summ--Transplnt/Endocr	RxSumTransEndo	2	3250
RX Summ--Other	RxSumOth	1	1420
Date Of Last Contact	Date of Last Contact	8	1750

---FOLLOW-UP/DEATH

Date of Last Contact	Date of Last Contact	No	No
Vital Status	Vital Status	1	1760
Cancer Status	Cancer Status	1	1770
Place Of Death	Place of Death	3	1940
Cause Of Death	Cause of Death	4	1910
ICD Revision Number	ICDRevNum	1	1920
Physician--Managing	Reporting Physician	8	2460
Physician--Follow-Up	Physician - Other	8	2470

---OVERRIDES

Over-ride Age/Site/Morph	OvrdAgeSite	1	1990
Over-ride Histology	OvrdHist	1	2040
Over-ride Leuk, Lymphoma	OvrdLeukLym	1	2070
Over-ride Site/Behavior	OvrdSiteBeh	1	2071
Over-ride Site/Type	OvrdSiteType	1	2030

---TEXT

Text--DX Proc--Path	Text Pathology	250	2570
Text--Histology Title	Text Histology	40	2590
Text--Primary Site Title	Text Primary Site	40	2580
Text--Remarks	Text	350	2680

WebPlus USERS NOTES

The following items serve as reminders for users of *WebPlus*.

- ✓ SDCR staff will set up an account for each practice that will include a **Facility ID** for one user.
- ✓ After the account is set up, *WebPlus* will generate an e-mail to the person who will be completing the web-based data form (also known as an abstract). This e-mail will provide a **password** that may be used to enter the system, but should be changed to a password that is easier to remember.
- ✓ **Multiple physicians—One person** may submit information for more than one physician. The practice will have a single facility ID.
- ✓ **Single practice —One person** may submit information. The practice will have a single facility ID.
- ✓ Users will create a new “case” or “abstract” for each patient. The abstract or web-based data form may be saved whether or not information entered is complete. Users may return to the abstract at any time by using the “open” feature. Users may view the abstract even after it has been “released” or sent to SDCR via the web.
- ✓ **Reportable cases** are those cases (prostate) identified either through patient/treatment information or pathology reports which indicate the patient as having been diagnosed with cancer at your facility, and who will not receive treatment elsewhere.
- ✓ When users click on the “**Save**” button, edits are activated. Edit messages contain helpful information to explain how to correct the information. Once a case has passed all edits, it may then be released to the SDCR.
- ✓ WebPlus is configured with an automatic ‘**time-out**’ **mechanism** after 30 minutes of idle time in which users will have to log-in again to access the system. Therefore, please remember to save work frequently to prevent this occurrence.
- ✓ For security, WebPlus is also configured with an **automatic ‘lock-out’** after users have attempted unsuccessfully (3 times) to log-in. If this occurs, please contact the SDCR administrator so that your password can be reset.
- ✓ SDCR recommends the use of **Internet Explorer** to access *WebPlus* as users of other browsers will sometime experience difficulties.

SDCR staff recognizes that many users will not have any previous experience in ‘abstracting.’ If having difficulties, for most fields it is permissible to enter ‘9’ for ‘**Unknown**.’ However, we would like to stress that this should be reserved for cases in which information is not readily obtainable and not as a routine practice.

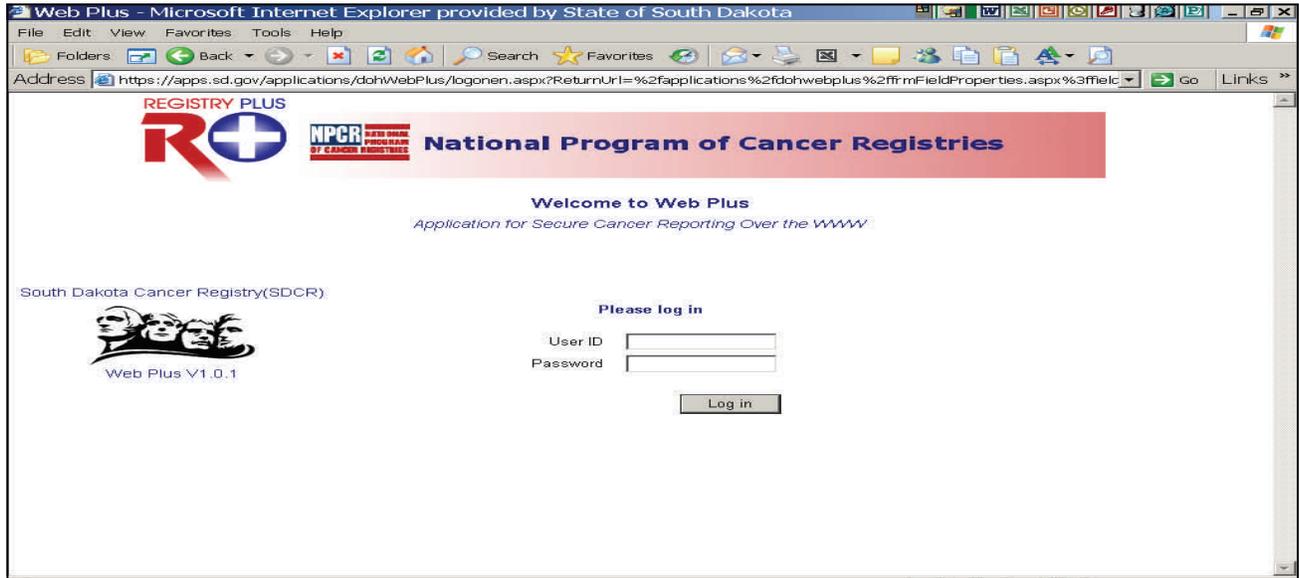
SDCR staff members are also available to answer questions toll free at 1-800-738-2301. Ask for Kay Darrington or call Kay directly at 605-773-6345 or Myrna Boodhoo Kightlinger at 605-773-5740.

Note: For patient confidentiality concerns, please remember to keep all patient information in a secure location while entering information into *WebPlus*.

OPENING *WebPlus*

Access website: <https://apps.sd.gov/applications/dohwebplus/logonen>

Screen 1: Log on to application by using the SDCR assigned username and password



Screen 2: Choose one of the above options to proceed

Web Plus



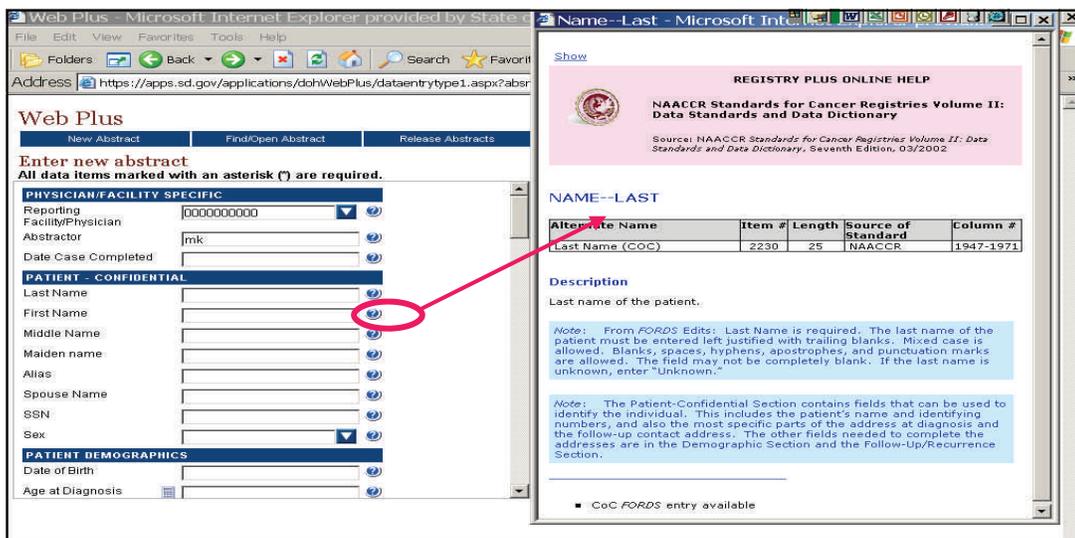
ENTERING A NEW ABSTRACT (DATA ENTRY PROCEDURE)

Please review the patient summary and/or pathology report before proceeding.

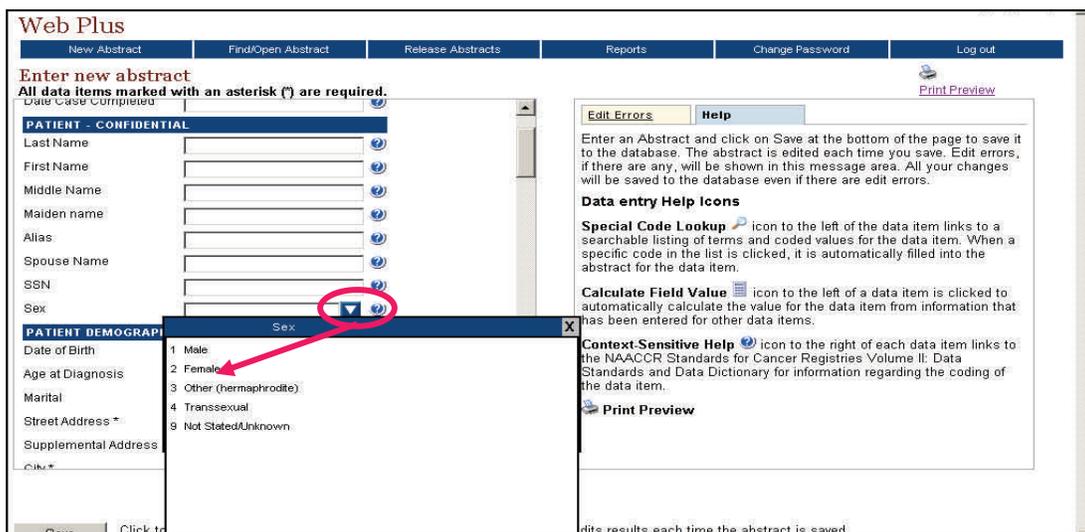
1. Select “new abstract” from the menu and a blank data form will appear.

2. Entering data:

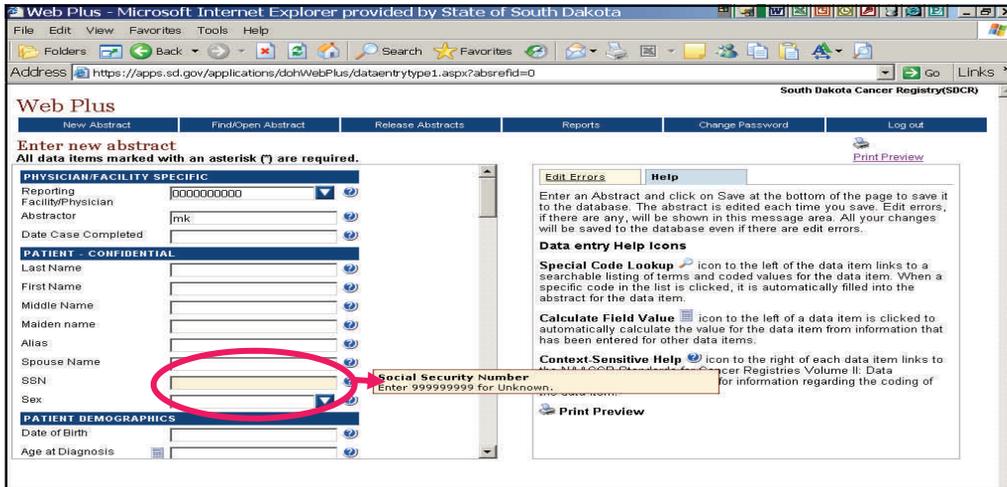
a. Before entering the requested information in each field, click the special help icon  and an on-line screen appears based on the NAACCR Standards for cancer Registries Volume 2. It includes information about the size of the field, what information to input and the organization.



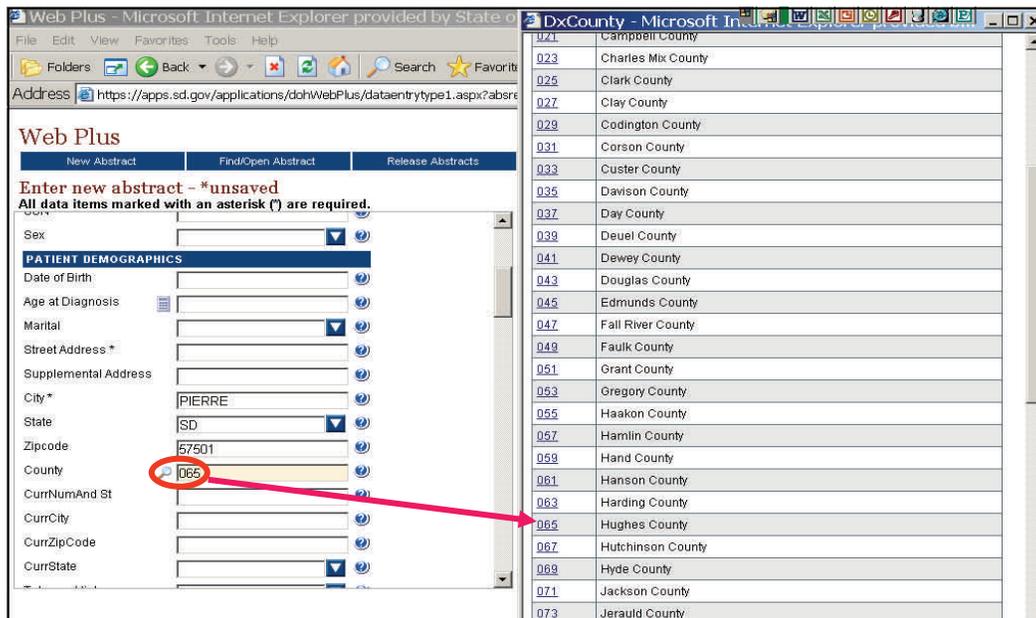
b. There are also “drop-down boxes  that provide choices for your answer. By double-clicking on the correct response, the field becomes populated.



C. Certain fields become tan when clicked, providing additional information



d. Some fields have a magnifying glass  which allows you to search for the appropriate codes. Click on the symbol for options or instructions to populate the field.



SAVING AN ABSTRACT

Note: please close the help box when completed as only one help box can be opened at a time.

After entering all data items, click “Save.” The following may occur:

1. If there are no errors, the abstract will be saved. The “Data Case Completed” field will be set with the current date.

You may then enter a new abstract, perform other functions or exit.

OR

2. If there are errors, the appropriate error messages will appear in the EDIT box, detailing errors. You will need to correct the EDITS and try saving again.

You may save the abstract despite errors. However, only abstracts that have passed all EDITS and have no critical fields missing will be exported.

AN ABSTRACT WITH EDIT ERRORS AND/OR CONTAINING MISSING CRITICAL FIELDS IS CONSIDERED INCOMPLETE.

The screenshot shows the 'Web Plus' application interface in a Microsoft Internet Explorer browser. The browser's address bar shows the URL: <https://apps.sd.gov/applications/dohWebPlus/dataentrytype1.aspx?absrefid=0>. The application title is 'South Dakota Cancer Registry(SDCR)'. The main content area is titled 'Update abstract' and includes a warning: 'All data items marked with an asterisk (*) are required.' The form is divided into three sections: 'PHYSICIAN/FACILITY SPECIFIC', 'PATIENT - CONFIDENTIAL', and 'PATIENT DEMOGRAPHICS'. The 'PHYSICIAN/FACILITY SPECIFIC' section includes fields for Reporting Facility/Physician (dropdown), Abstractor (text), and Date Case Completed (calendar). The 'PATIENT - CONFIDENTIAL' section includes fields for Last Name, First Name, Middle Name, Maiden name, Alias, Spouse Name, SSN, and Sex (dropdown). The 'PATIENT DEMOGRAPHICS' section includes fields for Date of Birth and Age at Diagnosis. At the bottom left, a 'Save' button is circled in red. To the right of the 'Save' button, a tooltip reads: 'Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.' On the right side of the form, there is an 'Edit Errors' tab with a 'Help' link. Below the tab, the text reads: '-----EDIT RESULT-----' and 'Editset Name: Central: SD UROLOGY'. A message states: 'There are edit errors in the abstract. Error messages along with the error fields are listed below. You can click on an error field to move to it in the data entry area. Click on the Save button to save the changes and rerun Edits.' Below this message, it says 'Total edit errors: 45' and lists 12 errors:

1. [Street Address](#) is required.
2. [Dx confirmation](#) is required.
3. [CS Tumor Size](#) is required.
4. [CS Extension](#) is required.
5. [CS TS evaluation](#) is required.
6. [CS Lymph Node](#) is required.
7. [CS Reg Nodes Eval](#) is required.
8. [CS Mets at diagnosis](#) is required.
9. [CS How Mets Evaluated](#) is required.
10. [Site Spec Fact 1](#) is required.
11. [Site Spec Fact 2](#) is required.
12. [Site Spec Fact 3](#) is required.

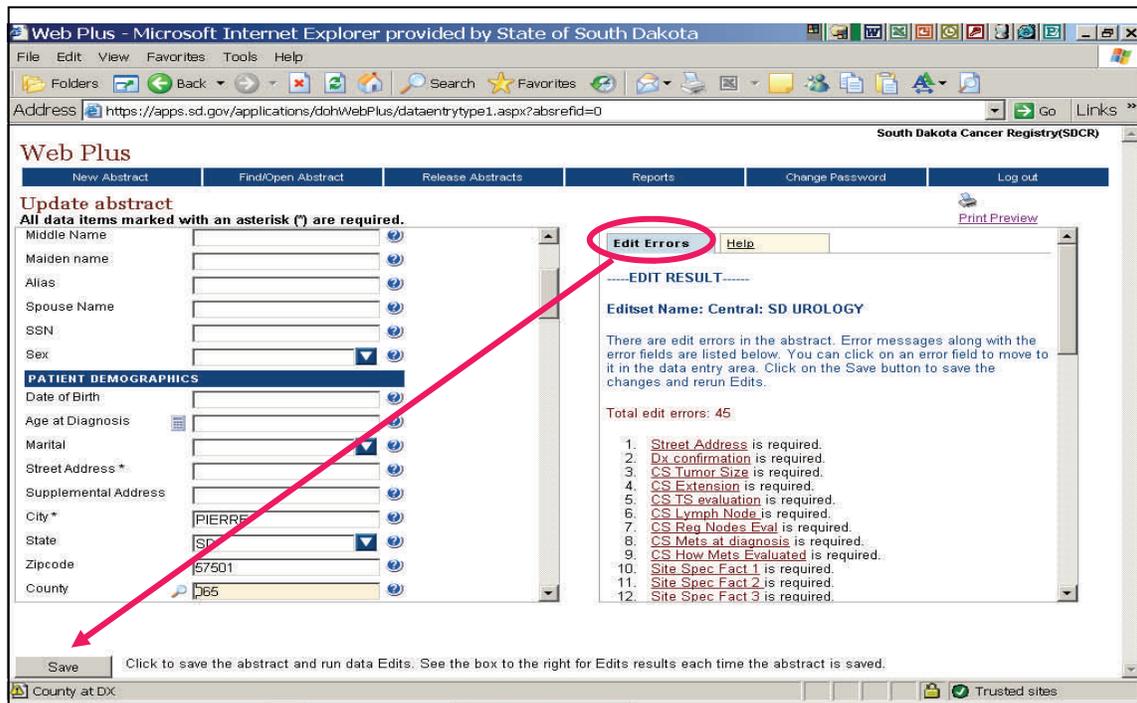
Information on correcting EDITS is on the following page. You may update abstracts and save when you can fill out the missing information.

1. Errors are displayed in the EDIT ERRORS tab.

EDITS

2. A list of fields with errors will be displayed below the error message.
3. Click on the error message to return to the active grid cell in order to correct the data.
4. Once the data is corrected, click on SAVE to save the changes and to re-run EDITS.

See chapter in the *CDC WebPlus* for further information.



Note: Users can save abstracts with edit errors but these will be considered incomplete by the system and will not upload to the central registry.

In order to complete these, please run reports under heading "REPORTS" or by going into FIND/OPEN ABSTRACT and entering last name or social security number for a case. You may open and complete or delete if it is not a case to be sent to the central registry.

1.

PRINT AND PRINT PREVIEW

Click on PRINT PREVIEW icon in the upper right hand corner to preview abstract/patient information.

2. Go back and correct any errors in the abstract.

OR

3. Go to file and PRINT the abstract.

To print more than one abstract:

Click on reports, and select the appropriate report to print multiple abstracts.

The screenshot displays the 'Web Plus' application interface within a Microsoft Internet Explorer browser. The browser's address bar shows the URL: `https://apps.sd.gov/applications/dohWebPlus/dataentrytype1.aspx?absrefid=0#`. The application header includes navigation tabs: 'New Abstract', 'Find/Open Abstract', 'Release Abstracts', 'Reports', 'Change Password', and 'Log out'. The main content area is titled 'Update abstract' and includes a note: 'All data items marked with an asterisk (*) are required.' The form is divided into three sections: 'PHYSICIAN/FACILITY SPECIFIC', 'PATIENT - CONFIDENTIAL', and 'PATIENT DEMOGRAPHICS'. The 'PHYSICIAN/FACILITY SPECIFIC' section contains fields for 'Reporting Facility/Physician' (0000000000), 'Abstractor' (mk), and 'Date Case Completed' (//). The 'PATIENT - CONFIDENTIAL' section contains fields for 'Last Name' (DISNEY), 'First Name' (WALTER), 'Middle Name', 'Maiden name', 'Alias', 'Spouse Name', 'SSN', and 'Sex'. The 'PATIENT DEMOGRAPHICS' section contains fields for 'Date of Birth' and 'Age at Diagnosis'. A 'Print Preview' icon is circled in red in the upper right corner of the form. A red arrow points from this icon to a separate browser window titled 'printabstract - Microsoft Internet Explorer provided by State of ...'. This window displays the 'Patient's Name: DISNEY, WALTER' and a list of fields with their corresponding values: 'Reporting Facility/Physician: South Dakota State Cancer Registry', 'Abstractor: mk', 'Date Case Completed: //', 'Last Name: DISNEY', 'First Name: WALTER', 'Middle Name:', 'Maiden name:', 'Alias:', and 'Spouse Name:'. At the bottom of the main application window, there is a 'Save' button and a note: 'Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.' The browser's status bar at the bottom indicates 'Done, but with errors on page.' and 'Trusted sites'.

FIND/OPEN ABSTRACTS

WebPlus provides an abstract query system which allows you to search your database to retrieve abstracts.

1. Select FIND/OPEN ABSTRACTS

2. Search by name (first and last) or SSN. Once the specific abstract is found, select OPEN to edit data or DELETE to discard.

Web Plus - Microsoft Internet Explorer provided by State of South Dakota

Address: <https://apps.sd.gov/applications/dohWebPlus/frmfindabstracthospitaluser.aspx>

South Dakota Cancer Registry(SDCR)

New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Find Abstract

Enter patient's "first or last" name or social security to search for. Search on partial name and social security is supported.

Name Social Security

Find

Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Actions	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status
Open Delete	26390	DUCK	DONALD	05/10/2006	500229944	10/20/1955	C341	1	dm	0	Complete

OR Click on FIND to get a list of all abstracts .

Web Plus - Microsoft Internet Explorer provided by State of South Dakota

Address: <https://apps.sd.gov/applications/dohWebPlus/frmfindabstracthospitaluser.aspx>

South Dakota Cancer Registry(SDCR)

New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Find Abstract

Enter patient's "first or last" name or social security to search for. Search on partial name and social security is supported.

Name Social Security

Find

Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Actions	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status
Open Delete	26384								mk	0	Complete
Open Delete	26387								mk	24	Incomplete
Open Delete	26389								mk	24	Incomplete
Open Delete	26390	DUCK	DONALD	05/10/2006	500229944	10/20/1955	C341	1	dm	0	Complete
Open Delete	26391	PAN	PETER	03/01/2006	500582222	07/21/1970	C182	0	dm	0	Complete
Open Delete	26392	CRICKET	JIMINEY	04/02/2006	599327781	11/14/1940	C619	0	dm	0	Complete
Open Delete	26393	WHITE	SNOW	03/06/2006	507498823	01/12/1959	C504	1	dm	0	Complete

Select OPEN to edit or DELETE to discard.

RELEASING ABSTRACTS

Click on RELEASE ABSTRACTS.

A list of abstracts will appear with “check boxes” appearing after each item. Only complete abstracts will appear.

Web Plus - Microsoft Internet Explorer provided by State of South Dakota

Address: <https://apps.sd.gov/applications/dohWebPlus/releaseabstracts.aspx>

South Dakota Cancer Registry(SDCR)

Web Plus

New Abstract Find/Open Abstract **Release Abstracts** Reports Change Password Log out

Release Abstracts

Please select the abstracts that you would like to release to your central registry by checking the box in the Release column. Then click the Release Selected Abstracts button at the bottom of the page. Please note that only completed abstracts are available for release.

AbsRefID	Last Name	First Name	Abstractor	Date Case Completed	Release
26390	DUCK	DONALD	dm	07/20/2006	<input type="checkbox"/>
26391	PAN	PETER	dm	07/20/2006	<input type="checkbox"/>
26392	CRICKET	JIMINEY	dm	07/20/2006	<input type="checkbox"/>
26393	WHITE	SNOW	dm	07/20/2006	<input type="checkbox"/>

Select All Unselect All Release Selected Abstracts

REPORTS

Choose "REPORTS" and select an option. See Chapter on reports in the CDC Manual for more information

For Example: Click Abstract updates and enter date range.

The screenshot shows the South Dakota Cancer Registry (SDCR) Web Plus interface. The 'Reports' menu item is circled in red. A secondary window titled 'AbstractUpdateLog' is open, showing a table of abstract update logs. A red arrow points from the 'Abstract Updates' link in the main interface to the 'AbstractUpdateLog' window.

Abstract ID	Location	Abstract ID	Timestamp
26422	Darrington	000000000	6/21/2006 5:36:00 PM
26422	Darrington	000000000	6/21/2006 5:37:00 PM
26422	Darrington	000000000	6/22/2006 9:53:00 AM
26423	Darrington	000000000	6/22/2006 10:01:00 AM
26423	Darrington	000000000	6/22/2006 10:02:00 AM
26410	Darrington	000000000	6/22/2006 10:06:00 AM
26410	Darrington	000000000	6/22/2006 10:06:00 AM
26424	Darrington	000000000	6/22/2006 10:06:00 AM
26433	myrna	000000000	6/30/2006 9:43:00 AM
26434	myrna	000000000	7/5/2006 2:47:00 PM
26434	myrna	000000000	7/5/2006 3:07:00 PM
26384	myrna	000000000	7/6/2006 7:24:00 AM

CHANGING PASSWORDS

Choose CHANGE PASSWORD and type in new password. Enter CHANGE to save new data.

Web Plus - Microsoft Internet Explorer provided by State of South Dakota

File Edit View Favorites Tools Help

Address <https://apps.sd.gov/applications/dohWebPlus/changepassword.aspx> Go Links >>

South Dakota Cancer Registry(SDCR)

Web Plus

New Abstract Find/Open Abstract Release Abstracts Reports **Change Password** Log out

Change Password

Please enter a new password below.

New password

Retype Password

Change

LOG OUT

When work has been completed, simply LOG out. *WebPlus* automatically times out after no use for 30 minutes.

DATA DICTIONARY- SD ABSTRACT

PHYSICIAN/FACILITY SPECIFIC

Reporting Hospital/Clinic/Physician

10 digit number provided by SDCR

Abstracted by (Filled by)

2 digit initial of the person completing the form.

Sequence Hospital Invisible to Abstractors.

Indicates the sequence of all neoplasms over the lifetime of the patient

Class of Case Invisible to Abstractor

Date case completed

The date the abstractor decided the case is completed and the case passed all edits.

MMDDYYYY

Standard edits check that this date is not later than the current date. This will be populated when the abstract is completed.

Type of Reporting Source Invisible to Abstractors

PATIENT CONFIDENTIAL

Last Name

Patient's last name in upper case.

If the name is longer than the allowed 15 spaces, key the first 25 letters of the last name.

Do not record Jr, Sr., III, etc in this field.

Do not use punctuation marks.

Examples

Mc Donald: record as MCDONALD

Jones-Smith record as JONES SMITH

St John record as ST JOHN

This field may be updated if the last name changes. Send the correction to the SDCR.

First Name

Record the patient's first name in upper case.

If the name is longer than the allowed space key the first 14 characters of the name.

Do not use any punctuation.

Examples

H. Edward Smith: record H as the first name and EDWARD as the middle name

H. E. Smith: record H E in the first name field with no punctuation.

Middle Name

Record the patient's middle name in upper case.

Record the middle initial only if the full middle name is unknown.

Leave blank by pressing enter if the patient does not have a middle name.

Do not use any punctuation.

Name-Maiden

Maiden name of female patients who are or have been married.

Name-Alias

Record an alternate name or AKA if used by the patient. A maiden name is not entered here.

Name-Spouse/Parent

Name parent if a child and spouse if married.

Social Security Number

Record the patient's social security number without dashes and without any letter suffix.

This is not always identical to the Medicare claim number

Code unknown as 99999999

PATIENT DEMOGRAPHICS

Street at Diagnosis—This is a critical field and cannot be left blank

Record the number and street address of the patient's usual residence when the cancer was diagnosed and treated. Leave a blank between numbers and words if space permits.

Do not use punctuation

Use all capital letters.

This field is very important. When the medical record consistently includes only a post office box or rural route, discuss the problem with administration or admitting. The SDCR needs the residential address not the billing address. The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report, and allow analysis of cancer clusters or environmental studies. Do not update this field if the patient's address changes over time.

If the patient had multiple tumors, the address may be different for subsequent primaries.

Use standard abbreviations.

□ Examples:

AVENUE	AVE
BOULEVARD	BLVD
CIRCLE	CIR
COURT	CT
DRIVE	DR
LANE	LN
PLACE	PL
ROAD	RD
STREET	ST

Address at Diagnosis-Supplemental

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.

City at Diagnosis

Record the city or town of the patient's usual residence when the cancer was diagnosed and treated. If patient resides in a rural area, record the name of the city or town used in their mailing address.

Do not use punctuation, special characters or abbreviations. The city should be spelled out, for example, key PIERRE.

Use all capital letters

If the patient had multiple tumors, the address may be different for each primary.

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field. Changing this field would destroy its usefulness.

State at Diagnosis

Record the U. S. postal service abbreviation for the state of the patient's usual residence when the cancer was diagnosed and treated. If the patient had multiple cancers, the address may be different for subsequent primaries. See appendix 1 for US codes and appendix 2 for Canadian provinces.

Zip Code at Diagnosis

For U.S. residents, record the patient's nine-digit extended zip code (also called postal code) at the time of diagnosis of this primary

When the nine-digit extended code is unavailable, record only the five-digit zip code, left justified, and leave the extended codes blank.

If the patient had multiple cancers, the zip code may be different for each primary.

Example:

The extended zip code 60611-2797 would be recorded as 606112797. When only five digits, 60611, are available, record 60611 _ _ _ _

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field. Changing this field would destroy its usefulness.

For Canadian residents, enter the 6 digit alpha numeric postal code.

If the permanent address is in a country other than Canada, United States or one of the United State's possessions, code as 8888888888.

County at Diagnosis

Record the county of the patient's usual residence when the cancer was diagnosed.

This data item is required for residents of South Dakota. Sometimes a patient who lives in a rural area, lives in a different county from the post office that serves them. It is important for the SDCR to have the county where the patient lives when diagnosed.

The codes are from the Bureau of Standards for the Federal Information Processing Standards. Refer to Appendix 3 for the FIPS codes. These are the only county codes the SDCR will accept.

For out-of-state patients, code 998.

If the patient had multiple cancers, the county may be different for subsequent primaries.

Patients with residence at diagnosis other than the United States or Canada: When the patient is a foreign resident write name in text or if unknown, write in unknown

Address Current-City

Name of city of the patient's current usual residence. If the patient has multiple tumors, the current city of residence should be the same for all tumors.

Address Current-No and Street

The number and street address or the rural mailing address of the patient's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same. Additional address information such as facility, nursing home, or name of apartment complex should be entered in item (2355) Addr At DX-Supplemental.

Address Current-Postal code

Postal code for the patient's current address.

Address Current –State

USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions) or Canadian province/territory of the patient's current usual residence. If the patient has multiple tumors, the current state of residence should be the same for all tumors.

Tobacco History

Record whether is currently using or has used tobacco products in the past. Tobacco products include

cigarettes or pipes, chewing snuff. Time frame for use should also be entered if known.

Alcohol History

Record whether current use or not; history of use and quantity.

Race1

Race is analyzed with the data item Spanish/Hispanic origin. **Both items must be recorded.**

Codes

01 White

02 Black

03 American Indian, Aleutian, or Eskimo

04 Chinese

05 Japanese

06 Filipino

07 Hawaiian

08 Korean

09 Asian Indian, Pakistani

10 Vietnamese

11 Laotian

12 Hmong

13 Kampuchean, (including Khmer and Cambodian)

14 Thai (effective with 1994 diagnoses)

20 Micronesian, NOS

21 Chamorran

22 Guamanian, NOS

25 Polynesian, NOS

26 Tahitian

27 Samoan

28 Tongan

- 30 Melanesian, NOS
- 31 Fiji Islander
- 32 New Guinean
- 96 Other Asian, including Asian, NOS and, Oriental, NOS
- 97 Pacific Islander, NOS
- 98 Other
- 99 Unknown

If the patient is multi –racial, please add information in text remarks.

Spanish/Hispanic Origin

This field must always be coded.

This item identifies persons of Spanish/Hispanic surname or ethnicity. A person of Spanish/Hispanic origin may be any race.

If you code “yes’ and know the origin of the person as outlined below, please include in text

Codes

- 0 Non-Spanish; non-Hispanic
- 1 Mexican (includes Chicano)
- 2 Puerto Rican
- 3 Cuban
- 4 South or Central American (except Brazil)
- 5 Other specified Spanish/Hispanic origin (includes European)
- 6 Spanish, NOS, Hispanic, NOS, Latino, NOS
- 7 Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic).
- 9 Unknown whether Spanish or not

Portuguese and Brazilians are not-Spanish and should be coded (0).

Birthdate

Date of birth of the patient. The birthdate is recorded in the month, day, year format (MMDDCCYY). A zero must precede single-digit months and days. Estimate date of birth when information is not available. It is better to estimate than to code as an unknown value.

Birthplace

Write in the U.S. state code or Canadian province of the birthplace of the patient. If the birthplace is another country, please write in the name of the country, e.g. Mauritius.

If you want to code the country, the codes are found at:

http://seer.cancer.gov/manuals/SPM_AppendixB.doc

Sex

Code patient's sex

- 1 Male
- 2 Female
- 3 Other (hermaphrodite)
- 4 Transsexual
- 5 Not stated

Marital Status at DX

Code the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Primary Payer at Diagnosis

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment. It could be Medicare or a private insurer such as Dakotacare. Use drop downs for appropriate codes.

Text-Usual Occupation

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Text-Usual Industry

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Family History of Cancer

Describe family history for parents and siblings especially if same type of cancer. Describe if any usual event such early diagnosis of an adult cancer or occupation associated cancer such as mesothelioma.

COMORBIDITY

Cormorbidity 1-4

Records the patient's pre-existing medical conditions and/or complications, other than neoplasms, during the patient's hospital stay for the treatment of this cancer.

CANCER IDENTIFICATION

Date of Diagnosis

Date of initial diagnosis for the tumor being reported whether clinically or microscopically confirmed. This must be a report from a medical practitioner.

Age at Diagnosis

The age at diagnosis is computer-generated. The SDCR requires this field to be completed. If the date of diagnosis is blank, or unknown, or the date of birth is unknown, the computer cannot calculate this field.

USE the *Calculate Age* button available on your software to allow the software to calculate the age.

Primary Site

Use the drop down box to find and record the ICD-O-3 topography code for the site of origin for all cases diagnosed from 1/1/2001. Consult a physician to identify the primary site or the most definitive site code if the medical record does not contain that information.

Do not record the decimal point.

- Example:** Breast, upper-outer quadrant appears in the ICD-O-3 as C50.4 and is recorded C504.

Use the subcategory 8 for **single** tumors that overlap the boundaries of two or more subsites and the point of origin are not known.

- **Example:** Code overlapping lesion (C10.8) when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

Use the subcategory 9 for multiple tumors that originate in one organ.

- **Example:** Multifocal breast cancer would be coded C50.9

Code adenocarcinoma in **multiple polyps** as a single primary even if they involve more than one segment of the colon.

- **Example:** Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary. Code to colon, NOS (C18.9).

- **Lymphoma:** Most lymphomas arise in lymph nodes (C77.-), or lymphatic tissue, such as tonsils, spleen, Waldeyer's ring, or thymus. Lymphomas arising in lymphatic tissue are coded to the site of origin (tonsil C09.-, spleen C42.2, Waldeyer's ring C14.2, or thymus C37.9) but analyzed with the "nodal" group. Extranodal lymphomas arise from lymphatic cells in organs such as intestine or stomach. Extranodal lymphomas are coded to the organ of origin.

- **Example:**

Code lymphoma of the stomach to (C16.-).

Lymphoma may be present in both an extra-lymphatic organ and at least one lymph node chain. Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician. Code to lymph nodes, NOS (C77.9) if the site of origin is not identified.

Mycosis Fungoides and Cutaneous Lymphoma - code to skin (C44.-).

Leukemia - code to bone marrow (C42.1).

Kaposi Sarcoma –code Kaposi sarcoma to the site in which it arises. Code to skin (C44) if Kaposi sarcoma arises simultaneously in the skin and another site and the primary site is not identified.

Melanoma Each occurrence of melanoma of the skin is a new/separate primary **UNLESS** a physician states otherwise. If a patient is diagnosed with metastatic melanoma and the primary site is not identified, code to skin, NOS (C44.9).

Primary Site Codes are available in the Topography section of the International Classification of Disease, 3rd Edition (ICD-O-3) or from the drop down in the software.

Laterality

Code for the side of a paired organ, or the side of the body on which the reportable tumor originated.

Codes

- 0 Not a paired site
- 1 Right: origin of primary
- 2 Left: origin of primary
- 3 Only one site involved, right or left origin unspecified
- 4 Bilateral involvement, lateral origin unknown; stated to be single primary; including both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
- 9 Paired site, but no information concerning laterality, midline tumor

Histologic Type ICD-O-3

Record the histology using the ICD-O-3 codes in the Morphology-Numerical section and in the Alphabetic Index . The ICD-O-3 identifies the morphology codes with an M preceding the code number. Follow the coding rules outlined in the ICD-O-3 coding manual pages 8-40.

Cases diagnosed from 1/1/2001 are coded using ICD-O-3 (purple cover).

Note: Cases diagnosed prior to 1/1/2000 are coded using ICD-O-2 (green cover), therefore some codes will be different in historical cases.

The codes for cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are interchangeable. If the physician states the patient has a malignant tumor, code 8000/3. If stated the patient has carcinoma, NOS, code 8010/3.

Always refer to the *International Classification of Diseases for Oncology*, Third Edition for cases diagnosed from 1/1/2001, and Second Edition, for cases diagnosed prior to 1/1/2001.

Behavior Code

Code for the behavior of the tumor being reported as follows in Codes in ICD-O-3, page 66

5th digit Behavior code for Neoplasms

- /0 Benign
- /1 Uncertain whether benign or malignant
 - Borderline malignancy
 - Low malignant potential
 - Uncertain malignant potential
- /2 Carcinoma *in situ*
 - Intraepithelial
 - Non-infiltrating
 - Non-invasive
- /3 Malignant/primary site
- /6 Malignant, metastatic site
- /9 Malignant, uncertain
 - whether primary or metastatic

Grade

Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Codes: See the grade tables on page 67 of ICD-O-3

- 1 Grade I
- 2 Grade II
- 3 Grade III
- 4 Grade IV
- 5 T-cell
- 6 B-cell
- 7 Null cell
- 8 NK (natural killer) cell
- 9 Grade/differentiation unknown, not stated, or not applicable

Diagnostic Confirmation

Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Codes

- 1 Positive histology
- 2 Positive cytology, no positive histology
- 4 Positive microscopic confirmation, method not specified
- 5 Positive laboratory test/marker study
- 6 Direct visualization without microscopic confirmation
- 7 Radiography and other imaging techniques without microscopic confirmation
- 8 Clinical diagnosis only (other than 5, 6, or 7)
- 9 Unknown whether or not microscopically confirmed

STAGE/DIAGNOSTIC PROGNOSTIC FACTORS

Please use the drop down icons and/or special look-up icons to select the appropriate code for the following fields. A complete Collaborative Stage (CS) Manual covering all cancers is provided to all abstractors. It is also available on line at :

http://training.seer.cancer.gov/module_collab_stage/unit01_sec01_what1s.html

This site offers an explanation of the collaborative stage and links to the CS for various cancer sites. The example provided below is for prostate cancer.

CS Tumor Size

CS Tumor Size is used to record the largest dimension, or the diameter of the primary tumor in millimeters (for example: 1 mm = 001, 1 cm = 010). There will be no tumor size for prostate, bladder and urethra cancer so record "999." Cancers of the penis and testes also do not use

tumor size for AJCC staging.

CS Extension

Site-specific codes provide extensive detail describing disease extent.

Codes (in addition to Site-Specific Codes)

- 00 *In situ*; noninvasive.
- 80 Further contiguous extension
- 95 No evidence of primary tumor
- 99 Unknown extension; primary tumor cannot be assessed; not stated in patient record

CS Tumor Size/Ext Eval

Record how the codes for the two items “CS tumor size “ and “CS extension” were determined based on the diagnostic methods employed.

CS Lymph Nodes

Identifies the lymph nodes involved with cancer at the time of diagnosis.

CS Reg Nodes Eval

Records how the codes for “CS lymph nodes” was determined based on the diagnostic method employed.

CS Mets at DX

Identifies the distant site(s) of metastatic involvement at time of diagnosis.

CS Mets Eval

Records how the code for the item “CS mets at DX” was determined based on the diagnostic methods employed.

Regional Nodes Examined

Record the number of lymph nodes that were removed and examined by the pathologist.

Regional Nodes Positive

Records the exact number of lymph nodes examined and found to be positive.

Regional Nodes Positive

Records the exact number of lymph nodes examined and found to be positive.

CS Site-Specific Factor 1- 6

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

AJCC

The following 7 AJCC data fields are derived from CS coded fields, using the CS algorithm

Derived AJCC Stage Group

Derived AJCC T Descriptor

Derived AJCC T

Derived AJCC N Descriptor

Derived AJCC N

Derived AJCC M Descriptor

Derived AJCC M

Derived AJCC--Flag

Summary Stage

The following two SS fields are derived using the CS algorithm.

Derived SS2000

Derived SS2000--Flag

CS Version 1st

This is the number of the version used to initially code the CS fields

CS Version Latest

This is the number of the versions used recently to derive the output fields.

TREATMENT- 1ST COURSE

TREATMENT DEFINITIONS

First course of treatment

First course of treatment includes all methods of treatment recorded in the original treatment plan and administered to the patient. Several items document the first course of cancer-directed therapy. A treatment plan describes the type(s) of treatment(s) intended to modify or control the malignancy. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, e.g. medical or clinic record, consultation reports and outpatient records. All cancer-directed treatments specified in the physician(s) treatment plan are part of the first course of therapy. A **treatment plan** may specify one or more modalities of treatment (surgery, radiation therapy, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment **regimen** may include combinations of concurrent or adjuvant therapies.

Only when there is no treatment plan, established protocol or management guidelines or if consultation with a physician advisor is not possible, use the principle: ***initial treatment must begin within four months of the date of initial diagnosis.***

Note: For users who have used other cancer registry software. There are differences in how software providers present the surgery codes. Some programs allow only one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events. If the patient has multiple surgeries of the primary site, code the ***Surgical Approach*** for the most invasive, definitive surgery (numerically highest code).

Time Period -- Leukemia Only

First course of therapy includes all cancer-directed treatments planned and administered by the physician(s) during or after the first diagnosis of leukemia. Record all remission inducing or remission-maintaining cancer-directed therapies as first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. Certain pediatric leukemia protocols span two years or more from induction to the end of maintenance. Induction, consolidation and maintenance are all first course of therapy.

No Treatment Option

No therapy is a treatment option (the patient refused treatment, the family/guardian refused treatment, the patient expired before treatment started, or the physician recommended no treatment or only observation until progression of the disease). Therefore, first course of therapy may be no treatment.

Date Of First Course Of Treatment

Date of first course of treatment is the month, day, century, and year (MMDDYYYY) of the first cancer-directed therapy. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

If the physician decides **not to treat the patient**, record the date of this decision as the date of initial treatment. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

□ **Example:**

On February 12, 2001 the physician stated the patient's early stage prostate cancer patient will be observed. Enter 02/12/2001 as the date of first course of treatment.

If the patient refused treatment, **record the date of this decision** as the date of initial treatment.

Record the date of death for **autopsy-only cases**. If the patient is diagnosed at the reporting facility and no further information is available (patient is lost to follow-up) record the date the patient was last seen at the reporting institution.

Surgical Approach

Surgical Approach describes the method used to approach the organ of origin and/or primary tumor. Code the approach for surgery of the primary site only. If there was no surgery to the primary site, **Surgical Approach** must be coded 0. If the field **Surgery of Primary Site** is 99 (Unknown if surgery performed; death certificate ONLY), code **Surgical Approach** 9 (Unknown; not stated; death certificate ONLY).

Endoscopy, image guided, is a generic term for guidance provided by any imaging technique including, but not limited to, CT scans, MRI scans, ultrasound, or radiographic imaging.

Open is a generic term describing all non-scope approaches. Procedures for which **Surgical Approach** would be coded open include, but are not limited to, mastectomy, excision of a melanoma of the skin, or excision of a brain tumor.

Open, assisted by endoscopy means that the scope is being used (present in the body) at the same time the primary tumor is resected. **DO NOT CODE** a procedure as assisted by endoscopy when the scope is used and removed prior to the resection or when it is inserted and used after the resection of the primary tumor.

□ Example:

A patient with lung cancer had a bronchoscopy and mediastinoscopy to evaluate whether the lesion is resectable. The scopes were removed **before** the surgeon performed a wedge resection. Code ***Surgical Approach*** open, NOT assisted by endoscopy.

If the patient has **multiple surgeries** of the primary site, code the ***Surgical Approach*** for the most invasive, definitive surgery (numerically highest code).

□ Example:

Patient had a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report stated carcinoma extending into the stalk. (Surgery of Primary Site code 27). A week later, the patient had a hemicolectomy, code 40. The hemicolectomy would be the most invasive, definitive surgery. The surgical approach would be coded open, not assisted by endoscopy (5).

Date of First Contact

MMDDYYYY

Date of first contact, as inpatient or outpatient, with reporting facility for the diagnosis and /or treatment of the tumor. The date may represent the date of the outpatient visit for biopsy, x-ray, scan, or laboratory test.

RX Date - Surgery

MMDDYYYY

Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed.

RX SUMM-Hormone

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

RX SUMM-HormoneCodes

- 00 None, hormone therapy was not part of the first course of therapy; not customary therapy for this cancer.
- 01 Hormone therapy.
- 82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
- 85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
- 86 Hormone therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
- 87 Hormone therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
- 88 Hormone therapy was recommended, but it is unknown if it was administered.
- 99 It is unknown if hormone therapy was recommended or administered; death certificate-only cases.

RX Date-Hormone

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

RX Summ-Surgery Primary Site

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes (in addition to the site-specific codes)

- 00 None. No surgical procedure of primary site. Autopsy only.
- 10-19 Site-specific codes. Tumor destruction; no pathologic specimen produced.
- 20-80 Site-specific codes. Resection. Path specimen produced.
- 90 Surgery, NOS.
- 98 Special codes for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease, ill-defined site, and unknown primaries (see site-specific codes for site/histologies included). Code 98 takes precedence over Code 00.
- 99 Unknown. Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate-only.

RX-ScopeReg LN Surgery

Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

Coding Instructions

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9), code 9.
- For lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–77.9), code 9.
- For an unknown or ill-defined primary (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9720, 9722–23, 9731–34, 9740–42, 9750–58, 9760–69, 9800–9941, 9945–46, 9948, 9950–89), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field “Surgical Procedure/Other Site”

Codes

- 0 No regional lymph nodes removed
- 1 Biopsy or aspiration of regional lymph node, NOS
- 2 Sentinel lymph node biopsy
- 3 Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
- 4 1 to 3 regional lymph nodes removed
- 5 4 or more regional lymph nodes removed
- 6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated
- 7 Sentinel node biopsy and code 3, 4, or 5 at different times
- 9 Unknown

RX Summary-Reg LN Examined

Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes

- 00 No regional lymph nodes removed
- 01 One regional lymph node removed
- 02 Two regional lymph nodes removed
- 90 Ninety or more regional lymph nodes removed
- 95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
- 96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
- 97 Regional lymph node removal documented as a dissection and number of lymph nodes unknown/not stated
- 98 Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
- 99 Unknown; not stated; death certificate-only

RX Summ Surgery Other Reg/Dis

Records the surgical removal of *distant* lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Codes

- 0 None
- 1 Non-primary surgical procedure performed
- 2 Non-primary surgical procedure to other regional sites
- 3 Non-primary surgical procedure to distant lymph node(s)
- 4 Non-primary surgical procedure to distant site
- 5 Any combination of codes 2, 3, or 4
- 9 Unknown

RX Summary-Date

Records the date on which radiation therapy began at any facility that is part of the first course of treatment. Record as MMDDYYYY

Codes (in addition to valid dates)

- 00000000 No radiation therapy administered; autopsy-only case.
- 88888888 When radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.
- 99999999 When it is unknown whether any radiation therapy was administered; the date is unknown, or the case was identified by death certificate-only.

Rx Surgery-Radiation

Codes for the sequencing of radiation and cancer-directed surgery given as part of the first course of treatment. Includes treatment given at all facilities as part of the first course.

Codes

- 0 no radiation and/or no cancer directed surgery
- 2 Radiation before surgery
- 3 Radiation after surgery
- 4 Radiation both before and after surgery
- 5 Intraoperative radiation
- 6 Intraoperative radiation with other radiation given before or after surgery
- 9 Unknown if radiation therapy administered

RX Summ-SURG/Rad/Seq

Codes for the sequencing of radiation and cancer-directed surgery given as part of the first course of treatment. Includes treatment given at all facilities as part of the first course

Codes

- 0 No radiation and/or no cancer-directed surgery
- 2 Radiation before surgery
- 3 Radiation after surgery
- 4 Radiation both before and after surgery
- 5 Intraoperative radiation
- 6 Intraoperative radiation with other radiation given before or after surgery
- 9 Sequence unknown, but both surgery and radiation were given

Rad-Regional RX Modality

Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Codes

- 00 No radiation treatment
- 20 External beam, NOS
- 21 Orthovoltage
- 22 Cobalt-60, Cesium-137
- 23 Photons (2-5 MV)
- 24 Photons (6-10 MV)
- 25 Photons (11-19 MV)
- 26 Photons (> 19 MV)
- 27 Photons (mixed energies)
- 28 Electrons
- 29 Photons and electrons mixed
- 30 Neutrons, with or without photons/electrons
- 31 IMRT
- 32 Conformal or 3-D therapy
- 40 Protons
- 41 Stereotactic radiosurgery, NOS
- 42 Linac radiosurgery
- 43 Gamma Knife
- 50 Brachytherapy, NOS
- 51 Brachytherapy, Intracavitary, Low Dose Rate (LDR)
- 52 Brachytherapy, Intracavitary, High Dose Rate (HDR)
- 53 Brachytherapy, Interstitial, Low Dose Rate (LDR)
- 54 Brachytherapy, Interstitial, High Dose Rate (HDR)
- 55 Radium
- 60 Radio-isotopes, NOS
- 61 Strontium - 89
- 62 Strontium - 90
- 80 Combination of beam with radioactive implants or radioisotopes, NOS
- 85 Other combinations of treatment modalities, NOS
- 98 Other, NOS
- 99 Unknown

RX Summ Chemo

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy were not given. Includes treatment given at all facilities as part of the first course.

- 00 None, chemotherapy was not part of the first course of therapy; not customary therapy for this cancer.
- 01 Chemotherapy, NOS.
- 02 Chemotherapy, single agent.
- 03 Chemotherapy, multiple agents.
- 82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
- 85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
- 86 Chemotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
- 87 Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
- 88 Chemotherapy was recommended, but it is unknown if it was administered.
- 99 It is unknown if chemotherapy was recommended or administered; death certificate-only cases.

RX Summ-BRM

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at this facility or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

- 00 None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer.
- 01 Immunotherapy.
- 82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
- 85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
- 86 Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
- 87 Immunotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
- 88 Immunotherapy was recommended, but it is unknown if it was administered.
- 99 It is unknown if immunotherapy was recommended or administered; death certificate-only cases.

RX Summ-Transplnt/Endocr

Identifies systemic therapeutic procedures administered as part of the first course of treatment at this facility and all other facilities or the reason they were not used. These include bone marrow transplants, stem cell harvests, and surgical and radiation endocrine therapy.

- 00 None, transplant procedure or endocrine therapy was not part of the first course of therapy; not customary therapy for this cancer.
- 10 Bone marrow transplant, NOS. A bone marrow transplant procedure was administered, but the type was not specified.
- 11 Bone marrow transplant—autologous.
- 12 Bone marrow transplant—allogeneic.
- 20 Stem cell harvest.
- 30 Endocrine surgery and/or endocrine radiation therapy.
- 40 Combination of a transplant procedure with endocrine surgery and/or radiation (code 30 in combination with 10, 11, 12 or 20).
- 82 Transplant procedure and/or endocrine therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).
- 85 Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy.
- 86 Transplant procedure and/or endocrine therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record.
- 87 Transplant procedure and/or endocrine therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
- 88 Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
- 99 It is unknown if a transplant procedure or endocrine surgery and/or radiation were recommended or administered. Death certificate-only cases and autopsy-only cases.

RX Summ-Other

Identifies other treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

- 0 None, all cancer treatment was coded to other modalities.
- 1 Other. Cancer treatment that cannot be appropriately assigned to other treatment modalities.
Used for hematopoietic diseases (M-9950-9989) treated by aspirin, phlebotomy, or transfusions (see notes below).
- 2 Other Experimental, code not defined. It may be used to record participation in institution-based clinical trials.
- 3 Other-Double Blind, a patient is involved in a double-blind clinical trial. Code the treatment actually administered when the trial code is broken.
- 6 Other-Unproven, cancer treatments administered by nonmedical personnel.
- 7 Refusal. The patient or patient's guardian refused treatment, which would have been coded as 1, 2, or 3.
- 8 Recommended; unknown if administered. Other treatment was recommended, but it is unknown whether it was administered.
- 9 Unknown; it is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Note: Aspirin (also known as acetylsalicylic acid [ASA] or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:

Date of Last Contact

MMDDYYYY Date of last contact with the patient, or date of death.

FOLLOW-UP/DEATH

Vital Status

Vital status of the patient as entered on the last day of contact and recorded as follows:

CODES

1 Dead

2 Alive

Cancer Status

Records the cancer status for this primary as of the date entered in item 1750 (Date of Last Contact). If the

- 1 No evidence of this cancer
- 2 Evidence of this cancer
- 9 Unknown, indeterminate whether this cancer is present

Place of Death

State or country where the patient died and where certificate of death is filed.

Codes (in addition to geocodes)

- 997 Not applicable, patient alive
- 999 Place of death unknown

ICD Revision Number Invisible to Abstractors

Physician-Managing

Enter the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

Physician Follow-up

Enter the physician currently responsible for the patient's medical care.

OVER-RIDES

To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct. These are invisible to the abstractor as the central registry will perform these functions.

Over-ride Age/Site/Morph

- Blank Not reviewed
- 1 Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed

Over-ride Histology

Blank Not reviewed

- 1 Reviewed: The behavior code of the histology is designated as “benign” or “uncertain” in ICD-O-2 or ICD-O-3, and the pathologist states the primary to be “*in situ*” or “malignant” (flag for a “Morphology Type & Behavior” edit)
- 2 Reviewed: The behavior code is “*in situ*,” but the case is not microscopically confirmed (flag for a “Diagnostic Confirmation, Behavior Code” edit)
- 3 Reviewed: Conditions 1 and 2 above both apply

Over-ride Leuk, Lymphoma

Codes

Blank Not reviewed

- 1 Reviewed: A patient was diagnosed with leukemia or lymphoma and the diagnosis was not microscopically confirmed

Over-ride Site/Type

Codes

Blank Not reviewed

- 1 Reviewed: The coding of an unusual combination of primary site and histologic type has been reviewed

Text

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Text-DXProc-Path (Example for prostate cancer)

Text area for information from cytology and histopathology reports, including Gleason score.

Include the correct grade. Use the following table:

Prostate Grade Conversion Table

Code	Gleason Score	Gleason Pattern	Terminology	Hist Grade
1	2,3,4	1,2	Well differentiated	I
2	5,6	3	Moderately differentiated	II
3	7,8,9,10	4,5	Poorly differentiated	III

Information about grade by number will be:

1 = *well differentiated*

2 = *moderately differentiated*

3 = *poorly differentiated*

4 = *undifferentiated*

If the Gleason score does not indicate a grade, use the “NOS” value “9.”

TEXT-Histology Title

Text area for information of histologic type, behavior, and grade in natural language. If some of this is entered in TEXT-Pathology, do not re-enter.

Text-Primary Site title

Text area for information of primary site in natural language.

Text-Remarks

Text area for information not elsewhere provided for and for overflow from other text areas. Enter any information that would aid in completing a cancer abstract of this patient.

Example: physician’s name, cancer hx.

SECTION IV APPENDICES

Appendix 1

UNITED STATES CODES

Alabama	AL	Maine	ME	Pennsylvania	PA
Alaska	AK	Maryland	MD	Rhode Island	RI
Arizona	AZ	Massachusetts	MA	South Carolina	SC
Arkansas	AR	Michigan	MI	South Dakota	SD
California	CA	Minnesota	MN	Tennessee	TN
Colorado	CO	Mississippi	MS	Texas	TX
Connecticut	CT	Missouri	MO	Utah	UT
Delaware	DE	Montana	MT	Vermont	VT
District of Columbia	DC	Nebraska	NE	Virginia	VA
Florida	FL	Nevada	NV	Washington	WA
Georgia	GA	New Hampshire	NH	West Virginia	WV
Hawaii	HI	New Jersey	NJ	Wisconsin	WI
Idaho	ID	New Mexico	NM	Wyoming	WY
Illinois	IL	New York	NY	OTHER	
Indiana	IN	North Carolina	NC	Puerto Rico	PR
Iowa	IA	North Dakota	ND	Virgin Islands	VI
Kansas	KS	Ohio	OH	Other than Canada or US	YY
Kentucky	KY	Oklahoma	OK		
Louisiana	LA	Oregon	OR		

Appendix 2

CANADIAN PROVINCES CODES

Providence		Providence	
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

Appendix 3 South Dakota County FIPS Codes

County Code	County Name
003	Aurora
005	Beadle
007	Bennett
009	Bon Homme
011	Brookings
013	Brown
015	Brule
017	Buffalo
019	Butte
021	Campbell
023	Charles Mix
025	Clark
027	Clay
029	Codington
031	Corson
033	Custer
035	Davison
037	Day
039	Deuel
041	Dewey
043	Douglas
045	Edmunds
047	Fall River
049	Faulk
051	Grant
053	Gregory
055	Haakon
057	Hamlin
059	Hand
061	Hanson
063	Harding
065	Hughes
067	Hutchinson

Appendix 4: ACCRONYMS / GLOSSARY

ACoS	American College of Surgeons
ASC	Ambulatory Surgical Center
CDC	Center for Disease Control and Prevention
CoC	Commission on Cancer
DOH	Department of Health
IRB	Institutional Review Board
HIM	Health Information Management
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries
SDCR	South Dakota Cancer Registry

Adenocarcinoma—a form of cancer that develops from a malignant abnormality in the cells lining a glandular organ such as in prostate.

Age-adjusted— modified to take account of the individual ages of a group.

Alpha-blockers - medication that act to relax certain type of muscle tissue such as heart muscle or for BPH in the prostate.

Antiandrogen—a substance which interfere with androgen, a male sex hormone, by taking over the androgen receptors.

Apex – the tip or bottom of the prostate farthest from the bladder.

Benign—relatively harmless; not cancerous;not malignant.

Benign Prostatic hypertrophy or hyperplasia (BPH) – a non cancerous condition of the prostate that results in the growth of both glandular and stromal (supporting connective) tumorous tissue which enlarges the prostate and obstructing urination (see prostatitis).

Bilateral—both sides

Biopsy—sampling of tissue to check for abnormalities.

BPH— Benign Prostatic Hyperplasia

Brachytherapy—a form of radiation therapy in which radioactive seeds or pellets are implanted to which emit radiation to kill surrounding tissue.

CAB—Complete Androgen Blockade (see CHT)

Carcinoma—a malignant new growth

CGA—chromogranin A; a small cell prostate cancer or neuroendocrine cell marker.

CHT—Combined Hormonal Therapy—the use of more than one hormone in therapy.

Combination therapy—see CHT

Cryoablation—see cryosurger

Cryosurgery—the use of liquid nitrogen probes to freeze a particular organ to extremely low temperatures to kill the tissue, including any cancerous tissue

Cypterone—an antiandrogen

DES—Diethylstilbestrol

DHT—see dyhyrotestosterone

Diethylstilbestrol-(DES)—a female hormone commonly used in the 1960s and 1970s for treatment of prostate cancer.

Dysplasia—see PIN

Dysuria—urination which is problematic or painful

Eulexin—brand or trade name of flutamide.

External Radatiion Therapy (External Beam Therapy)—a form of radiation therapy in which radiation is delivered by a machine pointed at the area to be radiated.

Flutamide—an antiandrogen used in the palliative hormonal treatment of advanced prostate cancer and sometimes in the adjuvant and neo-adjuvant hormonal treatment of earlier stages of prostate cancer.

Gleason Score—a widely used method for classifying the cellular differentiation of cancerous tissues; the less the cancerous cells appear like normal cells, the more malignant the cancer; two numbers, each from 1-5 are assigned successively to the two most predominant patterns of differentiation present in the examined tissue sample and are added together to produce the Gleason score; high numbers indicate poor differentiation and therefore cancer.

GHRH—enadotropin-releasing hormone-see LHRH Analogs.

Grade—a means of describing the potential degree of severity of a cancer based on the appearance of cancer cells under a microscope; see also Gleason Score.

Histology—the study of the appearance and behavior of tissue, usually carried out under a microscope by a pathologist (who is a physician) or a histologist (who is not necessarily a physician).

Hormone Therapy—the use of hormones, hormone analogs, and certain surgical techniques to treat disease (in this case advanced prostate cancer) either on their own or in combination with other hormones or in combination with other methods of treatment; because prostate cancer is usually dependent on male hormones to grow, hormonal therapy can be an effective means of alleviating symptoms and retarding the development of the disease.

Interstitial—within a particular organ; for example, interstitial prostate radiation therapy is radiation therapy applied within the prostate using implanted radioactive pellets or seeds; see also brachytherapy.

LHRH Analogs (or agonists)—Synthetic compounds that are chemically similar to Luteinizing Hormone Releasing Hormone (LHRH), but are sufficiently different that they suppress testicular production of testosterone by binding to the LHRH receptor in the pituitary gland and either have no biological activity and therefore competitively inhibit the action of LHRH, or has LHRH activity that exhausts the production of LH By the pituitary; used in the hormonal treatment of advanced prostate cancer and in the adjuvant and neoadjuvant hormonal treatment of earlier stages of prostate cancer, LHRH agonist (mimics natural LHRH but then shuts down LH production after continuous exposure).

Lymph Nodes—the small glands which occur throughout the body and which filter the clear fluid known as lymph or lymphatic fluid; lymph node filter out bacteria and other toxins, as well as cancer cells.

Malignancy—a growth or tumor composed of cancerous cells.

Malignant—cancerous; tending to become progressively worse and to result in death; having the invasive and metastatic (spreading) properties of cancer.

Metastasis—(plural metastases) a secondary tumor formed as a result of a cancer cell or cells from the primary tumor site (e.g., the prostate) traveling through the body to a new site and then growing there.

Metastatic—having the characteristics of a secondary tumor.

Neoplasia—the growth of cells under conditions that would tend to prevent the development of normal tissue (e.g., a cancer)

Palliative—designed to relieve a particular problem without necessarily solving it; for example, palliative therapy is given in order to relieve and improve quality of life, but does not cure the patient.

Palpable—capable of being felt during a physical examination by an experienced physician; in the case of prostate cancer, this normally refers to some form of abnormality of the prostate which can be felt during a digital rectal exam.

Pap—Prostatic Acid Phosphate; an enzyme now measured only rarely to decide whether prostate cancer has escaped from the prostate.

PIN—Prostatic Intraepithelial (or intraductal) Neoplasia; a pathologically identifiable condition believed to be a possible precursor of prostate cancer; also known more simply as dysplasia by many physicians.

Prolactin—(PRL) a trophic hormone produced by the pituitary that increases androgen receptors, increases sensitivity to androgens, & regulates production & secretion of citrate.

Prostatectomy—surgical removal of part or all of the prostate gland.

Prostate-Specific Antigen—see PSA

Prostatic Acid Phosphatase—see PAP

PSA—Prostate-Specific Antigen; a protein secreted by the epithelial cells of the prostate gland including cancer cells; an elevated level in the blood indicates an abnormal condition of the prostate gland, either benign or malignant; it is used to detect potential problems in the prostate gland and to follow the progress of Pca therapy (see SCREENING).

PSA Velocity—(PSAV); the rate at which PSA values increase assuming that the rate does not change.

Radical Prostatectomy—an operation to remove the entire prostate gland and seminal vesicles.

Refractory—resistant to therapy; e.g., hormone refractory prostate cancer is resistant to forms of treatment based on the use of hormones; (see mutation).

Resection—surgical removal.

Retropubic Prostatectomy—surgical removal of the prostate through an incision in the abdomen.

RP—Radical Prostatectomy.

RTPCR—see RT-PCR

RT-PCR—reverse transcriptase polymerase chain reaction; a technique which allows a physician to search for tiny quantities of protein, such as PSA in the blood or other body fluids and tissues; because today's reproducibility is poor, the test results are reported in vague terms like 'positive' or 'negative' rather than as numbers; see PSA RT-PCR.

Screening—to separate patients with tumors from those without tumors; multiple criteria are often used; the following PSA screening 'cutoff' levels for PCa are replacing the older 4.0 value. Age PSA 'cutoff:' 40-49 2.5ng/ml; 50-59 3.5ng/ml; 60-69 4.5ng/ml; 70-79 6.5ng/ml

State—a term used to define the size and physical extent of a cancer.

Staging—the process of assigning a stage to a particular cancer in a specific patient in light of all the available information; it is used to help determine appropriate therapy; there are two staging methods: the Whitmore-Jewett staging classification (1956) and the more detailed TNM (tumor, nodes, metastases) classification (1992) of the American Joint Committee on Cancer and the International Union Against Cancer.

TNM—(tumor, nodes, metastases) see Staging.

TRUS—Transrectal ultrasound; a method that uses echoes of ultrasound waves (far beyond the hearing range) to image the prostate by inserting an ultrasound probe into the rectum; commonly used to visualize prostate biopsy procedures.

TURP—transurethral resection of the prostate.

Watchful Waiting—active observation and regular monitoring of a patient without actual treatment.

Zoladex—trade or brand name for goserelin acetate, a LHRH agonist

SDCR ABSTRACT -DATA SOURCE

--- PHYSICIAN/FACILITY SPECIFIC ---

Reporting Hospital	Code provided by	Facility Specific
Abstracted By	Defaults to your	Facility Specific
Sequence Number—	SDCR fills in	Facility Specific
Class Of Case	SDCR fills in	Facility Specific
Date Case Completed	Defaults when	Facility Specific
Type Of Reporting Source		

PATIENT

Name—Last	Medical Accounting Records
Name—First	Medical Accounting Records
Name—Middle	Medical Accounting Records
Name—Maiden	Medical Accounting Records
Name—Alias	Medical Accounting Records
Name—Spouse/Parent	Medical Accounting Records
Social Security Number	Medical Accounting Records

PATIENT

Addr at DX—No & Street	Medical Accounting Records
Addr at DX—Supplementl	Medical Accounting Records
Addr at DX—City	Medical Accounting Records
Addr at DX—State	Medical Accounting Records
Addr at DX—Postal Code	Medical Accounting Records
County at DX	Medical Accounting Records
Addr Current—City	Medical Accounting Records
Addr Current—No & Street	Medical Accounting Records
Addr Current—Postal Code	Medical Accounting Records
County at DX	Medical Accounting Records

Addr Current—City	Medical Accounting Records
Addr Current—No & Street	Medical Accounting Records
Addr Current—Postal Code	Medical Accounting Records
Addr Current—State	Medical Accounting Records
Tobacco History	History and Physical
Alcohol History	History and Physical
Race 1	Medical Accounting Records
Race 2	Medical Accounting Records
Race 3	Medical Accounting Records
Race 4	Medical Accounting Records
Race 5	Medical Accounting Records
Spanish/Hispanic Origin	Medical Accounting Records
Birth Date	Medical Accounting Records
Birthplace	Medical Accounting Records
Sex	Medical Accounting Records
Marital Status at DX	Medical Accounting Records
Primary Payer at DX	Medical Accounting Records
Text—Usual Occupation	History and Physical
Text—Usual Industry	History and Physical
Family History of Cancer	History and Physical
Comorbid/Complication 1	History and Physical
Comorbid/Complication 2	History and Physical
Comorbid/Complication 3	History and Physical
Comorbid/Complication 4	History and Physical
Comorbid/Complication 5	History and Physical
Comorbid/Complication 6	History and Physical

CANCER IDENTIFICATION

Date of Diagnosis	Diagnostic/Op/Path Reports
Age at Diagnosis	Diagnostic/Op/Path Reports
Primary Site	Diagnostic/Op/Path Reports
Laterality	Pathology Report
Histologic Type ICD-O-3	Pathology Report
Behavior Code ICD-O-3	Pathology Report
Grade	Pathology Report
Diagnostic Confirmation	Pathology Report

STAGE/PROGNOSTIC FACTORS

CS Tumor Size	Pathology Report
CS Extension	Pathology Report
CS Tumor Size/Ext Eval	Pathology Report
CS Lymph Nodes	Pathology Report
CS Reg Nodes Eval	Pathology Report
CS Mets at DX	Pathology Report, H&P
CS Mets Eval	Pathology Report
Regional Nodes Examined	Pathology Report
Regional Nodes Positive	Pathology Report
CS Site-Specific Factor 1	Pathology/Lab report
CS Site-Specific Factor 2	Pathology/Lab report
CS Site-Specific Factor 3	Pathology Report
CS Site-Specific Factor 4	Pathology Report
CS Site-Specific Factor 5	Pathology Report
CS Site-Specific Factor 6	Pathology Report
Derived AJCC Stage Group	Derived algorithm
Derived AJCC T Descriptor	Derived algorithm

Derived AJCC T	Pathology Report
Derived AJCC N Descriptor	Pathology Report
Derived AJCC N	Pathology Report
Derived AJCC M Descriptor	Pathology Report
Derived AJCC M	Pathology Report
Derived AJCC—Flag	Pathology Report
Derived SS2000	Pathology Report
Derived SS2000—Flag	Pathology Report
CS Version 1st	Collaborative Stage Guide
CS Version Latest	Collaborative Stage Guide

TREATMENT

Date of 1st Contact	Medical/Accounting Records
RX Date—Surgery	Medical Notes
RX Summ—Hormone	Medical Notes
RX Date—Hormone	Medical Notes
RX Summ—Surg Prim Site	Medical Notes
RX Summ—Scope Reg LN	Medical Notes
RX Summ—Reg LN	Medical Notes
RX Summ—Surg Oth	Medical Notes
RX Date—Radiation	Medical Notes
RX Summ—Radiation	Medical Notes
Rad—Regional RX Modality	Medical Notes
RX Summ—Surg/Rad Seg	Medical Notes
RX Date—Chemo	Medical Notes
RX Summ—Chemo	Medical Notes
RX Summ-BRM	Medical Notes
RX Summ—	Medical Notes

RX Summ—Other
Date Of Last Contact

Medical Notes
Medical/Accounting

FOLLOW-UP/DEATH

Vital Status
Cancer Status
Place Of Death
Cause Of Death
ICD Revision Number
Physician—Managing
Physician—Follow-Up

Medical/Accounting
Medical/Accounting
Medical Records
Medical Records
Medical Records
Medical/Accounting
Medical/Accounting

OVERRIDES

Over-ride Age/Site/Morph
Over-ride Histology
Over-ride Leuk. Lymphoma
Over-ride Site/Behavior
Over-ride Site/Type

Invisible to abstractor
Invisible to abstractor
Invisible to abstractor
Invisible to abstractor
Invisible to abstractor

TEXT

Text—DX Proc—Path
Text—Histology Title
Text—Primary Site Title
Text—Remarks

Pathology Reports
Pathology Reports
Pathology Reports
All sources

Prepared by Mynna Boodhoo Kightlinger
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