

Chapter 3

GENERAL INSTRUCTIONS

Now that you have determined the reportability of each case and the number of primaries to be reported, you are ready to complete the abstract for submission to the state. This chapter provides some final reminders about reporting rules and then includes general instructions on completing the required data items for each case. Chapter 5, the data dictionary, provides specific information on each field.

Basic Reporting Rules for State Reporting

The following information provides some basic rules regarding cancer reporting to the state central cancer registry. Hospitals are required to report both inpatient and outpatient cancer cases for all active primary cancers diagnosed on or after 1976. Recurrences (with some exceptions) and metastatic sites (for primary cases previously reported) are not reportable. For example, patients with a history of a known cancer, presenting with a recurrence or progression of disease (Class 3 cases as defined by the ACoS), **for which the primary cancer has already been reported by that facility**, are not required to be reported to WCRS. However, patients presenting with metastatic disease or recurrence for which the original primary diagnosis was NOT reported by the hospital are reportable (the original primary diagnosis is reportable, not the recurrence or metastases).

Clinics/physician offices are required to report all active primary cancers for which treatment is provided for diagnoses on or after 1992. If treatment is not provided, the cancer must still be reported if the patient is NOT referred to a Wisconsin hospital within two months from the time first seen at the facility. Refer to Appendix IV for a detailed table on reportability differences for hospitals and clinics/physician offices.

Important Items to Remember

For ALL reporting facilities:

- Benign brain and Central Nervous System (CNS) cases are reportable if diagnosed on or after January 1, 2004.
- Incomplete abstracts (i.e., abstracts with required fields not completed) will be returned to the facility. The facility must supply data for the missing required fields and re-submit the records to WCRS.
- The Collaborative Staging Manual must be used to stage cases diagnosed on or after January 1, 2004. The SEER Summary Staging Manual 2000 is to be used for cases diagnosed between January 1, 2001 and December 31, 2003. The SEER Summary Staging Guide 1977 is to be used for cases diagnosed prior to January 1, 2001. See Appendix V for a complete list of websites where these manuals are available.

- The following coding manuals are needed to complete case reporting for WCRS. The table contains information on how to download these manuals if not already on site at the reporting facility.

Collaborative Stage Manual

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

Scroll to 'Manual' – Choose the option to download the complete staging manual. Use this manual to complete the Collaborative Stage (CS) fields required and recommended for reporting.

Multiple Primary and Histology Coding Rules

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

Scroll to 'Complete Manual' – Download the complete manual with the latest updates. Use this coding manual to determine the number of reports needed to complete for each case.

Data Collection of Primary Central Nervous System Tumors

<http://www.cdc.gov/cancer/npcr/training/pdfs/braintumorguide.pdf>

Use this manual to determine reportability and correct coding for benign brain and CNS tumors (reportable to WCRS beginning January 1, 2004).

Site-specific surgery information

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

From this site, scroll down the page and select Appendix B - site specific surgery codes. This will help you identify the correct surgery options for individual sites and choose the correct code when abstracting electronically.

Specific to Hospitals:

- All cancer cases diagnosed and/or treated for cancer in your facility after December 31, 1975, must be abstracted and reported to WCRS.
- Completed cases should be submitted to WCRS within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere.
- Electronic reporting is currently recommended for all hospitals and will be required by December 31, 2008. WCRS will provide free data entry software and data submission software upon request.

Specific to Clinics:

- All cancer patients receiving cancer-directed treatment in your facility after December 31, 1991, must be abstracted and reported to WCRS.
- Completed cases should be submitted to WCRS within three months of date of diagnosis, or date of initial contact if diagnosed elsewhere.

- Electronic reporting is currently recommended for all clinics and will be required by December 31, 2009. WCRS will provide free data entry software and data submission software upon request.

General Coding Instructions for Place of Residence at Diagnosis

The Wisconsin Cancer Reporting System collects information on place of residence at diagnosis. Rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: *U.S. Census Bureau Instructions*: “The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home.”
2. **Post Office Box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographic information for analyzing cancer incidence. Use the post office box address **only if** no street address information is available after follow-back.
3. Use residency information from a death certificate **only when** residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau rules for determining residence. The death certificate may give the person’s previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.
4. Do NOT use **legal status** or **citizenship** to code residence.

Persons with More than One Residence

Example: Persons who live in the south for the winter months but in the north during the summer months (or vice versa) or people with vacation residences that they occupy for a portion of the year.

- a. Code the residence where the patient spends the majority of time (usual residence).
- b. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence

Homeless people and transients are examples of persons with no usual residence. Code the patient’s residence at diagnosis such as the shelter or hospital where diagnosis was confirmed.

Temporary Residents of the Wisconsin Area

Code the place of **usual** residence rather than the temporary address for:

Migrant workers
Educators temporarily assigned to a university in the Wisconsin area
Persons temporarily residing with family during cancer treatment
Military personnel on temporary duty assignments (TDY)
Boarding school students below college level (code the parent's residence)

Code the residence where the student is living while attending **college**.

Code the address of the institution for **Persons in Institutions**. *U.S. Census Bureau definition:* "Persons under formally authorized, supervised care or custody are residents of the institution."

Persons who are incarcerated
Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals or wards
Residents of nursing, convalescent, and rest homes
Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine)

Armed Forces

For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships

The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and homeport. Refer to U.S. Census Bureau Publications for detailed rules:

<http://www.census.gov>

General Coding Instructions for Reporting Race

1. Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the U.S. 2000 Census. In Wisconsin, only about 1% of the population is multiracial. Most of the time you will only code one race field for the patient (in the Race 1 field). When there is only one race to be coded, then the Race 2-5 fields will be coded to '88' (meaning no other races listed). For cases diagnosed/reported after January 1, 2000, **all race fields must be coded (using '88's in the 'extra' race fields)**.

2. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.
3. If the person's race is a combination of more than one non-white race, code Race 1 to the first stated non-white race (02-98), Race 2 to the second, etc.

Example: Patient is stated to be Vietnamese and Black. Code Race 1 as '10' Vietnamese, Race 2 as '02' Black, and Race 3 through Race 5 as '88'.

4. Asian race codes are specific to unique groups and every attempt should be made to report the patient's most detailed race. Do not code '96' Asian if a more specific race has been indicated.

Example: A patient is described as Asian in a consultation note, but as second-generation Hmong in the history and physical. Code Race 1 as '12' Hmong.

5. The fields Place of Birth, Race, Marital Status, Last Name, Maiden Name, and Hispanic Origin are inter-related. Use the following guidelines in priority order:
 - a. Code the patient's stated race, if possible. Refer to Appendix IV, "Race and Nationality Descriptions from the 2000 Census and National Center for Health Statistics," for guidance.

Example 1: Patient is stated to be Hmong. Code Race 1 as '12' Hmong and Race 2-5 as '88.'

Example 2: Patient is stated to be German-Irish. Code Race 1 as '01' White and Race 2-5 as '88.'

Example 3: Patient is described as Arab. Code Race 1 as '01' White and Race 2-5 as '88.'

🔴* **Exception:** When the race is recorded as Oriental, Mongolian, or Asian (coded to 96 Other Asian) and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on **birthplace** information.

Example 1: The person's race is recorded as Asian and the place of birth is recorded as Japan. Code Race 1 as '05' Japanese because it is more specific than '96' Asian, NOS (Not Otherwise Specified), and Race 2-5 as '88.'

Example 2: The person describes himself as an Asian-American born in Laos. Code Race 1 as '11' Laotian because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'

6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

Example: The patient is described as Asian-American with Korean parents. Code Race 1 as '08' Korean because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'

7. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

Example 1: Patient described as a black female. Code Race 1 as '02' Black and Race 2-5 as '88.'

Example 2: Patient describes herself as multi-racial (nothing more specific) and nursing notes say "African-American." Code Race 1 as '02' Black and Race 2-5 as '88.'

Example 3: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as '25' Polynesian, Race 2 as '26' Tahitian, and Race 3-5 as '88.'

8. If race is unknown or not stated in the medical record and birthplace is recorded, in some cases race may be inferred from the nationality. Refer to Appendix VI to identify nationalities from which race codes may be inferred.

Example 1: Record states: "this native of Portugal..." Code Race 1 as '01,' White per the Appendix.

Example 2: Record states: "this patient was Nigerian..." Code Race 1 as '02,' Black per the Appendix.

●* **Exception:** If the patient's name is incongruous with the race inferred on the basis of nationality, code Race 1 through Race 5 as '99,' Unknown.

Example 1: Patient's name is Siddhartha Rao and birthplace is listed as England. Code Race 1-5 as '99,' Unknown.

Example 2: Patient's name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as '99,' Unknown.

9. Use of patient name in determining race:
 - a. Do not code race from name alone, especially for females with no maiden name given.

- b. In general, a name may be an indicator of a racial group, but should not be taken as the only indicator of race.
- c. A patient name may be used to identify a more specific race code.

Example 1: Race reported as Asian, name is Hatsu Mashimoto. Code Race 1 as '05' Japanese.

Example 2: Birthplace is reported as Guatemala and name is 'Jose Chuicol' [name is identified as Mayan]. Code Race 1 as '03' Native American.

- d. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone (without a statement about race or place of birth) cannot be used to determine the race code. Refer to ethnicity guidelines for further information.

Example: Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1-5 as '99,' Unknown, because nothing is known about her race.

- 10. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do **NOT** code a patient stated to be Hispanic or Latino as '98,' Other Race, in Race 1 and '88' in Race 2-5.

Example: Sabrina Fitzsimmons is a native of Brazil. Code Race 1 as '01,' White per Appendix, and Race 2-5 as '88.'

- 11. When the race is recorded as Negro or African-American, code Race 1 as '02,' Black, and Race 2-5 as '88.'

- 12. Code '03' should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America. For Central, South, or Latin American Indians, refer to the additional ethnicity coding guidelines under Spanish Surname or Origin.

- 13. Death certificate information may be used to supplement ante-mortem race information only when race is coded 'unknown' in the patient record, or when the death certificate information is more specific.

Example 1: In the cancer record Race 1-5 are coded as '99,' Unknown. The death certificate states race as 'Black.' Change the cancer record for Race 1 to '02,' Black and Race 2-5 to '88.'

Example 2: Race 1 is coded in the cancer record as '96,' Asian. The death certificate gives birthplace as China. Change Race 1 in the cancer record to '04,' Chinese and code Race 2-5 as '88.'

General Coding Instructions for Reporting Ethnicity

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Portuguese, Brazilians and Filipinos are not Spanish; code non-Spanish (code '0').
3. All information should be used to determine the Spanish/Hispanic Origin including the stated ethnicity in the medical record, stated Hispanic origin on the death certificate, birthplace, information about life history and/or language spoken found in the abstracting process and a last name and maiden name found on a list of Hispanic/Spanish names. Assign code '7' when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. Code '7' is ordinarily for central registry use only. If the origin is not stated in the medical record and the hospital registry does not have a list of Hispanic surnames, assign code '9,' "Unknown whether Spanish/Hispanic or not." Code '7' was adapted for use effective with January 1, 1994 diagnoses.

General Coding Rules for Reporting Neoplasm Behavior

The behavior of a neoplasm describes the level of malignancy of the tumor.

Behavior codes 0 (benign) and 1 (borderline) are reportable for intracranial and CNS sites only, beginning with January 1, 2004 diagnoses.

Metastatic or Nonprimary Sites

WCRS does not collect cancers with a metastatic (/6) behavior code. If the only pathologic specimen is from a **metastatic** site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

In situ

Clinical evidence alone cannot identify the behavior as *in situ* (/2); the code must be based on pathologic examination and documentation.

In situ and Invasive

Code the behavior as invasive malignant (/3) if any portion of the primary tumor is invasive no matter how limited; i.e., microinvasion.

Example: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant /3.

ICD-O-3 /Behavior Code Listing

ICD-O-3 may have only one behavior code, *in situ* /2 or malignant /3, listed for a specific histology. If the pathology report describes the histology as *in situ* /2 and the ICD-O-3 histology code is only listed with a malignant /3 behavior code, assign the histology code listed and change the behavior code to *in situ* /2. If the pathology report describes histology as malignant /3 and the ICD-O-3 histology code is only listed with an *in situ* /2 behavior code, assign the histology code listed and change the behavior code to malignant /3. See the Morphology and Behavior Code Matrix discussion on page 29 in ICD-O-3.

Example: The pathology report says large cell carcinoma *in situ*. The ICD-O-3 lists large cell carcinoma as 8013/3; there is only a malignant listing. Change the /3 to /2 and code the histology and behavior code to 8013/2 as specified by the physician.

Synonyms for <i>In situ</i>
AIN III (C211)
Behavior code '2'
Bowen disease (not reportable for C440-C449)
Clark level I for melanoma (limited to epithelium)
Confined to epithelium
Hutchinson melanotic freckle, NOS (C44_)
Intracystic, non-infiltrating
Intraductal
Intraepidermal, NOS
Intraepithelial, NOS
Involvement up to, but not including, the basement membrane
Lentigo maligna (C44_)
Lobular, noninfiltrating (C50_)
Noninfiltrating
Noninvasive
No stromal invasion/involvement
Papillary, noninfiltrating or intraductal
Precancerous melanosis (C44_)
Queyrat erythroplasia (C60_)
Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
VAIN III (C529)
VIN III (C51_)

General Coding Rules for Reporting Grade

1. The site-specific coding guidelines in Appendix VII include rules for coding grade for the following primary sites: prostate, kidney (renal), lymphoma, leukemia, astrocytoma, and sarcoma.
2. Code the grade from the final diagnosis in the pathology report. If there is more than one pathology report, and the grades in the final diagnoses differ, code the highest grade for the primary site from any pathology report.
3. If grade is not stated in the final pathology diagnosis, use the information in the microscopic section, addendum, or comment to code grade.
4. If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.

Example: Pathology report reads: Grade II adenocarcinoma with a focus of undifferentiated adenocarcinoma. Code the tumor grade as grade 4.

5. Code the grade from the **primary tumor** only, never from a metastatic site or a recurrence.
6. Code the grade for all **unknown primaries** to 9 (unknown grade) unless grade is explicit by histology (e.g., anaplastic carcinoma – grade 4).
7. Code the grade of the invasive component when the tumor has **both *in situ* and *invasive*** portions. If the ***invasive*** component **grade is unknown**, code the grade as unknown - 9.
8. Code the information from the **consult** if the specimen is sent to a specialty pathology department for a consult.
9. If there are **multiple pathology consults**, ask the pathologist or physician advisor to determine which information should be used.
10. Do **not code** the grade assigned to **dysplasia**, e.g., High grade dysplasia (adenocarcinoma *in situ*) would be coded to 9 (unknown grade).

Coding Grade for Cases without Pathology or Cytology Confirmation

Code the grade of tumor given on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report). Use the MRI or PET grade only when there is no tissue diagnosis.

***In situ* Tumors**

In situ tumors are not always graded. Code the grade if it is specified for an *in situ* lesion unless there is an invasive component. Do not code the *in situ* grade if the tumor has both *in situ* and invasive components.

Terminology Conversion Table

Description	Grade	WCRS Code
Differentiated, NOS	I	1
Well differentiated	I	1
Fairly well differentiated	II	2
Intermediate differentiation	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Moderately well differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
Dedifferentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

Two-Grade System

Some cancers are graded using a two-grade system; for example, colon cancer. If the grade is listed as 1/2 or as low grade, assign code '2.' If the grade is listed as 2/2 or as high grade, assign code '4.'

Two-Grade Conversion Table

Grade	Differentiation/ Description	WCRS Code
1/2, I/II	Low grade	2
2/2, II/II	High grade	4

Three-Grade System

There are several sites for which a three-grade system is used, such as peritoneum, endometrium, fallopian tube, prostate, bladder and soft tissue sarcoma. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see Three-Grade Conversion Table below). The expected outcome is more favorable for lower grades. If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to WCRS codes:

Three-Grade Conversion Table

Grade	Differentiation / Description	WCRS Code
1/3, I/III	Low grade	2
2/3, II/III	Intermediate grade	3
3/3, III/III	High grade	4

Changing Information Already Reported to WCRS

It is possible that after a cancer case has been abstracted and submitted to WCRS, additional information was added to the patient's chart, which may lead to changes in specific data items submitted on the initial abstract. It is permissible to change any data item, including the primary site and histology. Justification/explanation should accompany the change.

Example: The patient is originally diagnosed with an unknown primary cancer and after further investigation it is determined that the cancer is a primary of the lung. It is correct to send a notice of change to WCRS and change the primary site code and, if necessary, the stages.

Hint: Changing the primary site will require review of and possible changes to site-specific fields; e.g., surgery codes, staging, laterality, etc.

Note: *Changes should be sent to WCRS using the change-of-information notification located in the back of this manual. This will be made available soon on the WCRS Web site.*

Paper Abstracts

WCRS will accept paper abstracts until December 31, 2008 for hospitals and until December 31, 2009 for clinics. A copy of the official reporting form is included at the back of this manual. The form (a Word document) and mailing labels can be obtained directly from WCRS. Paper abstracts should be submitted in a well-sealed envelope, marked “CONFIDENTIAL” and mailed to:

Wisconsin Cancer Reporting System
P.O. Box 2659
Madison WI 53701-2659

Note: WCRS will no longer accept paper abstracts from Wisconsin hospitals after December 31, 2008 and clinic/physician offices after December 31, 2009. Please contact WCRS to inquire about approved electronic data entry and submission software.

Electronic Data Transmissions

Electronic data must be sent using the NAACCR Version 11 layout (see Appendix VIII for complete list of required and recommended data items and NAACCR layout position). Data must be sent using CRS Main Line or *WebPlus* software. Data sent via CRS Main Line should be electronically submitted to WCRSdata@dhfs.state.wi.us. Contact WCRS to obtain information about these data submission methods.

WCRS suggests the following submission schedule:

Annual caseload >500	Monthly
Annual caseload <500	Monthly or quarterly

If your facility has different data submission requirements or if CRS Main Line or *WebPlus* does not work at your facility, contact WCRS staff to discuss alternative methods.

