Texas Cancer Reporting News

October 2019
Vol. XXI, No. 2

Publication No. E10-10542

Registry Accomplishments

Calls for Data Results

The Texas Cancer Registry (TCR) recently received results from the Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR) annual Calls for Data. These events took place in Fall 2018 and included 2016 incidence data. NPCR and NAACCR evaluated the data on quality, completeness, and timeliness as demonstrated by meeting five key data quality criteria.

The TCR achieved NPCR "High Quality Data Standards" for diagnosis year 2016. It was also recognized as a CDC-NPCR Registry of Distinction. For the 13th time in its history, the TCR received NAACCR Gold Certification. Reaching this level of data quality and completeness is not possible without the efforts and dedication of Texas Cancer Reporters. The TCR thanks you for your contributions to cancer prevention and control, to the lives of cancer patients and their families, and to the health of Texans!

In This Issue

Cancer Article Highlights Potential of Population-Based Cancer Registries

The journal *Cancer* recently published "Unlocking the potential of population-based cancer registries". It addresses important advances in central cancer registries over the last several decades. It also describes using the population-based cancer registry in the following ways:

- Providing researchers random samples of cases that represent the underlying population
- Providing rapid case ascertainment
- Serving as a virtual tissue repository
- Guiding the implementation of evidence-based cancer control interventions
- Measuring changes in the cancer burden after the implementation of these interventions

You can download a free copy at onlinelibrary.wiley.com/doi/full/10.1002/cncr.32355.

Completeness by Region

Diagnosis Year 2017
As of September 17, 2019

93.7%
Texas Overall

91.4%
Region 1

93.3%
Region 2

95.9%
Region 3

92.7%
Region 4

87.3%
Region 5

93.4%
Region 6

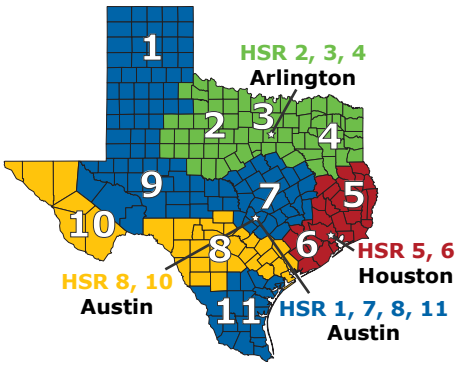
95.0%
Region 7

94.7%
Region 8

89.0%
Region 9

88.1%
Region 10

86.8%
Region 11



For More Information:

See the TCR Completeness Dashboard: bit.ly/2lU9Wjp

Epidemiology Corner

by Rebecca Sardell, PhD

Health Disparities in Uterine Cancer

In Texas, uterine cancer, also known as endometrial cancer, is the 4th leading cancer diagnosis in women. It is the 7th leading cancer cause of death for Texas women. The TCR estimates that 3,706 Texans will be diagnosed with uterine cancer and 707 will die of the disease in 2019.

> *Uterine cancer is the 4th leading cancer diagnosis and the 7th leading cancer cause of death in Texas women.*

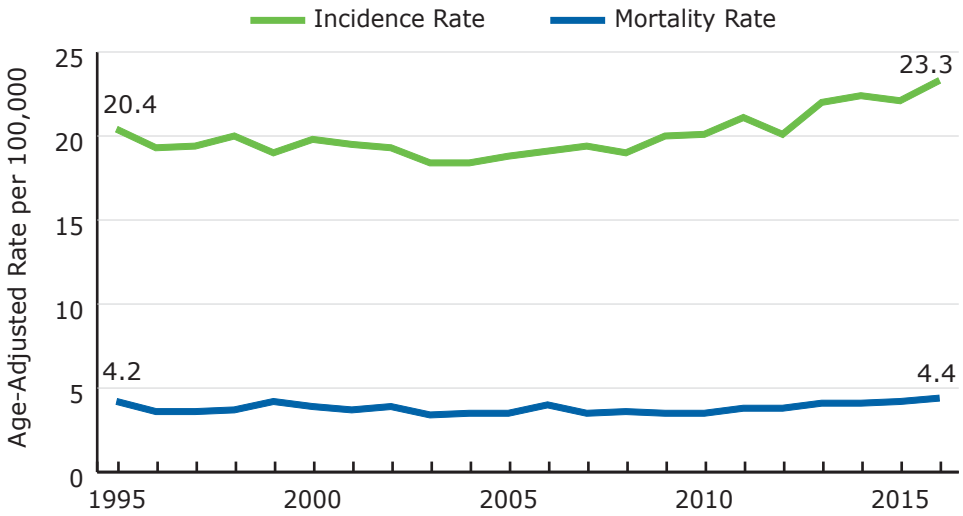
Trends

The uterine cancer incidence rate has increased by 2% per year in Texas since 2005. The mortality rate remained relatively stable overall, but it has increased 3 percent per year since 2009.

Hispanic women have had the largest increase in incidence—2.6 percent per year since 2005. The mortality rate has also increased significantly in Hispanics.

Similarly, uterine cancer incidence rates have increased nationwide. This is thought to partly reflect rising overweight and obesity rates.[1] Around 60 percent of uterine cancer cases are attributed to being overweight or obese.[2] However, additional unknown factors might also be involved.

Age-Adjusted Uterine Cancer Incidence and Mortality Rates, Texas, 1995–2016



Health Disparities

There is a substantial disparity in uterine cancer rates by race/ethnicity in Texas.

Incidence rates are currently highest in Hispanic and non-Hispanic (NH) blacks and lowest in NH Asian/Pacific Islanders (A/PI). NH blacks have an incidence rate that is moderately higher than NH whites, but their mortality rate is more than twice as high. The second highest mortality rate is in Hispanics.

Age-Adjusted Uterine Cancer Incidence Rates and Mortality Rates by Race/ Ethnicity, Texas, 2012–2016

Race/Ethnicity	Incidence Rate per 100,000	Mortality Rate per 100,000
NH White	21.4	3.5
NH Black	22.9	7.8
NH A/PI	13.2	2.7
Hispanic	23.0	4.1

Factors Influencing Disparities

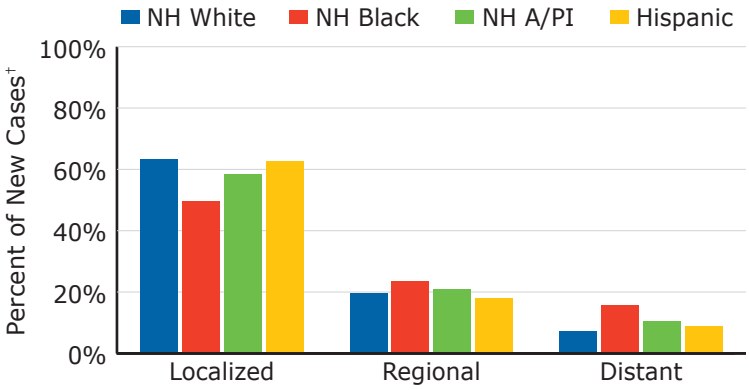
One possible reason for the large difference in mortality rates is the difference in stage at diagnosis. A smaller proportion of uterine cancer cases are diagnosed at the localized stage in NH blacks compared to other racial/ethnic groups.

As with most cancers, uterine cancer survival is highest for women diagnosed at the localized stage. However, even for patients diagnosed at the same stage, 5-year survival is lower for NH blacks compared to NH whites.

- Localized stage survival is 94% for NH whites and 88% for NH blacks.
- Regional stage survival is 75% for NH whites and 46% for NH blacks.
- Distant stage survival is 25% for NH whites and 10% for NH blacks.

The difference in mortality could also partly be due to different types of uterine cancer.[1] In Texas, over 60 percent of uterine cancers among NH whites, NH A/PIs, and Hispanics are endometriod carcinomas, compared to 43 percent in NH black women. Other carcinomas, carcinosarcomas, and sarcomas make up a higher percentage of uterine cancers among NH black women than in other race/ethnic groups. These other types of

Percent of New Uterine Cancer Cases by Stage at Diagnosis and Race/Ethnicity, Texas, 2012–2016



uterine cancer include histologies that are more aggressive and have fewer specific symptoms. This leads to a later stage at diagnosis, when treatment is less effective.

But even for patients diagnosed with the same histological type at the same stage, survival is consistently lower by 2 percent to 32 percent for NH black women compared to NH white women depending on the stage and type of tumor. This trend is seen nationwide.[3]

Possible factors leading to the disparity in survival and mortality rates for NH black women could be socioeconomic status, access to healthcare, and treatment decisions.[3]

References

[1] Henley SJ, Miller JW, Dowling NF, et al. Uterine Cancer Incidence and Mortality — United States, 1999–2016. MMWR 2018, 67(48):1333-1338.

[2] Islami F, Godling Sauer A, Miller KD, et al. Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. CA Cancer J Clin 2018, 68(1):31-54.

[3] Cote ML, Ruterbusch JJ, Olson SH, et al. The Growing Burden of Endometrial Cancer: A Major Racial Disparity Affecting Black Women. Cancer Epidemiol Biomarkers Prev 2015, 24:1407–15.

For More Information:

Rebecca Sardell, PhD
Epidemiologist
rebecca.sardell@dshs.texas.gov

TCR Data Products

The TCR recently published several new reports and data tables on our website. If you would like to be notified when new TCR products are available, sign up for email updates.

Datasets and Data Tables

- Cause-Specific Survival for Malignant Cancers Diagnosed 2007-2016
- Relative Survival for Malignant Cancers Diagnosed 2006-2015
- Potential Years of Life Lost Due to Cancer in Texas, 2012-2016

Reports on Screening Amenable Cancers

- Breast Cancer
- Cervical Cancer
- Colorectal Cancer

Report to the Texas Legislature

- 2019 Texas Cancer Registry Annual Report

Training Corner

by the TCR Training Team

Coding Updates

TCR Reporting Requirements

Beginning with cases diagnosed January 1, 2018, the TCR requires TNM data items for analytical cases from facilities accredited by the American College of Surgeons (ACoS). TNM data is not required from facilities that are not ACoS accredited.

This list contains the new data items required for cases diagnosed beginning January 1, 2018. Each item is followed by its NAACCR number. Some of this information was previously captured in the Collaborative Stage Site Specific Factors (SSF) prior to 2018. It will now be captured in the Site-Specific Data Items (SSDI).

- Phase I Radiation Treatment Modality (#1506) will replace Radiation Modality (#1570) and RX Summ—Radiation (#1360)
- Molecular Markers-Brain (#3816)
- Breslow Tumor Thickness-Melanoma (#3817)
- ER Summary–Breast (#3827)
- PR Summary–Breast (#3915)
- HER2 Overall Summary-Breast (#3855)
- Fibrosis Score-Liver and Intrahepatic Bile Ducts (#3835)
- Grade Clinical (#3843)
- Grade Pathological (#3844)
- Microsatellite Instability (MSI)-Colon and Rectum (#3890)
- PSA Lab Value-Prostate (#3920)
- LDH Pretreatment Value-Plasma Cell Myeloma, Melanoma of the Skin (#3932)Schema Discriminator 1 (#3926)
  - BileDuctsDistal/BileDuctsPerihilar/CysticDuct
  - EsophagusGEJunction (EGJ)/Stomach
  - Histology Discriminator for 9591/3
  - Lacrimal Gland/Sac
  - Melanoma Ciliary Body/Melanoma Iris
  - Nasopharynx/Pharyngeal Tonsil C111 only
  - Occult Head and Neck Lymph Nodes
  - Plasma Cell Myeloma Terminology
  - Primary Peritoneum Tumor
  - Thyroid Gland/Thyroglossal Duct
  - Urethra/Prostatic Urethra
- Schema Discriminator 2 (#3927)
  - Oropharyngeal p16
    - Chapter 10: HPV Mediated Oropharynx p16+
    - Chapter 11: Oropharynx (p16-) and Hypopharynx
  - Histology Discriminator for 8020/3
    - Undifferentiated carcinoma with squamous component
    - Undifferentiated carcinoma with glandular component
  - Undifferentiated carcinoma, NOS

All 2018 cases and prior years regardless of software must be abstracted in V18 format. The NAACCR Version 18C metafile is available for download on the TCR Website.

For More Information:

TCR Training Team

TCR.training@dshs.texas.gov
dshs.texas.gov/tcr/training.aspx

Reporting Calendar

We thank all Texas Cancer Reporters for your patience while national standard setters finalized the 2018 and 2019 cancer reporting requirements and necessary resources.

Because of the delays, the 2018 reporting calendar was revised. As of October, facilities should be reporting 2018 cases that were admitted through May 2018.

2018 Reporting Calendar

Cases Admitted in:	Report by:
January 2018	June 2019
February 2018	July 2019
March 2018	August 2019
April 2018	September 2019
May 2018	October 2019
June 2018	November 2019
July 2018	December 2020
August 2018	January 2020
September 2018	February 2020
October 2018	February 2020
November 2018	March 2020
December 2018	March 2020

Additionally, facilities should also be reporting cases admitted through April 2019. The 2019 reporting calendar follows TCR's standard policy of reporting cases within six months.

2019 Reporting Calendar

Cases Admitted in:	Report by:
January 2019	July 2019
February 2019	August 2019
March 2019	September 2019
April 2019	October 2019
May 2019	November 2019
June 2019	December 2019
July 2019	January 2020
August 2019	February 2020
September 2019	March 2020
October 2019	April 2020
November 2019	May 2020
December 2019	June 2020

ICD-O-3

The ICD-O-3 Implementation Task Force approved new codes, changes in behavior codes, and new terms associated with current codes for all cases diagnosed in 2018 or later. These changes reflect updates to the WHO Classifications for Tumors (Blue Books). The NAACCR website provides 2018 ICD-O-3 coding tables in PDF and Excel formats.

SSDI and Grade Manuals

Changes were made to the SSDI Manual and Grade Manual for the SEER*RSA version 1.7 This table lists manual and data item changes that relate to the reporting elements required by the TCR. More information for each item can be found in the NAACCR SSDI/Grade Change Log.

Manual Sections

- Timing for Collection of SSDI's
- Rounding Rules
- Recording Lab Values when "Less Than" or "Greater Than" are Used
- Source Documents

Data Items

- 3890: Microsatellite Instability
- 3835: Fibrosis Score
- 3932: LDH Pretreatment Lab Value
- 3927: Estrogen Receptor Summary
- 3915: Progesterone Receptor Summary
- 3855: HER2 Overall Summary

2018 Solid Tumor Rules

In July, SEER posted an update to the Solid Tumor Rules based on questions and suggestions from registrars and educators. The update includes major changes related to the Lung H and the Lung M rules. Additional revisions are minor, such as changes in terminology, additional definitions, and new notes and examples.

For more information, visit July 2019 Revision History for the Solid Tumor Rules on the SEER website.

Coding Errors

The TCR was proud to sponsor the 2019 Statewide Training this summer. Presenters Denise Harrison, Louanne Currence, and Deborah Roberson covered some great information regarding Solid Tumor Rules, extent of disease,

and site-specific coding. Because the Feedback on Abstracts session was so well received, we're sharing solutions to a few more coding errors that we see at the TCR.

Grade

According to the General Grade Coding Instructions for Solid Tumors (page 24), "if there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown."

Date of First Course of Treatment

The TCR is finding errors in cases where the regional lymph nodes were examined before the primary site surgical resection was done. The first course of treatment can be Scope of Regional Lymph Node Surgery and, if applicable, can be recorded as the Date of First Course of Treatment and/or Date of First Surgical Procedure.

According to the STORE Manual (page 248), "record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item."

Melanoma

According to the AJCC Staging Manual, 8th Edition (page 573), microsatellite, satellite and in-transit metastases are coded in the N category of AJCC TNM. A patient with microsatellite, satellite or in-transit metastases is considered a N1c (no regional lymph node involvement), N2c (one regional lymph node involved), or N3c (two or more regional lymph nodes involved). It is not coded to the M category.

2018-2019 Cancer Reporting Handbook

The 2018-2019 Cancer Reporting Handbook is now available! It contains updates about multiple primaries, solid tumor coding, site-specific data items, staging, TCR reporting requirements, and other vital information.

The 2018-2018 Cancer Reporting Handbook is now available to download from the TCR website. To request a hard copy, email TCR.Training@dshs.texas.gov.

Coding Tips

Surgery of Primary Site

SEER Coding Manual's Appendix C: Site Specific Coding Modules is a good resource for coding surgery of the primary site. The surgery codes are based on the STORE Manual and contain additional information and instructions. Here are some common coding errors received by the TCR.

Cystoprostatectomy

Cystoprostatectomy is surgery to remove the urinary bladder and the prostate (a combination cystectomy and prostatectomy). When coding this procedure, make sure you use the correct site-specific code. A cystoprostatectomy is coded different depending on whether the primary cancer site is bladder (71) or prostate (70).

Bladder

- 70 Pelvic exenteration, NOS
- 71 Radical cystectomy including anterior exenteration
  - For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.
  - For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

Prostate

- 70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
- Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

Melanoma

When the toe is amputated for melanoma of the skin, the correct surgery code is 47 (not 60). Code 47 is for the wide excision or re-excision of a lesion or minor (local) amputation with margins greater than 2cm.

Code 60 is for a major amputation. A major amputation is defined as the amputation of the lower limb above the ankle or of the upper limb above the wrist. A minor amputation is defined as the amputation of a hand or foot or of a part thereof.

- 45 Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
  - 46 WITH margins more than 1 cm and less than or equal to 2 cm
  - 47 WITH margins greater than 2 cm

  If the excision or re-excision has microscopically negative margins less than 1 cm OR the margins are more than 1 cm but are not microscopically confirmed, use the appropriate code, 20-36.

  [SEER Note: Assign code 47 for amputation of finger.

  Example: Amputation of finger for subungual melanoma]
- 60 Major amputation

Scope of Regional Lymph Node Surgery

For Breast, contralateral lymph nodes are considered distant and should not be included in Surgery Procedure of Other Site not in Scope of Regional Lymph Node Surgery.

Surgical Procedure of Other Site

The STORE Manual (page 261) says, "If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific Surgical Procedure of the Primary Site [1290 or 670] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code."

This means other organs defined in the Surgery of Primary Site should not be coded in Surgery to Other Sites. For example, if a patient has a partial colectomy with resection of a contiguous organ (the bladder), you code the Surgical Procedure of the Primary Site as a Code 32 (see STORE Manual, page 449). Do not code the bladder as a Surgical Procedure of Other Site.

Date of First Course of Treatment/First Course of Treatment

The STORE Manual (page 248) says, "Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in Scope of Regional Lymph Node Surgery. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] if applicable". This means you code the date of the regional lymph nodes were examined as the Date of First Course of Treatment and/or Date of First Surgical Procedure if regional lymph nodes were examined before the primary site surgical resection.

Text

All codes must be supported in the appropriate text field. Please refer to the 2018-2019 TCR Cancer Reporting Handbook (page 244) for more information on recording text.

Frequently Asked Questions

A number of hematopoietic diseases were not reportable until 2010, including transformations and newly reportable diseases. If these diseases were diagnosed prior to 2010, should I include them in the sequencing?

If the original hematopoietic disease was not reportable at time of its diagnosis, do not include it in the sequencing.

Can you clarify the use of "x" and blank when coding AJCC 8th Edition TNM?

The AJCC defines "X" for T and N categories that cannot be assessed. If the physician could not assess T or N for the patient and definitive information for T or N are not in chart, use TX or NX.

Blank should be used when:

- Information is not available in chart
- A valid AJCC category cannot be assigned
- The patient is not eligible for clinical or pathologic stage (categories are blank or stage group is blank or 99).

You must use blanks when it is indicated that patient did not meet classification criteria.

If patient meets classification criteria but no information about diagnostic workup of resection pathology is in chart, do not use X because it implies that physician did not assess or have information on the patient's T or N. Instead, you will use blank which indicates the registrar could not find the information in the chart.

With blanks you are telling everyone the registry did not have the information. This has been discussed for quite a few years now with everyone agreeing this was the best approach. It's important to know the difference between the physician not staging the case and the registrar not having access to the stage information.

What site code should be used for angiosarcoma of breast?

Code the primary site to breast (C50_). Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

Did You Know?

Alphabet Soup Method for Genetics Data for Diagnostic Confirmation

When determining whether to use Code 3 for diagnostic confirmation of hematopoietic or lymphoid tumors (9590-9992), think about alphabet soup. If you see letters, numbers, and plus signs in the diagnosis, it is a Code 3. Those letters, numbers, and plus signs are in the diagnosis documentation because immunophenotyping or genetic testing was done.

You should consult the Hematopoietic Database under the histology for the Definitive Diagnostic Methods. Assign Code 3 for cases with positive histology for the neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) and immunophenotyping, genetic testing, or JAK2 is listed in the Definitive Diagnosis in the Heme DB and the testing does one of the following:

- Confirms the neoplasm.
- Identifies a more specific histology (not preceded by ambiguous terminology).

Occult Breast Cancer

Occult breast cancer is defined as isolated metastatic lymphadenopathy with no palpable mass in the breast, no signs of primary breast cancer on mammography, and no detected primary tumor. In the case of an occult breast tumor, you can collect the Grade Data Item from the lymph node. According to the SSDI/ Grade 2018 forum, the "AJCC has confirmed that when there is an occult breast tumor (T0) that information from the nodes can be used to assign grade. We are currently reviewing the terminology to add to the manual (will be an addition for 2020). This would be an exception for breast only."

Grade

Beginning with cases diagnosed in 2018, the definition of grade has been expanded, and classification of grade now varies by tumor site and histology. The grading system for a cancer type may have two, three, or four grades. Now all grades will converted to a four-grade

Upcoming Trainings for Texas Cancer Reporters

The TCR Training Team offers a variety of training services and educational resources to Texas Cancer Reporters throughout the year. For more information, visit the TCR Education and Training webpage.

2019 Texas Cancer Registry Trainings Available Online

You can view audio versions of the TCR's 2019 training courses through FLccSC, a training resource developed by the Florida Cancer Data System and the South Carolina Central Cancer Registry.

You can find these trainings, as well as other continuing education courses and quizzes, on the FLssCS website.

NCRA Fall Webinar Series

The TCR is proud to host two NCRA webinar series this fall. All Texas cancer reporters are encouraged to attend the trainings. Webinars may be viewed at any of the TCR NCRA Webinar Host Sites throughout the state.

The first series focuses on coding and abstract essentials. Each webinar starts at 1:00 p.m. CT and lasts for one hour.

Coding and Abstract Essentials	
October 23	SSDI for Case Abstracting: 2018 and Forward
November 6	Navigating the STORE Manual
November 12	Radiation Oncology for the Cancer Registrar: All You Need to Know

The second series focuses on staging for select cancer sites. Each webinar starts at 1:00 p.m. CT and lasts for one hour.

Staging Cancer: Selected Sites	
November 13	Staging Kidney Cancer
November 20	Staging Tricky Tumors: Top Sites
December 4	Staging Prostate Cancer
December 11	Staging Hematopoietic and Lymphoma Cancer Cases

For more information, including course descriptions and a list of webinar host sites, visit the TCR NCRA Webinars webpage.

2019–2020 NAACCR Webinar Series

The TCR is excited to host the 2019-2020 NAACCR Webinar Series. All Texas cancer reporters are encouraged to attend the training and to complete a post-webinar quiz to obtain Continuing Education (CE) credit, which is required to maintain the CTR credential. Webinars may be viewed at any of the TCR NAACCR Webinar Host Sites throughout the state.

The new NAACCR webinar series began earlier this month and runs through September 2020. Each webinar begins at 8:00 a.m. CT and is approved for three CE hours.

2019–2020 NAACCR Webinar Series Calendar	
October 2, 2019	Breast
November 7, 2019	Bladder
December 5, 2019	Base of Tongue
January 9, 2020	Prostate
February 6, 2020	SSDIs: An In-Depth Look
March 5, 2020	Abstracting and Coding Boot Camp: Cancer Case Scenarios
April 2, 2020	Melanoma
May 7, 2020	Central Nervous System
June 11, 2020	Esophagus
July 9, 2020	Navigating the 2020 Survey Application Record (SAR)
August 6, 2020	Corpus Uteri
September 3, 2020	Coding Pitfalls

For more information, including course descriptions and a list of webinar host sites, visit the TCR NAACCR Webinars webpage.

TCR Training Requests

To request a basic or specialized training by TCR staff, complete the training request form on the TCR Website.

New TCR Staff

Yvonne Yin, PhD, joined the Quality Assurance Group as a Program Specialist II in May 2019. She is CTR eligible and currently enrolled in NCRA's Cancer Data Management online program. She obtained her BS at Hunan Agricultural University in China, her master's from University of South China, Medical School, in China and her PhD from Southern Illinois University, Medical School in Springfield, IL.

Debbie Robert, RHIT, joined the Southwest Texas Registry Operations Group as a Program Specialist II in May 2019. She has experience working at various clinics in Ohio. She has an associate's degree in Health Information Technology and is CTR eligible.

Ambika Sapkota, MSc, joined the Epidemiology Group as a Research Specialist IV in May 2019. Ambika most recently worked in the Bureau of Vital Statistics at the Missouri Department of Health and Senior Services, where she led data linkages between birth certificate, hospital discharge, Medicaid, and death certificate data. Ambika earned a BSc in Agriculture Economics and a MSc in Agronomy, both from Tribhuvan University, Nepal.

Kimber Green, RHIT, joined the Southwest Texas Registry Operations Group as a Public Health and Prevention Specialist III in June 2019. She has experience working in the medical records department and in the cancer registry at several hospitals in Mississippi. She has an associate's degree in Health Information Technology and is CTR eligible.

Kimberly Allen, BHA, CPC, joined the Quality Assurance Group as a Program Specialist II in June 2019. She earned her BA in Healthcare Administration in 2018 and is currently working on her master's in Healthcare Administration. She has been a certified coder since 2011 and is CTR eligible.

Jihan Solis, BS, joined the Southwest Texas Registry Operations Groups as a Public Health and Prevention Specialist III in June 2019. She has a BS in Public Health and has been a medical assistant for over 12 years. Jihan is CTR eligible.

Angela Alonzo, MPH, joined the Southwest Texas Registry Operations Group as a Public Health and Prevention Specialist III in September 2019. She earned her BS from Texas A&M San Antonio and her MPH from Walden University. She is CTR eligible.

Jessica Flores, BS, joined the Southwest Texas Registry Operations Group as a Public Health and Prevention Specialist III in October 2019. She earned her BS from the University of Texas Corpus Christi and is currently working on her master's from Lamar University. She is CTR eligible.

Are you interested in a career at the TCR?

You can search for open positions using the keywords "CESB" or "cancer epidemiology" on the Health and Human Services Job Center.

NPCR Data Quality Evaluation

Every 3–4 years, the TCR undergoes an independent data quality evaluation by the National Program of Cancer Registries (NCPR) at the Centers for Disease Control and Prevention. The NPCR does this because cancer surveillance data are so important and used for many public health and research-related activities.

This year, the TCR's evaluation assessment consisted of reviewing a sample of cases. It was also based on the existence of appropriate policies and procedures for the following:

- Assessment of data quality
- Text documentation
- Data consolidation
- Completeness of treatment information
- Assessment of utilization of the Multiple Primary/Histology (MP/H) rules for multiple primary tumors.

We're excited to announce that we have received our final report covering diagnosis years 2010–2016, and the TCR's overall data accuracy rate of merged (consolidated) data was 97.6%. They stated that the TCR is to be commended!

Texas Cancer Reporting News

October 2019
Vol. XXI, No. 2

Publication No. E10-10542

Newsletter Editor:
Katie Dahlquist, MEd

Toll Free: 1-800-252-8059
Main/Austin: 512-776-3080
Arlington: 817-264-4594
Houston: 713-767-3000

dshs.texas.gov/tcr

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

Recognition of TCR Funding Sources

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

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

Federal Grant Funding

We acknowledge the CDC for its financial support under Cooperative Agreement #1NU58DP006308.

State Agency Funding

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

For questions regarding information in this newsletter and suggestions for future issues, email Katie Dahlquist, katie.dahlquist@dshs.texas.gov.

This publication is supported through a CDC Cooperative Agreement. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Texas Cancer Reporting News is published twice a year by the Texas Cancer Registry, Texas Department of State Health Services. For past newsletter issues, please visit dshs.texas.gov/tcr/publications/newsletter.aspx.

Visit us online at dshs.texas.gov/tcr.

TEXAS Health and Human Services

Texas Department of State Health Services