Texas Cancer Reporting News

Cancer Registry Division 1100 West 49th Street Austin, Texas 78756 512-467-2239 1-800-252-8059

Vol.10, No. 3
Fall 1999

Texas Cancer Registry

Walter D. Wilkerson, Jr., M.D.
Chair, Texas Board of Health

William R. Archer III, M.D.
Commissioner of Health

From the Director

As we near the end of 1999, we are assuring that our cancer registry database, reporting software and computer equipment are Y2K ready. We did a test of our system several months ago and all went well. Our cancer reporting software, SandCrab Lite (Versions 2.1 and 3.0), is Y2K compliant. The Texas Cancer Registry (TCR)has followed the requirements outlined by the Texas Department of Health (TDH) to assure that all systems and equipment will be ready to go on January 1, 2000. We do not anticipate any significant interruptions in our processing of cancer records, so please keep on sending those cancer reports to us.

During our last legislative session, there was a change in our cancer incidence reporting law which became effective September 1, 1999. Chapter 82 of the Health and Safety Code (the Texas Cancer Incidence Reporting Act), amended September 1, 1999, was modified to include a provision that allows both cancer registries of hospitals and cancer treatment centers to release cancer information to each other, if desired. This does not apply to the cancer data that are reported to the TCR, i.e., the TCR will not release an institution's reported cancer data to another reporting institution except as allowed by law.

Cost recovery, the process of TDH (or its authorized representative) identifying and collecting unreported cancer cases from facilities required by law to report and charging for these associated costs, is a reality in Texas. Currently, staff of the TCR are collecting unreported cases for 1996 at one institution and the average cost for each case is approximately $72. This is the first cost recovery activity undertaken since our new cancer reporting rules went into effect in August 1998. As a reminder, all 1997 cancer reports are due to be submitted by December 31, 1999. Institutions failing to meet this deadline will be notified and the cost recovery process will begin.

With the new year comes changes in the requirements for when a cancer case must be reported. All 1998 cancer cases must be reported by July 1, 2000, and all 1999 cases by July 1, 2001. This is part of the phase-in period that was allowed for achieving the required 6-months reporting standard. Also, records must be reported at least quarterly. We strongly recommend that facilities not wait until these deadlines to report, but that they send records in monthly. This prevents a last minute rush on the cancer reporters part and allows adequate time for feedback from the TCR on the quality of the data being submitted. In addition, the TCR can process the information more timely if we receive an equal amount of records during each month of the year.

As with each year, comes new challenges for all of us. If there is something we at the TCR can do to help you overcome your new (or existing) cancer reporting challenges, please give us a call and we will see what we can do. We are all in this together.

Nancy S. Weiss, Ph.D.

News from the Regions

PHR 1, 9 & 10

Hello fellow Texans! We have some new faces in our Lubbock office. I am excited about being named the new Program Manager for Regions 1, 9, and 10. The future of this profession is definitely changing and with this change comes many challenges. Many times we need someone to guide us in the right direction or simply to have a friendly peer to exchange ideas. One of our goals in this office is to become an active

continued on page 2

Regions continued from page 1

resource and support for you not only for State cancer data, but in other areas of health care as well. The TCR has many different contacts which make us a great networking tool for you to utilize. If we do not have the answer we will put you in contact with someone who does. Let's learn from each other and together accept and embrace change on a daily basis. Pat Grabowski has been named our new Quality Control Auditor. Pat comes to us with 17 years experience with the State of Texas. She is extremely knowledgeable and skilled in the areas of data management and organizational techniques. By the way, she can type 100 words per minute with no mistakes. We welcome her as an added asset to our team. We are excited that our Regional Newsletter has become such a great success! We have had numerous requests from professionals who were given a copy through a friend including some out-of-state requests from Georgia, California, and Wisconsin. I look forward to meeting all of you. We have an open door policy so please stop by or call and introduce yourself. We look forward to hearing from you soon.

—*Kimberly Kinney*, ART, CTR
Regional Program Manager

PHR 2/3/4

Kudos to the majority of the facilities in PHR 2/3/4 that received the letter from the Texas Medical Association (TMA) stating that they had reported more than two-thirds of their expected cases for 1997. Many facilities have reported not only 100% of their 1997 cases but are completing 1998 cases and beginning 1999 reporting.

The TMA also contacted facilities that are out of compliance, and in July, the regional office sent out Reminder Cards to facilities that had not reported in the last quarter. This encouraged many to catch up on their reporting; so in the last month, we received tons of reports. Are we complaining? No way!! Keep them coming!!

The entire TCR staff did a terrific job on the TCR Conference. Many registrars and reporters commented on the informative and practical presentations. It was also a good opportunity to meet others in the field and to share ideas. We appreciate all of you who attended and helped make the conference such a success! Special thanks to: Our own Ron Tomlinson , Region 2/3's Director of Information Services, for his inspirational welcoming speech; Karen McCullough, CCS, Coding Supervisor, Good Shepherd Medical Center in Longview for her valuable presentation on "Reporting on SandCrab Lite"; and Judy Maynard, MPH, CTR, who did an excellent job of enlightening the audience with her topic "Contractor Expectations of Facility".

Cost recovery is a reality here in our region. We are currently working on a cost recovery basis to capture 1996 cases in a facility in our region. This cost recovery is to assure that data reported completely and timely by many are not jeopardized by the few who fail to do so. So remember, we are serious about compliance and cost recovery. Don't let it happen to you!

—*Elaine Allgood*, CTR
Regional Program Manager

PHR 5/6

The regional office of the TCR is announcing the expansion of our program to include our new Casefinding Specialist Yvonne Li. She comes to us from Birth Defects Monitoring Division and has previous experience with casefinding.

This past June, we mailed our first annual Regional Fact sheet. We want to thank all of our reporting facilities and our own Barry Wilson, a.k.a. the Cluster Buster, for the data that made this publication a reality.

Diann Purvis, our Regional Trainer and Data Coordinator, has been busy traveling during the months of June and July training the following facilities to name a few, TOPS Surgical Specialty Hospital, Memorial Medical Center Livingston, Doctor's Hospital Groves, and Conroe Regional Medical Center.

Our region would like to thank Diann Purvis for submitting the winning Tee-shirt at our TCR Conference held in July in Austin. We always knew we were working with a winner! Go Diann!

—*Marie Longoria*, CTR; *Judy Spong*, M.S.; *Diann Purvis*; *Yvonne Li and Wanda Taylor of the Region 5/6 Team*

PHR 7

Greetings from Austin! We all enjoyed meeting with many of you at the TCR Conference that was held here in Austin last July. It was great to be able to put a new face with a name and to discuss your reporting issues in person!

Staff have been busy closing out the 1997 cancer cases as well as the death clearance. We appreciate all of your hard work in reporting your cases in a timely manner and responding to our inquiries regarding death certificate cases and data discrepancies.

Many of you have participated in casefinding studies that were conducted in our region during the last quarter and we appreciate all of your cooperation. The purpose of per-

Regions continued from page 2

forming this quality assurance monitoring at your facility is to determine whether or not you are finding and reporting all of your cancer cases for a given year. It is also our goal to work with you to help you develop efficient procedures at your facility for identifying all of your cases. While we are visiting the facility, we also perform re-abstracting studies in which we go back to the patient's medical record to see if all the specific information on the cancer case was reported and if it agrees with the information that was reported. As time allows, we can discuss any data discrepancies that we find with the abstractor. This has been a great learning exercise for all of us! **Remember that the Texas Cancer Incidence Reporting Act requires that all 1997 cases be reported by December 31, 1999.**

The TCR recently mailed all hospitals a copy of a procedure for performing casefinding within a hospital facility. This procedure includes suggested methods for developing a system at your facility for finding all the cancer cases. Please take the opportunity to review this procedure because it can be a great help to you in evaluating and setting up a system for finding your cancer cases, improving quality, and managing your reporting functions which can increase your efficiency and save you time! Please contact us if you have not received your copy of this procedure.

—*Annette Van de Werken*, MS, RD, LD
Program Manager

PHR 8 & 11

The 1997 death clearance project is completed. We are very proud to report that we had a very enthusiastic 100% response from the reporting facilities in both PHR 8 and 11. This was primarily due to the dedication, hard work and many phone calls of our team member Lupe Garcia.

We would like to thank all the hospitals in PHR 8 and 11 for their participation in our September quarterly trainings. We will continue to have these quarterly trainings and hope that the hospitals will continue to benefit from them.

We are very sad to announce that Lupe Garcia and Michelle Tessaro, CTR have left the registry. We are very happy that Lupe has accepted a tremendous promotion with the Medical Transportation Program for PHR 8 and Michelle has accepted a position in the Birth Defects Monitoring Program for PHR 8. We wish them the best and they will be greatly missed.

—*Kathryn Woehler*, RN,MPH,CTR
Regional Program Manager

CANCER DATA WORK GROUP MEETING

The Cancer Data Work Group met for the third time on September 17, 1999, at the Renaissance Austin Hotel, to continue to address long-term solutions for further developing and implementing a complete, timely, accurate and useful cancer incidence reporting system for Texas. Attendees included representatives of the Texas Medical Association, Texas Hospital Association (THA), Texas Tumor Registrars Association, Physician Reliance Network, UT MD Anderson Cancer Center, Baylor University Medical Center, UT Houston School of Public Health at Houston, Texas A&M University Health Science Center, Baylor College of Medicine, American College of Surgeons, Texas Cancer Council, UT Medical Branch at Galveston, American Cancer Society Texas Division and the TCR.

Dr. Nancy Weiss, Director of the TCR, gave an update on the TCR including reporting completeness and compliance, results of the North American Association of Central Cancer Registries' Certification Process, the TCR Conference and the status of electronic cancer data submissions.

The Work Group's recent letter and survey that were sent to cancer reporters and hospital administrators regarding their completeness of cancer incidence reporting for 1997 were discussed in detail. Based on comments received both from the survey and in-person, those institutions who received the positive letter stating that more than two-thirds of their 1997 reports had been received did not take this to include complete submission for 1997. The Work Group expressed their regrets that the wording of the letter was not more clear for those facilities who indeed had reported all of their 1997 cases, since the letter was intended to be recognition and praise for these cancer reporters. Any future correspondence will be worded clearer. The recent increase in cancer reporting as reflected in Dr. Weiss' report could in part be contributed to the letter and survey. However, an increase in cancer reporting is always noted prior to a conference that TCR staff attend along with cancer reporters, and in this case, the letter and survey coincided with the timing of the TCR conference.

A sub-committee was appointed to write an RFP to secure funds to hire a contractor to evaluate the TCR. To address the hospital requirements for cancer reporting and the benefits of having complete, accurate and timely cancer incidence data for Texas, the Work Group will approach the THA and ask to be placed on the agenda of their annual conference. Other recommendations to improve cancer incidence reporting provided by Work Group representatives will be investigated. Reports on these activities will be discussed at the next meeting of the Work Group which will be held Friday, February 25, 2000, at the Renaissance Austin Hotel.

—*Jane Yoakum*

Cancer Case Completeness

PHR 1:	1996	89%	PHR 4:	1996	95%	PHR 7:	1996	97%	PHR 10:	1996	101%
	1997	83%		1997	78%		1997	91%		1997	91%
	1998	68%		1998	47%		1998	58%		1998	82%
	1999	10%		1999	5%		1999	7%		1999	3%
PHR 2:	1996	94%	PHR 5:	1996	95%	PHR 8:	1996	99%	PHR 11:	1996	100%
	1997	83%		1997	85%		1997	91%		1997	84%
	1998	66%		1998	40%		1998	70%		1998	38%
	1999	11%		1999	1%		1999	7%		1999	4%
PHR 3:	1996	92%	PHR 6:	1996	104%	PHR 9:	1996	96%	Statewide:	1996	97%
	1997	82%		1997	94%		1997	88%		1997	87%
	1998	43%		1998	58%		1998	76%		1998	55%
	1999	7%		1999	2%		1999	21%		1999	6%

As of November 5, 1999

Compliance

We have surpassed our goal of 95% statewide complete reporting for 1996, but are still lacking for reporting years 1997, 1998 and 1999. Please assist us in gaining more complete and current cancer information for Texas by reporting in a timely manner.

TCR Conference Summary

The TCR Conference that was held in Austin, July 28-30th was a terrific success! The agenda was filled with numerous informative and timely sessions that helped prepare all of us for cancer reporting in the new millennium. There was plenty of opportunity for networking and the sharing of "best practices" with colleagues from other hospitals across the state. The attendance was great due to the scholarship program in which 80 hospitals participated.

The conference began on Wednesday with a touching speech from Ron Tomlinson, Director of Information Services, TDH, PHR 2/3 in Arlington, who brought home to all of us that what we do can and does make a difference in our war against cancer.

Nancy Weiss, TCR Director provided an update on the status of the state registry, including measures of completeness and quality of the data, and what we hope to achieve in the next year.

Karen Torges of the American Cancer Society (ACS), Texas Division, reemphasized the importance of cancer data for the ACS' goals and how these data will help make an impact at the community level. Pandora Ashley from Scott & White Hospital in Temple provided the hospital's perspective on cancer reporting and Karen McCullough from Good Shepard Medical Center in Longview discussed advantages and hints for using the Sandcrab Lite reporting software.

Next, TCR staff gave an overview of what happens from when you report the data to the TCR to when you see a report of these data and the various steps that may require inquiry back to your facilities for clarification and/or submission of patient data.

Continued on page 5

Summary continued from page 4

On Thursday, Doctors Sue Carozza, Billy Phillips, John Young, and Larry Frankel, M.D., and Steven Roffers outlined how cancer data are used in various research, public health, hospital, and community settings. Dr. Young of Emory University, provided insight as to how cultural and resource issues affect decisions regarding international cancer prevention and control.

Dr. Fabio Valenzuela, Oncologist, gave an overview of current and new methods of radiation therapy.

Thursday afternoon and Friday morning were spent in two separate breakout sessions. The first was to provide basic training on how to report to the TCR. At the other breakout session, Dr. Linda McManus from the University of Texas Health Science Center in San Antonio showed specimens of benign and malignant tumors. This was extremely helpful in understanding how what we read in pathology reports relates to the true picture of the human body. Steven Roffers of Emory University showed the tricks of the trade for surfing the Internet for cancer registry related resources. Expectations for the cancer reporting contractor as well as contracting with the state for casefinding services were presented and discussed.

Friday's general session looked at ways of performing registry operations more efficiently through electronic medical records and electronic matching. This automation is not intended to replace the registrar. The expertise of these professionals is still essential for providing interpretation of this medical information and its application.

In summary, a wide range of topics were covered during the two day conference which helped motivate us all for many of the challenges as we move into the Y2K. We can be successful at meeting these challenges if we all work together!

—*Annette Van de Werken*, MS, RD, LD
Program Manager

TxTRA

Texas Tumor Registrars Association

October 20-22, 1999 was TxTRA's 27th Annual conference at the Red Lion Hotel, Houston, Texas. The primary focus this year was on prostate cancer. We hope you enjoyed the conference. Highlights of the conference will be featured in our next newsletter.

—*Leticia Vargas*, CTR

SANDCRAB Lite USER - UPDATE

A new version of SANDCRAB Lite is in the process of being developed. This new version (SANDCRAB Lite Version 3.1) will be Y2K compliant and will continue to be compatible with Windows 3.x, Windows 95, Windows NT, Windows 98, and DOS. Our plan is to distribute version 3.1 to current users by December 1, 1999. Fields that will be affected by the new version include:

Registry Number (will be lengthened, CCYY12345)
Diagnosis Date (will accept 9's)
Treatment Date (will accept 9's)

If you are upgrading your PC to a newer model with a speed of 300 MHZ or higher, there is an updated version of the SANDCRAB Lite files you need to request. The error message you will get with the existing SANDCRAB Lite 3.0 software is:

"An error has occurred in your program. To keep working anyway, click* Ignore *and save your work to a new file."

This is a WINDOWS error message. It comes up immediately after clicking on the SANDCRAB Lite icon. Using Windows 95, you have the options to ignore or cancel. Using Windows NT you only have the cancel option. If you get this message contact the TCR and we will ship a new file to override the problem. The new version of SANDCRAB Lite (version 4.0), due to be released in December 1999, will have the corrected version of this file included in the installation disk.

A SANDCRAB Lite survey was mailed out on May 24, 1999. This survey targeted facilities that use forms to report their cases and facilities that use SANDCRAB Lite V2.0 and V2.1 for DOS. According to our survey, 60 facilities report by paper forms. Out of those 60 facilities, 42 facilities are interested in using SANDCRAB Lite to report. This is very exciting for us because it increases our electronic reporting percentage and brings us closer to meeting our goals. However, our survey also told us that 27 facilities do not have a computer to use SANDCRAB Lite. If you have any questions about the survey, please contact the Austin office at 1-800-252-8059. Please remember, if your facility is still using version 2.0, please call and request a newer version!

—*Elena Faz*, CTR

Investigating Cancer Clusters

In April 1999, in response to concerns regarding a possible excess of cancer, the Cancer Registry Division (CRD) of the Texas Department of Health conducted an investigation into the occurrence of cancer in Slaton, Texas. These concerns were born out of a series of cases that started with a boy at an elementary school who had been diagnosed with a benign tumor. Following that, a third grader and a kindergartner, both girls, were diagnosed with non-Hodgkin's lymphoma. Shortly after the two girls had been diagnosed, another boy was diagnosed with brain cancer. In addition to these 4 childhood cases, one of the elementary school teachers was diagnosed with breast cancer. Many of the parents believe the school contains asbestos which is causing these cancers as well as others illnesses. The belief that the health problems were being caused by some exposure to an environmental contaminant led to phone calls to the media, city officials, the Texas Natural Resource Conservation Commission and the CRD.

The cancer cluster investigation is the primary tool used by the CRD to investigate concerns of excess cancer. A cluster is a greater than expected number of cancers occurring among people who may live or work in the same area, and who may develop the disease within a short time of each other. The existence of a cluster is not necessarily a reason for concern. The fact that cancer is so common means that many clusters will be explainable solely on the basis of chance.

This investigation evaluated the incidence data for cancers of the stomach, colon, pancreas, lung, prostate, breast, and leukemias for all ages combined in Slaton, Texas during the period 1990-1995. In addition, we also evaluated the incidence data for childhood (age 0-19) cancers of the bone, soft tissue, brain, and leukemias in Slaton, Texas during the same time period.

To determine whether an excess of cancer exists in Slaton, Texas, we calculated standardized incidence ratios (SIRs) by comparing the number of observed cases to what would be expected based on the race-, sex-, and age-specific cancer incidence experience of the entire state of Texas. When the SIR of a selected cancer is equal to 1.00, then the number of observed cases is equal to the number of cases which would be expected based on the incidence experience of the rest of the state. When the SIR is less than 1.00, fewer people developed cancer than we would have expected. Conversely, an SIR greater than 1.00 indicates that more people developed cancer than we would have expected. To determine if an SIR greater than 1.00 is statistically significant, or outside the variation likely to be due by chance, confidence intervals are also calculated.

The 95% confidence interval indicates the range in which we would expect the SIR to fall 95% of the time. The confidence interval is a statistical measure of the precision of the risk estimate. If the confidence interval contains 1.00, no statistically significant excess of cancer is indicated. The confidence intervals are particularly important when trying to interpret small numbers of cases. If only one or two (or even less than one) cases are expected for a particular cancer, then the report of three or four observed cases will result in a very large SIR. As long as the 95% confidence interval contains 1.00, that indicates that the SIR is still within the range one might expect based on the incidence experience of the rest of the state.

Our analysis of the incidence data (all ages combined) for Slaton, Texas during the period 1990-1995 showed that the number of cancer cases for all sites evaluated was either lower than or within the range we expected. However, our analysis of the incidence data for childhood (age 0-19) cancers showed a statistically significant excess of soft tissue cancers among female children in Slaton, Texas during the period 1990-1995.

We do not know why the number of soft tissue cancers is significantly elevated among the female children in Slaton, Texas. Determining the cause of any excess is beyond the scope of the cancer cluster investigation. However, part of any cancer cluster investigation is to evaluate the possibility that any excess observed is being caused by some exposure. One of the markers we look for is whether the excess is consistent across race/ethnicity or gender. For example, if a significant excess of a certain type of cancer exists among females, but not among males, it is unlikely that the excess seen in females is being caused by exposure to some specific environmental contaminant. If an exposure was present, we would expect the excess to be consistent in both genders.

This investigation showed a statistically significant excess of soft tissue cancers among female children (obs = 2.0; exp = 0.1; SIR = 20.0) in Slaton, Texas during the period 1990-1995. However, there were no reported cases of soft tissue cancers among male children in this area during the same time period. This finding is not consistent with an environmental exposure and the investigation was concluded.

Because of continued concerns among residents in Slaton, Texas, the CRD plans to expand the investigation study period through 1996 once those data are complete. We anticipate this will be around September 1999.

—Barry Wilson
Epidemiologist
Cancer Registry Division

The WHAT, HOW, WHY, and WHEN of the DEATH CLEARANCE process

What is death clearance?

Death clearance is an essential step in achieving complete population-based cancer reporting for a target year. It serves as a check on completeness of reporting and often identifies cases which should have been reported but were not. Death clearance includes identification of all deaths with cancer mentioned as the underlying cause of death on the death certificate which are not found in the TCR database.

How is death clearance done?

These cases are identified by matching the Bureau of Vital Statistics (BVS) death file to the full TCR database. Those cases that are not found in the TCR database must be followed-back to the facility where the death occurred. TCR staff must resolve each of the cases from the facility identified as missing from the TCR database. Resolution may entail obtaining an abstract (report) for the case, verifying that the patient was seen with no evidence of cancer or determining that there is no record of the case having been seen at the facility. The result of the follow-back from all missing cases must be incorporated in the TCR database by either adding the case or creating a "death certificate only" (DCO) case. (A "DCO" case is a case where, after follow-back with the facility preparing the death certificate, the only evidence of cancer is provided by the death certificate.)

Why is death clearance performed?

The proportion of DCO cases within a registry is often used as an indicator of the quality of the registration process and the data. The goal of the TCR is to have the DCO cases account for 3% or less of the total cancer cases for a given year. For the year 1995 data, DCOs comprised 6.5% of the TCR cases, and 5.4% for 1996. Quality of the data is affected by the proportion of DCOs because only limited data can be obtained from a death certificate versus a full abstract. Information such as treatment, specific primary site, and specific histology are not available from the death certificate. The cause of death on the death certificate is coded according to the International Classification of Diseases (ICD-9) which is not as specific for the coding of cancer as the International Classification of Diseases for Oncology (ICD-O).

When does death clearance need to be performed?

Death clearance should be performed when data collection is 80-85% complete for the given year. It is the last step in the data collection process. Timing must be carefully planned. You want data collection to be as complete as possible so you are not querying back to the facility on cases they are still needing to be reported, which results in double work. However, you want to allow enough time for the facilities to do the necessary follow-back in a reasonable amount of time before needing to prepare the cancer incidence reports for the target year.

When we performed our Death Clearance process for 1997 data in July, data collection was only 76% complete for the year. Although we had not reached the completion percentage we would have liked, it was critical to begin the death clearance process in order to meet necessary time frames for the submission of our data for the NAACCR CALL FOR DATA. With Texas being such a large state, the magnitude of data to be followed up was challenging. After the initial match with the BVS death file, there were over 5,500 potential DCO cases - 1,883 of those were distributed to field staff for follow-up and the remaining 3,659 were reviewed by TCR staff in Austin to determine if we had a previous record of the case. Thus, we were trying to reconcile a large number of records in a short time frame. Once we get the information on these cases back from the hospital, there are a number of processes and quality control checks that we have to put the data through to get it ready to be submitted for the call for data. These quality control checks can take several months to complete.

What is the NAACCR Call For Data?

It is a data submission process sponsored by the **North American Association for Central Cancer Registries** (NAACCR) where state central cancer registries contribute cancer incidence data to establish a national cancer data set. To be a part of this data set, your data must meet certain data quality criteria. NAACCR's goal is to include all 50 states in this data set. Being involved in this Call for Data provides Texas credibility as well as national exposure. It is also recommended by the **Centers for Disease Control & Prevention's National Program of Cancer Registries**, from whom a portion of our funding is obtained, that we participate. Our final data set for the Call For Data must be submitted by December 3, 1999.

Casefinding Tips for Reporting Facilities

In order to pick up more of the death certificate cases at your facility, review sources such as autopsy reports, death records, and ER records to locate other cases with a cancer diagnosis that may not be shown on your inpatient and outpatient medical records disease index. This will save you time because there will be fewer cases that you will need to query back on during the death clearance process.

—*Annette Van de Werken*, MS, RD, LD, *Program Manager*

Staffing News

Please join me in welcoming Chris Sparks and Robin Milner to the TCR. Chris is our Programmer Analyst. He is a graduate of Texas A&M where he also held his last position as a Programming Assistant. He enjoys anything that has to do with the outside such as hunting, fishing, and going to the beach. He also enjoys cats.

After 20 years of service at CIDC (Chronically Ill and Disabled Children's Services Program) Robin has (very happily) joined the team in the TCR Quality Assurance Section. Robin is a proud homeowner of three years and enjoys spending time at home with her dog Beau, visiting with friends, neighbors and family, bird watching, and reading.

We regret having to say farewell to Dr. Sue Carozza. Sue was our Senior Scientist within the Epidemiology Program. Sue will be taking a teaching position with the Texas A&M University Rural School of Public Health. Her talents and smiles will be sadly missed. We wish her well in her new endeavor.

—*Jackie Shaw*

CODING CORNER

Subject: Staging of pleural effusion

If a patient has pleural effusion, it is considered malignant UNLESS *more than one cytology is read as negative* AND *the fluid is not bloody and not an exudate.*

Revision: *In the "Workbook for staging of Cancer" it states that a malignant pleural effusion must be diagnosed by cytology or histology; this is in error. It has been corrected in the new version which should be ready this Fall.*

References: SEER Extent *of Disease page* 91 *note* 6 *and* AJCC *Cancer Staging manual,* 5th *edition page* 130.

Pleural effusion is, in most cases, caused by tumor on the pleura. If the primary is lung, the effusion may be caused by direct extension of the tumor into/through the visceral pleura or by discontinuous metastases on the pleural surface. When the primary is other than lung, the effusion is usually a result of tumor implants on the pleura (discontinuous metastases). There are a few other conditions that cause pleural effusion, but if any of these comorbidities is present, the presence is usually documented in the medical record. Please include this information when reporting your cases to the TCR.

—*Leticia Vargas*, CTR

How to Contact Us

Phone Numbers for Public Health Regions

Arlington (PHR's 2,3,4)		817/264-4479
Austin (PHR 7)		512/467-2239
	or	1-800-252-8059
Houston (PHR's 5,6)		713/767-3180
Lubbock (PHR's 1,9,10)		806/767-0323
San Antonio (PHR's 8,11)		210/949-2169

Texas Cancer Reporting News Staff

Editorial Committee:

Susan Perez, ART, CTR
Leticia Vargas, CTR
Elena Faz, CTR
Annette Van de Werken, MS, RD, LD
Barry Wilson
Jackie Shaw

Design and Production: TDH Art Department

Questions regarding information found in this newsletter, or suggestions for future editions can be directed to Susan Perez in Austin.

Just write us a note to let us know that you would like to be on our newsletter mailing list if you are not already receiving it.

TDH

Texas Cancer Reporting News
Texas Department of Health
Cancer Registry Division
1100 West 49th Street
Austin, Texas 78756