ARKANSAS CENTRAL CANCER REGISTRY

Data Acquisition and Monitoring

Thank you for all your hard work in submitting your 2022 and 2023 data. We completed our annual data submission to NPCR and are awaiting the results. Your efforts with death clearance activities was also extremely helpful as we reached less than 3% of death certificate only cases, which puts Arkansas in line with becoming certified by NPCR!

We will continue monthly data acquisition monitoring to be sure we're on top of things for the next data submission.

Death Clearance Activities

Death Clearance processes have begun for 2023 cancer related deaths. Facilities will receive letters if there are cases identified through a death certificate for which we do not have the case record in our database. The patient listing will be uploaded through Web Plus. Please download your list and complete an abstract on these cases. Follow the instructions and timeline provided in the letter so we may close this activity for the year. Your support of the Arkansas Central Cancer Registry is invaluable for monitoring the burden of cancer in our state.

2025 Updates

Please review the implementation guidelines for 2025 for all the updates, new data fields, and retired data fields. The Implementation Guidelines document (IG) provides an overview regarding changes in cancer surveillance reporting standards which the various stakeholders need to consider for 2025 diagnoses. There are links to source documents that are referenced throughout this IG, each being maintained by either the relevant standard setter or the North American Association of Central Cancer Registries (NAACCR). The NAACCR website continues to be an essential destination for the latest version of this Implementation Guide and for standards documents, including the Data Standards and Data Dictionary, v25, and its log of changes. 2025-Implementation-Guidelines_20250114.pdf

Data Quality Spotlight: Text Fields

Text Fields	Understanding what is required in the text fields helps the central registry validate coded data items. Please use these tips when completing your text fields.
Text--Place of Diagnosis	**Instructions:** Document the facility or physician office where the diagnosis was made. If the diagnosis was made at a small clinic or family practice, do not abbreviate the name of the practice unless it exceeds allowable space within the text box; please indicate "Mercy Regional Medical Center" versus "MRMC." **Rationale:** If your facility is not the diagnosing facility, this is used to validate where the diagnosis was made and provides rationale for Class of Case. If the patient is involved in a research study, researchers will know where the medical record can be obtained. **Example(s):** University of Arkansas for Medical Science
Text--Primary Site Title	**Instructions:** Document the primary site including applicable subsite along with laterality in this field. **Rationale:** Validates coded values of primary site and laterality. **Example(s):** Right Breast @ 10:00 or Right Breast, UOQ
Text-- Histology	**Instructions:** Document the histology, grade and the behavior of the tumor. **Rationale:** Validates that text agrees with coded values for histology, clinical or pathologic grade, and behavior. **Example(s):** Squamous Cell Carcinoma, G2 Adenocarcinoma, Gleason 6 or DCIS, high grade or Melanoma in situ
Text--Dx Proc-Lab Tests	**Instructions:** Document cancer-specific tumor markers and dates of applicable lab results other than cytology or histopathology and/or studies done to confirm the presence of metastatic disease.

	Rationale: This field validates the coding for site specific data items, special studies, some staging items and validates information used to assign more specific histology types. If the diagnosis was made clinically, it is used to confirm clinical diagnosis. **Example(s):** Breast: 1/1/25: ER+/PR+, HER-2 neg (Score 0) on IHC 1/10/25: HER-2 by FISH neg, ratio: 1.7 or Prostate:1/1/25 PSA 10 ng/mL (elevated) or Liver: 1/25/2025 Bilirubin 2.0 mg/dL, INR
Text--Path	**Instructions:** Use this field to pull pertinent information from pathology reports. This includes specimen collection dates, path report numbers, procedures, tissue specimens, and any language that describes primary site, histology, laterality, behavior, grade, extent of disease, tumor size, margins, or status of lymph nodes. **Rationale**: Validates the coding of Primary Site, Date of Diagnosis, Histology, Clinical or Pathologic Grade, Behavior, Diagnostic Confirmation, extent of disease-related fields, values selected for site-specific data items, and surgical procedure and treatment fields. Validates staging information such as Tumor Size Summary, lymph node involvement and metastasis. **Example(s):** 1/1/25 [Facility Name] (PS-14-5687) Ascending Colon Mass Bx: Invasive mod diff adenoca w/ mucinous and signet ring cell features; 1/15/25 [Facility Name] (SUR- 25-10587) Hemicolectomy: Sigmoid Colon, 8.0 cm, LVI: absent, Perineural Invasion: Neg, Margins (-), circumferential or radial 2.0 cm from proximal margins, LNs +2/5, +Liver Bx c/w mets, Omentum: neg. for malignancy or PTA 1/1/25 [Facility Name] (Path N/A): Ascending colon bx performed, per referral notes mod diff adenoca found in sigmoid colon
Text--PE	**Instructions:** Document the history, physical examination and clinical presentation information including any symptoms that led to workup and evaluation for cancer. This includes date of exam, age, sex, race, clinical tumor size, tumor location, palpability of lymph nodes, positive and negative clinical findings. **Rationale:** Validates Date of Diagnosis, Class of Case, Diagnostic Confirmation, clinical staging information, Race,

	Sex, Spanish/Hispanic ethnicity, and site-specific data items. **Example(s):** 1/1/25 51 YOWF, ref to med onc for consult for recent dx of cancer of the RLL Lung. Pt originally presented to ER for severe cough, imaging found nodule Rt Lung, Bx +adenoca, presents now for tx of cancer; PE: Gen: obese female, HEENT(-) No LNs palp; Lungs: Bilat crackles, Abd: Neg, NT, ND, GU: neg, Skin: NL
Text-- Remarks	**Instructions:** Document pertinent information not indicated in other text fields. Includes smoking history, family and personal history of cancer, comorbidities/complications not documented in PE, place of birth, date of death/vital status and justification of over-ride flags. **Rationale:** Used to verify coded information that is not contained in any other text field. Use to validate decisions for sequencing and/or multiple primaries versus recurrence if not indicated elsewhere. **Example(s):** Medicare+ private supplement. Married. Former smoking hx, quit 1984, 1ppd x10yrs, no ETOH hx, med rec states Ashkanzi Jewish decent, no fh ca, +personal hx of breast ca in 2010 s/p bilat mastectomy, reconstruction +chemo & rad. Per rule M5 new primary, tumor arose from breast tissue within the reconstruction. Ref SINQ 20120062 or Death Certificate Only, Autopsy only; and/or Patient record states “born in the Midwest” (justifies place of birth coded to USA). Referred to hospice 5/1/25, deceased 5/20/25.
Text--OP	**Instructions:** Document the date of surgical procedures or biopsies; include the location of tumor and what specimen was resected or biopsied. Document tumor size if provided and note if there was residual tumor or no evidence of disease. If a surgery is aborted give a brief explanation. Document all pertinent findings that provide information for staging. **Rationale:** Validates RX Summ--Dx/Stg Proc, Surg Primary Site, Reason for No Surg and staging decisions. **Example(s):** 1/1/25 Right Hemicolectomy, LN dissection, and Omentum Bx: Ascending colon, 8.0 cm mass removed, 5 peri-colonic LNs removed, bx in OP+ for adenoca, No

	evidence of residual tumor, margins clear. or 1/1/25 Laproscopic-assisted colectomy: Aborted, numerous suspicious liver lesions id'd on abdomen inspection. Surg not indicated.
Text--Scope	**Instructions:** Document the date and location of where the study occurred. If you do not have a facility name, use the doctor's name. Document all endoscopic examinations and findings that provide information for staging and treatment. **Rationale:** Validates RX Summ--Dx/Stg Proc, Surg Primary Site, staging decisions, Laterality, Primary Site, Diagnostic Confirmation, Histology. **Example(s):** 1/1/25 [Facility Name] Colonoscopy: Fungating ulcerated mass in terminal ilium, 2.0 cm, extends to margins, polyp near mass resected; 1/1/25 [Facility Name] EUS w/FNA: 3.0 cm colon mass found 42 cm from anal verge, unable to complete FNA due to circumference of tumor; 1/1/25 [Facility Name] Bronchoscopy w/FNA: in RLL, 2.5 cm mass found c/w malignancy, FNA performed.
Text--Imaging	**Instructions:** Document date, facility, imaging test performed and any pertinent results, findings and impressions. **Rationale:** Validates Date of Diagnosis, clinical stage-related fields, Tumor Size Summary, extent of disease-related fields, and Diagnostic Confirmation. **Example(s):** 1/1/25 [Facility Name] CT A/P: Two pancreatic masses, one 2.5 cm arising in head of pancreas and second 2.3 cm arising in junction of head and body of pancreas; rec MR Abd; 1/10/25 MRI ABD: Progressive pancreatic duct dilatation, suggesting intraductal papillary mucinous tumor of pancreas, solid component arising in head of pancreas, susp for malignancy.
Text--Staging	**Instructions:** Document the date, doctor's name and clinical and/or pathologic staging information and the source of the staging information. Include registrar staging information. **Rationale:** Validates summary stage, clinical evaluation and pathologic evaluation fields, documents registrar staging and stage group decisions.

	Example(s): 1/1/25 per Tumor Board Summary Stage I, localized or 1/1/25 Staged on colonoscopy: Summary Stage 1, No path performed and/or per registrar tumor not assessed, no +LNs/Mets per imaging.
Text--Surgery	**Instructions:** List of the surgical procedures performed and the dates. **Rationale:** Validates Date First Course RX , Date of Diagnosis, RX--Summ Surg Prim Site, Rx--Date Surg, RX SUMM--Surg/Rad Seq, Reason No Surgery. **Example(s):** 1/1/25 Right Hemicolectomy, LN dissection; 1/11/25 Omentum Biopsy
Text-- Radiation	**Instructions:** Document start and end date, facility, regional and boost modalities, regional and boost sites, treatment volume and total fractions. Also indicate sequence. **Rationale:** Validates Date First Course RX, Reason for No Radiation, Rx Date Radiation, RX SUMM--Surg/Rad Seq, RAD —Regional Rx Modality. **Example(s):** 1/4/25-3/13/25 [Facility Name]: 5,040 cGy to pelvis in 28 fx w/ 6 mV photons; 1,000 cGy total boost in 200 cGy x5 fx to tumor bed XRT modality unk. or Radiation tx given after surgery but tx summary not avail and dates unk.
Text--Chemo	**Instructions:** Document start date, facility or doctor's name and chemotherapy agents or regimen. If treatment was discontinued or not completed, state. **Rationale:** Validates RX Date Systemic, RX Date Chemo, RX Summ--Systemic/Surg Seq and/or Date First Course RX. **Example(s):** 1/2/25 [Treatment Ctr], Carboplatin+Taxol, discontinued due to adverse reaction/side effects and progression of disease. 2/4 cycles completed, or 1/1/25: Recommended Carboplatin+Taxol, pt refused or referred to [Outside Cancer Facility], unknown if chemo recommended or performed.
Text-- Hormone	**Instructions:** Document date started, facility or doctor name, and drug used. **Rationale:** Validates RX Date Systemic, RX Date Hormone, RX Summ-- Systemic/Surg Seq, Date First Course RX .

Text--BRM	**Example(s):** 1/1/25 [Facility Name]: Levothyroxin
Text--Other	**Instructions:** Document start date, facility or doctor name and immunotherapy agents. **Rationale:** Validates Date First Course RX, RX Summ--BRM, RX Summ-- Transplnt/Endocrine, RX Date BRM, RX Date Systemic. **Example(s):** 1/1/25 [Facility Name]: Herceptin or 1/1/25 [Facility Name]: Bone marrow transplant, donor cells **I**
	Instructions: Document treatment of tumor being reported with treatment that cannot be defined as surgery, radiation or systemic therapy. This includes clinical trials and palliative care for pain control or mets. **Rationale:** Validates RX--Summ Other, RX Date Other, Date First Course RX. **Example(s):** 1/1/25 [Treatment Facility]: Clinical Trial #POS5 given to pt. or 1/1/25: Palliative consult for rad to spinal mets.

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