ASANTE®

Community lives here.

Reportable Diagnosis Date of Diagnosis

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Team Asante swimming in data!

Objectives

- Review CoC and Oregon standards for reportable diagnoses and date of diagnosis issues
- Provide tools and resources for identifying reportable histologies and site/histology combinations
- Discuss information that can be used to establish date of diagnosis
- Present cases for discussion

Why

- Data items foundational to abstracting, not often covered in workshops
- Reportable diagnoses change over time
- CoC vs OSCaR reportable DX may not be the same
- Date of DX is used for measuring time from diagnosis to treatment and impacts Class of Case

What's covered

- Reportable diagnoses ←
- Date of diagnosis ←
- Primary site X
- Histology X
- Diagnostic confirmation X
- Multiple primaries X
- Class of Case X

Cool stuff!

Help has arrived!

- NAACCR's new web page
  - "Comparison of Reportable Cancers: CoC, SEER, NPCR and CCCR"
- Contains
  - reportable cancers, dates of when new histologies became reportable
  - exceptions (not reportable)
  - ambiguous terms
  - primary site codes for intracranial/CNS tumors
- Bookmark worthy!

Data Standards and Data Dictionary v23

- Historical Background
- Standards for Tumor Inclusion and Reportability
  - Overview
  - Multiple Primary Rules/Solid Tumor Rules
  - Carcinoma In Situ of the Cervix, CIN, and the Bethesda System
  - Comparison of Reportable Cancers: CoC, SEER, NPCR, and CCCR
  - Ambiguous Terminology
  - Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors

OSCaR list

Reportable Diagnoses

CoC	SEER	NPCR	CCCR
1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues* (2008).	1. Behavior code of 2 or 3 in ICD-O-3.2 plus the ICD-O-3.2 updates posted on the NAACCR website or, for 2010 and later diagnoses, behavior code 3 according to the WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008).	1. Behavior code 2 or 3 in ICD-O-3.2; behavior code 3 in WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008) (2010+); behavior code 2 or 3 in WHO Classification of Tumours 5th Ed. (2022+) (Refer to instructions provided by NPCR for detailed information.)	1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues* (2008).
2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in the "Primary Site Codes for Non-	2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in the "Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous	2. Primary intracranial and central nervous system tumors behavior code 0 or 1, including juvenile astrocytoma (M9421/3)* for primary sites defined in the "Primary Site Codes for Non-Malignant Primary Intracranial	2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors (ICD-O-3 topography codes C70-C72) (1/1/1992).

Ambiguousness

Ambiguous terms +ICD-O-3

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	

*Additional terms for nonmalignant primary intracranial and central nervous system tumors only

REF: STORE v 06/28/23 page 45

Ambiguous terms +ICD-O-3

- Use this list only to determine if case is **reportable**
- Ambiguous term **must be accompanied by an ICD-O-3 term**
  - Behavior code 2 or 3, or
  - Behavior code 0 or 1 for non-malignant CNS tumors
- Words in parentheses are optional
- Acceptable terms preceded by (non negating)modifier such as "mildly" is reportable

Acceptable ambiguous term + reportable ICD-O-3 term = case is reportable

Ambiguous terms +ICD-O-3

- "List of last resort"
  - What does this mean?
    - often initial DX will have ambiguous terms, especially imaging reports
    - if this is the ONLY information you have, you can report the case (such as path only cases)
    - okay to use for establishing date of diagnosis
    - See SEER PCSM 2023 page 12 for clarification of STORE/CoC lists
  - If physician opinion or further workup shows that there is no cancer diagnosis, don't report the case

Ambiguous terms & Date of DX 2023

CAForum: Imaging and biopsy diagnosis with Ambiguous Terms for 2023

Q: If you have imaging of a breast, liver, or prostate that uses ambiguous terms to constitute a diagnosis in the body of the report and then a positive biopsy follows at a later date, is the date of diagnosis the date of imaging or the date of the biopsy?

A: NCDB CTR Staff - If there is imaging containing CoC acceptable ambiguous terminology (per the reportability instructions in STORE), the date of the imaging would be captured as the Date of Initial Diagnosis.#

NOTE: this has always been acceptable for SEER

REF: https://cancerbulletin.facs.org/forums/node/144504

Cytology with ambiguous terms +ICD-O-3

Change with 2022 Manuals

- **Report** cytology with ambiguous terms IF
  - Subsequently confirmed by another method
    - The date of the cytology may be used as date of diagnosis

- **Do not report** cytology w/ambiguous terms IF
  - You do not have additional information
  - Subsequent workup does not confirm

REF: STORE v 06/28/23 page 46

Acceptable Reportable **Phrases - SEER**

- **Considered to be**[malignancy or reportable diagnosis]
- **Characteristic of** [malignancy or reportable diagnosis]
- **Appears to be**[malignancy or reportable diagnosis]
- **Most compatible with** [malignancy or reportable diagnosis]
- **Most certainly**[malignancy or reportable diagnosis]
- **In keeping with**
- **Malignant until proven otherwise**

REF: SEER Program & Staging Manual ver. 2023, page 11

Not Reportable **Phrases - SEER**

- **Highly suspicious for, but not diagnostic of** [malignancy or reportable diagnosis]
- **Most compatible with** [non-reportable diagnosis]such as [reportable diagnosis]
- **High probability for**[malignancy or reportable diagnosis]
- **Differential includes** [reportable diagnosis and non-reportable diagnosis]

REF: SEER Program & Staging Manual ver. 2023, page 12

Reportable Diagnosis

What is a reportable diagnosis?

- ICD-O-3 with behavior code 2 or 3
  - 0 or 1 for primary intracranial & CNS tumors DX 01/01/04 or later
- Occurs in the year, or later, deemed reportable
- May be modified with an acceptable ambiguous term or phrase
- Histology/primary site is not on the exception list

Examples

- "Neoplasm" & "tumor" are reportable **for CNS**
  - Are listed in ICD-O-3 with behavior codes /0 and /1
- "Mass" & "lesion" are **NOT** reportable
  - Are NOT listed in ICD-O-3

ICD-O-3 spreadsheet from NAACCR

https://www.naaccr.org/icdo3/#1582820761130-74100b9f-e677

- Previously known as "The Purple Book"
- Contains information about date reportable and primary site/histology combinations
- Updated yearly, annotated with dates of change
- You can sort and make personal notes on this list

CoC vs OSCaR reportable diagnoses

- Almost identical, a few differences
- For CoC facilities "Case Eligibility" as described in STORE Manual
- For OSCaR, **20XX OSCaR Reportable List** on website
  - If you work in non-CoC facility, this is the only list you need to use
- Or you can use the new NAACCR list *Recommended*

Reporting RADS - CoC

STORE - no RADS, no way

STORE ver. 06/28/23 page 46:

"All Rads are still being discussed amongst standard setters. An update on coding the Date of Diagnosis will be released once decided. Registrars should follow current rules in STORE to assign Date of diagnosis. CoC does not collect rads alone, a positive biopsy must confirm the diagnosis, the Date of Diagnosis is the date of the biopsy"

Discussion on challenge of differing standards
https://cancerbulletin.facs.org/forums/node/144363#post144786

Reporting RADS - SEER

SEER Appendix E1 - some RADS are reportable & can be used for date of diagnosis

- **Prostate**: PI-RADS 4 or 5
- **Liver**: LI-RADS LR-4 or LR-5 (definitively HCC)

Per American College of Radiology, these designations indicate the patient has cancer or almost certainly has cancer

REF: SEER Appendix E1

Tumor markers are not reportable

- Examples:
  - Cologuard
  - UroVysion
  - ThyroSure
  - PSA
- You must have additional confirmation or clinical impression from physician or other documentation
- Don’t use for date of diagnosis

Where to look for reportable DX

Anywhere in the medical record where a reportable DX is made by a recognized medical practitioner (MD or DO)

- Clinical impression must be from a physician. You cannot use an NP or PA
  - **REF: https://cancerbulletin.facs.org/forums/node/130503#post130515**

Date of Diagnosis

Date of diagnosis

The date of diagnosis is the month, day, and year the **reportable neoplasm was first identified**, clinically or microscopically, by a recognized medical practitioner

Source of Standard: SEER/COC

Date of Diagnosis

- In the absence of path, imaging or clinical diagnosis, 1st day of cancer treatment can be used
- Revising date of diagnosis:
  - If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, use that earlier date as date of diagnosis
    - Re-reading a path slide
    - Review of a CT report

Revising the diagnosis

For a single reportable event, you may subsequently revise the primary site and histology, but these events do not change where and when when a reportable diagnosis was first recognized.

Cases

Case 1- date of diagnosis?

07/18/23 voided urine cytology – suspicious for high-grade urothelial carcinoma

07/31/23 CT urogram – large mass right lateral bladder wall susp for primary neoplasm. Enlarged periaortic & bilateral iliac chain LN likely represent metastatic disease.

08/15/23 Urologist impression: CT shows large bladder mass and enlarged lymph nodes indicating metastatic disease.

Case 1- date of diagnosis **answer**

07/18/23 voided urine cytology – suspicious for high-grade urothelial carcinoma

07/31/23 CT urogram – large mass right lateral bladder way susp for primary neoplasm. Enlarged periaortic & bilateral iliac chain LN likely represent metastatic disease – *not reportable language*

08/15/23 Urologist impression: CT shows large bladder mass and enlarged lymph nodes **indicating metastatic disease**.

Physician impression confirms ambiguous term cytology

Case 2 - date of diagnosis?

06/19/23 Hospital A CT chest – 9 cm left perihilar mass w/extension into mediastinum, mediastinal LAD

06/23/23 Physician Office – constellation of findings rather concerning for malignancy, workup recommended

06/27/23 Imaging Facility PET – large LUL lung mass highly suspicious for malignancy

07/06/23 Hospital B – thoracentesis, cytology positive for malignancy

07/20/23 Hospital B – LUL lung BX c/w adenocarcinoma of lung origin

Case 2 - date of diagnosis **answer**

06/27/23 Imaging Facility PET – large LUL lung mass **highly suspicious for malignancy**

First date that reportable terms were used:

acceptable ambiguous terms + ICD-O-3 term with /3 behavior

Case 3 - date of diagnosis?

- 03/01/23 Bone marrow biopsy – plasma cell neoplasm
- 03/20/23 Physician – patient has negative bone survey, hypercalcemia and elevated SPEP. Bone marrow BX shows <10% plasma cells. Overall impression is smoldering myeloma.

Case 3 – date of diagnosis **answer**

- Use 03/20/23
  - Plasma cell neoplasm can indicate several diagnoses, not all are malignant
  - On 03/20/23, physician reviewed all available information, including imaging and labs, and made the diagnosis of plasma cell myeloma which is reportable.

REF: SINQ 20130168

Case 4 – is this case reportable?

- 01/15/23 CT chest 2.1 cm nodule posterior RUL lung. Differential diagnosis includes metastatic disease or inflammatory nodule

Case 4 – is this case reportable **answer**

- 01/15/23 CT chest 2.1 cm nodule posterior RUL lung. Differential diagnosis includes metastatic disease or inflammatory nodule

Not reportable, differential includes a diagnosis that is not cancer

Case 5 – is this case reportable?

- 06/15/23 MRI brain – 1.2 cm mass left frontal brain. Differential includes lymphoma or high-grade tumor such as a glioma.

Case 5 – is this case reportable **answer**

- 06/15/23 MRI brain – 1.2 cm mass left frontal brain. Differential includes lymphoma or high-grade tumor such as a glioma.

Reportable, differential includes 2 diagnoses that are both reportable

Case 6 – date of diagnosis?

05/15/23 Dr. Derm office - shave BX skin right ear helix

05/15/23 path - atypical junctional melanocytic proliferation concerning for early melanoma in situ, extending to peripheral margins

06/01/23 Dr. ENT surgery office – patient referred for skin lesion concerning for melanoma in situ. Impression: melanoma in situ of right outer ear. Plan excision.

06/15/23 Office Dr. ENT exc skin right helix.

06/15/23 path skin right helix – melanoma in situ, all margins negative by 4 mm or less.

Case 6 – date of diagnosis **answer**

06/01/23 Dr. ENT surgery office – patient referred for skin lesion concerning for melanoma in situ. **Impression: melanoma in situ of right outer ear.** Plan excision.

This is first mention of a reportable diagnosis

Case 7 – reportable?

- 06/28/23 Hospital brain MRI - Heterogeneously enhancing, centrally necrotic intra-axial 36 mm mass left temporal lobe. Imaging findings are most highly suggestive of a primary CNS neoplasm, likely high-grade glioma, although a solitary intracranial metastatic lesion cannot be excluded.

Case 7 – reportable **answer**

- 06/28/23 Hospital brain MRI - Heterogeneously enhancing, centrally necrotic intra-axial 36 mm mass left temporal lobe. Imaging findings are most highly suggestive of a primary CNS neoplasm, likely high-grade glioma, although a solitary intracranial metastatic lesion cannot be excluded.

Not reportable. "Mass" is not a reportable term. "Highly suggestive" and "likely" are not acceptable ambiguous terms. "Cannot be excluded" is not a recognized reportable term.

Case 8 – date of diagnosis?

- 02/01/23 MRI brain – right temporal lobe mass suspicious for gangliocytoma **9492/0**
- 02/15/23 resection of right temporal lobe mass
  - Final DX from path: glanglioneuroblastoma **9490/3**

Case 8 – date of diagnosis **answer**

02/01/23 – date of brain MRI. Gangliocytoma is a reportable non-malignant CNS tumor.

As better information is obtained from path, update abstract with that information and retain the original date of diagnosis

REF: SINQ 20200032

Case 9 – date of diagnosis?

- Hospital A: 1/1/23 Prostate needle BX path: 1/12 cores suspicious for adenocarcinoma w/less than 1 mm focus of atypical crushed glands.
- Physician: BX results are negative, no treatment needed
- Hospital B: 07/15/23 prostate needle BX path – prostatic adenocarcinoma

Case 9 – date of diagnosis **answer**

07/15/23 prostate needle BX path – prostatic adenocarcinoma

The initial path was suspicious for adenocarcinoma (ambiguous term DX), and the physician impression was that this did not represent malignancy.

REF: https://cancerbulletin.facs.org/forums/node/131883

Case 10 – date of diagnosis?

- 03/01/23 colonoscopy – mass encountered in ascending colon, BX taken
  - Physician impression: malignant mass in ascending colon, schedule for surgery
- 03/01/23 ascending colon path – suggestive of invasive adenocarcinoma
- 03/15/23 hemicolectomy performed, path – invasive adenocarcinoma

Case 10 – date of diagnosis **answer**

- **03/01/23** colonoscopy – mass encountered in ascending colon, BX taken
  - Physician impression: malignant mass in ascending colon, schedule for surgery

Although path did not confirm a malignancy, the physician impression was that this was cancer and treated it as such. Resection path confirmed.

However, if the resection did not confirm the malignancy, the case wouldn't be reportable.

Case 11 – date of diagnosis?

- 04/01/23 Hospital urology consult – imaging shows right renal mass most suggestive for RCCA. Patient is on pembrolizumab for mets melanoma, this may also be effective TX for possible RCCA. Recommend that he go on surveillance & follow-up w/repeat CT.
- 06/01/23 surgical oncology note – we discussed patient's right sided RCCA, urologist feels this is slow-growing tumor. Return in 6 months to discuss surgery.
- 09/01/23 FNA right kidney – renal cell carcinoma with clear cell features

Case 11 – date of diagnosis **answer**

06/01/23 surgical oncology note – we discussed patient's right sided RCCA, urologist feels this is slow-growing tumor. Return in 6 months to discuss surgery.

Per CAForum, reportable and date of diagnosis should be reviewed separately. 06/01/23 represents the first time reportable language was used.

However, if follow-back to physician indicates that they felt the patient had RCCA and surveillance was the initial treatment, then use that date.

REF:https://cancerbulletin.facs.org/forums/node/139888#post139898

Case 12 - is this case reportable?

- 5/1/23 Hospital urology office cystoscopy. Impression: left bladder wall neoplasm, likely a low-grade tumor.
  - Plan: schedule TURBT w/intravesical gemcitabine in 2-3 months after cardiac clearance

Case 12 - is this case reportable **answer**

Not reportable, no established DX, did not have treatment at this point.
"Neoplasm" and "tumor" can only be used for CNS.

Would need to reach out to physician to determine if they felt this was cancer.

REF: https://cancerbulletin.facs.org/forums/node/138697

Case 13 – is this case reportable?

- 03/15/23 mammogram
  - Body of report – diffuse inflammatory tissue, large right axillary LN consistent with inflammatory carcinoma of right breast
  - Final impression: extremely suspicious right breast with dense parenchyma and LAD in axilla, suggesting an inflammatory carcinoma

Case 13 – is this case reportable **answer**

Reportable

- 03/15/23 mammogram
  - Body of report – diffuse inflammatory tissue, large right axillary LN **consistent with** inflammatory carcinoma of right breast

Final impression: extremely suspicious right breast with dense parenchyma and LAD in axilla, suggesting an inflammatory carcinoma

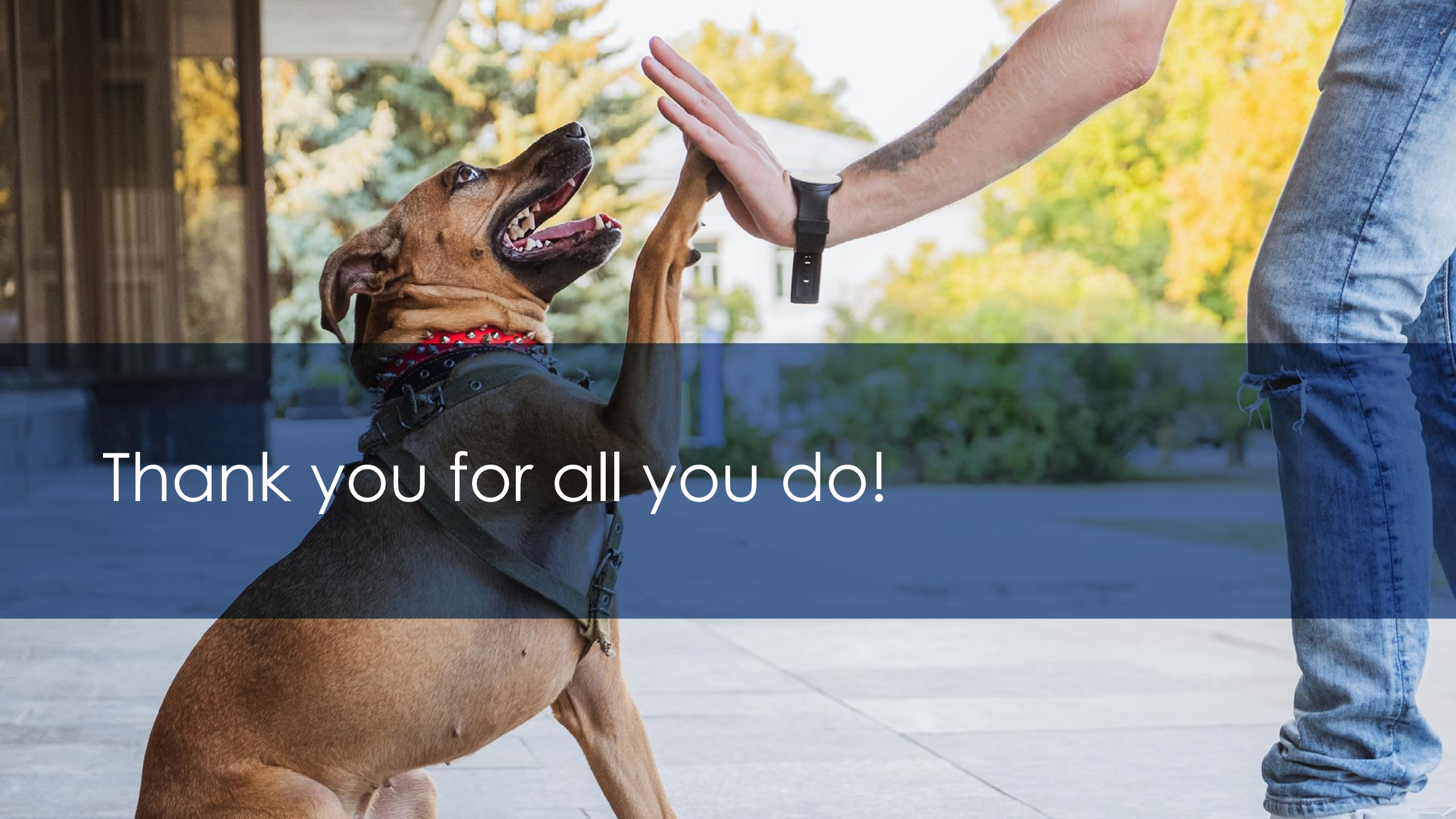
You can use language from the body of the imaging report even if the final impression does not use those terms.

REF: SINQ20071114

References and resources

- SEER Program Coding and Staging Manual 2023
  - SINQ
  - See Also Appendix E: Reportable and Non-reportable examples
- STORE Manual ver 06/28/2023
  - CAnswer Forum
- NAACCR Data Standards and Data Dictionary
- ICD-O-3

Questions?


Thank you for all you do!