Oregon State Cancer Registry Association

Summer Edition – July 2019

Presidents Message

Hello OCRA members,

A lot has been happening in the past few months. The NCRA conference was chock full of information and I'm still trying to process it all. The weather in Denver went from warm to cold and it even snowed. The Education Committee has been continuing their tireless work to deliver another great Fall Workshop. I want to give a shout out to Kelly Denniston, Education Committee Chair, for her exceptional efforts. The Nomination Committee has also worked tirelessly, to ensure OCRA's future. Another shout out to Kelly Bonafede, Nominating Committee Chair, for the hours spent making phone calls and sending emails. The Communications Committee, Veronica Bourbeau, Laura Wallace, and Carol Funk, have been working with great effort to make sure you receive this newsletter and that you can register for the Fall Workshop (don't miss this event) on the website. We have many more people working in the background that are volunteering their time to OCRA. My last shout out goes to each and every person that has dedicated their time and efforts to ensure OCRA's success. No matter how big or small, every effort counts. It makes me feel very proud that I have the privilege to be part of such a great team and organization.

Have I mentioned that you won't want to miss our Fall Workshop being held October 16th – 18th at Providence Willamette Falls Community Center, Oregon City? Don't forget to make your hotel reservations. Great speakers and a variety of topics will be sure to keep your interest. Rumor is…Richard Simmons might be offering a few exercise lessons!

As always, if you have ideas on what OCRA can do to help serve its members. I would love to hear your suggestions. Send me an email or give me call (rlamie@peacehealth.org, 541-222-2480).

Thank you!

Ron Lamie
2019 OCRA President

In this issue:

2019 Officers:
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Laura Wallace, RHIT,CTR
wallacel@ohsu.edu

OSCaR Updates (June 2019) Submitted by: Linda Shan

- OSCaR has received the NAACCR standard of Gold for our 1996-2016 data. This award recognizes population-based cancer registries that have achieved excellence in the areas of completeness of case ascertainment, data quality, and timeliness.

- OSCaR has been working on increasing cancer reporting with our non-hospital facilities and eliminating paper cases that are submitted. In February, we piloted Abstract Plus, a CDC software, with three designated Ambulatory Surgery Centers (ASC's) and Cancer Treatment Centers (CTC's) to increase electronic cancer reporting. In March and June of 2019 we sent out letters to identified ASC's and CTC's in the state of Oregon letting them know about the legal obligations in Cancer reporting and the launch of Abstract plus. Starting July 1, 2019, we will be launching Abstract Plus for ASC's and CTC's to use as an electronic means of reporting their cancer cases.

- OSCaR has updated Webplus and we are currently testing with a facility. We hope to test with this facility for several weeks to make sure we can receive cases and that the edits work. We also anticipate updating out Cancer Database, Rocky Mountain in the last week of June. We will keep everyone posted regarding progress of submitting cases in Webplus through the OSCaR ListServ.

- If you want to be added to the list for the NAACCR webinar series**.** Please send Linda Shan an email with your contact info and your facility. CE are available for these webinars if you take and pass the quiz.

SEER SINQ Q&A Moment

Question: 20190019

Question:
Solid Tumor Rules 2018/Histology--Brain and CNS: How is histology coded for a single meningioma tumor when the histology is a meningioma comprised of multiple specific subtypes/variants? See Discussion.

Answer:
Code the histology for the meningioma, transitional and angiomatous, WHO Grade I to Meningioma, NOS (9530/0). Since a mixed meningioma ICD-O code has not been proposed by WHO, we consulted with our expert neuropathologist.

The other option is to follow back with the pathologist and code what they feel is the predominant type. A new histology rule for coding mixed meningiomas will be added in a future update of CNS rules.

SEER* Educate-Learning Opportunities

Do You Need CEs? Heme 2018 Coding Exercises are now available in SEER*Educate!

These coding exercise focus on using the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual to code cases and provide rationales on the answer. SEER*Educate has made 30 practice cases available from the Training Menu in the Practical Application section. The National Cancer Registrars Association (NCRA) awarded continuing education (CEs) credits for each set of 5 cases. These were approved as Category A CEs.
https://educate.fredhutch.org/LandingPage.aspx

Importance of quality cancer data

by: Kameny Chan

Public health professionals and researchers all have the same goal: to reduce cancer burden and improve treatment. They all rely on cancer registry data for cancer trends and burden monitoring, cancer control and epidemiological research, public health program planning and clinical care improvement. Complete, accurate and reliable cancer data is extremely important. For example, research studies results can be skewed if data is missing or miscoded, incomplete case finding can result in underreporting of cancer incidence, and race/ethnicity misclassification can lead to the inequitable distribution of prevention resources to groups that are disproportionately affected. Hospital cancer registrars play an extremely important role in cancer research.

Breast and applying MPH or Solid Tumor rules

Submitted by: Deborah Towell

I recently pulled breast cases with a dx year 2016 and 2017 and with sequence numbers 01 and greater from our database. The goal was to check on the application of the correct MPH rules both on our end as we consolidate multiple cases on the same patient and from the hospital abstractor side.

I pulled 36 patients with multiple breast primaries who fit the criteria. After reviewing the cases and applying the MPH rules I reduced the number of multiple breast primaries from 36 patients to only 13 patients with multiple breast primaries. So that means there were 23 patients I consolidated into a single primary mostly by using rules M10 or M11, whichever came first.

Example:

Patient A: Diagnosed 06/15/17 with 2 tumors R breast, seq 01 was coded C50.4, 8500/3. Sequence 02 was coded C50.5, 8520/3. **Per rule M-10 this would be abstracted as a single primary with the histology code 8522/3.** So, I consolidated the 2 cases, changed the sequence numbers, histology, primary site changed to C50.9 and choose the largest tumor size.

Site Term and Code
Breast NOS C509 *Note:* Used for: • Non-contiguous **multiple** tumors in **different quadrants/subsites** of same breast

Rule M10 Abstract a **single primary**[i] when **synchronous** multiple tumors are **carcinoma NST/duct and lobular**.
- Both/all tumors may be a mixture of carcinoma NST/duct and lobular 8522 **OR**
- One tumor may be duct and another tumor lobular **OR**

Patient B: Diagnosed 11/30/16 with a tumor of the L breast, seq 01 coded to 8500/3. Seq 02 came in with dx date of 12/15/16, L breast and was coded to 8503/3. **Per rule M-11 this should be abstracted as a single primary.**

Rule M11 Abstract a **single primary**[i] when a **ductal** carcinoma occurs **after a combination code** in the same breast. See the following list:
- **DCIS** following a diagnosis of:
  - DCIS + lobular carcinoma in situ **8522/2 OR**
  - DCIS + in situ Paget **8543/2 OR**
  - DCIS + Invasive Paget **8543/3 OR**
  - DCIS mixed with other in situ **8523/2** (code used for cases diagnosed prior to 1/1/2018)
- **Invasive carcinoma NST/duct** following a diagnosis of:
  - Invasive duct + invasive lobular **8522/3 OR**
  - Invasive duct + invasive Paget **8541/3 OR**
  - Invasive duct + other invasive carcinoma **8523/3**

Please review your breast MPH/Solid tumor rules and definitions!

Coding Tips- Summary Stage 2018

- In situ diagnosis **can only be made microscopically.**
- **Did you know there is a difference between TNM and SEER summary for Colon in situ?**
  - For example, Colon in TNM states in situ includes intramucosal carcinoma (involvement of lamina propria with no extension through muscularis mucosae).
  - The same tumor in SEER Summary is considered localized according to the definition under localized.
- Beginning with Summary Stage 2018 there is no Code 5 for Regional, NOS
- Regional lymph nodes are listed for each chapter/site
  - If a lymph node chain is not listed in code 3, then the following resources can be used to help identify regional lymph nodes
  - Appendix C of the Hematopoietic Manual
  - Anatomy textbook
  - ICD-O-3 manual
  - Medical dictionary (synonym)
- Read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as physical exam and diagnostic imaging reports for mention of regional or distant disease
- Pathologic information takes precedence
- It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement

OCRA & OSCaR 2019 Fall Meeting Save the Date! Save the Date!

October 16 - 18, 2019

Providence Willamette Falls Community Center - Oregon City, Oregon

Featuring Wilson Apollo, CRT - Specializing in Radiation

Early Deadline: August 25, 2019 (entered for drawing for 15 min chair massage at the conference)

DEADLINE: September 15, 2019 – No refunds given after October 1, 2019

13 NCRA CE's including 5 from Category A – pending NCRA approval

There are two hotels that have been reserved for those needing them. A block of 10 rooms have been reserved at each facility; please make your reservations early and **please reference OCRA/Oregon Cancer Registrars Association when making your reservations.**

Monarch (5.7 miles from the facility off of I-205)
www.Monarchhotel.cc
12566 SE 93rd Ave, Clackamas, OR 97015
(503) 652-1515
Cutoff date: 9/24/18 - $109 single/double +tax

Best Western Plus Rivershore (0.6 miles from the facility) www.bestwestern.com
1900 Clackamette Dr, Oregon City, OR 97045
(503) 655-7141
Cutoff date: 9/30/18 - $109 single/double +tax

To register, visit the web at: **http://www.ocra-oregon.org.** Please note to complete the form in its entirety. If you have dietary requests, please email Martha Curl at: **Martha.Curl@providence.org**

While we will not be holding a Fall Workshop due to the Regional Conference in Portland in 2020, it is important that we look into the future for a host of our 2021 Fall Workshop.

Which facility will be willing to host our 2021 Fall Workshop?
Below is a list of Fall Workshop hosts by year for reference. Remember, the Fall Workshop is an important event where OCRA continues to provide educational opportunities to our cancer registry community. It's also a great way for us to get to know one another and network with others in the cancer registry field.

List of Fall Workshop hosts:

2008 Providence – Portland
2009 OHSU – Portland
2010 Kaiser – Portland
2011 Asante – Medford
2012 Legacy – Portland
2013 Salem – Salem
2014 Sky Lakes – Klamath Falls
2015 OHSU – Portland
2016 St Charles – Bend
2017 Asante – Medford
2018 PeaceHealth – Springfield
2019 Providence – Oregon City

Save the Date

2020 West Coast Regional Conference

Save the Date

Embassy Suites Portland Airport

7900 NE 82nd Ave, Portland, OR 97220
503-460-3000

Reservations cannot be made until one year out-so you may start calling August 11, 2019 and watch for a direct link to come out.

Note: This meeting qualifies, as per Standard 1.11 of the American College of Surgeons, for Commendation, CTR staff attending a national or REGIONAL cancer-related educational meeting at least once during the three-year survey cycle."

For more information, contact:

Mayra.llamas@providence.org 818 847-3839 Martha.curl@providence.org 541-466-0957

Oregon Cancer Registrar's Association

Hotel info:

- **Price $ 209.00 single/double**
  - Rate includes: 2 room suites
  - Fully cooked-to-order breakfast
  - Nightly evening reception (beer, wine, cocktails and snacks)
  - Rates guaranteed through July 12, 2020 but don't delay
- Room rate is guaranteed for 3 days before and after conference
- Overnight self-parking $15.00
- Parking for day use only $5.00. Note: if you leave and come back that is an additional $5. Limit one $5 parking per day.
- Complimentary airport shuttle 24 hours to and from hotel.
- Within walking distance to a MAX light rail stop.
- Cascade Station with 800,000 sq ft of retail and restaurant space within walking distance.

Other News/Announcements

Please note: due to the Regional Conference being held in August 2020 **there will not be a 2020 OCRA/OSCaR Fall Workshop**. A business meeting will be held incorporated with officer installation for OCRA members.

Nominate someone for the OCRA DMA this year! Link: **Deadline 7/31/19**
http://www.ocra-oregon.org/resources/distinguished-member-awards/

Michelle Henson Memorial Scholarship Award: **Deadline 8/31/19**
If you have recently taken your CTR exam, are an OCRA member and paid for it yourself, you are eligible to apply for this scholarship. **Link:** http://www.ocra-oregon.org/resources/michele-henson-memorial-scholarship-fund/

*NEW*April Fritz Memorial Scholarship to attend the OCRA FWS **Deadline 8/31/19**

OREGON CANCER REGISTRARS ASSOCIATION
APRIL FRITZ MEMORIAL SCHOLARSHIP AWARD
APPLICATION FORM

Name _____ Credentials _____

Institution _____ Phone _____

Address _____ City, State, Zip _____

I certify that the information provided in this application is correct, and that:

- I am an active member of the Oregon Cancer Registrars Association in good standing.
- I have not received this scholarship before.
- I am working full or part time in a cancer registry.

Signature of Applicant _____ Date _____

OCRA Standing Rule:

A. Criteria for application:
1. Applicant must be an Active member of OCRA in good standing.
2. Applicant may only receive this award once in a lifetime.
3. Applicant must not receive funding from another source.

B. Application and reimbursement process:
1. The April Fritz Memorial Education Award will be granted to one Active Member per year.
2. Applicant must submit an application to the Treasurer prior to the deadline.
3. The Executive Committee will select the recipient at the Executive Committee meeting prior to the Fall Workshop by lot (random drawing).
4. The recipient will be refunded their workshop registration fee upon attending the Fall Workshop.

Return completed application to: OCRA Treasurer

DEADLINE FOR E-MAIL/POSTMARK/FAX: August 31st

12/11/2018

News from the Commission on Cancer Educational Summit 2020: A Glimpse Into the Future

Health care providers committed to providing comprehensive, multidisciplinary, high-quality, patient-centered care are encouraged to join us for a glimpse into the future of the Commission on Cancer (CoC) and National Cancer Data Base (NCDB).

In 2020, the CoC will introduce accreditation standards that have undergone a significant change focusing on the provision of high-quality and measurable care and the NCDB will migrate to a new data platform. **Join us on November 21 for a full day of education focusing on the new CoC Standards. Stay for the half-day NCDB workshop on November 22 to learn more about the NCDB reports and tools, data submission process, and the new platform.**

Why Attend?
Attendees will leave the November 21 session with an understanding of the 2020 CoC accreditation standards along with strategies to ensure successful implementation and maximize performance. At the conclusion of the session, you will be able to:

- Understand the rationale that lead to the changes
- Describe the key changes affecting patient care
- Formulate strategies to address new requirements
- Learn about new resources, templates, and online education to support the new standards

On November 22, attendees will have an opportunity to learn how programs are performing concurrent abstracting and using the NCDB tools to meet data submission and performance standards. In addition, attendees will have the opportunity to view and comment on the new reporting platform, Rapid Cancer Reporting System (RCRS). At the conclusion of the session, you will be able to:

- Identify best practices in the development and implementation of a process to abstract cases concurrently
- Utilize the NCDB Reporting Tools to fulfil data reporting and performance standards.
- Understand the RCRS workflow

Who Should Attend?
The CoC Educational Summit 2020: A Glimpse into the Future is for all members of the multidisciplinary care team at health care facilities that treat patients with cancer, including but not limited to:

- Program leadership (Cancer Program Administrators, Cancer Committee Chairs, Cancer Liaison Physicians)
- Navigators
- Nurses
- Physicians
- Registrars
- Other members of the cancer committee or cancer care team

Centers for Disease Control and Prevention – Cancer Prevention and Control

Expected New Cancer Cases and Deaths in 2020

New Cancer Cases

Between 2010 and 2020, we expect the number of new cancer cases in the United States to go up about 24% in men to more than 1 million cases per year, and by about 21% in women to more than 900,000 cases per year.

The kinds of cancer we expect to increase the most are:

- **Melanoma (the deadliest kind of skin cancer) in white men and women**
- **Prostate, kidney, liver, and bladder cancers in men**
- **Lung, breast, uterine, and thyroid cancers in women**

Over the next decade, we expect cancer incidence rates to stay about the same, but the number of new cancer cases to go up, mostly because of an aging white population and a growing black population. Because cancer patients overall are living longer, the number of cancer survivors is expected to go up from about 11.7 million in 2007 to 18 million by 2020.

Why Some Kinds of Cancer Are Expected to Increase

Cigarette smoking is linked to many kinds of cancer, especially lung cancer. In the United States, smoking has declined since the first Surgeon General's Report on Smoking and Health was published in 1964. Accordingly, new cases of lung cancer have gone down since the mid-1980s in men and the late 1990s in women—faster in men than women. The number of new lung cancer cases in men is expected to stay the same between 2010 and 2020, but more than 10,000 additional new lung cancer cases are expected to be found in women each year by 2020.

Overweight and obesity raise risk for female breast, colorectal, esophageal, uterine, pancreas, and kidney cancers. After increasing over the past several decades, about two-thirds of adults and one-third of children are now overweight or obese. Except for breast and colorectal cancers, the number of weight-related cancers is expected to go up 30% to 40% by 2020.

Cancers caused by infections are also expected to increase. New cases of liver cancer are expected to go up more than 50%, likely the result of the increase in hepatitis infections, particularly in people born between 1945 and 1965. Oral cancers in white men are expected to increase by about 30%, likely the result of more human papillomavirus (HPV) infections.

Cancer Deaths

Between 2007 and 2020, the number of deaths is expected to go up 15.2% in men and 8.1% in women, although the rate of cancer deaths per 100,000 people in the United States is expected to keep going down**. We expect cancer death rates to drop most for:**

- **Prostate cancer (26.4%)**
- **Colorectal cancer (23.4%)**
- **Lung cancer (21.3%)**
- **Female breast cancer (19.6%)**
- **Cancers of the oral cavity and pharynx (16.0%)**
- **Cervical cancer (12.5%)**
- **Melanoma (7.4%)**

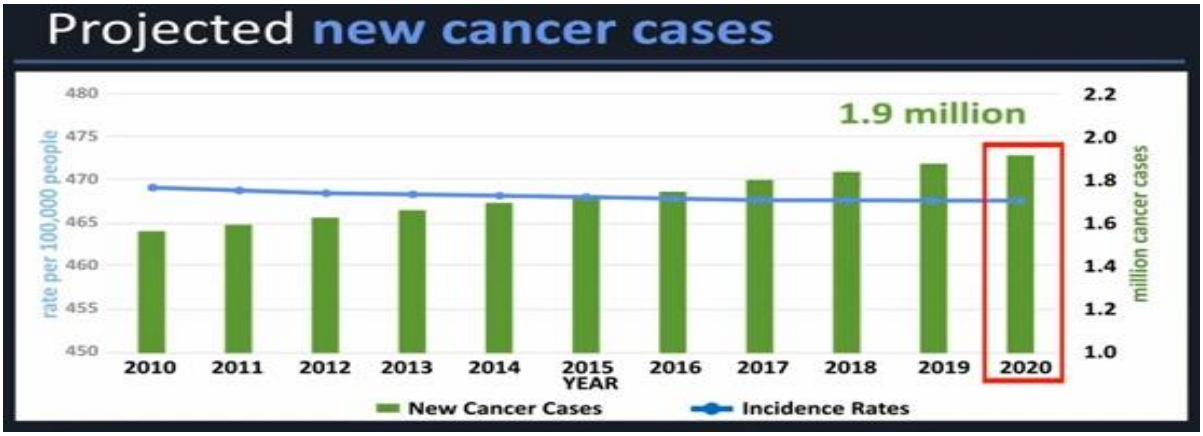
Between 1975 and 2009, the number of cancer deaths went up in both white and black Americans, mostly because of an aging white population and a growing black population. The cancer death rate began to drop in the early 1990s, mostly because of a decline in deaths from lung and prostate cancer in men, breast cancer in women, and colorectal cancer in both sexes.

Why Deaths from Some Kinds of Cancer Are Expected to Drop

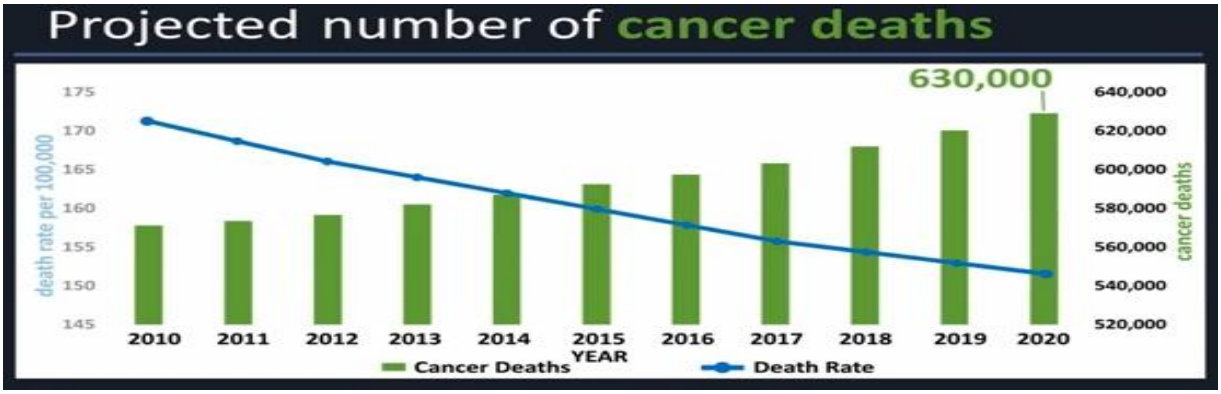
Fewer white women are expected to die from breast, cervical, and colorectal cancer because more white women are getting screened for these cancers, and because of better treatments. More access to high-quality health care has led to increased survival and fewer deaths for colorectal cancer, and to a lesser extent for female breast cancer and prostate cancer.

Citations: Weir HK, Thompson TD, Soman A, Møller B, Leadbetter S, White MC. Meeting the Healthy People 2020 objectives to reduce cancer mortality. *Preventing Chronic Disease* 2015;12:140482.
Weir HK, Thompson TD, Soman A, Møller B, Leadbetter S. The past, present, and future of cancer incidence in the United States: 1975 through 2020.External *Cancer* 2015;121(11):1827–1837.

Projected New Cancer Cases and Deaths, 2010 Through 2020



This graph shows that the number of new cancer cases is expected to increase from about 1.5 million per year in 2010 to 1.9 million per year in 2020, although the rate of people who get cancer is expected to stay about the same.



This graph shows that the number of cancer deaths is expected to increase from about 575,000 per year in 2010 to 630,000 per year in 2020. However, the rate of people who die from cancer is expected to decrease from about 171 per 100,000 people in 2010 to 151 per 100,000 people in 2020.

Page last reviewed: August 16, 2018. Content source: Division of Cancer Prevention and Control, Centers for Disease Control and Prevention

Message from the Newsletter Editor — Laura Wallace

Please **email any updates or educational information for the Fall Edition OCRA Newsletter to: wallacel@ohsu.edu** - I welcome any suggestions you may have to help make our newsletter even more informative.

Embedded is an eBook from himagine Solutions, Brad Justus - VP of Client Development, bjustus@himaginesolutions.com, has allowed me to share regarding **2018 Cancer Registry Changes**

himagine_CR_eBook_2019.pdf

CTR Question and Answer Support

1.

NCDB
CTR Staff

Join Date: Jul 2018
Posts: 1240

05-07-19, 12:44 PM #2

When radiation is not administered, Reason for No Radiation [1430] code 1, 2, 5, 6 or 7. If radiation is administered, code 0. Code 8 if radiation therapy was recommended, but it is unknown whether it was administered. Follow the coding instructions per STORE for all applicable data items.

See example #1 on the CTR Guide to Coding Radiation Therapy Treatment in the STORE.

Until the next version of STORE reflecting the most recent updates is released, registrars are encouraged to use the CTR Guide to Coding Radiation Therapy Treatment in the STORE, which takes precedence over the current version of the STORE (v1.0). This document may also be found in the Resources section of the National Cancer Database web page--https://www.facs.org/quality-programs/cancer/ncdb and in the subfolder Radiation under FORDS/STORE folder in CA Forum.

Updated on 5/7/19

Page 8 of the CTR guide to Coding Radiation Therapy notes to code the following fields when no radiation is given:

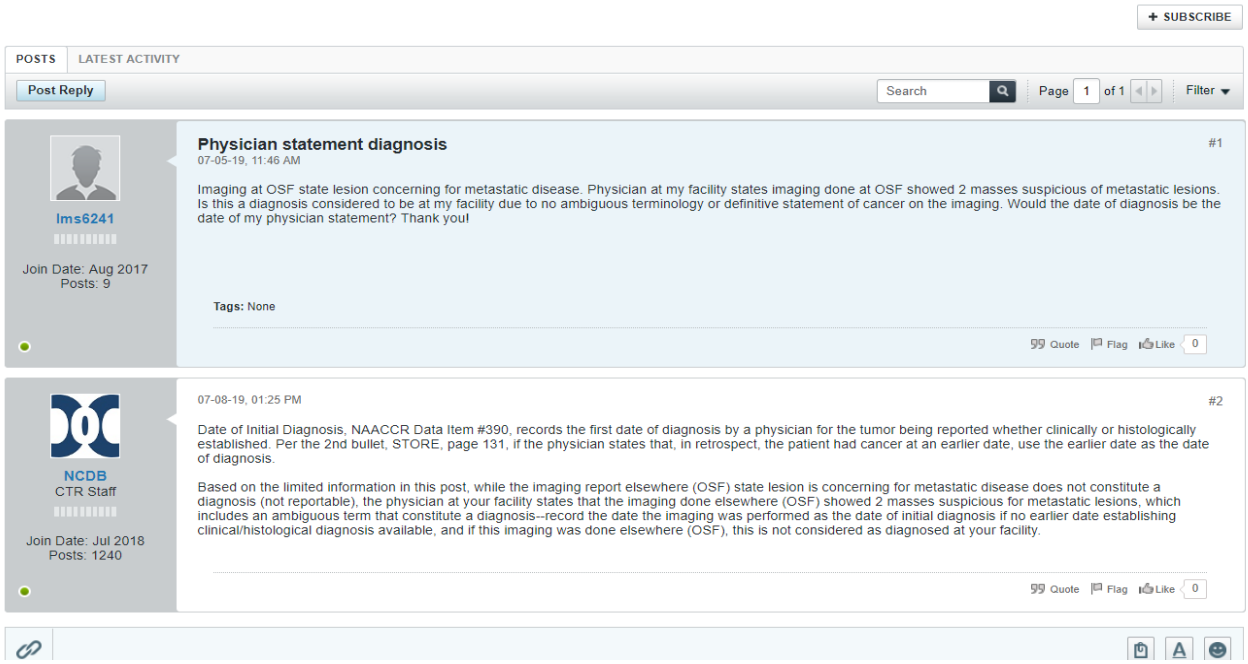
Seg	#	Field	Code/Definition
Summary	1	Rad/Surg Sequence	0 No radiation and/or Sur
	2	Reason No Rad	1 Not part of planned 1st
	3	Location of Rad	0
	4	Date Started/Flag	Blank/11
	5	Date Ended/Flag	Blank/11
	6	Number of Phases	00
	7	Discontinued Early	00
	8	Total Dose	000000
	9	Volume	00 No Radiation Treatment

Coding Logic

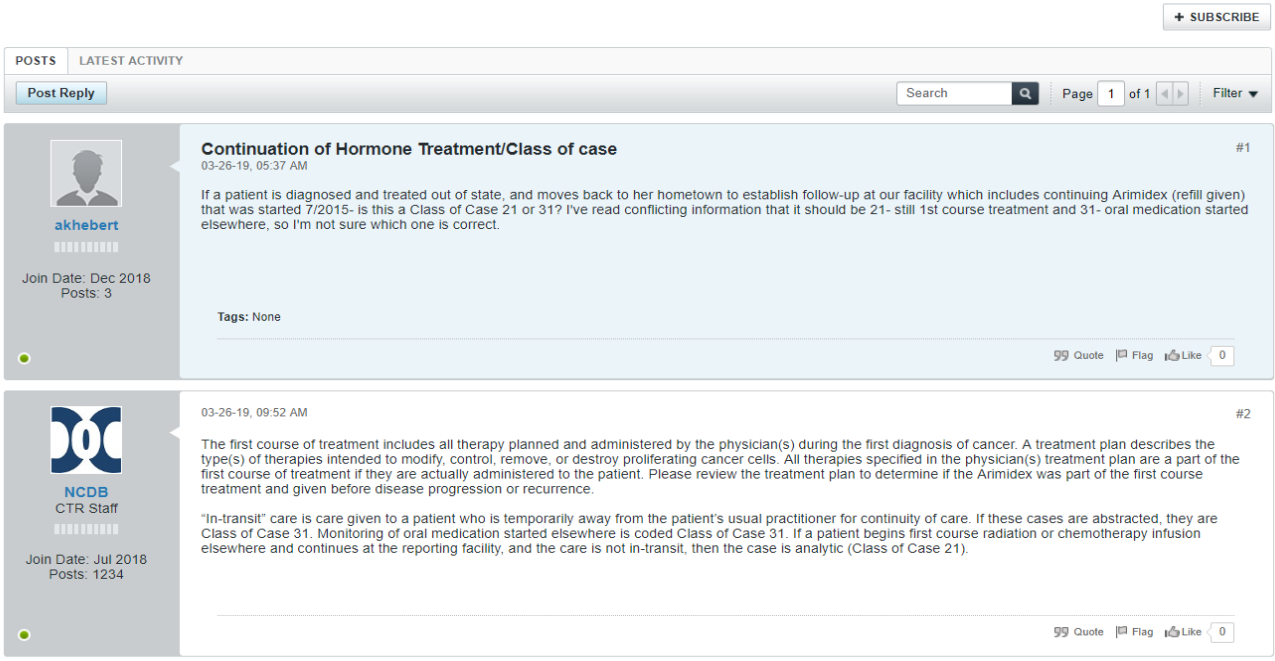
The committee assigned to the task of updating radiation coding has agreed that the following four radiation fields (not counting Rad/surg sequence) should be completed for each analytic case not receiving radiation as part of the first course of therapy. The redundancy here is deliberate.

- #2: Reason for No Radiation Therapy
- #4: Date Radiation Started – Flag: 11 No radiation planned or given. Depending on your registry software this may be entered in a separate field or directly into the date field.
- #6: Number of phases – clearly 0 if no radiation given
- #9: Phase I Volume – A code of 00 simply reinforces the codes above.

2.



3.



4. On the AJCC staging tab of METRIQ (that is the software I use, I assume it would be the same for other software), the Tumor Size is the actual Tumor Size for Melanoma, It is not the depth of invasion that is used to determine cT or pT.

5. The OP report is considered pathologic staging, not clinical.

6. SEER QUESTION Ask SEER CTR #20736

This pt has multiple primaries. SEQ 1 insitu bladder, 8130/2 in 2005; SEQ 2 RCC kidney, 2011; SEQ 3 adenoca of stomach, 2015. In 2018 pt has bx of periaortic mass and it is met poorly diff ca, favoring urothelial origin. The pathologist compared the path to all previous primaries. Per rule M6, I see this as a new primary, coding C689, urinary, nos. Another registrar, states that you change the seq 1 to invasive and it is a recurrence of that? Is this a new primary-SEQ 4 and would site C689 be correct?
Path review: The current periaortic mass is morphologically different from the prior left kidney typical clear cell renal cell carcinoma), and additional immunohistochemical stains demonstrate the renal cell carcinoma is negative for GATA-3 and P40.

Metastatic clear cell renal cell carcinoma is less likely. The current tumor shows morphological similarity as compared with the gastrointestinal adenocarcinoma. However, the current tumor cells are positive for GATA3 (weak) and P40, and negative for villin, which is in contrast to that of the gastrointestinal adenocarcinoma which is negative for GATA3 and P40, and positive for villin. These immunohistochemical results argue against the likelihood of metastatic gastrointestinal adenocarcinoma, and favor urothelial origin, although the patient's prior urothelial carcinoma was noninvasive and low grade.

SEER ANSWER

Patients with urothelial carcinomas in the bladder, both in situ and invasive, are routinely followed for recurrences. These tumors tend to recur over and over unless the bladder is removed. There is missing information as to status of the patient's bladder tumor between 2005 and 2018. There is no doubt that the 2018 tumor is from a bladder primary. Urothelial in situ disease can progress to invasive disease and it is not unusual for invasive components to not be identified and microinvasive disease is often present in15-25% of cases. Without evidence of a new bladder tumor, change the behavior for seq 1 to /3.

The SEER Data Quality Team

7. ADDITIONAL QUESTION

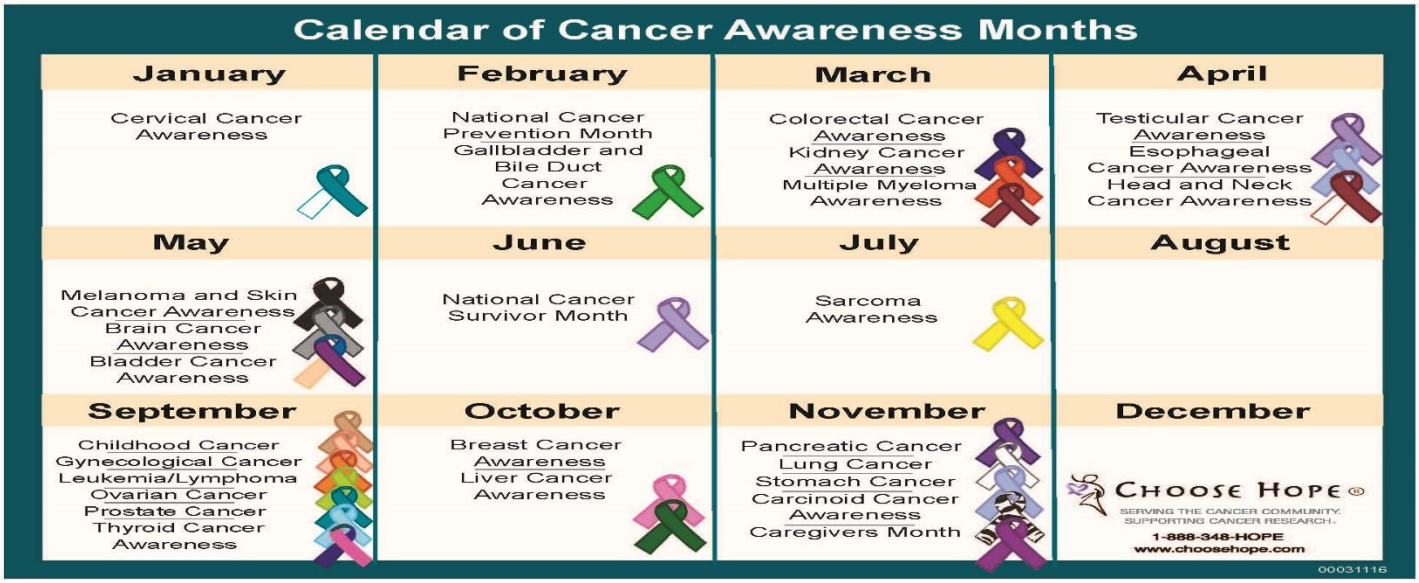
The pt has had 2 recurrences (insitu) dz of his bladder since and has been free of dz. If you are following the rules, wouldn't you use rule M6 for a new primary, invasive dz after insitu? Isn't this skewing data if you go back and change an insitu bladder (that was treated as insitu) from 2005, 13 years earlier, to an invasive code? Even with the pathology review, not confirming it is the same as the bladder primary (besides urothelial origin) you would say it's from the bladder and change to /3?

Is there somewhere in the book to reference this as no one seems to agree to this?
Thanks for further clarification.

SEER ANSWER

Per page 14 in the 2018 SEER Program manual, "Changing Information on the Abstract: #3, example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim." Unless there is evidence of a new bladder tumor, change the behavior of the original in situ to invasive. This has been a long standing instruction.

The SEER Data Quality Team



Cancer Awareness Ribbon Colors

All Cancers Lavender	Leukemia Orange
Apparendix Cancer Amber	Liver Cancer Emerald
Bladder Cancer Marigold/Blue/Purple	Lung Cancer White
Brain Cancer Grey	Lymphoma Lime
Breast Cancer Pink	Melanoma Black
Neuroendocrine Cancer Zebra Stripe	Multiple Myeloma Burgundy
Cervical Cancer Teal/White	Ovarian Cancer Teal
Childhood Cancer Gold	Pancreatic Cancer Purple
Colon Cancer Dark Blue	Prostate Cancer Light Blue
Esophageal Cancer Periwinkle	Sarcoma/Bone Cancer Yellow
Gallbladder/Bile Duct Cancer Kelly Green	Stomach Cancer Periwinkle
Head & Neck Cancer Burgundy/Ivory	Testicular Cancer Orchid
Hodgkins Lymphoma Violet	Thyroid Cancer Teal/Pink/Blue
Kidney Cancer Orange	Uterine Cancer Peach
Leiomyosarcoma Purple	Honors Caregivers Plum

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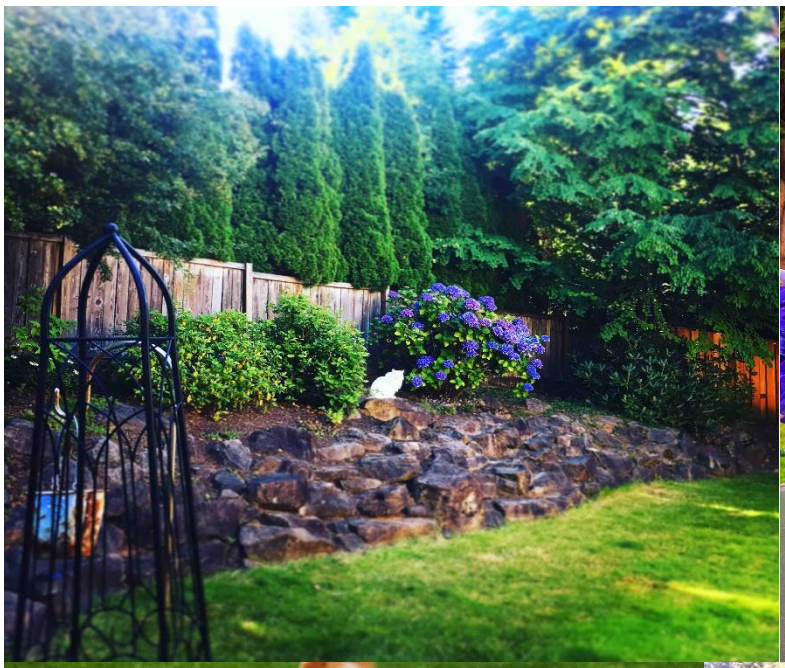
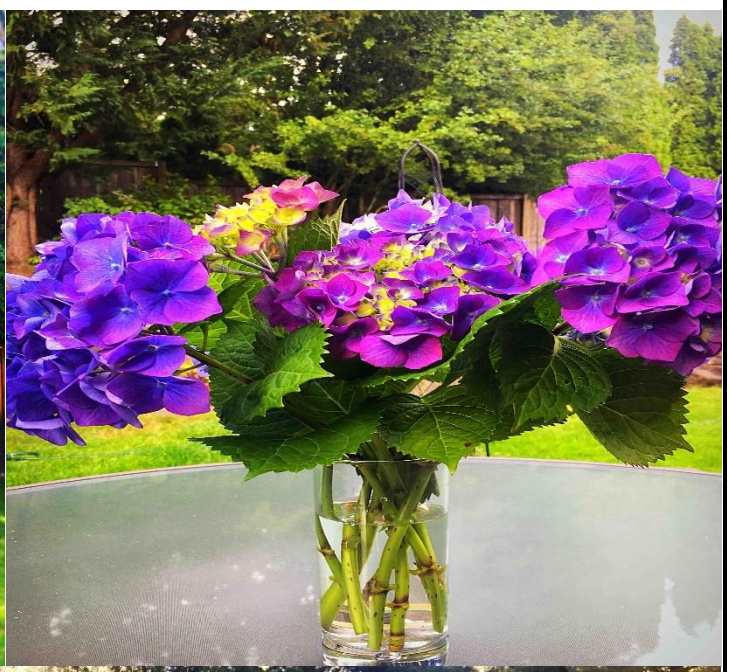
The gift that keeps on giving

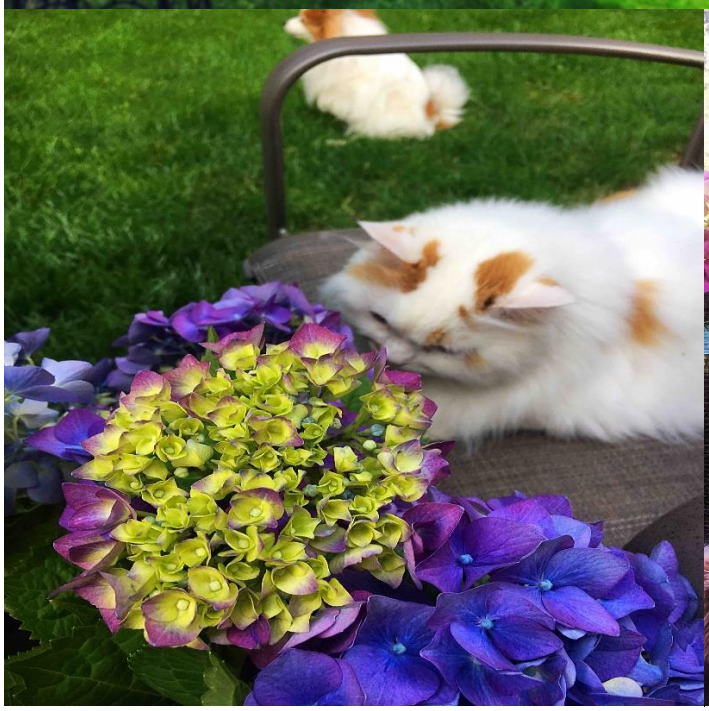
From Martha Curl

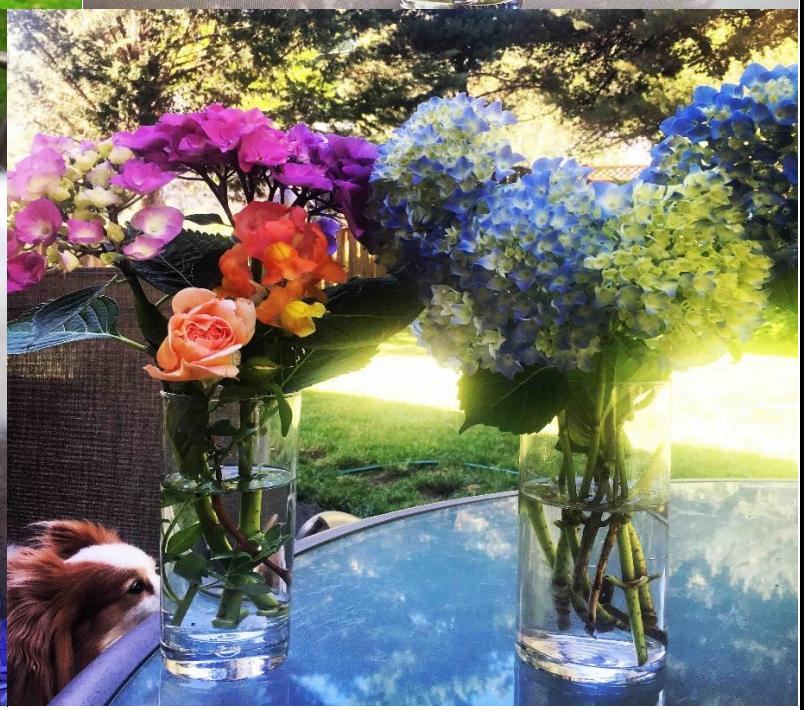
This donation came from my Ruralite Magazine article after my 50th birthday sock drive. A Sherwood Elks Member, Art Pohl, receives this magazine at their second home in a rural community. He took it back to the Elks and they held a sock drive and personal hygiene for two months. I received five boxes of socks (over 400 pairs) and two boxes of tooth brushes, tooth paste, soaps, etc.

I delivered all of the good to Ronald McDonald House on July 25, 2019









Sharing photos from my garden, summer 2019 ~ Laura