

Delaware Cancer Registry (DCR)

Hospital Reporting Procedure Manual



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Delaware Cancer Registry
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Division of Public Health
Delaware Health and Social Services
(302) 995-8605

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SECTION ONE

REGISTRY OPERATIONS

DCR SUBSECTION

WHY REPORT TO THE DELAWARE CANCER REGISTRY?

The Delaware Cancer Registry is a population-based cancer incidence registry responsible for collecting demographic, diagnostic, treatment and follow-up information. The information is collected from hospitals, labs, physicians, and free standing health care facilities. Both Delaware law and Federal law require data collection and submission.

Federal Law 102.3371, Delaware Cancer Control Act & Amendment are found in the appendix to this chapter.

WHO IS RESPONSIBLE TO REPORT?

All Hospitals, Laboratories, Physicians and free-standing Health Care Facilities are required to report all malignant diseases and conditions covered in the reportable list of cases (Reference Tables A and B in the appendix.)

WHAT DISEASES ARE REPORTABLE?

Reportable diseases include 1) those with a disease/condition in the International Classification of Diseases for Oncology (ICD-O-3) with a behavior code of 2 or greater and 2) benign tumors of the brain and central nervous system. These conditions are to be reported when they meet the criteria as defined by the FORDS Manual. Refer to Table A. *What To Report* and Table B. *Reportable Neoplasms (w/ICD-9-CM Diagnosis Code)* in the appendix for specific details.

DEFINITION: REPORTABLE CASE

A patient diagnosed with or treated for a reportable disease/condition in your facility is a reportable case.

Diagnosed at your facility: Whenever a cancer diagnosis is made at your facility, the case is reportable. Patients with a clinical diagnosis of cancer prior to admission that present to your facility for histological or cytological confirmation are to be reported too. Also, patients who are diagnosed in a staff physician's

office and present for staging, workup, treatment or treatment planning are reportable.

Treatment at your facility: Patients previously diagnosed, who present for treatment at your facility are required to be reported. Patients who are admitted for a non-reportable condition, who receive cancer directed treatment, are not required to be reported provided they have already been reported to the DCR. (To determine if a case has previously been reported, call the DCR.)

Example: A patient admitted for cardiac care received Lupron for prostate cancer during his hospitalization. Upon contacting the DCR, the case is found to be in the DCR database already. This case is not reportable.

Elsewhere: **Class of Case “3” patients** (i.e. patients diagnosed and treated elsewhere) who present to your facility for recurrence and/or subsequent treatment **are required to be reported.** To verify whether a case has already been reported simply contact the DCR. If it is determined that the case has not been reported, please follow procedures for reporting a case as detailed under subsections *When and How to Report?* and *Reporting Methods*.

Example: A patient was diagnosed and treated several years prior to presenting at the accessioning facility for treatment of recurrent or progressive disease.

Example: A patient with active cancer is admitted to the accessioning facility for other medical conditions.

Example: A patient for whom the accessioning facility developed a treatment plan or provided “second opinion” services, but the diagnosis and treatment were provided elsewhere.

Reporting Class of Case “3” cases helps to assure the completeness of the DCR database as a population based central cancer registry.

WHEN AND HOW TO REPORT?

WHEN: By law, cases are required to be reported within 180 days from the date of first contact at your facility either as an inpatient or an outpatient for the reportable disease.

HOW:

1. Your facility receives a data exchange package from the DCR. Complete the State Registry Processing Flow Sheet and following the instructions therein (see appendix).
2. Key in all changes from the Data Exchange Forms (DEFs) and Error Reports in the package from DCR. For any DEFs that you disagree with write an explanation of why you disagree and return these with your data exchange to the DCR.
3. Process the Download Diskette. This contains updates for your cases including follow-up information from other hospitals that also share these cases.

STOP! DO NOT continue to step 4 until it is time to process your data exchange.

4. Create a subset added and updated since your last data exchange and then run NAACCR GenEDITS on that subset. Correct all errors, run the error report again, and include a copy of the final summary pages with your data exchange submission. Be sure to keep a copy for your files.
5. Send the “Changes” and “New Cases” diskettes back to the DCR. These cases should be pulled off your system starting with the last date you pulled cases for the previous data exchange. If you are unsure of the date, contact the DCR.
6. Print an index of the cases pulled off the database for the data exchange.
7. Mail the DEFs you have completed since your last data exchange, the diskettes, the index of new cases, the completed processing flow sheet, a copy of the GenEDITS, and copies of all paper abstracts to the Delaware Cancer Registry.

Note: Prior to processing the data exchange, review your suspense cases to be sure that cases have not been entered twice or that they have not been forgotten.

This entire process should be done with each data submission as scheduled for your facility per the Data Exchange Submission Cycle. If you will need more time or are having trouble with processing the data exchange, contact the DCR at (302) 995-8605 for assistance.

REPORTING METHODS

Paper abstracts do *not* need to be submitted as was required in the past.

Electronic Submissions should be submitted via diskette or CD using the current NAACCR format; the NAACCR version used should be noted on the diskette. The GenEDITS program should be run on data prior to submission and all errors should be corrected prior to putting the cases on diskette.

If you cannot submit cases using the NAACCR format, contact the DCR for alternative means of submission.

DATA EXCHANGE FORMS

- A data exchange form (DEF) is used to initiate changes or corrections by both the hospital registries and the DCR. A DEF should be completed when you want to change a previously submitted case or when changing any DCR Required Data Set Item, such as stage, site, etc. A DEF does not need to be completed when changing information in text fields. Exception: a DEF must be completed when changing patient name. A sample DEF is included in the Appendix to this chapter.

Reminders...

- A DEF needs to be completed when changing Accession or Sequence Numbers.
- DEFs should be submitted with your data exchange.

REGISTRY OUTSOURCING

Any hospital wishing to outsource any of or its entire registry must request clearance for the outsourcing company with the DCR. This is to protect the integrity of the state's data as a whole. The individual or company providing outsourcing will be required to comply with all standards and regulations set by the DCR.

REGISTRY REFERENCE DATE

Any hospital wishing to change its reference date must submit a written request to the DCR for approval prior to requesting CoC approval. The request shall include the reasons for the reference date change and verification of approval from the hospital's Cancer Committee.

ABSTRACTING TIMELINESS

Abstracting must be completed within 180 days from the date of the initial contact for the reportable disease. This applies to reportable non-analytic cases as well as analytic cases.

DCR QUALITY CONTROLS

Hospital Site Audits: Site audits will be conducted on a regular basis by the DCR staff. Each hospital will be given ample notice prior to their audit to allow for date changes if there is a conflict. The hospital will be required to provide a Disease Index for its Medical Records Department one (1) month prior to the audit. The hospital will be required to provide charts for review; these will be requested by the DCR prior to the audit. The audit will include the following:

- Disease Index (one month prior to audit)
- Pathology report listing at the time of the audit
- Casefinding methods and sources
- Follow-up methods, sources and rate
- QA or QC measures
- Timeliness of abstracting
- Case re-abstracting (by DCR at time of audit)

Following the site audit, the hospital registrar and department manager/supervisor will be provided with a report detailing results and suggestions.

Data Exchange Quality Evaluation: This metric gives the hospital registry the percentage of errors from its last data exchange. It is a QA measure that assists the hospital registry in tracking error rates in its submissions and can help validate staffing of the hospital registry. A completed evaluation form is sent back with each data exchange. A sample Data Exchange Quality Evaluation form is included in the Appendix to this chapter.

Note: Errors attributed to a merge with your hospital's case and another hospital's case will not be included in the rate.

CONFIDENTIALITY & RELEASE OF INFORMATION

A facility may not release information included in an abstract that is from another facility without that facility's consent.

PROCEDURE MANUAL

A facility's cancer registry procedure manual must include DCR requirements where they apply in addition to the criteria set by the FORDS Manual.

SECTION TWO

GENERAL PRINCIPLES IN CODING

DCR SUBSECTION

HOSPITAL REGISTRY OPERATIONS

Hospital registry operations are determined and defined by the FORDS Manual. The items in Chapter 1 - General Procedures: Registry Operations are the only additions or modifications to Hospital registry operations.

STAGING

The DCR requires AJCC, SEER staging, and Collaborative Staging of all cases when applicable.

DATA ITEM INSTRUCTIONS

The DCR does not impose any additional instructions and guidelines other than those in the FORDS Manual pertaining to those data sets.

DCR REQUIRED DATA SET

Refer to Table C - DCR Required Data Items located in the appendix. It contains a listing of the data items required to be submitted for every reportable case sent to the DCR. Please note that some of these DCR required items are also supplemental (S) for the CoC. If you are not currently collecting any of these items, contact your software vendor to have them included.

ADDITIONAL ITEMS REQUIRED

Text is one of the most important tools we have to get the “big picture” of a case. Text is required to be submitted to the extent that it describes the following.

- Diagnosis
- Site
- Pathology
- Staging
- Treatment
- Recurrence

- Cause of Death

Some of this information will come from the physician notes or actual reports, but recording this text information is essential. In some cases it may be necessary to contact the physician for this information.

APPENDIX

TITLE 16

Health and Safety

Vital Statistics

CHAPTER 32. CANCER CONTROL ACT

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§ 3201. Short title.

This chapter may be cited as the Delaware Cancer Control Act. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3202. Purpose.

The intent of the General Assembly is to require the establishment and maintenance of a cancer registry for the State. This responsibility is delegated to the Department of Health and Social Services, along with the authority to exercise certain powers to implement this requirement. To ensure an accurate and continuing source of data concerning cancer and certain specified tumors of a benign nature, the General Assembly by this chapter requires certain health care practitioners and all hospitals, clinical laboratories and cancer treatment centers within the State to make available to the Department of Health and Social Services information contained in the medical records of patients who have cancer or tumors of a benign nature. It is intended that the product of these efforts will be a central data bank of accurate, precise and current

information regarding the subject diseases. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3203. Definitions.

The following words, terms and phrases, when used in this chapter, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning.

(1) "Benign tumor" means any nonmalignant neoplasm, regardless of the tissue of origin, that appears on the American College of Surgeons most recently published annual list of reportable cancers and benign tumors.

(2) "Cancer" means any malignant neoplasm, regardless of the tissue of origin, that appears on the American College of Surgeons most recently published annual list of reportable cancers and benign tumors.

(3) "Department" means the State of Delaware Department of Health and Social Services. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3204. Cancer registry.

The Department shall adopt, promulgate, amend and repeal any rules and regulations that are consistent with law relative to this chapter and necessary to achieve the purpose and requirements of this chapter. These rules and regulations shall include provisions for:

(1) The establishment and maintenance of an up-to-date registry that shall document every occurrence of cancer and of benign tumor in this State;

(2) The establishment of a procedure for reporting to the Department, within 180 days of initial diagnosis or treatment, every occurrence of cancer and of benign tumor in this State. Such procedure shall include the reporting of specified information that the Department deems necessary and appropriate for the recognition, prevention, control or cure of cancer and benign tumors, and shall minimally include the

reporting requirements of the National Cancer Data Base established by the American College of Surgeons, along with information regarding the patient's length of residency in Delaware, primary residential address in Delaware and the location and nature of the patient's primary past employment. Those required to report to the Department occurrences of cancer and benign tumors shall include:

a. Any physician, surgeon, dentist, podiatrist or other health care practitioner who diagnoses or provides treatment for cancer or benign tumors;

b. The designated representative of any hospital, dispensary, asylum or other similar public or private institution that diagnoses or provides treatment for cancer or benign tumors; and

c. The designated representative of any laboratory that examines tissue specimens which disclose the existence of cancer or benign tumor;

(3) The establishment of a procedure for the publication and distribution of forms, instructions and notices required by this chapter or necessary to accomplish the purpose of this chapter; and

(4) The establishment of a procedure to obtain follow-up information from those required to report occurrences of cancer and benign tumors pursuant to this chapter. Any follow-up information deemed necessary by the Department shall be submitted to the Department at least 1 time each year by those required to report occurrences of cancer and benign tumors.

This chapter and any rules or regulations issued pursuant to this chapter shall not apply to any person or private institution that, as an exercise of religious freedom, treats the sick or suffering by spiritual means through prayer alone. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1; 73 Del. Laws, c. 431, §§ 1, 2.)

§ 3205. Confidentiality of reports.

(a) Any report of an occurrence of cancer or benign tumor made pursuant to this chapter shall not be divulged nor made public in any way that might tend to disclose the identity of the person to whom it relates. However, patient-identifying information may be exchanged among cancer control agencies as authorized by the Department and upon receipt by the Department of satisfactory assurances by those agencies of the preservation of the confidentiality of such information.

(b) No individual or organization providing information to the Department in accordance with this chapter shall be deemed to be, or held liable for, divulging confidential information. (62 Del. Laws, c. 334, § 1; 63 Del. Laws, c. 288, § 1; 70 Del. Laws, c. 149, § 148; 70 Del. Laws, c. 391, § 1.)

§ 3206. Compulsion prohibited.

Nothing in this chapter shall be construed to compel any individual to submit to any medical or public health examination, treatment or supervision. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3207. Violations.

Any person or entity who violates any provision of this chapter shall be fined \$100 for each violation. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1; 73 Del. Laws, c. 431, § 3.)

§ 3208. Audit and Abstraction of records by department.

(a) Upon request of a person or organization required to report by § 3204 of this title, the Department may audit records and abstract information that is required to be reported.

(b) Any person or organization failing to report as required by this chapter shall permit the Department to audit records and abstract information that is required to be reported.

(c) The Department may charge a fee to be established by regulation to persons and organizations subjected to an audit pursuant to subsection (a) or (b) of this section. Said person or organization shall reimburse the Department. (73 Del. Laws, c. 431, § 3.)

§ 3209. [Reserved.]

NOTICE: The Delaware Code appearing on this site was prepared by the Division of Research of Legislative Council of the General Assembly with the assistance of the Government Information Center, under the supervision of the Delaware Code Revisors and the editorial staff of LexisNexis, includes all acts up to and including 75 Del. Laws, c. 441, effective September 7, 2006.

DISCLAIMER: Please Note: With respect to the Delaware Code documents available from this site or server, neither the State of Delaware nor any of its employees, makes any warranty, express or implied, including the warranties of merchantability and fitness for a particular purpose, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of any information, apparatus, product, or process disclosed, or represents that its use would not infringe privately-owned rights. This information is provided for informational purposes only. Please seek legal counsel for help on interpretation of individual statutes.

STATE REGISTRY PROCESSING FLOW SHEET

Check off as you complete each item.

	DATE COMPLETED
Receive package from state office (diskettes, NAACCR & Rocky Mountain error reports from previous data exchange, and this form).	
Key in all changes on state DEF forms and resolve error reports sent by the State Office.	
Load download diskette and process.	
Resolve all update errors on error reports generated from download diskette.	

WHEN IT IS TIME FOR YOU TO SUBMIT YOUR DATA EXCHANGE TO THE STATE, AND AFTER THE ABOVE HAS BEEN COMPLETED, CONTINUE TO THE NEXT STEP.

Create a subset of cases added and updated since your last data exchange and then run the NAACCR (CDC) edits error report on that subset (option M on the Report Program Menu, then option N). Correct all errors, run report again, and include a copy of the final summary pages with your next data exchange submission (be sure you keep a copy for your files.)	
Create "change" and "new cases" diskettes for the stat Registry (each option may require more than one diskette). You will be prompted by the computer for the exact date that you last sent data to the state. If you do not know the date, contact the state office now!	
Gather together all the DEFs you have completed since your last submission and mail the forms, the diskettes, an index of all new cases submitted, paper abstracts, a copy of the GenEDITS summary, and this sheet to the Delaware Cancer Registry.	
Resolve all update errors on error reports generated from download diskette.	

√ **BE SURE THAT YOUR SUBMISSION TO THE STATE REGISTRY INCLUDES:**

- { } DEFs
- { } DISKETTES
- { } INDEX OF NEW CASES
- { } ABSTRACTS NEW CASES*
- { } A COPY OF FINAL GENEDITS SUMMARY PAGES
- { } THIS COMPLETED FORM

CTR# _____ HOSPITAL# _____ REASON FOR DEF: _____ ACCESSION#: _____ DATE: _____

**DELAWARE HEALTH AND SOCIAL SERVICES
QA DATA EXCHANGE FORM (DEF)**

PATIENT NAME: _____

DATA ITEM	CHANGE TO	REASON
Patient Name		
Class of Case		
Dx Date		
Site		
Histology		
Grade		
Date of First CRS TX		(Include where Tx was administered.)
Additional TX		(Include where Tx was administered.)
Comments		

DELAWARE STATE CANCER REGISTRY

DATA EXCHANGE QUALITY EVALUATION

HOSPITAL _____

DATE_____

No. of cases submitted _____ **% of QA done** ___100_

No. of new cases _____ (excluding merges with other hospitals)

No. of cases with errors _____

COMMENTS:

IF YOU HAVE ANY QUESTIONS OF COMMENTS REGARDING THIS EVALUATION, FEEL FREE TO CONTACT THE DCR AT (302) 995-8605.

DATA EXCHANGE SUBMISSION CYCLE

Data Exchanges from	are due week	of
Christiana Care (410)	1	every month
Milford Memorial (480)	2	odd months
Kent General (485)	2	odd months
St. Francis (470)	3	odd months
AI DuPont Institute (451)	3	even months
Nanticoke Memorial (490)	4	odd months
Beebe Medical Center (460)	4	even months
VA Hospital (450)	1	each quarter (Jan, Apr, Jul, Oct)

Odd months: JAN, MAR, MAY, JUL, SEP, NOV

Even months: FEB, APR, JUN, AUG, OCT, DEC

Please direct questions to
DELAWARE CANCER REGISTRY
2055 Limestone Road, Suite 213
Wilmington, DE 19808
(302) 995-8605
(302) 995-8250

Table A. WHAT TO REPORT¹

	Cancer Site/Type Terms	ICD-O 3 rd Edition Codes
NEOPLASMS THAT ARE REPORTABLE TO THE DELAWARE CANCER REGISTRY	Malignancies (<i>see exclusions in non-reportable section below</i>) Malignant neoplasms Cancers	Behavior Code “3”
	“Carcinoma In Situ” (<i>see exclusions in non-reportable section below</i>) “Stage 0” “Noninvasive” “Intraepithelial” “Noninfiltrating” Includes: Vaginal Intraepithelial Neoplasia, grade III (VAIN III) Vulvar Intraepithelial Neoplasia, grade III (VIN III) Anal Intraepithelial Neoplasia, grade III (AIN III)	Behavior Code “2” Site Code; Morphology Code C52.__; M-8077/2 C51.__; M-8077/2 C21.1 ; M-8077/2
	<i>Non-malignant (benign or borderline) primary brain and central nervous system tumors,*</i> in any of the following sites: Brain..... Meninges..... Spinal cord, cranial nerves, and other parts of the central nervous system..... Pituitary gland..... Craniopharyngeal duct..... Pineal gland.....	Behavior Codes: “0” (Benign) <i>or</i> “1” (Borderline) Site Codes: C71.0 - 71.9 C70.0 - 70.0 C72.0 - 72.9 C75.1 C75.2 C75.3
NON- REPORTABLE NEOPLASMS	The following skin cancers are NOT reportable:** Basal cell carcinomas of the skin Epithelial carcinomas of the skin Papillary carcinomas of the skin Squamous cell carcinomas of the skin	Site code C44.__ with histology codes 8000-8110
	The following in situ neoplasms are NOT reportable: Carcinoma in situ of the cervix (CIS)..... Cervical Intraepithelial Neoplasia grade III (CIN III)..... Cervical Intraepithelial Neoplasia with severe dysplasia (CIN III). Prostatic Intraepithelial Neoplasia grade III (PIN III).....	Site Code; Morphology Code C53.__; M-8077/2 C53.__; M-8077/2 C53.__; M-8077/2 C61.9; M-8148/2

* including juvenile astrocytoma, pilocytic astrocytoma and piloid astrocytoma

** Note: Skin cancers in the genital sites (vagina, clitoris, labium, vulva, prepuce, penis and scrotum) **are reportable**.

¹ References: International Classification of Diseases for Oncology, 3rd Edition; NAACCR Standards for Cancer Registries, Vol II; 2004 Facility Oncology Registry Data Standards (FORDS) Manual.

Table B. ICD-9-CM Casefinding List for Reportable Tumors *(Effective 10/1/2006)*

Currently reportable cases with diagnosis date 2004 or later include **all invasive and in situ malignant neoplasms** and **specified benign neoplasms of the brain and CNS**, as listed below.

ICD-9-CM	Terminology
140.0 – 208.9	Malignant neoplasms*
225.0	Benign neoplasm of brain, NOS
225.1	Benign neoplasm of cranial nerves
225.2	Benign neoplasm of cerebral meninges; cerebral meningioma
225.3	Benign neoplasm of spinal cord, cauda equine
225.4	Benign neoplasm of spinal meninges, spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
230.0-234.9	Carcinoma in situ*
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord
237.6	Neoplasm of uncertain behavior of meninges, NOS; cerebral, spinal
237.70	Neurofibromatosis, Unspecified von Recklinghausen's Disease
237.71	Neurofibromatosis, Type One von Recklinhausen's Disease
237.72	Neurofibromatosis, Type Two von Recklinhausen's Disease
237.9	Neoplasm of uncertain behavior of other/unspecified parts of nervous system; cranial nerves
238.4	Polycythemia vera
238.6	Solitary plasmacytoma, extramedullary plasmacytoma
238.71**	Essential thrombocythemia
238.72**	Low grade myelodysplastic syndrome lesions
238.73**	High grade myelodysplastic syndrome lesions
238.74**	Myelodysplastic syndrome with 5q deletion
238.75**	Myelodysplastic syndrome, unspecified
238.76**	Myelofibrosis with myeloid metaplasia
238.79**	Other lymphatic and hematopoietic tissues
273.2	Gamma heavy chain disease; Franklin disease
273.3	Waldenstrom's macroglobulinemia
288.3	Hypereosinophilic Syndrome
289.83**	Myelofibrosis
795.06**	Papanicolaou smear of cervix with cytologic evidence of malignancy (without histologic confirmation) (positive Pap smear)

PLEASE CONTACT THE DELAWARE CANCER REGISTRY AT (302) 995-8605 IF YOU HAVE QUESTIONS

Note: Reportable diagnoses include juvenile astrocytoma, pilocytic astrocytoma and piloid astrocytoma.

* *Exclusions:* Basal and squamous cell carcinoma of skin, except of genitalia are not reportable. In situ carcinoma of the cervix uteri and PIN III are not reportable.

** New code effective 10/1/2006

Table C

DCR Required Data Items <i>(Effective January 1, 2007)</i>	COC Status
Patient Identification	
Institution ID number (FIN)	R
Reporting facility	R
Accession Number	R
Sequence Number	R
Medical Record Number	R
Patient Last Name	R
First Name	R
Middle Name	R
Maiden Name	S
Alias	S
Social Security Number	R
Address at Dx (number and street)	R
City/Town at Dx	R
State at Dx	R
Postal Code at Dx	R
County at Dx	R
Telephone	R
Place of Birth	R
Date of Birth	R
Age at Dx	R
Marital Status at Dx	S
Race	R
Spanish/Hispanic origin	R
Sex	R
Text-usual occupation	S
Text-usual industry	S
Abstracted by	R
Follow-up physician	R
Managing Physician	S
Primary Surgeon	R
Primary Payer at Dx	R
Cancer Identification	
Date of Dx	R
Primary Site	R
Laterality	R
Histologic Type ICD-0-3	R
Behavior Code ICD-0-3	R
Grade	R
Diagnostic Confirmation	R
Date of First Contact	R
Class of Case	R
Type of Reporting Source	S
Text – Dx Procedure (x-ray, scopes, lab tests, Op, path)	S

R = Required for COC
S = Supplemental for COC

Table C

DCR Required Data Items <i>(Effective January 1, 2007)</i>	COC Status
Staging	
CS Tumor Size	R
CS Extension	R
CS Lymph Nodes	R
CS Reg Node Eval	R
CS Mets at Dx	R
CS Mets Eval	R
CS Site-specific Factor 1	R
CS Site-specific Factor 2	R
CS Site-specific Factor 3	R
CS Site-specific Factor 4	R
CS Site-specific Factor 5	R
CS Site-specific Factor 6	R
CS Version first	R
CS Version latest	R
Text – Staging	S
First Course of Treatment	
Date of First Course Treatment	R
RX Hosp – Surg Prim Site	R
RX Hosp – Scope Reg LN Sur	R
RX Hosp – Reg LN Removed	R
RX Hosp – Surg Oth Reg/Dis	R
RX Hosp – Radiation	R
RX Hosp – Chemo	R
RX Hosp – Hormone	R
RX Hosp – BRM	R
RX Hosp – Other	R
RX Hosp – DX/Stg Proc	R
RX Date – Surg	R
RX Date - Radiation	R
RX Date – Chemo	R
RX Date – Hormone	R
RX Date – BRM	R
RX Date – Other	R
RX Date – Dx/Stg Proc	R
RX Summ – Surg Prim Site	R
RX Summ – Scope Reg LN Surg	R
RX Summ – Surg/Rad Sequence	R
Reason for No Surgery	R
RX Summ – Surg Oth Reg/Dis	R
RX Summ – DX/Stg Proc	R
RX Summ – Rad	S
RX Summ – Chemo	R
RX Summ – Hormone	R
RX Summ – BRM	R
RX Summ – Other	R

R=Required for COC
S=Supplemental for COC

Table C

DCR Required Data Items <i>(Effective January 1, 2007)</i>	COC Status
Reason for no radiation	R
Rad-Regional RX Modality	R
RX Summ—Systemic/Sur Seq	R
RX Summ – Transplnt/Endocr	R
RX Text	S
Follow-up	
Recurrence Date – first	R
Recurrence Type- First	R
Place of Death <i>(provide both code and text)</i>	S
Date of last contact or death	R
Vital Status	R
Cancer Status	R
Follow-up Source	R
Addr Current – Number and Street	R
Addr Current – City	R
Addr Current – State	R
Addr Current – Postal Code	R
Override Flags	R

R=Required for COC
S =Supplemental for COC