VERMONT

DEPARTMENT OF HEALTH

Vermont Cancer Registry

Vermont Cancer Registry Hospital Procedure Manual 2016

Vermont Department of Health

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Table of Contents

REPORTABLE NEOPLASMS

Effective Date

For all cases diagnosed on or after January 1, 2016, the instructions and codes in this manual take precedence over all previous instructions and codes.

Documentation and codes for historical data items can be found in earlier versions of the VCR Hospital Procedure Manual.

Who Reports

All health care facilities and health care providers diagnosing or treating cancer in the State of Vermont are required by the Cancer Registry Law (Appendix A), Title 18, Chapter 4 of the Vermont Statutes Annotated (VSA), to report cancer cases to the Vermont Cancer Registry.

When to Report

According to the VCR Law, cases must be reported to the VCR within 180 days after the date of first contact with the patient.

In practice, at least **90 percent of records must be reported within 180 days** after the date of first contact.

How to Report

See Chapter 7, Transmission of Case Information, for policies and procedures relating submitting data to the VCR.

Supplemental Data Collection Standards

Table 1-1. References Needed to Supplement VCR HPM 2016

Title	Purpose
FORDS: Revised for 2016 https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual	Contains definitions and coding instructions for most data items required by VCR. Explains how to determine case eligibility and interpret ambiguous terminology.
International Classification of Diseases for Oncology, 3rd ed. (ICD-O-3) http://codes.iarc.fr/	Used to assign primary site, histology, behavior and grade.
SEER Program Coding and Staging Manual 2016 http://seer.cancer.gov/tools/codingmanuals/	Use this reference specifically to code Grade and also as a back up to other references. **Updated 7/25/2016**
SEER Summary Staging Manual 2000 http://seer.cancer.gov/tools/ssm/	Used for directly coded SEER Summary Stage 2000. **Updated 12/2012.**
AJCC Cancer Staging Manual (7th ed.) http://www.cancerstaging.org/	Defines cancer stage based on tumor extension, lymph node involvement and metastasis. There is no online version of this manual, you must use the hard copy.
Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual (embedded in the Hematopoietic Database) http://seer.cancer.gov/tools/heme/index.html	Contains reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms. Download Hematopoietic Database Software Version 3.1.0 **Updated January 14, 2015**.
Multiple Primary and Histology Coding Rules http://seer.cancer.gov/tools/mphrules/	Site-specific multiple primary and histology coding rules. **Revised August 24, 2012**.
SEER*Rx – Interactive Drug Database version 3.2.0 http://seer.cancer.gov/seertools/seerrx/	A one-step lookup for coding oncology drug and regimen treatment categories. **Software updated May 26, 2016**. **Data revised September 30, 2014.**
VCR Required SSF Table	An Excel spreadsheet lists all the CS SSFs that are required by VCR.

Reference Date

All reportable cancers diagnosed or treated in the State of Vermont as of **November 1, 1993** must be reported to the VCR.

Vermont and Non-Vermont Residents

All cases of cancer diagnosed and/or receiving the first course of treatment in Vermont health care facilities and practitioners are reportable to the VCR, *regardless* of a patient's state of residence.

U.S. and Non-U.S. Residents

Only residents of the United States, its commonwealths, and territories are reportable to the VCR.

Reportable Diagnoses

Any questions on reportability may be directed to the VCR office at (802) 865-7749.

1. Behavior code of 2 or 3 in ICD-O-3.

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 Table 1-2.

Exceptions:

The following are **not** reportable to the VCR:

i. **Skin primary (C440-C449)** with any of the following histologies:
   Malignant neoplasm (8000-8005)
   Epithelial carcinoma (8010-8046)
   Papillary and squamous cell carcinoma (8050-8084)
   Basal cell carcinoma (8090-8110).

ii. **Carcinoma in situ of cervix** (/2) or cervical intraepithial neoplasia (CIN III) of the cervix (C530-C539).

iii. **Prostatic** intraepithelial neoplasia (**PIN III**) of the prostate (C619).

Table 1-2. Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

Code	Site	Code	Site
C70.0	Cerebral Meninges	C72.0	Spinal cord
C70.1	Spinal Meninges	C72.1	Cauda equine
C70.9	Meninges, NOS	C72.2	Olfactory nerve
C71.0	Cerebrum	C72.3	Optic nerve

C71.1	Frontal lobe	C72.4	Acoustic nerve
C71.2	Temporal lobe	C72.5	Cranial nerve, NOS
C71.3	Parietal lobe	C72.8	Other parts of the CNS
C71.4	Occipital lobe	C72.9	Other parts of the CNS
C71.5	Ventricle	C75.1	Pituitary gland
C71.6	Cerebellum	C75.2	Craniopharyngeal duct
C71.7	Brain stem	C75.3	Pineal gland
C71.8	Overlapping lesions of the brain		
C71.9	Brain, NOS		

Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable.**

Ambiguous Terminology

Ambiguous terms that constitute a diagnosis. These terms are to be used to determine reportability.

Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favors	Typical of
Malignant appearing	

Neoplasm* (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)
Tumor* (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)

Exception: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Ambiguous terms that **DO NOT** constitute a diagnosis without additional information.

Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Reportability & Class of Case

Cancers diagnosed and/or treated at the reporting facility **must** be reported to the VCR. Refer to Table 1-3 for a description of the required classes of case. Other classes of case **may** be reported to the VCR.

Table 1-3. Classes of Case* Required to Be Reported

Class of Case	Description
00	Initial diagnosis at the reporting facility AND all treatment (or a decision not to treat) was done elsewhere.
10, 11, 12, 13, 14	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course of treatment (or a decision not to treat) was at the reporting facility.
20, 21, 22	Initial diagnosis elsewhere AND all or part of first course of treatment was done at the reporting facility.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
40, 41, 42**	Diagnosis at a staff physician's office AND all of first course of treatment was at a staff physician's office or other facility.
43***	Pathology or other lab specimens only.

* Refer to the 2016 FORDS Manual, pages 113-115 of the print version (pages 130-132 of the PDF), for instructions on determining the class of case.
** Responsibility for reporting of staff physician-only cases varies by facility. It is the registrar's responsibility to make sure a determination is made for which entity (the facility or the staff physician's office) will assume the responsibility for reporting to the VCR.
*** Pathology-only (formerly "consult") cases may be reported in any format. Electronic reporting is preferred.

REGISTRY OPERATIONS

Each reporting facility is responsible for establishing a cancer registry or a third-party contract to meet its legal obligation for cancer reporting.

Registry operations include casefinding, abstracting, coding, staging, and quality assurance. Each hospital cancer registry (or contractor) must follow nationally-recognized standards for all of these cancer reporting activities.

Table 2-1 contains some helpful resources for cancer registrar education and training.

Table 2-1. Education and Training Resources

SEER Training Website http://www.training.seer.cancer.gov.
A. Fritz and Associates http://afritz.org/index.html.
ICD-9-CM and ICD-10 Casefinding Codes http://seer.cancer.gov/tools/casefinding/
National Cancer Registrars Association (NCRA) http://www.ncra-usa.org
AJCC Curriculum for Registrars https://cancerstaging.org

Recommended Qualifications for Cancer Registrars

Required

- Experience with medical terminology, anatomy & physiology.
- Ability to work independently.
- Knowledge of MS Office.
- Ability to navigate in a Windows environment.
- Attention to detail & documentation.
- Ability to seek guidance/clarification when necessary.
- Ability to follow step-by-step procedures.
- Ability to communicate effectively orally and in writing.
- Ability to establish and maintain effective working relationships.

Preferred

- Bachelor's degree.
- Ability to aggregate data for analysis and presentation.
- Ability to perform statistical analysis.
- Certified Tumor Registrar® credentials.

New Registrar Procedure

1. When a reporting institution designates a new cancer registrar, the VCR **must** be contacted immediately. VCR can provide some state-specific training to supplement formal training. To report a staffing change, or to inquire about training, contact VCR at (802) 865-7749.

2. All new abstractors operating in the state of Vermont must submit a file containing at least five cases for visual review. This applies to any new abstractor in the state of Vermont, regardless of experience or certification.

3. The Quality and Education Coordinator will visually review the cases and provide feedback to the new registrar. Particular attention will be given to the standard reporting guidelines set forth in the *VCR HPM* for coding, documentation, and data item definitions.

4. If requested by the Quality and Education Coordinator, the new registrar must provide additional information and make the necessary corrections to the previously reported cases. The cases will be resubmitted, re-reviewed and must pass quality assurance standards before any more reporting will be accepted from the new registrar.

5. Once this process is complete, the new registrar may submit additional cases, which will follow the typical visual review and feedback procedure.

Consultant Procedure

1. Any time a reporting institution plans to hire a cancer registrar consultant, the facility is **required** to provide the consultant's contact information to the VCR **before** any abstracting may be done by the consultant. The VCR will contact the consultant and provide him or her with a copy of the *VCR HPM*. Contact VCR at (802) 865-7749.

2. The reporting institution assumes full responsibility for the completeness and accuracy of the data reported by the consultant.

3. All state requirements are to be met. Failure to meet these expectations will result in rejection of the data.

4. Any time a consultant is newly hired in the state of Vermont, he or she must follow the New Registrar Procedure, above.

REQUIRED DATA ITEMS

The definitions and coding conventions for nearly all of the required data items may be found in the FORDS 2016 Manual (http://www.facs.org/cancer/coc/fordsmanual.html). For those items not cited in the FORDS, the description and coding information can be found using the HPM 2016 page reference.

Patient Identification

FORDS Item Name	FORDS 2016		HPM 2016
	Printed	pdf	
Accession Number	37	54	
Sequence Number	38-39	55-56	
Medical Record Number	40	57	
Social Security Number	41	58	
Last Name	42	59	
First Name	43	60	
Middle Name (Middle Initial)	44	61	
Alias			14
Maiden Name			14
Patient Address (Number and Street) at Diagnosis	45	62	
Patient Address at Diagnosis - Supplemental	46	63	
City/Town at Diagnosis (City or Town)	47	64	
State at Diagnosis (State)	48-49	65-66	
Postal Code at Diagnosis (Zip Code)	50	67	
Address at DX—Country	51	68	
County at Diagnosis	52	69	
Birthplace--State	61	78	
Birthplace--Country	62	79	
Date of Birth	63	80	
Date of Birth Flag	64	81	
Age at Diagnosis	65	82	
Race 1	66-67	83-84	
Race 2	68	85	
Race 3	69	86	
Race 4	70	87	
Race 5	71	88	
Spanish Origin - All Sources (Spanish/Hispanic Origin)	72	89	
Sex	73	90	
Primary Payer at Diagnosis	74-75	91-92	
Text - Usual Occupation			14
Text - Usual Industry			14-15
Class of Case	113-115	130-132	
Type of Reporting Source			15
Date of First Contact	118	135	
NPI-Reporting Facility			15

Cancer Identification

FORDS Item Name	FORDS 2016 Printed	FORDS 2016 pdf	HPM 2016
Date of First Contact Flag	119	136	
Date of Initial Diagnosis	120	137	
Date of Diagnosis Flag			16
Primary Site	121	138	
Text--Primary Site Title			16
Laterality	122	139	
Histology	123	140	
Text--Histology Title			16
Behavior Code	124-125	141-142	
Grade/Differentiation	126-127	143-144	16
Casefinding Source			16-17
Lymph-Vascular Invasion	128	145	
Diagnostic Confirmation	129-131	146-148	
Regional Lymph Nodes Examined	132	149	
Regional Lymph Nodes Positive	133	150	
Text--Physical Exam			24
Text--X-ray/Scan			25
Text--Scopes			26
Text--Lab Tests			27
Text--Operative Report			28
Text--Pathology Report			29
Text--Staging			30
Text--Remarks			30

Stage of Disease at Diagnosis

FORDS Item Name	FORDS 2016 Printed	FORDS 2016 pdf	HPM 2016
Tumor Size Summary	142-144	159-161	
Clinical T	157-158	174-175	16
Clinical N	159	176	16
Clinical M	160	177	16
Clinical Stage Group	161	178	16
Clinical Stage (Prefix/Suffix) Descriptor	162	179	16
Pathologic T	165-166	182-183	16
Pathologic N	167	184	16
Pathologic M	168	185	16
Pathologic Stage Group	169	186	16
Pathologic Stage (Prefix/Suffix) Descriptor	170	187	16
SEER Summary Stage 2000	173	190	16
CS Site-Specific Factor 1	187	204	
CS Site-Specific Factor 2	188	205	
CS Site-Specific Factor 5	191	208	
CS Site-Specific Factor 6	192	209	

CS Site-Specific Factor 8	194	211	
CS Site-Specific Factor 9	195	212	
CS Site-Specific Factor 10	196	213	
CS Site-Specific Factor 11	197	214	
CS Site-Specific Factor 13	199	216	
CS Site-Specific Factor 14	200	217	
CS Site-Specific Factor 15	201	218	
CS Site-Specific Factor 16	202	219	
CS Site-Specific Factor 25	211	228	

First Course of Treatment

FORDS Item Name	FORDS 2016		HPM 2016
	Printed	pdf	
Date of First Course of Treatment	229	247	
Date 1st Crs RX Flag	230-231	248-249	
RX Summ - Treatment Status	232	250	
Date of First Surgical Procedure	233	251	
RX Date - Surgery Flag	234-235	252-253	
Date of Most Definitive Surgical Resection of the Primary Site	236	254	
RX Date Mst Defn Srg Flag	237-238	255-256	
Text--Surgery			31
Surgical Procedure of Primary Site	239	257	
Scope of Regional Lymph Node Surgery	243-246	261-264	
Surgical Procedure/Other Site	251-252	269-270	
Reason for No Surgery of Primary Site	258	276	
Date Radiation Started	259	277	
RX Date - Radiation Flag	260-261	278-279	
Text--Beam Radiation			31
Text--Other Radiation			31
Regional Treatment Modality	267-269	285-287	
Radiation/Surgery Sequence	276-277	294-295	
Reason for No Radiation	281	299	
Date Chemotherapy Started	285	303	
RX Date – Chemo Flag	286-287	304-305	
Text--Chemotherapy			32
Chemotherapy	288-289	306-307	
Date Hormone Therapy Started	292	310	
RX Date – Hormone Flag	293-294	311-312	
Text--Hormones			32
Hormone Therapy (Hormone/Steroid Therapy)	295-296	313-314	
Date Immunotherapy Started	299	317	
RX Date – BRM Flag	300-301	318-319	
Text--Biological Response Modifiers (BRM)			32
Immunotherapy	302-303	320-321	
Hematologic Transplant and Endocrine Procedures	306-307	324-325	
Systemic/Surgery Sequence	308-309	326-327	
Date Other Treatment Started	310	328	

RX Date - Other Flag	311-312	329-330	
Text--Other			32
Other Treatment	313	331	

Outcomes

FORDS Item Name	FORDS 2016 Printed	FORDS 2016 pdf	HPM 2016
Date of Last Contact or Death	327	343	
Date of Last Contact Flag	328	344	
Vital Status	329	345	
Follow-Up Source	332	348	

Case Administration

FORDS Item Name	FORDS 2016 Printed	FORDS 2016 pdf	HPM 2016
Abstracted By	335	351	
Facility Identificaiton Number (FIN)	336	352	
Text--Place of Diagnosis			16
Override Site/TNM-Stage Group	345	361	
Override Age/Site/Morph	346	362	
Override Surg/DXConf	347	363	
Override Site/Type	348	364	
Override Histology	349-350	365-366	
Override Leuk, Lymphoma	351	367	
Override Site/Behavior	352	368	
Override Site/Lat/Morph	353	369	
Site Coding System – Current	360	376	
Morphology Coding System - Current	362	378	
ICD-O-3 Conversion Flag	365	381	
TNM Edition Number	366	382	
RX Coding System - Current	367	383	
CS Version Input Original (CS Version First)	371	387	
CS Version Input Current	372	388	
Date Case Last Changed			17
Date Case Completed			17
Date Case Report Exported			18
NAACCR Record Version			18
Record Type			18
Vendor Name			18

Vermont Specific Data Items

This chapter contains definitions and coding instructions for required data items that are not in the FORDS Manual.

Data Items Included in This Chapter

Patient Identification
Alias
Maiden Name
Text - Usual Occupation
Text - Usual Industry
Type of Reporting Source
NPI-Reporting Facility

Cancer Identification
Date of Diagnosis Flag
Text--Primary Site Title
Text--Histology Title
Grade/Differentiation
Casefinding Source

Stage of Disease at Diagnosis
SEER Summary Stage 2000
AJCC TNM 7th ed.

Case Administration
Text--Place of Diagnosis
Date Case Last Changed
Date Case Completed
Date Case Report Exported
NAACCR Record Version
Record Type
Vendor Name

Patient Identification

Alias

Records an alternate name or “AKA” (also known as) used by the patient, if known. Note that maiden name is entered in a separate field.

Maiden Name

Records the maiden name of female patients who are or have been married.

The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and **any variation of “unknown” or “not applicable” is not allowable.**

Text--Usual Occupation

Record the patient‘s usual occupation (i.e., the kind of work performed during most of the patient‘s working life before diagnosis of this tumor). **Do not record “retired.”** If usual occupation is not available or is unknown, record the patient‘s current or most recent occupation, or any available occupation.

Special Cases:

Child –patient is under 14 years of age code child
Homemaker – patient worked only at home
Student – patient was a student at time of diagnosis and had never held a job
Military – patient was part of the military for most of their working life
Never worked – patient was not a student or homemaker and had never worked

If no information is available, record “unknown.” This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

Text--Usual Industry

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and “service” components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry.

In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

In those situations where the usual occupation is not available or is unknown, the patient‘s current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient‘s current or most recent business/industry.

There should be an entry for Text--Usual Industry if any occupation is recorded. **If no information is available regarding the industry in which the reported occupation was carried out, record “unknown.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry.** This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

Type of Reporting Source

This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician‘s office, code this item 4).Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7.

Codes

1 Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3 Laboratory only (hospital-affiliated or independent)
4 Physician‘s office/private medical practitioner (LMD)
5 Nursing/convalescent home/hospice
6 Autopsy only
7 Death certificate only
8 Other hospital outpatient units/surgery centers

NPI-Reporting Facility

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

Cancer Identification

Date of Diagnosis Flag

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Leave this item blank if Date of Diagnosis has a full or partial date recorded.

Code 12 if the Date of Diagnosis can not be determined at all.

Text--Primary Site Title

Document information regarding the primary site and laterality of the tumor being reported.

Text--Histology Title

Document information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Grade/Differentiation

The coding instructions for cases diagnosed 1/1/2014 and forward may be found on the SEER website (http://seer.cancer.gov/tools/grade/.)

Casefinding Source

Code the source that first identified the tumor.

Codes
10 Reporting Hospital, NOS
20 Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21 Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22 Disease Index Review (review of disease index in the medical records department)
23 Radiation Therapy Department/Center
24 Laboratory Reports (other than pathology reports, code 20)
25 Outpatient Chemotherapy
26 Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27 Tumor Board
28 Hospital Rehabilitation Service or Clinic
29 Other Hospital Source (including clinic, NOS or outpatient department, NOS)

30 Physician-Initiated Case
40 Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50 Independent (non-hospital) Pathology-Laboratory Report
60 Nursing Home-Initiated Case
70 Coroner's Office Records Review
75 Managed Care Organization (MCO) or Insurance Records
80 Death Certificate (case identified through death clearance)
85 Out-of-State Case Sharing
90 Other Non-Reporting Hospital Source
95 Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99 Unknown

Stage of Disease at Diagnosis

SEER Summary Stage 2000

SEER Summary Stage 2000 is required for all sites. The coding manual for SEER Summary Stage 2000 may be found on the SEER website (http://seer.cancer.gov/tools/ssm/.)

AJCC TNM 7th ed.

Beginning with cases diagnosed 1/1/2016, directly code AJCC TNM for all sites. The coding manual for AJCC TNM 7th ed. may be found on the AJCC website (http://seer.cancer.gov/tools/ssm/.)

Case Administration

Text--Place of Diagnosis

This text area is for manual documentation of the **facility**, physician office, city, state, or county where the diagnosis was made.

Date Case Last Changed

Date the case was last changed or updated.

Date Case Completed

The date that: (1) the abstractor decided that the tumor report was complete, and (2) the case passed all edits that were applied.

Date Case Report Exported

Date the reporting facility exports the electronic abstract to a file for transmission to the central registry.

NAACCR Record Version

The version of North American Association of Central Cancer Registries (NAACCR) standards used to exchange the information. NAACCR Record Version 15.

Record Type

The NAACCR data exchange record type being used in a file of data exchange records. Code ‘A’ is the full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries).

Vendor Name

Name of the computer services vendor who programmed the system submitting the data. Abbreviate as necessary and keep a consistent name throughout all submissions. Include software version number where available. Code is self-assigned by vendor.

REQUIRED TEXT FIELDS

Text is an essential component of cancer abstracts and is used for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality documentation facilitates consolidation of records from multiple reporting sources for the same patient.

Dates of the diagnostic and treatment procedures are **needed** in the text fields to determine the admissibility of information for diagnosis date, staging, and first course of treatment.

Use of **standard abbreviations** in text fields is strongly encouraged. Refer to http://training.seer.cancer.gov for more information.

Data Items Included in This Chapter

Diagnostic Text Fields

- Text--Physical Exam
- Text--X-Ray/Scan
- Text--Scopes
- Text--Lab Tests
- Text--Operative Report
- Text--Pathology Report
- Text--Staging
- Text--Remarks

Treatment Text Fields

- Text--Surgery
- Text--Beam Radiation
- Text--Other Radiation
- Text--Chemotherapy
- Text--Hormones
- Text--Biological Response Modifiers (BRM)
- Text--Other Treatment

General Instructions

Beginning with 2010 cases, up to 1,000 characters are allowed per text field. This is two to three times the amount of space as 2009 cases and earlier. Text fields must contain enough information to support coding but **no extraneous information**.

- Review all information available in the medical record; note the most descriptive and concise text in the abstract. After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes.
- Use standard abbreviations.
- Do not include information that the registry is not authorized to collect.
- If information is missing from the record, state that it is missing.
- Avoid using all allowable space; simplify information when possible.
- Record positive and negative clinical findings. Record positive results first.
- Include only information that relates to this cancer; do not include information on comorbidity unless it specifically relates to the reason why a patient did not receive a particular treatment.
- Progression, recurrence, and follow-up are *not* required to be reported. Text related to these additional items should not be abstracted, unless specifically required by the reporting institution.
- Refer to the "Visual Review" section in Chapter 5 Quality Assurance.
- For more information, refer to: http://training.seer.cancer.gov/.

Descriptions to Record

- Date of physical exam.
- Age, sex, race/ethnicity.
- History that relates to cancer diagnosis.
- Primary site.
- Tumor histology, location and size.
- Palpable lymph nodes.
- Impression (when stated and pertains to cancer diagnosis).
- Treatment plan.

Supporting the Codes: Where to Look and What to Record

Primary Site

Where to look: Physical exam reports, x-rays, scans, scopes, operative reports, gross descriptions from pathology reports, consult notes.

What to record: Information that best describes the location of the primary tumor. Any mention of multiple tumors or foci should be noted. Record information-stating subsite.

Histology

Where to look: Pathology reports, cytology reports. For cases not microscopically confirmed, use reports from exploratory surgery, x-rays, scans, consults, and progress notes.

What to record: Histologic type, grade, and behavior. Record any factors which may have an effect in determining the proper histology, such as the presence of familial polyposis for a colon cancer.

Diagnosis Date

Where to look: History and physical exam, x-rays, scans, scopes, operative reports, pathology reports, consult notes, discharge diagnosis, discharge summary.

What to record: All information regarding the first statement of reportable diagnosis. The diagnosis date is often a clinical diagnosis and may not ever be confirmed histologically. If a clinically diagnosed case is later confirmed histologically, keep the first date.

Tumor Size

Where to look: Physical exam reports, x-rays, scans, scopes, operative reports, gross descriptions from pathology reports, consult notes.

What to record: The documented size of the primary tumor in centimeters or millimeters. When a gross tumor description and a microscopic tumor description are given in a pathology report, preference is given to the size of the microscopically analyzed cancer.

Tumor Extension

Where to look: Physical exam report, x-rays, scans, scopes, operative reports, pathology reports, consult notes, discharge diagnosis, discharge summary.

What to record: Depth of tumor invasion through the wall of an organ (such as the bladder or colon), involvement of adjacent structures or tissue. Include information about adjacent structures that are *not* involved by tumor.

Lymph Nodes

Where to look: Physical exam report, x-rays, scans, scopes, operative reports, pathology reports, consult notes, discharge diagnosis, discharge summary.

What to record: Any statement regarding possible involvement of lymph nodes. Identify lymph nodes by anatomical name as specifically as possible. Include the number and size of those involved as well as whether they are ipsilateral (same side), contralateral (opposite side), or bilateral (both sides). Size of metastasis within the lymph node and number of lymph nodes involved is essential in the staging of several cancer sites, including head and neck, sinuses, and breast.

Record the physician's statements describing palpability, mobility (including matting and/or fixation) of accessible lymph nodes, both regional and distant. Include information where regional lymph nodes are described as *not* being involved by cancer.

Metastasis to Distant Sites

Where to look: Physical exam report, x-rays, scans, scopes, operative reports, pathology reports, consult notes, discharge diagnosis, discharge summary.

What to record: Any information indicating distant metastasis at the time of diagnosis. The most common sites for metastasis are bone, lungs, brain, liver or any site spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

Record any statement from a physician or diagnostic test which suggests distant site involvement Refer to the Collaborative Stage Manual, Part II, individual site schemas for more information.

First Course of Treatment

Where to look: Operative reports, radiation therapy reports, chemotherapy reports, oncology consult reports, clinic notes, and subsequent admissions (history and physical, discharge summary).

What to record: Any information regarding treatment that modifies, controls, removes, or destroys primary or metastatic cancer. Record all cancer directed treatment planned, recommended, or performed by the physicians during the first diagnosis of cancer. Record the date a determination was made not to treat the patient, if applicable, as well as the reason.

Diagnostic Text Fields

Text--Physical Exam: Patient history and physical.

Examples:

Breast: 8/15/10, L palp breast mass, BSE x 1week ago. Breasts symmetrical w/o skin change. L breast: firm 2.5cm mass at 11:30 position near areola, no ax LAD, ROE neg.

Colon: Pt pres to Dr 3/6/10 w/melena; recent stool cards pos. Occ has sl red rectal bldg, blames on hemorrhoids. Colonoscopy 1yr/ago showed polyps but no lesions.

Esophagus: 5/7/10 72 yr male with cc coffee ground emesis + for blood. hemoccult +. Assess: UGI bleed. EGD in am. IDDM. Hx of CVA. Seizure d/o.

Hematopoietic: Patient has anemia with a WBC of 202,000. Peripheral blood smear done. Severe COPD and emphysema.

Melanoma: 10/9/10 Shave bx skin rt arm Dr's office. 11/7/10 Prob: 1.5cm melanoma insitu rt arm. Lungs clr. 1.5cm nevus dorsal surf rt arm w/healing bx site.

Prostate: Testicular pain. On 09/6/10, DRE revealed prostate nodule on right. PSA was 3.2. Sextant bx done in physician office revealed adenoca in multiple areas of prostate; Gleasons score=6.

Text--X-Ray/Scan: Documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

Examples:

Brain: 10/24/10 MRI lg mass rt frontal lobe extend into lt frontal lobe, 8x5.5x.67 cm 10/25/10 CT chest/abd/pelvis: no malignancy, no mets.

Breast: 7-13-10 Lt Mammogram: Mass lesion UOQ left breast, highly suggestive of malignancy. Biopsy suggested.

Lung: 4-27-10 CXR: 1.6 cm lesion RLL suspicious for malignancy; mediastinal lymphadenopathy with indeterminate right hilar lymph node prominence. 7-26-10 CT head: Neg. for mets. See Remarks and Path for other findings.

Submandibular Gland: 4/17/10 CT neck with contrast corresponding with palpable mass is an enhancing ovoid mass ant. to the rt sternocleidomastoid muscle and anterior to carotid sheath no other enl LN. 3.6 x 2.2 CT chest neg. 2/20/08 CT neck interval exc. no recurrence.

Rectum: 12/19/2010 CT ch/abd/pel. stable nodules in lungs. persistent low density focus in the rt lob of liver possible hemangioma, neoplasm a consideration. rectal wall thickening slightly increased.

Text--Scopes: Documentation from endoscopic examinations that provide information for staging and treatment.

Examples:

Colon: 10/13/10 Colonoscopy: lg friable mass proximal transverse colon, nearly obstructing lumen.

Esophagus: 5/7/10 EGD with bx. 1.5-2 cm mass just above the GE jct. esophageal ulcers. gastric ulcers and gastritis. duodenitis. No active bleeding.

Main Bronchus: 9/26/10 Bronchoscopy w/ brush/wash/needle bx. neg. 10/24/10 rt sided mediastinal mass. bronch with needle bx/wash and brush of bronchus intermedius + for cancer.

Pancreas: 12/13/10 Upper endoscopy. Findings: well-defined mass arising from pancreas, 3.3x3.2 cm; enlg celiac LN.

Stomach: 6-26-10 EGD: Inflammation was found in the antrum. A biopsy for H. pylori was taken. Multiple biopsies were obtained and sent to pathology. The gastroesophageal junction was 38cm from central incisors. Retroflexed views revealed no abnormalities.

Text--Lab Tests: Laboratory tests.

Suggestions for text:

- Date(s) of laboratory test(s).
- Type of laboratory test/tissue specimen(s).
- Record both positive and negative findings. Record positive test results first.
- Record reference values.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Tumor markers included, but are not limited to:
  - Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
  - Prostate Cancer: Prostatic Specific Antigen (PSA).
  - Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Examples:

Breast: ER/PR positive. Her2-neu by IHC negative for c-erb-B2.

Hematopoietic Disease: 5/5/10 PTH <3 (10-69) 5/8/10 Immunofixation serum;Monoclonal IgG kappa immunoglobulin (Reference Range:NEG) 5/14/10 Immunofixation urine; Free monoclonal kappa light chains and small amount of intact monoclonal IgG kappa immunoglobulin.

Breast: 3/1/10 ERICA: Pos (90% of tumor cells. PRICA Pos (in >90% tumor cells).

Colon: 2/12/10 CEA; 2.0.

Prostate: 9/21/10 PSA: 5.4 (0.0-4.0).

Text--Operative Report: Documentation of all surgical procedures that provide information for staging.

Suggestions for text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
- Number of lymph nodes removed.
- Size of tumor removed.
- Documentation of residual tumor.
- Evidence of invasion of surrounding areas.

Examples:

Breast: 5/22/10 lt breast PM US guid lt ax sln bx: 2 main les 1:00 2cm & 12:00 1cm no clin evid @ margs or ln's.

Colon: 10/31/10 Mass mid-transverse colon, no other intestinal masses ident. Liver smooth. No evid of gross metastases. Transverse colon resection w/ascdescending colon anastomosis.

Lung: 11/28/10 RLL lobectomy, subcarinal& hilar lymph node sampled. Ext adhesions of lung to pleural surface,no add'l findings noted.

Uterus: 11-20-10 Peritoneal cavity had adhesions between the small bowel and the omentum and the pelvic floor; left ovary was enlarged and adhered to the left pelvic side; omentum, pelvic and periaortic lymph nodes clinically negative; uterus was unremark.

Rectum: Low anterior resection: no evid mets; residaul palp tumor along lt wall of mid rectum.

Text--Pathology Report: Information from cytology and histopathology reports.

Examples:

Breast: 7-26-10 Bx lt breast: Adenoca. 8-22-10 Exc bx, node dissection: Duct adenoca, Grade 1, tumor .73 cm, focal DCIS, tumor. Margins negative; one sentinel & two axillary nodes negative.

Endometrium: 1-18-10 Bx endometrium: Adenoca, endometrioid typew/mucinous diff. FIGO I. 2-15-10 Mixed (60% endometrioid, 40% mucinous) ca, GR I involves entire endometrial cavity & invades myometrium; tumor 7 cm; 2/14 nodes +; ovaries/tubes negative.

Hematopoietic: 5/5/10; Peripheral blood;mild macrocytic anemia. Absolute lymphopenia. Bone Marrow; Plasma cell myeloma. 5/99/10; cytology from pleural fluid SUSP for MALIG

Ovary: 5/15/10 TAH, BSO: Clear cell ca, grade III, left ovary, confined to cyst lumen and not present on exterior surface of ovary. Right ovary, tubes, cervix, endometrium, myometrium, uterine serosa, omentum negative; 0/14 nodes +.

Prostate: 10-31-2010 Prostate biopsies: Rt mid lateral: Adenoca, Gleason's 3+4=7, tumor comprises 75% of specimen. Rt mid medial: Adenoca, Gleason's 4+3=7, tumor comprises 25% of specimen. Biopsies on left negative for malignancy.

Tongue: 10/05/10: Tongue bx, superficially invasive well differentiated squamous cell ca with ulceration. 1.5 cm white scaly lesion completely cut out. 10/18/10 re-excision, no residual invasive squamous cell ca. spec sz 2.0x1.1x0.4 cm.

Text--Staging: Document any unresolved discrepancies between physician and registry staging. Document additional information about physician staging.

Suggestions for text:

- Physician TNM stage.
- Other staging schemes, Dukes, Jewetts, Bloom Richardson.

Text--Remarks: Information that is given only in coded form elsewhere or for which the abstract provides no other place. Problematic coding issues can also be discussed in this section.

Suggestions for text:

- Smoking history.
- Family and personal history of cancer.
- Comorbidities.
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date.
- Place of birth.
- Justification of over-ride flags.

Examples:

Unknown Primary: Either tumor in brain was mets from some other primary & not GBM as originally suspected or he had GBM & another primary tumor that secondarily spread. Had consult w/ONC MD & RT MD & decision that CHEMO & RT would not help him.

Lung: As far as I can tell, patient was seen at HOSP A for more surgery/treatment.

Hematopoietic: Patient had only outpt lab work; no further info.

Treatment Text Fields

Text--Surgery: Information describing all surgical procedures performed as part of treatment.

Suggestions for text:

- Date of each procedure.
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.
- Lymph nodes removed.
- Regional tissues removed.
- Metastatic sites.
- Facility where each procedure was performed.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Text--Beam Radiation: Information regarding treatment of the tumor being reported with beam radiation.

Suggestions for text:

- Date radiation treatment began.
- Where treatment was given, e.g., at this facility, at another facility.
- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities.
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given.

Text--Other Radiation: Information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

Suggestions for text:

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility.
- Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131).
- Other treatment information, e.g., unknown if radiation was given.

Text--Chemotherapy: Information regarding chemotherapy treatment.

Suggestions for text:

- Date chemotherapy began.
- Where treatment was given, e.g., at this facility, at another facility.
- Type of chemotherapy, e.g., name of agent(s) or protocol.
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given.

Text--Hormones: Information about hormonal treatment.

Suggestions for text:

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility.
- Type of hormone or antihormone, e.g., Tamoxifen.
- Type of endocrine surgery or radiation, e.g., orchiectomy.
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given.

Text--Biological Response Modifiers (BRM): Information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Suggestions for text:

- Date treatment began.
- Where treatment was given, e.g., at this facility, at another facility.
- Type of BRM agent, e.g., Interferon, BCG.
- BRM procedures, e.g., bone marrow transplant, stem cell transplant.
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given.

Text--Other Treatment: Information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

Suggestions for text:

- Date treatment was started.
- Where treatment was given, e.g., at this facility, at another facility.
- Type of other treatment, e.g., blinded clinical trial, hyperthermia.
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given.

QUALITY ASSURANCE

Introduction

The quality assurance procedures of the VCR include the review of all cases submitted (electronic edits checks and visual review), as well as the administration of reabstracting and casefinding audits. These audits will measure both the accuracy of information being reported as well as completeness of reporting.

Data Acceptance Policy

All data must be submitted to the VCR as stated in Chapter 7 - *Transmission of Case Information* in order to be accepted for review and analysis. In addition, the data must pass at least 90% of the electronic edits processed, calculated as follows:

$$\frac{\text{\# Cases Having Zero Failures}}{\text{\# Cases in the Submittal}} \times 100$$

Electronic Edits

All submittals are processed through a series of electronic edits upon receipt. Whenever there is a change in reporting requirements, as often as once a year, VCR provides hospital cancer registry software vendors with the updated edit set.

Hospital registrars should work directly with their software vendor to ensure they have the most recent Vermont-specific electronic edit metafile. Any questions regarding electronic edits should be directed to the Quality and Education Coordinator, Linda Bloschies.

Quality Indicator Reports

Hospitals are evaluated quarterly for timeliness, accuracy and completeness. The Quality Indicator Reports are provided to the registrar and hospital leadership. Hospitals are compared to the state average and the following standards:

Timeliness:	Cases are reported within 180 days (per State statute).
Accuracy:	At least 90% of cases pass electronic edits.
Completeness:	100% of cases are reported within 6 months of the close of the diagnosis year.

Visual Review

Once a submittal has been processed through electronic edits, the cases undergo the visual review process. All cases are read by a member of the VCR quality control staff, with priority given to new registrars and certain primary sites. Accuracy is evaluated by comparing the abstracted text to the codes.

When a discrepancy is detected upon visual review, or more information is needed to support a code, VCR queries the reporting institution. Any case with errors is not eligible for data analysis until all errors detected are resolved.

Correction Process

Vermont hospitals are responsible for submitting data that meets the quality assurance standards of the VCR. When standards are met upon initial submission of data, the cases are immediately eligible for data analysis. If standards are not met upon initial submission, then the reporting institution must supply the VCR with additional information in a timely manner, so that corrections can be made, the cases can be accessioned, and the hospital can be credited.

Reabstracting Audits

Reabstracting audits measure how well a case submitted to the VCR reflects the information in a patient's medical record. Reabstracting is the process whereby one of the VCR's quality control staff members abstracts a medical record belonging to the reporting institution. Then the VCR staff member's abstract is compared to the case as it exists in the VCR database at the time of the audit. A standard set of data items, containing a minimum number of twenty, is evaluated for every case audited.

Differences are evaluated and tabulated. Hospitals are required to demonstrate 95% accuracy overall. If this is achieved, then no reply to the summary of findings is needed on behalf of the reporting institution. If this is not achieved, then any areas requiring improvement will be investigated with a follow-up review in 2-3 months.

Casefinding Audits

Casefinding audits measure how well a reporting facility identifies reportable cancers and submits them. VCR quality assurance staff review pathology reports and medical records disease indices for a given period of time, identify reportable cases, and compare this list to the cases actually reported within the same time period evaluated.

The percent complete is calculated. Hospitals are required to demonstrate 95% completeness. If this is achieved, then no reply to the summary of findings is needed on behalf of the reporting institution. If this is not achieved, then any areas requiring improvement will be investigated with a follow-up review in 2-3 months. Additionally, the reporting institution is required to abstract and submit cases for all reportable neoplasms found in the casefinding audit.

Death Clearance

A list is provided to hospitals annually to check for a record of the cancer on deceased individuals. This requires researching the registry database, the hospital patient index, and the medical records to determine if the cancer listed on the death certificate was diagnosed after October 31, 1993. For those cases diagnosed on November 1, 1993 or later, an abstract must be submitted.

TRANSMISSION OF CASE INFORMATION

Timeliness

Ninety percent of cases must be reported within 180 days of first contact.

Format

All facilities are required to report in machine-readable format.

The required format for reporting machine-readable cases (diagnosed January 2016 and after) is the NAACCR Record Layout Version 16.

Transmission of Data File

Data files are required to be transmitted via Web Plus. For more information, contact Holly Maynard at (802) 951-4062 or holly.maynard@vermont.gov.

Transmission of Supporting Information

All supporting information (Consult Case Form, supporting documentation, etc.) may be uploaded as electronic files using the non-NAACCR data file format within Web Plus. If you need to fax confidential information, please contact a VCR member so that we know confidential information is being faxed. Our fax number is (802) 651-1787.

Appendix A
Vermont Cancer Registry Law and Rules

The Vermont Cancer Registry Law

18 V.S.A. §§ 151-157

§ 151. Definitions

As used in this chapter:

(1) "Cancer" means all malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma, Hodgkins disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin.

(2) "Health care facility" shall have the meaning given in section 9432 of this title.

(3) "Health care provider" shall have the meaning given in section 9432 of this title.

§ 152. Establishment of cancer registry

(a) The commissioner shall establish a uniform statewide population-based cancer registry system for the collection of information determining the incidence of cancer and related data. The secretary shall adopt rules necessary to effect the purposes of this chapter, including the data to be reported and the effective date after which reporting by health care facilities and health care providers shall be required.

(b) All cancers diagnosed or treated in the state shall be reported to the representative of the health department authorized by the commissioner to compile the cancer data, or any individual, agency, or organization designated to cooperate with that representative.

(c) The commissioner shall establish a training program for the personnel of participating health care facilities and a quality control program for cancer data. The commissioner shall collaborate in studies with clinicians and epidemiologists and publish reports on the results of such studies. The commissioner shall cooperate with the National Institutes of Health and the Centers for Disease Control and Prevention in providing cancer incidence data.

§ 153. Participation in program

(a) Any health care facility diagnosing or providing treatment to patients with cancer shall report each case of cancer to the Commissioner or his or her authorized representative in a format prescribed by the Commissioner within 180 days of admission or diagnosis. If the facility fails to report in a format prescribed by the Commissioner, the Commissioner's authorized representative may enter the facility, obtain the information, and report it in the appropriate format. In these cases, the facility shall reimburse the Commissioner or the authorized representative for the cost of obtaining and reporting the information.

(b) Any health care provider diagnosing or providing treatment to patients with cancer shall report each cancer case to the Commissioner or his or her authorized representative within 180 days of diagnosis. Those cases diagnosed or treated at a Vermont facility or previously admitted to a Vermont facility for diagnosis or treatment of that instance of cancer are exceptions and do not need to be reported by the health care provider.

(c) All health care facilities and health care providers who provide diagnostic or treatment services to patients with cancer shall report to the Commissioner any further demographic, diagnostic, or treatment

information requested by the Commissioner concerning any person now or formerly receiving services, diagnosed as having or having had a malignant tumor. Additionally, the Commissioner or his or her authorized representative shall have physical access to all records that would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer, or medical status of any identified patient with cancer. Willful failure to grant access to such records shall be punishable by a fine of up to $ 500.00 for each day access is refused. Any fines collected pursuant to this subsection shall be deposited in the General Fund.

§ 154. Confidentiality

(a) All information reported pursuant to this chapter shall be confidential and privileged. The commissioner shall take strict measures to ensure that all identifying information is kept confidential.

(b) All identifying information regarding an individual patient, health care provider, or health care facility contained in records of interviews, written reports, and statements procured by the commissioner or by any other person, agency, or organization acting jointly with the commissioner in connection with cancer morbidity and mortality studies shall be confidential and privileged and shall be used solely for the purposes of the study. Nothing in this section shall prevent the commissioner from publishing statistical compilations relating to morbidity and mortality studies which do not identify individual cases or sources of information.

§ 155. Disclosure

(a) The Commissioner may enter into agreements to exchange confidential information with other cancer registries in order to obtain complete reports of Vermont residents diagnosed or treated in other states and to provide information to other states regarding their residents diagnosed or treated in Vermont.

(b) The Commissioner may furnish confidential information to the National Breast and Cervical Cancer Early Detection Program, other states' cancer registries, federal cancer control agencies, or health researchers in order to collaborate in a national cancer registry or to collaborate in cancer control and prevention research studies. However, before releasing confidential information, the Commissioner shall first obtain from such state registries, agencies, or researchers an agreement in writing to keep the identifying information confidential and privileged. In the case of researchers, the Commissioner shall also first obtain evidence of the approval of their academic committee for the protection of human subjects established in accordance with 45 C.F.R. part 46.

§ 156. Liability

(a) No action for damages arising from the disclosure of confidential or privileged information may be maintained against any person, or the employer or employee of any person, who participates in good faith in the reporting of cancer registry data or data for cancer morbidity or mortality studies in accordance with this chapter.

(b) No license of a health care facility or health care provider may be denied, suspended, or revoked for the good faith disclosure of confidential or privileged information in the reporting of cancer registry data or data for cancer morbidity or mortality studies in accordance with this chapter.

(c) Nothing in this section shall be construed to apply to the unauthorized disclosure of confidential or privileged information when such disclosure is due to gross negligence or willful misconduct.

§ 157. Vermont mammography registry

The confidentiality, disclosure, and liability provisions of sections 154, 155, and 156 of this title shall likewise apply to all mammography and pathology data relating to breast cancer and any associated identifying information acquired by the Vermont mammography registry (VMR). In the case of VMR, the rights and obligations of the health commissioner shall be assumed by the appropriate VMR governing body or official.

HISTORY: Added 1993; amended 2015.

CODE OF VERMONT RULES
AGENCY 13. AGENCY OF HUMAN SERVICES
SUB-AGENCY 140. DEPARTMENT OF HEALTH
CHAPTER 052. CANCER REGISTRY RULES

I. Introduction

Title 18, Section 152(a) of the Vermont Statutes Annotated (VSA) requires the Commissioner of Health to establish a uniform statewide population-based cancer registry system for the collection of information determining the incidence of cancer and related data.

These Cancer Registry Rules have been adopted to effect the purposes of the Cancer Registry Law, 18 VSA, Chapter 4.

II. Establishment of Cancer Registry

A Vermont Cancer Registry (VCR) is hereby established within the Department of Health to collect information regarding statewide cancer incidence and related data.

III. Effective Date of Reporting

A health care facility or health care provider diagnosing or providing treatment to cancer patients must report each case of cancer to the Director of the VCR within 120 days of admission or diagnosis as prescribed by these regulations.
The definitions of "health care facility" and "health care provider" appear as Title 18, Section 9432 of the Vermont Statutes Annotated.

IV. Data to be Reported

1. Reportable Cancers
All cancers with a behavior code of "2" (in situ) or "3" (malignant) in the latest edition of the International Classification of Diseases for Oncology (ICD-O) must be reported. However, the following skin cancers, as coded in ICD-0, are excluded from reporting:

A. 8000-8004 Neoplasms, malignant, NOS of the skin (C44.0-C44.9)
B. 8010-8045 Epithelial carcinomas of the skin (C44.0-C44.9)
C. 8050-8082 Papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
D. 8090-8110 Basal cell carcinomas of any site except genital sites

NOTE: Skin cancers in the genital sites (vagina, clitoris, labium, vulva, prepuce, penis, and scrotum) ARE reportable since they are more likely to metastasize than the usual carcinomas of the skin. (These cancers are reportable both nationally and internationally.)

All benign brain-related tumors occurring in any of the following sites must be reported:

A. The brain, meninges, spinal cord, cauda equine, a cranial nerve or nerves, or any other part of the central nervous system
B. The pituitary gland, pineal gland, or craniopharyngeal duct

2. Data Elements
The following data categories are required to be reported in a machine readable format approved by the Director of the VCR for each case of cancer:

A. Patient Identifiers and Demographics
B. Provider and Facility Identifiers
C. Cancer Identification
D. Extent of Disease at Diagnosis
E. First Course of Treatment
F. Follow-up

No follow-up data needs to be reported prior to January 1, 1995.

V. Quality Control

1. Each health care facility or health care provider shall permit periodic quality control reviews including casefinding, abstracting, coding, and data submission processing. Unless other arrangements are made with a facility or provider, no fewer than 10 working days notice is established as the minimum notice period applicable whenever the VCR wishes to have access to information on site at a facility.
2. The VCR will ensure the provision of cancer registry training and consultation.
3. Reporting facilities shall assist the VCR in annual reconciliation of cancer mortality and incidence data.

VI. Procedure Manual

In order to facilitate reporting and to protect the data collected, the VCR will supplement these regulations with a VCR Procedure Manual which will be made available to all data reporters. Any data fields delineated in the VCR Procedure Manual will be consistent with data sets defined by the American College of Surgeons and the North American Association of Central Cancer Registries.

All identifying information regarding an individual patient, health care provider, or health care facility contained in records of interviews, written reports, and statements procured by the Commissioner of Health or by any other person, agency, or organization acting jointly with the Commissioner in connection with cancer morbidity and mortality studies shall be confidential and privileged and shall be used solely for the purposes of the study. In accordance with the Cancer Registry Law, the Commissioner shall, however, be able to publish statistical compilations, enter into agreements to exchange information with other cancer registries, and furnish confidential information to other states' cancer registries, federal cancer control agencies, or health researchers.

To ensure the protection and confidentiality of the identifying information collected by the VCR, the VCR Procedure Manual will contain, among other things:

. Procedures to safeguard and secure the registry database and printed data generated from the database containing identifying information;

. Procedures to destroy (e.g., by shredding) all printed materials containing identifying information when such materials are to be disposed of;

. Procedures to make certain that all persons with access to VCR identifying information are aware of the Health Department's Confidentiality Regulation and policy and have signed a written statement acknowledging their responsibility to maintain confidentiality and subjecting them to penalties for violation of confidentiality requirements.18 V.S.A. § 152(a)

EFFECTIVE DATE: November 15, 1993 Secretary of State Rule Log # 93-79
AMENDED: May 10, 2002 Secretary of State Rule Log # 02-14;
June 1, 2004 Secretary of State Rule Log # 04-17

Appendix B
Vermont County Codes

County	Code
Addison	001
Bennington	003
Caledonia	005
Chittenden	007
Essex	009
Franklin	011
Grand Isle	013
Lamoille	015
Orange	017
Orleans	019
Rutland	021
Washington	023
Windham	025
Windsor	027

Appendix C

Vermont Cities, Counties and Codes

Acceptable Abbreviations:

St - Saint
N - North
S - South
E –East
W –West

Even though these words can be abbreviated, if the word is spelled out that is also acceptable. There are no other acceptable abbreviations at this time. For example, 'Junction' cannot be abbreviated to 'Jct.'

City/Town/Township	County
Adamant	023 Washington
Addison	001 Addison
Albany	019 Orleans
Alburg/Alburgh	013 Grand Isle
Alburg Center/Alburgh Center	013 Grand Isle
Alburg Springs/Alburgh Springs	013 Grand Isle
Amsden	027 Windsor
Andover	027 Windsor
Arlington	003 Bennington
Ascutney	027 Windsor
Athens	025 Windham
Averill	009 Essex
Avery's Gore	009 Essex
Bakersfield	011 Franklin
Baltimore	027 Windsor
Barnard	027 Windsor
Barnet	005 Caledonia
Barnumtown	001 Addison
Barnumville	003 Bennington
Barre	023 Washington
Barre City	023 Washington
Barre Town	023 Washington
Barton	019 Orleans

Bartonsville	025 Windham
Basin Harbor	001 Addison
Beebe Plain	019 Orleans
Beecher Falls	009 Essex
Bellows Falls	025 Windham
Belmont	021 Rutland
Belvidere	015 Lamoille
Belvidere Corners	015 Lamoille
Belvidere Center	015 Lamoille
Bennington	003 Bennington
Benson	021 Rutland
Benson Landing	021 Rutland
Berkshire	011 Franklin
Berlin	023 Washington
Berlin Corners	023 Washington
Bethel	027 Windsor
Binghamville	011 Franklin
Blissville	021 Rutland
Bloomfield	009 Essex
Bolton	007 Chittenden
Boltonville	017 Orange
Bomoseen	021 Rutland
Bondville	003 Bennington
Bordoville	011 Franklin
Bowlsville	021 Rutland
Bradford	017 Orange
Braintree	017 Orange
Braintree Center	017 Orange
Brandon	021 Rutland
Brattleboro	025 Windham
Bread Loaf	001 Addison
Bridgewater	027 Windsor
Bridgewater Center	027 Windsor
Bridgewater Corners	027 Windsor
Bridport	001 Addison
Brighton	009 Essex
Bristol	001 Addison
Brockway's Mills	025 Windham
Brookfield	017 Orange

Brookfield Center	017 Orange
Brookline	025 Windham
Brookside	007 Chittenden
Brooksville	001 Addison
Brownington	019 Orleans
Brownington Center	019 Orleans
Brownsville	027 Windsor
Brunswick	009 Essex
Brunswick Springs	009 Essex
Buck Hollow	011 Franklin
Buells Gore	007 Chittenden
Burke	005 Caledonia
Burke Hollow	005 Caledonia
Burlington	007 Chittenden
Cabot	023 Washington
Cadys Falls	015 Lamoille
Calais	023 Washington
Cambridge	015 Lamoille
Cambridge Junction	015 Lamoille
Cambridgeport	025 Windham
Canaan	009 Essex
Castleton	021 Rutland
Castleton Corners	021 Rutland
Cavendish	027 Windsor
Centerville	015 Lamoille
Central Park	025 Windham
Charleston/Charlestown	019 Orleans
Charlotte	007 Chittenden
Checkerberry Village	007 Chittenden
Chelsea	017 Orange
Chester	027 Windsor
Chester Depot	027 Windsor
Chimney Corner	007 Chittenden
Chimney Point	001 Addison
Chipman's Point	001 Addison
Chippenhook	021 Rutland
Chiselville	003 Bennington
Chittenden	021 Rutland
Clarendon	021 Rutland

Clarendon Springs	021 Rutland
Colbyville	023 Washington
Colchester	007 Chittenden
Cold River	021 Rutland
Collinsville	019 Orleans
Concord	009 Essex
Concord Corner	009 Essex
Cookville (Corinth P.O.)	017 Orange
Corinth	017 Orange
Corinth Center	017 Orange
Cornwall	001 Addison
Coventry	019 Orleans
Craftsbury	019 Orleans
Craftsbury Common	019 Orleans
Cuttingsville	021 Rutland
Danby	021 Rutland
Danby Four Corners	021 Rutland
Danville	005 Caledonia
Derby	019 Orleans
Derby Center	019 Orleans
Derby Line	019 Orleans
Dewey's Mills	027 Windsor
Dorset	003 Bennington
Dover	025 Windham
Downers	027 Windsor
Downingville	001 Addison
Dummerston	025 Windham
Dummerston Center	025 Windham
Duxbury	023 Washington
East Albany	019 Orleans
East Alburg	013 Grand Isle
East Arlington	003 Bennington
East Barnard	027 Windsor
East Barnet	005 Caledonia
East Barre	023 Washington
East Berkshire	011 Franklin
East Bethel	027 Windsor
East Braintree	017 Orange
East Brighton	009 Essex

East Brookfield	009 Orange
East Burke	005 Caledonia
East Cabot	023 Washington
East Calais	023 Washington
East Charlestown	019 Orleans
East Charlotte	007 Chittenden
East Clarendon	021 Rutland
East Concord	009 Essex
East Craftsbury	019 Orleans
East Dorset	003 Bennington
East Dover	025 Windham
East Dummerston	025 Windham
East Enosburg	011 Franklin
East Fairfield	011 Franklin
East Fletcher	011 Franklin
East Franklin	011 Franklin
East Georgia	011 Franklin
East Granville	001 Addison
East Hardwick	005 Caledonia
East Haven	009 Essex
East Hubbardton	021 Rutland
East Jamaica	025 Windham
East Johnson	015 Lamoille
East Lyndon	005 Caledonia
East Middlebury	001 Addison
East Monkton	001 Addison
East Montpelier	023 Washington
East Montpelier Center	023 Washington
East Orange	017 Orange
East Peacham	005 Caledonia
East Pittsford	021 Rutland
East Poultney	021 Rutland
East Randolph	017 Orange
East Richford	011 Franklin
East Roxbury	023 Washington
East Rupert	003 Bennington
East Ryegate	005 Caledonia
East Sheldon	011 Franklin
East Shoreham	001 Addison

East St. Johnsbury	005 Caledonia
East Thetford	017 Orange
East Topsham	017 Orange
East Wallingford	021 Rutland
East Warren	023 Washington
Eden	015 Lamoille
Eden Mills	015 Lamoille
Elmore	015 Lamoille
Ely	017 Orange
Emerson	027 Windsor
Enosburg	011 Franklin
Enosburg Falls	011 Franklin
Essex	007 Chittenden
Essex Center	007 Chittenden
Essex Junction	007 Chittenden
Evansville	019 Orleans
Ewells Mills	005 Caledonia
Fair Haven	021 Rutland
Fairfax	011 Franklin
Fairfax Falls	011 Franklin
Fairfield	011 Franklin
Fairfield Station	011 Franklin
Fairlee	017 Orange
Fairmont	023 Washington
Fays Corner	007 Chittenden
Fayston	023 Washington
Felchville (Reading P.O.)	027 Windsor
Ferdinand	009 Essex
Ferrisburg/Ferrisburgh	001 Addison
Ferrisburg Station/Ferrisburgh Station	001Addison
Fletcher	011 Franklin
Florence	021 Rutland
Forest Dale	021 Rutland
Foxville	017 Orange
Franklin	011 Franklin
Gageville	025 Windham
Gallup Mills	009 Essex
Gassetts	027 Windsor
Gaysville	027 Windsor

Georgia	011 Franklin
Georgia Center	011 Franklin
Georgia Plains	011 Franklin
Gilead	027 Windsor
Gilman	009 Essex
Glastenbury	003 Bennington
Glover	019 Orleans
Goose Green	017 Orange
Gordon Landing	013 Grand Isle
Goshen	001 Addison
Goshen Four Corners	001 Addison
Goulds Mills	027 Windsor
Grafton	025 Windham
Granby	009 Essex
Grand Isle	013 Grand Isle
Grand Isle Station	013 Grand Isle
Graniteville	023 Washington
Granville	001 Addison
Green River	025 Windham
Greensboro	019 Orleans
Greensboro Bend	019 Orleans
Groton	005 Caledonia
Guildhall	009 Essex
Guilford	025 Windham
Guilford Center	025 Windham
Halifax	025 Windham
Hancock	001 Addison
Hanksville	007 Chittenden
Hardwick	005 Caledonia
Harmonyville	025 Windham
Hartford	027 Windsor
Hartland	027 Windsor
Hartland Four Corner	027 Windsor
Hartwellville	009 Essex
Harvey	005 Caledonia
Healdville	021 Rutland
Heartwellville	003 Bennington
Hewetts Corners	027 Windsor
Highgate	011 Franklin

Highgate Center	011 Franklin
Highgate Falls	011 Franklin
Highgate Springs	011 Franklin
Hinesburg	007 Chittenden
Holden	021 Rutland
Holland	019 Orleans
Hortonia	021 Rutland
Hortonville	021 Rutland
Houghtonville	025 Windham
Hubbardton	021 Rutland
Huntington	007 Chittenden
Huntington Center	007 Chittenden
Hyde Park	015 Lamoille
Hydeville	021 Rutland
Ira	021 Rutland
Irasburg	019 Orleans
Irasville	023 Washington
Island Pond	009 Essex
Isle La Motte	013 Grand Isle
Jacksonville	025 Windham
Jamaica	025 Windham
Jay	019 Orleans
Jeffersonville	015 Lamoille
Jericho	007 Chittenden
Jericho Center	007 Chittenden
Jerusaleum	001 Addison
Johnson	015 Lamoille
Jonesville	007 Chittenden
Kansas	003 Bennington
Keeler Bay	013 Grand Isle
Kelley Stand	003 Bennington
Kents Corners	023 Washington
Killington	021 Rutland
Kirby	005 Caledonia
Lake Elmore	015 Lamoille
Lake Dunmore	001 Addison
Landgrove	003 Bennington
Larrabees Point	001 Addison
Leicester	001 Addison

Leicester Junction	001 Addison
Lemington	009 Essex
Lewis	009 Essex
Lewiston	027 Windsor
Lincoln	001 Addison
Londonderry	025 Windham
Lowell	019 Orleans
Lower Cabot	023 Washington
Lower Granville	001 Addison
Lower Plain	017 Orange
Lower Waterford	005 Caledonia
Ludlow	027 Windsor
Lunenburg	009 Essex
Lympus	027 Windsor
Lyndon	005 Caledonia
Lyndon Center	005 Caledonia
Lyndonville	005 Caledonia
Mackville	005 Caledonia
Maidstone	009 Essex
Mallett's Bay	007 Chittenden
Manchester	003 Bennington
Manchester Center	003 Bennington
Manchester Depot	003 Bennington
Maple Corner (Calais P.O.)	023 Washington
Maquam	011 Franklin
Marlboro	025 Windham
Marshfield	023 Washington
Mc Indoe Falls	005 Caledonia
Mechanicsville	007 Chittenden
Melville Landing	011 Franklin
Mendon	021 Rutland
Middlebury	001 Addison
Middlesex	023 Washington
Middlesex Center	023 Washington
Middletown Springs	021 Rutland
Miles Pond	009 Essex
Mill Village	017 Orange
Milton	007 Chittenden
Monkton	001 Addison

Monkton Boro	001 Addison
Monkton Ridge	001 Addison
Montgomery	011 Franklin
Montgomery Center	011 Franklin
Montpelier	023 Washington
Moretown	023 Washington
Moretown Common	023 Washington
Morgan	019 Orleans
Morgan Center	019 Orleans
Morristown	015 Lamoille
Morrisville	015 Lamoille
Morses Line	011 Franklin
Moscow	015 Lamoille
Mt. Tabor (Mount Tabor)	021 Rutland
Mt. Holly (Mount Holly)	021 Rutland
New Haven Junction	001 Addison
New Boston	027 Windsor
New Haven	001 Addison
New Haven Mills	001 Addison
Newark	005 Caledonia
Newbury	017 Orange
Newfane	025 Windham
Newport	019 Orleans
Newport Center	019 Orleans
Newport City	019 Orleans
Newport Town	019 Orleans
North Bennington	003 Bennington
North Calais	023 Washington
North Cambridge	015 Lamoille
North Clarendon	021 Rutland
North Concord	009 Essex
North Danville	005 Caledonia
North Derby	019 Orleans
North Dorset	003 Bennington
North Duxbury	023 Washington
North Enosburg	011 Franklin
North Fairfax	011 Franklin
North Fayston	023 Washington
North Ferrisburg/North Ferrisburgh	001 Addison

North Hartland	027 Windsor
North Hero	013 Grand Isle
North Hyde Park	015 Lamoille
North Kirby	005 Caledonia
North Landgrove	003 Bennington
North Montpelier	023 Washington
North Pawlet	021 Rutland
North Pomfret	027 Windsor
North Pownal	003 Bennington
North Randolph	017 Orange
North Rupert	003 Bennington
North Sheldon	011 Franklin
North Shrewsbury	021 Rutland
North Springfield	027 Windsor
North Thetford	017 Orange
North Troy	019 Orleans
North Tunbridge	017 Orange
North Walden	005 Caledonia
North Westminster	025 Windham
North Williston	007 Chittenden
North Windham	025 Windham
North Wolcott	015 Lamoille
Northfield	023 Washington
Northfield Center	023 Washington
Northfield Falls	023 Washington
Norton	009 Essex
Norwich	027 Windsor
Oakland	011 Franklin
Old Bennington	003 Bennington
Orange	017 Orange
Orleans	019 Orleans
Orwell	001 Addison
Panton	001 Addison
Passumpsic	005 Caledonia
Pawlet	021 Rutland
Peacham	005 Caledonia
Pearl	013 Grand Isle
Peasville	027 Windsor
Pekin	023 Washington

Perkinsville	027 Windsor
Peru	003 Bennington
Pikes Falls	025 Windham
Pittsfield	021 Rutland
Pittsford	021 Rutland
Pittsford Mills	021 Rutland
Plainfield	023 Washington
Pleasant Valley	015 Lamoille
Plymouth	027 Windsor
Plymouth Union	027 Windsor
Pomfret	027 Windsor
Pompanoosuc	027 Windsor
Post Mills	017 Orange
Poultney	021 Rutland
Pownal	003 Bennington
Pownal Center	003 Bennington
Prindle Corners	007 Chittenden
Proctor	021 Rutland
Proctorsville	027 Windsor
Prosper	027 Windsor
Putnamville	023 Washington
Putney	025 Windham
Quechee	027 Windsor
Randolph	017 Orange
Randolph Center	017 Orange
Rawsonville	025 Windham
Reading	027 Windsor
Readsboro	003 Bennington
Readsboro Falls	003 Bennington
Rhode Island Corners	007 Chittenden
Richford	011 Franklin
Richmond	007 Chittenden
Ricker Mills	005 Caledonia
Ripton	001 Addison
Riverton (West Berlin)	023 Washington
Robinson	027 Windsor
Rochester	027 Windsor
Rockingham	025 Windham
Rockville	001 Addison

Rocky Dale	001 Addison
Roxbury	023 Washington
Royalton	027 Windsor
Rupert	003 Bennington
Rutland	021 Rutland
Rutland City	021 Rutland
Rutland Town	021 Rutland
Ryegate	005 Caledonia
Ryegate Corner	005 Caledonia
Saint Albans	011 Franklin
Saint Albans Bay	011 Franklin
Saint Albans City	011 Franklin
Saint Albans Town	011 Franklin
Saint George	007 Chittenden
Saint Rocks	011 Franklin
Saint Johnsbury	005 Caledonia
Saint Johnsbury Center	005 Caledonia
Salisbury	001 Addison
Salisbury Station	001 Addison
Sandgate	003 Bennington
Saxtons River	025 Windham
Searsburg	003 Bennington
Shady Rill	023 Washington
Shaftsbury	003 Bennington
Shaftsbury Center	003 Bennington
Sharon	027 Windsor
Shawville	011 Franklin
Sheddsville	027 Windsor
Sheffield	005 Caledonia
Shelburne	007 Chittenden
Shelburne Falls	007 Chittenden
Sheldon Junction	011 Franklin
Sheldon Springs	011 Franklin
Sheldon	011 Franklin
Sherburne	021 Rutland
Sherburne Center (Killington P.O.)	021 Rutland
Shoreham	001 Addison
Shoreham Center	001 Addison
Shrewsbury	021 Rutland

Simonsville	027 Windsor
Simpsonville	025 Windham
Smithville	027 Windsor
Somerset	025 Windham
South Albany	019 Orleans
South Alburg/South Alburgh	013 Grand Isle
South Barre	023 Washington
South Burlington	007 Chittenden
South Cabot	023 Washington
South Cambridge	015 Lamoille
South Corinth	017 Orange
South Dorset	003 Bennington
South Duxbury	023 Washington
South Hero	013 Grand Isle
South Kirby	005 Caledonia
South Lincoln	001 Addison
South Londonderry	025 Windham
South Lunenburg	009 Essex
South Newbury	017 Orange
South Newfane	025 Windham
South Northfield	023 Washington
South Peacham	005 Caledonia
South Pomfret	027 Windsor
South Randolph	017 Orange
South Reading	027 Windsor
South Royalton	027 Windsor
South Ryegate	005 Caledonia
South Shaftsbury	003 Bennington
South Strafford	017 Orange
South Starksboro	001 Addison
South Tunbridge	017 Orange
South Vernon	025 Windham
South Vershire	017 Orange
South Walden	005 Caledonia
South Wallingford	021 Rutland
South Wardsboro	025 Windham
South Wheelock	005 Caledonia
South Windham	025 Windham
South Woodbury	023 Washington

South Woodstock	027 Windsor
Springfield	027 Windsor
St. Albans	011 Franklin
St. Albans Bay	011 Franklin
St. Albans City	011 Franklin
St. Albans Town	011 Franklin
St. George	007 Chittenden
St. Rocks	011 Franklin
St. Johnsbury	005 Caledonia
St. Johnsbury Center	005 Caledonia
Stamford	003 Bennington
Stannard	005 Caledonia
Starksboro	001 Addison
Stevens Mills	011 Franklin
Stockbridge	027 Windsor
Stowe	015 Lamoille
Strafford	017 Orange
Stratton	025 Windham
Sudbury	021 Rutland
Sunderland	003 Bennington
Sunderland Station	003 Bennington
Sutton	005 Caledonia
Swanton	011 Franklin
Taftsville	027 Windsor
Talcville	027 Windsor
Tarbellville	021 Rutland
Thetford	017 Orange
Thetford Center	017 Orange
Thetford Hill	017 Orange
Tinmouth	021 Rutland
Topsham	017 Orange
Topsham Four Corners	017 Orange
Townshend	025 Windham
Trow Hill	023 Washington
Troy	019 Orleans
Tunbridge	017 Orange
Tyson	027 Windsor
Underhill	007 Chittenden
Underhill Center	007 Chittenden

Underhill Flats	007 Chittenden
Union Village	017 Orange
Vergennes	001 Addison
Vernon	025 Windham
Vershire	017 Orange
Victory	009 Essex
Waits River	017 Orange
Waitsfield	023 Washington
Walden	005 Caledonia
Walden Station	005 Caledonia
Wallace Pond	009 Essex
Wallingford	021 Rutland
Waltham	001 Addison
Wardsboro	025 Windham
Wardsboro Center	025 Windham
Warners Grant	009 Essex
Warren	023 Washington
Warren Gore	009 Essex
Washington	017 Orange
Waterbury	023 Washington
Waterbury Center	023 Washington
Waterford	005 Caledonia
Waterville	015 Lamoille
Weathersfield	027 Windsor
Weathersfield Bow	027 Windsor
Weathersfield Center	027 Windsor
Websterville	023 Washington
Wells	021 Rutland
Wells River	017 Orange
West Addison	001 Addison
West Arlington	003 Bennington
West Barnet	005 Caledonia
West Berkshire	011 Franklin
West Berlin (Riverton P.O.)	023 Washington
West Bolton	007 Chittenden
West Braintree	017 Orange
West Brattleboro	025 Windham
West Bridgewater	027 Windsor
West Bridport	001 Addison

West Brookfield	017 Orange
West Burke	005 Caledonia
West Castleton	021 Rutland
West Charlestown/West Charleston	019 Orleans
West Corinth	017 Orange
West Cornwall	001 Addison
West Danville	005 Caledonia
West Dover	025 Windham
West Dummerston	025 Windham
West Enosburg	011 Franklin
West Fairlee	017 Orange
West Fairlee Center	017 Orange
West Glover	019 Orleans
West Groton	005 Caledonia
West Guilford	025 Windham
West Halifax	025 Windham
West Hartford	027 Windsor
West Haven	021 Rutland
West Lincoln	001 Addison
West Milton	007 Chittenden
West Newbury	017 Orange
West Norwich	027 Windsor
West Pawlet	021 Rutland
West Rupert	003 Bennington
West Rutland	021 Rutland
West Salisbury	001 Addison
West Swanton	011 Franklin
West Topsham	017 Orange
West Townshend	025 Windham
West Wardsboro	025 Windham
West Waterford	005 Caledonia
West Windsor	027 Windsor
West Woodstock	027 Windsor
Westfield	019 Orleans
Westford	007 Chittenden
Westminster	025 Windham
Westminster West	025 Windham
Westmore	019 Orleans
Weston	027 Windsor

Weybridge	001 Addison
Weybridge Hill	001 Addison
Wheelock	005 Caledonia
White River Junction	027 Windsor
Whiting	001 Addison
Whitingham	025 Windham
Wilder	027 Windsor
Williamstown	017 Orange
Williamsville	025 Windham
Williston	007 Chittenden
Wilmington	025 Windham
Windham	025 Windham
Windsor	027 Windsor
Winhall	003 Bennington
Winooski	007 Chittenden
Wolcott	015 Lamoille
Woodbury	023 Washington
Woodford	003 Bennington
Woodstock	027 Windsor
Worcester	023 Washington
Wrightsville	023 Washington

Appendix D
VCR Consult Case Form

Date Consult Submitted	
Reporting Facility	
Registrar's Name	

Patient Information:

Last Name	
First Name	
Middle Name (Initial)	
Maiden Name	
Patient Address at Diagnosis - Number and Street	
Patient Address at Diagnosis - Supplemental	
City/Town at Diagnosis	
State at Diagnosis	
Postal Code at Diagnosis	
Date of Birth	
Social Security Number	

Hospital Information:

Medical Record Number	
Physician Name	

Cancer Information:

Date Path/Cyt Report	
Path/Cyt Report Number	
Primary Site	
Histology	

Appendix E

Reference Manuals Based on Diagnosis Date

NAACCR Version	Effective Date	Reference Manuals Based on Diagnosis Date	Reference Release/Revised Date
Version 2016	1/1/2016	CoC FORDS Manual 2016	Revised for 2016
		Multiple Primary and Histology Coding Rules	Revised 8/24/2012
		SEER Program Coding and Staging Manual 2016	Revised 7/25/2016
		SEER Summary Staging Manual 2000	Revised 12/2012
		AJCC Cancer Staging Manual 7th ed.	
		Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual	Revised 1/14/2015
		ICD-O-3, 3rd ed.	
		SEER*Rx – Interactive Drug Database version 3.2.0	Software updated 5/26/2016 Data revised 9/30/2014
		VCR Required SSF Table	Revised 8/2016
Version 2015	1/1/2015	CoC FORDS Manual 2015	Revised for 2015
		ICD-O-3, 3rd ed.	Revised for 2000
		Collaborative Stage Data Collection System v0205	Revised 3/20/2014
		SEER Summary Staging Manual 2000, updated 12/2012	Revised 12/2012
		Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual v3.1.0	Revised 1/14/2015
		Multiple Primary and Histology Coding Rules	Revised 8/24/2012
		SEER*Rx – Interactive Drug Database v2.2.0,	Software updated 6/3/15 Data revised 9/30/2014
		AJCC Cancer Staging Manual 7th ed.	Errata Revised 4/26/2013
		VCR HPM 2015	Updated 2/2016
		VCR Required Site-Specific Table	Updated 9/2015
Version 14	1/1/2014	CoC FORDSManual 2013	Revised for 2013
		ICD-O-3, 3rd ed.	Revised 2000
		Collaborative Stage Data Collection System v0205	Revised 3/20/2014
		SEER Summary Staging Manual 2000, updated 12/2012	Revised 12/2012
		Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual v2.3.1	Revised 1/21/2014
		Multiple Primary and Histology Coding Rules	Revised 8/24/2012
		SEER*Rx – Interactive Drug Database v2.2.0,	Revised 8/2013
		AJCC Cancer Staging Manual 7th ed.	Errata Revised 4/26/2013
		VCR HPM 8.1	Updated 6/2014
		VCR Required Site-Specific Table	Updated 6/2014

Version 13	1/1/2013	CoC Fords: Revised for 2013 Collaborative Stage Data Collection System, Version 02.04 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, revised 2012 NCI Hematopoietic Database version 2.2 SEER Program Coding and Staging Manual 2013 VCR HPM 8 revised April 2013
Version 12.2	1/1/2012	CoC FORDS 2012 Collaborative Stage Data Collection System, Version 02.04.00 WHO ICD-O-3, 2000 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, revised 2012 NCI Hematopoietic Database version 2.1 SEER Program Coding and Staging Manual 2011 VCR HPM 7.2 revised June 2012
Version 12.1	1/1/2011	CoC FORDS 2011 Collaborative Stage Data Collection System, Version 02.03.02 WHO ICD-O-3, 2000 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, revised November 5, 2010 NCI Hematopoietic Database version 1.6.2 SEER Program Coding and Staging Manual 2010 VCR HPM 7.1 revised April 2011
Version 12	1/1/2010	CoC FORDS Revised for 2010 SEER Program Coding and Staging Manual WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Seventh Edition, 2010 Collaborative Stage Data Collection System, Version 02.00.00 VCR HPM, 7th Edition, 2010
Version 11.3	1/1/2009	CoC FORDS Revised for 2007 SEER Program Coding and Staging Manual 2007, Revision 1 WHO ICD-O-3, 2000

		SEER Summary Staging Manual, 2000 AJCC Staging Manual, Sixth Edition, 2002 Collaborative Staging Manual and Coding Instructions, Version 01.04.00 VCR HPM, 6th Edition, 2008
Version 11.2	1/1/2008	COC/FORDS Manual: Revised for 2007 Multiple Primary and Histology Coding Rules, 2007 SEER Program Code Manual, 2007 Collaborative Stage Manual and Coding Instructions, Version 01.04.00 VCR HPM, 6th Edition, 2008 WHO/ICD-O-3, 2000 AJCC Staging Manual, 6th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
Version 11.1	1/1/2007	COC/FORDS Manual: Revised for 2007 Multiple Primary and Histology Coding Rules, 2007 SEER Program Code Manual, 2007 Collaborative Stage Manual and Coding Instructions, Version 01.03.00 VCR HPM, 5th Edition, 2003 WHO/ICD-O-3, 2000 AJCC Staging Manual, 6th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
Version 11	1/1/2006	COC/FORDS Manual: Revised for 2004 SEER Program Code Manual, 1998 Collaborative Stage Manual and Coding Instructions, Version 01.02.00 VCR HPM, 5th Edition, 2003 WHO/ICD-O-3, 2000 AJCC Staging Manual, 6th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
Version 10.2	1/1/2005	Same as Version 10.1

Version 10.1	1/1/2004	COC/FORDS Manual, Revised for 2004 SEER Program Code Manual, 1998 Collaborative Stage Manual and Coding Instructions, Version 1.0 (implementation 1/1/2004) VCR HPM, 5th Edition, 2003 WHO/ICD-O-3, 2000 AJCC Staging Manual, 6th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
Version 10	1/1/2003	COC/FORDS Maual, 2003 SEER Program Code Manual, 1998 SEER Summary Stage Manual, 2000 WHO/ICD-O-3, 2000 AJCC Staging Manual, 6th Edition, 2002 VCR HPM, 5th Edition, 2003 SEER Extent of Disease Manual, 1998 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
Version 9.1	1/1/2002	Same as Version 9
Version 9	1/1/2001	COC/ROADS Manual, 1996 Rev. 1998 SEER Program Code Manual, 1998 WHO/ICD-O-3, 2000 SEER Summary Stage Manual, 2000 VCR HPM, 4th edition, 2001 AJCC Staging Manual, 5th Edition, 1997 SEER Extent of Disease Manual, 1998
Version 8	1/1/2000	VCR HPM, 3rd Edition, 2000 Same as Version 6 & 7 for all other references SEER Extent of Disease Manual, 1998
Version 7	1/1/1999	Same as Version 6
Version 6	1/1/1998	COC/ROADS Manual, 1996 Rev. 1998 SEER Program Code Manual, 1998 WHO/ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 5th Edition, 1997 SEER Extent of Disease Manual, 1998

		VCR HPM, 2nd Edition, 1998
Version 5.1	1/1/1997	Same as Verion 5
Version 5	1/1/1996	COC/ROADS Manual, 1996 SEER Program Code Manual, 1992 WHO/ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 4th Edition, 1992 SEER Extent of Disease Manual, 1992 VCR HPM, 1st Edition, 1993
Version 4	1/1/1994	COC/ACOS Data Acquisition Manual, 1994 SEER Program Code Manual, 1992 WHO/ICD-O-2, 1990 SEER Summary Staging Guide, 1977 AJCC Staging Manual, 4th Edition, 1992 SEER Extent of Disease Manual, 1992 VCR HPM, 1st Edition, 1993

Appendix F
2016 Reporting Requirements

There are a number of changes in federal cancer reporting requirements for 2016. Reportable tumors, as well as required data items, are affected.

The Vermont Cancer Registry (VCR) has adopted the smallest number of changes in order to still be in compliance with federal requirements. This email highlights changes to reporting effective with cases diagnosed on or after January 1, 2016.

Required Staging Schemes

Effective with cases diagnosed in 2016, CDC requires directly assigned SEER Summary Stage 2000 and AJCC TNM 7th Edition Clinical and Pathologic Stage. The Collaborative Stage Data Collection System Version 02.05 will continue to be used for cases diagnosed 2004-2015 and for the collection of the Site-Specific Factors (SSFs) for cases diagnosed 1/1/2016 and forward. In addition to the SSFs, Regional Nodes Positive and Examined and Lymph-vascular Invasion will continue to be required. All other CS input data items are no longer required.

Each component of the AJCC stage is important. Even if complete AJCC TNM information is not available in the record, any piece of staging information should be collected and reported. For example, if the T and N are available but no information is available on M, the T and N should be reported.

Site-Specific Factors

Site-Specific Factors (SSFs) that impact directly assigned AJCC-TNM 7th Edition Stage Group (e.g. PSA for prostate) or that are prognostic factors of interest will continue to be collected. SSFs that will be required by VCR are listed in Tables 1 and 2 below.

Table 1. VCR SSFs Required for Directly Assigned AJCC TNM Stage		
Site (CS Schema)	SSF	Description
Appendix	11	Histopathologic Grading
GISTPeritoneum	5 10	Mitotic Count Location of Primary Tumor
GIST Esophagus, GIST Small Intestine, GIST Stomach	6	Mitotic Count
GIST Appendix, GIST Colon, GIST Rectum	11	Mitotic Count
MycosisFungoides	1	Peripheral Blood Involvement
Placenta	1	Prognostic Scoring Index
Prostate	1 8 10	PSA Lab Value Gleason Score Gleason Score
Testis	13 15 16	Post Orchiectomy AFP hCG LDH Range

BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, Melanoma CiliaryBody, MelanomaIris, Nasopharynx, PharyngealTonsil, Stomach	25	Schema Discriminator

Table 2. VCR SSFs required by NPCR (but not for AJCC Staging)		
Site (CS Schema)	SSF	Description
Brain, CNS Other, Intracranial Gland	1	WHO Grade
Breast	1	ERA
	2	PRA
	8	HER2: IHC Value
	9	HER2: IHC Interpretation
	11	HER2: FISH Interpretation
	13	HER2: CISH Interpretation
	14	HER2: Result of other test
	15	HER2: Summary Result testing
	16	Combination of ERA, PRA and HER2 Testing

SSFs necessary to calculate Derived Summary Stage 2000 or Derived AJCC 7 Stage Group (for Collaborative Stage) are no longer required for cases diagnosed in 2016.

New Data Item

Tumor Size Summary

CSv2 Data Items that Continue to Be Required for 2016

Regional Nodes Positive
Regional Nodes Examined
Lymph-Vascular Invasion
CS Version Input Original
CS Version Input Current
CS Site-Specific Factors 1, 2, 5, 6, 8, 9, 10, 11, 13, 14, 15, 16, 25 (See Tables 1 and 2)

Data Items No Longer Required for 2016 (Required Historically for 2004-2015)

CS Site-Specific Factors 3, 4, 7, 12, 17-24
CS Tumor Size
CS Extension
CS Tumor Size/Ext Eval
CS Lymph Nodes
CS Mets at DX
CS Version Derived
Derived SS2000
Derived SS2000-Flag
CS Lymph Nodes Eval

CS Mets Eval
Derived AJCC-7 T
Derived AJCC-7 T Descript
Derived AJCC-7 N
Derived AJCC-7 N Descript
Derived AJCC-7 M
Derived AJCC-7 M Descript
Derived AJCC-7 Stage Grp
Over-ride CS 1-20

Changed Data Items

The allowable values for TNM data items now include a preceding "c" for "clinical" or "p" for "pathological" to describe the staging basis used for each category.

The word hermaphrodite formerly classified under code 3 in Sex is an outdated term. The definition was updated to code 3 Other (intersex, disorders of sexual development/DSD).

New ICD-O-3 Histology Codes

In December 2013, NAACCR published *Guidelines for ICD-O-3 Update Implementation*, which included a table of new ICD-O-3 codes and terms effective for 2015. However, the use of the new codes was postponed due to issues with adding these codes to the Collaborative Stage software. It is anticipated that these codes will be implemented in 2017 when the AJCC-TNM 8th Edition goes into effect.

For diagnosis year 2016, all standard setters have agreed to postpone the full set of codes and to use the alternate codes published in Table 2 of the NAACCR Guidelines for ICD-O-3 Update Implementation (Appendix D). See table, below, or visit http://www.naaccr.org/LinkClick.aspx?fileticket=5OHnOz811Dw%3d&tabid=161&mid=523.

If pathologists use any of the new terms in the "Description" column of this table, use the histology code in the column on the far right of the table.

Table 2 of the NAACCR Guidelines for ICD-O-3 Update Implementation (Appendix D)

ICD-O-3 Change	ICD-O-3 Histology Code (DO NOT use these codes)	Description	Comment	Use this Histology Code in 2015 and 2016
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*

New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	
*ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.				

Newly Reportable Conditions/Tumors

In 2014 and 2015, SEER added new reportable histology terms to their *Program and Coding Manual*. These terms had not been included in any ICD-O-3 errata and therefore were not addressed throughout the cancer surveillance community. CDC has reviewed the terms and determined that the following *are* reportable.

1. Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2).

2. Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._)

3. Based on pathologist consultation, metastases have been reported in some cystic pancreatic endocrine neoplasm (CPEN) cases. With all other pancreatic endocrine tumors now considered malignant, CPEN will also be considered malignant, until proven otherwise. Most CPEN cases are non-functioning and are REPORTABLE using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, grade 1 (assign code 8240/3) or neuroendocrine tumor, grade 2 (assign code 8249/3)

4. Laryngeal intraepithelial neoplasia, grade III (LINIII) (8077/2), C320-C329)

5. Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2), except Cervix and Skin

6. Mature teratoma of the testes in adults is malignant and REPORTABLE as 9080/3, but continues to be non-reportable in prepubescent children (9080/0). The following provides additional guidance:

- Adult is defined as post puberty
- Pubescence can take place over a number of years
- Do not rely solely on age to indicate pre or post puberty status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
- Do not report if unknown whether patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.

Version 2016 Software

I encourage each of you to contact your software vendor to ascertain when the Version 2016 software upgrade will be available, and then make arrangements with your facility IT staff to have someone available to oversee the upgrade process. Schedule firm implementation dates as early as possible to avoid delays.

Abstract cases diagnosed prior to January 1, 2016 before converting registry data or beginning to use Version 2016 software.

At this time I do not anticipate any delays in accepting 2016 data. We will notify you when Web Plus will be updated.

No changes were made to the SEER Hematopoietic & Lymphoid Database since January 2015.

No changes were made to the SEER*Rx Drug Database since September 2014 (web version) and June 2015 (software update).

2016 Edit Set

The 2016 VCR Hospital Edit Set will be required for all cases diagnosed 1/1/2016 and will be available once your software has been updated to the 2016 version. If you are using CNExT software, it will be built in to your 2016 update. If you are using Metriq, please contact me once you have your 2016 update and I will forward the metafile to you.

VCR Educational Meeting

Our annual educational meeting will be held in July this year. If you have any questions about the information in this email or suggestions for this year's meeting, please contact me.