Surely you have noticed this field on the follow-up screen. You may have also noted that it is shown as a blue field but in fact it is not required and is not CoC. It is pure Onco, but not for lack of trying. We proposed this field in the 1993 ROADS Data Task Force meetings, and again at the FORDS planning meeting in 2001.

It was rejected because of concern that the cause of death information would be a major burden for registrars. Certainly that is true in many communities. But, for those of you that can get this information, the payback can be substantial. In fact, for anyone doing clinical outcome and survival studies it is likely to be essential. Among other things the availability of this data can allow you to do cause-specific survival analysis which can give much better insight into the effect of a disease than its poor sister, relative survival. Cause specific survival has become an important reporting element in the medical literature. We doubt that any other registry system allows you to collect this kind of data, and we know that even if they did, they have not had the necessary analysis tools. Nor have we…until now.

With the next release of OncoLog you will have an enhanced survival analysis tool that will let you calculate tests of significance (P-values) on the difference in survival of any two study groups, perform relative survival calculations, time-to-event studies between any pair of dates, detailed life tables, and, of course, cause-specific survival analysis. Get ready for this. Code this very useful field whenever you can and let your doctors (especially those that publish) know that you will have this capability.

Several other enhancements will let you create publication-ready graphics with ease (great job, Tim!!).

Do You Know Your Cancer Registry History? – A Quiz
Who is credited with having performed the first outcomes analysis on cancer survival data? When?

You will find the answer to this quiz later in this Newsletter!
Optimal Use of the OncoLog RQRS/CP3R Reports

First things first: YES we are planning to add all of the new CP3R measures to our report (11 in all at last word) in the near future. That, of course, assumes that the CoC is able to provide detailed business rules for the measures on a timely basis. We will keep you posted.

We should begin the rest of this discussion with a disclaimer. The OncoLog report is not likely to duplicate the CP3R scores you will find on the NCDB “Data Link Contact Activity Menu”. Instead, we have designed it as a tool for achieving optimal performance before you submit your data to NCDB. There are several reasons our numbers are not likely to match theirs. We will summarize them here but a detailed report is available on request:

♦ Your data is always going to be more current.
♦ If any of your patients goes on to develop a second primary, and you report it, the first primary will be duplicated in the NCDB file (as a case with sequence number 00 and also as an otherwise identical case with sequence number 01) and counted twice in their CP3R report. This is a minor thing for recent years but can be significant if you are looking at scores for a few years ago. If you wish, you can go on line and manually censor the second record on the NCDB web site.
♦ In a careful audit with a large hospital’s data we identified a number of errors in the CP3R calculations as performed by the CoC.:
   ◇ For the BCSRT measure they have based NE status on clinical stage when it should be based on pathologic stage.
   ◇ For the HT measure patients are classified as NA if they are pNX, this is not correct. Any T1c or greater ER+ patient should be considered for HT regardless of nodal status.
   ◇ For the ACT measure CP3R currently calculates a case as compliant even if the time to chemo exceeds 4 months.
   ◇ For the 12RLN measure CP3R looks to clinical stage for eligibility when it should be looking at pathologic stage.

Note that we notified the CoC of these observations a few months ago and some of the problems may have been corrected by now.

Given all that information, how should YOU use OncoLog’s CP3R report? For our money the action is in the QA grids that accompany the color report. They have been designed to make it easy to identify non-concordant and soon to be non-concordant cases. We would suggest that you run the report at regular intervals (monthly or less) so you can identify cases approaching deadlines and notify the managing physicians. If your hospital is committed to achieving good scores you can also use these lists to identify providers with a high rate of non-concordance.

You may already know that, in response to user requests, we recently re-designed the report so that you can calculate scores on intervals other than the CoC standard of one year.

Quality measures are here to stay and, while they can bring some abstracting headaches, they will also increase your importance at your institution. Make them a high priority.

Run-time parameters in the RQRS/CP3R reports allow you to specify an additional title line (such as “Quarterly Report to Cancer Committee” and identify the requesting party (e.g. “Cancer Committee Chair”). With version 2 you have three additional options for controlling the content of the report:

♦ Time Interval for Calculations (default – 1 year): Select from five standard options, monthly, bi-monthly, quarterly, semi-annual and annual and the results will be grouped accordingly. Select option ‘06’ and the report will aggregate all cases from the start date you choose to the current date.
♦ Start Date (default - ‘01/01/2004’): Enter the first Date of Initial Diagnosis of interest for your report. All cases in the filter group with a Date of Initial Diagnosis before the start date will be ignored.
♦ Number of Intervals (current default 9): This determines the overall window of time your report explores. You may choose any number.
Presentation Pointers – Episode the 1st

Dr. Winston wanders into your office one day and asks you to rustle up some data from your registry and prepare a set of PowerPoint slides that he can show at a state meeting. Do you feel comfortable responding? Do you know how to assemble data in a graphic presentation that is easy to view and easy to understand? If not, we are here to help. Beginning with this issue we will be offering a series that addresses some of the key skills and principles you need to know. Many of the ideas we discuss will be drawn from the writings of Dr. Edward Tufte. Perhaps some of you saw our Medical Director’s presentation at NCRA this year. If you did, this series will be a bit of a review.

For this issue let’s talk about how you use the acreage available on a PowerPoint slide. From the program’s point of view you have an area of 7.5 x 10 inches to work with. Curiously, the aspect ratio (width/height) of a PowerPoint slide exactly matches that of Edison’s classic 35 mm film format, 1.33! Of course, what you see on your screen depends on your zoom setting. Clearly the choice of 7.5 x 10 is somewhat arbitrary. Why not 6 x 8 or 3 x 4 or for that matter, why not metric units? Anyway, when projected it will be much different.

When you place material on the slide be sure to think about the venue in which it will be projected. A small cancer conference is one thing, an NCRA meeting hall is another. As the top illustration demonstrates, in the big hall setting the bottom 25% or so of the image will be lost to much of the audience. Reserve that space for what Tufte calls “chart junk”, hospital logos, page numbers, copyright statements, etc. Be sure to put important text at the top. Many a great cartoon has fallen flat because the slide preparer left the caption at the bottom.

Also avoid the temptations of templates. In the bottom illustration hospital chart junk consumes the most useful top 25% of the slide and the swirls of a PowerPoint template are chewing on the left third leaving you with less than 50% of the useful slide area for your data, some of which will be obscured by heads.

Next time will provide some hints for getting your OncoLog graphics and tables on to your slides.

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1Professor emeritus of political science, computer science and statistics, and graphic design at Yale University and one of the world’s leading experts on visual presentations of data. Consider reading his monograph: The Cognitive Style of PowerPoint, or his fascinating The Visual Display of Quantitative Information. These and other related books are available from: Graphics Press LLC, P.O. Box 430, Cheshire, Connecticut, 06410 (www.edwardtufte.com)

Just to Clear the Air

We Take Issue with That!
Version 1.2 of Cancer Program Standards is out and by now I bet you have all read every word. It is a fine document apart from one grievous error (in the eyes of the world’s radiation oncologists) in the Forward. We quote: “Because surgical intervention was the ONLY available treatment for cancer at that time (1913)....”

So wrong!!! The first radiation treatment for cancer was probably on January 31, 1896 in Chicago and by 1913 it was a well-established modality with major treatment centers throughout the world.

On my bookshelf I have four antique textbooks of radiation therapy with copyright dates of 1902, 1906, 1909 and 1910 respectively (left to right in the picture). Many cures claimed! The 1910 volume is a massive tome covering diagnostic radiology, radiation therapy, magnetic therapy and electrostatic therapy. We have been killing cancers with radiation since shortly after surgeons first started washing their hands!

- TW
Spotlight on Long-Standing Programs

The ACoS recently recognized CoC-accredited cancer programs that have maintained their accreditation for 50 plus consecutive years. We would like to salute our “Long-Standing Programs”!

- University of Missouri/Ellis Fischel Cancer (1940) Columbia MO
- Oregon Health & Science University (1940) Portland OR
- Salem Hospital (1952) Salem OR
- Sentara Norfolk General Hospital (1954) Norfolk VA

Verification of CA State Accreditation

ONCO is now CA State Accredited!

ONCO, Inc. is proud to announce that we are now a fully approved software vendor for the California State Cancer Registry (CCR). We are excited to share the good news with you and are looking forward to having California clients come onboard with us! As a continual process, Onco will work closely with CCR staff in order to maintain the approval on future standard changes. Know anyone at any CA facilities??? Please pass the word on!

Did You Know?

Per SEER Hematopoietic Database:
9836/3- Precursor B Cell Lymphoblastic Leukemia/Lymphoma is now an obsolete code for cases diagnosed in 2012 and forward and is replaced with 9811/3- B Lymphoblastic Leukemia/Lymphoma, NOS.

For a list of the other obsolete codes as of 2012 and forward, copy and paste the link below into your web browser and go to Appendix E: http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Cancer Awareness Months

<table>
<thead>
<tr>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Prostate Cancer Awareness Month</td>
<td>National Breast Cancer Awareness Month</td>
</tr>
<tr>
<td>Leukemia Awareness Month</td>
<td>National Liver Cancer Awareness Month</td>
</tr>
<tr>
<td>Lymphoma Awareness Month</td>
<td>Lung Cancer Awareness Month</td>
</tr>
<tr>
<td>Ovarian Cancer Awareness Month</td>
<td>Pancreatic Cancer Awareness Month</td>
</tr>
<tr>
<td>Childhood Cancer Awareness Month</td>
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<tr>
<td>Gynecological Cancer Awareness Month</td>
<td></td>
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<tr>
<td>Thyroid Cancer Awareness Week</td>
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</tbody>
</table>
Edits Reminder

The “Date Case Completed-CoC” edit is generated only on analytic cases when running NAACCR edits. The CoC only requires analytic cases be submitted therefore the NAACCR edit does not review non-analytic cases. If you want to mark the case as completed for CoC, you still have to manually do this but will not have the visual reminder as you do with analytic cases.

A Course is a Course, of Course, of Course

An OncoLog client recently called wanting to know how to code chemotherapy for a case similar to the following: “An elderly woman was recently diagnosed with lung cancer in another community. Because of her age and co-morbidities the local medical oncologist elected to initiate treatment with single agent chemotherapy. After a period of time without obvious response she changed her point of care to our facility where the team elected to start her on a multi-agent regimen.” If we look to the “good book” (a.k.a. The FORDS) for guidance we get answers that seem somewhat conflicting. On page 19 you will find words that suggest that this patient should be coded to multi-agent chemotherapy (note the word “all”):

FIRST COURSE OF TREATMENT

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. “Active surveillance” is a form of

However, turn to page 266 and you get a somewhat different picture (but one that fits with the simplistic data field available):

I have had a running debate on this subject with my friends at the CoC for 20 years. In fact, a couple of years ago I wrote a seven page whitepaper on the subject but this is just a newsletter. Before creating a data field I like to ask how that data might be used in 10 or 20 years. At the four meetings of the ROADS Data Task Force in 1993 (I was the only physician to attend all four meetings) we did not anticipate using treatment data for the coming epoch of quality measures but we did consider the possibility of relating outcomes to treatment. It was this thinking that was behind the limited coding available for first course chemotherapy. Now it is a generally accepted fact that it is the first choice of systemic treatment that has the greatest impact on both survival and quality of life. In general subsequent treatment choices have much less impact. This is in fact why CP3R and other quality measures focus on that first choice of care.

In this situation I (opinion) would code the summary chemotherapy to single agent. Taking a literal interpretation of the FORDS I would code the facility’s chemo to multi-agent but I would use only the summary treatment in any outcome studies.

Ted Williamson, MD, PhD, CTR (ret), Medical Director

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2 My apologies to Mr. Ed

3 Available on request
ALEXANDER VON WINIWARTER (1848–1916). Dr. Winiwarter was a German surgeon and colleague of the famous Dr. Theodor Bilroth. In 1878, he published a statistical analysis of the outcomes of 548 cancer patients treated surgically by Dr. Bilroth. The concepts of classifying tumors by site and estimating cure rates based on years of survival were originated by Winiwarter. Winiwarter also pioneered the development of massage and compression procedures to treat lymphedema, an important element of breast cancer care today.