

## Chapter 3: General Instructions

Now that you have determined the reportability of each case and the number of primaries to be reported, you are ready to complete the abstract for submission to the State. This chapter includes general instructions on completing the required data items for each case. Chapter 5, the data dictionary, provides specific information on each required and some recommended fields.

### Important Items to Remember

- The SEER Summary Staging Manual 2018 must be used to assign the summary stage for all cases diagnosed from January 1, 2018, forward. The manual is available on line at <https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf>.
- Completed cases should be submitted to WCRS within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere. Breast cancer cases should be submitted to WCRS within 12 months of date of diagnosis or date of initial contact if diagnosed elsewhere (breast cancer treatment and sometimes staging information are often not complete within the six month time frame).

Timely Reporting Calendar		Timely Reporting Calendar for Breast Cases	
Month Case Dx/Seen	Month Case Due	Month Case Dx/Seen	Month Case Due
January	July	January	December
February	August	February	January
March	September	March	February
April	October	April	March
May	November	May	April
June	December	June	May
July	January	July	June
August	February	August	July
September	March	September	August
October	April	October	September
November	May	November	October
December	June	December	November

- Electronic reporting is required for all hospitals. WCRS will provide free data entry software (Abstract Plus) and data submission software upon request. Please note: Abstract Plus MUST be downloaded from the WCRS web site, do NOT download the generic version from CDC. The WCRS web site contains the customized version for Wisconsin reporters which include physician and facility tables for Wisconsin along with Wisconsin-specific edits.
- While Collaborative Stage is not required for cases diagnosed in 2016 or later, the Collaborative Staging Manual Version 2.05 must still be used to derive stage for cases diagnosed on or after January 1, 2004, through December 31, 2015.
- **Hospitals:** All **active** cancer cases diagnosed after December 31, 1975 must be abstracted and reported to WCRS (this includes cases that may not have been diagnosed or treated for cancer in your facility).
- **Clinics:** All cancer patients receiving cancer-directed treatment in your facility after December 31, 1991 must be abstracted and reported to WCRS. In addition, all cancer patients diagnosed in your facility that you do NOT treat and do NOT refer to a Wisconsin hospital must also be reported.
- **Early Case Capture (ECC) of Pediatric and Young Adult Cancers:** This project was conducted from 2014-2019. During that time, all reportable ECC data items for cancers diagnosed among children and young adults ages 0-19 were required to be submitted to WCRS within 30 days from the date of diagnosis. Appendix VI contains the data items that WCRS required for ECC reporting. Details are available on the [WCRS ECC web page](#).

**Note:** Refer to *Appendix IV* for a list of coding manuals and other resources needed to complete case reporting for WCRS.

## General Instructions - Place of Residence at Diagnosis

The Wisconsin Cancer Reporting System collects information on place of residence at diagnosis. Rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

### Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: *U.S. Census Bureau Instructions*: “The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home.”
2. **Post Office Box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographic information for analyzing cancer incidence. Use the post office box address **only if** no street address information is available after follow-back.
3. Use residency information from a death certificate **only when** residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau rules for determining residence. The death certificate may give the person’s previous home address rather than the nursing home address as the place of residence; use the nursing home address as the place of residence.
4. Do NOT use **legal status** or **citizenship** to code residence.

### Persons with More Than One Residence

**Example:** Persons who live in the south for the winter months but in the north during the summer months (or vice versa) or people with vacation residences that they occupy for a portion of the year.

1. Code the residence where the patient spends the majority of time (usual residence).
2. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

### Persons with No Usual Residence

Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at diagnosis such as the shelter or hospital where diagnosis was confirmed.

### Temporary Residents of the Wisconsin Area

1. Code the place of **usual** residence rather than the temporary address for:
  - a. Migrant workers
  - b. Educators temporarily assigned to a university in the Wisconsin area
  - c. Persons temporarily residing with family during cancer treatment
  - d. Military personnel on temporary duty assignments (TDY)
  - e. Boarding school students below college level (code the parent's residence)
2. Code the residence where the student is living while he/she is attending college.
3. Code the address of the institution for persons in institutions. *U.S. Census Bureau definition: "Persons under formally authorized, supervised care or custody are residents of the institution."*
  - a. Persons who are incarcerated
  - b. Persons who are physically disabled or have an intellectual disability, who are residents of homes, schools, hospitals or wards
  - c. Residents of nursing, convalescent, and rest homes
  - d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

### Persons in the Armed Forces and on Maritime Ships (Merchant Marine)

1. **Armed Forces:** For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.
2. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships:** The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and homeport. Refer to U.S. Census Bureau Publications for detailed rules: <http://www.census.gov>

## General Information - Reporting Race

Race refers to a person's physical characteristics, such as bone structure and skin, hair, or eye color.

Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the U.S. 2010 Census. In Wisconsin, only about 1% of the population is multiracial. Most of the time you will only code one race field for the patient (in the Race 1 field).

**Note:** When there is only one race to be coded, then the Race 2-5 fields will be coded to '88' meaning no other races are listed). If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field. If the person's race is a combination of more than one non-white race, code Race 1 to the first stated non-white race (02-98), Race 2 to the second, etc.

**IMPORTANT:** For cases diagnosed/reported after January 1, 2000, **all race fields must be coded (using '88's in the 'extra' race fields)**. All resources in the facility, including the medical record, face sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race.

### Priorities for Coding Multiple Races

1. Code **12** takes priority over all other codes.

**Example:** Patient is described as Hmong and Laotian. Code Race 1 as 12 (Hmong), Race 2 as 11 (Laotian).

2. Codes **02-32, 96-98** take priority over code **01**.
3. Code only the specific race when both a specific race and a non-specific race code apply.
  - a. Codes 04-17 take priority over code 96.
  - b. Codes 16-17 take priority over code 15.
  - c. Codes 20-32 take priority over code 97.
  - d. Codes 02-32 and 96-97 take priority over code 98.
  - e. Code 98 takes priority over code 99.

## General Instructions - Coding Race

**IMPORTANT:** See Coding Instruction 15, Exception, for the only situation in which name is taken into account when coding race.

1. Do **not** use patient name as the basis for coding race, especially for females with no maiden name given.

- a. A name may be an indicator of a racial group, but should not be taken as the only indicator of race.
- b. A patient name may be used to identify a more specific race code.

**Example 1:** Race reported as Asian, name is Hatsu Mashimoto. Code Race 1 as '05' Japanese.

**Example 2:** Birthplace is reported as Guatemala and name is 'Jose Chuicol' [name is identified as Mayan]. Code Race 1 as '03' Native American.

- c. A patient name may be used to infer Spanish ethnicity or place of birth, but a Spanish name alone without a statement about race or place of birth cannot be used to determine the race code.

**Example:** Alice Gomez is a native of Indiana (implied birthplace: United States). Code Race 1-5 as '99,' Unknown, because nothing is known about her race.

**Note:** Patient's ethnicity is not the same as patient's race. Refer to ethnicity guidelines for further information.

2. Code race using the highest priority source available according to the list below (when race is reported differently by two or more sources).

### Sources in Priority Order

- a. The patient's self-declared identification
- b. Documentation in the medical record
- c. Death certificate

**Note:** 'a' is the highest and 'c' is the lowest.

3. Assign the same race code(s) for all tumors for one patient.
4. Code the race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5.

**Note:** Code **88** for the remaining race fields (Race 2 – Race 5) when at least one race, but fewer than five races, are reported.

5. Use the associated text field to document.
  - a. Why a particular race code was chosen when there are discrepancies in race information.

**Example:** The patient is identified as Black in nursing notes and White in a dictated physical exam. Use a text field to document why one race was coded rather than the other.

- b. That no race information is available.
6. Code as **01** (White) when:
  - a. The race is described as White or Caucasian regardless of place of birth.
  - b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available.

**Note 1:** Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

**Note 2:** Do **not** code a patient stated to be Hispanic or Latino as '98,' Other Race, in Race 1 and '88' in Race 2-5. in this situation.

**Example 1:** Patient is a Latina. Code race as 01 (White).

**Example 2:** Sabrina Fitzsimmons is a native of Brazil. Code Race 1 as '01,' White per Appendix V, and Race 2-5 as '88'.

7. Code race as **02** (Black) when the stated race is African-American, Black, or Negro.
8. Assign code **03** for any person stated to be
  - a. Native American (western hemisphere) OR
  - b. Indian, whether from North, Central, South, or Latin America

9. Assign a specific code when a specific Asian race is stated.

**Example:** Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.

**Note 1:** Asian race codes are specific to unique groups and every attempt should be made to report the patient's most detailed race.

**Note 2:** Do not use code 96 when a specific race is known

**Note 3:** Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.

10. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

**Example 1:** Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.

**Example 2:** The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

**IMPORTANT:** This is the national standard that's applied in race algorithms (using place of birth to provide a more specific race category), central cancer registries adapt it as the best practice for race reporting of more specific Asian countries.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

**Example:** The patient is described as Asian-American with Korean parents. Code Race 1 as '08' Korean because it is more specific than '96' Asian, NOS, and Race 2-5 as '88.'

12. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of a race category.

**Example 1:** Patient describes herself as multi-racial (nothing more specific) and nursing notes say “African-American.” Code Race 1 as ‘02’ Black and Race 2-5 as ‘88.’

**Note:** Do not use code 96, 97, or 98 for “multi-racial.”

**Example 2:** Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as ‘25’ Polynesian, Race 2 as ‘26’ Tahitian, and Race 3-5 as ‘88.’

13. All race fields must be coded 99 (Unknown) when Race 1 is coded 99 (Unknown).

**Note:** Assign code 99 in Race 2-5 only when Race 1 is coded 99.

14. Death certificate information may be used to supplement ante-mortem race information only when race is coded ‘unknown’ in the patient record, or when the death certificate information is more specific.

**Example 1:** In the cancer record, Race 1-5 are coded as ‘99,’ Unknown. The death certificate states race as ‘Black.’ Change the cancer record for Race 1 to ‘02,’ Black and Race 2-5 to ‘88.’

**Example 2:** Race 1 is coded in the cancer record as ‘96,’ Asian. The death certificate gives birthplace as China. Change Race 1 in the cancer record to ‘04,’ Chinese and code Race 2-5 as ‘88.’

**Note:** Assign code 99 for death certificate only (DCO) cases when race is unknown.

15. If race is unknown or not stated in the medical record and birth place is recorded. Refer to Appendix V “Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics”.

**Note:** In some cases, race may be inferred from the nationality. Use Appendix V to identify nationalities from which race codes may be inferred.

**Example 1:** Record states: “this native of Portugal...” Code race as 01 (White) per Appendix V.

**Example 2:** Record states: “this patient was Nigerian...” Code race as 02 (Black) per the Appendix V.

**Exception:** Code Race 1 through Race 5 as 99 (Unknown) when patient’s name is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when the patient’s name is incongruent with the race inferred on the basis of nationality.

**Example 1:** Patient’s name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).

**Example 2:** Patient’s name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as 99 (Unknown).

16. When the patient face-sheet indicates “Race Other,” look for other descriptions of the patient’s race. When **no further race information is available**, code race as 99 (Unknown) and document that patient face-sheet indicates “Race Other,” and no further race information is available.
17. Patient photographs may be used with caution to determine race in the absence of any other information.

**Note:** Use caution when interpreting a patient photograph to assist in determining race. Review the patient record for a statement to verify race. The use of photographs alone to determine race may lead to misclassification of race.
18. Code race in the order stated when no other priority applies.

**Additional Coding Examples for Race**

**Example 1:** Patient stated to be Japanese. Code Race 1 as '05' (Japanese) and Race 2-5 as '88'.

**Example 2:** Patient stated to be German-Irish. Code Race 1 as '01' (White) and Race 2-5 as '88'.

**Example 3:** Patient described as Arabian. Code Race 1 as '01', (White) and Race 2-5 as '88'.

**Example 4:** Patient described as a black female. Code as '02', (Black) and Race 2-5 as '88'.

**Example 5:** The patient is described as Asian-American with Korean parents. Code Race 1 as '08' (Korean) because it is more specific than '96' (Asian) [-American].

**Example 6:** Patient stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black). Code in the order stated when no other priority applies.

**Example 7:** Patient described as Middle Eastern. Code as 01 (White).

**Example 8:** Patient described as Greek. Code as 01 (White).

**Example 9:** Patient is stated to be Vietnamese and Black. Code Race 1 as '10' Vietnamese, Race 2 as '02' black, and Race 3 through Race 5 as '88'.

**Example 10:** Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).

## General Instructions - Reporting Ethnicity (Spanish Surname or Origin)

**Note:** Ethnicity refers to cultural factors, including nationality, regional culture, ancestry, and language.

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Use all information to determine the Spanish/Hispanic Origin including:
  - a. Ethnicity stated in the medical record

**Note:** Self-reported information takes priority over other sources.
  - b. Hispanic origin stated on the death certificate
  - c. Birthplace
  - d. Life history and/or language spoken found in the abstracting process
  - e. Last name or maiden name found on a list of Hispanic/Spanish names
3. Assign code **6** when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.
4. Assign code **7** when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic.

**Note:** Code 7 is ordinarily for central registry use only.
5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish
  - a. Assign code **7** when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.
  - b. Assign code **0** when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.
6. Assign code 9 for death certificate only (DCO) cases when Spanish/Hispanic origin is unknown.
7. Do **NOT** code the Race field to '98,' Other Race, when a patient is determined to be Hispanic.

**Coding Examples - Reporting Ethnicity (Spanish Surname or Origin)**

**Example 1:** Married female, no maiden name, Race 99, born in Mexico, married name is not on Spanish surname list. Code as 1 (Mexican) using coding instruction 2.c.

**Example 2:** Married female, no maiden name, Race 01, born in Philippines, married last name not on Spanish surname list and medical record states "Hispanic." Code as 6 (Hispanic, NOS) using coding instruction 2.a.

**Example 3:** Married female, no maiden name, Race 99, born in Peru, married last name is on Spanish surname list, no statement regarding ethnicity available. Code as 4 (South or Central America) using coding instruction 2.c.

**Example 4:** Patient has two last names, one of the last names is on the Spanish surname list. Code as 7 (Spanish surname only) using coding instruction 4.

## General Instructions - Reporting Behavior

1. The behavior of a neoplasm describes the malignant potential of the tumor.
2. Behavior codes 0 (benign) and 1 (borderline) are reportable for intracranial and CNS sites only, beginning with January 1, 2004, diagnoses.

Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do not use the WHO grade to code behavior.

3. *In situ* noninvasive tumors (code 2): Clinical evidence alone cannot identify the behavior as *in situ* (/2); the code must be based on pathologic examination and documentation.
4. *In situ* and Invasive (code 3) components in the same tumor: Code the behavior as invasive malignant (/3) if any portion of the primary tumor is invasive no matter how limited; i.e., microinvasion.

**Example:** Pathology from mastectomy: Large mass composed of intraductal [*in situ*] carcinoma with a single focus of invasion. Code the behavior as malignant /3.

Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be *in situ*.

**Example:** Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma *in situ*; right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

5. ICD-O-3 Manual Histology/Behavior Code Listing: The ICD-O-3 manual may have only one behavior code, either *in situ* /2 or malignant /3, listed for a specific histology.

If the pathology report describes the histology as *in situ* /2 and the ICD-O-3 histology code is only listed with a malignant /3 behavior code, assign that histology code and change the behavior code to *in situ* /2, to match the pathologist's findings.

Likewise, if the pathology report describes histology as malignant /3 and the ICD-O-3 histology code is only listed with an *in situ* /2 behavior code, assign that histology code and change the behavior code to malignant /3, again, to match the pathologists' findings. Refer to the Morphology and Behavior Code Matrix discussion in the ICD-O-3 manual for more information.

**Example:** The pathology report states large cell carcinoma *in situ*. The ICD-O-3 lists large cell carcinoma as 8013/3; only as malignant. Change the behavior code of /3 to /2 and code the histology and behavior code to 8013/2 as specified by the pathologist.

**Note:** Make sure the behavior code in the appropriate text field was confirmed by pathology. In addition, your software edits may require using an override code for this rare situation.

#### Common Synonyms for In Situ, Noninvasive Tumors

- AIN III (anal canal)
- Behavior code '2'
- Bowen disease (not reportable for skin primary cancers)
- Clarks level I for melanoma (limited to epithelium)
- Confined to epithelium
- Hutchinson melanotic freckle, NOS
- Intracystic, non-infiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to, but not including, the basement membrane
- Lentigo maligna
- Lobular, noninfiltrating
- Noninfiltrating
- Noninvasive
- No stromal invasion/involvement
- Papillary, noninfiltrating or intraductal
- Precancerous melanosis
- Queyrat erythroplasia
- Stage 0
- VAIN III (Vagina, NOS)
- VIN III (Labium majus and minus, clitoris, vulva, NOS)

## General Instructions - Reporting Grade

### Hematopoietic and Lymphoid Neoplasms

Historically the cell lineage indicator (B-cell, T-cell, Null cell, NK-cell) was collected in the Grade data item. Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms will no longer be collected for cases diagnosed 1/1/2018 and forward.

**IMPORTANT:** Grade is no longer applicable for Hematopoietic and Lymphoid Neoplasms for cases diagnosed 2018 and forward.

- **For cases with histologies 9590/3-9992/3, the clinical grade must be coded to '8'.**
- **Grade fields are coded to '8', not applicable**
  - **Exception:** Follicular lymphomas occurring in the Lymphoma Ocular Adnexa schema.

### Solid tumors - Grade, Differentiation

For solid tumors diagnosed 2018 and forward, grade will be collected in three different data items, Grade Clinical, Grade Pathological, and Grade Post Therapy, and the codes and coding instructions will depend on the type of cancer. The tables for grade were restructured for 2018. There may be a combination of numeric and alphabetic codes within the same table, according to this template.

Template for a Cancer-Specific Grade Table	
Codes	Grade Description
1-5	Site-specific grade system category
8	Not applicable (Hematopoietic neoplasms only)
9	Grade cannot be assessed; Unknown
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated and anaplastic
E	Site-Specific grade system category
H	High grade
L	Low grade
M	Site-specific grade system category
S	Site-specific grade system category
Blank	(Post therapy only)

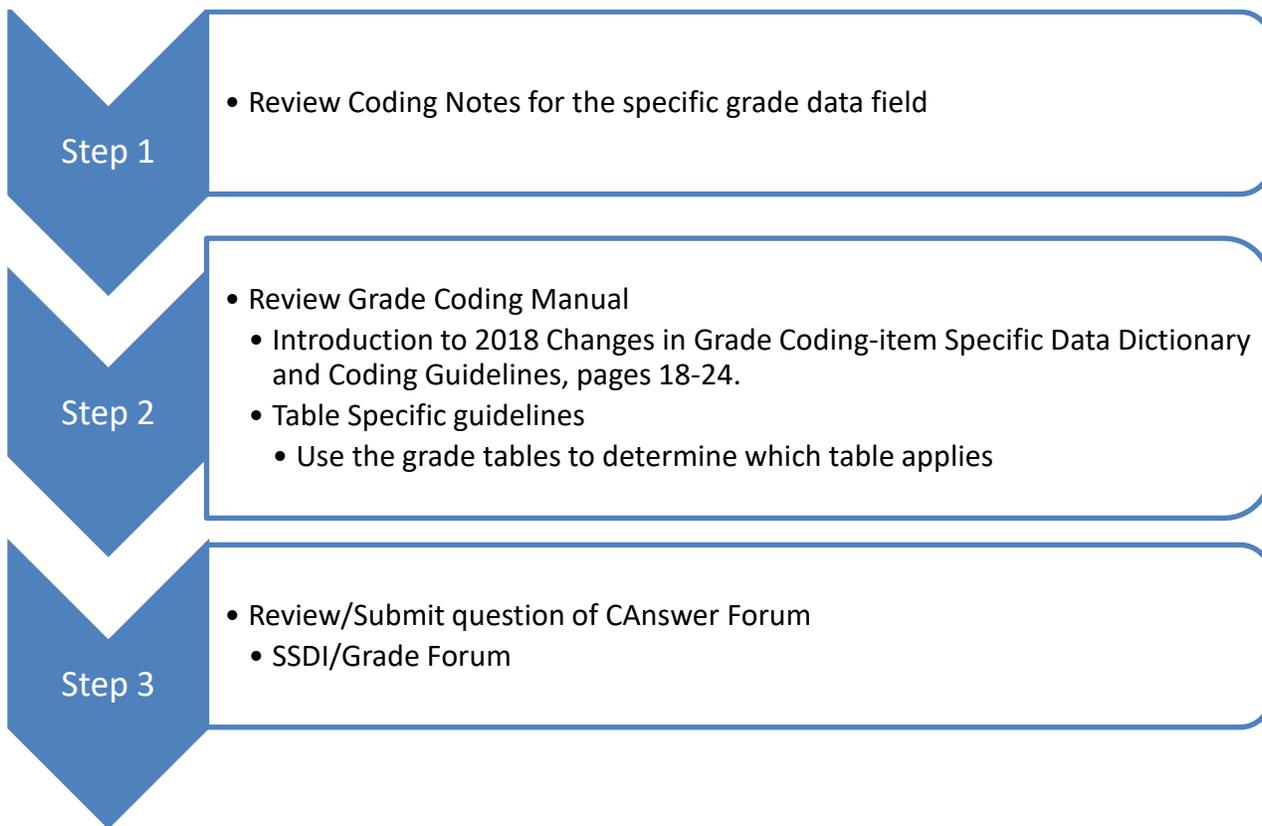
## Grade Coding Instructions - Solid Tumors

1. Code the grade from the primary tumor only.
  - a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site
  - b. If primary site is unknown, code grade to **9**.
2. If there is more than one grade for the same primary site; code the highest grade within the applicable grade table.
3. In situ and/or combined in situ/invasive component:
  - a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.
  - b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
4. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code clinical grade based on information prior to neoadjuvant therapy even if grade is unknown during the clinical timeframe. Grade can now be collected in grade post therapy cases when grade is available from post neoadjuvant surgery

**See the individual site-specific Grade Clinical tables for additional notes:**

<https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1527608547>

## Steps for Coding Grade



### Step 1

#### **Grade Clinical**

This input is used for staging.

#### **Coding Guidelines**

**Note 1:** Clinical grade must not be blank.

**Note 2:** Assign the highest grade from the primary tumor.

**Note 3:** Priority order for codes.

### Step 2

<https://www.naaccr.org/SSDI/Grade-Manual.pdf?v=1527608547>

### Step 3

<http://cancerbulletin.facs.org/forums/>

## General Instructions - Time Frames for Grade

The three new grade data items reflect the points in time in the patient's care when grade may be assessed.

### Required by WCRS for All Cases

#### ***Grade Clinical***

For the Grade Clinical data item, record the grade of a solid primary tumor before any treatment. Treatment may include surgical resection, systemic therapy, radiation therapy, or neoadjuvant therapy. All surgical procedures are not treatment, e.g. TURB and endoscopic biopsies.

#### ***Grade Pathological***

For the Grade Pathological data item, record the grade of a solid primary tumor that has been surgically resected and for which no neoadjuvant therapy was administered. If AJCC pathological staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.

#### ***Grade Post Therapy***

For the Grade Post Therapy data item, record the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC post therapy staging is being assigned, the tumor must have met the surgical resection requirements for yp in the AJCC manual. Neoadjuvant therapy must meet guidelines or standards, and not have been given for variable or unconventional reasons as noted in the AJCC manual. This data item corresponds to the yp staging period only.

## Changing Information Already Reported to WCRS

It is possible that after a cancer case has been abstracted and submitted to WCRS, additional information was clarified or added to the patient's chart, which may lead to changes in specific data items submitted on the initial abstract.

1. Do not submit changes as a regular new report.
2. Changes to specific reporting fields below should be submitted to WCRS.
  - Last name
  - First name
  - Middle name
  - Maiden name
  - Address at diagnosis; includes city, county, state and zip code
  - Race
  - Spanish/Hispanic origin
  - Sex
  - Birthdate
  - Social Security number
  - Date of diagnosis
  - Primary site
  - Morphology type, behavior and grade
  - Laterality
  - Diagnostic confirmation
  - Summary Stage
  - Type and date of first course definitive treatment
3. Submissions will be accepted in two formats:
  - a. Fax the change to 608-266-2431, or
  - b. Use the 'M' NAACCR electronic record layout. (Contact your vendor for specific instructions on submitting these changes if using the M layout.)

## Paper Reporting Forms

Paper reports should only be completed when electronic reporting options are not working properly at the reporting facility. Contact WCRS directly if you are having problems reporting electronically. Hospitals using Abstract Plus may submit cases diagnosed prior to 2003 on paper (due to the difficulty of clearing staging edits).

The official reporting forms are available from the WCRS website at:

<https://www.dhs.wisconsin.gov/wcrs/reporterinfo/manual.htm>. If it is necessary to use paper, the forms should be faxed to WCRS or submitted in a well-sealed envelope, marked "CONFIDENTIAL" and mailed to:

Wisconsin Cancer Reporting System  
P.O. Box 2659  
Madison WI 53701-2659

## Electronic Data Transmissions

Electronic data must be sent using the NAACCR Version 18 layout (see web site for a complete list of required data items). Data must be sent using Web Plus software. Contact WCRS to obtain a Web Plus account (user ID and password) for secure data submission.

**IMPORTANT:** Web Plus passwords expire every six months. If you do not submit your cases regularly, you will need to contact WCRS to have your password reset.

WCRS requests the following submission schedule to maintain timely reporting and reduce issues with Web Plus password expirations:

Submission Schedules	
Annual Caseload	Schedule
More than 500	Monthly
Less than 500	Monthly or quarterly