Wisconsin Cancer Reporting System
Reporting Manual

Updated for 2025 Diagnoses

Wisconsin Cancer Reporting System
Office of Health Informatics
Division of Public Health
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Overview

The primary purpose of this WCRS Coding Manual is to assist Wisconsin cancer reporters in reporting cancer cases to the Wisconsin Cancer Reporting System (WCRS), as mandated by Wis. Stat. § 255.04, Cancer Reporting.

All reporters should refer to this **Reporting Manual**, the **WCRS Data Dictionary** (available on the Reporting Requirements Webpage) and the materials referenced within when abstracting. In addition, reporters should utilize the WCRS Coding Resources Webpage, which includes links to various reference materials and tools to be used while abstracting.

Since the passage of Public Law 102-515 Cancer Registries Amendment Act by the 102nd Congress in October 1992, there has been a tremendous effort by all national agencies collecting cancer data to unify and standardize data sets. With the establishment of the National Program of Cancer Registries (NPCR) in 1994, all central registries funded by the Centers for Disease Control and Prevention (CDC) through NPCR are required to follow stringent data management procedures; provide training for state personnel and hospital/clinic reporting staff; publish an annual report; and conduct casefinding and re-abstracting audits at randomly selected facilities.

Although WCRS began receiving CDC/NPCR funding in 1995, the Wisconsin Legislature had already established the registry in 1976; therefore, our index year is 1976. WCRS collects data that are compliant with required NPCR data elements; meet standard requirements designated by the North American Association of Central Cancer Registries (NAACCR) for incidence reporting and endorsed by CDC; and assist WCRS staff when assessing data quality. WCRS also uses the data to provide useful feedback to submitting facilities for quality assurance activities and administrative purposes.

What is the Wisconsin Cancer Reporting System?

The Wisconsin Cancer Reporting System (WCRS) collects and processes information on cancer cases in Wisconsin. In addition, WCRS provides data and produces reports on cancer incidence and mortality statewide and other geographic areas in Wisconsin, by gender, anatomic site (e.g. breast, lung, colon, and prostate) and stage of disease.

One of the oldest cancer registries in the country, WCRS has been collecting information on Wisconsin residents with cancer for over 40 years. The first state mandate requiring hospitals and physicians to report cancer cases was passed in 1976 by the Wisconsin State Legislature. WCRS began collecting data from Southeast Wisconsin that year. In 1978, WCRS began collecting data statewide.

In 1995, WCRS began receiving funding from CDC through a cooperative agreement under the Cancer Registries Amendment Act. These funds have permitted WCRS to make improvements in the collection and processing of data, such as increasing the number and quality of data elements collected on each cancer patient, consistent with standards of NPCR. Also through this agreement, WCRS began applying national standard edits to cancer cases. Since 1995, WCRS data have been available on public use query sites, provided to researchers, and submitted annually to CDC and standard setters.

In 2004, per the Benign Brain Tumor Cancer Registries Amendment Act, WCRS began collecting data on brain and nervous system tumors classified as benign or uncertain behavior. While these won't metastasize beyond the tissue they originated, they are treated aggressively as if they were malignant, which is one of the main reasons those cases are reported.

Why Report to WCRS?

Submission of data is mandated under Wis. Stat. § 255.04, Cancer Reporting.

WCRS is a population-based cancer registry responsible for collection of demographic, diagnostic, and treatment information on patients with active cancer disease that was diagnosed or treated at hospitals, laboratories and physicians throughout Wisconsin. In determining case reportability, WCRS follows rules of the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute (NCI). Data items are based on fields required or recommended by the National Program of Cancer Registries (NPCR) for central registries. Additional fields are required for quality assurance.

WCRS collects a variety of information that can be used for research, public health planning, and evaluation. Because the data are population-based, it can be used to monitor incidence patterns in the state.

Data collected by WCRS are used to:

- Determine cancer rates and trends.
- Prepare health policy and planning.
- Conduct research in epidemiological studies, including case-control studies.
- Evaluate cancer control interventions.
- Identify and target high-risk populations.
- Respond to public concerns regarding perceived excesses of cancer.

WCRS plays an important role in research to identify causes of cancer. Researchers have used the data to identify cancer patients who could be interviewed about possible exposures they had before being diagnosed with cancer. These responses can then be compared to interview responses of people without cancer to determine whether there were different exposures.

Who Reports to WCRS?

By law, all Wisconsin hospitals, laboratories, and physicians in certain settings must report information concerning any person diagnosed as having cancer or a precancerous condition to WCRS, as mandated by Wis. Stat. § 255.04, Cancer Reporting.

> ***Note*:** Physicians in the following settings are required to report: radiation treatment centers, ambulatory surgery centers, nursing homes, hospice centers, clinics, private offices, and diagnostic and treatment centers.

A facility may be small or large, and the extent of information submitted varies depending on facility size, services available to the patient, and reporting methods for each facility. Some facilities have

their own cancer registries, while others have limited registries or no registry and only provide the minimum data required by Wisconsin law.

In addition to in-state facility submissions, WCRS has established formal agreements with many states and territories to exchange information regarding cancer patients.

Information Collected About Patients with Cancer

In 1976, when WCRS started collecting data, only a minimal amount of information about the patient and tumor was collected. Over the years, as the population ages and knowledge about the disease increases, along with continued research, the volume of cancer cases has increased, and the amount of data collected for each case has expanded. Data can be divided into two major types: information pertaining to the disease process and socio-demographic information about the patient. If a person is diagnosed with more than one type of cancer in their lifetime, the same information is collected for each new unique tumor.

Examples of disease-process information:

- Anatomic site of the tumor, such as *breast*, *lung*, or *lymph nodes*.
- Stage of disease at the time of diagnosis
- Cancer cell type, such as *leukemia*, *melanoma*, and *osteosarcoma*.
- Type of first course treatment rendered to destroy the tumor

Examples of socio-demographic information:

- Sex
- Age at diagnosis
- Race
- Address at diagnosis
- Occupation
- Place of birth
- Ethnicity

File Retention

There is no statute governing how long reporting facilities must keep cancer case abstracts or files. However, WCRS recommends retaining them for at least seven years.

Cancer Report Transmission and Processing

Electronic data must be sent using the appropriate NAACCR format, which is communicated in various emails to reporting facilities and software vendors throughout the year. Electronic cancer reporting is required. WCRS uses a secure internet application called Web Plus for data submissions. See the WCRS webpage about Web Plus for more information. Contact WCRS to obtain a Web Plus account.

Once WCRS receives the uploaded files, they are processed through a series of computerized and manual operations before the files can be used for analysis.

WCRS data uses multiple-source reporting to ensure statewide coverage and completeness because patients are often seen at more than one facility for diagnosis, treatment, or follow up. On average, 1.6 reports are received for each primary tumor diagnosed.

- WCRS monitors the number of cases submitted by each facility and the total number of cases for a given diagnosis year. Completed cases should be submitted to WCRS within six months of date of diagnosis, or date of initial contact if diagnosed elsewhere.

WCRS requires the following submission schedule to maintain timeliness:

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

Death Clearance Process

Data collection on Death Certificate Only (DCO) cases is mandated by Wisconsin Statutes and is in compliance with all HIPAA requirements. A DCO case means the only source of information about the cancer was from the death certificate. The process of linkage and follow-back to identify missed cases is called “Death Clearance” and is required by CDC. WCRS begins the Death Clearance process once most of the data for the most recent diagnosis year are received and processed.

When the Wisconsin Vital Records Section receives death certificates, an underlying cause of death (UCOD) is assigned based on the causes of death listed. Up to 20 conditions can be factored in the determination of the UCOD, including history of cancer, which can be listed regardless of whether the person died as a direct result of the cancer. For example, if the decedent died from pneumonia but was diagnosed with prostate cancer two years prior, the cancer is listed as a significant condition on the death certificate.

Each year WCRS links death certificates to the WCRS database to identify persons in the database who have died and adds the date and UCOD to the record. In instances when no person match is found, or when the type of cancer on the death certificate is different from that recorded in the WCRS database, the result is a DCO case, meaning the cancer was listed on the death certificate but WCRS does not have a record of that cancer. WCRS is required to follow-back with the hospital, physician, or coroner listed on the death certificate to request information on the cancer diagnosis. If a DCO case is proven not to be reportable to WCRS (for example, if the patient was actually a resident of another state when diagnosed) the DCO case is deleted. When a full abstract is provided for a missed case, the case is no longer considered a DCO case, and the abstract is added to the database as a complete case.

The Death Clearance process improves the completeness of data and identifies missing data submissions or facilities that need to improve their casefinding routines. If a facility receives many DCO cases, it probably means that there was a failed file submission or your casefinding routine is not catching all of the reportable cancers and needs to be updated. WCRS cannot use solely the information on the death certificate to abstract a case because it does not provide the true year of diagnosis, stage of disease, histology, treatment provided, and other information.

Determining Reportability for State Reporting

Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements for WCRS are established by the National Program of Cancer Registries (NPCR). A "Reportable List" includes all diagnoses to be collected and reported by WCRS to NPCR.

A reportable diagnosis made by a recognized medical practitioner may appear on a variety of medical documentation including but not limited to:

- Pathology report
- Cytology report
- Imaging report
- Discharge diagnosis
- History and physical
- Other parts of medical record
- Death certificate
- Autopsy Report

Reportable

- Cases diagnosed or on or after January 1, 1992, for all non-hospital facilities.
- All patients with reportable cancers regardless of their residence at diagnosis. This includes patients which reside outside of Wisconsin, are incarcerated, or live outside of the United States.
- Cases with in situ and invasive behavior (code 2 or 3 in ICD-O-3.2)
- Cases with behavior code 3 in WHO Classification of Tumours of Hematopoietic and Lymphoid Tissues (2008) (2010+).
- Cases with behavior code 2 or 3 in WHO Classification of Tumours 5th Ed. (2022+)
- Benign and borderline primary intracranial and central nervous system tumors with behavior code 0 or 1. Refer to ICD-O-3 for cases diagnosed 2004-2020 and ICD-O-3.2 for cases diagnosed 2021+.
    - An intracranial or a CNS neoplasm identified only by diagnostic imaging is reportable.
    - "Neoplasm" and "tumor" are reportable terms for brain and CNS because they are listed in ICD-O with behavior codes of /0 and /1.
        - *Note:* "Mass" and "lesion" are not reportable terms for brain and CNS because they are not listed in ICD-O with behavior codes of /0 or /1.
    - For cases diagnosed prior to 1/1/2023, pilocytic astrocytoma/juvenile pilocytic astrocytoma are reportable in North American as malignant 9421/3 for all CNS sites with the exception of the optic nerve.
        - When the primary site is optic nerve and the diagnosis is either optic glioma or

pilocytic astrocytoma, the behavior is non-malignant and coded 9421/1.

    - Beginning with cases diagnosed 1/1/2023 forward, pilocytic astrocytoma/juvenile pilocytic astrocytoma are to be reported as 9421/1 for all CNS sites.

- Early or evolving melanoma in situ, or any other early or evolving melanoma (2021+).
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 (/2016+).
- Pancreatic intraepithelial neoplasia (PanIN III) (2016+).
- Penile intraepithelial neoplasia III (PeIN III) (2016+).
- Low-grade appendiceal mucinous neoplasm (LAMN) has a behavior of /2 and /3 making it reportable (2022+).
- Vaginal intraepithelial neoplasia III (VAIN III) (C529).
- Vulvar intraepithelial neoplasia III (VIN III) (C510-C519).
- Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211).

Behavior Code Changes

- Carcinoid, NOS of the appendix C181, behavior changed to 3 effective 2015 (2015+).
- GIST tumors, all histologies changed to behavior 3 in ICD-O-3.2 (2021+).
- Thymomas, most behaviors changed to 3 in ICD-O-3.2 (2021+). See Exceptions.
- High-grade appendiceal mucinous neoplasm (HAMN) behavior changed to 3 (2022+).
- Post Transplant Lymphoproliferative Disorder (PTLD) behavior changed to 3 (2025+).

Exceptions (Not Reportable)

- In situ carcinoma of cervix (/2), any histology, cervical intraepithelial neoplasia (CIN III), or SIN III of the cervix (C530-C539).
- Prostatic intraepithelial neoplasia (PIN III) (2001+)
- Microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).
- Colorectal tumors with the following morphologic description: Serrated dysplasia, high grade; Adenomatous polyp, high grade dysplasia; Tubular adenoma, high grade; Villous adenoma, high grade; Tubulovillous adenoma, high grade.
- Skin cancers (C440-C449) with any of the following histologies:

    - Malignant neoplasm (8000-8005)
    - Epithelial carcinoma (8010-8046)

- Basal cell carcinoma (8090-8110), papillary and squamous cell carcinoma (8050-8084) are not reportable except those arising in the following mucoepidermoid sites:
    - Lip (C00.0-C00.9)
    - Anus and Anal canal (C21.X)
    - Vulva (C51.0-C51.9)
    - Vagina (C52.9)
    - Penis (C60.0-C60.9)
    - Scrotum (C63.2)

Ambiguous Terminology

The contents of this section are adapted from the SEER Coding Manual.

Reportable malignancies are stated by a recognized medical practitioner. The medical record usually presents the diagnosis clearly; however, physicians sometimes use vague or ambiguous terms to describe a tumor when its behavior is uncertain.

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required. Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report.

Ambiguous Terminology Guidelines

If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included.

- Report cases that use the words on the list below or an equivalent word such as “favored” rather than “favor(s).”
- Do **not** substitute synonyms such as “supposed” for presumed or “equal” for comparable. Do not substitute “likely” for “most likely.”
- Use all available information first, and seek clarification from clinicians whenever possible.
- Equivalent to “Diagnostic for” malignancy or reportable diagnosis. These phrases are reportable when no other information is available.
- Equivalent to “not diagnostic for” malignancy or reportable diagnosis. These phrases are **NOT** reportable when no other information is available.
- There may be ambiguous terms preceded by a modifier, such as “mildly” suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.

- If there is no information to the contrary, report a case described as "malignant until proven otherwise."
    - The patient should have further work up to prove or disprove the findings. When additional information becomes available, update as necessary. Use text fields to describe the details.
- **Ambiguous Terminology should be considered references of last resort when determining reportability.** The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor.

Ambiguous Terms Diagnostic of Cancer

***Note*:** Ambiguous terms not listed below are not reportable.

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

Cytology

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

- Accession cases with cytology diagnoses that are positive for malignant cells.
- Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.
    - **Exception**: When a subsequent biopsy of a urinary site is negative, do not report.
- **Do not** accession a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later.
    - ***Note 1***: “Suspicious cytology” means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.
    - ***Note 2***: **This is a change to previous instructions.** The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology.

Ambiguous Term Guidelines for Hematopoietic and

Lymphoid Neoplasms

- Do not report the case when biopsy or physician's statement confirms a non-reportable condition or proves the ambiguous diagnosis is wrong.
    - ***Example***: CT scan shows enlarged lymph nodes suspicious for lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. Do not report the case. The pathology is more reliable than the scan; the negative biopsy proves that the ambiguous diagnosis was wrong.
- Report the case when the patient is treated for a reportable neoplasm.
    - ***Note 1:*** Report the case if the diagnostic tests are inconclusive, equivocal, or negative.
    - ***Note 2***: For treatment information see the National Cancer Institute's Physicians' Data Query (PDQ) website or the SEER*Rx Antineoplastic Drugs Database
- Report the case when there is a clinical diagnosis (physician's statement) of reportable hematopoietic or lymphoid neoplasm.
    - ***Note 1***: The clinical diagnosis may be a final diagnosis found within the medical record or recorded on a scan (CT, MRI for example).
    - ***Note 2***: Report the case even if the diagnostic tests are equivocal.
- Report the case when a reportable diagnosis appears in any text or report described as a Definitive Diagnostic Method in the Hematopoietic database.
    - ***Note***: Definitive diagnostic methods differ depending upon the histology.

Clinical Diagnoses

Cases diagnosed clinically are reportable. In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession a case based on the clinical diagnosis (when a recognized medical practitioner says the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the discharge diagnosis on the face sheet or other parts of the medical record.

- ***Note***: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.
    - ***Exceptions***
        - Patient receives treatment for cancer. Report the case.
            - ***Note***: Standard treatments for cancer may be given for non-malignant conditions. Follow back with the physician to clarify if needed.
        - It has been six months or longer since the negative biopsy, and the physician

continues to call this a reportable disease. Report the case.

When a Patient is seen by a Clinic and a Hospital

Ordinarily when a patient is seen by one or more freestanding clinics or physician offices and by one or more hospital, each facility will independently report the case. In each case, the date of initial diagnosis will be the same for each reporting facility. Here are some examples.

- If a patient is diagnosed by a freestanding clinic and sent to a hospital for treatment, the hospital will report the case. The clinic only needs to report the case if it also provided some definitive, first-course treatment.

- If a patient is diagnosed by a freestanding clinic and the patient is NOT referred to a Wisconsin hospital, the clinic must report the case even if the clinic does not treat the patient.

- If a clinic diagnoses a case, sends the patient to the hospital for surgery, but the clinic provides chemotherapy, radiotherapy or any non-surgical cancer-directed therapy before or following the surgery, both the clinic and the hospital will report the case. The criterion requiring clinic reporting is that it provided some of the first-course treatment.

- If a hospital 1) diagnosed a case OR 2) provided first-course treatment OR 3) saw the patient for a non-cancer issue BUT the medical record indicated the patient has active cancer, it must report the case. Any follow-up clinic visits are not reportable by the clinic unless it provides first-course treatment.

- If a hospital or clinic sees a patient with active disease that is metastases or a recurrence, the original primary IS reportable under the conditions above if the original primary had not been reported by the facility when it was first diagnosed.

In many Wisconsin communities, larger health systems and hospitals routinely abstract cancer cases diagnosed or treated at their affiliated local freestanding clinics and physician offices (or those in geographic proximity) through a formal or informal arrangement with those facilities. This often occurs between facilities that share the same electronic health record system. The following situations apply:

- The facility having its cases reported routinely by another facility IS responsible for reporting any required cases not completed by the reporting facility.

- The reporting facility must report the first-course treatment provided by all facilities, not just the treatment provided at the reporting facility’s location.

- The facilities must maintain accurate, current updates on these reporting agreements and send notification via email to WCRS when first initiated or changes are made.

Additional Non-Hospital-Only Requirements

Patients diagnosed at your facility but not treated at your facility are only reportable when the patient is **not** referred to a Wisconsin hospital within 2 months.

Additional Hospital-Only Requirements

- All active primary cancers are reportable regardless if your facility participated in diagnosis and/or treatment. For reportable cases which your facility did not diagnose and/or treat, WCRS is aware that a facility may not have enough information to enter specific codes for treatment or staging besides “unknown” or “not available in chart” but could document additional information, as stated by physicians or otherwise noted in the chart, in appropriate text fields. These types of cases are required by central cancer registries. It is a “catchment” requirement to cover instances when the facility diagnosing or treating the patient does not report the case as required.

- Patients who die at your facility with active cancer, even if they were not diagnosed nor treated at your facility.

- Patients who received initial diagnosis and first-course therapy at another facility but are now seen at your facility for diagnosis and/or treatment of recurrent or metastatic disease.

***Example 1*:** Patient was originally diagnosed with prostate cancer in 2006 at another facility and is admitted to your facility in 2015 with a questionable chest x-ray. A biopsy shows metastatic adenocarcinoma consistent with a prostate primary. This case is reportable. Report all information you have on the original prostate cancer diagnosis, staging and treatment.

Example 2: Patient with a history of breast cancer diagnosed and treated elsewhere five years ago is admitted to your facility’s ER for a broken hip. The patient was not diagnosed with a recurrence or treated for her breast cancer during this admission. This case is not reportable.

Note: Report all available information regarding the original diagnosis, stage at diagnosis and the original first-course treatment, if available. Do not provide information on the recurrence or metastatic treatment.

Differences in Hospital and Non-hospital Requirements

Item	Hospital	Non-Hospital
Diagnosis Date	Diagnosed 1976 and forward	Required: 1992 and forward. Accepted: 1976 and forward
Coverage*	All patients for which a medical record is created regardless of residence (WCRS requires out of state cases to be reported)	Patients of clinics or physician offices whose records are not maintained with a hospital's inpatient records
Reportable Cases by Nature of Care	Diagnosed and/or treated by the hospital **OR** admitted for any reason with active cancer (including diagnosis, treatment, palliative care, terminal care, care for noncancerous condition)	Clinic provided definitive, first-course cancer treatment **OR** diagnosed at clinic, but treatment not provided at clinic and patient not referred to Wisconsin hospital within 2 months of diagnosis

*Coverage maintains the emphasis on hospital reporting, and supplements hospital reports with clinic reports for the types of cancers only seen in an outpatient setting or the clinic first-course treatment

not provided and/or reported by a hospital.

Cases Not Reportable to WCRS

- Patients who have a *history* of cancer (not active cancer) and no diagnosis or treatment at your facility.
- Records, slides or patients seen only in consultation to confirm a diagnosis where no chart is created in your facility. If a chart is created, it is reportable.
- Pathology cases that are consultative readings of slides submitted from outside facilities.
    - ***Exception***: If the outside facility is an out-of-state facility or pathology laboratory, the case is reportable.
- Metastatic sites or recurrences of a primary cancer that was already reported by your facility.
- Patients diagnosed before 1976.

Modification Records

The change/correction procedure ensures that the most accurate information is available to users by enabling reporting facilities to provide updated or corrected information to WCRS after the original case has been transmitted. The information originally collected on the abstract should be changed or modified under the following circumstances:

- Changes to data items which trigger Modification record creation—this list of data items is made available to software vendors with each new version.
- To correct coding or abstracting errors (for example, errors found during quality control activities).
- When clarifications or rule changes retroactively affect data item code.
- When better information is available later.
- When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted.

  Example 1*:* Consults from specialty labs, pathology report addenda or comments or other information have been added to the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

  Example 2**:** At the time a case was reported to WCRS, the primary site was *unknown*. On a subsequent admission several months later, the primary site was documented as upper lobe of the left lung. **Submit an update** to revise the primary site, laterality and any information that may have become available.

Submission of Modification Records

- Do NOT submit changes in a new regular Abstract (Record Type “A”). Use of a special Modification record format (Record Type “M”) is required.
- Contact your vendor for instructions on creating and exporting modification records.
- If your software does not support modification record creation, do not submit changes as a new abstract. Contact WCRS directly to make changes to an existing abstract.

Casefinding Techniques

The contents of this section are adapted from the SEER Coding Manual

Casefinding (case ascertainment) is the process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

A casefinding list is not the same as a reportable list. Casefinding lists are intended for searching a variety of cases, so you don't miss any reportable cases.

WCRS requires casefinding from the Comprehensive ICD-10-CM Casefinding Code list for Reportable Tumors. WCRS recommends that facilities review cases from the Supplemental list ICD-10-CM. Casefinding Code lists in pdf and Excel format are located on the SEER website.

Use the casefinding lists to screen prospective cases and identify cases for inclusion in the registry. Include all casefinding sources when searching for reportable cases.

Casefinding Sources

- Inpatient/Outpatient Admission/Discharge Documents
- Pathology/Cytology Pathology Reports
- Surgery Logs/Schedules
- Radiology
- Nuclear Medicine
- Radiation Therapy Logs
- Chemotherapy Outpatient Logs
- Emergency Room Records
- Autopsy Reports
- Pain Clinic Logs

It is essential to include review of the disease index, which is usually provided by Health Information Management (HIM) or Medical Records Departments. Other tracking tools such as medical and radiation oncology clinic logs help ensure that all reportable cases are identified.

It is advisable to form an alliance with staff from HIM, radiation oncology and pathology departments to develop a systematic method to receive necessary information from them.

Never rely solely on the pathology department to provide reportable cases. Doing so excludes cases that the facility has no diagnostic tissue reports. Cases diagnosed elsewhere but treated at your facility and those diagnosed radiographically or clinically, without tissue confirmation would be missed during casefinding.

Determining Multiple Primaries

Now that you have learned how to determine if a case is reportable, you must next determine if the case is a single or a multiple primary. Determining multiple primaries is done through utilization of the Solid Tumor Rules for solid tumors, and the Hematopoietic and Lymphoid Neoplasm Database for hematopoietic and lymphoid neoplasms.

Solid Tumors

Use the Solid Tumor Rules to determine the number of primaries to abstract and the histology to code. Information about how to navigate and use the solid tumor rules to determine multiple primaries and histologies can be found in the Solid Tumor Rules General Instructions, which is available on the Solid Tumor Rules webpage.

Apply the general instructions and site-specific instructions for determining multiple primaries. The Solid Tumor Rules and General Instructions replace the 2007 Multiple Primary & Histology (MP/H) Rules for the following sites:

- Breast
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites
- Cutaneous Melanoma (for cases diagnosed 1/1/2021 and forward)
- Other Sites (for cases diagnosed 1/1/2023 and forward)
    - For cases diagnosed 1/1/2007-12/31/2022, the 2007 MP/H and 2007 General Instructions are to be used, with a few exceptions, which are excluded from the Other Sites module for 1/1/2018 forward.
        - Rectosigmoid and rectum which are included in the Colon Solid Tumor Rules.
        - Peripheral nerves with are included in the Malignant CNS and Peripheral Nerves Solid Tumor Rule

Transplanted organs

Transplanted organs or tissue may originate from organs or tissue from the patient's own body (called autograft) or another human donor (homograft or allograft). Accession a new primary in the transplanted organ as you would any new primary, applying the current Solid Tumor Rules. Code the primary site to the location of the transplanted organ (in other words, code the malignancy where it resides or lies).

To view and download the appropriate solid tumor module for your case, visit the Solid Tumor Rules webpage, which provides links to all documents and instructions for using them.

Hematopoietic and Lymphoid Neoplasms

Solid Tumor Rules do not apply to hematopoietic and lymphoid neoplasms. Instead, reference the Hematopoietic and Lymphoid Coding Manual and corresponding Hematopoietic and Lymphoid Neoplasm Database to determine multiple primaries.

- These rules are for cancer registries and are not followed by physicians.
- Follow the rules stated in this manual and abstract the number of primaries based on the rules. This may, or may not, agree with what the physician indicates in the patient record. However, physician interpretation can sometimes factor into determining reportability, diagnostic confirmation, or primary site; this is addressed in the specific coding instructions for those sections.

The SEER Hematopoietic Project site provides data collection rules for hematopoietic and lymphoid neoplasms for 2010+. There are two tools for use with these rules:

1. Hematopoietic & Lymphoid Neoplasm Database (Heme DB)
    a. A tool to assist in screening for reportable cases and determining reportability requirements.
    b. The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasm (9590/3-9992/3).
2. Hematopoietic & Lymphoid Neoplasm Coding Manual
    a. Reportability instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

First Course of Treatment

First course of treatment is defined as all treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. First course of treatment ends when there is documentation of disease progression, recurrence, or treatment failure.

For **Solid Tumors**, including benign and borderline intracranial and CNS tumors, information about First Course of Treatment and Treatment Timing can be found in the SEER Coding Manual.

For **Hematopoietic and Lymphoid Neoplasms**, refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual.

Refer to the WCRS Data Dictionary when coding treatment items (including, but not limited to data items beginning with “RX-SUMM”). The WCRS Data Dictionary can be found on the WCRS Reporting Requirements webpage. It provides instructions, guidelines, and reference materials for all required data items, including treatment data items.

Grade

The contents of this section are adapted from Grade Manual, which can be found on the NAACCR SSDI/Grade Webpage.

The Grade Coding Instructions and Tables (Grade Manual) is the primary resource for documentation and coding instructions for Solid Tumor Grade for cases diagnosed on or after January 1, 2018. Registrars should refer to the Grade Manual for all guidelines, coding instructions and timeframes.

The Grade Manual should be used to code the following data items:

- Grade Clinical
- Grade Pathological
- Grade Post Therapy Clin (yc)
- Grade Post Therapy Path (yp)

Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC-recommended grade tables where applicable.

In addition to understanding the concept and structure of the Grade Tables, it is critically important to review all of the general information included in the Manual. Do not rely on edit failures and drop down values within software to assign grade. **Always refer to the Grade Manual.**

Particular attention should be paid to understanding coding instructions for grade tables where **both an AJCC-preferred grade system and the generic grade system are allowable codes**, coding guidelines for Grade Clinical, Grade Pathological, Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items and coding instructions for **generic grade categories**.

Hematopoietic Neoplasms

Grade is not applicable for Hematopoietic neoplasms diagnosed 2018 and later. Historical information for cases diagnosed prior to 1/1/2018 can be found in the Grade Manual.

Contact

Contact our the WCRS data inbox at DHSWCRSdata@dhs.wisconsin.gov with any questions regarding cancer reporting.