## Revision History

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Introduction

OncoTraX: Cancer Registry is an integrated collection of computer programs and routines, which work together in assisting the Cancer Registrars to create and maintain a cancer patient database. The software creates case listings and registry reports for Cancer Boards (Cancer Conferences), special studies, and the Annual Report recommended by the American College of Surgeons (ACoS).

The software allows the Cancer Registrars to:

1. Perform case finding.
2. Identify potential cases to include in your registry, enter the pertinent data directly into the computer system, and maintain patient follow-up information on an annual basis.
3. Enter abstracts.
4. Download and transmit data electronically to the VA Central Cancer Registry, state central registries, the National Cancer Database for the ACoS Call for Data.
5. Produce several reports by using an option in the Utility menu.
   Note: Several reports within the software provide basic information; however, for more specific reports, you need to know basic FileMan functions. Any and all data collected within an abstract can be pulled back into reports.
6. Print out by year the number of cases by site, including sex, race, and stages.
7. Generate follow-up reports as required by the ACoS.
   Note: OncoTraX is in complete compliance with all ACoS required data elements, and is updated as changes occur.

OncoTraX is used by cancer registrars and meets all requirements set forth by the American College of Surgeons for approved cancer programs.

Note: OncoTraX makes extensive use of Help screens, but it does not replace the use of your reference manuals.

This manual deals with the three most commonly used areas of the software. These are the main functions of registry work used to maintain the cancer registry.

1. **Case Finding/Suspense Module** allows you to perform an automated case finding search of relevant hospital databases (pathology, radiology, and patient treatment files) for cases meeting specific criteria for inclusion in the registry.
2. **Abstracting/Printing** allows you to enter coded data into the database directly or by utilizing auto-coding techniques. The software is site-specific prompt driven; the only data elements presented are those pertinent to the site you are abstracting.
3. **Follow-Up** in OncoTraX assists you in following your patients. The database automatically reminds you when it is time to do a follow-up on a patient. You can update each patient’s record with new follow-up information. The software comes with a variety of follow-up letters, which may be customized to fit the needs of individual facilities.

When using the electronic version of the manual to search for information, click Edit on the menu bar and select Find (binoculars icon). Enter the word or words for which you are looking and Microsoft Word searches the document.
**Recommended Users**

This manual is intended for VA registrars using the OncoTraX: Cancer Registry software.

**Related Manuals**

Every cancer registry office should have the following reference material.

*Note:* Use the older editions of the reference materials when entering old cases.

- *Facility Oncology Registry Data Standards* (FORDS), 2011 and after
- *Registry Operations and Data Standards* (ROADS), prior to 2003 cases
- *Facility Oncology Registry Data Standards* (FORDS), 2003 and after
- *Collaborative Staging Manual and Coding Instructions*
  Collaborative Staging was added to OncoTraX in July 2004. Use the *Collaborative Staging Manual and Coding Instructions* for all cases diagnosed in 2004 and after.
- *AJCC Cancer Staging Manual, 5th edition, for entering older cases*
- *SEER Summary Staging Manual, 2000*
- *Summary Staging Guide, 1977*
- *SEER Extent of Disease, 1988; Codes and Coding Instructions*, 2nd edition, 1994
- *SEER Extent of Disease, 1998; Codes and Coding Instructions*, 3rd edition, 1998
- *SEER Program Coding and Staging Manual, 2004* (on CD)
- *SEER*Rx - *Interactive Antineoplastic Drugs Database*
  The interactive antineoplastic drugs database (helpful when abstracting) is available from SEER on the following website: [http://www.seer.cancer.gov/tools/seerrx/](http://www.seer.cancer.gov/tools/seerrx/)
- *SEER Self Instructional Manuals for Tumor Registrars*
  SEER self instructional manuals are available for download on the following website: [http://www.seer.cancer.gov/training/manuals/](http://www.seer.cancer.gov/training/manuals/)
- *Cancer Registry Management Principles and Practice, 3rd edition*

**Recommended Websites**

  Website for the National Cancer Institute
  Home page for the Commission on Cancer, American College of Surgeons, Cancer Programs
  Highlights for the month from the Commission on Cancer, American College of Surgeons, Cancer Programs

• [http://web.facs.org/coc/default.htm](http://web.facs.org/coc/default.htm)
  American College of Surgeons, Commission on Cancer: Inquiry and Response System (I & R)
  Available to all cancer care professionals. It is a repository of thousands of questions and answers related to the Approvals and Accreditation Program, the National Cancer Data Base (NCDB), the American Joint Committee on Cancer (AJCC), and the Facility Oncology Registry Data Standards (FORDS).

  Website for the National Cancer Registrars Association

  Website for the American Joint Committee on Cancer (AJCC)

• [http://cancerstaging.org/cstage/manuals.html](http://cancerstaging.org/cstage/manuals.html)
  Website for Collaborative Staging

  All links for the Veterans Health Administration Cancer Program

  SEER’s Training Web Site provides web-based training modules for cancer registration and surveillance. When the site is complete, it will comprise about 30 training modules, each covering a particular cancer registration training subject.

  Download the SEER*Rx - Interactive Antineoplastic Drugs Database, version 1.1.1 (replaces Book 8)

  Collaborative Staging Manual and Coding Instructions Part I

  Collaborative Staging Manual and Coding Instructions Part II


• [http://seer.cancer.gov/manuals/EOD10Dig.pub.pdf](http://seer.cancer.gov/manuals/EOD10Dig.pub.pdf)


  Facility Oncology Registry Data Standards (FORDS): Revised for 2011

**OncoTraX Conventions**

You must have a working knowledge of VistA conventions, in order to maneuver easily in OncoTraX. The table contains frequently used characters and their descriptions with examples.
<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><code>&lt;ret&gt;</code></td>
<td><code>&lt;ret&gt;</code> is the symbol for the Return or Enter key. Type <code>&lt;ret&gt;</code> after every response, or to bypass a prompt or accept a default. <strong>Note:</strong> Do not press it more than necessary; you do not want to bypass an opportunity to enter valuable information.</td>
</tr>
<tr>
<td><code>?</code></td>
<td><code>?</code> (one question mark) Type <code>?</code> at any prompt to view a message explaining the requested information or how to enter it.</td>
</tr>
<tr>
<td><code>??</code></td>
<td><code>??</code> (two question marks) Type <code>??</code> at any prompt to view detailed instructions and/or a list of choices.</td>
</tr>
</tbody>
</table>
| `//`      | `//` (two slash marks) Type `//` after text for the default response.  
  - If you accept the default answer, press `<ret>` to continue to the next prompt.  
  - For a different choice, type the choice and press `<ret>`.  
  - Press Enter at `//` and the word before the slashes becomes the default response.  
  - Type `?` at `//` and a list of choices displays.  
  **Example**  
  ```  
  PREVIOUS HISTORY OF CANCER: No // ?  
  Choose from:  
  0 No  
  1 Yes  
  9 Unknown  
  ``` |
| `^`       | `^` (caret) is Shift + 6 on the keyboard and is also called the up-caret symbol.  
  - Type `^` to exit an option and return to the menu;  
  - Type `^` to jump to another field.  
  **Example**  
  Type `^ DATE DX` at the field prompt to jump to the **DATE DX** field.  
  ```  
  DATE DX: 04/05/2005//  
  DX FACILITY: BUFFALO VA MEDICAL CENTER//  
  PRIMARY SITE: PROSTATE//  
  TEXT-PRIMARY SITE TITLE: PROSTATE//  
  LATERALITY: Not a paired site//  
  HISTOLOGY (ICD-O-3): ADENOCARCINOMA, NOS//  
  HISTOLOGY CODE: 8140/3  
  TEXT-HISTOLOGY TITLE: ADENOCARCINOMA, NOS// ^DATE DX  
  DATE DX: 04/05/2005//  
  ```  
  **In the Abstract**  
  - Go from one field to another in most areas of an abstract  
  **type `^<field name>`**  
  - Go completely out of the abstract |
<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>type ^ without a field name</strong></td>
</tr>
<tr>
<td></td>
<td>- Edit a field already completed</td>
</tr>
<tr>
<td></td>
<td><strong>type ^&lt;field name&gt;</strong> to return to the field and then edit.</td>
</tr>
<tr>
<td></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td></td>
<td>CLASS OF CASE: 1 Dx here, 1st tx here</td>
</tr>
<tr>
<td></td>
<td>FACILITY REFERRED FROM: NONE/ ^CLASS OF CASE</td>
</tr>
<tr>
<td></td>
<td>CLASS OF CASE: Dx here, 1st tx here//</td>
</tr>
<tr>
<td>@</td>
<td>@ (at symbol) is Shift + 2 on the keyboard.</td>
</tr>
<tr>
<td></td>
<td>Type @ to delete data values stored in fields.</td>
</tr>
<tr>
<td>...</td>
<td>... (three dots)</td>
</tr>
<tr>
<td></td>
<td>Type ... to replace all data in a field.</td>
</tr>
<tr>
<td></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td></td>
<td>TX Primary Cancer cannot be assessed Replace ... With</td>
</tr>
<tr>
<td></td>
<td>At the Replace prompt, type ... and press Enter. When With displays, type new data.</td>
</tr>
<tr>
<td></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td></td>
<td>CLINICAL T: T3 Chest wall/diaphragm/mediastinal pleura etc Replace ... With</td>
</tr>
<tr>
<td></td>
<td>There is a submenu when ... displays after a menu option.</td>
</tr>
<tr>
<td></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td></td>
<td>ANN *Annual Reports ...</td>
</tr>
<tr>
<td></td>
<td>Select ANN and the following displays.</td>
</tr>
<tr>
<td>AAR</td>
<td>Annual ACoS Accession Register (80c)</td>
</tr>
<tr>
<td>API</td>
<td>Annual ACoS Patient Index (132c)</td>
</tr>
<tr>
<td>ASL</td>
<td>Annual Primary Site/GP Listing (132c)</td>
</tr>
<tr>
<td>ACL</td>
<td>Annual Patient List by Class of Case (80c)</td>
</tr>
<tr>
<td>SST</td>
<td>Annual Primary Site/Stage/Tx (132c)</td>
</tr>
<tr>
<td>TST</td>
<td>Annual ICD0 Topography/Stage/Tx (132c)</td>
</tr>
<tr>
<td>SDX</td>
<td>Annual Status/Site/Dx-Age (132c)</td>
</tr>
<tr>
<td>HIS</td>
<td>Annual Histology/Site/Topography (80c)</td>
</tr>
<tr>
<td>ACT</td>
<td>Annual Cross Tabs (80c)</td>
</tr>
<tr>
<td>CPR</td>
<td>Print Custom Reports</td>
</tr>
<tr>
<td>Dates</td>
<td>Several date formats are acceptable.</td>
</tr>
<tr>
<td></td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td></td>
<td>010102, 1-1-02, 1/1/02, 01/01/2002, January 1, 2002</td>
</tr>
<tr>
<td></td>
<td>If the year is omitted, the computer uses <strong>Current Year</strong>.</td>
</tr>
</tbody>
</table>
Character | Description
---|---
Device prompt | To send a report to a printer, type the name of the printer at the Device prompt.  
  • If the printer is shared, queue your report by entering Q at the Device prompt and then the name of the printer at the next prompt.  
  • To view a report on your computer screen, press the <ret> key at the Device prompt.  

When *capturing a file*, type 0;269;9999999 at the Device prompt.  
**Note:** When you learn to *capture files* from the software, you can also learn many ways to display data.

Space bar return | Press the **space bar** to re-enter the last selection made at a particular level.  
  (This feature may be limited for some options.)  
  **Example**  
  • At a submenu, the space bar enters the last submenu option accessed.  
  • At a field, the space bar re-enters whatever was last entered, to any other field within the same option.  
  **Note:** Press the space bar, and then press the Return key, not both at the same time.

Report options | Report options with 80c in the name; require an 80-character line printer.  
  Report options with 80c in the name; look correct when viewed on your monitor.  
  Report options with 132c in the name; require a 132-character line printer.  
  Reports with 132c in the name do not look correct when viewed on your monitor—the text wraps.  
  **Note:** A printer that can print both 80c and 132c is recommended.

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**OncoTraX Menu**

The main OncoTraX menu is the first screen that displays when you sign on to the program. The OncoTraX menu displays the version number of the OncoTraX: Cancer Registry software running on your system.  

**Example**  

```
ONCOTRAX CANCER REGISTRY V2.11 PATCH ONC*2.11*54
```

The functions on the OncoTraX Option list also display.  

```
SUS  *..Case Finding/Suspense ...  
ABS  *..Abstracting/Printing ...  
FOL  *..Follow-up Functions ...  
LIS  *..Registry Lists ...  
ANN  *..Annual Reports ...  
STA  *..Statistical Reports ...  
UTL  *..Utility Options ...
```
• The Select OncoTraX Option: prompt is the starting point for all of the modules within the software.

• At the prompt, type in an option/module three-letter abbreviation. The group of related submenu options displays.

Example
Select OncoTraX Option: SUS *..Case Finding/Suspense

************ Suspense Cases ************
CF Automatic Case Finding-Lab Search
LR Print Case Finding-Lab Report
RA Automatic Case Finding-Radiology Search
PT Automatic Case Finding-PTF Search
SE Add/Edit/Delete 'Suspense' Case
SP Print Suspense List by Suspense Date (132c)
NP Patients in Suspense with no primaries
DI Disease Index

Getting Started

Before using OncoTraX for the first time, you must define your registry’s parameters. If OncoTraX is already being used by the registry and you are a new registrar, review the registry’s parameters because you may need to update them.

To access the registry’s parameters:
1. From the main OncoTraX menu, select UTL *..Utility Options...
2. From the Utility Options, select TR Define Cancer Registry Parameters

Example
SUS *..Case Finding/Suspense ...
ABS *..Abstracting/Printing ...
FOL *..Follow-up Functions ...
LIS *..Registry Lists ...
ANN *..Annual Reports ...
STA *..Statistical Reports ...
UTL *..Utility Options ...
Select OncoTraX Option: UTL *..Utility Options...

**************UTILITY OPTIONS**************
DP Delete OncoTraX Patient
DS Delete Primary Site/GP Record
EA Edit Site/AccSeq# Data
LG List Topographic Site Groups
LT List Topography Codes by Site Group
AR Create a report to preview ACoS output
CT Create ACoS Data Download
SR Create a report to preview State/VACCR output
CC Create State/VACCR Data Download
TR Define Cancer Registry Parameters
AC Enter/Edit Facility file
CDD1 Print Condensed DD--OncoTraX Patient file
CDD2 Print Condensed DD--OncoTraX Primary file
PSR Purge Suspense Records
SP Purge Patient Records with No Suspense/Primaries
CS Restage CS cases using latest version
TIME Timeliness Report

**Define Cancer Registry Parameters**

Use **Define Cancer Registry Parameters** to update/change parameters, such as the name of the Cancer Registrar.

You are required to put in information for the following fields.

Select ONCOLOGY SITE PARAMETERS HOSPITAL NAME:

**HOSPITAL NAME:** Type the name of your medical center as you want it to display.

**STREET ADDRESS:** Type the street address of your medical center.

**ZIP CODE:** Type the zip code for your medical center.

**REFERENCE DATE:** Type the year: *first* day of the *first* month of the year the registry *first* starts capturing data.

**CANCER REGISTRAR:** Type the name of the cancer registrar (3 - 30 characters in length) as you want it to display on letters and reports.

**PHONE NUMBER:** Type the phone number of the cancer registrar's office.

**STATE HOSPITAL #:** Type the number assigned by the state to your medical center.

**INSTITUTION ID #:** Type the registry number assigned by the American College of Surgeons. Use the ID to define the registry in the ACoS Call for Data.

**CENTRAL REGISTRY #:** Type the registry number assigned by the state central registry, where applicable.

**Note:** This field may be left blank.

**VISN:** Type the Veterans Integrated Service Network number.

**CS URL:** Type the URL address for the Collaborative Staging computer algorithms: [http://vaww.va.gov/cstage/cgi-bin/cstage.exe](http://vaww.va.gov/cstage/cgi-bin/cstage.exe)

**Note:** Copy and paste the address, so as not to make a mistake when typing.

**DIVISION:** Type in your division or site number. It is a required field, even for a single division site.

**Note:** Case finding does not work when Division is blank; type in the name of the hospital or the division.
Select AFFILIATED DIVISION: Type the name of the division that is associated with the primary division for purposes of the cancer registry.

- If you are not an integrated site, bypass the Define Cancer Registry Parameters prompt by pressing <RET>.
- If you are an integrated site and each site/division manages its own cancer registry, bypass the Define Cancer Registry Parameters prompt by pressing <RET>.
- If you are an integrated site and one or more sites/divisions do not have a cancer registry and you are responsible for tracking patients from one or more of those sites in your cancer registry, type the name of each in Select AFFILIATED DIVISION.

Select QA USER: Type the name of the cancer registrar.

Example

REFERENCE DATE: ??

1. Record the reference date for the registry. This date is listed as the first day of the first month of the year the registry first starts keeping data.
2. Enter the date in format: 010106.
SUS Case Finding and Suspense Module

The SUS Case Finding and Suspense module provides a way to automatically find eligible cases or manually add the patients to Suspense.

Case finding is a systematic method of locating all eligible cases to enter (accession for abstracting) into your database. One of the unique features of the OncoTraX software is Automatic Case Finding. Enter a range, start date and end date, and the computer searches pathology (CF), radiology (RA) and the Patient Treatment File (PT) for eligible cases in that date range. Each search is run separately according to your input. Cases meeting the defined criteria are captured electronically and added to Suspense.

The Suspense Date field, the cases are held in Suspense until they are accessioned for abstracting or manually deleted.

- The suspense date is pulled into the abstract as the DATE DX. The date can be changed, if necessary.
- After reviewing the Suspense cases, you may find some that are not required in the registry. You can manually delete them; refer to Deleting a VA Patient from Suspense, page 14.
- You may find some cases that are recurrences of an already documented primary. Recurrences require a follow up. The recurrences must be updated using RF Recurrence/Sub Tx Follow-up, page 27 in the Follow-up Module. Update the follow-up using PF Post/Edit Follow-up, page 26.
- After you do a follow up for a patient, you must manually delete the patient from the Suspense file; refer to Deleting a VA Patient from Suspense, page 14.

- Cases that are accessioned are automatically deleted from Suspense.

Case Finding/Suspense Menu
CF Automatic Case Finding-Lab Search
LR Print Case Finding-Lab Report
RA Automatic Case Finding-Radiology Search
PT Automatic Case Finding-PTF Search
SE Add/Edit/Delete from Suspense
SP Print Suspense List by Suspense Date (132c)
NP Patients in Suspense with no primaries
DI Disease Index

Note: For your date range, run CF, RA, and PT only once. If you repeat the search for your date range, cases already reviewed end up in your Suspense file.

CF Automatic Case Finding - Lab Search

Use this option to search the Lab files to build a Suspense list of cases. When the search is complete, you can print the Suspense list on a selected device/printer.

Start with Date: .
Go to Date: Type the end date of the search, such as 1/31/04
If the year is omitted, the computer uses Current Year.
Device: Type the name of your printer.
*************** LAB CASE FINDING ***************
This option will search the LAB DATA file
for cases to add to the Suspense List.
Start Date: Type the begin date of the search.
If this option was used previously, the previous end date is the begin
date, such as JUL 1, 2005
End Date: JUL 31, 2005
Dates OK? Y/
Press Enter.

Note: The option searches for ICD-O morphology codes 800-998, excluding
Behavior Code /0 (Benign) codes.
Exceptions to the search criteria:
Benign Cancers of the central nervous system will be included.
Squamous cell neoplasms (805-808) of the skin will be excluded.
Basal cell neoplasms (809) will be excluded.
DEIVCE: HOME/

Your report shows the total number of patients identified.

Example
CASE FINDING LIST your hospital VAMC 03/10/2004
Patient Name PtID# Lab Test Organ/Tissue Morph/Disease-SNOMED
SUSPENSE DATE: 7-5-2005
ONCOPATIENT1 09999 07/15/2005-SP LUNG, UPPER 80703-SQUAMOUS CELL

LR Print Case Finding - Lab Report
Use this option to generate a list of patients from Suspense, identified in Pathology with
reportable malignancies in the CF Automatic Case Finding - Lab Search. You can print all lab
cases in Suspense by entering <ret> at the start date prompt or print only those cases within a
specified date range.
Start with Suspense Date: First//: Type the begin date for the search or press Enter to
print all cases.
Go to Suspense Date Last: Type the end date for the search or press the <ret>
key to accept the last date available.
Device: Type the name of your printer.
Example

Select *..Case finding/Suspense Option: lr Print Case finding-Lab Report
START WITH SUSPENSE DATE: FIRST/
DEVICE: UCX REMOTE TCPIP

CASE FINDING LIST  WASHINGTON DC VAMC  03/10/2004

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>PtID#</th>
<th>Lab Test</th>
<th>Organ/Tissue</th>
<th>CODE-Morphology</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOURCE: CYTOPATHOLOGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONCOPATIENT1</td>
<td>L9999</td>
<td>07/08/2005-CY</td>
<td>BRONCHIAL WAS</td>
<td>69760-USPICIOUS</td>
</tr>
<tr>
<td>SOURCE: SURGICAL PATHOLOGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONCOPATIENT2</td>
<td>N9999</td>
<td>07/10/2005-SP</td>
<td>SKIN OF UPPER</td>
<td>87203-MELANOMA,NOS</td>
</tr>
</tbody>
</table>

Last Contact: 04/03/1998

<table>
<thead>
<tr>
<th>Acc/Sequence</th>
<th>Primary Site</th>
<th>Last Cancer Status</th>
<th>Date DX</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-00139/00</td>
<td>SKIN, FACE NOS</td>
<td>Unknown</td>
<td>04/03/1998</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Note: Patient N999 has a primary from 1998; so that information also displays.
When the patient has a history of malignancy, you must verify whether this new finding is a recurrence or a new primary. If it is a recurrence,
   i. Document this recurrence using the FOL Follow-up module.

RA Automatic Case Finding - Radiology Search

Use this option to search the Rad/Nuc Med (Radiology/Nuclear Medicine) Patient file for suspicious malignancies and add the cases to your Suspense list in the OncoTraX Patient file.
Select Start Date: Type the begin date for the search or use the default date.
Select Ending Date: Type the end date for the search.
Device: Type the name of your printer.

RADIOLOGY CASE FINDING LIST  WASHINGTON DC VAMC  07/18/2005

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>PtID#</th>
<th>Exam Date</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONCOPATIENT1</td>
<td>B1111</td>
<td>07/18/2005</td>
<td>CT THORAX W/O CONTRAST</td>
</tr>
<tr>
<td>ONCOPATIENT2</td>
<td>D9999</td>
<td>07/18/2005</td>
<td>ULTRASOUND ABDOMEN LTD</td>
</tr>
</tbody>
</table>

Note: This option only yields results if Radiology is entering internal Code 8 or Code 9, not an ICD-9 Code for Radiology. Many patients identified through these options may not actually have cancer and need to be manually deleted from Suspense. To delete, refer to Deleting a VA Patient from Suspense, page 14.
**PT  Automatic Case Finding - PTF Search**

Use this option to search the PTF (Patient Treatment File) and add the cases to your Suspense list in the OncoTraX Patient file. After you enter the dates for your search, the program lists the codes to capture during this search.

**Note:** Suspense date = Admission day +1.

**Select Start Date:** Type the begin date for the search or use the default date.

**Select Ending Date:** Type the end date for the search.

**Device:** Type the name of your printer.

**Example**

Start Date:  02-01-2004/  FEB 01, 2004
Go to Date:  2-10  FEB 10, 2004
Dates ok? Y/ ES
We will capture codes 140.0 to 239.9
From: FEB 01, 2004 To: FEB 10, 2004
Including codes:
042.2,259.2,273.1,273.2,273.3,273.9,284.9,288.3 & 289.8
V-Codes: 07.3,07.8,10.0-9,58.0-1,66.1,66.2,67.1-2,76,77.1

**Note:** These are the codes searched for and added to your Suspense file.

(Eliminating BENIGN 209.0-229.9)

-------------------------------------------------------------------------
-PTF-CASE FINDING LIST  WASHINGTON DC VAMC  03/10/2004
Patient Name  PtID#  Admit - Disch  Level/ICD9-Description
-------------------------------------------------------------------------
ONCOPATIENT1  A9999  02/03/2004-02/04/2004  ICD-6/0-HX-PROSTATIC MALIGNA
ONCOPATIENT2  G9999  02/06/2004-02/06/2004  ICD-8/0-HX OF BLADDER MALIGN
PTF CASE FINDING RESULTS
38 Cases found
2 New Patients added
2 New cases added

**Note:** Although there were 38 cases found during this time period, only 2 of the 38 were not already in Suspense.

**SE  Add/Edit/Delete from Suspense**

Use this option to manually add patients to the Suspense file, to modify patient information in the file, or to manually delete patients from Suspense.

**Adding a VA Patient to Suspense**

To enter a patient in the Suspense file:
1. Type the patient PID#; refer to the Glossary on page 94.
2. The program asks: do you want to add the patient as a New OncoTraX Patient? Response is **YES**.

3. At the Suspense Date: prompt, type the provisional date of the diagnosis. You can edit the date when the abstract is complete.

   **Note:** You must enter a date; this date becomes the Date of Diagnosis in the abstract.

### Editing a VA Patient in Suspense

To modify patient information in the Suspense file:

1. Type the patient PID#; refer to the *Glossary* on page 94.
2. At the Suspense Date: prompt, change the date.

### Deleting a VA Patient from Suspense

To remove a patient from the Suspense file:

1. Type the patient PID#; refer to the *Glossary* on page 94.
2. Press @ (shift + 2) to delete the patient.

**Example**

```
Select ONCOTRAX PATIENT NAME: 19999
Searching for a VA Patient, (pointed-to by NAME)
ONCOPATIENT1 12-21-99 999999999 NO NSC VETERAN
Enrollment Priority: GROUP 8c Category: ENROLLED End Date:
...OK? Yes// (Yes)
Patient Name: ONCOPATIENT
Date of Last Contact or Death:
Vital Status:
Follow-Up Status:
SUSPENSE DATE: FEB 10,2004// @
SURE YOU WANT TO DELETE THE ENTIRE SUSPENSE DATE? y (Yes)
This patient is not on suspense and has no primaries.
This patient's record has been deleted.
```

### **SP Print Suspense List by Suspense Date (132c)**

Use this option to print a list of patients currently in Suspense by the suspense date. The printout lists patients according to how they are identified; first by the source (through Surgical Pathology, Cytopathology, Electron Microscopy, Autopsy, PTF, Radiology, or manual entry) and then in the order of the suspense date. The printout lists the patient's name, the patient's SSN or identifier, Organ/Tissue, Lab Morphology, and Suspense, Admission and Discharge Dates.

**Note:** **132c** (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

`Start with Suspense Date: FIRST/:` Press the `<ret>` key to accept FIRST. All the cases with suspense dates display.
Go to Suspense Date:

Type a date for a Go to Suspense Date prompt.
Type the end date of the range for the printout.

Example

START WITH SUSPENSE DATE: FIRST//

Patient Name SSN Organ/Tissue Lab Morphology Suspense Dt Admission Discharge

SOURCE: SURGICAL PATHOLOGY

ONCOPATIENT1 999-99-9999 LOBE OF LUNG LIGNANT MELANOMA JAN 6,2006 JAN 6,2006 JAN 10,2006
ONCOPATIENT2 999-99-9999 SIGMOID COLON ENOCARCINOMA,MODERATEL JAN 6,2006 JAN 6,2006 JAN 10,2006

NP  Patients in Suspense with No Primaries

This option prints a list of OncoTraX patients that are in Suspense, but do not have a primary.

Example

<table>
<thead>
<tr>
<th>ONCOTRX PATIENT ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>ONCOPATIENT2</td>
</tr>
</tbody>
</table>
ABS  Abstract Entry and Printing Module

The Abstract Entry and Printing module is used for abstracting cases. An abstract is a summary of pertinent information about the patient, the cancer, the treatment, and the outcome. Components include patient demographic information, cancer identification, extent of disease, stage at diagnosis, first course of treatment, recurrence, and subsequent therapies or progression and follow-up.

- An abstract must be completed for all cases that meet the criteria for inclusion in the registry. (The standards are set forth by the American College of Surgeons and VACCR reportable lists.)
- If a patient has multiple primary malignancies, an abstract must be prepared for each additional primary.
- An abstract must be completed within six months from the date of first contact.

Abstract Entry/Print Menu
*************** ABSTRACT ENTRY/PRINT ***************
AI Complete Abstract
EE Abstract Edit Primary
NC Print Abstract NOT Complete List
IR Patient Summary
QA Print Abstract QA (80c)
EX Print Abstract-Extended (80c)
PA Print Complete Abstract (132c)
MA Print QA/Multiple Abstracts
AS Abstract Screens Menu (80c) ...

AI  Complete Abstract

Note: To complete an abstract, you need the Facility Oncology Registry Data Standards (FORDS), which describe every field in the abstract and the selections for those fields. Keep a copy of FORDS close at hand for reference.

The Complete Abstract option is the main entry point for abstracting new cases or editing existing abstracted cases.

OncoTraX is prompt driven. Once a specific Topography Code is selected, all successive prompts displayed are specific. Some of the data captured in the case finding and suspense process, as well as demographic data, are automatically transferred and inserted into the appropriate fields within the abstract; however you can edit the data if necessary.

Note: The OncoTrax Conventions on page 3 are helpful in maneuvering around an abstract.
Abstracting a Case

You begin an abstract by searching for the patient to determine if the patient is new to the VA. If you do not enter data in all required fields, you cannot change the status of the abstract to Complete (3).

Adding a New Patient

1. At the prompt, type the patient PID#; refer to the Glossary on page 94.
2. Respond YES to the prompt: Are you adding 'LAST,FIRST' as a new ONCOTRAX PATIENT (the 24673RD)? No/

Example

Enter patient name: h9999

Searching for a VA Patient, (pointed-to by NAME)

Searching for a Non-VA or Ambiguous Patient, (pointed-to by NAME)

Searching for a VA Patient

1  H3315 LAST,FIRST  *SENSITIVE* *SENSITIVE* NO  EMPLOYEE
2  H3315 LAST,FIRST1 7-7-15  095093315  NO  COLLATERAL  SY/
3  H3315 LAST,FIRST2 11-9-58  118483315  NO  NON-VET(OTHER) SY/
4  H3315 LAST,FIRST3 10-4-48  069423315  YES  SC VETERAN
5  H3315 LAST,FIRST4 6-4-22  096123315  NO  NSC VETERAN

ENTER '^' TO STOP, OR

CHOOSE 1-5: 1  LAST,FIRST  *SENSITIVE* *SENSITIVE* NO  EMPLOYEE

...OK? Yes//  (Yes)

Are you adding 'LAST,FIRST' as

a new ONCOTRAX PATIENT (the 24673RD)? No//  y  (Yes)

The following information is contained in the Patient file

NOT editable - See your MAS department IF in error

Name: LAST,FIRST

DOB:   DEC 24, 1953  Address:  1111 THIRD AVENUE
SSN:  999-00-9999  Washington DC  20422
SEX:  Female
POB:  Not Stated  888-8888, EXT.  1111

NOK:
************* OncoTraX Patient file DATA *************

Place of birth.............: UNKNOWN
Race 1.....................:
Race 2.....................:
Race 3.....................:
Race 4.....................:
Race 5.....................:
Spanish origin.............:
Sex.........................: FEMALE
Agent Orange exposure......:
Ionizing radiation exposure:
Chemical exposure..........:
Asbestos exposure..........:
Persian Gulf service.......:
Middle East service........:
Somalia service............:

Edit patient data? YES// n NO

Continue with Patient History? Yes// n NO

Register a Primary for this patient? Yes// YES

Editing an Existing Patient

1. Respond NO to the prompt: Are you adding 'LAST, FIRST' as a new ONCOTRAX PATIENT (the 24673RD)? No/

2. At the prompt: Edit patient data? YES// y YES

3. Type in the patient’s remaining demographic information.
   Some information is automatically imported from the patient’s electronic record; and some information is taken from the patient’s chart

   Example
   Edit patient data? YES// y YES
   Note: Answer No to Edit patient data?, if you are not going to complete this section now; such as when accessioning a patient to remove from Suspense.

   PLACE OF BIRTH: New York//
   RACE 1: White//
   RACE 2: NA//
   RACE 3: NA
   RACE 4: NA
   RACE 5: NA
   SPANISH ORIGIN: Non-Spanish, non-Hispanic
   SEX: Male//
Note: These fields are automatically brought into the abstract from information in the patient’s electronic record. Enter 99 for Unknown.

AGENT ORANGE EXPOSURE : No//
IONIZING RADIATION EXPOSURE: No//
CHEMICAL EXPOSURE: No
ASBESTOS EXPOSURE:

Note: These two fields are not automatically populated. This information is found in the patient’s chart. Leave no blanks.
PERSIAN GULF SERVICE: No//
MIDDLE EAST SERVICE: No//
SOMALIA SERVICE: No//

Would you like to see a PROBLEM LIST for this patient to assist you in entering the COMORBIDITY/COMPLICATION #1-6 prompts? Yes//   YES

Note: All problems from the cover sheet display. Select them as required by ACoS.

<table>
<thead>
<tr>
<th>DATE OF ONSET</th>
<th>ICD</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>266.2</td>
<td>B-COMPLEX DEFIC NEC</td>
</tr>
<tr>
<td>2003</td>
<td>110.4</td>
<td>DERMATOPHYTOSIS OF FOOT</td>
</tr>
<tr>
<td>2001</td>
<td>401.9</td>
<td>HYPERTENSION NOS</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>780.79</td>
<td>OTHER MALAISE AND FATIGUE</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>110.1</td>
<td>DERMATOPHYTOSIS OF NAIL</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>414.9</td>
<td>CHR ISCHEMIC HRT DIS NOS</td>
</tr>
</tbody>
</table>

4. A registrar often finds that a patient’s occupation is not in the list. When ?? (two question marks) display after the occupation, it means the occupation is not in the list. You can add an occupation.

Continue with Patient History? Yes//   YES
Select USUAL OCCUPATION: DOG TRAINER ??

a. Type an existing occupation.

b. When it is echoed back, type in the new occupation.

c. At the prompt: Are you adding DOG TRAINER as a new ........, type YES with the suggested SNOMED code.

Example
Select USUAL OCCUPATION: TEACHER IN EDUCATION (THIRD LEVEL)

USUAL OCCUPATION............: TEACHER IN AGRICULTURAL SCIENCE (THIRD LEVEL) // DOG TRAINER

Are you adding 'DOG TRAINER' as a new OCCUPATION FIELD (the 1750TH)?
No// Y (Yes)

OCCUPATION FIELD SNOMED CODE: 1750
**Note:** This SNOMED code is specific to your facility, however you can enter free text into these fields.

**Entering a First Primary for a Patient**

1. Press **Enter** at the prompt default.
   Register a Primary for this patient? Yes//
   Select (first) Primary 'SITE/GP':

2. At the prompt, Primary 'SITE/GP': type the site group name or the ICD-0 Topography code (C code).
   The case is assigned to the appropriate group and all subsequent fields display only the information relating to the selected site.

******** CREATE FIRST PRIMARY RECORD FOR THIS PATIENT*******

PATIENT: LAST, FIRST

Select first Primary SITE/GP: BREAST

Ok to ADD?: Yes// YES
Creating a new Primary record for LAST, FIRST

ACCESSION YEAR: 2007//

ACCESSION NUMBER: 200700224//
SEQUENCE NUMBER: 00//

LAST, FIRST
BREAST
999-00-999
9999

Primary Menu Options

1. Patient Identification
2. Cancer Identification
3. Stage of Disease at Diagnosis
   Collaborative Staging (2004+ cases)
4. First Course of Treatment
5. Patient Care Evaluation
6. Over-ride Flags

A All - Complete Abstract

Enter option: All//

LAST, FIRST
Patient Identification
999-00-9999
BREAST
3. A new primary record is created for this patient and you are prompted for:

Accession Year: Type the year the case was added to the registry.

**Note:** The current year is the default, but you can type in any year.

Accession No.: Press **Enter** to accept the accession number.

**Note:** The next available accession number for the accession year displays.

Sequence No.: If this is the first primary for the patient, press **Enter** to accept the sequence number **00**.

If this is not the first primary for the patient, all the primaries for the patient are listed, and you can edit any of the primaries or add another.

If the sequence number is not correct, such as when a patient had a previous cancer diagnosis and was treated elsewhere, type **02**.

---

**Editing a New or an Existing Primary**

1. Type a new primary SITE/GP.
   The program takes you to the body of the abstract.

   E  **EDIT** existing Primary
   A  **ADD** another Primary
   F  Follow-Up
   Q  Quit Patient

   EDIT/ADD primary for this patient: Edit//

2. Select **A** to edit all the information or select the portion of the abstract you want to edit.

   Primary Sub-menu Options

   1. Patient Identification
   2. Cancer Identification
   3. Stage of Disease at Diagnosis
   4. First Course of Treatment
   5. Patient Care Evaluation
   A  All - Complete Abstract

   **Note:** If you only want to edit one section of the abstract, select that number.

---

**Adding a Second Primary**

1. Select AI, the Abstract/Printing option.

   Select *..Abstracting/Printing Option: AI Complete Abstract
   Enter patient name: **LAST, FIRST**

   Place of birth..............: NEW YORK
   Race 1......................: WHITE
Race 2.....................: NA  
Race 3.....................: NA  
Race 4.....................: NA  
Race 5.....................: NA  
Spanish origin.............: NON-SPANISH, NON-HISPANIC  
Sex.........................: MALE  
Agent Orange exposure......: NO  
Ionizing radiation exposure: NO  
Chemical exposure.........: UNKNOWN  
Asbestos exposure..........: UNKNOWN  
Persian Gulf service.......: NO  
Middle East service........: NO  
Somalia service............: NO  
Comorbidity/Complication #1: 401.9  HYPERTENSION NOS  
Comorbidity/Complication #2: 724.2  LUMBAGO  
Comorbidity/Complication #3:  
Comorbidity/complication #4:  
Comorbidity/Complication #5:  
Comorbidity/Complication #6:  

Note: The personal information entered for the first primary displays and you can edit it or accept it as it is.

Edit patient data? YES// NO  
Continue with Patient History? Yes// NO

<table>
<thead>
<tr>
<th>Acc/Sequence</th>
<th>Primary Site</th>
<th>Last Cancer Status</th>
<th>Date DX</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-00898/00</td>
<td>BONE MARROW</td>
<td>Evidence this CA</td>
<td>06/23/2004</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Select one of the following:
E  EDIT existing Primary  
A  ADD another Primary  
F  Follow-Up  
Q  Quit Patient  

2. To add another primary for the patient select ADD another Primary.

EDIT/ADD primary for this patient: Edit// ADD another Primary

*********** ADD PRIMARY ***********  
LAST, FIRST  
ACCESSION NUMBER: 2004-00898  
SEQUENCE NUMBER: 02//

Note: The sequence number is updated. The first sequence number is changed from 00 to 01 and the additional one is 02.

3. Type the site or topography code and press Enter.
Select another Primary 'SITE/GP': LUNG NOS

4. Continue following the prompts.

**Completing an Abstract**

After you finish an abstract, you must change the abstract status to **Complete (3)**. OncoTraX reviews all mandatory fields and if any are not filled in, you are unable to code the abstract status as Complete. When an abstract is not complete and you have a large amount of data, you can change the status to partial or minimal.

An incomplete abstract generates a list of empty required fields. Go back into the abstract and fill in the empty required fields—**leave no blanks**.

In Abstract Status, you decide when to call an *incomplete* abstract. You can leave it as *incomplete* and do nothing more. To change the status, type the number, the first letter, or the entire word.

**Note:** You cannot set the abstract to **Complete**, if any of the required fields are left blank.

**Example**

```
ABSTRACT STATUS
ABSTRACT STATUS: Incomplete// ?
Choose from:
  0 Incomplete
  1 Minimal data
  2 Partial
  3 Complete

ABSTRACT STATUS: Incomplete// c Complete??
```

Abstract Status may not be set to COMPLETE unless ALL REQUIRED DATA FIELDS HAVE BEEN ENTERED.

The following REQUIRED fields have not been entered for this primary:

- ALCOHOL HISTORY
- DATE OF SURGICAL DISCHARGE
- DATE RADIATION STARTED
- DIAGNOSTIC CONFIRMATION
- EXTENSION

**Note:** Alcohol History, Tobacco History, Family History, and Occupation Information are considered patient demographic fields. You *cannot* ^ from these fields back to the patient. You must exit out of the abstract and go back into AI.

You *can* ^ to any primary field, such as Date of Surgical Discharge, Date Radiation Started, Diagnostic Confirmation, and Extension, and so on.

Example: ^Date of Surgical Discharge.
**EE  Abstract Edit Primary**

The Abstract Edit Primary option allows you to edit only information related to the cancer and not to a patient’s demographics. Only the primary fields of the abstract are brought up. This option allows you to pull up a patient using only the Accession/Sequence Number.

**Note:** The Accession/Sequence Number must be typed exactly as in the example.

Select *..Abstracting/Printing Option: EE  Abstract Edit Primary
Select primary or patient name: 2000-00163/00
PROSTATE  Last, First

**Note:** The site and patient’s name are echoed back to you.

**NC  Print Abstract NOT Complete List**

The Print Abstract NOT Complete List option allows you to print a list of records with an Abstract Status of Incomplete, Minimal, and Partial. The report shows the accession/sequence number, patient name, SSN, ICDO topography, and the date of diagnosis. Records are sorted according to the Status and Patient Name.

**Example**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ACC/SEQ NUMBER</th>
<th>PRIMARY SITE</th>
<th>COC</th>
<th>DATE DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONCOPatient1</td>
<td>999-99-9999</td>
<td>UNKNOWN PRIMAR</td>
<td>1</td>
<td>07/29/2005</td>
</tr>
<tr>
<td></td>
<td>2005-00537/00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONCOPatient2</td>
<td>999-99-9999</td>
<td>SKIN, TRUNK</td>
<td>1</td>
<td>03/02/1995</td>
</tr>
<tr>
<td></td>
<td>1995-00136/01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONCOPatient3</td>
<td>999-99-9999</td>
<td>RECTOSIGMOID J</td>
<td>1</td>
<td>10/18/2005</td>
</tr>
<tr>
<td></td>
<td>2005-00752/01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONCOPatient4</td>
<td>999-99-9999</td>
<td>ESOPHAGUS, LOW</td>
<td>1</td>
<td>10/27/2005</td>
</tr>
<tr>
<td></td>
<td>2005-00763/00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Only AI and EE allow you to enter data into an abstract.

**IR  Patient Summary**

The Patient Summary option allows you to produce a brief summary of the data found in a patient’s abstract.

**QA  Print Abstract QA (80c)**

The Print Abstract QA option allows you to print a user-friendly abstract, which physicians can use when doing the ACoS required QA portion of registry abstracts.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

**EX  Print Abstract-Extended (80c)**

The Print Abstract Extended option allows you to print a condensed version of a complete abstract.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.
PA Print Complete Abstract (132c)

The Print Complete Abstract option allows you to print a complete abstract, which includes capturing the extended data set or to print without personal identifiers (sensitive information), specifically name and SSN.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

MA Print QA/Multiple Abstracts

The Print QA/Multiple Abstracts option allows you to print quality assurance/multiple abstracts.

AS Abstract Screens Menu (80c)

The Abstract Screens Menu option allows you to print or view on your screen, various portions of a patient’s abstract.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.
**FOL  Follow-up Module**

The Follow-up module provides follow up information based on the date of last contact. A patient is considered delinquent or lost to follow-up when no contact is made within 15 months after the date of last contact. Lost cases remain delinquent in follow-up until further information is obtained.

*************** FOLLOW-UP FUNCTIONS **************
PF Post/Edit Follow-up
RF Recurrence/Sub Tx Follow-up
FH Patient Follow-up History
DF Print Due Follow-up List by Month Due
LF Print Delinquent (LTF) List
FP Follow-up Procedures Menu ...

**Note:** The first screen contains the information from the last posted follow-up note. The system prompts you to enter new follow-up information, beginning with Date of Last Contact or Death.

**PF  Post/Edit Follow-up**

The Post Follow-up option allows you to post and edit follow-up information.

**PF Post/Edit Follow-up:** Type the patient's PID#; refer to the *Glossary* on page 94.

**Date of Last Contact or Death:** Date of last contact with the patient and not the date you are entering the patient information. To edit the date of contact, select the date and press *Enter*. To add new follow-up information, type a new date.

**DATE ENTERED, REGISTRAR:** The system automatically enters the date you are entering the follow-up and the registrar’s name.

**VITAL STATUS:** Type A for Alive or D for Dead.

**FOLLOW-SOURCE:** From the FORDS manual, select allowable fields.

**COMMENTS:** Type information from the patient’s last contact.

**Example**
Patient seen in Oncology clinic, no evidence of disease recurrence.

or
Patient seen in urology clinic, PSA <0.05.

**CANCER STATUS:** Choose from the following:
1. No evidence of this tumor
2. Evidence of this tumor
9. Unknown/not stated if this tumor present

**Note:** Every *Complete* abstract must have follow-up posted.
**RF Recurrence/Sub Tx Follow-up**

The Recurrence/Sub Tx Follow-up option allows you to document the first recurrence and/or subsequent treatment. Date of first recurrence is the date a medical practitioner diagnoses a recurrence of a cancer after a disease-free period. Recurrence means the return or reappearance of the cancer after a disease-free period.

Select Initiation Date:

Recurrence/Sub Tx Follow-up: Type the patient's or PID#; refer to the Glossary on page 94.

Type of First Recurrence:
Enter the appropriate code for the first recurrence for this primary.

**Note:** To bring up a list of selections, type ?? at the prompt.

Select Subsequent Course of Treatment

If the patient did not receive subsequent treatment, press Enter.
If the patient did receive subsequent treatment, type the date treatment began.

Treatment fields display:

- SURGERY OF PRIMARY SITE:
- SURGERY OF PRIMARY SITE DATE:
- RADIATION:
- RADIATION DATE:
- CHEMOTHERAPY:
- CHEMOTHERAPY DATE:
- HORMONE THERAPY:
- HORMONE THERAPY DATE:
- IMMUNOTHERAPY:
- IMMUNOTHERAPY DATE:
- HEMA TRANS/ENDOCRINE PROC:
- HEMA TRANS/ENDOCRINE PROC DATE:
- OTHER TREATMENT:
- OTHER TREATMENT START DATE:
- PLACE:
- SUBSEQUENT THERAPY COMMENTS:

No existing text

Edit? NO/
To enter a comment, type Y.

Initiation Date: For each recurrence for this primary, type the date the course of treatment began.

******************************************************************************
** POST/EDIT FOLLOW-UP *******************************************************
******************************************************************************

Update the follow-up now.

**Note:** The subsequent course of treatment may consist of multiple treatments. If a patient did not receive a particular treatment, be sure to code it 00 for no treatment. Do not leave any treatment fields blank.
**FH  Patient Follow-up History**

The Patient Follow-up History allows you to print the patient's follow-up history, including when the next follow-up is due. Type the patient's name and a device, or print to your screen.

**DF  Print Due Follow-up List by Month Due**

The Print Due Follow-up List by Month Due option allows you to print a list of follow-ups that are due for a selected date range. They display by month due, along with the SSN, primary site, last date of contact, and date of diagnosis.

Your previous date range selection displays automatically. You want to be current by doing a patient due for follow-up in the month that the follow-up is scheduled; however, with other duties to perform, you may not be able to do this. In this case, work on the Lost To Follow-up list.

**Example**

```
START WITH DUE FOLLOW-UP: // 12-2005 (DEC 2005)
GO TO DUE FOLLOW-UP: LAST// 12-31-05 (DEC 31 2005)

TUMOR REGISTRY - DUE FOLLOW-UP Washington DC VAMC DEC 21, 2005 PAGE: 1
*******************************************
Patient Name Med Rec# Contact Primary Site/Gp Date Dx
*******************************************
DUE FOLLOW-UP: DEC 2005
ONCOPATIENT1 999-99-9999 12/1/2004 TESTIS 03/13/1986
ONCOPATIENT2 999-99-9999 12/31/2004 MELANOMA 11/05/2004
ONCOPATIENT3 999-99-9999 12/14/2004 SOFT TISSUE 04/19/2002
COUNT 3
```

**LF  Print Delinquent (LTF) List**

The Print Delinquent (LTF) List option allows you to print a list of all patients whose Due Follow-up date is over 3 months (are not seen/contacted for over 15 months). These patients are considered lost to follow-up. The report is sorted by the month and year the follow-up was due and prints the SSN, date of last contact, Site/Gp, and date of diagnosis.

**Note:** You may want to use this option frequently; if you are in a crunch, run only this list and work to reduce these numbers.

**Example**

```
ONCOLOGY DELINQUENT (LTF) LIST

NAME SSN CONTACT DATE SITE/GP DATE DX
DUE FOLLOW-UP: MAY 1997
ONCOPATIENT1 999-99-9999 5/03/1996 BLADDER 10/25/1993
DUE FOLLOW-UP: JUN 2005
ONCOPATIENT2 999-99-9999 06/07/2004 PROSTATE 05/14/1998
DUE FOLLOW-UP: AUG 2005
ONCOPATIENT3 999-99-9999 08/19/2004 PROSTATE 02/06/1985
DUE FOLLOW-UP: SEP 2005
```
FP  Follow-up Procedures Menu

The Follow-up Procedures Menu option allows you to manage follow-up by providing a list of contacts for the patient, follow-up letters, and a summary report of the patient follow-up.

- **PI**  Patient Follow-up Inquiry – view the last time a patient had follow-up and the status of the cancer at that time.
- **AC**  Add Patient Contact – view contacts for a specific patient and add other contacts. Additional contacts may be useful when doing follow-up on a patient.
- **AF**  Attempt a Follow-up – document the date for which you want a patient follow-up and the method you used.
- **PL**  Print Follow-up Letter – print a follow-up form letter to send to obtain follow-up.
- **EL**  Add/Edit Follow-up Letter – edit or create other follow-up letters specific to your facility.

**Follow-up Letter**

To send a letter to a patient, use the **AC**, **AF**, and **PL** options, in this sequence.

**To generate a follow up letter:**

```
Select OncoTraX Cancer Registry Option: fol  *..Follow-up Functions
************ FOLLOW-UP FUNCTIONS ************
PF Post/Edit Follow-up
RF Recurrence/Sub Tx Follow-up
FH Patient Follow-up History
DF Print Due Follow-up List by Month Due
LF Print Delinquent (LTF) List
SR Follow-up Status Report by Patient (132c)
FP Follow-up Procedures Menu ...
Select *..Follow-up Functions Option: FP

Follow-up Procedures Menu
PI Patient Follow-up Inquiry
AC Add Patient Contact
AF Attempt a Follow-up
```
Select Follow-up Procedures Menu Option: **AC Add Patient Contact**

********** DISPLAY CONTACTS **********

Select Patient: T9999  (Type the PID# to bring up patient or patient's name)

Searching for a VA Patient, (pointed-to by NAME)
LAST,FIRST 10-23-26 000129999

All of the contacts for this patient are displayed

**AVAILABLE CONTACTS**

-------------

Patient LAST, FIRST
000 999-0000
1269 STREETNAME ST
City, ST 00000

Next of Kin LAST, FIRST1, NEXT OF KIN
000 999-0000
0000 STREETNAME ST
City, ST 00000

********** ADD/EDIT CONTACTS **********

for: Last, First

**To send a letter to a patient:**

Select **TYPE OF FOLLOW-UP CONTACT: Guardian// PT Type PT.**

**TYPE OF FOLLOW-UP CONTACT: Patient//**

**CONTACT NAME: LAST, FIRST1//**

Go to the Contact File to edit the contact's name and address.

**CONTACT: LAST, FIRST1//**

STREET ADDRESS 1: 0000 STREETNAME ST//
STREET ADDRESS 2:
STREET ADDRESS 3:
ZIP CODE: City, ST 00000

**Note:** Always check the Zip Code field. The first town alphabetically with the zip code is selected. Compare it with the address in CPRS and select the correct town.

PHONE: 000 999-0000/
TITLE: Mr// Type a title without a period (Mr Mrs Ms and so on)
COMMENTS:
Select one of the following:
1 Display Contacts
2 Edit Contact
3 Attempt a Follow-up  Select 3 Attempt a Follow-up.
4 Another Patient
5 Exit Option

Select Action: 3//  Attempt a Follow-up

*********** ATTEMPT A FOLLOW-UP ***********

for Last, First

Select FOLLOW-UP ATTEMPT DATE: JUL 5, 2005//
FOLLOW-UP ATTEMPT DATE: JUL 5, 2005//
TYPE: ?
How will you be obtaining follow-up information?
Choose from:
1 Chart Review
2 Phone Contact
3 Letter Contact  Select 3 Letter Contact
8 Other

THE CONTACT: LAST, First1,// Type the patient’s last name.
RESULT: Pending//
REMARKS:

Generate Letter...!!

Specify TYPE Contact letter: ?? ?? (two question marks)
brings up a list from which to select a type.
Choose from:
1 PATIENT *Washington LETTER*
2 PATIENT *Washington 2* DOT MATRIX
3 PATIENT *Washington 3 LETTER*
4 PATIENT *Washington NEW*
5 PATIENT TESTING LETTER
CHOOSE 1-5: 1 PATIENT *Washington LETTER*

DEVICE:  (ENTER YOUR PRINTER)

To edit the follow-up letter:

Follow-up Procedures Menu
  PI Patient Follow-up Inquiry
AC Add Patient Contact
AF Attempt a Follow-up
PL Print Follow-up Letter
EL Add/Edit Follow-up Letter
FR Individual Follow-up Report
UP Update Contact File

Select EL Add/Edit Follow-up Letter.

EL Add/Edit Follow-up Letter

Select letter to Add/Edit: PAT
Type PAT.

1 PATIENT *Washington LETTER*
2 PATIENT *Washington DOT MATRIX
3 PATIENT *Washington 2 LETTER*
4 PATIENT *Washington NEW*
5 PATIENT TESTING LETTER

Press <RETURN> to see more, '^' to exit this list, OR

CHOOSE 1-5:
1 PATIENT *Washington LETTER*

NAME: PATIENT *Washington LETTER* Replace To change the name, type ... and press Enter. Type the name change for the letter.
FORM TYPE: PATIENT// ?
DESCRIPTION:
No existing text
Edit? NO/
MAIN FORM BODY: . . .

Our hospital has a clinical program engaged in following the progress of our former patients. We are interested in knowing how you are doing.
Edit? NO// YES Respond YES to edit the letter.

This takes you into the text editor (like VistA E-MAIL), where you can make changes to the wording of the letter. Do not change anything that is between the upright characters.

Example
[PATIENT NAME]

This information is automatically pulled from other parts in VistA. If you delete an upright or alter the text in the upright, the information is not placed into your letter.

Edit? NO// YES

Example of the editing screen

DO NOT CHANGE ANYTHING WITHIN THE UPRIGHTS OR DELETE THEM

|INDENT(10)| DEPARTMENT OF VETERANS AFFAIRS
            |HOSPITAL NAME|
            |HOSPITAL STREET ADDRESS|
            |HOSPITAL CITY,ST ZIP|

|LAST(FOLLOW-UP ATTEMPTS:FOLLOW-UP ATTEMPT DATE)|
|SSN|
Example of a follow-up letter to a patient

Our hospital has a clinical program engaged in following the progress of our former patients. We are interested in knowing how you are doing.

Would you be kind enough to answer the questions listed below? Your assistance will add to the success of this program and help us achieve better patient care in our hospital. A self-addressed stamped envelope is enclosed for your convenience.

Thank you for your participation.

Sincerely,
Cancer Registrar

Today's date: ____________

What is your present status?
_____ Free of cancer  _____ Not free of cancer

Are you able to work or carry on normal activity?  _____ YES, Normal
_____ Limited  _____ Capable, but limited  _____ Incapable  _____
Bedridden

Have you seen a doctor outside of the VA Medical Center?
_____ Yes  _____ No  If "Yes", who and where:

____________________________________________________________________

IF THE PATIENT IS D E C E A S E D, Please give date and place of death:

____________________________________________________________________

What was the cause of death?  _____ Cancer  _____ Not Cancer
_____ Other causes (specify)  ___________________________

Please list any other symptoms relating to your condition not covered in the above items on the back of this sheet.
This page intentionally left blank for double-sided printing.
**LIS Registry Lists Module**

The Registry Lists module is a menu of registry listings containing various accession registers, and patient and site reports.

Any 132c report requires a printer that prints 132 columns. Any 80c report requires a printer that prints 80 columns. The majority of the reports produce information that includes the entire database. If you have 20 years of data in your registry, the report contains all 20 years of data. For data from a specific year, use the options in the ANN *..Annual Reports ...* module.

************Cancer Registry Lists************

AA Accession Register-ACoS (80c)
AS Accession Register-Site (80c)
AE Accession Register-EOVA (132c)
PA Patient Index-ACoS (132c)
PS Patient Index-Site (80c)
PE Patient Index-EOVA (132c)
IN Primary ICDO Listing (80c)
SG Primary Site/GP Listing (80c)
IW Primary ICDO Listing (132c)

**AA Accession Register-ACoS (80c)**

The Accession Register-ACoS list allows you to print all records. This contains the ACoS required Accession Register data items.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

Press Enter at the START WITH prompt.

For a complete register:

```
START WITH ACC/SEQ NUMBER: FIRST// <Enter>
To get all records beginning with the same year:
For a single accession year (e.g. 2003):
START WITH ACC/SEQ NUMBER: FIRST// 2003-00000
GO TO ACC/SEQ NUMBER: LAST// 2003-99999
To get a Specific range of records:
START WITH ACC/SEQ NUMBER: 2004-00400 -00//
GO TO ACC/SEQ NUMBER: 2004-00500
```

<table>
<thead>
<tr>
<th>ACC/SEQ#</th>
<th>PATIENT NAME</th>
<th>ICDO</th>
<th>TOPOGRAPHY</th>
<th>DATE DX</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-00400/00</td>
<td>ONCOPATIENT1</td>
<td>C42.0</td>
<td>BLOOD</td>
<td>06/03/2004</td>
<td>2004</td>
</tr>
<tr>
<td>2004-00408/00</td>
<td>ONCOPATIENT2</td>
<td>C02.9</td>
<td>TONGUE NOS</td>
<td>06/24/2004</td>
<td>2004</td>
</tr>
<tr>
<td>2004-00409/00</td>
<td>ONCOPATIENT3</td>
<td>C18.7</td>
<td>COLON, SIGMOID</td>
<td>06/24/2004</td>
<td>2004</td>
</tr>
</tbody>
</table>
AS Accession Register-Site (80c)

The Accession Register Site list allows you to select a range of accession years or a range of accession numbers.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

You are provided with the following data:

<table>
<thead>
<tr>
<th>ACC/SEQ #</th>
<th>PATIENT NAME</th>
<th>SSN</th>
<th>PRIMARY SITE/GP</th>
<th>DATE DX</th>
<th>YEAR</th>
</tr>
</thead>
</table>

AE Accession Register-EOVA (132c)

The Accession Register-EOVA list is similar to AA Accession Register-ACoS, but displays more fields.

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

**PA Patient Index-ACoS (132c)**

The Patient Index-ACoS allows you to print the Patient Index, which contains all elements required by the ACoS Cancer Program, for all the patients in the registry. The list is very long.

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

**Example**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>MED RECORD#</th>
<th>S</th>
<th>DT-BIRTH</th>
<th>DT-DEATH</th>
<th>ACC/SEQ-NO</th>
<th>DATE DX</th>
<th>ICD-TOPOGRAPHY</th>
<th>ICD-MORPHOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONCOPATIENT1</td>
<td>000-00-0000</td>
<td>M</td>
<td>07/25/1940</td>
<td>07/25/2000</td>
<td>2000-00371/00</td>
<td>09/25/1992</td>
<td>C18.5-COLON</td>
<td>SPLENIC</td>
</tr>
</tbody>
</table>

PS Patient Index-Site (80c)

The Patient Index Site list provides an alphabetical list of the entire registry.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>SSN</th>
<th>SX</th>
<th>ACC/SEQ #</th>
<th>PRIMARY SITE/GP</th>
<th>DATE DX</th>
</tr>
</thead>
</table>

PE Patient Index-EOVA (132c)

The Patient Index-EOVA is similar to PA Patient Index Site, but provides slightly different information.

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.
IN  Primary ICDO Listing (80c)

The Primary ICDO Listing provides a list of all cases in the entire registry by the ICDO codes. The list begins with ICDO-SITE: C00-LIP. The list is very long.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>SSN</th>
<th>YEAR ACC/SEQ #</th>
<th>TOPOGRAPHY</th>
<th>DATE DX</th>
</tr>
</thead>
</table>

SG  Primary Site/GP Listing (80c)

The Primary Site/GP Listing provides a list of all cases in the entire registry by requested site/gp. The previous selection displays as the default.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

* Previous selection: SITE/GP equals LUNG

START WITH SITE/GP: LUNG// PANCREAS  
Type PANCREAS.

GO TO SITE/GP: LAST// PANCREAS  
Previous selection: ICDO TOPOGRAPHY-CODE from C34.0 to C34.9

START WITH PRIMARY SITE CODE: C34.0// C25  
For a specific primary site use only that code

Example
List for an ICDO Code, sorted alphabetically.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>SSN</th>
<th>YEAR ACC/SEQ #</th>
<th>TOPOGRAPHY</th>
<th>DATE DX</th>
</tr>
</thead>
</table>

IW  Primary ICDO Listing (132c)

The Primary ICDO Listing provides a list of all patients by all primary site codes in the entire registry.

**Note:** If you have time, experiment with this listing to see all that it can provide.
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ANN  Annual Reporting Module

The Annual Reporting module is a menu of annual reports.

- Annual Reports
  AAR  Annual ACoS Accession Register (80c)
  API  Annual ACoS Patient Index (132c)
  ASL  Annual Primary Site/GP Listing (132c)
  ACL  Annual Patient List by Class of Case (80c)
  SST  Annual Primary Site/Stage/Tx (132c)
  TST  Annual ICDO Topography/Stage/Tx (132c)
  SDX  Annual Status/Site/Dx-Age (132c)
  HIS  Annual Histology/Site/Topography (80c)
  AST  Annual Site/ICDO Topography/Histology (80c)
  ACT  Annual Cross Tabs (80c)
  CFR  Print Custom Reports

- The Annual ACoS Accession Register and Annual ACoS Patient Index are required for ACoS approval.
- Print Custom Reports allows you to retrieve data requested by your staff from your database. It requires knowledge of basic FileMan functions.

**AAR  Annual ACoS Accession Register (80c)**

The ACoS Annual Accession Register is an annual report required by ACoS. The report is sorted by accession /sequence number within a specific accession year and a count of the records prints at the end.

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.

**Select year:**  2005  
**Type specific year.**

**Example of the report**

<table>
<thead>
<tr>
<th>ACC/SEQ-No</th>
<th>Patient Name</th>
<th>ICDO - Topography</th>
<th>Date Dx</th>
<th>C</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975-00334/04</td>
<td>ONCOPATIENT1</td>
<td>C44.1  SKIN, EYELID</td>
<td>01/19/2005</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1987-00118/03</td>
<td>ONCOPATIENT2</td>
<td>C80.9  UNKNOWN PRIMARY</td>
<td>05/10/2005</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2005-00055/00</td>
<td>ONCOPATIENT3</td>
<td>C61.9  PROSTATE</td>
<td>02/08/2005</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**API  Annual ACoS Patient Index (132c)**

The Annual ACoS Patient Index is an annual report of the required ACoS items for an accession year. A count of the records prints at the end.

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

**Select year:**  
**Type specific year.**

**Example – fields in this report**
**ASL  Annual Primary Site/GP Listing (132c)**

Note: **132c** (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

The Annual Primary Site/GP Listing is an annual report sorted first by accession year and then by the primary site/group.

**Example**

START WITH ACCESSION YEAR: FIRST// 2003
GO TO ACCESSION YEAR: LAST// 2003
START WITH SITE/GP: FIRST// BLADDER

Note: Type the SITE/GP in capital letters.

GO TO SITE/GP: LAST// BLADDER

**Example – fields in this report**

A list of all patients from the year 2003 with a primary Bladder cancer displays.

**ACL  Annual Patient List by Class of Case (80c)**

The Annual Patient List by Class of Case is an annual report listing all patients alphabetically, for a specific year for each class of case.

Note: **80c** (80 columns) presents an easy-to-read display on the computer screen.

**Example – fields in this report**

| Patient Name | Med Rec# | Sx | Acc/Seq# | Site/Group | Date Dx |

**SST  Annual Primary Site/Stage/Tx (132c)**

The Annual Primary Site/Stage/Tx is an annual report listing patients for a specific year and specific site and stage.

Note: **132c** (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

START WITH ACCESSION YEAR: 2005/
GO TO ACCESSION YEAR: LAST// 2005

* Previous selection: SITE/GP equals PHARYNX

START WITH SITE/GP: PHARYNX/
GO TO SITE/GP: PHARYNX/

**Example – fields in this report**

| PT ID | TX | TREATMENT | SURG DATE | SURGERY | RAD DATE | RADIATION | CHEMO DT | CHEMOTHERAPY | HT DATE | HORMONE TPY |
**TST Annual ICDO Topography/Stage/Tx (132c)**

The Annual ICDO Topography/Stage/Tx is an annual report listing cases by stage and site for a selected accession year and selected ICDO-topography.

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

**START WITH ACCESSION YEAR:** 2006// 2005

**GO TO ACCESSION YEAR:** 2006// 2005

* Previous selection: ICDO-SITE CODE from C00 to C90

**START WITH PRIMARY SITE CODE PREFIX:** C00//

**GO TO PRIMARY SITE CODE PREFIX:** C90// C02

**Example**

```
ICDO-SITE CODE: C32

W5321 C32.0  NONE
         ------
       1
R3493 C32.0  XRT  00/00/0000  06/13/2005 Beam radiation  00/00/0000 None 00/00/0000 None
         ------
       1
       1
       2

STAGE GROUPING-AJCC: I

B4704 C32.0  XRT  00/00/0000  03/03/2005 Beam radiation  00/00/0000 None 00/00/0000 None
         ------
       1
       1
       1

STAGE GROUPING-AJCC: II

B6985 C32.0  NONE
         ------
       1
P7689 C32.1  SUR  09/02/2005
         ------
       1

H7872 C32.1  XRT/CMX  00/00/0000  07/13/2005 Beam radiation  07/18/2005 Multiagent 00/00/0000 None
         ------
       1
       3
       3
COUNT  6
```
**SDX Annual Status/Site/Dx-Age (132c)**

The Annual Status/Site/Dx-Age is an annual report listing patients for a specific accession year.  

**Note:** 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.  

Annual report - sorted first by Accession year  
Then by Class Category (Non-analytic/Analytic)  
Then by Status, Site/GP, and Diagnosis Age Gp.  
Enter four digit ACCESSION YEAR,  
For Class category: either 'A'  
for Analytic, or first to last.  

**Example**  
START WITH ACCESSION YEAR: 2005  
GO TO ACCESSION YEAR: LAST// 2005  
* Previous selection: CLASS CATEGORY equals 1 (ANALYTIC)  
START WITH CLASS CATEGORY: 1// ANALYTIC  
GO TO CLASS CATEGORY: 1// ANALYTIC  
DEVICE:  
PRIMARY LIST  
DX AGE-GP: 60-69  
ONCOPATIENT1  999-99-9999  2005-00054/00  02/02/2005 ANUS NOS SQUAM CELL CARC T1 NO MO I  SUR  
ONCOPATIENT2  999-99-9999  2005-00272/00  03/22/2005 ANUS NOS SQUAM CELL CARC TX NX NX Unkno UR/CMX  

**HIS Annual Histology/Site/Topography (80c)**

The Annual Histology/Stage/Topography is an annual report listing.  

**Note:** 80c (80 columns) presents an easy-to-read display on the computer screen.  

START WITH ACCESSION YEAR: 2005//  
GO TO ACCESSION YEAR: LAST// 2005  
START WITH SITE/GP: PHARYNX//  
GO TO SITE/GP: PHARYNX//  

**Example**  
*****************************************************************************  
2005 - ANALYTIC              Washington DC VAMc   DEC 21,2005   PAGE: 1  
Patient Name  Med Rec#  Sx  Acc/Seq#  ICDO-Topography  Date Dx  
********************************************************************************  
ICDO HISTOLOGY-CODE: 8070/3  
SITE/GP: PHARYNX  
   ICDO-SITE CODE: C01  
   PATIENT NAME: ONCOPATIENT1  
ONCOPATIENT1  999-99-9999  M  2005-00096/00 TONGUE BASE  03/14/2005  
   ICDO-SITE CODE: C09  
   PATIENT NAME: ONCOPATIENT2  
ONCOPATIENT2  999-99-9999  M  2005-00494/00 TONSILLAR FOSSA  07/12/2005  
   ICDO-SITE CODE: C10  
   PATIENT NAME: ONCOPATIENT3  
ONCOPATIENT3  999-99-9999  M  2005-00029/00 OROPHARYNX NOS  01/27/2005  
COUNT  4  ---------------
**ACT  Annual Cross Tabs (80c)**

The Annual Cross Tabs is an annual report that is very long. Queue this report after hours.

*Note:* 80c (80 columns) presents an easy-to-read display on the computer screen.

**CPR  PRINT Custom Reports**

The PRINT Custom Reports option allows you to create custom reports using VA FileMan.

*Note:* It is very helpful to have some FileMan training from the computer department at your facility. Also, with knowledge of capturing files and opening them in Microsoft Excel, you can create a very usable and professional document.

You can retrieve any data that you enter into an abstract. Create a report by specifying:

- file from which the information is coming, OncoTraX Primary (#165.5), OncoTraX Patient (#160), or OncoTraX Contact (#165);
- fields that contain the data;
- how to separate/sort the data; and
- information to be printed.
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STA Statistical Reporting Module

The Statistical Reporting module allows you to obtain 5-year survival information on your data. You can search for user-defined criteria.

****************STATISTICAL REPORTS****************
TS Treatment by Stage - Cross tabs
SP Survival by Site
SS Survival by Stage
TX Survival by Treatment
SU Survival Routines
DS Define Search Criteria

DS Define Search Criteria

The Define Search Criteria option allows you to define criteria to obtain 5-year survival information from:
SP Survival by Site
SS Survival by Stage
TX Survival by Treatment

In order to use SP, SS, TX, or SU (Survival Routines), you must first create a template using DS Define Search Criteria.

Use DS to create search templates for Survival Analysis.

Note: Name templates beginning with ONCOZ for user-defined templates rather than software-distributed names, ONCOS.

Select one of the following:
1 ONCOTRAX PRIMARY
2 ONCOTRAX PATIENT
3 ONCOTRAX CONTACT
Select File: 1 ONCOTRAX PRIMARY
We will search entries in ONCOTRAX PRIMARY file...

-A- SEARCH FOR ONCOTRAX PRIMARY FIELD: SITE/GP
-A- CONDITION: ?

Answer with CONDITION NUMBER, or NAME
Choose from
1 NULL
2 CONTAINS
3 MATCHES
4 LESS THAN
5 EQUALS
6 GREATER THAN
YOU CAN NEGATE ANY OF THESE CONDITIONS BY PRECEDING THEM WITH "'" OR "-
SO THAT "'NULL'" MEANS "NOT NULL"
-A- CONDITION: CONTAINS
-A- CONTAINS: LUNG NOS

-B- SEARCH FOR ONCOTRAX PRIMARY FIELD: ACCESSION YEAR
-B- CONDITION: GREATER THAN
-B- GREATER THAN: 1995

-C- SEARCH FOR ONCOTRAX PRIMARY FIELD: ACCESSION YEAR
-C- CONDITION: LESS THAN
-C- LESS THAN: 2001

-D- SEARCH FOR ONCOTRAX PRIMARY FIELD: CLASS CATEGORY
-D- CONDITION: EQUALS
-D- EQUALS: ANALYTIC

-E- SEARCH FOR ONCOTRAX PRIMARY FIELD:

Note: If you want to include more data, continue with E. If not, press Enter and at IF, type the letters of your search criteria. The screen echoes back your selections.

IF: ABCD SITE/GP CONTAINS (case-insensitive) "LUNG NOS"
and ACCESSION YEAR GREATER THAN 1995
and ACCESSION YEAR LESS THAN 2001
and CLASS CATEGORY EQUALS "1" (ANALYTIC)

or

STORE RESULTS OF SEARCH IN TEMPLATE: ONCOZ LUNG NOS SURVIVAL

Name the template beginning with ONCOZ.

Press Enter to start the sort.

Note: You do a sort make sure that data is available. You can sort and print any data you want to view.

SORT BY: NUMBER// AJCC STAGE
START WITH AJCC STAGE: FIRST//
   WITHIN AJCC STAGE, SORT BY:
FIRST PRINT FIELD: !PID#
THEN PRINT FIELD: DATE DX
THEN PRINT FIELD: TREATMENT PLAN
THEN PRINT FIELD:
Heading (S/C): ONCOTRAX PRIMARY STATISTICS Replace
Running Survival Options.
   SP Survival by Site
   SS Survival by Stage
   TX Survival by Treatment

SP Survival by Site

Survival by Site produces a 5-year survival by site, from the criteria you set in the DS Define Search Criteria.
SS Survival by Stage

Survival by stage produces a 5-year survival by AJCC Stage, from the criteria you set in the DS Define Search Criteria.

TX Survival by Treatment

Survival by Treatment produces a 5-year survival by the treatment, from the criteria you set in the DS Define Search Criteria.

Each of the three options also generates a list of patients who are dropped from the search and why.

Example including reason

Cases dropped: 4

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>REASON FOR BEING DROPPED</th>
</tr>
</thead>
<tbody>
<tr>
<td>L9999 ONCOPATIENT1</td>
<td>SURVIVAL MONTHS 0</td>
</tr>
<tr>
<td>Y1111 ONCOPATIENT2</td>
<td>SURVIVAL MONTHS 0</td>
</tr>
</tbody>
</table>

Example of the survival information for the template

ONCOTRAK PRIMARY Template ONCOZ LUNG NOS SURVIVAL 96-99

Life Table

<table>
<thead>
<tr>
<th>Yrs</th>
<th>% Alive</th>
<th># Left</th>
<th>Deaths</th>
<th>Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100.0</td>
<td>416</td>
<td>259</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>37.7</td>
<td>157</td>
<td>73</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>20.2</td>
<td>84</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>16.1</td>
<td>67</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>11.8</td>
<td>49</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>10.2</td>
<td>33</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

TS Treatment by Stage - Cross Tabs

The Treatment by Stage – Cross tabs option allows you to print cross-tabs for all analytic cases for treatment by stage groups (I, II, III, IV). It is a large report and not user-friendly to view.
**UTL Utility Options Module**

The Utility Options module allows you to manage the information in your OncoTraX database. You can correct errors, delete records, and create data disks to send to national and state databases.

- **RS** Registry Summary Reports
- **DP** Delete OncoTraX Patient
- **DS** Delete Primary Site/GP Record
- **EA** Edit Site/AccSeq# Data
- **LG** List Topographic Site Groups
- **LT** List Topography Codes by Site Group
- **AR** Create a report to preview ACoS output
- **CT** Create ACoS Data Download
- **SR** Create a report to preview State/VACC output
- **CC** Create State/VACC Data Download
- **TR** Define Cancer Registry Parameters
- **AC** Enter/Edit Facility file
- **CDD1** Print Condensed DD--OncoTraX Patient file
- **CDD2** Print Condensed DD--OncoTraX Primary file
- **PSR** Purge Suspense Records
- **SP** Purge Patient Records with No Suspense/Primaries
- **CS** Restage CS cases using latest version
- **TNM** Compute percentage of TNM forms completed
- **TIME** Timeliness Report

**RS Registry Summary Reports**

The Registry Summary Reports provide a quick count for:

- **T**–Today
- **A**–Annual (132c)
- **F**–Follow-up

The *Today* report gives you an overview of the entire registry on the day and time you run the report.

```
Analytical: 10144
Non-Analytical: 1515
Total: 11659
WORKLOAD STATISTICS
```

The *Annual* report gives you the number of cases for the selected year by site, race, sex, and the AJCC Stage. There are two options to choose from after you select the year.

```
Analytic cases only? YES/
m
```
Answer 'YES' if you want only analytic cases (CLASS OF CASE 0-2) displayed.
Answer 'NO' if you want all cases (analytic and non-analytic) displayed.

The **Follow-up** report offers two options that meet the ACoS requirements.

Follow-up rate calculation parameters (select 1 or 2):
1) All analytic patients from the cancer registry reference date
2) All analytic patients diagnosed within the last five years, or from the cancer registry reference date, whichever is shorter

**Example of selection 1**

<table>
<thead>
<tr>
<th>FOLLOW-UP RATE FOR ALL PATIENTS (LIVING AND DEAD)</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients from registry reference date</td>
<td>11808</td>
<td>100%</td>
</tr>
<tr>
<td>1. Less benign/borderline (behavior code 0/1)</td>
<td>- 183</td>
<td></td>
</tr>
<tr>
<td>2. Less Carcinoma in situ CERVIX cases</td>
<td>- 9</td>
<td></td>
</tr>
<tr>
<td>3. Less cases of in situ/localized basal and</td>
<td>- 1068</td>
<td></td>
</tr>
<tr>
<td>squamous cell carcinoma of skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Less foreign residents</td>
<td>- 0</td>
<td></td>
</tr>
<tr>
<td>5. Less nonanalytic (includes recurrent cases</td>
<td>- 1234</td>
<td></td>
</tr>
<tr>
<td>class of case 3,4,5, 8 &amp; 9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUBTOTAL CASES = ANALYTIC CASES**
(class of case 0, 1, 2)  
(A) 9314 100%

1. Less number dead
(B) 6881 74%

**SUBTOTAL CASES (NUMBER LIVING)**  
(C) 2433 26%

1. Less number current (known to be alive in the last 15 months)
(D) 2380 26%

**TOTAL (LOST TO FOLLOW UP OR NOT CURRENT)**  
(E) 53 * 1%

(* should be 20%)

**Note:** Percent should be 20% or less.

Successful follow-up currency (all patients)  
(F) 9261 ** 99%

(** should be 80%)

**Note:** Percent should be 80% or greater.

<table>
<thead>
<tr>
<th>FOLLOW UP RATE FOR LIVING PATIENTS ONLY</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the total number from Line C</td>
<td>2433</td>
<td>100%</td>
</tr>
<tr>
<td>Subtract the total number from Line D</td>
<td>- 2380</td>
<td>*** 98%</td>
</tr>
<tr>
<td>Total lost/not current of living patients</td>
<td>- 53</td>
<td>2%</td>
</tr>
</tbody>
</table>

***
**DP  Delete OncoTraX Patient**

The Delete OncoTraX Patient option allows you to delete an OncoTraX patient from the OncoTraX Patient file. You can also delete any associated records in the OncoTraX Primary file.

**Note:** Once you delete an abstract, you cannot undelete it. If you delete a patient by mistake, you have to manually re-enter the patient’s abstract.

**DS  Delete Primary Site/Gp Record**

The Delete Primary Site/Gp Record option allows you to delete a selected primary record for a specific OncoTraX patient.

**EA  Edit Site/AccSeq# Data**

The Edit Site/AccSeq# Data option allows you to edit/correct accession numbers, sequence numbers, diagnosis dates, and so on.

**AR  Create a Report to Preview ACoS Output**

The Create a Report to Preview ACoS Output option allows the cancer registrar to preview the contents of the specified accessions intended as output for the ACoS.

**CT  Create ACoS Data Download**

The Create ACoS Data Download option allows you to create the file for submission to the American College of Surgeons (ACoS), in response to the annual call for data.

**SR Create a Report to Preview State/VACCR Output**

The Create a Report to Preview State/VACCR Output option allows you to print the state extract data in a report format.

**CC  Create State/VACCR Data Download**

The Create State/VACCR Data Download option allows you to create a file for the transmission of cancer registry information, including confidential patient identity data to the State collecting agencies. This extraction routine includes/downloads only patients from your state based on ZIPCODE and COUNTY AT DIAGNOSIS. It also blanks out communicable diseases and substance abuse, which are protected by federal law.

**TR  Define Cancer Registry Parameters**

The Define Cancer Registry Parameters option allows you to set up the OncoTraX: Cancer Registry software. You must use this option first, in order to make several of the follow-up options work. For more information, refer to software implementation in the *Oncology Technical Manual and Software Security Guide* at [http://www.va.gov/vdl/documents/Clinical/Oncology/onc211_tm.doc](http://www.va.gov/vdl/documents/Clinical/Oncology/onc211_tm.doc).
**AC Enter/Edit Facility File**

The Enter/Edit Facility File option allows you to enter new facilities in the Facility file or change the data for a facility.

**CDD1 Print Condensed DD--OncoTraX Patient file**

The Print Condensed DD-OncoTraX Patient file option allows you to view the data dictionary, which lists all patient information files in the abstract. Use this option when doing custom reports.

**CDD2 Print Condensed DD--OncoTraX Primary file**

The Print Condensed DD-OncoTraX Primary file option allows you to view the data dictionary, which lists all primary information files in the abstract. Use this option when doing custom reports.

**PSR Purge Suspense Records**

The Purge Suspense Records option allows you to enter multiple dates in the suspense file when deleting. *Use this option with caution.*

**SP Purge Patient Records with No Suspense/Primaries**

The Purge Patient Records with No Suspense/Primaries option allows you to purge OncoTraX Patient records with no suspense records and no primaries.

**CS Restage CS Cases**

The Restage CS Cases option allows you to correct a problem in Collaborative Staging; use the most current version of collaborative staging. *Run it only once.*

**TNM Compute Percentage of TNM Forms Completed**

The Compute Percentage of TNM Forms Completed option allows you to compute the percentage of Primary Tumor, Regional Lymph Nodes, and Distant Metastasis forms completed.

**TIME Timeliness Report**

The Timeliness Report computes the percentage of cases within the selected date range, which have an ELAPSED DAYS TO COMPLETION value less than 180 days.
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Reporting to VA Central Cancer Registry

You must report data to the VA Central Cancer Registry once a month.

Select *..Utility Options Option: cc Create State/VACCR Data Download
DISPLAY/PRINT on-line instructions? No// NO

Available record layouts:

1) VACCR Record Layout v11.1 (VA Registry)
2) NAACCR State Record Layout v11.1

Select record layout: 1  VACCR Record Layout v11.1

Facility Identification Number (FIN): 6211145//
Select date field to be used for Start/End range: ?

Select the date field you wish to use for this download's Start/End range prompts.

Select one of the following:

1 Date Case Completed <<<<<<<<< USE TO REPORT NEW CASES
2 Date Case Last Changed<<<<<<USE TO REPORT UPDATED CASES

Select date field to be used for Start/End range: 1  Date Case Completed
Start, Date Case Completed:  010107
End, Date Case Completed:  013007

These are your current settings:

Record layout.........................: VACCR EXTRACT V11.1
Facility Identification Number (FIN): 6330250
Start date..........................: 1/1/11
End date............................: 1/30/11

Note: Keep a record of the date ranges already sent, so that you do not send the range a second time.

Are these settings correct? YES//

------------------------------------------------------------------------------------------------------------------
|Please activate your PC capture program. The data will be     | |
sent in 2 minutes or when you press the return key.             | |
------------------------------------------------------------------------------------------------------------------
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Utility Tools

PC Capture Program

1. Activate your PC capture program.
2. Create a folder on your hard drive or network drive, in which you can save the data for VACCR.
3. Click Save. Make sure the Save as text is not selected; refer to the KEA Term illustration.
4. Data scrolls across your screen. When the data is done scrolling, a ⏯ (backward question mark) displays.
5. Click the appropriate item on your Toolbar to End Capture.
6. Using Microsoft Word, open the file you created.
7. Scroll to the end of the document. A square displays; it was the ⏯.
8. You must delete the square. Place the cursor to the right of it and backspace twice.
9. Use  (disk icon) on your Toolbar to Save your file. Do not save the file in Word format.

KEA Term - Illustrated Directions

Note: If your terminal emulation software is not KEA, you may see different options.

Activating your PC capture program

1. Start a capture g File using KEA.
2. Click Tools at the top of the VISN 5 Mirror – KEA 420 window.
3. Click Capture Incoming Data.
4. Create a folder on your hard drive or network drive and name it so you know what is in the file.
5. Make sure the **Save as text** is not selected.

6. Click **Save**. The dialog box closes and the data scrolls across the screen. This can take a long time, depending on how many cases are sent.

7. When the data is done scrolling, a ë (backward question mark). displays, click **Tools**.

8. Click **End Capture**.

9. Open the newly created file in Microsoft Word.  
   Example illustration: M:\VACCR\Washington\VACCR 1-4-04 to 1-31-04.txt  
   **Save in:** Buffalo  
   **File name:** VACCR 1-4-04 to 1-31-04  
   **Save as type:** .txt  

This is the file that you send by email to the VA Central Registry.

**Emailing the VACCR file**

The file you created must be emailed to the VA Central Registry. There are two methods by which you can do this.

VA PKI (Privacy Key Initiative) in your Microsoft Outlook.  
If you do not have VA PKI, request it from the ISO at your facility.

**State Reporting**

Sending data to the State Central Registry is up to your cancer program/medical center/section.  
When you receive a *standing letter of request* and you receive approval from your supervisors to release the data, send the data to the State Central Registry. Sending data to the state is 100% voluntary for VA cancer registries; refer to Article VI of the constitution.
Article VI (The Supremacy Clause)

All debts contracted and engagements entered into, before the adoption of this Constitution, shall be as valid against the United States under this Constitution, as under the Confederation.

This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.

The Senators and Representatives before mentioned, and the members of the several state legislatures, and all executive and judicial officers, both of the United States and of the several states, shall be bound by oath or affirmation, to support this Constitution; but no religious test shall ever be required as a qualification to any office or public trust under the United States.

You decide the frequency and timeframe in which to send the data. The process is similar to the one for reporting to VACCR.

1. Start in the Utility Options

2. Select CC Create State/VACCR Data Download

***************UTILITY OPTIONS***************

DISPLAY/PRINT on-line instructions? No// NO

Available record layouts:

1) VACCR Record Layout v11.1 (VA Registry)
2) NAACCR State Record Layout v11.1

Select record layout: 2  NAACCR State Record Layout v11.1

Facility Identification Number (FIN): 6211145//
Select date field to be used for Start/End range: ?

Select the date field you wish to use for this download’s Start/End range prompts.

Select one of the following:

1  Date Case Completed <<<<<<<< USE TO REPORT NEW CASES
2  Date Case Last Changed<<<<<<<<USE TO REPORT UPDATED CASES

Select date field to be used for Start/End range: 1  Date Case Completed
Start, Date Case Completed:  010107
End, Date Case Completed:  013107

Analytic cases only? YES// NO  <<<<< If you want to report only Analytic cases choose yes, you can ask your state if they want them or not.

These are your current settings:
Record layout: STATE EXTRACT V11.1
Facility Identification Number (FIN): 6211145
State to be extracted: NY
Start date: 1/1/07
End date: 1/31/07
Analytic cases only: NO

Note: Keep a record of the date ranges already sent, so that you do not send the range a second time.
Are these settings correct? YES/

PC Capture Program

1. Activate your PC capture program.
2. Create a folder on your hard drive or network drive, in which you can save the data for VACCR.
3. Click Save. Make sure the Save as text is not selected; refer to the KEA Term illustration.
4. Data scrolls across your screen. When the data is done scrolling, a ❄ (backward question mark), displays.
5. Click the appropriate item on your Toolbar to End Capture.
6. Using Microsoft Word, open the file you created.
7. Scroll to the end of the document. A square displays; it was the ❄.
8. You must delete the square. Place the cursor to the right of it and backspace twice.
9. Use 🗑️ (disk icon) on your Toolbar to Save your file…. Do not save the file in Word format.
This is the file that you send to the state. You need instructions from your state, regarding how to transmit the data.

Downloading Your Data from VistA for the ACoS

1. Start in Utility Options.
2. Select CT Create ACoS Data Disk.
3. Activate your PC capture program when you see:

   |Please activate your PC capture program. The data will be sent in 30 seconds or when you press the return key.
4. Name the file, 8 characters or less.

5. Move the file to an accessible place on your hard drive or network drive. The filename in the path to the file cannot contain more than 8 characters.

   **Note:** Do not place the file on your desktop. The path to the file is too complicated for this strictly MS DOS program. (M:\2004BUF.TXT)

6. Data scrolls across your screen. When the data is done scrolling, a ? (backward question mark) displays.

7. Click the appropriate item on your Toolbar to **End Capture**.

8. Using Microsoft Word, open the file you created.

9. Scroll to the end of the document. A square displays; it was the ?.

10. You must delete the square. Place the cursor to the right of it and backspace twice.

11. Use Disk icon (disk icon) on your Toolbar to **Save** your file… *Do not save the file in Word format.*

12. If a dialog box displays, click **Yes**.


14. Make a note of the filename and the path to it.

   **Note:** Run the data through EDITS, before sending it to the ACoS.

---

**Downloading and Installing GenEdits > NEED LATEST<<<**

1. Create a folder on your drive (like M: drive) and name it **GenEdits**.


3. On the ACS menu on the left side of the page, click **National Cancer Data Base (NCDB)**.

4. Under Data Submission Information, click **Downloading, Installing, and Running GenEDITS with the Current NCDB Edit Metafile**

5. Click **Instructions for Downloading and Installing the NCDB Metafile and EDITS Software Beginning October 2006 (850K PDF)** to print the instructions.

6. Click **Back** in your browser, to return to the ACoS site.

7. Under NCDB Submission Metafiles, click the **NCD_110B (740K EXE)** file to download it to the GenEdits folder you created in step 1.

8. Click **Save** and navigate to the **GenEdits** folder.

9. Click **Close**.

10. Click **Download Software** and automatically go to the NAACCR website, Centers for Disease Control and Prevention (CDC).


12. Click **Save** and navigate to the **GenEdits** folder.

13. Click **Close**.

14. Go to page 5 of your printed instructions and follow them.
Running Genedit for ACoS Call for Data

1. To open Genedit, double-click the icon.

2. In the Open Configuration File list box (pink box), double-click NCDB110B. Depending on where you installed the Genedit program, the first line is similar to:
   Configuration File: M:\GENEDIT\NCDB110B.GCF
   The second line is:
   EDITS Runtime Metafile <.RMF>:
   NCD_110B.RMF

3. Type the path to your file.
   Input Data File: M:\NCDB\2005.TXT
   Note: It is important to include the file extension in lower case (.txt) or upper case (TXT).

4. Type the path for saving your edits report.
   Error Message: M:\NCDB.2005.rpt

5. On line 3, delete Use Picker Dialog, and type the path to your file.
   Example: M:\2005buf.txt

6. At Error Message, type the location to save your edits for printing.
   Example: M:\2005ed.rpt

7. When all lines are filled in correctly, click Run! at the top of the window. The edits report is sent to your location; as in the example: M:\2005ed.rpt.
8. Go to Microsoft Word (or whatever Word Processing Software you use).
9. Open the file and correct your errors.
10. When your errors are corrected, download the data again and re-run the data through the edits.
    
    **Note:** If you still have errors, correct those and keep doing this until you have no errors. Then proceed to the ACoS website and submit your data to the college.

You are ready to send the data to the NCDB. Go to the ACoS website: 
http://www.facs.org/cancer/index.html

**Sending Your File to ACoS**

1. Log on to the website, https://web.facs.org/datalinks/ with your User ID and password.
2. Select Submit Patient Level Data and Direct submission from my registry.
3. Click Continue.
4. Click **Browse** and find your data file; as in the example: M:\2003buf.txt.
5. Click **Submit**.
VistA Setup

VistA can be set up in different ways.

**Line Editor**

If you are set up with **Line Editor** in VistA, your screen for entering text can look like the example, TEXT-DX PROC-PE:. The number lines make editing a little difficult.

**Example of the Line Editor Screen**
**Screen Editor**

You can change to a more user-friendly word processing screen. Using the Screen Editor, you are able to move around easily, format your text, and do many things that are impossible with the line editor.

1. To change to the Screen Editor, type `^EDIT USER CHARACTERISTICS.`
2. Tab or arrow down to PREFERRED EDITOR: LINE EDITOR – VA FILEMAN.

3. Change LINE to SCREEN.
Example of the Screen Editor Screen

You can type in this screen, just like in Microsoft Word or Word Perfect. You are able to change margins, format text, join lines together, cut and paste text, easily delete text, and so on.

Type **F1H** (H for help) to access word processing Help commands for the Screen Editor.
There are four Help screens to which you can navigate. Use the Arrow keys (to the left of the number pad) to move around the Help screens. Help Screen 3 of 4 is the most useful of the Help screens.

Example of Help Screen 3 of 4
Example of Help Screen 2 of 4
Menu Options

When you sign on to VistA, your screen may be set up not to display menus. You may want to change your set up options, so that you can see your menu choices.

1. At Select OncoTraX: Cancer Registry Option, type \^EDIT USER CHARACTERISTICS.
2. Arrow down to AUTO MENU: and type ? Your options display.
3. Select 1 YES, MENUS GENERATED.
Your menu choices display when you access VistA.
Edits within OncoTraX

If there are inter-field problems, warning messages display when you attempt to change the ABSTRACT STATUS (165.5,91) to Complete. These warning messages are the VistA inter-field edit checks. You can override these warnings.

<table>
<thead>
<tr>
<th></th>
<th>WARNING: REPORTING HOSPITAL = REFERRING FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>WARNING: REPORTING HOSPITAL = TRANSFER FACILITY</td>
</tr>
<tr>
<td>3</td>
<td>WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) -REFERRING FACILITY may not be blank</td>
</tr>
<tr>
<td>4</td>
<td>WARNING: CLASS OF CASE = 3 (Dx ew, 1st rx ew) REFERRING FACILITY may not be blank</td>
</tr>
<tr>
<td>5</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew)-DATE OF FIRST CONTACT..: later than SURGERY OF PRIMARY SITE DATE.:</td>
</tr>
<tr>
<td>6</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT. later than RADIATION DATE..............:</td>
</tr>
<tr>
<td>7</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than RADIATION THERAPY TO CNS DATE:</td>
</tr>
<tr>
<td>8</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than CHEMOTHERAPY DATE.............:</td>
</tr>
<tr>
<td>9</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..:</td>
</tr>
<tr>
<td>10</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than IMMUNOTHERAPY DATE.............:</td>
</tr>
<tr>
<td>11</td>
<td>WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than OTHER TREATMENT DATE............:</td>
</tr>
<tr>
<td>12</td>
<td>WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) DATE OF FIRST CONTACT..: earlier than DATE DX.........................:</td>
</tr>
<tr>
<td>13</td>
<td>WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) CLASS OF CASE must be 5 (Dx at autopsy)</td>
</tr>
<tr>
<td>14</td>
<td>WARNING: CLASS OF CASE = 5 (Dx at autopsy) TYPE OF REPORTING SOURCE must be 6 (Autopsy only)</td>
</tr>
<tr>
<td>15</td>
<td>WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) DIAGNOSTIC CONFIRMATION must be 1 (Pos histology) or 6 (Direct visualization)</td>
</tr>
<tr>
<td>16</td>
<td>WARNING: TYPE OF REPORTING SOURCE = 7 (Death certificate only) DIAGNOSTIC CONFIRMATION must be 9 (Unk if microscopically confirmed)</td>
</tr>
<tr>
<td>Line</td>
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<td>17</td>
<td>XXX is a paired site LATERALITY may not be 0 (Not a paired site)</td>
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<td>XXX is an unpaired site LATERALITY must be 0 (Not a paired site)</td>
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<td>BONES, PELVIS, SACRUM, COCCYX is a paired site</td>
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<td>BEHAVIOR CODE = 2 (In situ) SUMMARY STAGE must be 0 (In situ)</td>
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<td>BEHAVIOR CODE = 3 (Malignant) SUMMARY STAGE may not be 0 (In situ)</td>
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<td>HISTOLOGY = 8331 FOLLICULAR ADENOCA, WELL DIFF GRADE/DIFFERENTIATION must be 1 (Grade I)</td>
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<td>HISTOLOGY = 8851 LIPOSARCOMA, WELL DIFF GRADE/DIFFERENTIATION must be 1 (Grade I)</td>
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<td>HISTOLOGY = 9511 RETINOBLASTOMA, DIFFERENTIATED GRADE/DIFFERENTIATION must be 1 (Grade I)</td>
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<td>HISTOLOGY = 9083 TERATOMA, INTERMEDIATE GRADE/DIFFERENTIATION must be 2 (Grade II)</td>
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<td>HISTOLOGY = 8020 CARCINOMA, UNDIFFERENTIATED GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 8021 CARCINOMA, ANAPLASTIC NOS GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9062 SEMINOMA, ANAPLASTIC TYPE GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9390 CHOROID PLEXUS PAPILLOMA GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9401 ASTROCYTOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9451 OLIGODENDROGLIOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9512 RETINOBLASTOMA, UNDIFF GRADE/DIFFERENTIATION must be 4 (Grade IV)</td>
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<td>HISTOLOGY = 9696 LYMPHOMA, LYMPH. POOR DIFF. NOD GRADE/DIFFERENTIATION must be: 3 (Grade III) or 5 (T-cell) or 6 (B-cell) or 7 (Null cell)</td>
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<td>HISTOLOGY = 9694 LYMPHOMA, LYMPH. INT. DIFF. NOD GRADE/DIFFERENTIATION must be: -2 (Grade II) or 5 (T-cell) or 6 (B-cell) or 7 (Null cell) or 9 (Unknown)</td>
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<td>WARNING: HISTOLOGY = 9683 LYMPHOMA CENTROBLASTIC DIFFGRADE/DIFFERENTIATION must be: 4 (Grade IV) or 5 (T-cell) or 6 (B-cell) or 7 (Null cell)</td>
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<td>WARNING: GRADE/DIFFERENTIATION = 5 (T-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)</td>
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<td>WARNING: GRADE/DIFFERENTIATION = 6 (B-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)</td>
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<td>WARNING: GRADE/DIFFERENTIATION = 7 (Null cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)</td>
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<td>WARNING: GRADE/DIFFERENTIATION = 8 (Natural killer cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)</td>
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<td>WARNING: BEHAVIOR CODE = 3 (Malignant) EXTENSION may not be 00 (In situ)</td>
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<td>WARNING: ICDO-TOPOGRAPHY = XXX PATHOLOGIC EXTENSION = XXX</td>
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<td>45</td>
<td>PATHOLOGIC EXTENSION may only be coded for PROSTATE (C61.9) cases</td>
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<td>46</td>
<td>WARNING: NODES POSITIVE (REGIONAL) = 01-97 LYMPH NODES may not be 0 (No lymph nodes)</td>
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<td>WARNING: ICDO-TOPOGRAPHY = XXX HORMONE THERAPY = 2 (Endocrine surgery and/or radiation) Only BREAST and PROSTATE cases may be coded as receiving endocrine surgery or endocrine radiation</td>
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<td>WARNING: STATUS = Dead PLACE OF DEATH may not be blank</td>
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<td>49</td>
<td>WARNING: STATUS = Dead CAUSE OF DEATH and STATE DEATH CERT may not both be blank</td>
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<td>50</td>
<td>WARNING: For race combinations RACE 1 may not be 'White'</td>
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<td>51</td>
<td>WARNING: A specific race code may not occur more than once</td>
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<td>52</td>
<td>If REGIONAL NODES EXAMINED is 99 (Unknown if nodes examined, NA), REGIONAL NODES POSITIVE must be 99 (Unk if nodes + or -, NA)</td>
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Edits within Genedits

Messages display for the NAACCR edits (Genedits version) - NAACR110VC (Version 11.0 C). The edit set is Veterans Administration; the cross-field edits are skipped when a single-field edit fails.

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<tr>
<td>RX Summ--Scope Reg 98-02, Primary Site, ICDO3(COC)</td>
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<tr>
<td>RX Summ--Surg Approch,RX Summ--Surg Site 98-02(COC)</td>
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<td>RX Summ--Surg Prim Site, Diag Conf (SEER IF76)</td>
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<tr>
<td>Name of Edit</td>
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<td>----------------------------------------------------------------------------</td>
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<tr>
<td>RX Summ--Surg Site 98-02, RX Summ--Surg Site (COC)</td>
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<tr>
<td>RX Summ--Surgical Approch, Date of DX (COC)</td>
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<tr>
<td>RX Summ--Surgical Approch, Primary Site (COC)</td>
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<tr>
<td>RX Summ--Surgical Margins, Primary Site,ICDO2 (COC)</td>
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<td>RX Summ--Surgical Margins, Primary Site,ICDO3 (COC)</td>
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<td>RX Summ--Transplnt/Endocr, Primary Site (SEER IF28)</td>
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<tr>
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<tr>
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<td>Seq Num--Hosp, Primary Site, Morph ICDO3 (COC)</td>
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<td>Errors</td>
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<td>Surgery, Reason No Surg (COC)</td>
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<td>Systemic RX, Surgery, Systemic/Sur Seq (COC)</td>
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<td>TNM Clin Stage Group, TNM Items, ICDO3 (COC)</td>
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<tr>
<td>TNM Clin Stage Group, TNM Path Stage Group (COC)</td>
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<td></td>
</tr>
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<tr>
<td>TNM Path Stage Group, TNM Items, ICDO3 (COC)</td>
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<tr>
<td>Tumor Marker 1, Primary Site, Morph ICDO2 (COC)</td>
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<td>Tumor Marker 1, Primary Site, Morph ICDO3 (COC)</td>
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<tr>
<td>Tumor Marker 2, Primary Site (COC)</td>
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<tr>
<td>Tumor Marker 3, Primary Site (COC)</td>
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</table>
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACoS</td>
<td>American College of Surgeons</td>
</tr>
<tr>
<td>AJCC</td>
<td>American Joint Committee on Cancer</td>
</tr>
<tr>
<td>API</td>
<td>Application Program Interface</td>
</tr>
<tr>
<td>COC</td>
<td>Commission on Cancer</td>
</tr>
<tr>
<td>CS</td>
<td>Collaborative Staging</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DOD</td>
<td>Date of Death</td>
</tr>
<tr>
<td>EOD</td>
<td>Extent of Disease</td>
</tr>
<tr>
<td>EOVA</td>
<td>East Orange VA Medical Center</td>
</tr>
<tr>
<td>FORDS</td>
<td>Facility Oncology Registry Data Standards</td>
</tr>
<tr>
<td>ICD-O</td>
<td>International Classification of Diseases for Oncology</td>
</tr>
<tr>
<td>NAACCR</td>
<td>North American Association of Central Cancer Registries</td>
</tr>
<tr>
<td>NCDB</td>
<td>National Cancer Data Base</td>
</tr>
<tr>
<td>NCI</td>
<td>National Cancer Institute</td>
</tr>
<tr>
<td>NCRA</td>
<td>National Cancer Registrars Association</td>
</tr>
<tr>
<td>NPCR</td>
<td>National Program of Cancer Registries</td>
</tr>
<tr>
<td>PID#</td>
<td>Patient Identification Number First initial of the last name plus the last four digits of the SSN: W9999</td>
</tr>
<tr>
<td>PTF</td>
<td>Patient Treatment File</td>
</tr>
<tr>
<td>Report 80C</td>
<td>Report contains 80 columns and requires a printer that prints 80 columns</td>
</tr>
<tr>
<td>Report 132C</td>
<td>Report contains 132 columns and requires a printer that prints 132 columns; on screen the text wraps.</td>
</tr>
<tr>
<td>SEER</td>
<td>Surveillance, Epidemiology and End Results</td>
</tr>
<tr>
<td>SNOMED</td>
<td>Systematized Nomenclature of Medicine</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>TNM</td>
<td>Primary Tumor, Regional Lymph Nodes, Distant Metastasis</td>
</tr>
<tr>
<td>VACCR</td>
<td>VA Central Cancer Registry</td>
</tr>
<tr>
<td>VISN</td>
<td>Veterans Integrated Service Network</td>
</tr>
</tbody>
</table>
This page intentionally left blank for double-sided printing.
Appendix A: OncoTraX: Cancer Registry V.2.11 - Patch ONC*2.11*47  

Associated Patches: (v)ONC*2.11*46 <= must be installed BEFORE `ONC*2.11*47'

Subject: EDITS Application Program Interface (API)

Category: INPUT TEMPLATE
          ROUTINE
          DATA DICTIONARY
          ENHANCEMENT
          PRINT TEMPLATE

Description:

This patch is available via FTP in a KIDS distribution file. The Host File is named ONC211P47.KID and is located in the [ANONYMOUS.SOFTWARE] directory of the following OI Field Offices.

Preferred Address:

First available ftp server download.vista.med.va.gov

<table>
<thead>
<tr>
<th>SPECIFIC FIELD OFFICE</th>
<th>FTP ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>ftp.fo-albany.med.va.gov</td>
</tr>
<tr>
<td>Hines</td>
<td>ftp.fo-hines.med.va.gov</td>
</tr>
<tr>
<td>SLC</td>
<td>ftp.fo-slc.med.va.gov</td>
</tr>
</tbody>
</table>

All Data Dictionary modifications and additions have been reviewed and approved by the Data Base Administrator.

This patch will implement the EDITS API.

When the registrar attempts to set the ABSTRACT STATUS (#165.5,91) to 3 (Complete), three things will occur:

1. The program will first check to make sure that all of the "required" data items have been filled in. This is currently being done.

2. Once all of the "required" data items have been filled in, the program will pass the abstract through a series of local inter-field edit checks. This is also currently being done.
3. Once all of the local inter-field edit checks have been resolved (or overridden), the program will invoke the EDITS API and pass the abstract through the EDITS application. This feature is new with this patch.

Example:

```
ABSTRACT STATUS: Incomplete// Complete
All required data fields have been entered.
Beginning inter-field edit checks...
No inter-field edit check warnings.

Calling EDITS API... <--new with this patch
```

If the EDITS API encounters errors the error messages will be displayed followed by the following message:

```
EDITS errors were encountered. ABSTRACT STATUS is unchanged.
```

Example:

```
Calling EDITS API...

Date of Last Contact, Date of Diag. (NAACCR IF19)
E:Date of Diagnosis and Date of Last Contact conflict
Date of Diagnosis (283) = 12092004
Date of Last Contact (1294) = 09052003

RETURN to continue, '^' to exit, or Edit# for help:

<table>
<thead>
<tr>
<th>Edit Set</th>
<th>Errors</th>
<th>Warnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans Administration</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

EDITS errors were encountered. ABSTRACT STATUS is unchanged.
```

Note: Each error will be numbered sequentially. If the registrar wishes to see additional information about a specific error, he/she may enter the sequential error number after the "RETURN to continue, '^' to exit, or Edit# for help:" prompt for additional error information.

If EDITS errors are encountered, the registrar should then review the error messages and resolve any data conflicts.

If the EDITS API does not encounter any errors the program will do the following:

- ABSTRACT STATUS will be set to 3 (Complete).
- A unique checksum value will be computed for the abstract.
- DATE CASE COMPLETED will be set to the current date.
• ABSTRACTED BY will be set to the registrar who 'completed' the abstract.

The following messages will be displayed:

No EDITS errors or warnings.

ABSTRACT STATUS.......: Complete
DATE CASE COMPLETED....: 03/21/2007
ABSTRACTED BY...........: REGISTAR, TEST
DATE CASE LAST CHANGED:
CASE LAST CHANGED BY...

Computing checksum value for this abstract...

Once an abstract has successfully passed through the EDITS API and its ABSTRACT STATUS set to 3 (Complete), if the registrar makes a change which will affect the abstract's NAACCR record, he/she will see the following message:

You have made a change to a 'Completed' abstract.
This abstract needs to be re-run through the EDITS API.

Calling EDITS API...

If no EDITS errors are encountered the registrar will see the following message:

No EDITS errors or warnings. ABSTRACT STATUS = 3 (Complete).

If EDITS errors are encountered the registrar will see the following message:

EDITS errors were encountered.

The ABSTRACT STATUS has been changed to 0 (Incomplete).

Each time a 'complete' abstract is changed the abstract will be date-stamped with the date of the most recent change and the name of registrar making the change.
In addition to implementing the EDITS API this patch contains the following enhancements and problem resolutions:

1. **NAACCR Version 11.1**

   NAACCR Version 11.1 has been implemented with this patch. To support this implementation the following additions/modifications have been made:

   d. The following new data items have been added to the ONCOLOGY PRIMARY (#165.5) file:
      
      AMBIGUOUS TERMINOLOGY DX (#165.5,159)
      DATE OF CONCLUSIVE DX    (#165.5,193)
      MULT TUM RPT AS ONE PRIM (#165.5,194)
      DATE OF MULTIPLE CANCERS (#165.5,195)
      MULTIPLICITY COUNTER     (#165.5,196)

      These data items have been placed in the "Cancer Identification" section of the abstract and will only appear for 2007+ cases.

   e. **STATE AT DX (#165.5,16)**

      The description of code ZZ has been changed:
      - Old description: US, NOS; Canada, NOS; Unknown
      - New description: Residence unknown

      Two new codes have been added:
      - CD (Resident of Canada, NOS)
      - US (Resident of United States, NOS)

   f. **MANAGING PHYSICIAN (#165.5,2.2)**

      With the implementation of FORDS in patch ONC*2.11*36, data item MANAGING PHYSICIAN was discontinued. This data item is being reactivated to support NAACCR version 11.1 data item NPI--PHYSICIAN-MANAGING [2465] 2595-2604. MANAGING PHYSICIAN is required for cases diagnosed on or after January 1, 2007.

2. **STAGE GROUP PATHOLOGIC (#165.5,87) computation using CLINICAL M**

   Following message was received from Jerri Linn Phillips, the Manager -- Information, Technology, and Data Standards Section, National Cancer Data Base, Commission on Cancer:

   "The experts on the AJCC Executive Committee agreed without exception that the intent is that staging for metastatic disease is 'clinical' unless there is pathologic information confirming the presence of distant metastases. There are no circumstances of 'pM0.' Further, the assumption should be 'cM0' unless there is clinical or pathological evidence of metastases. There are extremely few if any circumstances of 'Mx' disease.

   For computing pathologic stage, use pT and pN. Then, if pM is 1, 1A, 1B, 1C, or 1M use it; otherwise use the value of cM (whether it is blank, cMX, cM0, cM1, cM1a, cM1b, cM1c or 88) to calculate pathologic stage group."
As per these instructions, the algorithm for computing STAGE GROUP PATHOLOGIC has been changed to use CLINICAL M in lieu of PATHOLOGIC M in the event that PATHOLOGIC M is not 1, 1A, 1B, 1C or 1M. If CLINICAL M is used the following message will be displayed:

CLINICAL M will be used to calculate PATHOLOGIC STAGE GROUPING.

Example:

CLINICAL T: T1 2 cm or less in greatest dimension
CLINICAL N: N0 No regional lymph node metastasis
CLINICAL M: M0 No distant metastasis

Computed CLINICAL STAGE GROUPING: I (T1 N0 M0)

PATHOLOGIC T: T1 2 cm or less in greatest dimension
PATHOLOGIC N: N0 No regional lymph node metastasis
PATHOLOGIC M: MX Distant metastasis cannot be assessed

CLINICAL M will be used to calculate PATHOLOGIC STAGE GROUPING.

Computed PATHOLOGIC STAGE GROUPING: I (T1 N0 M0)

3. Duplicate entries in COUNTY (#5.1) file
   There were two SAN DIEGO entries in the COUNTY file for the state of California. The duplicate entry has been deleted. Any abstracts with a COUNTY AT DX (#165.5,10) value which pointed to the deleted entry have had their COUNTY AT DX values converted to the remaining SAN DIEGO entry.

4. OTHER STAGING SYSTEM (#165.5,39)
   a. In patch ONC*2.11*45 we retired the data item OTHER STAGE for all 2006+ cases. This was done as per the NAACCR 2006 Implementation Guidelines and Recommendations. It has been requested that this data item be reactivated for all cases for VACC use.
   b. In order to be consistent with NAACCR terminology the data item OTHER STAGE has been renamed OTHER STAGING SYSTEM.
   c. For 2007+ cases the OTHER STAGING SYSTEM choices are restricted to the C-D-S, RAI, D-S, FAB, EXTENSIVE and LIMITED choices.
   d. OTHER STAGING SYSTEM has been added to VACC EXTRACT V11 record layout in columns [1513-1527].

5. No AJCC TNM staging
   a. LENTIGO MALIGNA MELANOMA (8742/3)
In patch ONC*2.11*44 "no staging" stuffing logic was added for LENTIGO MALIGNA (8742/2) and LENTIGO MALIGNA MELANOMA (8724/3). This stuffing was incorrect for 8742/3. LENTIGO MALIGNA MELANOMA (8742/3) is stageable. LENTIGO MALIGNA (8742/2) is not 8742/3 has been removed from the "no staging" stuffing logic.

b. Carcinoid Cancers
In patch ONC*2.11*43 we implemented "no staging" stuffing for carcinoid Cancers of the following sites:
- C16. STOMACH
- C17. SMALL INTESTINE
- C23.9 GALLBLADDER
- C24. EXTRAHEPATIC BILE DUCTS/AMPULLA OF VATER
- C25. EXOCRINE PANCREAS
This list has been expanded in this patch to include:
- C18. COLON
- C19.9 RECTOSIGMOID JUNCTION
- C20.9 RECTUM NOS
- C21. ANAL CANAL
This change will mimic the Collaborative Staging TNM coding/staging computation for carcinoid Cancers of these sites.

c. GIST of PANCREAS, HEAD (C25.0)
There is no TNM coding or staging schema for AJCC 6th Edition PANCREAS, HEAD (C25.0) cases with an HISTOLOGY (ICD-O-3) value of GIST (GASTROINTESTINAL STROMAL) (8936/0, 8936/1, 8936/2 or 8936/3). For these cases the TNM and staging fields will be stuffed with the "no staging" values.

d. PANCREAS, ISLETS (C25.4)
In patch ONC*2.11*44 we implemented "no staging" stuffing for PANCREAS, ISLETS (C25.4) cases combined with specific histology values. In this patch we are removing the histology test. All PANCREAS, ISLETS (C25.4) cases will now be stuffed with the "no staging" values.

e. MYCOSIS FUNGOIDES (9700/3) AND SEZARY DISEASE (9701/3) OF SKIN, VULVA, PENIS, SCROTUM
C44.0-C44.9, C51.0-C51.9, C60.0-C60.9, C63.2
Sixth Edition Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis and Scrotum cases have a TNM staging schema. These cases were being stuffed with "no staging" values. This was incorrect. These cases may be staged.

Note: Pre-Sixth Edition Mycosis Fungoides and Sezary Disease cases and Mycosis Fungoides and Sezary Disease cases with primary sites other than Skin, Vulva, Penis or Scrotum do not have a TNM staging schema. Their TNM fields will be stuffed with the appropriate "no staging" values.
6. Excluding sensitive patient data from the Complete Abstract (132c)
When the registrar chooses to print the Complete Abstract (132c) the following prompt displays:

   Exclude sensitive patient data? No//

If the registrar answers "YES", the following data item values will be masked from display:

   PATIENT NAME
   SSN
   HOME STREET ADDRESS
   HOME CITY
   ADDRESS AT DX
   ADDRESS AT DX - SUPP
   CITY/TOWN AT DX
   TELEPHONE
   NEXT OF KIN

7. DATE DX (#165.5,3)
According to FORDS (page 89), DATE DX should be coded 99999999 "when the date of initial diagnosis is unknown". The registrars were not allowed to enter a DATE DX value of 99/99/9999. This has been fixed.

8. FOLLICULAR LYMPHOMA, GRADE 3 (9698/3)
For FOLLICULAR LYMPHOMA, GRADE 3 (9698/3), if GRADE/DIFF/CELL TYPE was not 1 (Grade 1), the following inter-field edit warning was displayed when the registrar set the ABSTRACT STATUS (#165.5,91) to 3 (Complete).

   WARNING: HISTOLOGY = FOLLICULAR LYMPHOMA, GRADE 3
              GRADE/DIFF/CELL TYPE must be 1 (Grade 1)

   This inter-field edit has been removed.

9. FOL *..Follow-up Functions ... [ONCO FOLLOWUP MENU]
FP Follow-up Procedures Menu ... [ONCO FOLL PROCEDURE MENU]
PL Print Follow-up Letter [ONCO FOLL-PRINT LETTER]
If the registrar selected a second patient within a single [PL Print Follow-up Letter] session, the LAST FOLLOW-UP CONTACT (#160,15.1) value from the first patient would be carried over to the second patient. This has been fixed.

10. SEQUENCE NUMBER--CENTRAL [380] 281-282
    The NAACCR data item SEQUENCE NUMBER--CENTRAL was being extracted with a value 88 or 99 (depending on BEHAVIOR CODE). This was incorrect. SEQUENCE NUMBER--CENTRAL should have a value of <BLANK>. This has been fixed.
Note: This change backs out part of item 8 of patch ONC*2.11*46.

11. [UTL *..Utility Options ...]
   [CC Create State/VACCR Data Download]
   The [CC Create State/VACCR Data Download] has been enhanced. The registrar may now use either
   DATE CASE COMPLETED or DATE CASE LAST CHANGED for the Start/End date range.
   Such as:
   Select *..Utility Options Option: CC Create State/VACCR Data Download
   DISPLAY/PRINT on-line instructions? No// NO
   Available record layouts:
   a. VACCR Record Layout v11.1 (VA Registry)
   b. NAACCR State Record Layout v11.1

   Select record layout: 1  VACCR Record Layout v11.1

   Facility Identification Number (FIN): 6211145//
   Select date field to be used for Start/End range: ?

   Select the date field you wish to use for this download's Start/End range prompts.

   Select one of the following:
   Date Case Completed
   Date Case Last Changed

12. New inter-field edit checks
   New inter-field edit checks have been added which will check for the presence of codes 88 and
   88/88/8888 in the following data items and, if found, prohibit the registrar from 'completing' the abstract.
   The following data items will be checked for code 88 (Recommended, unknown if admin):
   CHEMOTHERAPY
   CHEMOTHERAPY @FAC
   HORMONE THERAPY
   HORMONE THERAPY @FAC
   IMMUNOTHERAPY
   IMMUNOTHERAPY @FAC
   HEMA TRANS/ENDOCRINE PROC
   The following data items will be checked for date values of 88/88/8888:
   DATE RADIATION STARTED
   RADIATION @FACILITY DATE
DATE RADIATION ENDED
CHEMOTHERAPY DATE
CHEMOTHERAPY @FAC DATE
HORMONE THERAPY DATE
HORMONE THERAPY @FAC DATE
IMMUNOTHERAPY DATE
IMMUNOTHERAPY @FAC DATE
HEMA TRANS/ENDOCRINE PROC DAT

13. TYPE OF REPORTING SOURCE (#165.5,1.2)
   DATE OF NO TREATMENT (#165.5,124) stuffing
   REASON NO SURGERY OF PRIMARY (#165.5,58)
   If TYPE OF REPORTING SOURCE = 6 (Autopsy only) or 7 (Death certificate only) and a
   DATE OF NO TREATMENT has been entered, the program will now stuff REASON NO
   SURGERY OF PRIMARY with 9 (Unknown).

14. TIMELINESS REPORT
   A new option, [TIME Timeliness Report], has been added to the [UTL*.Utility Options...]
   menu. This option will compute the percentage of cases within the selected date range
   which have an ELAPSED DAYS TO COMPLETION value less than 180 days.

Routine Summary:

The following routines are included in this patch. The second line of these routines should look like:
   <tab>;2.11;ONCOLOGY;**[patch list]**;Mar 07, 1995

CHECK^XTSUMBLD results:

<table>
<thead>
<tr>
<th>Routines</th>
<th>Pre Patch 47</th>
<th>Post Patch 47</th>
<th>Patch List</th>
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</tbody>
</table>

**Test Sites**

Upstate New York HCS
Installation Instructions:

1. This patch is being distributed as a KIDS Host File:
   ONC211P47.KID
2. This patch should be installed when the ONCOLOGY users are off the system.
3. The routines included in this patch should be installed in the production UCI.
4. This patch will take approximately 5 minutes to install. Only Oncology users need to be off the system. The ONCOLOGY options do not need to be disabled during the installation of this patch. Your customer support representative will answer any questions regarding this patch.

5. Recommended responses to the following installation questions:
   Want KIDS to INHIBIT LOGONs during the install? YES// NO
   Want to DISABLE Scheduled Options, Menu Options, and Protocols? YES// NO

Routine Information:

The checksums below are new checksums, and can be checked with CHECK1^XTSUMBLD.

Routine Name: ONCACD0
Before: B41786309  After: B50497175  **9,12,20,24,25,28,29,30,36,37,38,40,41,44,45,47**

Routine Name: ONCACD1
Before: B35592372  After: B37943122  **9,12,14,18,20,22,24,25,26,28,29,31,36,37,41,43,47**

Routine Name: ONCACDU2
Before: B61697601  After: B62930508  **12,18,20,21,22,24,26,27,29,30,31,32,34,36,37,38,39,41,46,47**

Routine Name: ONCCS
Before: B25089621  After: B25211155  **40,43,44,47**

Routine Name: ONCEDIT
Before: B41142697  After: B75961355  **27,28,34,36,39,42,43,45,46,47**

Routine Name: ONCEDIT2
Before: B39455814  After: B39277416  **27,28,32,33,44,47**

Routine Name: ONCGENED
Before: n/a  After: B17687088  **47**

Routine Name: ONCMPH
Before: n/a  After: B1505699  **47**

Routine Name: ONCNTX
Before: B81342152  After: B84335165  **13,15,16,19,22,25,26,27,32,33,34,36,37,38,39,41,42,43,44,45,46,47**

Routine Name: ONCOAI
Before: B27854044  After: B26893541  **6,15,17,18,19,25,26,27,28,29,32,33,34,35,43,45,47**

Routine Name: ONCOAIF
Before: B23300069  After: B41938394  **11,15,16,24,25,26,27,28,37,45,47**
Routine Name: ONCOAIP  
Before: B80340597   After: B83328289  **1,5,6,7,11,13,15,16,18,19,22,  
24,27,28,32,33,34,35,36,37,38,  
39,40,42,43,44,45,46,47**

Routine Name: ONCOCOM  
Before: B34787186   After: B38430146  **1,6,11,12,13,14,16,17,19,25,  
36,42,43,44,46,47**

Routine Name: ONCOCOS  
Before: B16347858   After: B10396818  **5,13,16,17,19,22,24,36,42,45,47**

Routine Name: ONCODEL  
Before: B20966808   After: B17087670  **7,15,19,22,27,28,30,36,47**

Routine Name: ONCODIS  
Before: B1458506    After: B1400361  **6,7,9,10,11,12,13,14,15,16,  
17,18,19,20,21,22,23,24,25,26,  
27,28,29,30,31,32,33,34,35,36,  
37,38,39,40,41,42,43,44,45,46,  
47**

Routine Name: ONCODSR  
Before: B76463285   After: B77463937  **1,5,6,7,11,13,15,16,18,27,36,  
37,42,46,47**

Routine Name: ONCODXD  
Before: B16132012   After: B17370508  **11,13,15,16,18,36,47**

Routine Name: ONCOEDC  
Before: B9401955    After: B20416700  **6,7,13,27,36,41,47**

Routine Name: ONCOEDC1  
Before: B45858620   After: B50397068  **27,28,29,34,36,39,41,42,47**

Routine Name: ONCOFDP  
Before: B14517564   After: B14858104  **1,5,16,22,25,26,47**

Routine Name: ONCOFTS  
Before: B11936445   After: B13108300  **24,25,47**

Routine Name: ONCOFUP  
Before: B6380858    After: B4130796   **2,22,25,47**

Routine Name: ONCOGEN  
Before: B45716953   After: B47169178  **6,7,11,13,16,17,18,22,24,25,  
26,29,44,46,47**
Routine Name: ONCOPA1
Before: B64644517  After: B51172298  **13,15,16,18,28,33,34,36,40,41,42,43,44,45,46,47**

Routine Name: ONCOPA1A
Before: B21375895  After: B35964884  **15,19,27,33,34,36,40,44,45,46,47**

Routine Name: ONCOPA3
Before: B31483342  After: B32549593  **13,15,18,25,26,33,34,36,37,44,45,46,47**

Routine Name: ONCOPMA
Before: B19369393  After: B20386342  **6,25,44,46,47**

Routine Name: ONCOPMB
Before: B21853476  After: B23097667  **11,23,25,44,46,47**

Routine Name: ONCOPMP
Before: B5147157  After: B5186790  **13,23,25,39,46,47**

Routine Name: ONCOTN
Before: B72159549  After: B74591340  **1,3,6,7,11,15,19,22,25,28,29,35,36,37,41,42,43,44,46,47**

Routine Name: ONCOTNO
Before: B12536210  After: B13190026  **1,6,7,11,15,27,32,35,47**

Routine Name: ONCOUTC
Before: B15510360  After: B16162194  **5,24,25,47**

Routine Name: ONCPCI
Before: B14621628  After: B17696827  **15,19,24,26,27,28,33,35,36,42,43,44,45,46,47**

Routine Name: ONCPRE47
Before: n/a  After: B1068749  **47**

Routine Name: ONCPEDS
Before: B4903225  After: B5294026  **15,19,22,28,34,36,40,45,47**

Routine Name: ONCPST47
Before: n/a  After: B1743811  **47**

Routine Name: ONCSAPI
Before: B227298  After: B5208764  **40,47**

Routine Name: ONCSAPI1
Before: B23736526  After: B25134181  **40,41,47**

Routine Name: ONCSAPID
Before: B20217307  After: B21856891  **40,47**

Routine Name: ONCSAPIE
Before: B48334363  After: B50726698  **40,47**

Routine Name: ONCSAPIR
Before: B20113305  After: B26610695  **40,41,44,47**
Routine Name: ONCSAPIT
Before: B63834837  After: B76432501  **40,41,47**
Routine Name: ONCSAPIU
Before: B5721954  After: B7316141  **40,47**
Routine Name: ONCSAPIV
Before: B7451329  After: B11259789  **40,47**
Routine Name: ONCSAPIX
Before: B9724342  After: B9859486  **40,47**
Routine Name: ONCSED01
Before: n/a  After: B13507255  **47**
Routine Name: ONCSED02
Before: n/a  After: B17490289  **47**
Routine Name: ONCSED03
Before: n/a  After: B44378907  **47**
Routine Name: ONCSED04
Before: n/a  After: B25577841  **47**
Routine Name: ONCSEDEM
Before: n/a  After: B3657858  **47**
Routine Name: ONCSNACR
Before: n/a  After: B6005907  **47**
Routine Name: ONCSYMP
Before: B12957496  After: B11984863  **43,47**
Routine Name: ONCTIME
Before: n/a  After: B5620212  **47**

Appendix B: OncoTraX: Cancer Registry V.2.11 – Changes in 2006

Site/GP changes

a. LUNG  this site/gp is now obsolete use either
   • LUNG NOS
   • LUNG SMALL CELL (includes the following histologies)
     8041/2  SMALL CELL CARCINOMA IN SITU
     8041/3  SMALL CELL CARCINOMA, NOS
     8042/2  OAT CELL CARCINOMA IN SITU
b. RECTUM/ANUS
   - The SITE/GP RECTUM/ANUS is renamed RECTUM.
   - A new SITE/GP called ANUS was created.
   - If the PRIMARY SITE CODE value is one of the following values, the SITE/GP will be changed from RECTUM to ANUS:
     C21.0 ANUS NOS
     C21.1 ANAL CANAL
     C21.2 CLOACOGENIC ZONE
     C21.8 RECTUM/ANUS/CANAL OVERLAP

c. LYMPH NODE SITE/GP was changed to LYMPHOMA.

d. SKIN - this site/gp now contains all skin cancers except melanoma.

e. MELANOMA was added as a new site/gp.

CLASS OF CASE was added to the PRIMARY ABSTRACT NOT-COMPLETE Report

New field TNM (BEST)

A new computed field, TNM (BEST), was created. This field displays the "best" TNM string as determined by the clinical/pathological hierarchy rules. Also, the existing computed field, AJCC STAGE, was renamed STAGE GROUP (BEST).

LATERALITY

MENINGES, CEREBRAL (C70.0) became a "Paired Organ Site" with the implementation of FORDS. 2004+ cases for this site now are prompted for LATERALITY. Pre-2004 cases will continue to have their LATERALITY value stuffed with 0 (Not a paired site).

Print Abstract

- The [EX Print Abstract-Extended (80c)] report was modified and redesigned.
- A new option, [QA Print Abstract QA], was added. This option replaces the [BA Print Abstract-Brief (80c)] option.

Options Deleted

TD Print Suspense List by Month/Terminal Digit (132c)
CS Print Complete Suspense List by Term Digit (132c)
BA Print Abstract-Brief (80c)
RADIATION SEQUENCE was removed from the [RF Recurrence/Sub Tx Follow-up] dialog

In accordance with the FORDS "Instructions for Coding" (FORDS page 138), SCOPE OF LN SURGERY (F) are now stuffed with a code 9 (Unknown/NA) in the following circumstances

a. For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9).

b. For lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9).

c. For an unknown or ill-defined primary site (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myelo-proliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

SURGERY OF PRIMARY (F) DATE FIRST SURGICAL PROCEDURE

- DATE FIRST SURGICAL PROCEDURE is no longer be stuffed with 00/00/0000 if SURGERY OF PRIMARY (F) = 00 (None; no surgery; autopsy ONLY).
- DATE FIRST SURGICAL PROCEDURE is no longer be stuffed with 99/99/9999 if SURGERY OF PRIMARY (F) = 99 (Unknown; death certificate ONLY).

DATE FIRST SURGICAL PROCEDURE was relocated within the abstract input dialog. It now appears after SURG PROC/OTHER SITE @FAC DATE.

FOL *..Follow-up Functions PF Post/Edit Follow-up CANCER STATUS

When posting or editing a follow-up the registrar is prompted to update the CANCER STATUS for each primary for this patient. This updating process is now DIVISION specific. For multidivisional facilities the registrar is only prompted to update the CANCER STATUS of primaries, which belong to their DIVISION. For single-division facilities this change is transparent.

CODE DESCRIPTION CHANGES

For the following fields the descriptions for codes 1 and 2 are changed.

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<th>Code</th>
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<th>New code description</th>
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<tr>
<td>2</td>
<td>Negative</td>
<td>Within normal limits</td>
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<tr>
<td>CHEST XRAY</td>
<td>BRONCHOSCOPY</td>
<td>PET SCAN</td>
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<tr>
<td>CT SCAN</td>
<td>MEDIASTINOSCOPY</td>
<td>BARIUM ENEMA</td>
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