Collaborative Stage Transition Newsletter
October 17, 2014

Introduction
This is the latest issue in a series of newsletters providing communication updates from organizations within the cancer surveillance community to share with their members and other constituents. It addresses the processes and ongoing efforts to coordinate and effectively transition from the Collaborative Staging v2 system to the AJCC TNM staging standard, which includes collection of information regarding related biomarkers and prognostic factors. Shortly after the decision was made to transition from Collaborative Stage, a CS Transition Group was formed as an information sharing and planning forum. This group brings together the four data collection agencies/organizations (Statistics Canada/Canadian Council of Cancer Registries, CDC/NPCR, NCI/SEER, and American College of Surgeons CoC), the agency responsible for staging rules (AJCC), the cancer surveillance umbrella organization (NAACCR), the organization representing cancer registry professionals (NCRA), and the American Cancer Society. The CS Transition Group provides a collaborative opportunity to identify issues involved in the transition and to share the tasks involved in developing best practices for both the overall surveillance community and the individual agencies/organizations to address this change.

The agencies and organizations participating in this communication recognize that the transition away from CS is a major change and are committed to working with stakeholders to develop appropriate implementation plans and processes. This transition continues to be a work in progress and the partners are working hard to answer the many questions that have yet to be fully addressed. As answers become available, they will be shared and communicated to the surveillance community through the updates provided in subsequent sections. In addition, all of the partners continue to provide opportunities for members to identify issues and concerns. If you have ideas that you feel are important for the partners and/or the CS Transition Group to consider, please email them to Patricia Murphy (Murphy, Patricia (NIH/NCI)), who will collate and disseminate them.

As a reminder, the initial change in 2016 for CDC and NCI registries will be focused on the transition to directly assigned TNM stage, but will not eliminate all CS variables. In particular, most Site Specific Factors (SSFs) will continue to be required as they are either: a) a critical component of stage assignment; or b) essential to understanding the cancer (predictive or...
prognostic factors). Thus the initial transition will focus on assignment of T, N, M, and the AJCC TNM stage group. As the coordinating bodies, we will clarify which additional variables and which SSFs will continue to be required, but our intent is to carefully evaluate which are essential and which are feasible to be collected by the registrar. The methods/studies and processes that will be used to make these determinations are described below. It is worth noting Item 4 in the NCI project list (NCI coordinating with NPCR and NAACCR to assess needs for changes in algorithms, and other IT needs related to the transition). One important aspect of the move to AJCC TNM stage and the maintenance of the SSFs is that the data warehouse and the API that is being developed will eliminate obsolete variables and values, simplifying what registrars must consider in their abstraction.

Each participating entity continues to perform specific and coordinated tasks focused on assessing needs for the transition, projecting its impact, and coordinating the logistical components to implement the changes. Updates to these activities are described below along with the organization and task leader responsible for that activity.

**Agency Updates**

Following are summaries, written by the respective agency/organization, that report on the status of each activity being undertaken by the organization. We intend to continue providing regular updates on these activities. In some cases you will note that agencies are working independently on specific issues, while in other cases shared project work is underway.

We have identified several common questions and provided responses from NCI/SEER, CDC/NPCR, and the CoC. These are available in previous newsletters and on the web at [http://seer.cancer.gov/registrars/cs-tnm/](http://seer.cancer.gov/registrars/cs-tnm/). To access the website, the username is tmnnews and the password is cs*transition.

**Current and planned activities by the partner organization in relation to the CS Transition:**

- **A. American Cancer Society**
  
  *See Section G (NCI), Item 9*

- **B. AJCC**

  AJCC has developed cancer staging education for cancer registrars and the surveillance community through the support of the CDC. This education will assist registrars with the transition to directly assigning AJCC TNM stage.

  The presentations are available on the AJCC website [here](http://).
Approach
We are taking a new approach to these presentations. We have included comprehensive information on the slides so they can be used for self-study. This style eliminates the need to read speakers’ notes in order to understand the slides’ content and meaning. They can also be used as a lecture to a larger group, and handouts are available to download.

Format
These presentations are PDF files that will open in Adobe Reader, which is readily available, free software. Adobe Reader allows the presentations to be viewed in their intended format, eliminating any viewing problems that could occur for users who either do not own certain commercial software or own a different version of it. Ctrl-L or View-Full Screen Mode will enable the best viewing, and slides can be advanced using the arrow keys, page up or down, or a presentation remote control. Handouts can also be downloaded.

Presentations Available
1. Registrar’s Guide to Chapter 1, AJCC Seventh Edition
   Description
   Guide to understanding the rules in AJCC, including general rules for T, N, and M, clinical and pathologic stage classification, rules for stage grouping, additional guidelines, and staging form.
   Learning Objectives
   • Describe intent and purpose of AJCC staging
   • Utilize general rules for AJCC staging
   • Employ stage classification and T, N, M category principles
   • Demonstrate stage grouping principles
   • Recognize additional guidelines available
   • Evaluate best use of cancer staging data form
   • Relate options for stage documentation in medical record
   • Identify resources for AJCC staging

2. Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging
   Description
   Explanations and guidance to the registrar on key topics including: Blank vs. X in registry data fields, ambiguous terminology, stage classification to use based on treatment provided, and guidelines from other sources.
   Learning Objectives
   • Recognize difference in definitions of blank and X
   • Demonstrate correct usage of blank and X
   • Employ critical thinking to terminology used
   • Analyze physician terminology intent by multiple methods
   • Determine stage classifications to apply by treatment choice
• Utilize appropriate guidelines
• Identify resources for AJCC staging

Questions may be submitted to the CAnswer Forum. New subforums have been added to the AJCC forum explicitly for these presentations.

The intent is to provide accurate detailed information to guide the registrars in learning or refreshing their knowledge of AJCC TNM staging. AJCC, as the authoritative source for our staging system, is seeking to meet the needs of cancer registrars and the surveillance community in using AJCC TNM staging.

Visit the AJCC Registrar Education page to view these educational resources and learn about what is coming next.

C. Statistics Canada and the Canadian Council of Cancer Registries

CS Transition Timing in Canada:

The Canadian Council of Cancer Registries (CCCR) met on September 10th and approved a recommendation from the Canadian Cancer Staging Work Group (CCSWG) to target January 1, 2017 for the transition of stage data collection from Collaborative Stage to TNM. Canada would therefore make its implementation coincide with the release of AJCC Version 8. The CCCR felt that the timelines required to meet a January 1, 2016 transition date to TNM stage could not be met by both our Provincial and Territorial Cancer Registries and our partners at Statistics Canada.

Definition of TNM Data Variables for Canada:

A subgroup of the CCSWG met on September 18th and 19th to further define the data elements required in Canada to transition from Collaborative Stage to TNM staging in 2017. This group reviewed the elements of CS data collection and will be finalizing recommendations and sending them to our stakeholders for input and eventually approval by CCCR in the coming months.

TNM Data Collection Strategies:

Members of Council and the Work Group are also starting to examine strategic approaches to maximize the collection of TNM stage data in Canada using automated tools. Canada remains concerned about stage data collection capacity moving forward and will be looking for opportunities to support cancer registry staff in their data collection efforts. Such support will help ensure that stage data will be available in a high-quality, timely and efficient manner.
D. Centers for Disease Control and Prevention

1. **CDC-NPCR has formed an internal transition workgroup.** The major focus of this workgroup is to implement a smooth, timely staging transition. The NPCR internal workgroup collaborates with partner organizations in the cancer surveillance community and provides NPCR specifics to state cancer registries. Throughout the summer and early fall, this team has had bi-weekly conference calls and on-site meetings to plan staging transition activities and timelines. Updates from this workgroup’s activities are included below.

2. **Communication**
   a. CDC held its Program Directors’ meeting August 11-12, where we received additional input from NPCR registries on the collection of AJCC staging by central registries. The feedback provided during roundtable discussions and working sessions has been used in planning current CDC-NPCR transition workgroup activities, such as software and NPCR Stage Transition Guidance. CDC sent out the NPCR newsletter September 23, which included summary information on the transition. Future newsletters will include updated information.
      
      **Status:** Information will be sent to NPCR Program Directors
      
      **Contact Person:** Mary Lewis, CDC-NPCR

   b. CDC has established a specific email address for NPCR registries to submit transition questions. Questions and answers will be posted on the NPCR SharePoint. The email address is: cancerstaging@cdc.gov
      
      **Status:** Ongoing
      
      **Contact Person:** Mary Lewis, CDC-NPCR

3. **Guidelines for Implementation**
   
   **Purpose:** The NPCR Stage Transition Guidance document that will serve as an implementation guide for NPCR-required data items through the transition is being edited and updated by CDC. These guidelines may serve as a foundation for a complete implementation guide and will address details of data definitions, collection and editing requirements, plans for submission of TNM data, and other issues of concern to NPCR participants.

   **Status:** The document is in draft stage. Opportunities to comment on a draft version will be provided to NPCR registries.

   **Contact Person:** Joe Rogers, CDC-NPCR
4. Education

a. **Purpose:** Provide education and education materials to all cancer reporters. The first education offering of AJCC and Summary Stage took place at the NCRA Annual Meeting in May. Approximately 100 people attended the training. The complete presentations, with speakers’ notes, are available on the NPCR SharePoint.

**Status:** Complete

b. CDC-NPCR is developing site-specific training presentations with speakers’ notes for both AJCC Staging 7th Edition and SEER Summary Stage 2000. CDC is uploading PowerPoint presentations of these training presentations and educational materials to the CDC NPCR SharePoint portal as they become available. Over the past month, the following files have been added: PowerPoint presentations related to AJCC Chapter 1 and AJCC coding of blanks and X, as well as PDF files for explaining blanks, X, and ambiguous terminology and support of AJCC staging and a Registrar’s Guide to Chapter 1 of the AJCC, 7th Edition. For NPCR registries to download these files, just go to the SharePoint Portal and look under the Education and Training Coordinators section, Shared Documents section, Stage Transition folder. These files will also be shared with NCRA so that they can post them to their website for non-NPCR registries, via a link to the special section on the Center for Cancer Registry Education site for TNM and Summary Stage training:

[www.cancerregistryeducation.org/tnm-ss-resources](http://www.cancerregistryeducation.org/tnm-ss-resources)

c. If NPCR or SEER registry staff need assistance logging into the SharePoint site, please contact Lynda Douglas (het9@cdc.gov).

**Status:** On-going

**Contact Person:** Mary Lewis, CDC-NPCR

d. CDC-NPCR revised the cooperative agreement with AJCC from support of CS stage to transition activities for AJCC stage. The expanded cooperative agreement with AJCC includes the following:

- Production of effective training materials
- Mechanisms to disseminate training (classroom, online, webcasts, etc.)
- Establishment and maintenance of a mechanism to respond to staging questions
**Status:** AJCC has developed a training plan that includes staging tips that were not explicitly explained in the AJCC Staging Manual 7th Edition. See item “4b” above for how these files are being shared with registries.

**Contact Person:** Mary Lewis, CDC-NPCR

5. **IT Needs**

   CDC-NPCR has continued discussions with providers of central registry software for NPCR states and will work with Subject Matter Experts at NCI to review software development, including edits programs, over the fall. The software providers were asked to communicate their needs to CDC-NPCR in May, and CDC has been going through their responses over the summer and planning next steps.

   **Status:** On-going.

   **Contact Person:** Joe Rogers, CDC-NPCR

E. **Commission on Cancer**

   See Section G (NCI), Item 9

F. **NAACCR**

   No new updates

G. **NCI**

1. **Evaluation of the frequency of pTNM in the surgical pathology report**

   The Georgia, Detroit, and Louisiana registries have agreed to participate in this study to evaluate how often pTNM information is available in pathology reports. We are working with Artificial Intelligence in Medicine (AIM) and they have been preparing the software for this study, which has already undergone a preliminary test in the Georgia registry. We expect that the data collection will run between the end of October and the end of the year.

   **Estimated completion date:** December 2014

   **Contact person:** Carol Kosary/Annie Noone

2. **Comparison of cases restaged with AJCC TNM**

   We had great participation for the study that closed in August. More than 800 participants completed at least one case! Most participants were CTRs from the US. They also had a wide range of experience, from just starting out to more than 40 years of experience. We are analyzing both the participant data and the staging data available in the medical records. Analysis will include comparison of clinical and pathologic TNM group stage assigned by the participants to adjudicated responses.
from two seasoned and experienced registrars. In instances where there is disagreement, a third or fourth registrar is requested to review and adjudicate.

In addition to the stage assigned by registrars, we will evaluate the consistency and availability of clinical and pathologic TNM and Group stage in a variety of commonly available medical record document types. This will include an evaluation of the accuracy of data elements overall and in relation to their timing (e.g. preoperative, postoperative) found in the medical records. The results will be used to determine whether a hierarchy of document sources could be developed for registrars to use in the field; such a hierarchy would reduce the frequency and/or effort involved for registrars to assign stage.

**A sneak peak of results:** Preliminary results indicate that participants were able to assign Summary Stage 2000 reliably for breast, but SS 2000 for colon, lung, and ovary demonstrated more variability. More detailed analyses are ongoing, but preliminary results suggest that the focus of the CDC training materials for SS 2000 is targeted appropriately.

*Distribution of Summary Stage 2000 Assigned by Participants for a Random Case Selected for Each Cancer Site.*
3. **Evaluation of Site Specific Factors (SSFs)**
   
The SSFs evaluation is continuing on schedule. While initially the attention was on high-incidence tumors, now the review process focuses on completing all schemas relevant to a system/site. At this point, schemas pertinent to digestive, genitourinary, and musculoskeletal systems were completed.

   **Timeline for completion:** February 2015  
   **Contact person:** Valentina Petkov

4. **NCI coordinating with NPCR and NAACCR to assess needs for changes in algorithms and other IT needs related to the transition**  
   *No new updates*

5. **Development of training aids to help registrars assign TNM**  
   *No new updates*

6. **Develop and lead focus groups consisting of hospital and central registrars (who perform abstraction)**

   **Purpose:** Determine needs as identified by the individuals who are performing the abstraction. The groups identified issues, commented on proposed changes, and assisted in determining the impact and feasibility of what is being proposed at the organizational level. The format was similar to that used for assessing the MPH rules. The project included three focus groups via teleconference, with the following categories of participants:

   **Focus Group I:** Ten new registrars who use CSv2 on a daily basis.
A new registrar is one who has been using the CSv2 coding manual for two years or less and has minimal experience with AJCC TNM staging. (Completed)

**Focus Group II:** Ten experienced registrars who use CSv2 on a daily basis. An experienced registrar is one who has used the SEER rules and manual and/or Collaborative Staging for five years or more and has experience with AJCC TNM staging. (Completed)

**Focus Group III:** Central Registry registrars whose primary activity is performing editing, quality control, and/or case consolidation tasks. These registrars should be experienced with SEER rules and CSv2 and have at least minimal experience with AJCC TNM staging. (Completed)

**TNM Transition: Summary of Focus Groups I and II**

Focus Groups I and II have been completed. While the differences between Groups I and II were mostly in experience or years in the registry profession, several common points were noted by both groups. The focus groups were held via teleconference and conducted using a professional facilitator.

**Focus Group I:** Ten people participated in Focus Group I. This group consisted of people with less than five years of registry experience and represented both CoC hospitals and central registries. The participants were all fairly new to the field, with an average of three years in the business. Most participants had recently passed the CTR exam or were about to take it. The participants were knowledgeable about CS but had never heard of Summary Stage until they studied for the CTR exam. They did not use Summary Stage in their work, which may be related to the ability to derive Summary Stage 2000 from CS. The participants had some experience with AJCC TNM, and coding TNM varied among the abstractors. The Manuals most preferred by Focus Group I were FORDS, MPH, Hematopoietic and Lymphoid Neoplasm Manual, the AJCC Manual, Collaborative Staging Manual, and ICD-O-3. They also asked for “Cheat Sheets” or Quick Reference Cards to assist them in coding. This group mentioned that they use the AJCC apps on their iPhones, iPads, and tablets. Ideally, they would like to see the AJCC Manual made more user friendly to registrars or have separate versions of the Manual targeted for clinicians versus registrars. These registrars would like to see clear, concise information about OBSOLETE codes and factors and have those removed from the software. They were informed that the OBSOLETE codes would be removed in the upcoming software.

**Focus Group II:** Fourteen registrars participated in Focus Group II. This group consisted of people with more than five years of registry experience. Number of years in the Cancer Registry Profession ranged from 6 to 35 years. Participants were from CoC hospitals and central registries, and one person owned a large contracting company that employs about 75 registrars. All participants have a clear understanding of CS. Codes 999 and 998 remain an issue, and clear instruction would be beneficial to both hospital and central registries. When asked about research activities (CS versus AJCC staging),
the consensus was that most physicians do not know about CS and they look for SEER Summary Stage or AJCC TNM. Of interest, all participants were familiar with SEER Summary Stage. Thirteen of fourteen participants love summary stage, and it is easy for everyone from medical staff to administrators and physicians to understand. They think it is a valuable reference and worth pursuing. In terms of problems with TNM, Focus Group II participants said there is a universal problem with access to the right records since so much of the testing, etc. is not being done in hospitals now. They want the standard setter’s organizations to address this problem. Physicians often combined clinical and pathologic when dictating TNM. They ask that staging become universal.

**Common Points from Both Focus Groups:**

- Both groups named the NAACCR interactive training webinars and in-person workshops as their top choices for types of training vehicles.
- Both groups agreed that clinicians would not fill out the AJCC Staging Form.
- Both groups thought that there would be no issues with vendors if they receive the information on time. The issues arise with the internal hospital IT departments because of the challenges facing registrars, such as firewall problems. Registry updates are not seen as high priority with their IT departments.
- The manuals most preferred by both groups were MPH, Hematopoietic & Lymphoid Neoplasms, FORDS, ICD-O-3, AJCC TNM Manual, and SEER Program Manual.
- Both groups would like to see the FORDS Manual and SEER Manual combined. They prefer the examples in the SEER Manual to those in FORDS. When they cannot figure out an answer from the FORDS Manual, they go to the SEER Manual.
- The impact on their workload of switching to TNM/Summary Stage will depend upon the changes to be made, additional text documentation necessary to support coding, the learning curve involved, and staffing. Currently, the registries are understaffed, so keeping up with the workload while absorbing new changes and new requirements are concerns.
- Both groups asked that the TNM Transition Leadership provide a letter for all registrars to take to their hospital administration. The letter would explain that the transition from CS to TNM does not mean a decrease in workload, but rather that registry staff need to be reduced.

**Focus Group III:** The final focus group was completed on September 29, 2014. The group was composed of central registrars whose primary duties include editing and consolidation of incoming abstracts and documents and performing quality review.

A report summarizing the results of the discussions will be provided in a subsequent newsletter. The report will be qualitative, as numbers and percentages are generally not appropriate for focus group research. Therefore, reporting will be descriptive and present the meaning of the data as opposed to a summary of data.

**Timeline:** Report to be completed by October 20, 2014

**Contact person:** Lois Dickie
7. Development of Summary Stage 2016
   No new updates

8. TNM Data Item Change Proposal

A standardized mechanism for changing TNM-related data items through the CS to TNM Transition Group has been established; this will ensure consistency in evaluating and considering each proposed data item change. The purpose of this standardized process is to make certain that not only has the clinical or scientific relevance been evaluated (Submitter and TNM Advisory Group), but also that a technical review and evaluation is performed (by the Technical Advisory Group). The recommendation of the TAG is then submitted to the TNM Advisory Group for final approval. Once reviewed and approved, the form will be submitted to the Change Management Board at NAACCR and incorporated into the Uniform Data Standards for subsequent inclusion in NAACCR Standards Volume II.
9. **Comparison of Directly Assigned TNM and CS Derived TNM in NCDB database (NCI, CoC, ACS Update)**

One effort to evaluate the potential impact of the change from CS to directly assigned TNM was to compare the level of agreement between directly assigned TNM and CS-derived TNM values within the NCDB data set. NCDB included clinical and pathological TNM along with information about who assigned the stage variable for a case. Clinical TNM was compared with CS-derived values, where the CS eval fields showed that the staging was based on clinical information. Similarly, pathologic TNM was compared with CS values based on pathology.

It is important to note that there are differences between how AJCC TNM is assigned and how the CS algorithm works, and these dissimilarities can lead to differences in derived and assigned TNM. However, the intent of this comparison is not to assert that one value is right while another is wrong, but rather to enable the surveillance community to anticipate the types of differences that we might see in incidence trends when moving from CS to directly assigned TNM. The following excerpt from the Fords Manual gives insight into the difference between the two systems.¹

“As a “best stage” system, CS makes use of the most complete information available to stage the tumor. The *AJCC Cancer Staging Manual* distinguishes between clinical staging, based on information available prior to primary treatment, and pathologic staging, based on information gathered as a product of the treatment process (particularly surgery). It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N, and M stage components based on the source of information used to validate the most extensive spread of the tumor, and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.”

For this analysis, we considered cases diagnosed in 2010 and 2011 for lung, breast, and colorectal cancer. For each cancer site, we calculated the percent agreement and a Kappa score. A kappa score is a measurement of agreement that is considered more
robust than percent agreement since it accounts for agreements that would occur by chance. Comparisons were by the following three levels:

- **Subcategory match** – TNM subcategories (for example, T1a, N1b, etc.)
- **Category match** – major T and N categories (for example, T1, N1, etc.)
- **M0/Mx vs M+** — whether or not metastatic disease was found

Cases were included in the comparison only if they had both a CS value and a directly assigned value. So if CS values were based on clinical information, the case would be excluded from any comparison of pathologic information.

There were some differences between the codes derived in CS and those used to assign TNM. CS uses NOS codes (for example T1NOS, N1NOS) that are described differently in the FORDS manual. We considered a T1NOS to be a match at the subcategory level with T1 and a match with (T1, T1a or T1b) at the category level. NOS codes generally had a lower level of agreement than other subcategories.

Table 1 shows that directly assigned pathologic T and N agreed very well with the CS-derived values (agreement is considered “very good” for kappa scores between 0.8 and 1.0). In the cases where agreement was lower at the subcategories level, T value for lung and N value for breast cancer, the differences were mainly within the same category. For example, a common difference seen for breast cancer pathologic N was a directly assigned value of N0 and a CS value of N0 (i+). For lung cancer, the most common disagreement for pathologic T was directly assigned T2 and CS value of T2a. The agreement for clinical TNM was worse than for pathologic TN but still fell in the “good” to “very good” range (agreement is considered “good” if the kappa score is between 0.6 and 0.8).
### Table 1: Percent Agreement and Kappa Scores, Clinical and Pathologic TNM

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Category</th>
<th>M0/Mx vs M+</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>T</td>
<td>N</td>
</tr>
<tr>
<td>% Agree</td>
<td>Kappa Score</td>
<td>% Agree</td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>80%</td>
<td>0.75</td>
</tr>
<tr>
<td>Lung</td>
<td>74%</td>
<td>0.69</td>
</tr>
<tr>
<td>CRC</td>
<td>84%</td>
<td>0.79</td>
</tr>
<tr>
<td>Path</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>91%</td>
<td>0.88</td>
</tr>
<tr>
<td>Lung</td>
<td>80%</td>
<td>0.76</td>
</tr>
<tr>
<td>CRC</td>
<td>93%</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Most breast and CRC cases were staged pathologically within CS, whereas most lung cases were staged clinically. Since approximately three quarters of the lung cases were in the clinical comparison group, we explored the low agreement of clinical T for lung cancer in Table 2. The agreement remained low even when considering the comparison on the category level.
Table 2: Frequency of Clinical T for Lung Cancer

<table>
<thead>
<tr>
<th>Derived in CS</th>
<th>Directly Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
</tr>
<tr>
<td>T1</td>
<td>16655</td>
</tr>
<tr>
<td>T2</td>
<td>800</td>
</tr>
<tr>
<td>T3</td>
<td>613</td>
</tr>
<tr>
<td>T4</td>
<td>711</td>
</tr>
</tbody>
</table>

TNM was staged by clinicians more often for pathologic stage, but even for clinical values it was staged by clinician (treating physician or pathologist) or a combination of clinician and registrars around 70% of the time.

Figure 1: Staged By Variable

There are several cautions in interpreting these results. It is unclear whether CS informed the assigning of clinical and pathologic TNM. If CS information was considered when assigning TNM, then the agreement that we saw may be better than what will actually occur after CS information is no longer available. The information considered does not include all hospitals, and there may be differences between the hospitals included and not included in the NCDB data.
**Reference**


**H. NCRA**

1. **Education – Special TNM and Summary Stage Training Section on NCRA’s Center for Cancer Registry Education**
   NCRA created a special section of its Center for Cancer Registry Education to serve as a hub for NCRA training on TNM and Summary Stage. To learn more, go to [www.CancerRegistryEducation.org/tnm-ss-transition](http://www.CancerRegistryEducation.org/tnm-ss-transition).

   **Live Webinar Series on TNM and Summary Stage**
   NCRA has designed a Fall 2014 live webinar series to provide a review of the general staging rules for both TNM and Summary Stage, along with four specific sites. These webinars will be archived and made available as learning modules on NCRA’s Center for Cancer Registry Education in December 2014. NCRA is creating another live TNM and Summary Stage webinar series for spring 2015 that will focus on additional specific sites.

   **Summary Staging: Skills for the Cancer Registrar**
   - Summary Stage: General Rules (Oct. 1); Steven Peace, BS, CTR
   - Summary Stage: Staging the Colon (Oct. 14); Shirley Jordan Seay, PhD, OCN, CTR
   - Summary Stage: Staging the Breast (Oct. 15); Lynda Douglas, CTR

   **TNM Staging: Skills for the Cancer Registrar**
   - TNM: General Rules (Oct. 22); Carole Eberle, CTR
   - TNM: Staging the Colon/Rectum (Nov. 6); Jayne Holubowsky, CTR
   - TNM: Staging Gynecologic Cancers (Dec. 10); Barbara Denton, CTR

   **Contact person:** Peggy Meehan ([pmeehan@ncra-usa.org](mailto:pmeehan@ncra-usa.org))

2. **Credentialing** – Council on Certification is actively monitoring the transition efforts and will post any CTR examination changes related to new content on its website [www.ctrexam.org](http://www.ctrexam.org)

   **Contact person:** Michael Hechter ([mhechter@ncra-usa.org](mailto:mhechter@ncra-usa.org))

3. **Policy** – NCRA’s President will be forming a Transition to Directly Coded Stage Task Force to work with all NCRA committees in identifying information, education, and
all efforts where internal documents, products, and publications need editing or modification to support the transition.

**Contact person:** Lori Swain ([lswain@ncra-usa.org](mailto:lswain@ncra-usa.org))

4. **Social Media** – Created web page on the NCRA website dedicated to “all things transition” with the purpose of being a one-stop shop for NCRA members as the transition moves forward: ([http://www.ncrausa.org/i4a/pages/index.cfm?pageid=4132](http://www.ncrausa.org/i4a/pages/index.cfm?pageid=4132))

**Contact person:** Janice Ford ([jford@ncra-usa.org](mailto:jford@ncra-usa.org))