



**OncoTraX: Cancer Registry
User Manual**

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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)*, 2007 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*, 6th edition on cancer cases diagnosed beginning January 1, 2003
- *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/>
- *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/>
- *ICD-O-3*, International Classification of Diseases for Oncology (ICD-O), 3rd edition
- *ICD-O-2*, International Classification of Diseases for Oncology (ICD-O), 2nd edition
- *Cancer Registry Management Principles and Practice*, 2nd edition

Recommended Websites

- <http://cancer.gov/>
Website for the National Cancer Institute
- <http://www.facs.org/cancer/index.html>
Home page for the Commission on Cancer, American College of Surgeons, Cancer Programs
- <http://www.facs.org/cancer/cocflash/june02.html>
Highlights for the month from the Commission on Cancer, American College of Surgeons, Cancer Programs
- <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).
- <http://www.ncra-usa.org/>
Website for the National Cancer Registrars Association
- <http://www.cancerstaging.org/>
Website for the American Joint Committee on Cancer (AJCC)
- <http://cancerstaging.org/cstage/manuals.html>
Website for Collaborative Staging
- <http://vaww1.va.gov/cancer/>
All links for the Veterans Health Administration Cancer Program
- <http://www1.va.gov/cancer/page.cfm?pg=16>
VA Central Cancer Registry (VACCR)
- <http://www.training.seer.cancer.gov>
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.
- <http://www.seer.cancer.gov/tools/seerrx/>
Download the SEER*Rx - Interactive Antineoplastic Drugs Database, version 1.1.1 (replaces Book 8)
- http://vaww1.va.gov/cancer/docs/Oncology_Directory_11_06R.xls
VA Cancer Registry Directory
- <http://www.cancerstaging.org/cstage/csmanualpart1.pdf>
Collaborative Staging Manual and Coding Instructions Part I
- <http://cancerstaging.org/cstage/CSPart2Manual.pdf>
Collaborative Staging Manual and Coding Instructions Part II

- <http://seer.cancer.gov/manuals/codeman.pdf>
The SEER Program Code Manual, Third Edition, 1998
- <http://seer.cancer.gov/manuals/EOD10Dig.pub.pdf>
SEER Extent of Disease - 1988, Codes and Coding Instructions, Third Edition, .January 1998
- <http://www.facs.org/cancer/coc/cocprogramstandards.pdf>
Commission on Cancer: Cancer Program Standards 2004 Revised Edition, ACoS required standards for approved cancer programs
- <http://www.facs.org/cancer/coc/fords/fordsoriginal2003.pdf>
FORDS: Facility Oncology Registry Data Standards
Complete FORDS online for use with 2003 cases. These take a long time.
- <http://www.facs.org/cancer/coc/fords/fordsrevised0605.pdf>
FORDS: Facility Oncology Registry Data Standards
Complete FORDS online for use with 2004 cases and after
- <http://www.facs.org/cancer/coc/fordsmanual.html>
Facility Oncology Registry Data Standards (FORDS): Revised for 2007

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.

Character	Description
<ret>	<ret> is the symbol for the Return or Enter key. Type <ret> after every response, or to bypass a prompt or accept a default. Note: Do not press it more than necessary; you do not want to bypass an opportunity to enter valuable information.
?	? (one question mark) Type ? at any prompt to view a message explaining the requested information or how to enter it.
??	?? (two question marks) Type ?? at any prompt to view detailed instructions and/or a list of choices.

Character	Description
//	<p>// (two slash marks) Type // after text for the default response.</p> <ul style="list-style-type: none"> • 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. <p>Example</p> <pre>PREVIOUS HISTORY OF CANCER: No// ? Choose from: 0 No 1 Yes 9 Unknown</pre>
^	<p>^ (caret) is Shift + 6 on the keyboard and is also called the up-caret symbol.</p> <ul style="list-style-type: none"> • Type ^ to exit an option and return to the menu; • Type ^ to jump to another field. <p>Example Type ^ DATE DX at the field prompt to jump to the DATE DX field.</p> <pre>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// Type a new date after DATE DX:</pre> <p>In the Abstract</p> <ul style="list-style-type: none"> • Go from one field to another in most areas of an abstract type ^<field name> • Go completely out of the abstract type ^ without a field name • Edit a field already completed type ^<field name> to return to the field and then edit. <p>Example</p> <pre>CLASS OF CASE: 1 Dx here, 1st tx here FACILITY REFERRED FROM: NONE/ ^CLASS OF CASE CLASS OF CASE: Dx here, 1st tx here//</pre>

Character	Description
@	<p>@ (at symbol) is Shift + 2 on the keyboard. Type @ to delete data values stored in fields.</p>
...	<p>... (three dots) Type ... to <i>replace</i> all data in a field.</p> <p>Example TX Primary Cancer cannot be assessed Replace ... With</p> <p>At the Replace prompt, type ... and press Enter. When With displays, type new data.</p> <p>Example CLINICAL T: T3 Chest wall/diaphragm/mediastinal pleura etc Replace ... With</p> <p>There is a submenu when ... displays after a menu option.</p> <p>Example ANN *Annual Reports ...</p> <p>Select ANN and the following displays.</p> <p>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) ACT Annual Cross Tabs (80c) CPR Print Custom Reports</p>
Dates	<p>Several date formats are acceptable. Examples 010102, 1-1-02, 1/1/02, 01/01/2002, January 1, 2002 If the year is omitted, the computer uses Current Year.</p>
Device prompt	<p>To send a report to a printer, type the name of the printer at the Device prompt.</p> <ul style="list-style-type: none"> • 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. <p>When <i>capturing a file</i>, type 0;269;9999999 at the Device prompt.</p> <p>Note: When you learn to <i>capture files</i> from the software, you can also learn many ways to display data.</p>

Character	Description
Space bar return	<p>Press the space bar to re-enter the last selection made at a particular level. (This feature may be limited for some options.)</p> <p>Example</p> <ul style="list-style-type: none"> • 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. <p>Note: Press the space bar, and then press the Return key, not both at the same time.</p>
Report options	<p>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.</p> <p>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.</p> <p>Note: A printer that can print both 80c and 132c is recommended.</p>

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*47
```

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>

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 15.
- 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 28 in the Follow-up Module. Update the follow-up using [PF Post/Edit Follow-up](#), page 27.
- 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 15.
- 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.

DEVICE: 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: 1r Print Case finding-Lab Report
START WITH SUSPENSE DATE: FIRST//
DEVICE: UCX REMOTE TCPIP

```
-----  
CASE FINDING LIST          UPSTATE NEW YORK HCS          03/10/2004  
Patient Name      PtID#      Lab Test          Organ/Tissue      CODE-Morphology  
-----  
SOURCE: CYTOPATHOLOGY  
ONCOPATIENT1      L9999      07/08/2005-CY    BRONCHIAL WAS    69760-USPICIOUS  
SOURCE: SURGICAL PATHOLOGY  
ONCOPATIENT2      N9999      07/10/2005-SP    SKIN OF UPPER    87203-MELANOMA,NOS  
Last Contact: 04/03/1998  
Acc/Sequence      Primary Site          Last Cancer Status      Date DX          Status  
-----  
1998-00139/00    SKIN, FACE NOS      Unknown                  04/03/1998      Complete
```

- 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.
 - ii. Manually delete the case from the Suspense, using [SE Add/Edit/Delete Suspense Case](#), page 14 in the SUS Case Finding/Suspense 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          BUFFALO VAMC          07/18/2005  
Patient Name      PtID#      Exam Date          Procedure  
-----  
ONCOPATIENT1      B1111      07/18/2005        CT THORAX W/O CONTRAST  
ONCOPATIENT2      D9999      07/18/2005        ULTRASOUND ABDOMEN LTD
```

- 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 15.

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      BUFFALO 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 95.

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 95.
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 95.
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. or type a date for a Go to Suspense Date prompt.

Go to Suspense Date:

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

```
ONCOTRAX PATIENT ONLY
Patient Name      SSN          Suspense          Last Admit      Last Disch
-----
ONCOPATIENT1     999-99-9999 FEB  3, 2004      03/07/2004     03/09/2004
ONCOPATIENT2     999-99-9999 FEB  2, 2004      01/30/2004     02/04/2004
```


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 4 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 95.
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 CITY,NEW YORK
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:

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.

DATE OF ONSET	ICD	DIAGNOSIS
2003	266.2	B-COMPLEX DEFIC NEC
2003	110.4	DERMATOPHYTOSIS OF FOOT
2001	401.9	HYPERTENSION NOS
UNKNOWN	780.79	OTHER MALAISE AND FATIGUE
UNKNOWN	110.1	DERMATOPHYTOSIS OF NAIL
UNKNOWN	414.9	CHR ISCHEMIC HRT DIS NOS

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.

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 ICDO 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  
999-00-9999
```

```
BREAST
```

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 BREAST
999-00-9999

Reporting Hospital.....:
Marital status at Dx.....: MARRIED/COMMON LAW
Patient address at Dx.....: 1111 FIRST AVENUE

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
Acc/Sequence  Primary Site      Last Cancer Status  Date DX      Status
-----
2004-00898/00  BONE MARROW          Evidence this CA    06/23/2004   Complete
```

```
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

NAME	SSN	ACC/SEQ NUMBER	PRIMARY SITE	COC	DATE DX
ONCOPatient1	999-99-9999	2005-00537/00	UNKNOWN PRIMAR	1	07/29/2005
		ABSTRACT STATUS: Incomplete			
ONCOPatient2	999-99-9999	1995-00136/01	SKIN, TRUNK	1	03/02/1995
		ABSTRACT STATUS: Minimal data			
ONCOPatient3	999-99-9999	2005-00752/01	RECTOSIGMOID J	1	10/18/2005
ONCOPatient4	999-99-9999	2005-00763/00	ESOPHAGUS, LOW	1	10/27/2005
		ABSTRACT STATUS: Partial			

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 95.

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 95.

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    UPSTATE NEW YORK HCS    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
                999-99-9999    12/1/2004    TESTIS                07/27/1999
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
                                     DATE
                                     LAST
NAME          SSN          CONTACT          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				
ONCOPATIENT4	999-99-9999	09/01/2004	ENDOCRINE, OTHER	06/24/1996
ONCOPATIENT5	999-99-9999	09/13/2004	BREAST	03/22/2000
COUNT 5				

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
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

```

Type a patient name at the prompt.

- **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
 PL Print Follow-up Letter
 EL Add/Edit Follow-up Letter
 FR Individual Follow-up Report
 UP Update Contact File
 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 720109211

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 *BUFFALO LETTER*
- 2 PATIENT *SYR* DOT MATRIX
- 3 PATIENT *SYRACUSE LETTER*
- 4 PATIENT *SYRACUSE NEW*
- 5 PATIENT TESTING LETTER

CHOOSE 1-5: 1 PATIENT *BUFFALO 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

Select EL Add/Edit Follow-up Letter.

FR Individual Follow-up Report

UP Update Contact File

EL Add/Edit Follow-up Letter

Select letter to Add/Edit: PAT

Type PAT.

1 PATIENT *BUFFALO LETTER*

2 PATIENT *SYR* DOT MATRIX

3 PATIENT *SYRACUSE LETTER*

4 PATIENT *SYRACUSE NEW*

5 PATIENT TESTING LETTER

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

CHOOSE 1-5:

1 PATIENT *BUFFALO LETTER*

NAME: PATIENT *BUFFALO 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|

528/111H

|LOWERCASE(ONCOFIRSTNAME LASTNAME(LAST FOLLOW-UP CONTACT)) ||TAB|
 |LAST FOLLOW-UP CONTACT:STREET ADDRESS 1|
 |WRAP|
 |LAST FOLLOW-UP CONTACT:STREET ADDRESS 2|
 |LAST FOLLOW-UP CONTACT:STREET ADDRESS 3|
 |NOWRAP|
 |LAST FOLLOW-UP CONTACT:ZIP CODE|

Dear |LAST FOLLOW-UP CONTACT:TITLE|. |LOWERCASE(LAST NAME)|,
 Text below this line may be changed.

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|

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 DECEASED, 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.

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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
```

ACC/SEQ#	PATIENT NAME	ICDO	TOPOGRAPHY	DATE DX	YEAR
2004-00400/00	ONCOPATIENT1	C42.0	BLOOD	06/03/2004	2004
2004-00408/00	ONCOPATIENT2	C02.9	TONGUE NOS	06/24/2004	2004
2004-00409/00	ONCOPATIENT3	C18.7	COLON, SIGMOID	06/24/2004	2004

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:

ACC/SEQ #	PATIENT NAME	SSN	PRIMARY SITE/GP	DATE DX	YEAR
-----------	--------------	-----	-----------------	---------	------

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

```
PATIENT NAME MED RECORD# S DT-BIRTH DT-DEATH ACC/SEQ-NO DATE DX ICD-TOPOGRAPHY L ICDO-MORPHOLOGY
-----
ONCOPATIENT1 000-00-0000 M 07/25/1940 07/25/2000 2000-00371/00 09/25/1992 C18.5-COLON, SPLENIC
```

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.

PATIENT NAME	SSN	SX	ACC/SEQ #	PRIMARY SITE/GP	DATE DX
--------------	-----	----	-----------	-----------------	---------

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.

PATIENT NAME SSN YEAR ACC/SEQ # TOPOGRAPHY DATE DX

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

GO TO PRIMARY SITE CODE: C34.9// C25.9

Example

List for an ICDO Code, sorted alphabetically.

PATIENT NAME	SSN	YEAR	ACC/SEQ #	TOPOGRAPHY	DATE DX

ICDO CODE: C25.0					
LAST, FIRST A	000-00-0000	2002	2002-00072/00	PANCREAS HEAD	02/20/2002
ICDO CODE: C25.1					
LAST, FIRST B	000-00-0000	1978	1978-00089/00	PANCREAS BODY	05/01/1978
LAST, FIRST C	000-00-0000	2005	2005-00143/02	PANCREAS BODY	03/23/2005
ICDO CODE: C25.2					
LAST, FIRST D	000-00-0000	2006	2006-00001/00	PANCREAS TAIL	01/01/2006
LAST, FIRST E	000-00-0000	1985	1985-00347/03	PANCREAS TAIL	07/17/1985
ICDO CODE: C25.9					
LAST, FIRST F	000-00-0000	2005	2005-00089/00	PANCREAS NOS	05/01/2005
LAST, FIRST G	000-00-0000	1998	1998-00019/00	PANCREAS NOS	02/01/1998

IW Primary ICDO Listing (132c)

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

PRIMARY SITE: C00.0-LIP, EXTERNAL UPPER

PATIENT NAME SSN DOB DOD YEAR ACC/SEQ# DATE DX TOPOGRAPHY MORPHOLOGY

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)
CPR 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

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

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

PATIENT NAME MED RECORD# DT-BIRTH DT-DEATH ACC/SEQ-NO ICDO - TOPOGRAPHY MORPHOLOGY L

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.

PATIENT NAME MED RECORD# S DT-BIRTH DT-DEATH ACC/SEQ DATE DX ICDO TOPOGRAPHY ICDO MORPHOLOGY

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//


```

SUBCOUNT      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 N0 M0 I SUR
ONCOPATIENT2 999-99-9999 2005-00272/00 03/22/2005 ANUS NOS SQUAM CELL CARC TX NX MX 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                UPSTATE NEW YORK HCS                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  -----
SUBCOUNT                               3

```

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: ?

Type ? to view choices.

Answer with CONDITION NUMBER, or NAME

Type a condition.

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

Use only analytic cases for survival data.

-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

PATIENT	REASON FOR BEING DROPPED
-----	-----
L9999 ONCOPATIENT1	SURVIVAL MONTHS 0
Y1111 ONCOPATIENT2	SURVIVAL MONTHS 0

Example of the survival information for the template

ONCOTRAX PRIMARY Template ONCOZ LUNG NOS SURVIVAL 96-99

Life Table

Yrs	% Alive	# Left	Deaths	Losses
-----	---------	--------	--------	--------

0	100.0	416	259	0
1	37.7	157	73	0
2	20.2	84	17	0
3	16.1	67	18	0
4	11.8	49	6	10
5	10.2	33	3	5

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.

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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/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
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
Suspense: 4 Incomplete: 68 Minimal: 4 Partial: 35 Complete: 1311
```

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.

```
Select year for summary: (1952-2006): 2005//
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

FOLLOW-UP RATE FOR ALL PATIENTS (LIVING AND DEAD)	NUMBER	PERCENT
Total patients from registry reference date	11808	100%
1. Less benign/borderline (behavior code 0/1)	- 183	
2. Less Carcinoma in situ CERVIX cases	- 9	
3. Less cases of in situ/localized basal and squamous cell carcinoma of skin	- 1068	
4. Less foreign residents	- 0	
5. Less nonanalytic (includes recurrent cases class of case 3,4,5, 8 & 9)	- 1234	
 SUBTOTAL CASES = ANALYTIC CASES (A)	 9314	 100%
(class of case 0, 1, 2)		
 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.

=====

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

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.

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): 6211145
Start date.....: 1/1/07
End date.....: 1/30/07

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

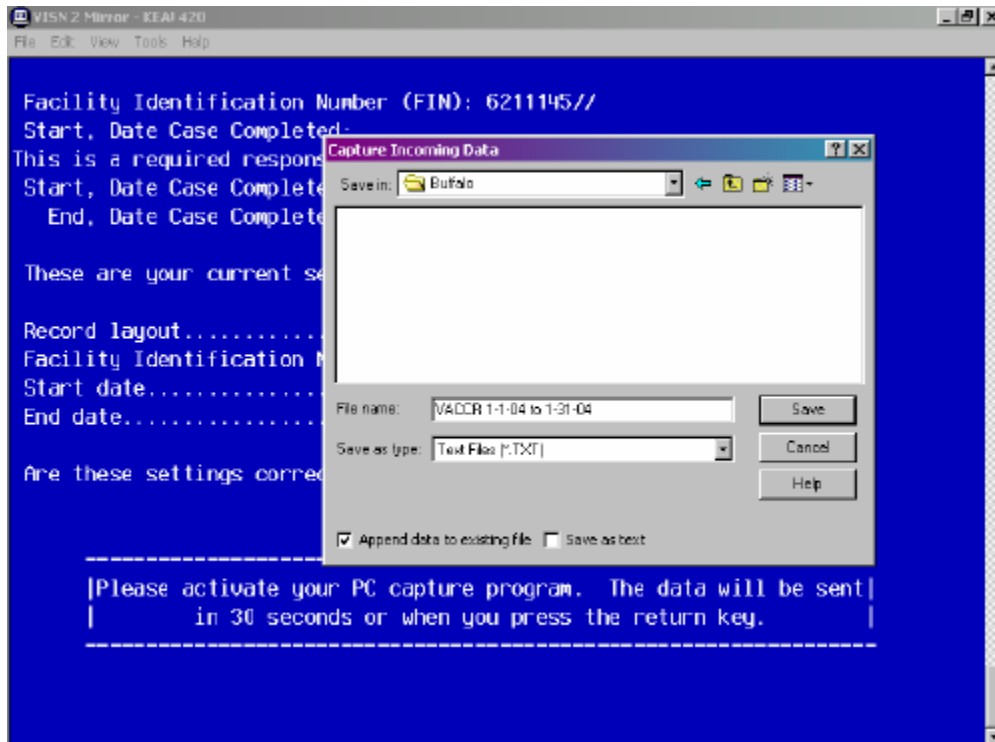
1. Activate your PC capture program.
2. Create a folder on your hard drive or network drive, in which you can save the data for VACCR.
3. Click **Save**. Make sure the **Save as text** is not selected; refer to the KEA Term illustration.
4. Data scrolls across your screen. When the data is done scrolling, 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.*
10. Close the file.

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 2 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 ? (backward question mark).displays, click **Tools**.
8. Click **End Capture**.
9. Open the newly created file in Microsoft Word.
 Example illustration: M:\VACCR\Buffalo\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//

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

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.*
10. Close the file.

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) on your Toolbar to **Save** your file.... *Do not save the file in Word format.*
12. If a dialog box displays, click **Yes**.
13. Close the file.
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

1. Create a folder on your drive (like M: drive) and name it **Genedits**.
Use your network drive for this and if you should receive a new computer, you will not have to do this again.
2. Go the ACoS website: <http://www.facs.org/cancer/index.html>
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).
11. Under Installation Instructions, click Download [EDITS Version 1.0 \(4.7M\)](#) released November 2001.
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 Genedits for ACoS Call for Data



1. To open Genedits, double-click the icon, `Genedits.pif`
2. In the Open Configuration File list box (pink box), double-click **NCDB110B**.
Depending on where you installed the Genedits program, the first line is similar to:
Configuration File: M:\GENEDIT5\NCDB110B.GCF

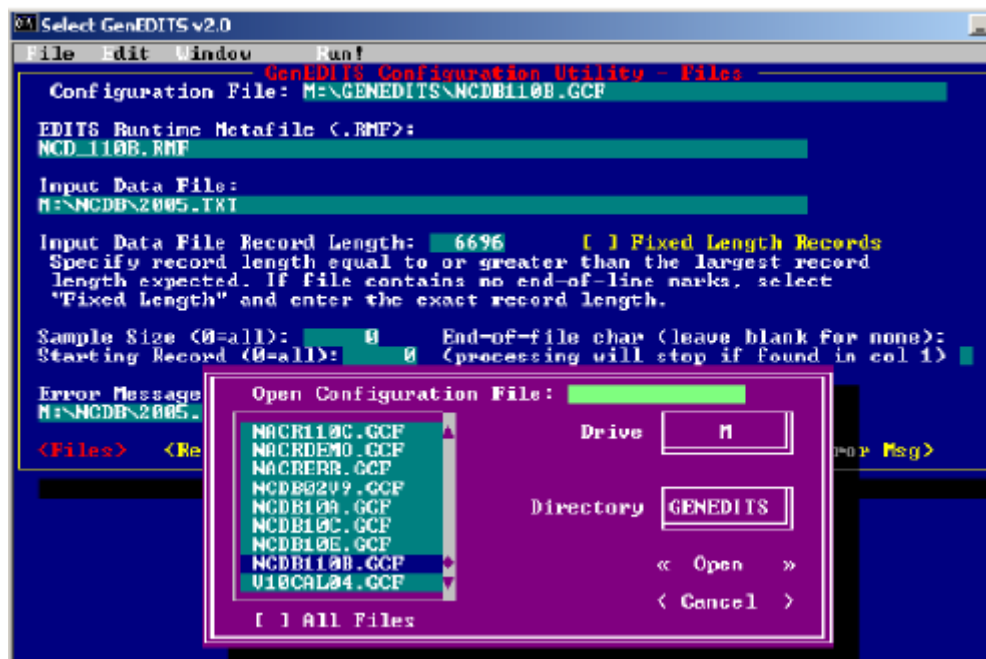
The second line is:

```
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**.

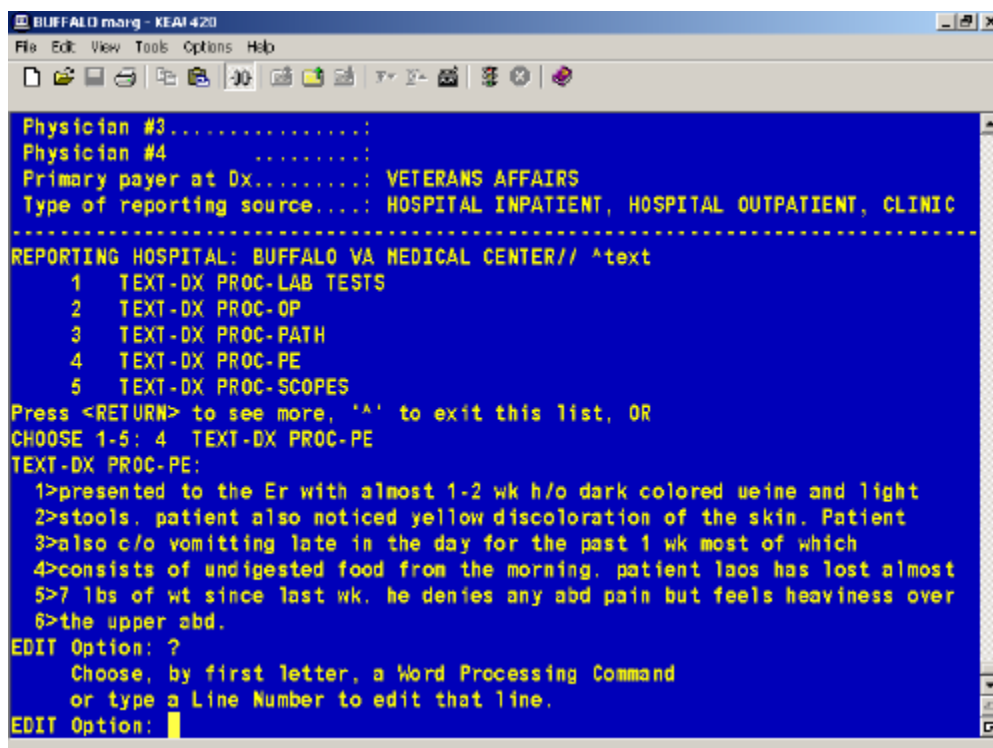
VistA Setup

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

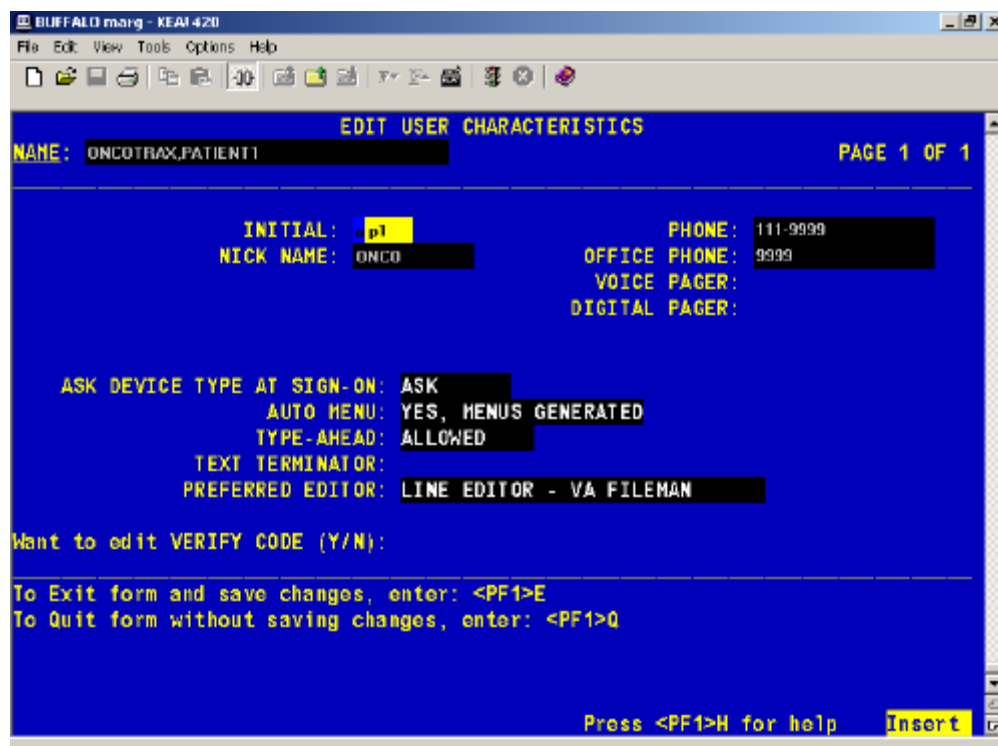


```
BUFFALO marg - KEA1420
File Edit View Tools Options Help
[Icons]
Physician #3.....:
Physician #4.....:
Primary payer at Dx.....: VETERANS AFFAIRS
Type of reporting source....: HOSPITAL INPATIENT, HOSPITAL OUTPATIENT, CLINIC
-----
REPORTING HOSPITAL: BUFFALO VA MEDICAL CENTER// ^text
 1 TEXT-DX PROC-LAB TESTS
 2 TEXT-DX PROC-OP
 3 TEXT-DX PROC-PATH
 4 TEXT-DX PROC-PE
 5 TEXT-DX PROC-SCOPES
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 4 TEXT-DX PROC-PE
TEXT-DX PROC-PE:
 1>presented to the Er with almost 1-2 wk h/o dark colored urine and light
 2>stools. patient also noticed yellow discoloration of the skin. Patient
 3>also c/o vomitting late in the day for the past 1 wk most of which
 4>consists of undigested food from the morning. patient laos has lost almost
 5>7 lbs of wt since last wk. he denies any abd pain but feels heaviness over
 6>the upper abd.
EDIT Option: ?
  Choose, by first letter, a Word Processing Command
  or type a Line Number to edit that line.
EDIT Option: |
```

Screen Editor

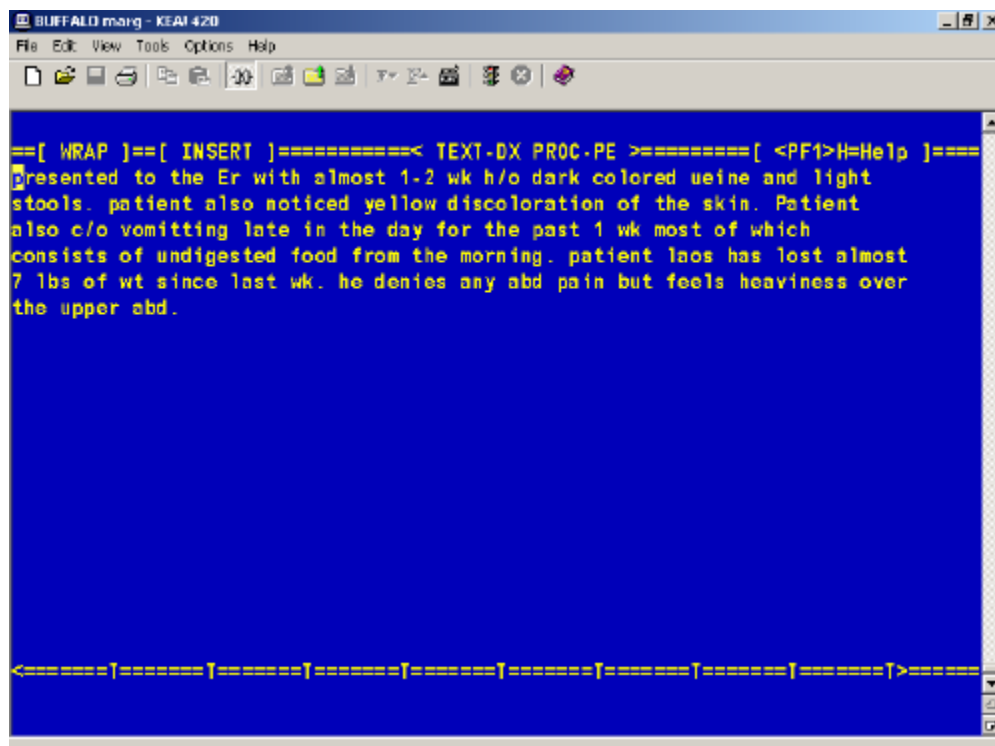
You can change to a more user-friendly word processing screen. Using the **Screen Editor**, you are able to move around easily, format your text, and do many things that are impossible with the line editor.

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

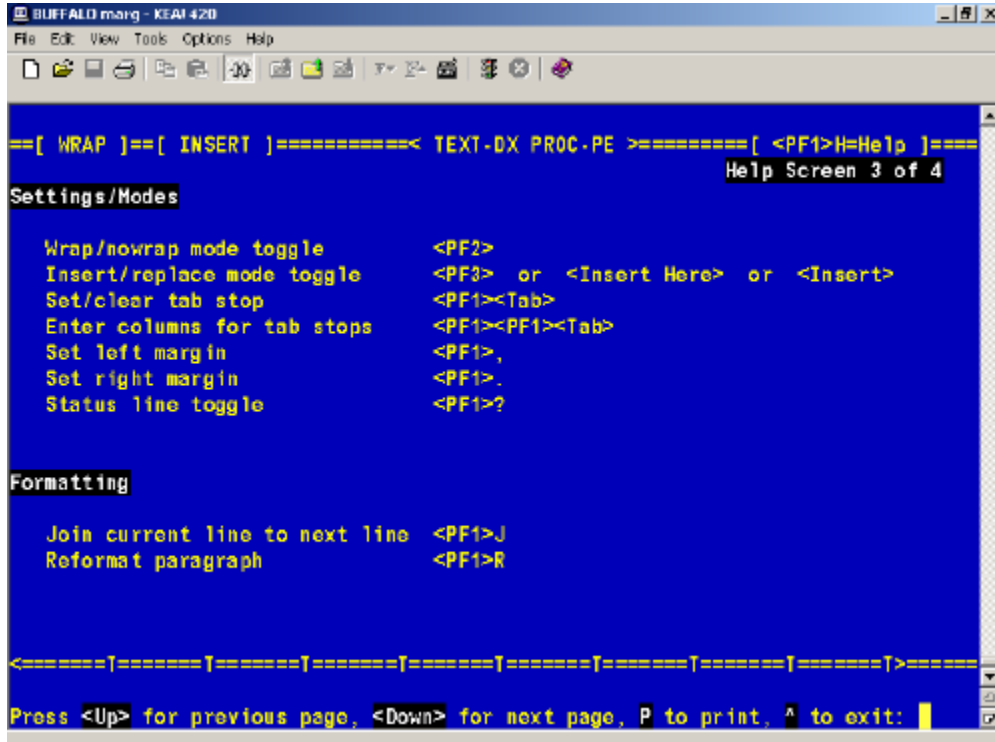


You can type in this screen, just like in Microsoft Word or Word Perfect. You are able to change margins, format text, join lines together, cut and paste text, easily delete text, and so on.

Type **F1H** (H for help) to access word processing Help commands for the Screen Editor.

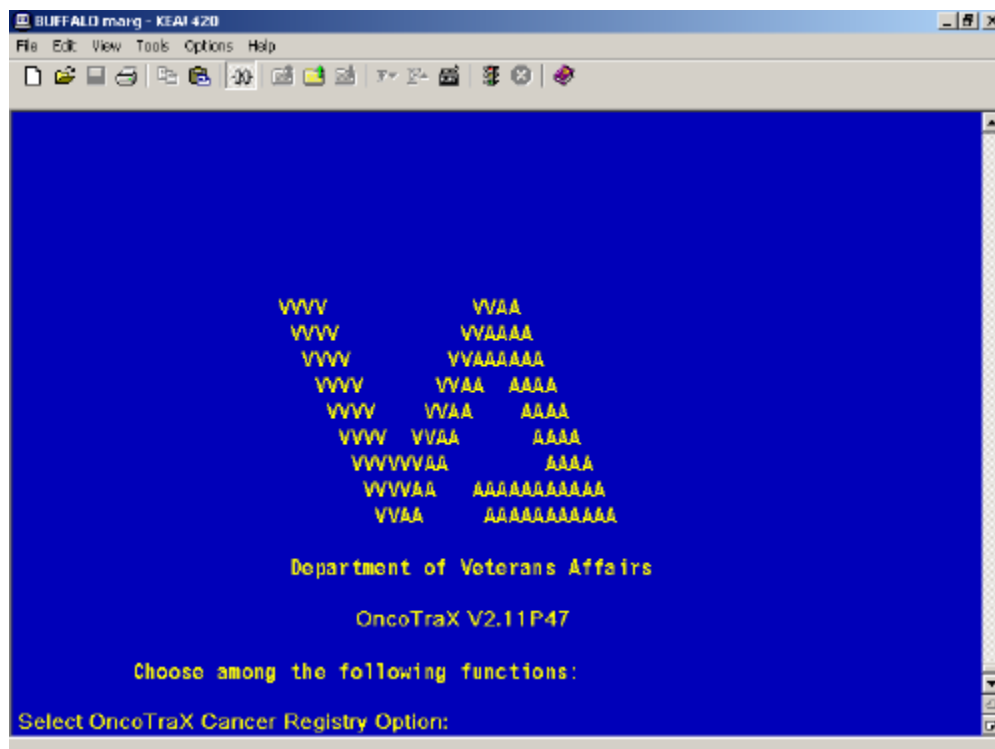
There are four Help screens to which you can navigate. Use the Arrow keys (to the left of the number pad) to move around the Help screens. Help Screen 3 of 4 is the most useful of the Help screens.

Example of Help Screen 3 of 4

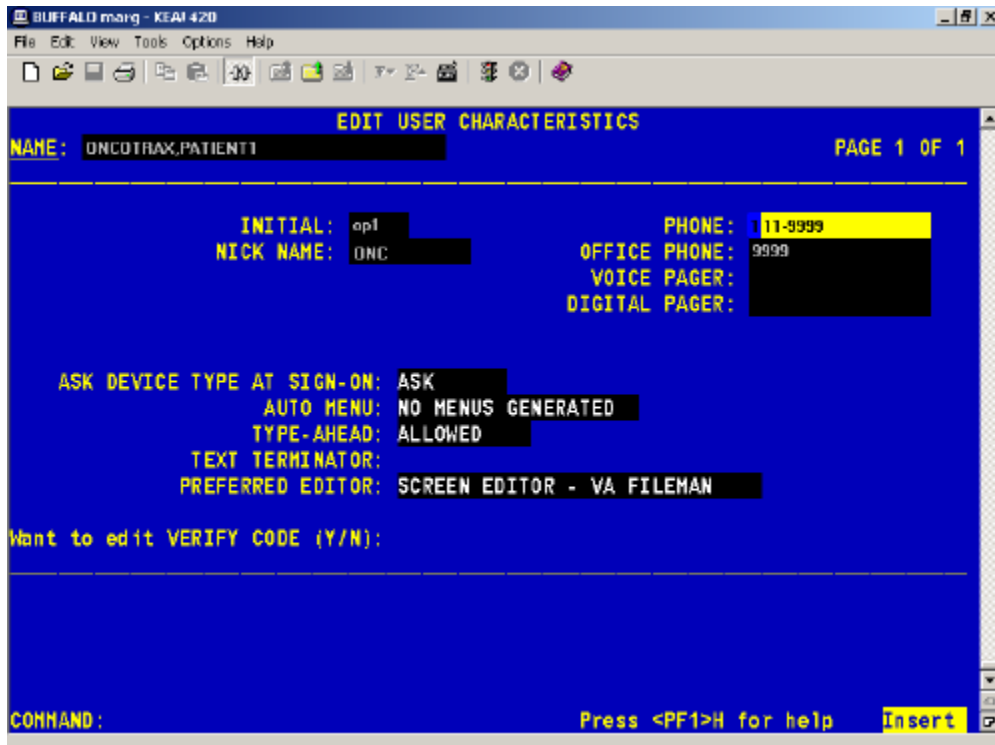


Menu Options

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.

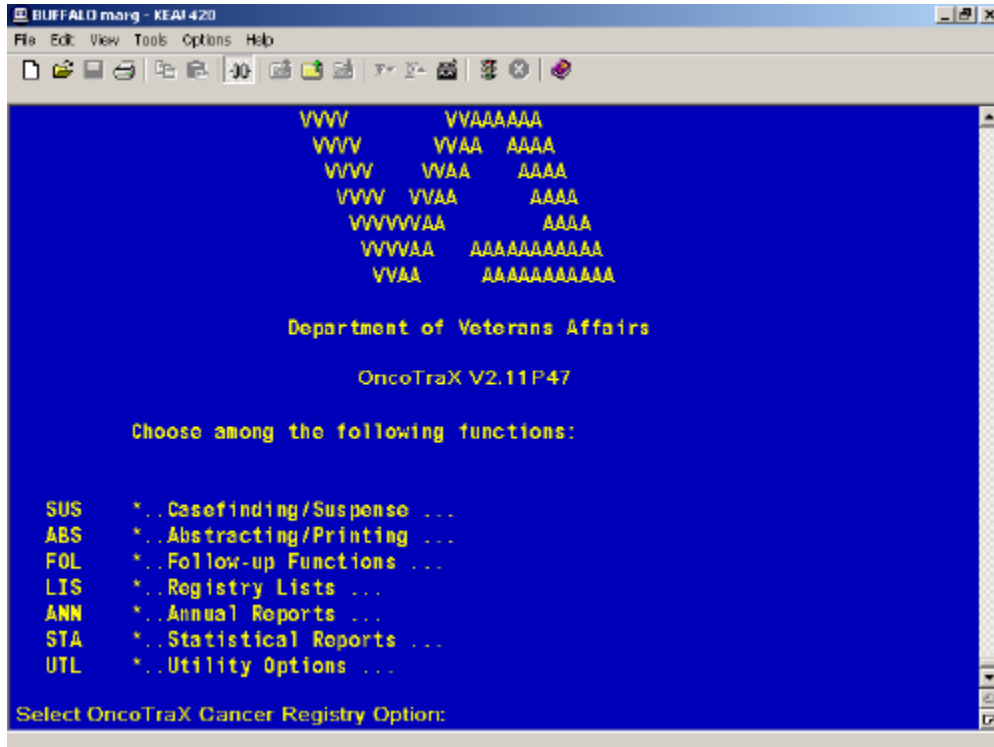


1. At Select OncoTraX: Cancer Registry Option, type **^EDIT USER CHARACTERISTICS**.
2. Arrow down to **AUTO MENU:** and type **?** Your options display.

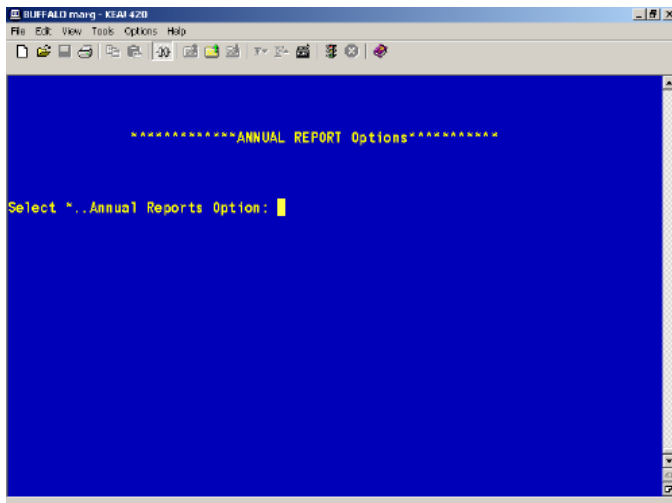


3. Select 1 YES, MENUS GENERATED.

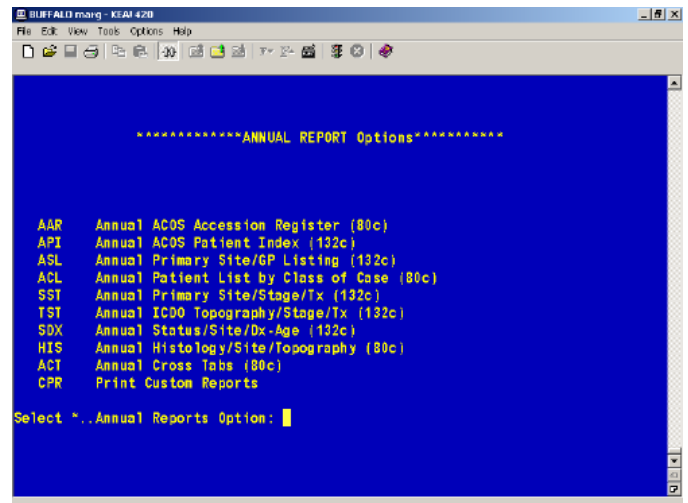
Your menu choices display when you access VistA.



Before



After



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.

1	WARNING: REPORTING HOSPITAL = REFERRING FACILITY
2	WARNING: REPORTING HOSPITAL = TRANSFER FACILITY
3	WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) -REFERRING FACILITY may not be blank
4	WARNING: CLASS OF CASE = 3 (Dx ew, 1st rx ew) REFERRING FACILITY may not be blank
5	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew)-DATE OF FIRST CONTACT.: later than SURGERY OF PRIMARY SITE DATE.:
6	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT. later than RADIATION DATE.....:
7	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT.: later than RADIATION THERAPY TO CNS DATE:
8	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT.: later than CHEMOTHERAPY DATE.....:
9	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT.:
10	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT.: later than IMMUNOTHERAPY DATE.....:
11	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT.: later than OTHER TREATMENT DATE.....:
12	WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) DATE OF FIRST CONTACT.: earlier than DATE DX.....:
13	WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) CLASS OF CASE must be 5 (Dx at autopsy)
14	WARNING: CLASS OF CASE = 5 (Dx at autopsy) TYPE OF REPORTING SOURCE must be 6 (Autopsy only)
15	WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) DIAGNOSTIC CONFIRMATION must be 1 (Pos histology) or 6 (Direct visualization)
16	WARNING: TYPE OF REPORTING SOURCE = 7 (Death certificate only) DIAGNOSTIC CONFIRMATION must be 9 (Unk if microscopically confirmed)

17	WARNING: XXX is a paired site LATERALITY may not be 0 (Not a paired site)
18	WARNING: XXX is an unpaired site LATERALITY must be 0 (Not a paired site)
19	WARNING: BONES, PELVIS, SACRUM, COCCYX is a paired site
20	WARNING: BEHAVIOR CODE = 2 (In situ) SUMMARY STAGE must be 0 (In situ)
21	WARNING: BEHAVIOR CODE = 3 (Malignant) SUMMARY STAGE may not be 0 (In situ)
22	WARNING: HISTOLOGY = 8331 FOLLICULAR ADENOCA, WELL DIFF GRADE/DIFFERENTIATION must be 1 (Grade I)
23	WARNING: HISTOLOGY = 8851 LIPOSARCOMA, WELL DIFFGRADE/DIFFERENTIATION must be 1 (Grade I)
24	WARNING: HISTOLOGY = 9511 RETINOBLASTOMA, DIFFERENTIATED GRADE/DIFFERENTIATION must be 1 (Grade I)
25	WARNING: HISTOLOGY = 9083 TERATOMA, INTERMEDIATE GRADE/DIFFERENTIATION must be 2 (Grade II)
26	WARNING: HISTOLOGY = 8020 CARCINOMA, UNDIFFERENTIATED GRADE/DIFFERENTIATION must be 4 (Grade IV)
27	WARNING: HISTOLOGY = 8021 CARCINOMA, ANAPLASTIC NOS GRADE/DIFFERENTIATION must be 4 (Grade IV)
28	WARNING: HISTOLOGY = 9062 SEMINOMA, ANAPLASTIC TYPE GRADE/DIFFERENTIATION must be 4 (Grade IV)
29	WARNING: HISTOLOGY = 9082 TERATOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
30	WARNING: HISTOLOGY = 9390 CHOROID PLEXUS PAPILLOMA GRADE/DIFFERENTIATION must be 4 (Grade IV)
31	WARNING: HISTOLOGY = 9401 ASTROCYTOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
32	WARNING: HISTOLOGY = 9451 OLIGODENDROGLIOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
33	WARNING: HISTOLOGY = 9512 RETINOBLASTOMA, UNDIFFGRADE/DIFFERENTIATION must be 4 (Grade IV)
34	WARNING: 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)
35	WARNING: 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)

36	WARNING: HISTOLOGY = 9683 LYMPHOMA CENTROBLASTIC DIFFGRADE/DIFFERENTIATION must be: 4 (Grade IV) or 5 (T-cell) or 6 (B-cell) or 7 (Null cell)
37	WARNING: GRADE/DIFFERENTIATION = 5 (T-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
38	WARNING: GRADE/DIFFERENTIATION = 6 (B-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
39	WARNING: GRADE/DIFFERENTIATION = 7 (Null cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
40	WARNING: GRADE/DIFFERENTIATION = 8 (Natural killer cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
41	WARNING: No TNM classification is available for LYMPHOMA SUMMARY STAGE cannot be blank
41	WARNING: No TNM classification is available for KAPOSII'S SARCOMA SUMMARY STAGE cannot be blank
43	WARNING: BEHAVIOR CODE = 3 (Malignant) EXTENSION may not be 00 (In situ)
44	WARNING: ICDO-TOPOGRAPHY = XXX PATHOLOGIC EXTENSION = XXX
45	PATHOLOGIC EXTENSION may only be coded for PROSTATE (C61.9) cases
46	WARNING: NODES POSITIVE (REGIONAL) = 01-97 LYMPH NODES may not be 0 (No lymph nodes)
47	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
48	WARNING: STATUS = Dead PLACE OF DEATH may not be blank
49	WARNING: STATUS = Dead CAUSE OF DEATH and STATE DEATH CERT may not both be blank
50	WARNING: For race combinations RACE 1 may not be 'White'
51	WARNING: A specific race code may not occur more than once
52	If REGIONAL NODES EXAMINED is 99 (Unknown if nodes examined, NA), REGIONAL NODES POSITIVE must be 99 (Unk if nodes + or -, NA)

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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.

Name of Edit	Errors	Warn	Skipped
Addr at DX--City (NAACCR)			
Addr at DX--Postal Code (NAACCR)			
Addr at DX--State (NAACCR)			
Age at Diagnosis (SEER AGEDX)			
Birth Date (NAACCR DATEEDIT)			
Birthplace (COC)			
Cause of Death (SEER COD)			
Census Cod Sys 1970/80/90 (SEER RESSYST)			
Census Tr Cert 1970/80/90 (SEER CENSCERT)			
Census Tr Certainty 2000 (SEER)			
Census Tract 1970/80/90 (SEER TRACT)			
Census Tract 2000 (SEER)			
County at DX (NAACCR)			
CS Extension (CS)			
CS Lymph Nodes (CS)			
CS Mets at DX (CS)			
CS Site-Specific Factor 1 (CS)			
CS Site-Specific Factor 3 (CS)			
CS Version 1st (CS)			
Date of 1st Crs RX--COC (NPCR)			
Date of Diagnosis (NAACCR DATEEDIT)			
Date of Initial RX--SEER (NPCR)			
Date of Last Contact (NAACCR DATEEDIT)			
Derived SS2000 (CS)			
Derived SS2000--Flag (CS)			
Diagnostic Confirmation (SEER DXCONF)			

Name of Edit	Errors	Warn	Skipped
Follow-up Source Central (NAACCR)			
Grade (COC)			
Histologic Type ICDO3 Conversion (NAACCR)			
ICD Revision Number (NPCR)			
ICD-O-3 Conversion Flag (NAACCR)			
Laterality (SEER LATERAL)			
Name--First (NAACCR)			
Name--Last (NAACCR)			
Name--Middle (NAACCR)			
Patient ID Number (SEER CASENUM)			
Primary Payer at DX (NPCR)			
Primary Site (SEER SITE)			
Race 1 (SEER RACE)			
Race 2 (NAACCR)			
Race 3 (NAACCR)			
Race 4 (NAACCR)			
Race 5 (NAACCR)			
Rad--Regional RX Modality (NPCR)			
Reason for No Surgery (NPCR)			
RX Summ--BRM (NPCR)			
RX Summ--Chemo (NPCR)			
RX Summ--Hormone (NPCR)			
RX Summ--Other (NPCR)			
RX Summ--Surg/Rad Seq (NPCR)			
RX Summ--Systemic/Sur Seq (COC)			
RX Summ--Transplnt/Endocr (NPCR)			
Sex (SEER Sex)			
Social Security Number (NAACCR)			
Spanish/Hispanic Origin (SEER SPANORIG)			
Summary Stage 1977 (NAACCR)			

Name of Edit	Errors	Warn	Skipped
Summary Stage 2000 (NAACCR)			
Type of Reporting Source (SEER RPRTSRC)			
Vital Status (COC)			
Ambiguous Terminology DX (SEER)			
Behavior ICDO2 (COC)			
Behavior ICDO3 (COC)			
CS Version Latest (CS)			
Date of Conclusive DX (SEER)			
Date of Multiple Tumors (SEER)			
Histologic Type ICDO2 (COC)			
Histologic Type ICDO3 (SEER)			
Mult Tum Rpt As One Prim (SEER)			
Multiplicity Counter (SEER)			
RX Summ--Scope Reg LN Sur (COC)			
RX Summ--Surg Oth Reg/Dis (COC)			
RX Summ--Surg Prim Site (COC)			
Abstracted By (COC)			
Accession Number--Hosp (COC)			
Archive FIN (COC)			
COC Coding Sys--Current (COC)			
COC Coding Sys--Original (COC)			
CS Mets Eval (CS)			
CS Reg Nodes Eval (CS)			
CS Site-Specific Factor 2 (CS)			
CS Site-Specific Factor 4 (CS)			
CS Site-Specific Factor 5 (CS)			
CS Site-Specific Factor 6 (CS)			
CS Tumor Size (CS)			
CS Tumor Size/Ext Eval (CS)			
Cancer Status (COC)			

Name of Edit	Errors	Warn	Skipped
Class of Case (COC)			
Comorbid/Complication 1 (COC)			
Comorbid/Complication 10 (COC)			
Comorbid/Complication 2 (COC)			
Comorbid/Complication 3 (COC)			
Comorbid/Complication 4 (COC)			
Comorbid/Complication 5 (COC)			
Comorbid/Complication 6 (COC)			
Comorbid/Complication 7 (COC)			
Comorbid/Complication 8 (COC)			
Comorbid/Complication 9 (COC)			
County at DX (COC)			
Date Case Completed (NAACCR DATEEDIT)			
Date of 1st Contact (COC)			
Derived AJCC M (CS)			
Derived AJCC M Descriptor (CS)			
Derived AJCC N (CS)			
Derived AJCC N Descriptor (CS)			
Derived AJCC Stage Group (CS)			
Derived AJCC T (CS)			
Derived AJCC T Descriptor (CS)			
Derived AJCC--Flag (CS)			
Derived SS1977 (CS)			
Derived SS1977--Flag (CS)			
EOD--Tumor Size (COC)			
Follow-Up Source (COC)			
Morph Coding Sys--Current (NAACCR)			
Morph Coding Sys--Originl (NAACCR)			
NPI--Archive FIN (NAACCR)			
NPI--Reporting Facility (NAACCR)			

Name of Edit	Errors	Warn	Skipped
Next Follow-Up Source (COC)			
Primary Payer at DX (COC)			
RX Coding System--Current (COC)			
RX Date--DX/Stg Proc (COC)			
RX Date--Most Defin Surg (COC)			
RX Date--Other (COC)			
RX Date--Radiation (COC)			
RX Date--Radiation Ended (COC)			
RX Date--Surgery (COC)			
RX Date--Surgical Disch (COC)			
RX Date--Systemic (COC)			
RX Hosp--BRM (COC)			
RX Hosp--Chemo (COC)			
RX Hosp--DX/Stg Proc (COC)			
RX Hosp--Hormone (COC)			
RX Hosp--Other (COC)			
RX Hosp--Palliative Proc (COC)			
RX Hosp--Reg LN Examined (COC)			
RX Hosp--Scope Reg 98-02 (COC)			
RX Hosp--Scope Reg LN Sur (COC)			
RX Hosp--Surg Oth 98-02 (COC)			
RX Hosp--Surg Oth Reg/Dis (COC)			
RX Hosp--Surg Prim Site (COC)			
RX Hosp--Surg Site 98-02 (COC)			
RX Summ--BRM (COC)			
RX Summ--Chemo (COC)			
RX Summ--DX/Stg Proc (COC)			
RX Summ--Hormone (COC)			
RX Summ--Other (SEER OTHERRX)			
RX Summ--Palliative Proc (COC)			

Name of Edit	Errors	Warn	Skipped
RX Summ--Reconstruct 1st (SEER RECONST)			
RX Summ--Reg LN Examined (COC)			
RX Summ--Scope Reg 98-02 (COC)			
RX Summ--Surg Oth 98-02 (COC)			
RX Summ--Surg Site 98-02 (COC)			
RX Summ--Surg/Rad Seq (SEER RADSEQ)			
RX Summ--Surgical Approach (COC)			
RX Summ--Surgical Margins (COC)			
RX Summ--Transplnt/Endocr (COC)			
Race Coding Sys--Current (NAACCR)			
Race Coding Sys--Original (NAACCR)			
Rad--Boost Dose cGy (COC)			
Rad--Boost RX Modality (COC)			
Rad--Location of RX (COC)			
Rad--No of Treatments Vol (COC)			
Rad--Regional Dose: cGy (COC)			
Rad--Regional RX Modality (COC)			
Rad--Treatment Volume (COC)			
Readm Same Hosp 30 Days (COC)			
Reason for No Radiation (COC)			
Reason for No Surgery (SEER NCDSURG)			
Recurrence Date--1st (COC)			
Recurrence Type--1st (COC)			
Regional Nodes Examined (COC)			
Regional Nodes Positive (COC)			
Reporting Hospital (COC)			
Site Coding Sys--Current (NAACCR)			
Site Coding Sys--Original (NAACCR)			
TNM Clin M (COC)			
TNM Clin N (COC)			

Name of Edit	Errors	Warn	Skipped
TNM Clin Stage Group (COC)			
TNM Clin Staged By (COC)			
TNM Clin T (COC)			
TNM Edition Number (COC)			
TNM Path Descriptor (COC)			
TNM Path M (COC)			
TNM Path N (COC)			
TNM Path Stage Group (COC)			
TNM Path Staged By (COC)			
TNM Path T (COC)			
Morphology--Type/Behavior ICDO3 (SEER MORPH)			
Morphology--Type/Behavior ICDO2 (SEER MORPH)			
Addr at DX--Postal Code, Addr at DX--State (COC)			
Age, Birth Date, Date of Diagnosis (NAACCR IF13)			
Age, Histologic Type, COD, ICDO3 (SEER IF43)			
Age, Primary Site, Morph ICDO3--Adult (SEER)			
Age, Primary Site, Morphology ICDO3 (SEER IF15)			
Autopsy Only, RX (NPCR)			
Behavior Code ICDO3, Seq Num--Central (SEER IF114)			
Behavior ICDO3, Summary Stage 2000 (NAACCR)			
Birth Date, Date of Diagnosis (NAACCR IF47)			
Census Tract 1970/80/90, Census Cod Sys (SEER IF45)			
Cervix In Situ ICDO3 (SEER IF88)			
County at DX, Addr at DX--State (NAACCR)			
CS Extension, Bladder Schema (CS)			
CS Extension, CS Lymph Nodes, CS Mets at DX (CS)			
CS Extension, Hematopoietic (CS)			
CS Extension, Primary Site, Behavior ICDO3 (CS)			
CS Extension, Primary Site, Histol ICDO3 (NAACCR)			
CS Extension, Renal Pelvis/Ureter Schema (CS)			

Name of Edit	Errors	Warn	Skipped
CS Items, Date of DX (NPCR)			
CS Items, Death Certificate Only (CS)			
CS Items, DX Pre-2004 (CS)			
CS Items, Type Reporting Source (NPCR)			
CS Lymph Nodes, Primary Site, Histol ICDO3 (NAACCR)			
CS Mets at DX, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 1, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 3, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 3, RX Summ--Surg, Prostate Schema (CS)			
CS Version 1st, CS Version Latest (CS)			
Date of 1st Crs RX--COC, Date Init RX--SEER (NPCR)			
Date of Last Contact, Date of Diag. (NAACCR IF19)			
Death Certificate Only, RX (NPCR)			
Derived Items, Date of DX (NPCR)			
Derived Items, DX Pre-2004 (CS)			
Derived SS2000--Flag, Derived SS2000 (CS)			
Diagnostic Confirm, Seq Num--Central (SEER IF23)			
Diagnostic Confirmation, Behavior ICDO3(SEER IF31)			
Diagnostic Confirmation, Histology ICDO3(SEER IF48)			
Edit Over-rides (SEER REVIEWFL)			
Follow-up Source Central, Date of DX (NPCR)			
ICD Revision Number, Cause of Death (SEER IF37)			
ICD-O-3 Conversion Flag, Histology ICDO3(SEER IF95)			
Laterality, Primary Site (NAACCR IF24)			
Laterality, Primary Site, Morph ICDO3 (SEER IF42)			
Primary Site, Behavior Code ICDO3 (SEER IF39)			
Primary Site, Laterality (SEER IF82)			
Primary Site, Morphology-Imposs ICDO3 (SEER IF38)			
Primary Site, Morphology-Type ICDO3 (SEER IF25)			
Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR)			

Name of Edit	Errors	Warn	Skipped
RX Summ--Scope Reg LN Sur, Site, ICDO3 (SEER IF109)			
RX Summ--Surg Prim Site, Primary Site, ICDO3 (COC)			
Seq Num--Central, Prim Site, Morph ICDO3(SEER IF22)			
Sex, Primary Site (SEER IF17)			
Summ Stg 2000, Site, Hist ICDO3, Rpt Srce (NAACCR)			
Summary Stage 1977, Date of Diagnosis (NAACCR)			
Summary Stage 2000, Date of Diagnosis (NAACCR)			
Type of Rep Srce(DC),Seq Num--Cent,ICDO3(SEER IF04)			
Type of Report Srce(DC/AO), COD (SEER IF09)			
Type of Report Srce(DC/AO), Date of Dx (SEER IF02)			
Type of Report Srce(DC/AO), Diag Conf (SEER IF05)			
Type of Report Srce(DC/AO), Vit Stat (COC)			
Vital Status, Cause of Death (COC)			
Age, Histologic Type, COD, ICDO2 (SEER IF43)			
Age, Primary Site, Morphology ICDO2 (SEER IF15)			
Behavior ICDO2, Behavior ICDO3 (SEER IF115)			
Behavior ICDO2, Date of Diagnosis (NAACCR)			
Behavior ICDO2, Histology ICDO2 (NAACCR)			
Behavior ICDO2, Summary Stage 1977 (NAACCR)			
Behavior ICDO3, Date of Diagnosis (NAACCR)			
CS Lymph Nodes, Regional Nodes Positive (CS)			
CS Reg Nodes Ex, Pos, Site, Hist ICDO3, Report(CS)			
Cervix In Situ ICDO2 (SEER IF88)			
Diagnostic Confirmation, Behavior ICDO2(SEER IF31)			
Diagnostic Confirmation, Histology ICDO2(SEER IF48)			
Hemato ICDO2, Summ Stg 1977, Type Rpt Srce (NAACCR)			
Histology ICDO2, Date of Diagnosis (NAACCR)			
Histology ICDO3, Date of Diagnosis (NAACCR)			
Laterality, Primary Site, Morph ICDO2 (SEER IF42)			
Lymphoma, Prim Site, Summ Stg 1977, ICDO2 (NAACCR)			

Name of Edit	Errors	Warn	Skipped
Primary Site, Behavior Code ICDO2 (SEER IF39)			
Primary Site, Morphology-Imposs ICDO2 (SEER IF38)			
Primary Site, Morphology-Type ICDO2 (SEER IF25)			
RX Summ--Scope Reg LN Sur, Site, ICDO2(COC)			
RX Summ--Surg Prim Site, Primary Site, ICDO2 (COC)			
Seq Num--Central, Prim Site, Morph ICDO2(SEER IF22)			
Summ Stg 1977, Site, Hist ICDO2, Rpt Srce (NAACCR)			
Type of Rep Srce(DC),Seq Num--Cent,ICDO2(SEER IF04)			
Unknown Site, Summary Stage 1977, ICDO2 (NAACCR)			
Addr Current--State, Date of Diagnosis (COC)			
Ambiguous Terminology DX, Date of DX (SEER IF157)			
COC Coding Sys--Curr, COC Coding Sys--Orig (COC)			
COC Coding Sys--Original, Date of Diagnosis (COC)			
CS Extension, CS Tumor Size, Site, Hist ICDO3 (CS)			
CS Extension, SSF 1, Thyroid Schema (CS)			
CS Items, Class of Case (COC)			
CS Items, Date of DX (COC)			
CS Lymph Nodes, Nodes Pos, SSF3, Breast Schema(CS)			
CS Lymph Nodes, SSF 1, Head/Neck Schemas (CS)			
CS Lymph Nodes, SSF 3,4,5, Breast Schema (CS)			
CS Mets Eval, Primary Site, Histol ICDO3 (NAACCR)			
CS Reg LN Eval, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 1, OthCNS/OthEndocrine Schemas (CS)			
CS SSF 1, RX Summ--Surg, Retinoblastoma Schema(CS)			
CS SSF 2, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 3, Breast Schema (CS)			
CS SSF 4, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 4, RX Summ--Surg, Testis Schema (CS)			
CS SSF 5, Primary Site, Histol ICDO3 (NAACCR)			
CS SSF 5, SSF 6, Grade, Prostate Schema (CS)			

Name of Edit	Errors	Warn	Skipped
CS SSF 6, Breast Schema (CS)			
CS SSF 6, Primary Site, Histol ICDO3 (NAACCR)			
CS TS/Ext Eval, Primary Site, Histol ICDO3 (NAACCR)			
CS TS/Ext Eval, Surgery (CS)			
CS TS/Ext Eval, Surgery, Prostate Schema (CS)			
CS Tumor Size, Primary Site, Histol ICDO3 (NAACCR)			
CS Tumor Size, SSF 1, Malign Melanoma Schemas (CS)			
CS Tumor Size, Site, Histol ICDO3 (CS)			
Class of Case, Date of 1st Cont, Date of DX (COC)			
Class of Case, RX (COC)			
Class, Date Diag, Date Last Cont, Vit Stat (COC)			
Comorbid/Complication 1 - 10 (COC)			
Comorbid/Complication 1, Date DX (COC)			
Date Case Completed, Date of Diagnosis (NAACCR)			
Date of 1st Crs RX--COC, Date Last Contact (COC)			
Date of 1st Crs RX--COC, Date of DX (COC)			
Date of 1st Crs RX--COC, Dates of RX (COC)			
Date of Multiple Tumors, Date of DX (SEER IF165)			
Derived AJCC--Flag, Derived AJCC (COC)			
Derived Items, Date of DX (COC)			
Derived SS1977--Flag, Derived SS1977 (CS)			
EOD--Tumor Size, Date of Diagnosis (COC)			
Edit Over-rides (NAACCR)			
Follow-Up Source, Date of Diagnosis (COC)			
Follow-Up Source, Vital Status (COC)			
Hemato ICDO2, Summ Stg 1977, Class of Case (NAACCR)			
Hematopoietic, TNM, ICDO2 (NAACCR)			
Hematopoietic, TNM, ICDO3 (NAACCR)			
Hist/Behav ICDO2, Hist/Behav ICDO3 (SEER IF126)			
Histology ICDO2, Date DX, Date 1st Contact (NAACCR)			

Name of Edit	Errors	Warn	Skipped
Histology ICDO3, Date DX, Date 1st Cont (NAACCR)			
Histology, Primary Site, Tumor Size, ICDO2 (COC)			
Histology, Primary Site, Tumor Size, ICDO3 (COC)			
Laterality, Primary Site (COC)			
Morph Coding Sys--Curr, Morph Coding Sys--Orig(COC)			
Morph Coding Sys--Originl, Date of Diagnosis (COC)			
Mult Tum Rpt As One Prim, Date of DX (SEER IF155)			
Multiplicity Cntr, Date of Mult Tum (SEER IF163)			
Multiplicity Counter, Date of DX (SEER IF156)			
Next Follow-Up Source, Date of Diagnosis (COC)			
Obsolete Codes - CS Extension (SEER IF146)			
Obsolete Codes - CS Lymph Nodes (SEER IF147)			
Obsolete Codes - CS Mets at DX (SEER IF148)			
Obsolete Codes - CS SSF 1 (SEER IF149)			
Obsolete Codes - CS SSF 3 (SEER IF150)			
Obsolete Codes - CS SSF 4 (SEER IF151)			
Over-ride Misuse (NAACCR)			
Primary Site, AJCC Stage Group - Ed 3/4, ICDO2(COC)			
Primary Site, AJCC Stage Group - Ed 5, ICDO2 (COC)			
Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC)			
Primary Site, AJCC Stage Group - Ed 6, ICDO3 (COC)			
Primary Site, Histology, Behav ICDO3 (NAACCR)			
Primary Site, Morphology-Type ICDO2 (COC)			
Primary Site, Morphology-Type ICDO3 (COC)			
Primary Site, No AJCC Scheme-Ed 5, ICDO2 (NAACCR)			
Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR)			
RX Date--DX/Stg Proc, Date Last Contact (COC)			
RX Date--Most Defin Surg, Date Last Contact (COC)			
RX Date--Most Defin Surg, Date of DX (COC)			
RX Date--Most Defin Surg, RX Date--Surgery (COC)			

Name of Edit	Errors	Warn	Skipped
RX Date--Most Defin Surg, Surg Prim Site (COC)			
RX Date--Other, Date Last Contact (COC)			
RX Date--Other, Date of Diagnosis (COC)			
RX Date--Rad Ended, Date Last Contact (COC)			
RX Date--Rad Ended, RX Date--Radiation (COC)			
RX Date--Rad Ended, Rad--Location of RX (COC)			
RX Date--Rad Ended, Rad--No of Treatments Vol (COC)			
RX Date--Rad Ended, Rad--Regional Dose: cGy (COC)			
RX Date--Rad Ended, Rad--Regional RX Modality (COC)			
RX Date--Rad Ended, Rad--Treatment Volume (COC)			
RX Date--Radiation, Rad--Location of RX (COC)			
RX Date--Radiation, Rad--No of Treatments Vol (COC)			
RX Date--Radiation, Rad--Regional Dose: cGy (COC)			
RX Date--Radiation, Rad--Regional RX Modality (COC)			
RX Date--Radiation, Rad--Treatment Volume (COC)			
RX Date--Surgery, Date Last Contact (COC)			
RX Date--Surgical Disch, Date Last Contact (COC)			
RX Date--Surgical Disch, Date of DX (COC)			
RX Date--Surgical Disch, Date--Most Def Surg (COC)			
RX Date--Surgical Disch, Surg Prim Site (COC)			
RX Date--Systemic, Date Last Contact (COC)			
RX Date--Systemic, Systemic RX (COC)			
RX Hosp--BRM, RX Summ--BRM (COC)			
RX Hosp--Chemo, RX Summ--Chemo (COC)			
RX Hosp--DX/Stg Proc, RX Summ--DX/Stg Proc (COC)			
RX Hosp--Hormone, RX Summ--Hormone (COC)			
RX Hosp--Other, Date of Diagnosis (COC)			
RX Hosp--Other, RX Summ--Other (COC)			
RX Hosp--Palliative Proc, RX Summ--Pall Proc (COC)			
RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC)			

Name of Edit	Errors	Warn	Skipped
RX Hosp--Scope Reg 98-02, Primary Site, ICDO2(COC)			
RX Hosp--Scope Reg 98-02, Primary Site, ICDO3(COC)			
RX Hosp--Scope Reg 98-02, RX Hosp--Scope Reg (COC)			
RX Hosp--Scope Reg 98-02,RX Hosp--Reg LN Rem (COC)			
RX Hosp--Scope Reg LN Sur, Primary Site,ICDO2(COC)			
RX Hosp--Scope Reg LN Sur, Primary Site,ICDO3(COC)			
RX Hosp--Surg Oth 98-02, Primary Site (COC)			
RX Hosp--Surg Oth 98-02, RX Hosp--Surg Oth (COC)			
RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC)			
RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC)			
RX Hosp--Surg Prim Site, Primary Site, ICDO2 (COC)			
RX Hosp--Surg Prim Site, Primary Site, ICDO3 (COC)			
RX Hosp--Surg Site 98-02, Primary Site (COC)			
RX Hosp--Surg Site 98-02, RX Hosp--Surg Site (COC)			
RX Summ--BRM, Vital Status (COC)			
RX Summ--DX/Stg Proc, RX Date--DX/Stg Proc (COC)			
RX Summ--Hormone, Vital Status (COC)			
RX Summ--Other, RX Date--Other (COC)			
RX Summ--Reconstruct 1st, Date of DX (COC)			
RX Summ--Reconstruct 1st, Primary Site (COC)			
RX Summ--Reg LN Examined, Date of DX (COC)			
RX Summ--Scope Reg 98-02, Date of DX (COC)			
RX Summ--Scope Reg 98-02, Primary Site, ICDO2(COC)			
RX Summ--Scope Reg 98-02, Primary Site, ICDO3(COC)			
RX Summ--Surg Approach,RX Summ--Surg Site 98-02(COC)			
RX Summ--Surg Oth 98-02, Date of DX (COC)			
RX Summ--Surg Oth 98-02, Primary Site (COC)			
RX Summ--Surg Prim Site, Diag Conf (SEER IF76)			
RX Summ--Surg Site 98-02, Date of DX (COC)			
RX Summ--Surg Site 98-02, Primary Site (COC)			

Name of Edit	Errors	Warn	Skipped
RX Summ--Surg Site 98-02, RX Summ--Surg Site (COC)			
RX Summ--Surgical Approch, Date of DX (COC)			
RX Summ--Surgical Approch, Primary Site (COC)			
RX Summ--Surgical Margins, Primary Site,ICDO2 (COC)			
RX Summ--Surgical Margins, Primary Site,ICDO3 (COC)			
RX Summ--Systemic/Sur Seq, Date of DX (COC)			
RX Summ--Transplnt/Endocr, Primary Site (SEER IF28)			
RX Summ--Transplnt/Endocr, Vital Status (COC)			
Race Coding Sys--Curr, Race Coding Sys--Orig (COC)			
Race Coding Sys--Current, Race 2, 3, 4, 5 (NAACCR)			
Race Coding Sys--Original, Date of Diagnosis (COC)			
Rad--Regional RX Modality, Date of Diagnosis (COC)			
Rad--Regional RX Modality, Reason for No Rad (COC)			
Readm Same Hosp 30 Days, Date of Diagnosis (COC)			
Reason for No Radiation, RX Date--Radiation (COC)			
Reason for No Radiation, Vital Status (COC)			
Reason for No Surgery, Vital Status (COC)			
Recurrence Date--1st, Date Last Contact (COC)			
Recurrence Date--1st, Date of 1st RX--COC (COC)			
Recurrence Date--1st, Date of Diagnosis (COC)			
Recurrence Type--1st, Cancer Status (COC)			
Recurrence Type--1st, Recurrence Date--1st (COC)			
Regional Nodes Ex, Reg Nodes Pos (COC)			
Seq Num--Hosp, Primary Site, Morph ICDO2 (COC)			
Seq Num--Hosp, Primary Site, Morph ICDO3 (COC)			
Site Coding Sys--Curr, Site Coding Sys--Orig (COC)			
Site Coding Sys--Original, Date of Diagnosis (COC)			
Summ Stg 2000, Site, Hist ICDO3, Class (NAACCR)			
Summary Stage 1977, Class of Case (COC)			
Summary Stage 1977, Histology ICDO2 (COC)			

Name of Edit	Errors	Warn	Skipped
Summary Stage 1977, Primary Site-Ed 4, ICDO2 (COC)			
Summary Stage 1977, Primary Site-Ed 5, ICDO2 (COC)			
Summary Stage 1977, TNM Stage Group (COC)			
Summary Stage 2000, Primary Site-Ed 5, ICDO3 (COC)			
Summary Stage 2000, Primary Site-Ed 6, ICDO3 (COC)			
Surgery, RX Date--Surgery, ICDO2 (COC)			
Surgery, RX Date--Surgery, ICDO3 (COC)			
Surgery, Rad, Surg/Rad Seq (COC)			
Surgery, Reason No Surg (COC)			
Systemic RX, Surgery, Systemic/Sur Seq (COC)			
TNM Clin Stage Group, TNM Items, ICDO3 (COC)			
TNM Clin Stage Group, TNM Path Stage Group (COC)			
TNM Edition Number, Date of Diagnosis (COC)			
TNM Edition Number, No AJCC Ed 5 Scheme,ICDO3(COC)			
TNM Edition Number, No AJCC Ed 6 Scheme,ICDO3(COC)			
TNM Edition, TNM Clin Stage, TNM Path Stage (COC)			
TNM Path Stage Group, TNM Items, ICDO3 (COC)			
Tumor Marker 1, Primary Site, Morph ICDO2 (COC)			
Tumor Marker 1, Primary Site, Morph ICDO3 (COC)			
Tumor Marker 2, Primary Site (COC)			
Tumor Marker 3, Primary Site (COC)			

Glossary

ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
API	Application Program Interface
COC	Commission on Cancer
CS	Collaborative Staging
DOB	Date of Birth
DOD	Date of Death
EOD	Extent of Disease
EOVA	East Orange VA Medical Center
FORDS	Facility Oncology Registry Data Standards
ICD-O	International Classification of Diseases for Oncology
NAACCR	North American Association of Central Cancer Registries
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
NPCR	National Program of Cancer Registries
PID#	Patient Identification Number First initial of the last name plus the last four digits of the SSN: W9999
PTF	Patient Treatment File
Report 80C	Report contains 80 columns and requires a printer that prints 80 columns
Report 132C	Report contains 132 columns and requires a printer that prints 132 columns; on screen the text wraps.
SEER	Surveillance, Epidemiology and End Results
SNOMED	Systematized Nomenclature of Medicine
SSN	Social Security Number
TNM	Primary <u>T</u> umor, Regional Lymph <u>N</u> odes, Distant <u>M</u> etastasis
VACCR	VA Central Cancer Registry
VISN	Veterans Integrated Service Network

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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

SPECIFIC FIELD OFFICE	FTP ADDRESS
Albany	ftp.fo-albany.med.va.gov
Hines	ftp.fo-hines.med.va.gov
SLC	ftp.fo-slc.med.va.gov

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:
```

Edit Set	Errors	Warnings

Veterans Administration	1	0

```
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.....: REGISTRAR,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 VACCR 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 VACCR 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:

Routines	Pre Patch 47	Post Patch 47	Patch List
ONCACD0	8382728	9880953	9,12,20,24,25,28,29,30,36,37,38,40,41,44,45,47
ONCACD1	8073960	9016349	9,12,14,18,20,22,24,25,26,28,29,31,36,37,41,43,47
ONCACDU2	12538189	12739597	12,18,20,21,22,24,26,27,29,30,31,32,34,36,37,38,39,41,46,47
ONCCS	7684551	7749965	40,43,44,47
ONCEDIT	12013927	16699994	27,28,34,36,39,42,43,45,46,47
ONCEDIT2	11672426	11530713	27,28,32,33,44,47
ONCGENED	NA	4456593	47
ONCMPH	NA	772333	47
ONCNTX	19634035	19933124	13,15,16,19,22,25,26,27,32,33,34,36,37,38,39,41,42,43,44,45,46,47
ONCOAI	10896931	10763845	6,15,17,18,19,25,26,27,28,29,32,33,34,35,43,45,47
ONCOAIF	7602999	10645913	11,15,16,24,25,26,27,28,37,45,47
ONCOAIP	15078512	15184481	1,5,6,7,11,13,15,16,18,19,22,24,27,28,32,33,34,35,36,37,38,39,40,42,43,44,45,47
ONCOCOM	14761911	15372855	1,6,11,12,13,14,16,17,19,25,36,42,43,44,46,47
ONCOCOS	8670469	3986872	5,13,16,17,19,22,24,36,42,45,47
ONCODEL	9424671	7815059	7,15,19,22,27,28,30,36,47

Routines	Pre Patch 47	Post Patch 47	Patch List
ONCODIS	946759	882328	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
ONCODSR	23965238	24760189	1,5,6,7,11,13,15,16,18,27,36,37,42,46,47
ONCODXD	6561673	6740826	11,13,15,16,18,36,47
ONCOEDC	3875977	5777440	6,7,13,27,36,41,47
ONCOEDC1	15238076	16162553	27,28,29,34,36,39,41,42,47
ONCOFDP	6495937	6508239	1,5,16,22,25,26,47
ONCOFTS	6012030	6719520	24,25,47
ONCOFUP	4419161	2001836	2,22,25,47
ONCOGEN	16080209	15339610	6,7,11,13,16,17,18,22,24,25,26,29,44,46,47
ONCOPA1	20988769	16672410	13,15,16,18,28,33,34,36,40,41,42,43,44,45,46,47
ONCOPA1A	13260368	19076404	15,19,27,33,34,36,40,44,45,46,47
ONCOPA3	14947350	15139652	13,15,18,25,26,33,34,36,37,44,45,46,47
ONCOPMA	9389256	9625788	6,25,44,46,47
ONCOPMB	8865602	9117815	11,23,25,44,46,47
ONCOPMP	2681596	2609181	13,23,25,39,46,47
ONCOTN	19577694	19437705	1,3,6,7,11,15,19,22,25,28,29,35,36,37,41,42,43,44,46,47
ONCOTNO	4502893	4606342	1,6,7,11,15,27,32,35,47
ONCOUTC	6496862	6615790	5,24,25,47
ONCPCI	6351712	7223627	9,12,20,24,25,28,29,30,36,37,38,40,41,44,45,47
ONCPRE47	NA	DELETE AFTER INSTALL	
ONCPSD	3087665	3435544	15,19,22,28,34,36,40,45,47
ONCPST47	NA	DELETE AFTER INSTALL	

Routines	Pre Patch 47	Post Patch 47	Patch List
ONCSAPI	13057	596751	40,47
ONCSAPI1	5176117	5389596	40,41,47
ONCSAPID	5312683	5614284	40,47
ONCSAPIE	6714259	7086861	40,47
ONCSAPIR	4007167	4606834	40,41,44,47
ONCSAPIT	7479426	8109981	40,41,47
ONCSAPIU	1723015	1899299	40,47
ONCSAPIV	2063954	2942747	40,47
ONCSAPIX	2404582	2434276	40,47
ONCSED01	NA	1819025	47
ONCSED02	NA	3526596	47
ONCSED03	NA	7657292	47
ONCSED04	NA	3995312	47
ONCSEDEM	NA	1310272	47
ONCSNACR	NA	1660021	47
ONCSYMP	6699972	6490797	43,47
ONCTIME	NA	2540166	47

Test Sites

Upstate New York HCS

Washington, DC

Houston, TX

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: ONCPSD	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
 - 8042/3 OAT CELL CARCINOMA
 - 8043/2 SMALL CELL CARCINOMA IN SITU, FUSIFORM CELL
 - 8043/3 SMALL CELL CARCINOMA, FUSIFORM CELL
 - 8044/2 SMALL CELL CARCINOMA IN SITU, INTERMED CELL
 - 8044/3 SMALL CELL CARCINOMA, INTERMEDIATE CELL
 - 8045/2 COMBINED SMALL CELL CARCINOMA IN SITU
 - 8045/3 COMBINED SMALL CELL CARCINOMA
- 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)
WS	Edit/print worksheet
FA	Print Due Follow-up/Admission List
TD	Print Due Follow-up List by 'Terminal Digit'
CI	Cross Tabs (ICDO-Site) - Total Registry
CR	Cross Tabs (User Selectable) - Total Registry
CT	Cross Tab Routines

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.

Code	Old code description	New code description
1	Positive	Abnormal
2	Negative	Within normal limits

CHEST XRAY	BRONCHOSCOPY	PET SCAN	SIGMOIDOSCOPY
CT SCAN	MEDIASTINOSCOPY	BARIUM ENEMA	CT ABDOMEN/PELVIS
			COLONOSCOPY

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