

Surveillance Action Group: National Staging Initiative

2009 Report: Collaborative Stage Baseline Assessment

**Standard Indicators for a Baseline Review as of
March 2009**

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1. Background

In June 2008 the Canadian Partnership Against Cancer launched the Facilitation of National Cancer Staging, designed to support the enhancement of cancer control information. The purpose of this initiative is to achieve national, population-based, electronic Collaborative Stage (CS) data – at a minimum for colorectal, breast, prostate and lung – no later than the 2010 coding year. The overall approach for this four year initiative is to focus on the development and implementation of electronic solutions for the capture of stage information in conjunction with established national standards. Proposals from provincial/territorial cancer registries (PTCRs) were received and reviewed by an external peer review panel whose recommendations included a baseline audit so that the progress of this initiative can be monitored over time. This recommendation was approved and adopted and accompanies the deliverables for 2008/09 funding.

The National Staging Secretariat acknowledges the contribution of this WG and CCO for providing the template for the baseline reporting.

2. Overview

2.1 Purpose

The Standard Indicators for a Baseline Review was intended to capture information to support the National Staging Initiative of the Canadian Partnership Against Cancer. The CS Baseline Assessment took a snapshot of the PTCR status at a given point in time (2007 data*) to measure improvement/advances with regard to staging (impacted by NSI project, PHAC training, CCR reporting responsibilities etc).

* 2008 data referenced if 2007 data not available

2.2. Participants in the Baseline Assessment Work Group

The Baseline Review Workgroup was comprised of provincial/territorial volunteers charged with defining an initial set of CS and pathology performance measures or indicators that could be calculated in a consistent manner and monitored over time for programs participating in the National Staging Initiative.

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2.3. Participating Provincial/Territorial Cancer Registries

Provincial/territorial cancer registries (PTCRs) received an invitation on February 17th to participate in the CS Baseline Review to measure the status of Collaborative Stage, pathology and secondary analysis of Canadian Cancer Registry (CCR) data elements; thereby meeting the objectives of the National Staging Initiative as a deliverable in the initial PT funding allocation (November 2008-March 2009).

NL: Susan Ryan

NS: Maureen MacIntyre, Stuart Frith

PE: Kim Vriends

NB: Suzanne Leonfellner, Stacey White

ON: Mary Bevan

MB: Gail Noonan, Donna Turner

SK: Heather Stuart, Leona Svensrud, Riaz Alvi, Jon Tonita, Karen Robb

AB: Carol Russell

BC: Sharon Tamaro, Karin Eyres, Cathy MacKay

2.3.1 Non participants

QC: Due to restructuring.

3. BASELINE ASSESSMENT REVIEW PROCESS

The CS Baseline Assessment focused on CS, which is driven by accurate topography and histology coding, therefore a secondary analysis of appropriate CCR data elements was conducted. In addition, areas specific to pathology that identified potential indicators were flagged for review. Based on the outcome, a more in-depth review of these data elements may be brought forward as recommendations for inclusion during future CS Quality Audits.

The survey was disseminated February 17, 2009 and returned March 31, 2009.

3.1. Current Use

The results of the CS Baseline Assessment will be used as a point in time baseline measure to track improvement/advances with regard to staging and measure the status of Collaborative Stage, pathology and secondary analysis of Canadian Cancer Registry (CCR) data elements.

What Q's can be answered now?

Results of the baseline assessment can be used to:

1. Assess the current and/or future workload within cancer registries and pathology departments
2. Capture new information within cancer registries
3. Establish a repository of information useful in research studies
4. Share information among stakeholders to realize economies of scale
5. Determine the need for improved electronic reporting systems

3.2 Future Use

The results of the baseline assessment (and CS Audit) will be used to develop CS recommendations and data quality indicators, and be compiled into a final report.

The CS Assessment will transition to a Progress Assessment that will track progress and identify potential areas of concern.

What Q's can be answered in the future?

A comprehensive data set can be used to:

1. Determine appropriate percent complete (e.g., 90%, 95%)
2. Improve quality care
3. Improve understanding of:
 - a. incidence and mortality data
 - b. patterns of care
 - c. patient outcomes
 - d. disease prognosis
4. Support clinical practice
5. Monitor trends
6. Establish standards and improve the quality of cancer care delivery
7. Identify opportunities for improvement and/or change
8. Support policy and decision makers

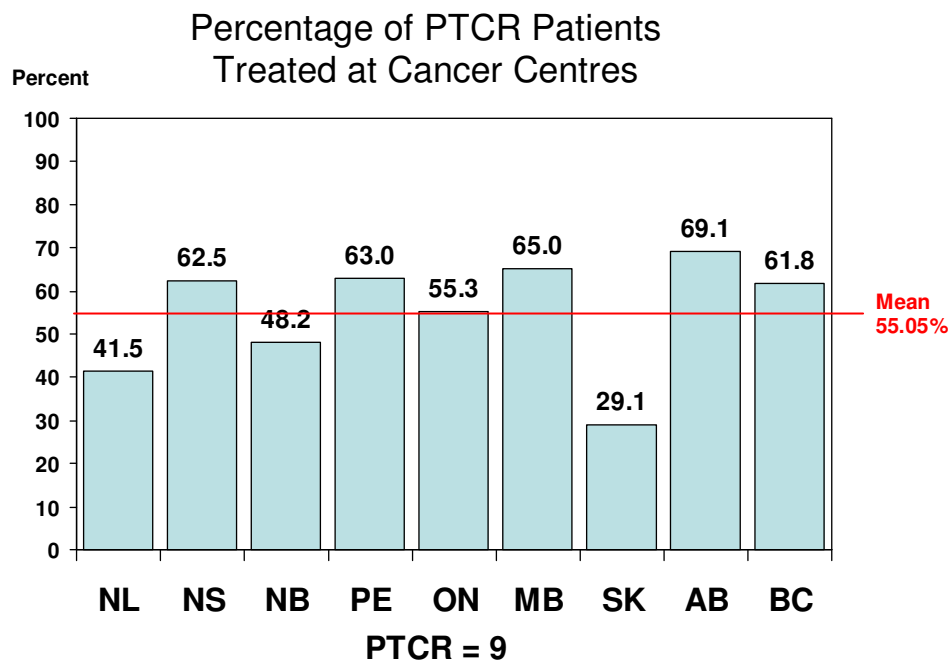
4. RESULTS OF THE BASELINE ASSESSMENT

4.1 Aggregate Findings

Currently there are considerable variations in the collection of staging information across Canada. Canada's thirteen PTCRs are represented as 10 (N=10) contract with CPAC as British Columbia reports for the Yukon, Alberta reports for the North West Territories and Ontario reports for Nunavut. For the purposes of this baseline assessment N=9 as Quebec was unable to participate.

4.2 Per indicator

Indicator 1. Proportion of patients diagnosed in 2007 and presenting to P/T cancer treatment centres (N=9)



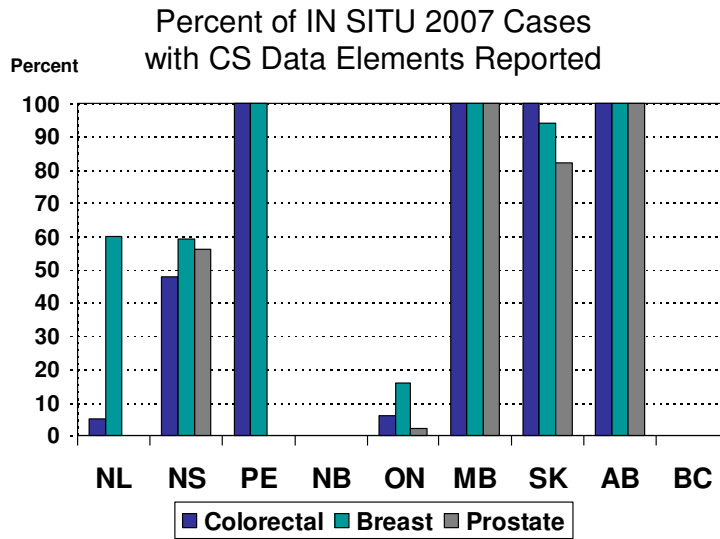
- Indicator #1 documents the proportion of patients presenting to a cancer agency with a reportable disease (as per CCR standard) mean rate is 55.05%.
- Cancer agencies provide cancer treatment services, particularly radiotherapy.
- Anatomic disease sites diagnosed and treated outside cancer treatment centres may provide unique challenges for CS data collection. However, some PTs are moving towards models for CS data collection in non-cancer centres.

Indicator 2. Access to patient information (N=9)

	Electronic	Manual	Other
Surgery	5	7	2
Pathology	6	7	2
Cytology	6	7	1
Radiology	5	6	1
Diagnostic Imaging	5	6	1
Surgery without histology	5	7	1
Clinical Information	5	7	1
Death certificates	4	4	1

- Indicator #2 documents the various formats PTCRs access patient information (physical /electronic access to charts/reports for: pathology, surgery, diagnostic imaging etc).
- Some PTCRs have hybrids of electronic access to some locations while others are more manual.
- Nova Scotia may have considered online access to medical records as not equivalent to electronic access and listed access as 'other'.
- Alberta did not report data in a way that distinguishes electronic from manual data.

Indicator 3. Does PTCR collect/submit in situ cases to CCR (N=9)

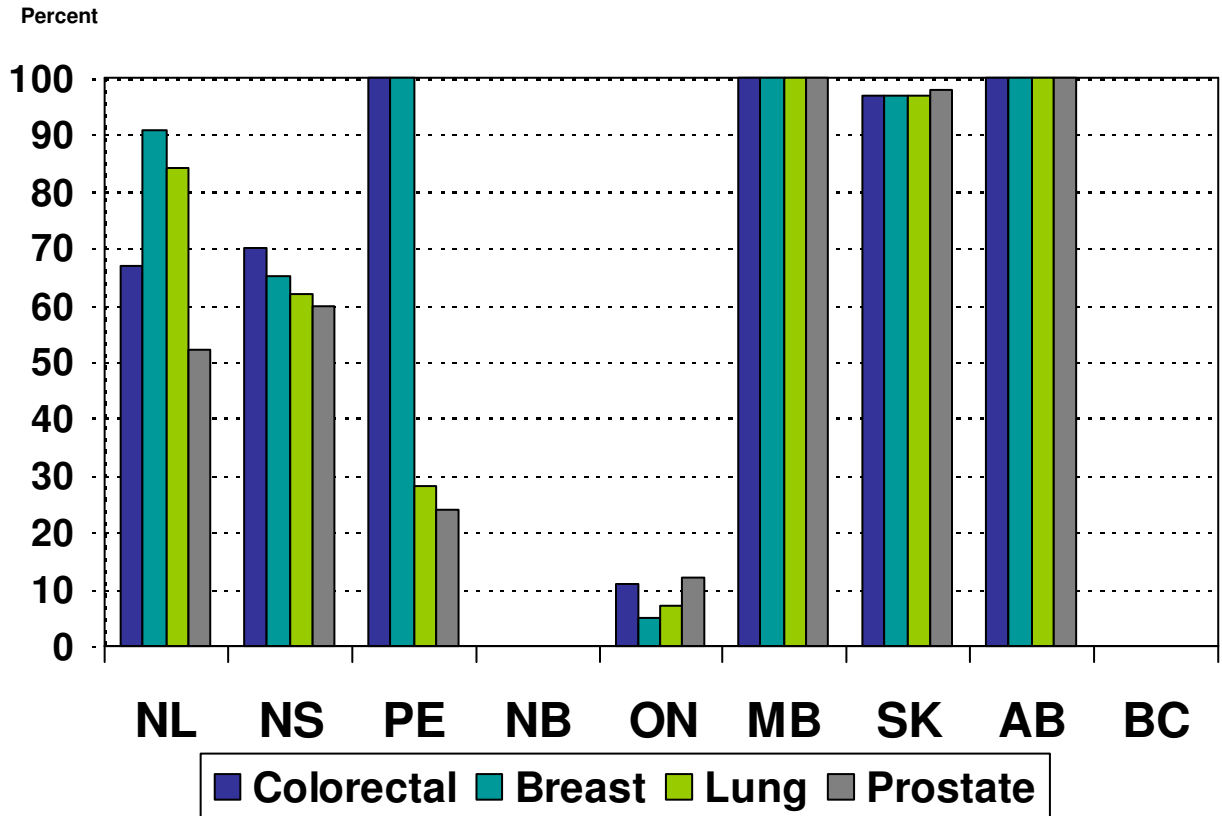


Collect 9 Submit to CCR 9

- Indicator #3 documents that all 9 PTCRs collect and submit in situ cases to the CCR.
- ON indicated that 1/2 collection is incomplete
- AB reported 2/2 (100%) of in situ lung cases with CS elements.

Indicator 4. Proportion of INVASIVE 2007 incident cancer cases with CS data elements completed (N=9)

Percent of INVASIVE 2007 Cases with CS Data Elements Reported



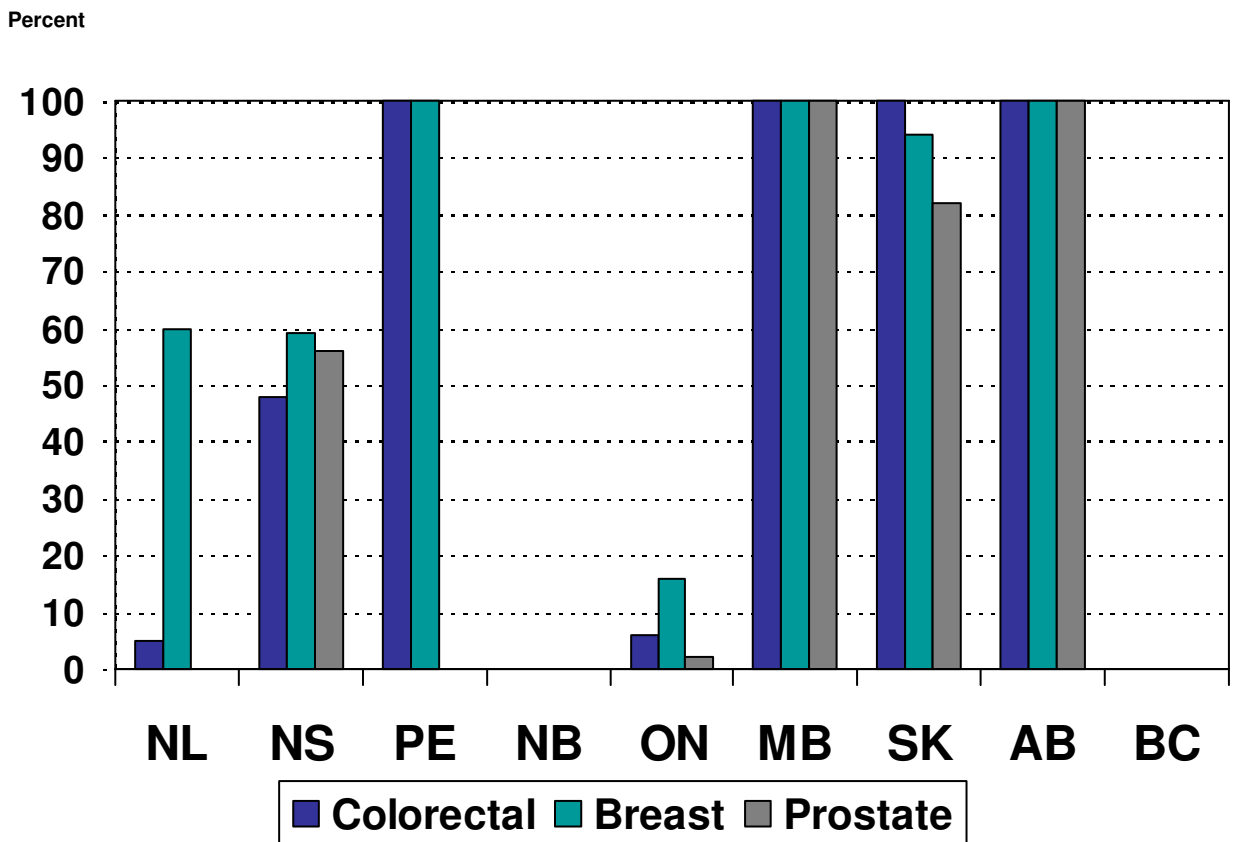
Note: NB and BC did not report CS data elements in 2007

- Indicator #4 documents the proportion of new invasive incident cases with CS data elements completed: Colorectal (C18., C19.9, and C20.9), Breast (C50.), Lung (C34.) and Prostate (C61.9).
- The description of stage (anatomical extent of disease at diagnosis) is one the most powerful predictors of survival. In 2004, the CS staging system was introduced (US and Canada) to reduce the duplication of effort and provide a common staging schema for registry use and from which the other major staging categories (AJCC TNM 6th) could be electronically derived.

- BC has not implemented CS collection at the provincial level; NB started in 2008.

Indicator 5. Proportion of IN SITU 2007 incident cancer cases with CS data elements completed (N=9)

Percent of IN SITU 2007 Cases with CS Data Elements Reported



Note: NB and BC did not report CS data elements in 2007. AB reported 2/2 (100%) of in situ lung cases with CS elements.

- Indicator #5 documents the proportion of new in situ incident cases with CS data elements completed: Colorectal (C18., C19.9, and C20.9), Breast (C50.), Lung (C34.) and Prostate (C61.9).
- The proportion of new cases of cancer diagnosed at a treatable early stage (in situ or localized) is important to evaluate the success of early detection programs such as screening programs.
- No PTCR reported any in situ lung cases.

- In situ prostate is not reportable to the CCR beginning with cases diagnosed in 2007
- BC has not implemented CS collection; NB started in 2008.
- ON submits in situ but it is incomplete

Indicator 6. Can PTCR run most recent CS computer algorithm (N=9)

No 2 Yes 7

- Indicator #6 documents the number of PTCRs that can run the CS algorithm at the PT level.
- The CS algorithm determines the derived TNM elements and stage group (and Summary stage). The classification or stage of each tumour is determined by the computer in a consistent and accurate manner. (CS Manual part 1)

Indicator 7A. Proportion of INVASIVE 2007 cases with pathologic TNM elements recorded

PT	NL	NB	ON	SK ('Best' stage)	AB (combined path + clin)	BC
pTNM Inv - Total	8%	27.40%	33%	72.85%	73%	24.6%
pTNM Inv - Colorectal	48%	53.80%	35%	97.75%	93%	48.1%
pTNM Inv - Breast	75%	70.20%	69%	99.71%	97%	85.7%
pTNM Inv - Lung	8%	0	24%	90.06%	95%	12.9%
pTNM Inv - Prostate	50%	16.9	19%	99.18%	94%	12.2%

Indicator 7B. Proportion of INVASIVE 2007 cases with clinical TNM elements recorded

PT	NL	NB	ON	BC
cTNM Inv - Total	7%	16.70%	37%	42.8%
cTNM Inv - Colorect	11%	15.40%	27%	35.2%
cTNM Inv - Breast	7%	10.10%	46%	85.7%
cTNM Inv - Lung	59%	0	48%	52.7%
cTNM Inv - Prostate	38%	30.90%	44%	51.6%

- Indicator #7 documents the proportion of invasive incident cases with a complete TNM and pathological or clinical stage group (AJCC/UICC)

reported: Total CS (C00.0-C80.9), Colorectal (C18._, C19.9, C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).

- The description of stage (anatomical extent of disease at diagnosis) is one the most powerful predictors of survival. The general rules of the TNM system have been incorporated into the general rules for CS.
- NS and PE collect CS data elements only. MB did not comment. AB included all cases in 'path' section. SK data is reported 'best' stage (a combination of pathologic data supplemented by clinical data where pathologic is not available).
- As CS increases within PTCRs, TNM reporting decreases.
- As of the 2010 CCR Call for Data, the CCR is no longer collecting AJCC TNM.

Indicator 8A. Proportion of IN SITU 2007 cases with pathologic TNM elements recorded

	PT	NL	NB	SK ('Best' stage)	AB	BC
pTNM IS - Total		2%	54.40%	55.54%	100%	15.1%
pTNM IS - Colorectal		0	100%	100%	100%	1.1%
pTNM IS - Breast		43%	100%	100%	100%	79.6%
pTNM IS - Prostate		0	0	63.64%	100%	0

Indicator 8B. Proportion of IN SITU 2007 cases with clinical TNM elements recorded

	PT	NL	NB	BC
cTNM IS - Total		1%	5.7%	17.4%
cTNM IS - Colorectal		0	0	1.1%
cTNM IS - Breast		16%	0	79.6%
cTNM IS - Lung		0	0	0
cTNM IS - Prostate		1%	0	3.8%

- Indicator #8 documents the proportion of in situ incident cases with a pathological or clinical stage group (AJCC/UICC) reported: Total CS (C00.0-C80.9), Colorectal (C18._, C19.9, and C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).
- The proportion of new cases of cancer diagnosed at a treatable early stage (in situ or localized) is important to evaluate the success of early detection programs such as screening programs.

- NS and PE collect CS data elements only. MB did not comment. ON could not estimate proportion staged because review of in situ cases was not complete. SK data is reported 'best' stage (a combination of pathologic data supplemented by clinical data where pathologic is not available).

Indicator 9. Number of pathology labs reporting to PTCR

PT	Public labs (Rep/Total)	Private labs (Rep/Total)	Status
NL	6/7	0/0	Voluntary
NS	9/9	0/0	Legislation
NB	8/8	0/0	Legislation
PE	1/1	0/0	Not stated
ON	87/87	6/6	Public: Legislation Private: voluntary
MB	3/3	4/4	Legislation
SK	9/9	0/0	Legislation
AB	7/7	4/4	Legislation
BC	NA	NA	NA (Not answered)

- Indicator #9 documents the number of pathology labs reporting to PTCRs.
- Pathology labs are most often the primary source of cancer incidence reporting for Provincial/Territorial Cancer Registries. It is becoming more apparent that access to the complete medical record is necessary to supplement this information.
- Timeliness, completeness and quality of data at the registry are often dependent on how and when information is transmitted by pathology laboratories.

Indicator 10. Format of pathology reports (N=9)

The proportion of pathology reports submitted manually to the PTCR. (e.g., paper, fax in narrative, synoptic-like or synoptic format)

Percent reporting electronic/manual

PT	# of Labs	% Electronic	% Manual	Manual-Paper
NL	6	100%	0%	
NS	9	0%	100%	
NB	8	0%	100%	
PE	1	95%	5%	
ON	93	90%	10%	
MB	7	0%	100%	Paper x 6 hosp Fax x 1 hosp
SK	9	41.9%	58.1%	
AB	11	##%	65.9%	Unable to estimate
BC				

- Indicator #10 documents the number of reporting labs and the percent by format of their pathology reports.
- The proportion of pathology reports that are submitted electronically to the PTCR meet the following criteria: Narrative, CAP content, Single text field data, Synoptic-like structured format, Electronic reporting tools using drop down menus, Standardized reporting language, Data elements stored in discrete data fields (completely paperless and direct data feed into the PTCR).

Format of reports

PT	Level I	Level II	Level III	Level IV	Comment
NL		2.3%	97.7%		
NS		85.1	15.0		
NB					6 hosps at Lv II, 2 hosps at Lv III
PE			100%		
ON		5.5%	75.2%	19.3%	
MB	95%		5%		
SK					Unable to estimate
AB	E-yes	E-yes	E-yes	E-yes	Manual: paper, fax
BC					

The proportion of pathology reports submitted manually to the PTCR. (e.g., paper, fax in narrative, synoptic-like or synoptic format)

Summary

- Format (Synoptic, electronic or manual) of pathology reports for colorectal, breast, lung and prostate (total combined) by pathology laboratory
- Electronic synoptic reports in discrete data field formats aligned to the CAP cancer checklist standard format provides a thorough and clear recording of pathology findings to ensure timely diagnosis, prognosis, and best treatment choices for the patient. (Source: CCO/Dr. Srigley)
- No information reported from BC.

Indicator 11. Uses of Stage Data (N=8)

	# PTCRs
Web Reports	1
Journal articles	1
Conferences	3
Abstracts	1
Presentations	5
Monographs	3
Annual reports	6
Other	3
Total	23

- Indicator # 11 documents the number of Reports or publications using stage information involving any of the four major cancers including: web reports, journal articles, conference abstract/presentations, monographs/annual reports and other.

4.3 Recommendations

1. Due to the evolving environment in Canada, on a go-forward basis the baseline assessment will transform to a progress assessment due March 31 of each year.
 - a. Based on results and feedback from participants the survey questions may be modified annually.
2. Expand to evaluate/trend pathology reports against the CAP cancer checklist content for:
 - a. Completeness- Proportion of pathology reports with core CAP content by 4 cancer sites by path lab.
 - b. Document format-narrative vs. synoptic like by pathology laboratory.
3. Promote the utilization of CS data; focus on improving data quality through use.
4. Identify results so PTCRs have the opportunity to share their experience with other PTCRs that are focused on like goals.

5 REFERENCES

Committee on Data and Quality Management (2009). *Collaborative Stage Status Update Survey*

Edge, S. B. (2009). Collaborative Staging Site-Specific Factors and Other New Data Items: Understanding Their Importance and Impact on Patient Care. NCRA: The Connection, pp16-17. Winter 2008-09.

The Standard Indicators for a Baseline Review February 10, 2009

Background: In June 2008 the Canadian Partnership Against Cancer launched the Facilitation of National Cancer Staging, designed to support the enhancement of cancer control information. The purpose of this initiative is to achieve national, population-based, electronic Collaborative Stage (CS) data – at a minimum for colorectal, breast, prostate and lung – no later than the 2010 coding year. Proposals from provincial/territorial cancer registries (PTCRs) were received and reviewed by an external peer review panel whose recommendations included a baseline audit so that progress against this initiative can be monitored over time. This recommendation was approved and adopted and accompanies the deliverables for 2008/09 funding.

This Baseline Review was created using a small working group (Appendix A) comprised of provincial/territorial volunteers charged with defining an initial set of CS and pathology performance measures or indicators that can be calculated in a consistent manner and monitored over time for programs participating in the National Staging Initiative.

Purpose: The Standard Indicators for a Baseline Review is intended to capture baseline indicators in support of the National Staging Initiative of the Canadian Partnership Against Cancer.

Due date: Complete and return an electronic copy to Elaine Hamlyn (elaine.hamlyn@partnershipagainstcancer.ca) on or before March 31, 2009.

Indicator #1:	Patients presenting to a provincial/territorial cancer treatment centre
Working Definition	Proportion of patients presenting to a cancer agency ^G
Working Numerator	Number of new incident cancer cases presenting to a cancer agency
Working Denominator	Provincial/territorial cancer incidence ^G volume
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007
Context	Presentation with a reportable disease (CCR standard). Explanatory variable. Agencies provide cancer treatment services, particularly radiotherapy.

*If actual numbers are unknown, please indicate if an estimate is used

^G Please refer to Appendix C: Glossary

Indicator #2:	Access to patient information
Working Definition	What kind of access to patient information does your registry have? (physical /electronic access to charts/reports for: pathology, surgery, diagnostic imaging etc)
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007

Indicator #3:	Collect/Submit in situ^G cases
Working Definition	Does your PTCR collect/submit in situ cases to the Canadian Cancer Registry (Y/N)
3A	Does your PTCR collect in situ cases? If no, skip Q3B, Q5 and Q8
3B	Does your PTCR submit in situ cases to the Canadian Cancer Registry (CCR)?
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007

Indicator #4:	Capture of invasive^G Collaborative Stage Data
Working Definition	Proportion of new invasive incident cases with CS data elements ^G completed: Total CS (C00.0-C80.9), Colorectal(C18._, C19.9, C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).
Working Numerator	Number of new invasive stageable ^G incident cases with CS completed - Total, and Colorectal, Breast, Lung, Prostate
Working Denominator	Total number of new invasive stageable incident cases
Analytic variables and levels	Report by province
Data Sources	Provincial Cancer Agencies
Reference Period	2007
Context	The description of stage (anatomical extent of disease at diagnosis) is one the most powerful predictors of survival. In 2004, the CS staging system was introduced (US and Canada) to reduce the duplication of effort and provide a common staging schema for registry use and from which the other major staging categories (^G AJCC TNM 6 th) could be electronically derived.

*If actual numbers are unknown, please indicate if an estimate is used

^G Glossary

Indicator #5:	Capture of in situ Collaborative Stage Data
Working Definition	Proportion of new in situ stageable incident cases with CS data elements completed: Total CS (C00.0-C80.9), Colorectal(C18._, C19.9, C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).
Working Numerator	Number of new in situ stageable incident cases with CS completed - Total, and Colorectal, Breast, Lung, Prostate
Working Denominator	Total number of new in situ stageable incident cases
Analytic variables and levels	Report by province
Data Sources	Provincial Cancer Agencies
Reference Period	2007
Context	The proportion of new cases of cancer diagnosed at a treatable early stage (in-situ or localized) is important to evaluate the success of early detection programs such as screening programs.

*If actual numbers are unknown, please indicate if an estimate is used

Indicator #6:	CS Algorithm^G
Working Definition	Can your PTCR run the most recent version ^G of the CS algorithm to determine derived ^G stage group? (Y/N)
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007
Context	When data abstraction is complete, the data abstractor activates the computer algorithm to derive the values for the items in the TNM system and Summary stage. The classification or stage of each tumour is actually determined by the computer in consistent and accurate manner. (CS Manual part 1)

Indicator #7:	Capture of invasive TNM Stage Data
Working Definition	Proportion of invasive incident cases with a complete TNM and pathological or clinical stage group (AJCC/UICC) reported: Total CS (C00.0-C80.9), Colorectal(C18._, C19.9, C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).
Working Numerator	Number of invasive stageable incident cases for which a valid stage value is available - Total, and Colorectal, Breast, Lung, Prostate
Working Denominator	Total number of invasive stageable incident cases - Total, and Colorectal, Breast, Lung, Prostate
Analytic variables and levels	Report by province
Data Sources	Provincial Cancer Agencies
Reference Period	2007
Context	The description of stage (anatomical extent of disease at diagnosis) is one the most powerful predictors of survival. The general rules of TNM system have been incorporated into the general rules for CS. This indicator is reported for those provinces that do not collect CS stage in indicator #3 or are collecting both TNM and CS.

*If actual numbers are unknown, please indicate if an estimate is used

Indicator #8:	Capture of in situ TNM Stage Data
Working Definition	Proportion of in situ incident cases with a pathological or clinical stage group (AJCC/UICC) reported: Total CS (C00.0-C80.9), Colorectal(C18._, C19.9, C20.9), Breast (C50._), Lung (C34._) and Prostate (C61.9).
Working Numerator	Number of in situ stageable incident cases for which a valid stage value is available - Total, and Colorectal, Breast, Lung, Prostate
Working Denominator	Total number of in situ stageable incident cases
Analytic variables and levels	Report by province
Data Sources	Provincial Cancer Agencies
Reference Period	2007
Context	The proportion of new cases of cancer diagnosed at a treatable early stage (in-situ or localized) is important to evaluate the success of early detection programs such as screening programs. This indicator is reported for those provinces that do not collect CS stage in indicator #4 or are collecting both TNM and CS.

*If actual numbers are unknown, please indicate if an estimate is used

Indicator #9:	Number of pathology laboratories reporting to the PTCRs
Working Definition	Number of pathology laboratories (public and private) within a province/territory
9A	Number of pathology laboratories within a province/territory <ul style="list-style-type: none"> - Private - Public
9B	Number of pathology laboratories that have a reporting relationship with the PTCRs. Please specify if this is legislated, contractual, voluntary etc. <ul style="list-style-type: none"> - Private - Public
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007 (year of diagnosis)
Context	Pathology labs are the primary source of cancer information for most Provincial/Territorial Cancer Registries. Timeliness, completeness and quality of data at the registry are often dependent on how and when information is transmitted by pathology laboratories.

*If actual numbers are unknown, please indicate if an estimate is used

Indicator # 10	Format of pathology reports by laboratory
Working Definition	Format (Synoptic, electronic or manual) of pathology reports for CRC, breast, lung and prostate (total combined) by pathology laboratory (Appendix B)
10A	Proportion of pathology reports that are submitted electronically to the PTCR that meet the following criteria: <ul style="list-style-type: none"> - Narrative, - CAP content, - Single text field data, - Synoptic-like structured format - Electronic reporting tools using drop down menus, - Standardized reporting language, - Data elements stored in discrete data fields^G (completely paperless and direct data feed into the PTCR)
Working Numerator	Number of electronic cancer pathology (CCO: resection) reports received by provincial cancer agency synoptically in discrete data field format
Working Denominator	Number of cancer pathology (CCO: resection) reports received by provincial cancer agency
10B	Proportion of pathology reports submitted manually to the PTCR. (e.g., paper, fax in narrative, synoptic-like or synoptic format)
Working Numerator	Number of manual pathology reports received by provincial cancer agency
Working Denominator	Number of cancer pathology reports received by provincial cancer agency
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	Current year (to provide current reflection of pathology)
Context	Electronic synoptic reports in discrete data field formats ^G aligned to the CAP cancer checklist standard format provides a thorough and clear recording of pathology findings to ensure timely diagnosis, prognosis, and best treatment choices for the patient. (Source: CCO/Dr. Srigley)

*If actual numbers are unknown, please indicate if an estimate is used

Indicator #11:	Stage data used in Publications/Reports
Working Definition	Number of publications using stage information involving any of the four major cancers.
Working Numerator	Number of Reports and Publications: Web reports, journal articles, conference abstract/presentations, monographs/annual reports and other.
Analytic variables and levels	Report by province/territory
Data Sources	Provincial/Territorial Cancer Agencies
Reference Period	2007
Context	An indicator to demonstrate the use of stage data in population health publications/reports.

*If actual numbers are unknown, please indicate if an estimate is used

Appendix A:

Baseline Indicator Workgroup:

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Appendix B: Examples of Narrative, Synoptic-Like and Synoptic Reports.

Note: a Synoptic-Like Report that contains the discrete data fields found in the synoptic report in the format of a tumour summary (for example) is considered a synoptic report.

Pathology Report Formats: Narrative, Synoptic-Like, and True Synoptic

Narrative Report

Narrative Report

Patient Name: Jane Doe Date of Birth: 141151 Age/Sex: 52F
 (DOB) Number: 000000 Location: LAB Status: RDS REF Health Card#: 000000000

DIAGNOSIS:
 MODIFIED RADICAL MASTECTOMY SPECIMEN (LEFT):
 - INVASIVE DUCTAL CARCINOMA (see microscopic)
 - METASTATIC DUCTAL CARCINOMA INVOLVING AXILLARY LYMPH NODE. (see microscopic)

GROSS DESCRIPTION:
 This modified radical mastectomy consists of an ellipse of skin measuring 13 cm ML x 7 cm SI with underlying fibrotic breast tissue measuring 18 cm ML x 8.5 cm SI x 4.5 cm AP. There is an axillary tail measuring 8 x 5 x 2 cm. A normal nipple and areola, the latter measuring 2.8 cm in diameter are present. On the upper outer aspect of the skin, there is a 2-cm healed transverse scar. The outer aspect of the specimen is painted with marking ink.

On sectioning the breast, there is a firm tan-gray tumour nodule measuring 3 x 2 x 1 cm, located in the left upper outer quadrant. The remainder of the breast consists of fatty tissue admixed with white streaks of breast atrophy. The tumour is 1 cm from the closest (deep) margin. Nine lymph nodes are identified in the axillary fat. They range from 0.5 to 1.2 cm in greatest dimension.

MICROSCOPIC DESCRIPTION:
 Sections of the breast reveal an infiltrating ductal carcinoma of usual type. There is moderate tubule formation (2/3) and the nuclei show moderate degree of pleomorphism. There are approximately 8 mitoses per 10 high power fields. The modified SBR is 2/3. A minor ductal carcinoma in situ is identified in the axillary tail. The modified SBR is 1/2. There is no evidence of in situ ductal carcinoma. The largest diameter of the tumour is 5 mm. No evidence of extramammary spread. One of 9 lymph nodes from the axillary fat contains metastatic ductal carcinoma. The largest diameter of the tumour is 5 mm. No evidence of extramammary spread.


True Synoptic Report

Specimen type	- left modified radical mastectomy
Tumour site	- left outer upper quadrant
Tumour size	- 3 x 2 x 1 cm
Histologic type	- ductal, NOS
Histologic grade	- 2/3 (modified SBR) - tubules - 2/3; - nuclei - 2/3; - mitoses - 2/3
Margins	- uninvolved by invasive carcinoma
Distance to closest margin	- 1 cm to deep margin
Number of nodes examined	- 9
Number of nodes involved	- 1

Synoptic-Like Report

GROSS DESCRIPTION: Modified radical mastectomy consists of an ellipse of skin measuring 13 ML x 7 cm SI with underlying fibrotic breast tissue measuring 18 cm ML x 8.5 cm SI x 4.5 cm AP. Axillary tail measures 8x5x3cm. Normal nipple and areola measuring 2.8 cm diameter. There is a 2 cm healed transverse scar on the upper outer aspect of skin. Outer aspect painted with marking ink. A firm tan-gray tumour nodule measuring 3 x 2 x 1 cm is located 1 cm from the closest (deep) margin in the upper left quadrant.

MICROSCOPIC DESCRIPTION:
 Invasive Tumour Size: 3 x 2 x 1 cm
 Type: infiltrating ductal carcinoma
 Grade: 2/3 (tubules - 2/3; nuclei - 2/3; mitoses - 2/3; 8 mitoses/10 HPF)
 Lymph nodes: 1/9 contains metastatic ductal carcinoma. Greatest diameter of tumour is 5 mm; no evidence of extramammary spread.



Source: Cancer Care Ontario

Appendix C: Glossary

AJCC TNM	The American Joint Committee on Cancer's staging system in an internationally standardized methodology to describe the anatomic extent of cancer at the time of initial diagnosis and before the application of definitive treatment by indicating tumour characteristics (T), lymph node involvement (N) and Metastasis (M) (Source: AJCC 6 th Ed)
Cancer agency	Agencies provide cancer treatment services, particularly radiotherapy. (Source: The Making of the Canadian Cancer Registry)
CCR	Canadian Cancer Registry
Collaborative stage (CS)	The Collaborative Staging System is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. The Collaborative Staging System is based on and compatible with terminology and staging in the sixth edition of the AJCC Cancer Staging Manual published in 2002. The general rules of the TNM system have been incorporated into the general rules for Collaborative Staging. (Source: CS Manual Part I)
Collaborative Stage Algorithm	A computer program that returns a set of values based on inputs entered by the cancer abstractor. The classification or stage of each tumour is actually determined by the computer in a consistent and accurate manner. This algorithm allows one to obtain both the American Joint Committee on Cancer (AJCC) stage and the SEER historic stage . The AJCC stage is used clinically, but its definitions change over time. The definitions of the SEER historic stages have remained constant over time (Source: CS Manual)
Collaborative Stage derived stage	Derived stage comes from the computer algorithm that classifies each case in multiple staging systems: the 6 th edition of AJCC TNM system, Summary Stage 1997(SS1977) and SEER Summary Stage 2000 (SS2000) (Source: CS Manual)
CS data elements	Collaborative Stage items collected by cancer registrars: <ul style="list-style-type: none"> - tumour size and extension - lymph nodes - metastasis - Evaluation fields which determine if the stage is clinical or pathologic - Site specific factors (Source: CS Quick Points)
cTNM	Clinical stage group. Based on evidence acquired before primary treatment, including but not limited to physical examination, imaging, endoscopy, biopsy and surgical exploration. Is assigned prior to any cancer-directed treatment and is not changed on the basis of subsequent information. Source: AJCC TNM 6 (Indicator 7, 8)
Discrete Synoptic Pathology Rate	The percentage of all coded pathological resection reports that are standardized against the CAP reporting standard for which Discrete Data Field format is available at the PTCR. (Source: CCO)
Electronic Synoptic	An electronic synoptic report in discrete data field format allows for the standardized collection (against the CAP cancer checklists), transmission,

report in Discrete Data Field Format (DDF)	storage, retrieval, and sharing of data between clinical information systems (Source: CAP. "An Overview of the College of American Pathologists Cancer Checklists." (January 2009). 2 Feb. 2009 < http://www.cap.org/apps/docs/committees/cancer/cancer_protocols/Overview_CAP_Cancer_Checklists_090115.pdf >.) (Indicator #9)
In situ cancer	Early cancer that is present only in the layer of cells in which it began (not invading the basement membrane) ICD-0 Behaviour code 2.
Incidence count	The number of new cases of a given cancer diagnosed during a given time period.
Invasive Cancer	Cancer that has spread beyond the layer of tissue in which it developed and is growing into surrounding, healthy tissues -- generally, the stage is either "localized", "regional", or "distant".
PTCR	Provincial/territorial cancer registry.
pTNM	Pathological stage group. Based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination. Source: AJCC TNM 6 (Indicator 7, 8)
Stage at Diagnosis	The stage that the cancer has progressed to at the time of diagnosis (SEER).
Stageable	Cases having site/histology combinations with defined staging procedures, based on the American Joint Committee on Cancer Staging Manual. (Source: CCO)
CS version	http://www.cancerstaging.org/cstage/csblastemailv01.04.01-03-25-08.pdf
Electronic access	
Manual access	Manual access to patient information - hard copy patient record

References:

Cancer Care Ontario

CPAC Action Group working on National Indicators

College of American Pathologists. CAP Cancer Protocols and Checklists (January 9, 2009). Retrieved February 10, 2009 from http://www.cap.org/apps/cap.portal?_nfpb=true&cntvwrPtl_t_actionOverride=%2Fportlets%2FcontentViewer%2Fshow&_windowLabel=cntvwrPtl_t&cntvwrPtl_t%7BactionForm.contentReference%7D=committees%2Fcancer%2Fcancer_protocols%2Fprotocols_index.html&_state=maximized&_pageLabel=cntvwr

Collaborative Staging Quick Points (n.d.) Retrieved February 10, 2009.

<http://www.cancerstaging.org/cstage/index.html>