



OCCR QUARTERLY



OKLAHOMA GETS THE GOLD

By Raffaella Espinoza, MPH

Once again the Oklahoma Central Cancer Registry (OCCR) achieved **GOLD** certification from the North American Association of Central Cancer Registries (NAACCR) for its annual data submission in November 2017. The OCCR submitted cancer data for 367,757 Oklahoma cancer cases diagnosed from 1997-2015 to the Centers for Disease Control and Prevention (CDC)-National Program of Cancer Registries (NPCR) and NAACCR.

Cancer registries that meet the **GOLD** standard for registry certification have achieved the highest NAACCR standard for complete, accurate, and timely data to calculate standard incidence statistics for the year reviewed. The following criteria for a single year of data (Dx year 2015) must be met to achieve **GOLD** certification:

- ◆ Case ascertainment has achieved 95% or higher completeness.
- ◆ A death certificate is the only source for identification of fewer than 3% of reported cancer cases.
- ◆ Less than 0.1% duplicate case reports are in the file.
- ◆ All data variables used to create incidence statistics by cancer type, sex, race, age, and county are 100% error free.
- ◆ Less than 2% of case reports in the file are missing meaningful information on age, sex, and county.
- ◆ The file is submitted to NAACCR for evaluation within 23 months the close of the diagnosis year under review.

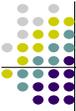
The OCCR also received a NPCR award which designated the registry as a “U.S. Cancer Statistics Registry for Surveillance.” This important work would not be possible without the hard work and dedication of Oklahoma cancer reporters. We wish to thank you for your valuable contribution to cancer control and prevention in Oklahoma.



September 2018

Inside this issue:

Best Wishes, Raffaella	2
Timely Reporting	2
On to the Next Chapter	3
Melanoma Surgery Coding	4
Facility Spotlight	5
PHI and OCCR	5
Coding Race and Spanish Origin	6-7
OCRA Fall Education Conference	7
Cancer Vaccine	8-9
New Cervical Cancer Screening Recommendations	10
NAACCR Webinar Schedule	10
Staff Directory	11
OCCR Job Posting	11



BEST WISHES, RAFFAELLA

By Susan Nagelhout, CTR

The OCCR is sad to announce that Raffaella Espinoza, Cancer Surveillance Coordinator for the Center for Health Statistics, has resigned her position effective September 14, 2018.

Raffaella graduated from Oklahoma University Health Science Center College of Public Health with an MPH in Epidemiology and a BA in Anthropology. Before coming to work at the OCCR, she worked for eight years at the New York City Department of Health and Mental Hygiene.

She began working for the OCCR in July 2015. During her tenure, the OCCR has achieved gold certification from NAACCR for its annual Call for Data for the last three submission years.



Raffaella has accepted the position of Analytics and Dissemination Administrative Program Manager with the Center for Health Statistics here at the Oklahoma State Department of Health. She will manage the Analytics and Dissemination Division ensuring high quality, timely, actionable information is disseminated to internal and external stakeholders. She will continue developing reports on Oklahoma cancer statistics, as well as meeting other data analytic needs of the agency.

Even though Raffaella will be greatly missed by the OCCR team, we send out best wishes for much success in her new position.

A truly great boss is hard to find, difficult to part with, and impossible to forget.

TIMELY REPORTING

By Susan Nagelhout, CTR

In September, the OCCR will be providing each facility with a Timeliness Report. The report details the number and percentage of the facility's cases that were submitted to the OCCR within 180 days of diagnosis for the last three complete years.

Oklahoma Administrative Code 310 establishes that "All hospitals, clinics, laboratories, pathologists, physicians or dentists, or all facilities providing diagnostic or treatment services in relation to cancer diseases or precancerous conditions, shall report all cancer within 180 days of diagnosis."

Facilities should adhere to the following guidelines for case submission:

- Report all cancer cases within 180 days of diagnosis, **even if all treatment at your facility has not been completed.** Report as much treatment information as possible and include any planned or incomplete treatment in the text.
- Do not report a cancer case before the 180-day deadline **IF** treatment at your facility has not been planned and/or started. [Specifically for Commission on Cancer (CoC) facilities reporting to National Cancer Data Base (NCDB) for Rapid Quality Reporting].
- Do not hold submission of a case to record information on treatment performed at an outside facility. Document in text the treatment being performed at outside facility.
- For Class of Case 32 ONLY, report the case within 180 days of first contact for treatment at your facility.

The OCCR will continue to monitor reporting timeliness as this ensures that all cancer cases for Oklahoma residents are included in state and national incidence counts.



ON TO THE NEXT CHAPTER

By Christina Panicker, MBA, CTR

Shortly after our last newsletter, Jessica Freeman was offered an opportunity that involved leaving the OCCR where she has been the Treatment Center Consultant and lead on Death Clearance for over six years. Colleague and fellow consultant, Christina Panicker, spoke with Jessica about her time with the OCCR.



Jessica Freeman, AA, CTR

Christina: What will you miss about working with the OCCR?

Jessica: I will miss being the last person to touch an abstract before it is sent off for data research and analysis. Since the central registry collects data from multiple facilities, a significant portion of my job was on consolidating information that came in on the same patient. I enjoyed combining the information from different facilities to produce a complete “story” that included everything from the time of diagnosis to treatment.

Christina: What will you miss about the OCCR team?

Jessica: My work family! Spending more time at the office than home, it was important for me to have coworkers that I enjoyed being around, could talk to about personal “life” things, while working together as a team. The OCCR team worked under seemingly impossible deadlines while encountering multiple obstacles but always stayed focused and positive. While working at the OCCR for over 6 years I went through some serious life changes. Everyone supported and encouraged me through it all. I will miss Raffaella’s kindness, Leslie’s protectiveness, Susan’s “ease” and mentoring, Christy’s ability to figure anything out, Kaela’s calming presence, Christina’s helpfulness, and Judy’s humor!

Christina: How has cancer registry changed your perspective?

Jessica: Working at the central registry allowed me to see the “big picture” of cancer data and how vital education and training of registrars in the state is. It also allowed me to see how budget cuts and appointment of resources affected the quality of data, not only at the state level, but also within the facilities.

Christina: How has it changed your perspective on healthcare?

Jessica: I never understood the importance of public health until working at the state registry. Since we were housed in the state health department, I was able to see how all of the different programs worked together and how important data was to each of them.

Christina: What are you doing now?

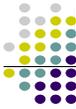
Jessica: I am working from home as a remote cancer registrar for Med Partners. Currently I am abstracting cases for a CoC-accredited facility in Seattle, Washington.

Christina: Do you have any thoughts to share with other registrars?

Jessica: The best way that I learned was by getting it wrong, so do not fear mistakes! I had several facility registrars apologize for “bugging me” or “asking dumb questions” when they called me. I would always tell them that it is my job to help them in any way I could and to call as many times as they wanted. The OCCR team is there to help you with your questions so if you are stuck or do not understand, just ask! Also, if you love abstracting and do not have your CTR credential, do what you can to get it. I went back to college while working at the OCCR and while it took me 5 years, I was able to get the required associates degree so that I could take the test. CTRs are rare; there are not very many and there is a HUGE demand for them! It’s a great career that offers tons of flexibility, continued learning, and most importantly, a positive and important contribution to humanity.

The OCCR wishes only the best to Jessica on this new adventure and appreciates her hard work and contributions to the registry. She will be missed.





MELANOMA SURGERY CODING

By Christy Dabbs, AA, CTR

Beginning in April of 2013 clarifications were made by the Commission on Cancer (CoC) through the CANSWER forum regarding when to code melanoma biopsies as SDSP 02 or Surgery 27. The determining factor is the MACROSCOPIC margin status.

When to code a biopsy as 02 Incisional Biopsy or 27 Excisional Biopsy

Surgical Diagnostic and Staging Procedure (SDSP)

- **02 Incisional Biopsy** of the primary site ONLY when stated in the biopsy procedure report AND the pathology report as GROSS POSITIVE MARGINS (seen with the naked eye). This is rarely ever stated thus code 02 is rarely used.
- **Surgery**
27 Excisional biopsy if only the peripheral or deep margins are involved as stated on the pathology report for the biopsy specimen.
- If the biopsy was performed at an outside facility and no information is available, assume the biopsy is excisional and use code 27.

The CANSWER Forum posts below were referenced in the 2016 NAACCR Webinar on Melanoma in the Q&A document and in the writing of this article. You must have a CANSWER forum account to view these posts. If you do not have one, accounts are free and one can be requested from the CoC at <http://cancerbulletin.facs.org/forums/>

Melanoma Bx Clear Margins: <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/surgical-diagnostic-and-staging-procedure/6099-melanoma-clear-margs>

Coding Shave Biopsy: <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/8595-how-is-shave-bx-to-be-coded>

Macroscopic Margin in both Op and Path Reports: <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/surgical-diagnostic-and-staging-procedure/59109-melanoma-confusion-with-dx-staging-procedure-vs-date-of-1st-surg-proc>

Melanoma biopsy with negative margins: <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/61441-melanoma-biopsy-with-negative-margins>

When to use surgery codes 30-33

- **Code 30:** When a wide local excision is performed for clear margins AND you do not know which type of biopsy was performed AND pathology reports the margins as 1cm or less or no residual melanoma.
- **Codes 31-33:** When a wide local excision is performed for clear margins AND the biopsy was shave (31), punch (32) or incisional (33) AND pathology reports the margins as 1cm or less or no residual melanoma.

When to use surgery codes 34-36

What is Mohs? A Mohs procedure is multiple excisions performed in stages, while the patient waits, until the margins are clear. This is done in one visit. Physicians who perform Mohs surgery are specially trained in three areas: 1) as the surgeon who removes the cancerous tissue, 2) as the pathologist who analyzes the lab specimens and 3) as the surgeon who closes or reconstructs the wound¹. Mohs surgery is most often performed on basal cell carcinoma and squamous cell carcinoma, both of which are not reportable to OCCR.

When to use surgery codes 45-47²

- **Code 45:** wide excision or reexcision of a lesion or minor (local) amputation with margins more than 1cm, NOS. **Margins MUST be microscopically negative.**
- **Code 46:** WITH margins more than 1cm and less than or equal to 2cm, as documented in the pathology report.
- **Code 47:** WITH margins greater than 2cm, as documented in the pathology report.

If the excision or reexcision has microscopically confirmed negative margins less than 1cm OR the margins are more than 1cm but are not microscopically confirmed; use the appropriate code, 20-36.

¹ Skin Cancer Foundation. (2018). Retrieved August 13, 2018, from <https://www.skincancer.org/skin-cancer-information/mohs-surgery>

² American College of Surgeons. (n.d.). Appendix B: Site-Specific Surgery Codes. In *FORDS 2016* (p. 403).



FACILITY SPOTLIGHT - Alliance Health Ponca City

By Leslie Dill

Alliance Health Ponca City (AHPC) is a 140-bed acute care hospital located in northern Oklahoma. A Joint Commission accredited facility with more than 40 active physicians, it provides inpatient and outpatient care.



Debra Edwards

This quarter, the OCCR shines its spotlight on the AHPC Cancer Registry, which was originally established in 1997. Debra Edwards is a full time inpatient coder for AHPC and the sole cancer reporter. She abstracts one day a week to report an average of 155 new cancer cases per year. Originally studying for a degree in nursing, Debra decided to switch gears and focus on tumor registry and inpatient coding at a hospital in Kansas. In 2015, Debra started inpatient coding for AHPC. In early 2017, registry supervisor, Cindy Lee, expanded Debra's responsibilities to include cancer registry reporting.

On a more personal note, Debra has been married for 31 years and has two grown sons. She has one five year old granddaughter and is anxiously awaiting the arrival of a grandson in December. Debra loves the summer months for camping, boating and fishing with her family. She claims, however, she is not very good at catching fish and is better at feeding them!

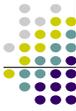
Debra has done an outstanding job of reporting for AHPC in a timely and accurate manner. The OCCR commends her on a job well done!

PATIENT HEALTH INFORMATION AND OCCR

By Kaela Howell, RHIA

The OCCR works closely with the health entities in the state in an effort to collect the most complete and accurate data possible. In this endeavor, protected health information (PHI) is often the topic of communication. The safety of this information is of high priority, not only to comply with the laws of HIPAA, but also to protect the rights of those whose information with which we are entrusted. The OCCR has multiple methods to securely communicate with outside resources regarding PHI. This can be through a phone call, a fax, an encrypted email through GlobalCerts™ and, if there is a large amount of information, you may receive notification that a file is available for download from WebPlus.

In the effort to minimize the risk of exposing PHI, the OCCR would like to communicate that information received through non-encrypted email is vulnerable to unauthorized access. Responses or inquiries containing PHI may be sent securely through any of the previously listed methods of OCCR communication, including postal service mail marked confidential. Please contact the Oklahoma Central Cancer Registry if you have any questions regarding the transmission of PHI.



CODING RACE AND SPANISH ORIGIN

By Susan Nagelhout, CTR

Recording *Race* and *Spanish/Hispanic Origin* in a cancer abstract is vitally important for research and cancer control activities. The codes allow for comparing stage at diagnosis and/or treatment by race.

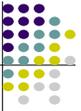
The OCCR requires cancer reporters to apply the coding instructions from the Standards for Oncology Registry Entry (STORE) Manual when coding *Race* and *Spanish/Hispanic Origin*. The STORE manual can be downloaded from here: https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoaan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Tips for Coding Race

1. All resources in the facility should be used to determine race. Resources include medical record, face sheet, and physician and nursing notes.
2. Code the race of the patient in fields *Race 1*, *Race 2*, *Race 3*, *Race 4* and *Race 5*. Code 88 (not applicable) for the remaining race fields (*Race 2* – *Race 5*) when at least one race, but fewer than five races, are reported.
3. When coding multiple races:
 - Code 07 takes priority over all other codes
 - Codes 02-32, 96-98 take priority over code 01
4. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white.
 - Code race as White (01) when there is a statement that the patient is Hispanic or Latino OR when the race on the face sheet is listed as Hispanic, and no further information is available. **DO NOT** code race as Other (98) in this situation.
5. If the race on the face sheet is Other or Unknown and the nationality of the patient is stated, refer to Appendix D of the SEER Program and Coding Manual 2015, “Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics” for assistance in determining race. (https://seer.cancer.gov/archive/manuals/2015/SPCSM_2015_AppendixD.pdf).
6. All race fields (*Race 2* – *Race 5*) must be coded 99 (unknown) when *Race 1* is coded 99.

Article continued on page 7



CODING RACE AND SPANISH ORIGIN

continued from page 6

Spanish/Hispanic Origin Table:

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specific Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name, but he/she cannot be assigned to any category of 1-5)
7	Spanish surname only (The only evidence of the person's Hispanic origin is the surname or maiden name, and there is no contrary evidence that the person is not Hispanic)
8	Dominican Republic
9	Unknown whether Spanish or not; no stated in patient record

Coding Tips for Spanish/Hispanic Origin

1. Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
2. Code 0 (non-Spanish, non-Hispanic) for Portuguese and Brazilian persons.

2018 OCRA FALL EDUCATIONAL WORKSHOP

By Leslie Dill

The Oklahoma Cancer Registrars Association (OCRA) will be holding the 2018 FALL EDUCATIONAL CONFERENCE at INTEGRIS Cancer Institute on October 25 – 26 in Oklahoma City. The first full day will feature Louanne Curcurrence, RHIT, CTR. Louanne's presentation will include AJCC 8th Edition, solid tumor rules and SSDI information for four major primary sites, plus AJCC Chapter 1 rules. With a cancer registry career spanning 20+ years, Louanne is a cancer registrar in Kansas City, MO and one of the "associates" of April Fritz and Associates.

The OCRA is offering a full conference package for both days and a one-day option. **The deadline for registration is October 5th.** Pending National Cancer Registrars Association (NCRA) approval, up to 10.5 continuing education hours will be awarded.

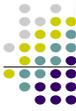


The conference registration form, hotel reservation information and a complete conference agenda, can be found on the OCRA website <http://ocra-ok.org/>.

For questions, please contact:

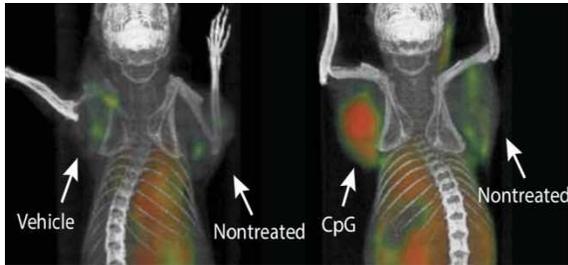
Anna McIntosh 405-773-6610, anna.mcintosh@integrisok.com
 Aleisha Williams 405-773-6609, aleisha.williams@integrisok.com
 Susan Nagelhout 405-271-9444 x57006, susann@health.ok.gov.





CANCER “VACCINE” CURED TUMOURS IN MICE

Article submitted by Judy Hanna, HT (ASCP), CTR and originally published February 2018 in the journal [Science Translational Medicine](#) by Michelle Starr.



An injectable "vaccine" delivered directly to tumours in mice has been found to eliminate all traces of those tumours, cancer researchers have found - and it works on many different kinds of cancers, including untreated metastases in the same animal.

Scientists at Stanford University School of Medicine have developed the potential treatment using two agents that boost the body's immune system, and a human clinical trial in lymphoma patients is currently underway.

"When we use these two agents together, we see the elimination of tumours all over the body," said senior researcher, oncologist Ronald Levy.

"This approach bypasses the need to identify tumour-specific immune targets and doesn't require wholesale activation of the immune system or customisation of a patient's immune cells."

Cancer immunotherapy is tricky. Because cancer cells are produced by the body, the immune system doesn't see them as a threat the same way it sees invaders like viruses.

That's why some cancer immunotherapy treatments focus on training the immune system to recognise cancer cells as a problem. It's an effective area of treatment, but one that often involves removing the patient's immune cells from their body, genetically engineering them to attack cancer, and injecting them back in – a process that is both expensive and time-consuming.

The Stanford vaccine could be much cheaper and easier.

It doesn't work like the vaccines you might be familiar with. Instead of a prophylactic administered prior to infection, the researchers gave it to mice that already had tumours, injecting directly into one of the affected sites.

"Our approach uses a one-time application of very small amounts of two agents to stimulate the immune cells only within the tumour itself," Levy said.

"In the mice, we saw amazing, body wide effects, including the elimination of tumours all over the animal."

The vaccine exploits a peculiarity of the immune system. As a tumour grows, the immune system's cells, including T cells, recognise the cancer cells' abnormal proteins and move in to take care of business.

But cancer cells can accumulate mutations to avoid destruction by the immune system, and suppress the T cells, which attack abnormal cells.

The new vaccine works by reactivating these T cells.

It combines two key agents. The first is a short piece of DNA called CpG oligonucleotide. This, together with other nearby immune cells, amplifies the expression of an activating receptor on T cells called OX40, which is a member of tumour necrosis factor receptor superfamily.

The second agent is an antibody that binds to OX40, activating the T cells to fight cancer cells.

These two agents are injected together in microgram amounts directly into the tumour. This means that they only activate T cells inside the tumour, ones that have already recognised cancer cells as a threat.

Article continued on page 9



CANCER “VACCINE” CURED TUMOURS IN MICE

continued from page 8

These cells get to work on the tumour, but some of the T cells then leave the site of the tumour to find and destroy other tumours in the body.

To test it, laboratory mice were transplanted with mouse lymphoma in two places, or genetically engineered to develop breast cancer.

Of the 90 mice with lymphoma, 87 were completely cured - the treatment was injected into one tumour, and both were destroyed. The remaining 3 had a recurrence of the lymphoma, which cleared up after a second treatment.

The treatment was also effective on the mice genetically engineered to develop breast cancer. Treating the first tumour often, but not always, prevented the recurrence of tumours, and increased the animals' lifespan, the researchers said.

The team then tested mice with both lymphoma and colon cancer, injecting only the lymphoma. The lymphoma was destroyed, but the colon cancer was not. This demonstrates that T cells in tumours are specific to that kind of tumour - so the treatment isn't without limitations.

But it does mean that immunotherapy is possible without genetically engineering cells outside the body; or, as is the case with a previous vaccine, extracting cancer RNA, treating it, injecting it into the body, and applying an electric charge to deliver it to immune cells.

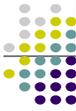
Its efficacy is about to be tested, though. The clinical trial currently underway is expected to recruit 15 patients with low-grade lymphoma to see if the treatment works on humans.

If it's effective, the treatment may be used in the future on tumours before they're surgically extracted to help prevent metastases, or even prevent recurrences of the cancer.

"I don't think there's a limit to the type of tumour we could potentially treat, as long as it has been infiltrated by the immune system," Levy said.



On Wednesday, August 15th, 2018, a very important email was sent to all cancer reporters from the OCCR Data Manager, Christy Dabbs. This email was regarding **critical 2018 reporting updates**. Please check your inbox and be certain that you received this. If you did not, contact Christy at ChristyD@health.ok.gov or 405-271-6225, ext. 57121.



NEW CERVICAL CANCER SCREENING RECOMMENDATIONS INCLUDE HUMAN PAPILLOMAVIRUS (HPV) TEST

By Raffaella Espinoza, MPH

On August 21st 2018, through the Journal of the American Medical Association, the US Preventive Services Task Force (USPSTF) released new guidelines for cervical cancer screening¹. Cervical cancer screening is aimed to identify high-grade precancerous cervical lesions to prevent the progression to cervical cancer, which is mostly caused by human papillomavirus (HPV). Early stage cervical cancer is usually treated with surgery (hysterectomy) or chemotherapy. After reviewing extensive evidence based research on the screening for cervical cancer, the USPSTF is confident that the new set of guidelines that include HPV tests will reduce potential overtreatment due to false positives, and more importantly, reduce cervical cancer incidence and mortality rates. According to a recent study, the HPV test can detect precancerous lesions earlier than the Pap smear².

Grade A screening recommendation for individuals with a cervix, regardless of sexual history or HPV vaccination status, includes:

- Women aged 21 to 29 should be screened with Pap smear every three years.
- Women aged 30-65, can be screened with either HPV test alone every five years, or pap smear test alone every three years, or combination (Pap smear and HPV test) every five years.
- Recommend no screening for women; younger than age 21, older than age 65, or who have had a hysterectomy with removal of cervix.

The recommendation provides an opportunity for wider spread of cervical cancer screening in Oklahoma where, according to the 2016 Oklahoma Behavioral Risk Factor Surveillance Survey, 21.2% of women aged 21 to 65 reported that they did not receive Pap smear screening in last 3 years³. While these recommendations include HPV tests conducted by a provider, at home HPV tests have been researched and may be a future possibility⁴.

1. US Preventive Services Task Force. "Screening for Cervical Cancer: US Preventive Service Task Force Recommendation Statement" JAMA. 2018; 320(7): 686-674
2. Van Niekerk, Dirk, et al. "Effect of Screening With Primary Cervical HPV Testing vs Cytology Testing on High-grade Cervical Intraepithelial Neoplasia at 48 Months: The HPV FOCAL Randomized Clinical Trial" JAMA. 2018; 320(1): 52-43
3. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Aug 21, 2018]. URL: <https://www.cdc.gov/brfss/brfssprevalence/>.
4. Y. Delere, et al. "Cervicovaginal self-sampling is a reliable method for determination of prevalence of human papillomavirus genotypes in women aged 20 to 30 years" J. Clin. Microbiol. 2011; 49: 3519-3522

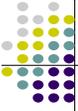
NAACCR WEBINAR SERIES

By Leslie Dill

The OCCR has purchased the 2018-2019 NAACCR Cancer Registry and Surveillance Webinar Series. These are FREE webinars available to all Oklahoma cancer reporters and will be hosted in two locations for your convenience: INTEGRIS Southwest Medical Center (Oklahoma City) and Cancer Treatment Centers of America (Tulsa).

You may register to attend the live webinars on the dates listed below, or you choose to listen to a recording on your own. Recordings are usually available the week following the live webinar. Whether you prefer the live webinar or listening to the recording later, registration is required by emailing SusanN@health.ok.gov.

- 10/4/18 - Collecting Cancer Data: Lung
- 11/1/18 - Collecting Cancer Data: Pharynx
- 12/6/18 - Collecting Cancer Data: Breast
- 1/10/19 - Collecting Cancer Data: Testis
- 2/7/19 - Collecting Cancer Data: Solid Tumor Rules
- 3/7/19 - Abstracting and Coding Boot Camp: Cancer Case Scenarios
- 4/4/19 - Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasms
- 5/2/19 - Collecting Cancer Data: Neuroendocrine Tumors
- 6/6/19 - Collecting Cancer Data: Ovary
- 7/11/19 - Hospital Cancer Registry Operations - Topic TBD
- 8/1/19 - Collecting Cancer Data: Colon
- 9/5/19 - Coding Pitfalls



Center for Health Statistics | OCCR
Oklahoma State Department of Health
1000 NE 10th Street, Oklahoma City, OK 73117-1299

Phone: 405-271-6225
Fax: 405-271-9061

Website: <http://occr.health.ok.gov>

OCCR Staff Directory 405 - 271 - 9444

Amber Sheikh, MPH, ext. 57111
Raffaella Espinoza, MPH, ext. 57103
Christina Panicker, MBA, CTR, ext. 57108
Christy Dabbs, AA, CTR, ext. 57121
Judy Hanna, HT (ASCP), CTR, ext. 57148
Kaela Howell, RHIA, ext. 57138
Leslie Dill, ext. 57120
Marva Dement, BBA, BS, CTR, ext. 57119
Susan Nagelhout, CTR, ext. 57006



Open the door to a future with OCCR.

We are now accepting applications for
Cancer Registry Consultant.
Click [here](#) for more information.

Filing Deadline 9/20/2018



Funding was made possible by the Centers for Disease Control and Prevention (CDC) and the National Program of Cancer Registries, grant number 1 NU58DP006285 - 01 - 00.

This publication was issued by the Oklahoma State Department of Health (OSDH), an equal opportunity employer and provider. A digital file has been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries in compliance with section 3 -114 of Title 65 of the Oklahoma Statutes and is available for download at www.documents.ok.gov | www.health.ok.gov | September 2018