

**SEER\*DMS Auto-Consolidation and Validation Work Group**  
**Meeting Summary**  
**January 10, 2023**  
**2:00 to 3:00 p.m. EST**

Representatives from the NCI, IMS, the Scientific Consulting Group, Inc. (SCG), and 12 cancer registries participated in the SEER\*DMS Auto-Consolidation and Validation Work Group (WG) call on January 10, 2023. Participants included:

**REGISTRIES:**

Idaho	<b>NCI:</b> Kathleen Loomis, Marina Matatova, Serban
Illinois	Negoita, Jennifer Ruhl
Iowa (Bobbi Matt, WG co-chair)	
Kentucky	<b>IMS:</b> Suzanne Adams, Linda Coyle, Fabian Depry,
Louisiana	Nicki Schussler, Jennifer Stevens
Massachusetts	
Minnesota	<b>SCG:</b> Carolyn Fisher, rapporteur
New Jersey	
New Mexico	
New York	
Seattle	
Utah	

**Action Items**

Participants agreed to the following action items:

- Registry representatives will review their data searches in #10354 on Sentinel Lymph Nodes (LNs) Positive and Examined Pairs auto-consolidation logic and provide input by late February 2023.
- IMS will revise and post the updated priority logic for prostate Site-Specific Data Items (SSDIs) for Number of Cores Positive and Examined and will develop SQL data searches. (Tech Report #11616)
- IMS will post the Gleason Score/Pattern/Grade and Tertiary logic to Squish, and generate SQL data searches. (Tech Report 11724).

**IMS Updates**

***Sentinel LNs Positive and Examined Pairs: Priority for Auto-Consolidation***

Suzanne noted that IMS recently added data searches (i.e., SQL code to examine actual cases) for Sentinel LNs Positive and Examined Pairs for breast and melanoma cases diagnosed in 2018 and beyond, all of which can be accessed in Squish issue #10354. She explained that current proposed auto-consolidation logic would create a manual review for conflicts in the number of nodes positive, but the higher values are selected for the number of nodes examined when there is a conflict, given there also is no conflict in the number of positives. The data searches assess known values (not codes of 95 or greater), and returns cases in which the number of Sentinel LNs positive or examined on the CTC was less than the number on the record, meaning a lower number was manually chosen for the CTC value over an available higher number. Registries should investigate why the lower value was chosen and if there is a problem with the proposed auto-consolidation logic. Because of the different information being assessed—scope, facility of the surgery, and regional LNs positive and examined—The logic for these fields has proven to be more complicated than originally anticipated because registries expressed they

wanted to take into account multiple fields, such as Scope of Regional Lymph Node Surgery, which facility performed the surgery, and Regional Lymph Nodes Positive and Examined . Over time, as the logic is used, IMS will have a better idea of what needs to be reviewed and what to automate. Registry representatives should review the data searches and provide feedback by the end of February 2023.

### ***Extent of Disease (EOD) Proposed Auto-Consolidation Logic: Liver***

Bobbi explained that she requested that Scope of Regional Lymph Node Surgery be added to the SQL. In reviewing the Iowa registry cases, she observed that the lower values were more accurate because the record's value was based on isolated tumor cells (ITCs) as recorded positive. Suzanne recommended grouping data based on Scope when performing these reviews. This approach will reveal a pattern that might explain why the lower value is being selected over the higher value. Using Scope also might help ensure that edits are not missed. More information can be accessed in Squish #10343.

### **Future Approaches to SSDIs**

With the completion of the logic for PSA Lab Value, the next step is to determine approaches for the remaining SSDIs. One suggestion was to keep with the laboratory values. The other option is to focus on primary sites. Bobbi asked which of these two options would be more beneficial, recognizing that there are pros and cons to both.

### ***Discussion***

The Seattle registry representative suggested grouping by site because it is easier to monitor and track your work. Marina confirmed that auto-consolidation of the remaining SSDIs by site is the consensus.

### **Prostate SSDIs Auto-Consolidation Logic**

Suzanne and Bobbi briefly reviewed the existing codes and presented the proposed logic.

### ***Number of Cores Positive and Examined (NAACCR # 3897 and 3898, Schema ID 00580)***

Similar to the Sentinel LN, for 2018 cases and beyond, the logic is to take both values from one record, with one exception. The SSDI manual instructs to code from the first biopsy not the second, even if the second has more cores positive.

If a conflict exists across facilities, then the proposed logic is to assess whether the Date of DX is more than 30 days ago or if the admission date is more than 6 months ago, then perform a manual review. IMS will incorporate Date of Diagnosis in the SQL. This information can be accessed in Squish #11616.

Participants discussed the options for a manual review of records: date of DX more than 30 days or admission date of more than 6 months ago.

The Iowa registry typically observes one primary of the prostate per lifetime. In some cases, active surveillance was performed for 1 to 2 years and then a prostatectomy was performed.

The Seattle registry prefers the proposed timing but noted that prostate biopsies in one facility are reviewed several months later in a slide review at another facility, resulting in admission date differences. For this reason, Seattle registrars would prefer to manually review these types of cases. Suzanne added a note to include a stipulation for manual review when the timing is outside of the windows noted earlier.

Suzanne reminded the WG of the known codes for Cores Positive/Examined (*SSDI Manual*) and outlined the following auto-consolidation priority codes for pairs.

#### *Discussion*

Participants discussed the priority order. Jennifer Ruhl clarified that it is possible to have suspected prostate cancer and have a negative result from a needle core biopsy, which could be due to the location of the needle. Although rare, the biopsy might not confirm prostate cancer when metastatic disease is identified via imaging.

The coding logic will be finalized and posted to a Squish issue for registries to provide feedback. IMS also will write SQL code for data searches.

#### ***Gleason Score/Pattern/Grade and Tertiary (NAACCR # 3838, 3840, Schema ID 00580)***

Suzanne explained that a Gleason Pattern is the two digit primary and secondary that is added to arrive at the Gleason Score, which is then used to determine the Grade code. If neoadjuvant therapy is given and there is a conflict, then a manual review will be performed. Jennifer clarified that neoadjuvant therapy is treated differently in pathological and clinical records.

#### *Gleason Score Clinical*

Registrars first evaluate all records (i.e., Gleason Pattern Clinical, Gleason Score Clinical, and Gleason Grade Clinical), identify those with the best Gleason Score Clinical, and implement the Score logic. If only one record is selected, all three fields are taken. For the second step, if more than one record is identified, the Gleason Pattern Clinical logic should be implemented to find the record that has the best Clinical Pattern value.

#### *Discussion*

The Seattle registry observed that it is possible to have the review of slides, which would take priority but could be a lower number. This suggests a need for manual review. Jennifer confirmed that if the consultation (or consult) review of slides differs from the original pathology board's report, the consult takes priority.

Participants were unable to confirm the actual percentage of cases having a review of slides. The Minnesota registry could potentially identify consult cases based on a pathology prefix they use.

Bobbi thought that the SQL data searches will provide insight into the differences in Gleason Score selections, which can be reviewed with the proposed logic. High percentages of lower values, likely from re-reads, will prompt a manual review. Participants agreed with this approach.

Bobbi and Jennifer confirmed that values 25 or 52 mapped to Grade unknowns and Jennifer recommended a manual review.

### *Gleason Score Pathological*

Suzanne noted that when the clinical grade is higher, the clinical grade code should be used for the pathological grade code.

### *Gleason Tertiary Pattern*

Lastly, Suzanne reviewed the Tertiary Pattern logic.

### *Discussion*

Bobbi asked whether the surgery codes would be included. Jennifer explained that the SSDI WG discussed not including surgical NOS codes in pathological and suggested that the system prompt a manual review.

Suzanne noted that IMS will post the coding logic and generate SQL data searches.

### **Upcoming SEER\*DMS Meetings**

The next Auto-Consolidation and Validation WG call is April 4, 2023.