

ACS Cancer Conference 2025

March 12-14 | Phoenix, AZ

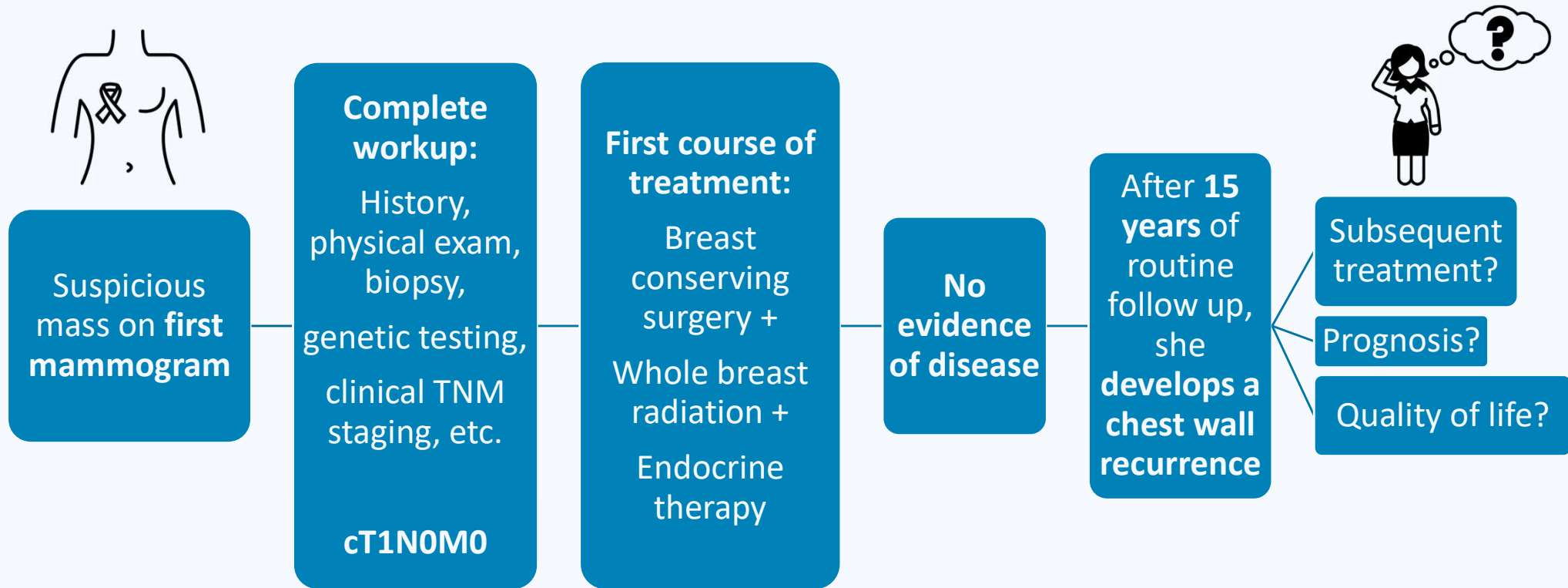
Defining the Landscape of Cancer Recurrence Data: Challenges and Opportunities

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Jane's Cancer Journey: 40 Year Old Female



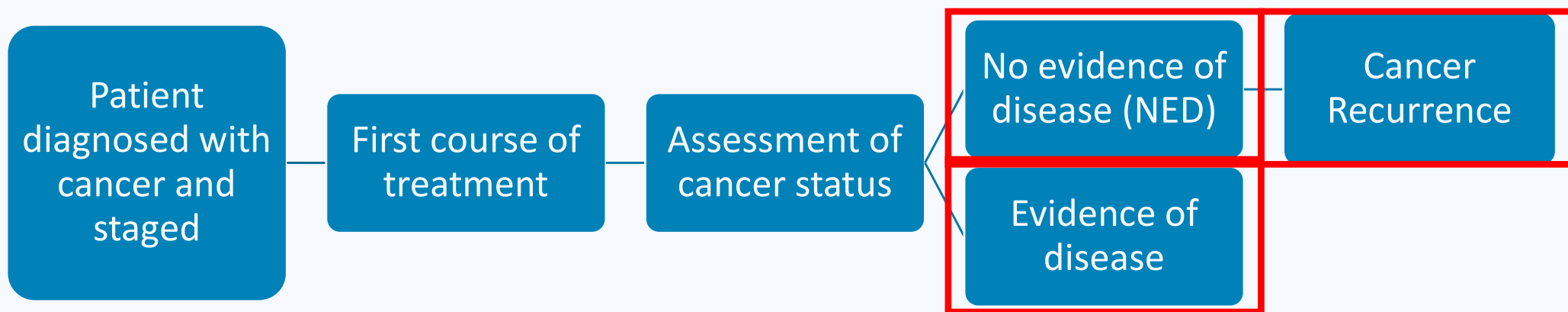
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Agenda

- Patient centric journey
 - From diagnosis to subsequent cancer status evaluation
- Current landscape of recurrence data
 - Overview of data elements
- Challenges identified through a cancer registry survey
- Opportunities and next steps

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From Diagnosis to First Cancer Status Evaluation



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Current Landscape: Overview of Data Elements

2025 Standards for Oncology Registry Entry (STORE) Definition for “Recurrence”

Recurrence Definition

Local recurrence: recurs in initial primary organ

Trocar recurrence: organ removed, recurs in scar tissue from removal

Regional recurrence: recurs in adjacent organ or lymph nodes draining the organ

Distant recurrence: recurs in a location beyond regional

Once the first recurrence has been recorded, do not update recurrence items further.

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There are 33 Codes for “Type of First Recurrence”

- Code 00: Patient became disease-free after treatment and has not had a recurrence
- Codes 04-62: Recurrence of known type
- Code 70: Never disease free
- Code 88: Recurrent disease with unknown type
- Code 99: Unknown if disease recurred or if patient was ever disease free

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STORE 2025

Type of First Recurrence

Code	Label
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence, and there is insufficient information available to code to 13–17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21–27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes (20–25) and local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence, to a site not listed in 46–62 or there is insufficient information available to code to 46–62.

46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes lymphoma, leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51–58) and local, trocar and/or regional recurrence (10–15, 20–25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51–59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

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Standards for Oncology Registry Entry (STORE). <https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-call-for-data/registry-manuals/>

Recurrence Data is Also Influenced by Abstracting Rules

Type of First Recurrence

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Check the *SEER Multiple Primary and Histology Coding Rules Manual* or the 2018 Solid Tumor Rules to determine which subsequent tumors should be coded as recurrences.

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Surveillance, Epidemiology, and End Results (SEER) Solid Tumor Rules

- Determine abstraction of a new primary cancer vs recurrence
- Site specific rules, predefined time limits
 - Range: 60 days for cutaneous melanoma to 5 years for breast cancer

Rule M7 Abstract **multiple primaries**ⁱⁱ when melanomas are diagnosed more than 60 days apart.
Example: An **invasive** melanoma that occurs **more than 60 days after** an **in situ** melanoma is a multiple primary.
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

- Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. The **ONLY exception** is when a **pathologist compares slides** from the subsequent tumor to the “original” tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician’s statement of “recurrence” or “recurrent”.

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Challenges to Data Collection Identified Through a Cancer Registry Staff Survey

Cancer Registry Staff Survey

- Sent to all CoC-accredited hospital cancer registries (N=1,445) in 2023
 - 565 responses (39.1%)
- Multiple choice and open-ended questions
- **Goal: Assess recurrence data abstraction processes and identify challenges to data abstraction**

Questions assessed:

1. Cancer recurrence follow up processes and challenges with abstraction
2. Recurrence definitions and abstracting practices

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Chan K, Palis BE, Cotler JH, et al. Quality of Cancer Recurrence Data in the National Cancer Database: A Reappraisal of Reporting Readiness. *Ann Surg Oncol*. 2025;32(3):1553-1564. doi:10.1245/s10434-024-16801-9

Inadequate Clinical Documentation is a Challenge

At your hospital, what are challenges to collecting recurrence data?

Recurrence is not well documented	251 (50.5)
“No evidence of disease” is not well documented	337 (67.8)
Insufficient resources	243 (48.9)
Insufficient education	113 (22.7)
There is no requirement	99 (19.9)
Insufficient administrative support	126 (25.4)

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Inadequate Physician Documentation

- “When...**MD does not specify NED, we as ODS's can only assign unknown for Cancer status and recurrence.** If there is an actual recurrence which falls within the guidelines, **we cannot capture the recurrence** because the patient was never "disease free" due to NO MD statement.”
- “No clear instructions from NCDB regarding "NED". Abstractors are still not able to enter "disease free" even when patients have completed treatments and on surveillance, but **MDs did not indicate "NED."** There have been **years of recurrence of poor quality info** that our facilities have not been using such data.”

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Abstracting Rules May Conflict with Clinical Documentation

Clinical Example:

A patient with Stage I pancreatic adenocarcinoma diagnosed in 2020, treated with a margin negative Whipple procedure and adjuvant therapy. **After 2 years of no evidence of disease, presents with a new lesion at the surgical bed.**

Please code the following case when there is a) surgeon documentation and b) pathology documentation:

- a. Cancer recurrence
- b. New primary

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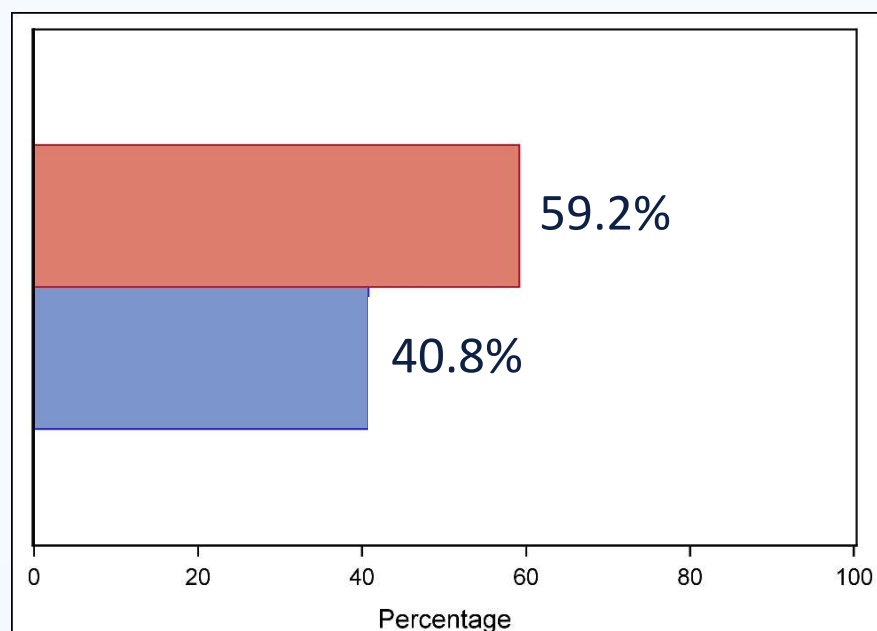
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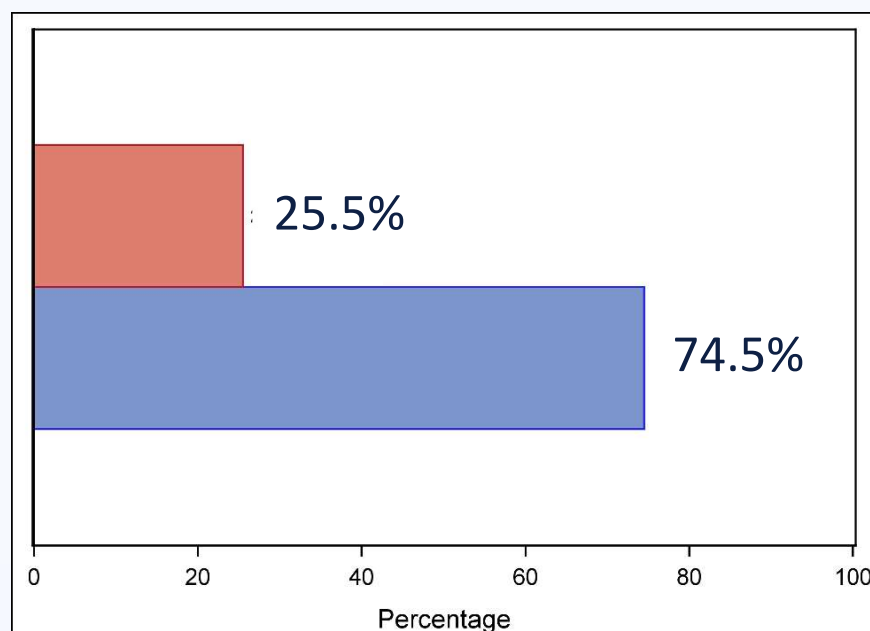
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Based on abstracting rules, is this a recurrence or new primary?

a. Surgeon documentation



b. Pathology documentation



■ Cancer recurrence ■ New primary

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Discrepancies with Abstracting Rules

- “I don't think we face other challenges other than **physicians not being aware of the rules the CTR has to go by**. We are **definitely not on the same page** in staging, rules, abstracting, etc. It's like we operate in two different rules w/different sets of standards.”
- “There is a **disconnect between the cancer surveillance rules for reporting new primaries and clinician awareness**.”
- “**The terminology that physicians use does not match up with the definitions of recurrence in Solid Tumor Rules**... Standard setters should look at how **revising the definition to match clinical practice**.”

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Key Challenges

- Multiple data elements and challenges in interpretation that may create heterogeneity in reporting
- Discrepancies between documentation and abstracting rules
 - Misalignment with clinical practice
- Inadequate physician documentation of cancer status
 - NED
 - Recurrence

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Opportunities and Next Steps

Opportunity #1: Standardize Definitions

Challenge #1: Multiple data elements and challenges in interpretation that may create heterogeneity in reporting

- Reviewing and refining definitions for cancer status:
 - No evidence of disease
 - Recurrence
 - Progression
- What is needed to assess cancer status?
 - Physical exams, imaging, labs, pathology, etc.
- Disease specific vs disease agnostic?
 - For example, a patient with multiple cancers

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Opportunity #2: Harmonize Documentation and Abstracting Rules

Challenge #2: Discrepancies Between Documentation and Abstracting Rules

- How can we align abstracting rules with clinical practice?
- Need for development of clinical best practices to determine new primary vs recurrence

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Opportunity #3: Improving Physician Documentation

Challenge #3: Inadequate Physician Documentation

- Implementation of synoptic reporting for cancer status
 - Increases documentation and abstraction of critical data elements
- Requirements for data collection
 - CoC-accreditation Standard

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Next Steps

- **AJCC Recurrence Working Group**
 - 23 partner organizations
 - American College of Surgeons Cancer Programs
- **Initial goals:**
 - Defining cancer status
 - Standardization of cancer status definitions
 - Explore recurrence or retreatment classification (rTNM)

/ Member Organizations

- [American Association of Pathologists' Assistants](#)
- [American Cancer Society](#)
- [American College of Physicians](#)
- [American College of Radiology](#)
- [American College of Surgeons](#)
- [American Head and Neck Society](#)
- [American Society for Radiation Oncology](#)
- [American Society of Clinical Oncology](#)
- [American Society of Colon and Rectal Surgeons](#)
- [American Urological Association](#)
- [Canadian Partnership Against Cancer](#)
- [Centers for Disease Control and Prevention](#)
- [College of American Pathologists](#)
- [International Collaboration on Cancer Reporting](#)
- [National Cancer Database](#)
- [National Cancer Institute](#)
- [National Cancer Registrars Association](#)
- [National Comprehensive Cancer Network](#)
- [North American Association of Central Cancer Registries](#)
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Thank you!