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| Analytic Flag\* |
| Value | Meaning | Conditions for Use |
| 0 | Non-reportable disease |  |
| 1 | Yes, Analytic | The patient’s case is seen at your RCC at diagnosis or during first course treatment, provided there has been no progression of the disease before the RCC registration date. In another words, they are still undergoing the first course of treatment and did not become sicker before entering the treatment offered by your RCC. N.B., be mindful that some cancers can progress so quickly that it is possible for a patient to become sicker while still be in the middle of first course treatment.  |
| 2 | No, Not Analytic /non-analytic | Any case that presents to your RCC as progression, relapse or metastases. A second opinion – a consultation at your RCC solicited by the diagnosing or treating hospital. |
| 9 | Unknown if Analytic or Not | There is not enough information to know whether the case is analytic or not within your medical records or in information sent by another institution upon the patient’s referral to your RCC. |
| (blank) | Not a legitimate value | Blank is an error and ≤ 5% are expected. If you are not sure, put in value 9.  |

Specific requirements surround Analytic Cases, i.e. CCO requires that AJCC stage be submitted for Analytic Cases (see “staging documentation”), and the RCC should be able to fill out the diagnosis date for its Analytic Cases.  If an Analytic Case does not have an AJCC staging scheme it is exempt from the staging requirement.

\*Note: when the disease first presents to the RCC, if it is analytic at that time, the analytic flag should not be changed if the patient returns for progression, relapse or recurrence of that same disease.  However, the flag may be changed in the original report if a mistake was made or unknown becomes known.

Here are examples of other scenarios where the analytic flag should be corrected.

* If a disease is discovered to be reportable after all, the flag should be changed from 0 or 9 to the appropriate value (either 1 or 2).
* If a case is initially thought to be analytic but is subsequently discovered to have been previously diagnosed elsewhere and treatment finished elsewhere, the flag should be changed from 1 to 2.  In this scenario, it also may be the case that the topography, histology, behaviour, and/or laterality and/or the diagnosis date might also need to be changed (the current presentation may be metastatic).

These examples are not exhaustive. Contact Informatics@cancercare.on.ca if unsure of the correct analytic flag setting in a particular case.

The due date for staging (**10 months after registration**) is a good time to check whether you need to change the value. If you want to get credit for your analytic cases, always make sure that you have set the value correctly. It is expected that the least used value will be 9, and that 9 will also be the value most often changed to either 1 or 2.

Please **note**, that this rule does not apply to reporting of hematopoietic or CNS tumours that transformed from either benign or boarder line to a malignant disease. Consequently, sites can continue to make corrections to the Analytic Flag passed the due date mentioned above.

## Caveat – the Risk of Sending Stage for Non-analytic Cases

CCO will not try to prevent RCCs from sending in stage for non-analytic cases, provided these cases can be identified. That means that the Analytic Flag field is set to 2, not analytic. However, we would like RCCs to understand that there is inherent risk in sending in data this way. The most obvious risk is that analysts (there are hundreds between CCO and organizations like ICES) will themselves neglect to fully understand the significance of the Analytic Flag field. This may happen regardless of how thoroughly Data Book documents the field. The field stage labels say “at diagnosis”. That this can be overruled by the contents of the Analytic Flag field is the difficulty.

The second risk is that not all of the non-analytic stage that is provided to CCO may actually be stage at presentation. There may be exceptions among the centres where the intent is really to give the diagnostic stage, even if the patient is presenting as a recurrence. It may well be the correct diagnostic stage, but again, over the whole province, we would not like to rest our data quality on that hope. Also, allowing stage for non-analytic cases make the denominator of analytic, stagable cases very fuzzy. The point of the analytic field is to keep the denominator and numerator of analytic cases in a non-ambiguous state.

The point of reviewing the Analytic Flag instructions with the RCCs is to help us all take advantage of this great opportunity to finally be speaking the same staging language. Our hope with AJCC 8th edition is that staging done at CCO and at the RCCs will together become a very valuable resource for every use.