Evaluating Gastric Cancer Misclassification: a Potential Explanation for the Rise in Cardia Cancer Incidence

Anna Mia Ekström, Lisa B. Signorello, Lars-Erik Hansson, Reinhold Bergström, Anders Lindgren, Olof Nygren

Background: Reports of dramatic increases in gastric cardia cancer incidence warrant concern. However, the recent introduction of a separate diagnostic code, the lack of a consensus definition of the cardia area, and the accelerating interest in cardia cancer may affect classification practices. Little is known about the magnitude of cardia cancer misclassification in large cancer registries.

Methods: In a well-defined Swedish population (1.3 million), we uniformly classified all patients with newly diagnosed gastric adenocarcinoma (from 1989 through 1994) with respect to gastric subsite, and we used this patient group as our gold standard. We then evaluated the completeness of the Swedish Cancer Registry in registering gastric adenocarcinomas against this gold standard and, further, assessed the completeness of cardia cancer registration and the rate of falsely included cases to estimate the potential impact on observed incidence trends.

Results: Our gold standard contained 1337 case subjects with gastric adenocarcinoma. Overall, the Swedish Cancer Registry was 98% complete with regard to gastric adenocarcinomas and had a 4% rate of falsely included cases. The completeness of coding cardia cancer was only 69%, and the positive predictive value for cardia cancer was 82%, with no improvement over time. Conclusions: Although overall completeness of gastric cancer registration by the Swedish Cancer Registry was excellent, accuracy in registering cardia tumors was surprisingly low. Our estimates suggest that true cardia cancer incidence could be up to 45% higher or 15% lower than that reported in the Cancer Registry. This margin of error could accommodate the observed increase in cardia cancer in Sweden. Therefore, secular trends in cardia cancer incidence should be interpreted cautiously. [J Natl Cancer Inst 1999;91:786–90]

In sharp contrast to the remarkable downward trend in distal gastric cancer incidence since the second world war (1–4), there have been several reports of increasing rates of adenocarcinoma in the gastric cardia with an annual increase of up to 4%–5% in the United States (2,5,6). Swedish Cancer Registry (hereafter the Cancer Registry) data indicated an annual 2.5% increase from 1970 through 1985 (7). Other register-based observations from Western Europe (8–10) and Australia (11) of absolute and relative increases in incidence have strengthened the suggestion that cardia cancer is epidemiologically distinct from distal gastric cancer.

Until the late 1980s, relatively little emphasis was put on the distinction between cardia and distal gastric cancer, because the possibly fundamental difference between these two cancer sites had not yet become evident. Cancer of the cardia was coded separately from other gastric cancers only after the 8th revision of the International Classification of Diseases (ICD-8). In the United States, a separate code was first introduced in 1973 (in the Surveillance, Epidemiology, and End Results Program1). England (1960), Sweden (1970), and Switzerland (1970) began to use a code for cardia cancer somewhat earlier. Most countries, however, did not start using a code for cardia cancer until the late 1970s (France and Scotland, 1975; Italy, 1976; and The Netherlands, 1978). To date, there is no consensus in the definition of the cardia area. Conse-
quent, misclassification of gastric cancer site may not be negligible.

Before designating the gastric cardia as a cancer site of rapidly increasing incidence, it is crucial to address whether the observed increase can be explained by a shift in classification. The increased focus on cardia cancer in the literature could conceivably result both in a greater completeness of registration and in a higher rate of falsely included patients. To our knowledge, there is no published information about the magnitude of misclassification of cardia cancer in the high-quality cancer registers, which are the sources of the recent alarming reports. In the absence of a concurrent gold standard registration, retrospective analyses are uninformative.

We have explored the possibility that misclassification was a major cause of the reported increase in incidence of cardia cancer by taking advantage of the comprehensive organization for the rapid ascertainment of records of gastric cancer cases. This organization was created for a population-based case-control study in Sweden over the 6-year period from 1989 through 1994 (12). Our meticulous search for new cases of cardia cancer resulted in the identification of case subjects who were uniformly characterized with regard to cancer site. These patients then were used as our gold standard against which gastric cancer registration in the same well-defined population was validated.

**Subjects and Methods**

**Ascertainment of Case Subjects With Gastric Cancer**

We identified all patients with newly diagnosed gastric cancer occurring in five counties (two northern high-risk counties and three southern average-risk counties; total population = 1.3 million) from 1989 through 1994 from the following sources: 1) contact persons at all hospitals in the study area during the entire period under study, 2) continuous surveillance of all patients with definite or suspected gastric cancer whose specimens were evaluated by the pathology departments of the hospitals in the study, and 3) monthly double checks with the regional cancer registries. For several years after the end of the study, we used update reports from the regional cancer registries to acquire data on any case subject missed because of long delays in reporting. We obtained clinical data prospectively through special reports completed by clinicians that included tumor stage and the tumor’s location that was precisely drawn on a specially designed form. Furthermore, we scrutinized all hospital case reports (including pathology reports), and an experienced pathologist (A. Lindgren) re-evaluated all available histologic slides (95%) without reference to the initial report. From all the data collected, we classified each case subject with regard to cancer status (gastric cancer, yes or no) and site (cardia, noncardia, and site unspecified). Cancer of the gastric cardia was defined as an adenocarcinomatous lesion with its center located within 1 cm proximal and 2 cm distal of the esophagogastric junction (13). We did not consider the possible presence of a short-segment Barrett’s metaplasia (14) when classifying sites because the Cancer Registry does not take this into account when classifying tumors and because the importance of this histologic abnormality was not widely accepted by clinicians when the patients were reported to the Cancer Registry.

We restricted all analyses to patients with incident gastric adenocarcinoma (the histologic type of 98% of all gastric cancer) (15) that became clinically overt before death. Thus, patients with cancer diagnosed incidentally at autopsy were not included. For 5% of all the patients with incident cancer, we could not establish tumor type (histologic material was not available) and so made our best assumption—based on all data available—about gastric cancer status (yes or no). Reliable classification of gastric site was impossible for 6% of all the patients with incident cancers; thus, for this group, we made no assumptions regarding subsite.

**Swedish Cancer Registry**

Nationwide cancer registration began in Sweden in 1958. Clinicians, pathologists, and cytologists must, by law, report all newly diagnosed cancers to regional cancer registers, which in turn report to the national Cancer Registry. Thus, for the majority of patients, the Cancer Registry receives double notifications. Cancers identified through death certificates alone are not included in the Cancer Registry. The vast majority of gastric cancer diagnoses in the Cancer Registry are histologically well substantiated; overall, 99% of all gastric tumors in males and 98% of all gastric tumors in females are histologically verified. The Cancer Registry used a modified version of the ICD-7 throughout the study period that specified the various gastric sites by the following codes: corpus and distal stomach, 151.0; cardia, 151.1; multiple sites, 151.8; and site unspecified, 151.9.

**Evaluation of Swedish Cancer Registry Completeness and Cardia Classification**

First, the Cancer Registry was evaluated with respect to completeness of overall gastric adenocarcinoma registration in the studied counties. Initially, we searched the Cancer Registry for all records of patients who were living in the study area and who were registered with a diagnosis of gastric cancer (ICD-7 code 151). We then excluded patients who were registered with nonadenocarcinoma and those who were diagnosed incidentally at autopsy. A file with our prospectively collected case subjects was then linked to the Cancer Registry by using the national registration numbers as individual identifiers (16). We considered missed patients in the Cancer Registry to be patients in our gold standard dataset who did not match any record in the Cancer Registry.

We calculated completeness of the Cancer Registry as the number of patients with true gastric adenocarcinoma recorded in the Cancer Registry divided by the total number of case subjects with adenocarcinoma ascertained through our prospective registration (our gold standard). This total included seven patients registered in the Cancer Registry whom we did not know about initially but accepted after re-evaluation of their cancer diagnoses. Falsely included case subjects were those with nongastric tumors erroneously registered as gastric cancers by the Cancer Registry. The denominator in the rate of false inclusions was the total number of patients with gastric adenocarcinoma recorded in the Cancer Registry.

Second, to analyze the completeness and rate of falsely included case subjects in the Cancer Registry’s classification of cardia cancer, we restricted this analysis to case subjects for whom we had adequate data on the site of the tumor. In these analyses, the completeness of the Cancer Registry was defined as the proportion of patients with cardia cancer in the gold standard registration who were correctly recorded as cardia case subjects in the Cancer Registry. Falsely included patients were patients with noncardia tumors whose tumors were erroneously registered as cardia cancers in the Cancer Registry. The denominator in the rate of falsely included patients was the total number of patients with gastric cardia cancer recorded in the Cancer Registry. The positive predictive value of a diagnosis of cardia cancer in the Cancer Registry (the probability that in the Cancer Registry a patient recorded as having cardia cancer truly had such a cancer) was calculated as the number of patients with true cardia cancer in the Cancer Registry (as determined by the gold standard) divided by the number of all patients with a cardia cancer code in the Cancer Registry.

**Results**

**Completeness of Gastric Cancer Registration in the National Swedish Cancer Registry**

The Cancer Registry recorded 1388 patients with gastric cancer that occurred in the five counties studied during the period under study. Of these cancers, 22 (2%) were gastric cancer tumors but not adenocarcinomas (16 carcinoids or endocrine tumors and six other tumors). The degree of mismatch between the Cancer Registry and the gold standard incidence of gastric adenocarcinoma is shown in the Venn diagram in Fig. 1. In total, 59 patients (4%) were falsely included as having incident gastric cancer (33 esophageal tumors, four other nongastric tumors, 20 nonmalignant lesions in the stomach, one recurring cancer, and one gastric tumor found first at autopsy). After these exclusions, 1307 patients with true gastric adenocarcinoma were recorded in the Cancer Registry. Our gold standard registration identified 1337 patients with adenocarcinoma. Thus, the completeness of the Cancer Registry with respect to gastric adenocarcinoma was 1307 (98%) of 1337 patients. The positive predictive value of a gastric adenocarcinoma diag-
Misclassification of Cardia Cancer in the National Swedish Cancer Registry

The agreement between Cancer Registry data regarding the incidence of cardia cancer and our gold standard data is shown in the Venn diagram in Fig. 2. A total of 150 patients with gastric cardia cancer were recorded in the Cancer Registry and 178 patients were recorded in the gold standard registration. Of the former 150 patients, at least 23 (15%) were falsely included as cardia cancers (all had distal gastric cancer); four more patients had tumors that could not be classified by site using the gold standard and so may also have been falsely included. Thus, the number of patients with true cardia cancer recorded in the Cancer Registry was 123. Hence, the completeness of the Cancer Registry with respect to cancer of the gastric cardia was 123 (69%) of 178 patients. Of the 55 patients with cardia cancer missed by the Cancer Registry, 28 patients had had their tumors classified as ICD-7 code 151.9 (site unspecified) and 18 cancers had been classified as ICD-7 code 151.0 (corpus and distal stomach). The remaining nine patients were among those completely unknown to the Cancer Registry. The positive predictive value of a diagnosis of cardia cancer in the Cancer Registry was 123 (82%) of 150 patients.

Misclassification due to inclusion of patients with false cardia cancer was slightly more common in men; 78% of the case subjects falsely included as having cardia cancer were males and 75% of the true cardia cancer patients were males. The rates of missed case subjects were 28% and 41% among men and women, respectively. The falsely included patients were older than the patients with true cardia cancer; mean (95% CI) ages were 75.7 years (95% CI = 71.7–79.7) versus 67.7 years (95% CI = 65.9–69.5). The mean age among the missed case subjects was 68.6 years (95% CI = 64.9–72.2). There was no improvement in the rate of false inclusions over time. The tendency was rather the opposite; a 10% (seven of 71 patients) false inclusion rate during the first half of the study increased to 20% (16 of 79 patients) in the second half of the study.
The completeness, on the other hand, went up. The rate of missed patients decreased from 36% (34 of 95 patients) during the first part of the study (from 1989 through 1991) to 25% (21 of 83 patients) during the second part (from 1992 through 1994).

**DISCUSSION**

The Cancer Registry’s completeness (98%) and positive predictive value (96%) for gastric adenocarcinoma registration overall from 1989 through 1994 should be considered satisfactory; however, the rate of misclassification of the location within the stomach was substantial. When we used the rather conservative criteria for cancer of the gastric cardia [13] in the gold standard registration, we found that no more than 69% of these cancers were recorded in the Cancer Registry as being of cardia origin (ICD-7 code 151.1). Almost one third of the true cardia tumors were reported to emanate from the corpus/fundus (ICD-7 code 151.0) or to be gastric tumors without further specifying the location (ICD-7 code 151.9). Moreover, at least 15% of the patients diagnosed with cardia cancer in the Cancer Registry did not, in fact, fulfill our topographic criteria. The deficit due to misclassification of cardia cancers as noncardia cancers was nearly balanced by a false inclusion of noncardia tumors, and consequently the reported incidence of cardia cancer in the Cancer Registry was approximately the true incidence. Our data, however, clearly demonstrate that misclassification creates a range of uncertainty around the incidence figures that needs to be taken into account when interpreting the reports of dramatically rising incidence rates.

According to our estimations of the rates of false inclusions and missed patients, the true incidence could be as much as 45% [I_{obs}(1/complete)] higher or 15% [I_{obs} - I_{obs}(false inclusion rate)] lower than the rates reported by the Cancer Registry. In the absence of concurrent stringent gold standard data for periods other than the period under study, we are unable to draw any firm conclusions with regard to secular trends in rates of misclassification. Because a separate ICD code for cardia cancer was introduced in 1970, the failure to use this code assumingly resulted in a high rate of missed patients in the Cancer Registry. More recently, however, a growing awareness of the specifics of cardia cancer may instead have led to increasing rates of false inclusions.

As an example of the potential effects of the misclassification, we applied the levels of misclassification observed in our study to the data on secular trends in the incidence of cardia cancer in Sweden published by Hansson et al. [7]. According to that study, for men, the incidence of cancer of the gastric cardia increased from 1.9 to 3.0 cancers per 10^5 person-years (person-years = the total observed number of years added over subjects at risk) between the first period from 1970 through 1973 and the second period from 1982 through 1985. With the extreme assumption that the rates of missed patients and falsely included patients in the early period were 31% (our observed rate) and 0%, respectively, versus 0% and 15% (our observed rate of falsely included patients) in the latter period, the first incidence rate could have been as high as 2.8 [1.9 x (1/0.69)] per 10^5 person-years, and the second incidence could have been as low as 2.6 [3.0 – (3.0 x 0.15)] per 10^5 person-years. Thus, the entire increase in incidence could theoretically be explained by misclassification, particularly because the rate of missed patients in the early 1970s may have been greater than that observed from 1989 through 1994.

Our concern over the possibility of spuriously inflated secular trends due to misclassification is supported by a separate analysis of time trends of gastric cancer during the same study period. In this analysis, with meticulous case ascertainment and uniform classification of tumor site, we found no signs of a trend in incidence for cardia cancer during the 6 years of observation (unpublished results).

The misclassification observed in our study could not explain the greater than threefold increases in incidence reported from other countries [5,8]. However, because the Cancer Registry compares well with most other national registers, because the prerequisites for implementation of uniform diagnostic coding may have been particularly favorable in Sweden with its centralized health care system and relatively small medical community, and because the ongoing case–control study may have stimulated more stringent coding, our data may be a conservative estimate of misclassification in other countries.

Although our criteria for cancer of the gastric cardia are widely used, there is no worldwide consensus of what characteristics should be used to define this diagnostic category. Clearly, our criteria are conservative. If we had used more liberal criteria and classified gastric tumors with their center within 2 or 3 cm of the gastroesophageal junction, the completeness of the registration in the Cancer Registry would have been even lower (as would the rate of false inclusions). Thus, the problem of misclassification cannot be resolved by applying other diagnostic criteria.

We conclude that the observed increase in adenocarcinomas of the gastric cardia may have been inflated by misclassification, possibly fueled by an increase in diagnostic awareness. It may be of considerable interest to estimate the accuracy of site classification in other countries with a reported increase in cancer of the gastric cardia.

**REFERENCES**


NOTES

1Editor’s note: SEER is a set of geographically defined, population-based central tumor registries in the United States, operated by local nonprofit organizations under contract to the National Cancer Institute (NCI). Each registry annually submits its cases to the NCI on a computer tape. These computer tapes are then edited by the NCI and made available for analysis.

Supported by Public Health Service grant R01CA50959 from the National Cancer Institute, National Institutes of Health, Department of Health and Human Services.

We thank Lotti Barlow, The Cancer Registry, Centre for Epidemiology, The National Board of Health and Welfare, Sweden, for providing us with population data.

Manuscript received October 7, 1998; revised February 22, 1999; accepted March 5, 1999.