In The Abstract

A Quarterly Newsletter from the Kentucky Cancer Registry

OCTOBER 2013

INSIDE THIS ISSUE:

KCR 2013 Fall Workshop in Review

The 27th Annual Advanced Cancer Registrars' Workshop ***"Registrars Striving for Excellence"*** was conducted September 12th and 13th at the Marriott in Louisville and was very well attended. Educational presentations by physician specialists Dr. Whitney Jones, Dr. Goetz Kloecker and Dr. Susanne Arnold were outstanding! Dr. Thomas Tucker gave a great presentation on redefining the role of the Central Cancer Registry. Thanks to Lynda Douglas, NPCR Education and Training Coordinator, as well for her coding presentations. The registrar's toolkit was the hit above all … thank you: Marie Brown, Jodee Chumley and Cathy Reising! Dr. Eric Durbin & Isaac Hands with KCR Informatics Team discussed the "new age" of electronic data, giving registrars an understanding of how technology is being used to aid in state cancer reporting.

Sherry Gabehart, registrar at Hardin Memorial Hospital, received the Judith Ann Cook Excellence Award, presented by Dr. Tucker. A delicious buffet luncheon was enjoyed at the Marriott Hotel. Drawings for door prizes and the word game added a fun diversion during the workshop! Thanks to Joel Wheeler, Barbara Bray, and kudos to Marynell Jenkins on successfully coordinating an excellent workshop. Their hard work is appreciated by registrars all around Kentucky!

The NCRA Program Recognition Committee awarded 9.75 CE hours for two-day attendance at the 2013 KCR Fall Workshop. ….6.5 CE hours was awarded for those who attended the workshop on Thursday only and 3.25 CE hours for Friday only. **The NCRA event number for this program is 2013–087.**

UK Markey Cancer Center Gains NCI Designation

It is with great pleasure that we share with you some exciting news.

The UK Markey Cancer Center has earned National Cancer Institute (NCI) designation.

This is a distinction that signifies **national excellence** in clinical care and cancer research. Markey is **the only NCI-designated cancer center in Kentucky** and one of only a handful in the nation. To earn this designation, the center had to pass a rigorous review process. (UKNOW 7/12/13).

People News

New Hires:

Nicole Catlett, Regional Coordinator	Kentucky Cancer Registry
Kelly Pictor, QA Coordinator	Kentucky Cancer Registry
Shawn Chambers	University of Kentucky
Dianna Wiles	Baptist Health Madisonville
Jan Michno	Norton Healthcare
Reita Pardee Quick	University of Kentucky
Mary Hodson	Baptist Health Louisville
Nazarelle Drake	Lourdes Hospital
Rhonda Paul	University of Kentucky
Kathy Clark	Pikeville Medical Center

Promotions:

Emily Reed, QA Abstracting & Training Manager, Kentucky Cancer Registry

New CTRs:

Amanda Coffey, CTR	Lake Cumberland Regional Medical Center
Jo Ann Smith, CTR	Taylor Regional Hospital
Andrea White, CTR	Baptist Health Lexington
Kim Kimbler, CTR	Kentucky Cancer Registry
Tonya Brandenburg, CTR	Kentucky Cancer Registry
Celia Love, CTR	Kentucky Cancer Registry
Dorene Johnson, CTR	KentuckyOne Health Louisville
Marcia Withers, CTR	KentuckyOne Health Louisville
Marsha Tucker, CTR	Murray-Calloway County Hospital
Laura Cook, CTR	The Medical Center at Bowling Green
Sara Adams, CTR	Kentucky One Health Lexington

Resignations:

Nicole Catlett	Baptist Health Louisville
Corrie Mitchell	St. Elizabeth Healthcare
Rhonda Paul	Kentucky Cancer Registry
Bev Shackelford	St. Elizabeth Edgewood
Susie Brindley	Jennie Stuart Medical Center
Lowena Ginter	Highlands Regional Medical Center
Sharlene Moore	VA Medical Center-Lexington

ACoS Approved Programs

Norton Healthcare – 3 yr accreditation w/commendations & also received NAPBC certification in early 2012.
Kosair Children's Hospital – 3 yr accreditation w/ commendations
Baptist Health Louisville - 3 yr accreditation w/commendations.
University of Louisville - 3 yr accreditation w/commendations.
Owensboro Health Regional Hospital - 3 yr accreditation w/outstanding achievement award
Baptist Health Madisonville - 3 yr accreditation w/commendations
The Medical Center in Bowling Green - 3 yr accreditation w/commendations
Baptist Health Paducah - 3 yr accreditation w/commendations
King's Daughters Medical Center – 3 yr accreditation w/accreditation award
Pikeville Medical Center – 3 yr accreditation w/commendations.
Highlands Regional Medical Center – 3 yr accreditation

NCRA's 40th Annual Educational Conference:
May 15 - 18, 2014
Gaylord Opryland Resort & Convention Center
Nashville, TN

The Kentucky Cancer Registry has changed to a new phone system.
All the numbers have changed and are posted on the Wiki page. There are direct numbers and no more extensions.
The main number is (859) 218-6227. The fax number is (859) 257-4177.

The Wiki page is now back up and running! All it takes is a click to see email addresses for all KY registrars! Please be sure to check out the weekly updates! If you have any news to add, please contact Tonya Brandenburg at tbrand@kcr.uky.edu as she is now managing the Wiki page. Thanks Tanya!

Abstracting Bits & Pieces

***** A new Death Clearance report came out in late September. This process provides helpful follow-up information, the official cause of death code from KY death certificates, and also county of birth information to hospital registries.
* All CTRs must pay a maintenance fee annually ($25 for NCRA members) in addition to the annual membership fee. Non-members pay $105 per year to maintain their CTR credential. (NCRA website)
* NAACCR webinars are available on KCR website for viewing and you can earn 3 continuing education units (CEUs).
* You can see all the CAP protocols for individual sites on the College of American Pathologist's website at www.cap.org/ which is a great reference for registrars including good notes and illustrations for resources.
* The NCCN guidelines for all cancer sites are available for review on the National Comprehensive Cancer Network website at www.nccn.org/professionals/physician_gls/f_guidelines.asp

30th ANNIVERSARY OF THE CTR

2013 marks the 30th anniversary of the CTR credential. Since 1983, this nationally recognized credential sets the standard for professional excellence in the cancer registry field and is widely used in the recruitment and retention of registry personnel. In the past 30 years, over 7,000 individuals have attained the CTR.

Golden Bug Award

Congratulations to our latest Golden Bug winner – Jennifer Smothers, CTR, KentuckyOne Health in Louisville. Jennifer found a bug in the CPDMS accepted topography codes for CLL/SLL (9823/3) on cases diagnosed 2012 and forward. Pete Ransdell has already fixed this. Thank you all for alerting us to potential software errors!

Congratulations to Dr. Eric Durbin and Dr. Robin Vanderpool for being recognized for their academic excellence and research/service accomplishments. The awards are a reflection of their dedication and passion for excellence.

Dr. Durbin - Excellence in Infectious Disease Epidemiology - Dr. Glyn Caldwell Book Awards

Dr. Vanderpool - The Dean's Outstanding Teaching Performance Award

Employment Opportunities

*St. Elizabeth Edgewood will have a position opening soon.
Please contact Cathy Reising at (859) 301-2436.
*KCR will have an opening for a Casefinding Auditor in January 2014.
Please contact Marilyn Wooten at (859) 218-2101 or marilyn@kcr.uky.edu

Did You Know?

CS Data Collection in 2014 and 2015
Cancer programs were recently notified that the Collaborative Stage Data Collection System (CS) will be discontinued after 2015. Until then, it is alive and well. (CoC Source, Oct 2013).

New Marker Identified for Early Diagnosis of Lung Cancer
Sep. 17, 2013 — A protein called isocitrate dehydrogenase (IDH1) is present at high levels in lung cancers and can be detected in the blood, making it a noninvasive diagnostic marker for lung cancers, according to a study published in *Clinical Cancer Research*, a journal of the American Association for Cancer Research. (Science Daily website; 9/17/13).

CQIP is coming
The Commission on Cancer (CoC) is planning to release the first edition of an annual Cancer Quality Improvement Program (CQIP) report on Nov. 30, 2013, to each of its accredited cancer programs. This data-driven report will be customized for each facility. The report is based on the data your cancer program has submitted to the National Cancer Data Base (NCDB) and will include comparisons data from your facility to national data from all CoC programs. Only members of your cancer program will be able to view your individual report. To prepare for the release, you need to review your performance rates for the 2010 and 2011 CP3Rs and make any requisite corrections by Nov. 1, as your performance on these measures will be incorporated into the CQIP as of that date. Please work with your registry staff to review your current CP3R data and reconcile any incorrect or missing data. Thank you for your help in making CQIP a success. (CoC brief Oct 2, 2013).

Did You Know? (*continued*)

Liquid biopsy could improve cancer diagnosis and treatment

Science Codex

A microfluidic chip developed at the University of Michigan is among the best at capturing elusive circulating tumor cells from blood—and it can support the cells' growth for further analysis. The device, believed to be the first to pair these functions, uses the advanced electronics material graphene oxide. In clinics, such a device could one day help doctors diagnose cancers, give more accurate prognoses, and test treatment options on cultured cells without subjecting patients to traditional biopsies. (CoC brief Oct 2, 2013).

Stanford scientists build a microscope to spot the seeds of cancer

Stanford Report

The rule of thumb with cancer is that the earlier you can detect the disease, the more effective the treatment, and hence better potential outcomes. Currently, doctors draw a patient's blood and analyze it using special antibodies to detect the presence of the seeds, called circulating tumor cells (CTCs). This method works well if CTCs are present in large numbers, but may fail to detect smaller numbers released by earlier tumors. Now, a team of engineers, scientists, and doctors from Stanford is developing a mini-microscope that might be able to noninvasively detect the CTCs earlier than ever, allowing for earlier interventions. (CoC brief Oct 2, 2013).

UK Initiates First Cancer Reporting Model of its Kind in U.S.

The University of Kentucky has created the nation's first working model for electronic health record (EHR) reporting of cancer cases to the state's cancer registry.

Cancer incidence is higher in Kentucky than in any other state in the U.S. The EHR model allows Kentucky oncologists and other providers to feed clinical data to the Kentucky Cancer Registry in "real time," helping epidemiologists see trends in cancer statistics more quickly than before. It is an important step towards ensuring the statewide cancer control efforts have the most current information about cancer diagnoses and treatments in Kentucky.

The project was funded as part of the American Recovery and Reinvestment Act (ARRA) Comparative Effectiveness Research activities through the Centers for Disease Control and Prevention. Principal investigators Tom Tucker and Eric Durbin were awarded a sub-contract in the amount of $976,449 to develop the methods and standards for physician EHRs to report directly to the Kentucky Cancer Registry, the state's population-based cancer surveillance system.

"This project is laying the groundwork for electronic reporting not only in Kentucky but across the United States," said Durbin, director of Cancer Informatics at the Kentucky Cancer Registry.

The model was officially put in use Oct. 19. Reports for five cancer cases newly diagnosed by Dr. Halden H. Ford were securely transmitted from Paducah Dermatology PLLC, in Paducah Kentucky, using the Team Chart Concept (TCC) EHR system, provided by Ulrich Medical Concepts, Inc.

This breakthrough represents the culmination of an important collaboration between Paducah Dermatology, Ulrich Medical Concepts, the Kentucky Regional Extension Center, the Kentucky Health Information Exchange, the Kentucky Cancer Registry and the Centers for Disease Control and Prevention to provide complete, timely, and accurate data needed to combat cancer in the Commonwealth.

"This is an important step toward making cancer related comparative effectiveness research studies possible in Kentucky," said Tucker, director of the Kentucky Cancer Registry.

The Kentucky Cancer Registry, the Kentucky Regional Extension Center and Kentucky Health Information Exchange are currently partnering with 43 additional cancer care providers across the state to establish EHR reporting to the registry.

Physician EHR reporting to cancer registries officially becomes part of the Centers for Medicare and Medicaid Services Meaningful Use Stage 2 on Jan. 1, 2014. This incentive program is designed to improve healthcare through the increased utilization of information technology by healthcare providers.

CODING REMINDERS

-When abstracting colorectal cases that have only had a polypectomy performed your SSF4 (tumor deposits) and SSF6 (CRM) should be coded to 998 (no surgery of primary site performed). See CS manual part I, section II site specific instructions for reference/resource.
-Bloom Richardson Grade/Bloom Richardson Score (BRG/BRS) is typically not given for in-situ cancers. Registrars should code SSF7 to 999 unknown BRG/BRS. This is not to be confused with coding the grade/differentiation item in case level. You can use the table in CPDMS manual for converting in -situ grade to SEER code.
Low grade = SEER grade 1
Intermediate grade = SEER grade 2
High grade = SEER grade 3
-When abstracting breast cases that you are coding a clinical Tumor Size based on imaging or Physical Exam, your SSF6 must be 987 (clinical tumor size coded). Remember that a biopsy showing invasive carcinoma with no in-situ present on the path, only represents a core of tissue and does not accurately describe the entire tumor, so to code this as entire tumor invasive is not an accurate assessment of the entire tumor. See CS manual part I, section II, site specific instructions for table I-8 which is located on page 87 for reference.
-When abstracting lung cases that do not have surgical resection, SSF2 (visceral pleural invasion) should be coded 998 as there was no histologic exam of pleura to determine involvement.
-Registrars should not code brushings, washings, cell aspirations and hematologic findings (peripheral blood smears) as non-definitive surgical procedures. (CPDMS
Manual item #50090, CPDMS.net help).
-The SEER*Rx Database was updated 8/6/13 so if you are using an older version that is saved on your desktop you will need to download the current & updated version.

SEER*Rx Interactive Antineoplastic Drugs Database *
***Data last updated: August 6, 2013**

Calendar of Events

October 2013 - National Breast Cancer Awareness Month
November 28-29, 2013 - Thanksgiving Holiday - KCR Office Closed
December 31, 2013 - CTR CEU cycle ends - CE summary forms must be submitted to the NCRA if you passed the CTR exam in an odd-numbered year
December 31, 2013 - NCRA membership expires - 2014 renewal deadline is 1/31/14
December 24, 2013 - January 1, 2014 - UK Winter Holiday - KCR Office Closed
January 20, 2014 - Martin Luther King Holiday - KCR Office Closed
January 31, 2014 - Spring CTR Exam Application Deadline
March 2014 - CTR Exam Window (dates not posted yet)

SEER Coding Questions

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Is this two primaries or one? See discussion.

Discussion
Extensive right-sided cervical, supraclav, hilar, mediastinal, gastrohepatic adenopathy. 3/16/2012 bx of cervical nodes shows Diffuse Large B Cell Lymphoma. 04/18/2012 bone marrow shows follicular lymphoma. Treatment started after the bone marrow, pt was given CHOP/Rituxan.

Answer
This is one primary, histology 9680/3.
Rule M14 states that if the original diagnosis is the acute neoplasm (the DLBCL) and a second diagnosis is the chronic (follicular lymphoma) and there is no treatment for the acute neoplasm, it is a single primary. Code the acute neoplasm: the DLBCL.(SINQ 2013-0084; last updated 8/12/13, ***2012 Heme & Lymph Manual & DB)***

Question
Reportability--Heme & Lymphoid Neoplasms: Are plasma cell dyscrasia & Multiple Myeloma synonyms? Is plasma cell dyscrasia reportable? See discussion.

Discussion
Bone Marrow Biopsy & aspirate state: Plasma cell dyscrasia with IgG kappa expression with FISH (+) for the following abnormalities: 3 copies of 1q21 (25/30 plasma cells) and an extra CCND1 signal (25/34 plasma cells) which is indicative of the presence of other chromosome 11 abnormalities possibly trisomy 11, a change known to occur in plasma cell neoplasms. Flow cytometry: A monoclonal plasma cell population is present, co-expressing cIgG, cKappa, CD56, & CD117 (up to 14% of analyzed cells

Answer
This is not a reportable case. Plasma cell dyscrasia and multiple myeloma are not synonymous terms.
Plasma cell dyscrasia (PCD) is not reportable. PCD is a diverse group of neoplastic diseases that produce a serum M component (monoclonol immunoglobin).
Usually these patients have a plasma cell morphology such as multiple myeloma or heavy chain disease. However, the registrar cannot diagnose multiple myeloma or heavy chain disease (or any other plasma cell neoplasm). There must be a physician statement and/or a positive biopsy. (SINQ 2013=0079; last updated 7/11/13, ***2012 Heme & Lymph Manual & DB).***

Question
Histology--Heme & Lymphoid Neoplasms: What is the correct code for follicular lymphoma grade 1-2? It looks like a grade 1 is higher than a grade 2. I read a recent article where grade 1-2 is a new grade.

Answer
Code to Follicular Lymphoma, grade 2, histology 9691/3. For follicular lymphoma, when there is a grade such as 1-2, take the higher grade, even though the grade 1 histology code is higher. (SINQ 2013-0065; last updated 7/12/13, **2012 Heme & Lymph Manual & DB).**

Question
Primary site--Heme & Lymphoid Neoplasms: Are the heme primaries coded to bone marrow (C421) or blood (C420)?

Answer
Leukemias are coded to C421.
The ONLY neoplasm that is coded to C420 is Waldenstrom's macroglobulinemia, histology 9761.
Please refer to the Hematopoietic Database and Manual for further instructions on coding primary site. (SINQ 2013-0064; last updated 7/11/13, **2012 Heme & Lymph Manual & DB).**

Question
Multiple primaries--Heme & Lymphoid Neoplasms: Is bilateral extranodal orbital lymphoma a single primary or multiple primary (same histology present in both orbits)?

Answer
Per Rule M2 in the 2012 Hematopoietic database, a single histology is a single primary. This includes bilateral involvement of lymph nodes and/or organs. (See Note 1). (SINQ 2013-0060; last updated 7/11/13, **2012 Heme & Lymph Manual & DB).**

SEER Coding Questions....*continued*

Question
Grade-Pancreas: Grade rules state to code the grade from the primary tumor only, never from a metastatic site or a recurrence. If the primary tumor extends into a structure and that structure was biopsied and graded, can that grade be used? Is this considered part of the primary tumor OR does it have to be the primary organ/structure? See discussion.

Discussion
Example: pancreatic tumor extends into the duodenum, duodenum is biopsied and confirms moderately differentiated adenocarcinoma consistent with pancreatic primary. Should grade be coded 2 based on the primary extending into duodenum OR grade 9 since the pancreas itself was not biopsied? Can this be clarified in the manual?

Answer
For one tumor involving a contiguous site, when there is no tissue specimen available from the primary site, you may code the grade based on the tissue from the tumor in the contiguous site. This instruction is included in the upcoming grade instruction document. (SINQ 2013-0009; last updated 7/31/13)

Question
MP/H--Breast: See discussion section. What histology code do I use for the left breast?

Discussion
11/6/12 US guided biopsy left breast & left axilla with invasive ductal carcinoma. At the same time, the right breast & right axilla were biopsied, also revealing invasive ductal carcinoma. The patient underwent 6 months of chemotherapy. May 2013 patient underwent bilateral mastectomies. Left mastectomy specimen showed invasive lobular cancer, pleomorphic type with 11 axillary LNs negative. Right mastectomy no residual malignancy & 11 LNs negative.

Answer
Code duct and lobular CA 8522/3.
A biopsy produces a small amount of tissue and, in this case, found the invasive duct but not the lobular carcinoma. The chemotherapy will be more effective in shrinking or eliminating the duct carcinoma, which explains why no duct was left when the patient had a mastectomy. In this case, we need to think about the findings and process. The lobular carcinoma was present prior to the chemotherapy. However, from the small sample, only duct was identified in the biopsy. After neoadjuvant chemo, only the lobular was left. (SINQ 2013-0089; last updated 8/12/13, ***2007 MPH rules****).*