A Quarterly Newsletter from the Kentucky Cancer Registry

In The Abstract

LARGE HOSPITAL EDITION AUGUST 2008

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Fall Workshop Around the Corner

It's almost that time of year again - Fall Workshop time! Registration for the KCR Annual Advanced Cancer Registrar's Workshop will be $85.00, and the **registration deadline is August 22nd**. Please send your registration form, along with your payment, to Barbara Bray at the KCR office.

This year's workshop will be held at the Embassy Suites (859.455.5000), 1801 Newtown Pike in Lexington. Be sure to mention your attendance at the KCR Workshop in order to qualify for the special rate of $146.08 per night. If you have not already made your reservations, chances are by this time, the block of rooms that were reserved for our event have already been filled due to another event scheduled at the same time. There are two nearby hotels that you can check with: Holiday Inn North (859.233.0512) and the Marriott (859.231.5100). Both of these hotels are across the street from the Embassy Suites.

Did You Know?

- NCI researchers are working on a new method to study which mutations may lead to breast cancer in a gene that is already known to increase susceptibility to that disease. (NCI 7/6/08)
- Lab studies involving multiple myeloma cells show that by blocking a protein named "IRF4", the myeloma cells are killed. (NCI 6/23/08)
- After skin cancer, breast cancer is the most common cancer diagnosed in women in the U.S.A. (www.cdc.gov/cancer/breast 7/11/08)
- Oral cancer is the number one cause of cancer deaths in men born in India. (International Agency for Research on Cancer website 7/26/08)
- The International Association of Cancer Registries will hold its 2008 Annual Scientific Meeting in Sydney, Australia November 18-20. (www.iacr.com.fr/)

Abstracting Bits and Pieces

◊ CPDMS.net Abstractor's Manual was updated on 7/9/08.

◊ 100% of 2007 cases were due for completion as of 7/1/08. How is your registry's timeliness?

◊ The NCRA Program Recognition Committee has awarded 4 CE hours for those who attended the KCR Spring Training. The program has been assigned the following event number: **2008-099**.

◊ NPI facility numbers must be entered into registry databases prior to NCDB submissions.

◊ Schwannomas of peripheral nerves arising in/around the spinal cord are not reportable.

People News

New Hires:

Sarah Campbell	Owensboro Medical Health System, Owensboro
Shona Harper	University of Kentucky Hospital, Lexington
Marynell Jenkins	KCR, Regional Coordinator, Lexington
Vicki LaRue	Greenview Hospital, Bowling Green
Lisa Witt	KCR, Non-hospital Facilities and Death Clearance Coordinator

Resignations:

Shona Harper	Lake Cumberland Regional Hospital, Somerset
Karen Magsig	Jewish Hospital, Louisville
Toni Tillotson	KCR, Lexington

Golden Bug Award

Robin Centers at Central Baptist in Lexington found a bug in data entry in case text, whereby it was possible to input more text than allowed, which could potentially lead to loss of some information. Congratulations and thank you, Robin, for identifying the latest golden bug!

Brain Surgery Codes

There have been numerous miscodings of primary brain tumor surgeries, according to the Commission on Cancer. FORDS codes 20, 40 and 55, implemented without special instructions in 2003, appear to be the culprits! The CDC "Flash" (June 2008) highlighted the need for brain surgery coding review and corrections as needed.

Clearer surgery descriptions were provided as follows:

Code	Updated description
20	Local excision/biopsy of mass: Use for removal of primary tumor OR debulking (*less than full removal*). Code used for most primary brain surgery.
40	Partial resection: Use for partial resection of a lobe.
55	Gross total resection: Use for gross total resection of a lobe. (Less common form of surgical treatment.)

The CoC advises registries to review all brain surgery cases since 2003 with surgery codes 40 and 55. Review operative reports and make corrections as needed. In addition, an error in The Brain Book has been identified in regards to the coding of diagnostic/incisional brain biopsies. These procedures provide minimal tumor tissue for histologic interpretation. They should be coded to "N", Non-definitive surgery of primary site, instead of surgical procedure code 20.

CoC Date of First Contact

Since the Date of First Contact descriptions were revised a couple of years ago by FORDS, registrars have been reeling. One aspect has been particularly problematic for many of us, so a thorough review has been conducted. This data field is specific to the CoC data. There were no SEER guidelines.

Although the CPDMS Abstractor's Manual includes this data field and its description, the field originated from the CoC. There are numerous interpretations of this field. The most confusing statement appears to be as follows: *"The Date of First Contact is the date the patient reported to the facility for the treatment or pre-treatment work-up….."*

Recent scouring of I&R turned up some responses as late as November 2007 that caused us to re-evaluate the Date of First Contact question. In particular, number 24696 asks the accession year when a patient is referred for radiation therapy in one year, but did not actually begin XRT until months later in the following year. The I&R answer to this was to use the year in which the XRT treatment plan was developed. If during the initial consult visit in 2006, a treatment plan was developed, and the patient did not start treatment until 2007, the accession year would be 2006. If the treatment plan was developed at the time of actual treatment in 2007, use accession year 2007.

Another I&R question (#21278) asks about a class 2 patient seen in consultation 1/1/07, who then returned 7 months later to begin XRT. Since this would affect abstracting timeliness, can the date treatment began be coded as the Date of First Contact? The response directed the registrar to use the 1/1/07 consult date IF the treatment plan was also developed at that time. I&R goes on to state the case would be abstracted within 6 months of date of first contact and treatment planned but not given. (Of course, we can all cite cases where patients do not return for treatment.) At KCR, we do not code treatment until we know it has actually been received.

Timeliness remains a concern for cases such as these, but our hands are tied by the CoC/FORDS interpretations. For future abstracts involving Date of First Contact questions or clarifications, please contact the CoC - I&R directly. Coordinators will no longer focus on this field.

(References: CPDMS Abstractor's Manual; CoC I&R 7/16/08)

Calendar of Events

August 2-3, 2008 - CTR Exam Prep Workshop, Baltimore

August 12-14, 2008 - KCR Abstractor's Training, Lexington

August 31, 2008 - CTR Exam Application Deadline

September 1, 2008 - Labor Day Holiday - KCR Office closed

September 4-5, 2008 - KCR Fall Workshop, Lexington (Embassy Suites)

September 8-22, 2008 - SEER MP/H Reliability Study

September 13-27, 2008 - CTR Exam Testing Window

KCR Partners with CDC for Research on Human Papillomavirus (HPV) in Selected Cancers

Pre-invasive cervix cancer

KCR is one of three state central cancer registries collaborating with the Centers for Disease Control and Prevention (CDC) on a surveillance pilot project for precancerous cervical lesions. The human papillomavirus (HPV) is a known cause of cervical cancer in women. In efforts to fight against this cancer, a vaccine against four HPV subtypes, including the two that are associated with cervical cancer, was developed and approved by the FDA. With the advent of this vaccine called Gardasil, the surveillance of precancerous cervical lesions has become very important in order to establish baseline incidence levels and to monitor the effectiveness of the vaccine over time.

Gardasil has only recently been introduced, so KCR will begin collecting current data for this project. KCR will be working with representatives of AIM (E-Path Reporting) to enable the software to transmit eligible cases from the hospitals currently using E-Path. A great advantage of E-Path reporting! Not only can E-Path help cancer registrars with more accurate case ascertainment and reporting, it can also help KCR (and that means YOU!) lead the way in future research studies by making our state's data more accessible. Cancer registrars in hospitals that do not have E-Path will soon be contacted to develop a procedure for sending eligible cases to KCR for abstraction.

More information regarding the study, including the case eligibility criteria, will soon be coming your way. Please contact Mary Jane Byrne at 859-219-0773 ext 228 or email mjbyrne@kcr.uky.edu if you have any questions about this very important study.

Human Papillomavirus (HPV) Genotypes in Selected Cancers

The Kentucky Cancer Registry is working with the CDC on another new project which involves obtaining tumor tissue from selected cancers for analysis of human papillomavirus (HPV) genotypes. Kentucky is one of four registries (including Louisiana, Florida and Michigan) participating in this pilot project to develop a systematic approach to monitoring HPV genotypes in several types of HPV-related cancers: cervical, vulvar, anal, penile, and head and neck. Data from the four participating cancer registries are being used to obtain a statewide random sample of cases diagnosed in 2004-2005; from these cases tissue samples of the tumors will be obtained for HPV-typing analysis at CDC. This will be the first time a systematic approach has been taken to conduct analysis on population-based data, with a long-term goal of monitoring changes in HPV types over time. KCR is now in the process of contacting pathology labs across the state to assist in providing tissue samples to CDC for analysis using a standardized protocol. The CDC will provide certificates of participation to facilities that assist with this important project.

More about E-path…

E-path is short for "electronic pathology reporting." The Artificial Intelligence in Medicine (AIM) Company has developed software that will read path reports and isolate the possible reportable cancer conditions for you. No more manual path casefinding! SEER is currently funding E-path installation in Kentucky path labs. Thirteen of the largest Kentucky labs have already installed E-path so far and 72 more are in the process of installation. Since increased reliance on electronic transfer of medical data is the way of the future, KCR has determined that E-path will be one of the tools on the leading edge of cancer registration. It will play a significant role in the two HPV and cancer investigations mentioned above. Therefore, we are strongly encouraging Kentucky hospitals to begin the process. Marilyn Wooten, KCR Manager for Casefinding, will be contacting those of you who do not have E-path soon to discuss this very important opportunity. For any questions, contact her at 859-219-0773 ext 227 or email marilyn@kcr.uky.edu.

SEER Coding Questions

These recently finalized coding questions are provided as a means of additional education.

Question 1: Histology--Endometrium: Do we code the polyp 8210 as we do in colon, or do we use 8323 for the mixed adenocarcinoma? Please see discussion.

Discussion: Endometrial polyp: Endometrial adenocarcinoma, endometroid type, Figo 1, with focal mucinous differentiation arising from a mixed endometrial and endocervical polyp. There was no residual tumor in the TAHBSO.

Answer: Code the histology to 8210 [Adenocarcinoma in adenomatous polyp] using rule H12.
(SINQ #2007-1112; 2007 SEER Manual, pg C-1134)

Question 2: Primary site--Brain and CNS: What is the primary site code for sphenoid meningioma WHO grade 2?

Answer: The most appropriate site code is C313 [sphenoid sinus]. A meningioma of the sphenoid sinus is not a reportable benign brain/CNS tumor.
Meningiomas may arise from any location where meninges exist (e.g. nasal cavity, paranasal sinuses, middle ear, mediastinum).
{http://www.nyp.org/health/olfactory-groove-sphenoid-wing-meningiomas.html}
According to the WHO Classification of CNS tumors, while the vase majority of meningiomas arise in intracranial, intraspinal or orbital locations, other common sites include olfactory grooves, sphenoid ridges, and other locations.
However, meninges of the sinus are not cerebral or spinal meninges, Meningiomas of the sinus do not have the same prognosis and may not be treated in the same manner as CNS meningiomas. The laws enacted for the collection of benign brain and CNS tumor data do not extend to benign tumors of the sinus.
(SINQ #2007-1121; WHO Class CNS Tumors, pg 165; ICD-O-3)

Question 3: Ambiguous terminology/Reportability--Leukemia: Is a 'suspicious peripheral blood smear' the same as a suspicious cytology? Please see discussion.

Discussion: Patient has a peripheral blood smear that is stated on path report to be 'suspicious for malignancy.' The microscopic description states that the 'lymphoid populations raises the concern of chronic lymphocytic leukemia.' Nothing further was done. Is this a reportable case? If so, should it be coded as a leukemia or a malignancy NOS?

Answer: Do not accession a leukemia case based only on a "suspicious" peripheral blood smear. If a confirmed diagnosis, clinical confirmation or further information becomes available later, accession the case at that time.
(SINQ #2008-1017; 2007 SEER Manual, pg 3)

Question 4: CS Extension/CS Mets at DX--Wilm's Tumor: What is the CS tumor extension for bilateral Wilm's tumors? Would CS mets at diagnosis be 40?

Answer: Code laterality as bilateral, code the greatest extension from either side in CS extension.
Code CS Mets at diagnosis 00 [None] UNLESS true distant metastases were identified.
(SINQ #2008-1022; 2007 SEER Manual, pgs C-863-865)

Question 5: **CS Site Specific Factor--Breast: How is SSF6 coded when CS tumor size is coded from a clinical report, not from pathology? Please see discussion.**

Discussion: A breast ultrasound displays a 2 cm tumor. Core biopsy diagnosis is lobular carcinoma in situ. No further record for patient. Tumor size coded to 020. Should SSF6 be coded to 010 "Entire tumor reported as in situ (no invasive component reported)" because it was pathologically confirmed, or to 888 because size was coded based on a clinical exam - the ultrasound?

Answer: *Code SSF6 888 (Clinical tumor size coded). Since the size recorded in CS Tumor Size was not determined pathologically, 888 must be coded in SSF6.*
Note: The code in SSF6 pertains to pathologic tumor size when CS Tumor Size is coded based on pathologic size.
(SINQ #2008-1024; 2007 SEER Manual, pg C-708)

Bladder Case Question

This case was reviewed at spring training, and registrars requested that it be included in the newsletter….

"Mrs. Smith" was diagnosed on April 3, 2007 with a non-invasive transitional cell carcinoma of the bladder. She returned on May 28, 2007 with an invasive transitional cell carcinoma of the bladder. Is this a multiple primary? NO! Follow Multiple Primary Rules (Urinary chapter) all the way down to M6 or M11 (*see note under M11*).

The invasive diagnosis followed the non-invasive by less than 2 months, so this is abstracted as one primary with behavior code 3.

If the diagnosis of invasive transitional cell carcinoma occurred after June 3, 2007, it would be a new primary, per rule M5.

If the second diagnosis was non-invasive, just like the one on April 3, 2007, it would **not** be a new primary, regardless of when it was diagnosed, per rule M6.