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Looking Ahead to Spring Training

As registrars continue thawing out around the state following the recent ice storm, the words “spring training” bring pleasant thoughts of warmth, new growth, and a new beginning. Three sessions have already been scheduled, one each in Madisonville, Elizabethtown, and Lexington. Topics to be covered this spring include a new data item for 2009 cases, comparative statistics, and a practical coding session.

Choose one of these locations for your KCR-sponsored spring 2009 training:

- ◆ April 24, 2009 (8:30am – 4:30pm) Central Time Zone
Regional Medical Center of Hopkins County, 900 Hospital Drive,
Madisonville KY
Trover Clinic Tower, 8th floor, Loman C. Trover Room
- ◆ April 29, 2009 (8:30am – 4:30pm) Eastern Time Zone
Hardin Memorial Hospital, 913 North Dixie Avenue,
Elizabethtown KY
5th Floor; use Elevator A
- ◆ April 30, 2009 (9:00am – 5:00pm) Eastern Time Zone
St. Joseph Hospital, One St. Joseph Drive (*corner of Waller Ave
& Harrodsburg Rd*), Lexington KY
1st Floor Auditorium

Please let Barbara Bray at KCR know which training session you will attend. Her phone number is 859-219-0773 ext 281. You can reach Barbara via e-mail at bbray@kcr.uky.edu. CE hours are being requested from NCRA.

*** * * NAACCR Webinar Date Correction * * ***

The June 2009 NAACCR Webinar presentation “Collecting Cancer Data: Prostate” has encountered a date change. Please note that this webinar, hosted by The Medical Center Bowling Green, has been changed from 6/4/2009 TO **6/11/2009**. The session will be presented from 9:00am-12:00pm ET.

Please contact Jana Thornton or Paula Alford at 270-745-1288 if you plan to attend.

New Hires:

Michael Anderson	St. Joseph Hospital, Lexington
Rachel Maynard	KCR Non-hospital Facilities Abstractor
Tammie Rogers	University of Kentucky Hospital, Lexington

Promotions:

Mary Ellen Ford	KCR Regional Coordinator
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Golden Bug Award



Rhonda Paul from Norton HealthCare is our latest Golden Bug winner! Rhonda discovered an inconsistency between the printable and the downloadable versions of the ACoS Followup Report, which was fixed immediately. The KCR IT staff thanks Rhonda for this latest "bug alert."

Abstracting Bits and Pieces

- ◇ Cancer incidence rates in Kentucky for year 2006 are now available on the KCR website.
- ◇ Errata for Volume I of April Fritz' Cancer Registry CASEbook can be downloaded from the A. Fritz and Associates, LLC website (www.afritz.org/). The Cancer Registry CASEbook Volume II is now available from this website as well.
- ◇ The cervical carcinoma-in-situ research study began on 1/1/09. Mary Jane Byrne, Quality Assurance Manager for Field Studies at KCR, will oversee this project.
- ◇ For 2009, cancers that develop "in utero," will be assigned the diagnosis date and treatment date(s) on which they occur, even if they are before the date of birth. This will be covered at Spring Training.
- ◇ 2009 Cancer Program Standards are available online at www.facs.org/cancer/coc/programresources.html

Did You Know?

- The AJCC 7th Edition Staging Manual will include new chapters on Merkel Cell Carcinoma, GIST, Adrenal Gland, and Mucosal Melanoma of Head & Neck, among others.
- IARC (International Agency for Research on Cancer, a part of WHO) launched the World Cancer Report 2008 on 12/19/08. Go to www.iarc.fr/ to view “Recent Releases.” Reportedly, the cancer burden doubled on earth during the last 30 years of the twentieth century. (IARC website 1/09)
- Twenty-five year old neuroblastoma survivor Emily Hoskins played on the wheelchair basketball team and won GOLD in Athens and Beijing. She is currently working on her master of clinical psychology degree at Murray State University. (ACS News, 1/5/09)
- NCI’s “Annual Report to the Nation on the Status of Cancer, 1975-2005...” was published in November 2008. Featured trends included lung cancer incidence and death rates, tobacco use, and tobacco control by state. Visit the NCI website to read more on our nation’s cancer data.
- ACoS Survey Savvy 2009 is scheduled for March 31-April 1, 2009 at the Grand Hyatt in Denver CO. A pre-workshop for new cancer programs will be offered March 30th. “Improving Patient Care through CoC Standards” is the title. Registration must be received by March 9, 2009. Cost and registration information can be found in the ACoS Flash, Nov/Dec 2008 edition.

Add MD NPI Numbers to Physician Support Files

Remember to update your physician support files while abstracting 2008 cases with MD NPI numbers. It is important to include these numbers with 2008 cases. Fields that need an attached NPI number are “Primary Surgeon,” “Alternate Following MD,” and “Other MD.” Once the NPI number has been entered for a particular MD, you will not have to update that piece of information again. Be ahead of the game and get these entered now! Use Data Analysis to identify physicians recorded in these fields for 2008 diagnoses; then use Reports - Support Files to verify that these physicians have NPI numbers recorded.

Calendar of Events



February 19, 2009 - NCRA CTR Exam Prep Webinar - Statistics
 February 26, 2009 - NCRA CTR Exam Prep Webinar - CTR Exam Tips
 March 3-21, 2009 - CTR Exam “Window”
 March 23-27, 2009 - KCR Abstractor’s Training – Lexington KY
 April 13-17, 2009 - National Cancer Registrars Week
 April 24, 2009 - KCR Spring Training – Madisonville KY (Trover Tower)
 April 29, 2009 - KCR Spring Training – Elizabethtown KY (Hardin Memorial)
 April 30, 2009 - KCR Spring Training – Lexington KY (St Joseph Hospital)
 May 31-June 3, 2009 - NCRA Annual Conference – New Orleans LA

Scope of Regional Lymph Node Coding

Registrars have been unsure how to code the “scope of regional lymph node surgery” when two different types of lymph node procedures have taken place on different dates and in different facilities. ACoS-approved facilities need to show the complete surgical “picture” in the most definitive surgery treatment fields.

Take for example, a breast cancer case in which a lumpectomy and sentinel lymph node biopsy took place at one facility on one date. A couple of weeks later, the patient underwent a modified radical mastectomy at another facility for her most definitive surgery. How should the scope of regional lymph node field be coded for the second (most definitive) surgery? After considering the various dates, facilities, and codes, KCR Director of Operations, Frances Ross, responded that the appropriate code for this situation would be “7”: sentinel node biopsy and regional nodes removed at different times. The most definitive surgery is the one that will be picked up by the NCDB submission, and it should include the full description of lymph node procedures experienced by that patient for first course of surgery.

Histology Question - Clarifying “Focal Features”

Pathology reports from several facilities in our commonwealth have included histological descriptions of a particular carcinoma with focal other features. One example is a breast case of lobular carcinoma with focal ductal features. It has been very difficult to follow the MP/H rules and attempt to code this type of case....

QA Manager, Reita Pardee, recently submitted this scenario to the SEER Committee that works on resolving MP/H questions, and we have a definite answer! Ignore the “focal features” portion, and code the original diagnosis. In this case, we would ignore “focal ductal features” and code the case as a pure lobular carcinoma.

Another example to illustrate this new histology coding instruction is as follows: a lung case of squamous cell carcinoma with foci of papillary differentiation. Ignore the “foci of papillary differentiation” and code the case as a pure squamous cell carcinoma.

In essence, the clarification directs registrars to ignore “focal, focus, or foci” of another type carcinoma in the coding of cancer HISTOLOGY. Please make a note to that effect in your current MP/H book, and remember to code the majority tumor in this type of case. It will be updated in the next MP/H manual.

The following recently finalized SINQ questions are offered for your continuing education:

Question 1: Reportability: Is the following tumor(s) reportable? MRI of thoracic spine shows intramedullary hemangiomas in the bodies of T5 and T6.

Answer: Intramedullary hemangiomas in T5 and T6 are not reportable. These benign tumors originate in the bone, not spinal canal, cord or dura. Benign tumors of the bone are not reportable. According to WHO, the most common sites of involvement are the vertebral bodies, followed by craniofacial skeleton and long bones. (SINQ #2008-1125; WHO Class Bone Tumours, pg 320)

Question 2: Reportability/Date of diagnosis--Liver: Does the final diagnosis of a scan have higher priority than the findings of the discussion in the body of the report? Please see discussion.

Discussion: A patient with liver cancer becomes transplant eligible when the tumor is 2 cm in size. Frequently, liver tumors will be watched (no biopsy) for months until they meet the 2 cm size criteria. In the meantime, multiple scans will describe the tumor using variations of ambiguous terms that drift in and out of reportability. One day the tumor is labeled “presumed hepatocellular carcinoma.” Weeks later it is back to “worrisome for hepatoma.” A single scan will use different terms in different sections of the report. Example case: Abdominal CT reveals a 1 cm liver lesion. Per the discussion portion of the scan, the lesion is consistent with hepatocellular carcinoma. Per final diagnosis: 1 cm liver lesion, possibly hepatocellular carcinoma. Would this report be considered diagnostic of cancer? Would the date of this report be the date of diagnosis? (Patient did receive a liver transplant for hepatocellular carcinoma months later).

Answer: When a reportable ambiguous term is used in one part of a report or the medical record and a non-reportable ambiguous term is used in another part of the report or the medical record, accept the reportable term and accession the case. The example above is reportable. “Consistent with” is a reportable ambiguous term. Accept “consistent with” over the non-reportable term “possibility.” The date of this report would be the date of diagnosis if this is the earliest report using reportable terminology. (SINQ #2008-1119; 2007 SEER Manual, pgs 4 & 61)

Question 3: Surgery of Primary Site--Brain and CNS: How is this field to be coded when a patient undergoes stereotactic biopsy of a brain tumor? Path specimen consists of four fragments of tissue measuring .7, .6 and .3 cm.

Answer: Assign code 20 [Local excision (biopsy) of lesion or mass. Specimen sent to pathology from surgical event 20]. (SINQ #2008-1118; 2007 SEER Manual, Appendix C, pg C-1015)

Question 4: MP/H Rules/Histology--Rectum: When not specifically mentioned as part of the histology, do we consider the adenoma a second histologic type, or just a further physical description of the tumor? Please see discussion.

Discussion: Rectal tumor resection (APR) path report final dx: “mucinous carcinoma, see comment.” The comment is the CAP-format tumor summary, which states “histologic type: adenocarcinoma with extensive mucin production (mucinous or colloid carcinoma). Additional pathologic findings: adenomas - tumor arises in a tubulovillous adenoma.” If you follow the rules and only consider the final dx you would code a different histology than if you consider the ‘additional path findings.’

Answer: Other Sites histology rule H12 applies in this case. Assign histology code 8263 [adenocarcinoma in tubulovillous adenoma]. Use information from the CAP protocol and from comments associated with the final diagnosis to code histology. The fact that the malignancy arose in a polyp can be taken from anywhere in the medical record; not limited to the final diagnosis. Based on the information provided for this case, the histology is adenocarcinoma with extensive mucin production (mucinous or colloid carcinoma) arising in a tubulovillous adenoma. (SINQ #2008-1100; 2007 SEER Manual, Appendix C, pg C-1133)

Question 5: MP/H Rules/Histology--Breast: A path report for a 2007 breast case states: in-situ carcinoma with comedo necrosis. Does the comedo necrosis make this a comedocarcinoma in situ? Please see discussion.

Discussion: According to the new MPH rules, I understand we are to consider descriptive features. There is no coding guidance or reference to “necrosis” within the Breast MPH rules. Based on SEER SINC ID: 20021002, the “comedo necrosis” would not be coded at all for pre-2007 cases. Does this still hold true for 2007+ cases? Please clarify. Thank you.

Answer: *Comedo necrosis is not synonymous with comedocarcinoma. If no further information is available for this case, code as carcinoma in situ.
(SINC #2008-1111; 2007 SEER Manual, Appendix C, pg C-693)*

Question 6: MP/H Rules/Histology--Breast: Patient has single invasive left breast tumor diagnosed in 2008. Final pathology diagnosis is “invasive solid papillary carcinoma.” No mention of ductal in report. What is histology?

Answer: *Code the histology 8255 [adenocarcinoma with mixed subtypes] according to rule H19. Start with rule H10 and stop at rule H19. Rule H19 is the first rule that applies to this unusual case.
(SINC #2008-1122; 2007 SEER Manual, Appendix C, pg C-693)*