

INSIDE THIS ISSUE:

Secure Transmission of Information	1
2010 Spring Training	1
People News	2
ACoS Approved Programs	2
Breast Cancer Center Accreditation	2
Golden Bug Award	2
Did You Know?	3
Treatment Notes Expansion	3
Multiple Urinary Tumors	4
Upcoming NCRA Annual Conference	4
Bits & Pieces	5
Calendar of Events	5
2010 Casefinding List	6-7
SEER Coding Questions	8-9

Secure Transmission of Information

Hospital registrars are acutely aware of the sensitive nature of personal health information. The enactment of HIPAA in 2001 alerted most Americans to the frequent transmission of their private health information among medical providers and health related organizations. As part of the public health surveillance sector, the Kentucky Cancer Registry has established policies to handle confidential patient information in the most secure manner possible.

There are three acceptable means of sending personally identifying information to KCR: by “snail mail” in a sealed opaque envelope, by secure fax transmission at (859)219-0557, or by the secure file exchange server (FES) on the KCR website. Under no circumstance is anyone to send identifying patient information (such as name or SSN) to KCR via email! KCR does not send such information to hospitals via email, nor can we accept such from hospitals without consequences.

All KCR staff recently completed on-line security awareness training, compliments of the National Institutes of Health. The NIH takes security breaches very seriously. We in turn must do the same. Henceforth, should anyone send private patient information via email to KCR, supervisors on both ends will be notified immediately. Additional reprimands will be up to the discretion of the facility involved. Facilities with secure intranet capabilities may be accustomed to sending personal information via email within their hospital systems. However, they are not secure when communicating over the internet. Visit the NIH website (<http://irtsectraining.nih.gov/>) as a “general public user” for additional security awareness training.

2010 Spring Training

KCR’s Spring Training this year will be a total of 3 days...(2 days for CSv2 and 1 day for Hematopoietic Diseases and other 2010 changes).

Please see the Calendar of Events on page 5 for dates and locations of the various trainings.

You may contact Barbara Bray at bbray@kcr.uky.edu to register for the location you wish to attend. The trainings will be held from 8:00am-4:30pm.

New Hires:

Sheena Batts	KCR Quality Assurance Specialist
Laura Cook	Medical Center at Bowling Green
Leah Driscoll	KCR Quality Assurance Specialist
Vicki LaRue	St. Joseph Hospital, Lexington

Resignations:

Sherri Halstead	King's Daughters Medical Center, Ashland
Vicki LaRue	Greenview Hospital, Bowling Green

ACoS Approved Programs

- Owensboro Medical Health Center has been notified of receiving three-year approval with commendations in six standards. Great job – Bonnie Roberts, Vanessa Sorrels, Sarah Campbell, and Coby Rose!
- University of Louisville Hospital has received results from their most recent survey: full three-year approval with commendations in five standards. Congratulations are extended to Mary Wilson, Michelle Weaver, Vivian Wyatt, Carole Miller, Shelly Scheer, and Kevin Moore.

Breast Cancer Center Accreditation

U of L's James Graham Brown Cancer Center has been awarded full three-year accreditation by the National Accreditation Program for Breast Centers (NAPBC). News of the first program in Kentucky to be awarded the NAPBC distinction was released on January 20th. Kentucky First Lady Jane Beshear joined U of L President James Ramsey, Brown Cancer Center Director Donald Miller, MD., and many others in this announcement. Ongoing accreditation will become a part of routine ACoS Cancer Program surveys at U of L Hospital. (*Brown Cancer Center online news 2/2/10*)

Golden Bug Award



Congratulations to the latest Golden Bug winner - Jodee Chumley at Norton Healthcare, Louisville. Jodee discovered a bug where the Follow-up Date of Last Contact warning was incorrectly setting the inter-record incomplete flag.

- The Annual Report to the Nation on the Status of Cancer was released on December 12, 2009. Of note, both incidence and mortality rates have declined during the last few years. Murray State University graduate Dr. Brenda Edwards is Associate Director of the Surveillance Research Program of the NCI. Quoted in the article “Keeping Tabs on Cancer Rates,” Dr. Edwards describes what a cancer registry is and how data are collected. (<http://benchmarks.cancer.gov/> 1/19/10)
- A recent online study reported that ingestion of multivitamins, folate, and leafy green vegetables may offer protection against lung cancer in smokers, both current and former. (“Diet May Protect Against Gene Changes in Smokers,” Cancer Research, 1/12/10)
- A drug studied in clinical trials involving multiple myeloma patients has been shown to increase the disease-free time interval. Lenalidomide was administered 100 days after patients received autologous stem cell transplants, and it was continued until evidence of myeloma progression. A 58% reduction in risk of disease progression was demonstrated. (NCI website, 1/19/10)
- The Cancer Genome Atlas is the name of the research section of NIH that focuses on increasing our knowledge of cancer genetics. With new discoveries will come new treatments. (NIH website, 1/29/10)

Treatment Notes Expansion

The “Treatment Notes” box at the end of every therapy has been expanded to accommodate all treatment information gathered to back up the preceding treatment codes. QA Manager Reita Pardee wants registrars to know that documentation within the expanded treatment notes box does not need to be duplicated in the General Remarks section of the abstracted text. (Some facilities require full text documentation in the General Remarks section.)

For chemotherapy treatments: verify the start date, indicate if it is an estimated date, plus enter the chemo drugs administered in the treatment notes box, in order to justify the code applied. Radiation therapy has become much more detailed with ACoS-mandated fields in recent years. In the radiation treatment notes box, be sure to include the start date, modality (dominant treatment mode such as external beam, IMRT, brachytherapy, radioisotopes...), volume (treatment target), and end date.

Registrars polled to date have expressed much satisfaction with this treatment notes field expansion. It is easier to add back-up information while in the treatment itself, rather than going to the separate text section to type in the specifics. This improvement should be helpful for re-coding auditors and registrars, alike!

Multiple Urinary Tumors - A SEER Clarification

It is common knowledge that patients with cancer in one urinary site may develop cancers in other urinary sites. Deciding whether the most recent tumor is a new primary or “recurrence” has not been clearly understood. The standard response since 2007 has been “Read your MP/H rules.” Expert answers have been contradictory when asked specific urinary-scenario questions.

KCR has obtained a new clarification from SEER regarding the urinary multiple primaries rules. This clarification may change the way registrars handle the determination of number of urinary primaries. Mark your MP/H Coding Manual Urinary Chapter accordingly:

“Rule M6 applies only to **bladder** tumors. M7 applies to tumors in **any of the urinary sites covered by this set of rules** when the tumors are more than three years apart.”

An example of urinary tumors that would utilize this recent clarification is as follows: patient had invasive urothelial carcinoma of right renal pelvis in 2005. Invasive papillary urothelial carcinoma of bladder trigone developed in 2009. How many primaries does this patient have? Go through the urinary multiple primary rules until you find one that exactly “fits.” You will pass through M3, M4, M5, M6 (only one of these tumors is in the bladder), and STOP at M7: Tumors [in any urinary site covered in this chapter] diagnosed more than three (3) years apart are multiple primaries. Since patient had one renal pelvis tumor in 2005 and a second tumor in the bladder in 2009, M7 fits. Abstract the bladder case as a second primary. With this January 2010 clarification, we can begin the New Year with greater urinary cancer insight! Always read the MP/H rules when abstracting. Go through each rule until one fits the current scenario. Only stop at the current rule if it fits your case scenario precisely.

NCRA 36th Annual Conference

“*An Oasis of Information and Education*” is the theme for this year’s National Cancer Registrars Association Conference. Palm Springs, California will play host to this annual pilgrimage of cancer registrars in search of enlightenment and CE credits! Visit www.ncra-usa.org to register online. The host hotel is already booked solid, but other area resorts have availability.

Abstracting Bits & Pieces

- ◆ Attention melanoma abstractors! Remember that CS Tumor Size pertains to the size across the **surface** of the lesion – its maximum measurement across the top of the melanoma in millimeters. **CS Tumor Size should never be coded from the depth of the lesion.** If the surface size is not provided in the medical record, code to ‘999.’ Thickness (depth) should only be coded in Site Specific Factor #1. The depth is coded in HUNDRETHS of millimeters. Check the CS manual melanoma section examples to make sure depth is converted correctly and coded in the appropriate field.
- ◆ Blood transfusions should not be coded ‘1’ under “Other Treatment” for acute leukemias. (SINQ#2004-1007 & NCRA Advanced Hematopoietic Training 1/09)
- ◆ Breast grade codes depend upon whether the cancer is in-situ or invasive. In-situ breast cancer grading falls under the “3-tier grading system.” Invasive breast grading falls under the SBR grading system. Always refer to the Abstractors’ Manual when coding grade.
- ◆ The 2008 re-coding audit (1st half of 2008 abstracts) is underway in the KCR office.
- ◆ The CPDMS.net Abstractors’ Manual was updated on 1/11/2010. Read your manual!

2010 CTR Certification

Two testing periods have been designated for cancer registrars’ certification in 2010. The Spring Exam window will be March 6-20. The Fall Exam window will be September 11-25. Visit www.ctrexam.org to obtain the CTR Exam Handbook.

Calendar of Events



March 6-20 - CTR Exam Window
March 25 & 26 - “CSv2” - Crowne Plaza Hotel, Lexington
April 1 & 2 - “CSv2” - Trover Tower, Madisonville
April 6 - “Hematopoietics & Other Changes” - Crowne Plaza, Lexington
April 8 & 9 - “CSv2” - Hardin Memorial Hospital, Elizabethtown
April 12-16 - NCRA Week
April 19-23 - SEER/NCRA Conference, Palm Springs CA
April 28 - “Hematopoietics & Other Changes” - Hardin Memorial, Elizabethtown
April 29 - “Hematopoietics & Other Changes” - Trover Tower, Madisonville
May 3-5 - Abstractor’s Training - KCR office, Lexington
Sept 9-10 - KCR Annual Fall Workshop - Embassy Suites, Lexington

Fiscal Year 2010 Casefinding List: Expanded Version

Some ranges are expressed with only 1 decimal place (e.g. 237.0-237.9) while some codes within that range may have two decimal places (e.g. 237.71 and 237.72). All codes in the range are included.

Comprehensive ICD-9-CM Casefinding Code List for Reportable Tumors (Effective Date: 1/1/2010)	
ICD-9-CM Code^	Explanation of Code
140.0 – 208.92	Malignant Neoplasms
209.00 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site <i>Reportable inclusion terms:</i> <i>High grade neuroendocrine carcinoma, any site</i> <i>Malignant poorly differentiated neuroendocrine tumor NOS</i>
209.31 – 209.36	Merkel cell carcinoma Note: Effective date 10/1/09
209.70 – 209.79	Secondary neuroendocrine tumors Note: Effective Date 10/1/09 <i>Reportable inclusion terms:</i> <i>Secondary carcinoid +tumors</i> Note: All neuroendocrine or carcinoid tumors specified as secondary are malignant
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) <i>Reportable inclusion terms:</i> <i>Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica</i>
227.4	Benign neoplasm of pineal gland
230.0 – 234.9	Carcinoma in situ <i>Reportable inclusion terms:</i> <i>Intraepithelial neoplasia III</i>
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system
238.4	Polycythemia vera (9950/3)
238.6	Neoplasm of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) <i>Reportable inclusion terms:</i> <i>Plasmacytoma NOS (9731/3)</i> <i>Solitary myeloma (9731/3)</i>
238.71	Essential thrombocythemia (9962/3) <i>Reportable inclusion terms:</i> <i>Essential hemorrhagic thrombocythemia</i> <i>Idiopathic (hemorrhagic) thrombocythemia</i>
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) <i>Reportable inclusion terms:</i> <i>Refractory anemia (RA) (9980/3)</i> <i>Refractory anemia with excess blasts-1 (RAEB-1) (9983/3)</i> <i>Refractory anemia with ringed sideroblasts (RARS) (9982/3)</i> <i>Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3)</i> <i>Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)</i>
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) <i>Reportable inclusion terms:</i> <i>Refractory anemia with excess blasts-2 (RAEB-2)</i>
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) <i>Reportable inclusion terms:</i> <i>5q minus syndrome NOS</i>

238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) <i>Reportable inclusion terms:</i> <i>Agnogenic myeloid metaplasia</i> <i>Idiopathic myelofibrosis (chronic)</i> <i>Myelosclerosis with myeloid metaplasia</i>
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) <i>Reportable inclusion terms:</i> <i>Lymphoproliferative disease (chronic) NOS (9970/1)</i> <i>Megakaryocytic myelosclerosis (9961/3)</i> <i>Myeloproliferative disease (chronic) NOS (9960/3)</i> <i>Panmyelosis (acute) (9931/3)</i>
273.2	Other paraproteinemias <i>Reportable inclusion terms:</i> <i>Franklin's disease (heavy chain) (9762/3)</i> <i>Heavy chain disease (9762/3)</i> <i>Mu-chain disease (9762/3)</i>
273.3	Macroglobulinemia <i>Reportable inclusion terms:</i> <i>Waldenström's macroglobulinemia (9761/3)</i> <i>Waldenström's (macroglobulinemia) syndrome</i>
288.3	Eosinophilia Note: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is "Hypereosinophilic syndrome (9964/3)."
V10.0 – V10.89	Personal history of malignancy Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.90	Personal history of unspecified malignant neoplasm Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment
V12.41	Personal history of benign neoplasm of the brain

Also, these ICD-O-3 morphology codes will change from behavior code /1 to /3 effective for 2010 cases. Please note these changes in your ICD-O-3 book.

- 9751 Langerhans cell histiocytosis, NOS
- 9831 T-cell large granular lymphocytic leukemia
 - T-cell large granular lymphocytosis
 - NK-cell large granular lymphocytic leukemia
 - Large granular lymphocytosis, NOS
- 9975 Myeloproliferative disease, NOS

When Should We Use the 2-Tier Grading System?

The 2-tier grading system is used for colon, rectum, rectosigmoid, and heart primaries. Only two codes are used in this system – code '2' for low grade, well differentiated, moderately differentiated, or grade 1 of 2; code '4' for high grade, poorly differentiated, undifferentiated, or grade 2 of 2. The CAP protocol checklist shows these two possible choices for colorectal primaries.

SEER Coding Questions

Review these recently revised or finalized SINQ questions as an added learning tool:

Question 1: Reportability/Ambiguous Terminology: Because there is a caveat in the SEER Program Coding Manual, 3rd edition, to ignore adverbs such as “strongly” when assessing reportability, should a term such as “likely” cancerous be considered reportable given that the expression “most likely” cancerous is reportable?

Answer: “Likely cancerous” is NOT reportable. The CoC, NPCR, and SEER have agreed to a strict interpretation of the ambiguous terms list. Terms that do not appear on the list are not diagnostic of cancer.

History: **Prior to 1/1/2010** “Likely cancerous” is reportable. See the 2004 SEER Manual, pg 4, note under 1.b. “Most likely” appears on the reportable list. “Likely” is a form of “Most likely.”
(SINQ#2005-1079, last updated 01/15/10; 2007 SEER Manual, pgs 3-4)

Question 2: Grade: SINQ#2002-0059 says not to use FIGO grade to code differentiation. It also says SEER is evaluating whether the ICD-O-3 6th digit differentiation codes accurately represent the FIGO grade. For the time being, do not code FIGO grade. What is the result of the evaluation? Any new information regarding FIGO grade?

Answer: Do not code FIGO grade in the grade field. The conversion from a three-grade system to a four-grade system does not work for FIGO grade three. Since FIGO G3 includes both poorly differentiated and undifferentiated, it cannot be converted. FIGO grade may be captured in a CS site specific factor in the future.
(SINQ#2009-1073, last updated 11/27/09; 2007 SEER Manual, pg 86)

Question 3: MP/H Rules – Bladder: Rule M7 says, “Tumors diagnosed more than three (3) years apart are multiple primaries.” **Is this supposed to say “BLADDER tumors diagnosed more than 3 years apart are multiple primaries”? See discussion.

Discussion: The reason I ask is that you could have an invasive urothelial bladder tumor diagnosed in 2004 and an in-situ TCC of the ureter diagnosed in 2009 and per rule M7, this would be a separate primary. Is that the intent of rule M7, since it is before rule M8 that says “Urothelial tumors in two or more of the following sites are a single primary: Renal pelvis (C659), Ureter (C669), Bladder (C670-C679), Urethra/prostatic urethra (C680)?

Answer: Rule M7 pertains to renal pelvis, ureter, bladder and other urinary sites as defined by the topography codes listed in the header of these rules. An invasive urothelial bladder tumor followed more than three years later by an in-situ TCC of the ureter are separate primaries. Rule M8 applies when the tumors in these sites are diagnosed within three years of each other.
(SINQ#2009-1110, 2007 SEER Manual, C-830)

Question 4: MP/H Rules – Multiple primaries – Breast: How is the statement “Either local recurrence or potentially a met” to be interpreted? See discussion.

Discussion: Patient underwent mastectomy in 1986 for infiltrating ductal carcinoma of left breast. Excision of left chest wall mass in March 2009 showed ductal carcinoma consistent with breast primary. Path comment stated it would be compatible with either local recurrence or a met. The patient’s primary breast carcinoma material is not available for direct comparison. MP/H rules instruct us to ignore mets. Reference SINQ#2005-1102; 2005-1131.

Answer: The MP/H rules do not apply to metastasis. If there is no further information available for this case, the MP/H rules do not apply to the 2009 diagnosis.
(SINQ#2009-1114; 2007 SEER Manual, pg 7, #A.7)

Question 5: MP/H Rules – Multiple primaries – Lung: How many primaries are to be accessioned for the following case: Adenocarcinoma of the lung in the right middle lobe of the lung and bronchioalveolar carcinoma, non-mucinous type, in the right upper lobe? See discussion.

SEER Coding Questions-*continued*

Discussion: Bilobectomy revealed two tumors, adenocarcinoma in the right middle lobe and bronchioalveolar carcinoma, non-mucinous type, in the right upper lobe. MP/H rule M10 states that tumors with non-small cell carcinoma (8046) and a more specific non-small cell type (chart 1) are a single primary. Does rule M10 apply to only those cases for which one tumor is stated to be non-small cell, NOS? Or do we use chart 1 to identify specific subtypes? For this case, using chart 1, would we note that bronchioalveolar is a subtype of adenocarcinoma and count this case as a single primary? Most of the MP/H rules schemas offer an option of considering an adenocarcinoma and a more specific type of adenocarcinoma to be a single primary. Would we apply rule M10 to this case and count it as a single primary? Or would we move on to rule M11 and count the case as two primaries?

Answer: *Rule M11 applies. Accession two primaries. Rule M10 applies only to cases for which one tumor is stated to be "non-small cell carcinoma".*
(SINQ#2009-1119; 2007 SEER Manual C-496)