A Quarterly Newsletter from the Kentucky Cancer Registry

In The Abstract

LARGE HOSPITAL EDITION JANUARY 2011

INSIDE THIS ISSUE:

KCR Data Featured by CDC

Kentucky Cancer Registry data were highlighted on a CDC webpage December 6, 2010. Dr. Thomas Tucker spoke on the same topic, colorectal cancer data, at the KCR Fall Workshop in September. Although the CDC article is not currently posted, it can be found in the December 2010 archives. A copy is provided here in appreciation of the Kentucky cancer registrars' dedication to the collection of high-quality data:

Kentucky: Using Cancer Registry Data to Reduce the Burden of Colorectal Cancer

The Kentucky Cancer Registry recognized that colorectal cancer incidence and deaths were increasing in the state, and only about one-third of the eligible population had been screened for colorectal cancer. In addition, the Registry discovered that colorectal cancer was the second most common cause of cancer death in men and women combined. Since colorectal cancer has known screening and early detection methods, the Registry presented the data to state and regional cancer control representatives, encouraging them to implement cancer control activities to address this problem. Since the Registry first identified the problem using 2001 data, the state of Kentucky began working collaboratively to address this issue. The Registry has continued to highlight the need for intervention and monitor progress. In partnership with state and regional comprehensive cancer control programs (Kentucky Cancer Consortium and Kentucky Cancer Program), Kentucky has reduced the burden of colorectal cancer significantly. The percentage of eligible Kentuckians who were screened with sigmoidoscopy or colonoscopy rose from 34.7% in 1999 to 63.7% in 2008. Colorectal cancer incidence among men and women combined fell from 68.5 per 100,000 population in 2001 to 57.1 per 100,000 population in 2006, and deaths fell from 22.4 to 18.9 per 100,000 during the same time period.

Using registry data to focus on colorectal cancer has resulted in fewer Kentuckians being diagnosed with and dying from the disease. In addition, this success provides opportunities to address other cancer priorities areas using cancer registry data. (Original CDC website posting 12/07/10; www.cdc.gov/Features/CancerPrograms/)

People News

New Hires:

Cassie Geiger	St. Elizabeth Healthcare, Ft. Thomas
Sherrie Halstead	Norton Healthcare, Louisville
Audra Hillerman	Pikeville Medical Center, Pikeville
Tamika Hudson	Norton Healthcare, Louisville
Marsha Tucker	Murray-Calloway County Hospital, Murray

Promotion:

Anne Fields	KCR Casefinding Auditor, Lexington

Resignations:

Pam Collier	Highlands Regional Medical Center, Paintsville
Sherry Fralick	Jennie Stuart Medical Center, Hopkinsville
Kristie Kneebone	Murray-Calloway County Hospital, Murray
Kelly Pictor	KCR Casefinding Auditor, Lexington

New CTRs:

Erin Collins-Buchanan	Central Baptist Hospital, Lexington
Scott Myers	King's Daughters Medical Center, Ashland

Name Change:
Serenea Pabst (St. Elizabeth Healthcare, Ft. Thomas) is now Serenea Lewis

ACoS Approved Programs

* St. Elizabeth Healthcare, Edgewood has received notice of full three-year approval with commendations in ALL areas following their most recent survey. This qualifies their facility as a 'candidate' for the 2010 Outstanding Achievement Award. Congratulations to Cathy Reising and her team of registrars!
* St. Elizabeth Healthcare, Ft. Thomas has also received full three-year approval with commendations 'across the board.' This facility likewise qualifies as a candidate for the 2010 Outstanding Achievement Award. Please accept our hearty best wishes, Ft. Thomas registrars!

Breast Cancer Center Accreditation

Owensboro Medical Health Systems' Breast Center was recently awarded full three-year accreditation by the National Accreditation Program for Breast Centers. This is the third facility in Kentucky to receive the award. Congratulations to our breast cancer center colleagues in Owensboro!

NAACCR Comes to Louisville

The Kentucky Cancer Registry is hosting the 2011 Annual Conference of the North American Association of Central Cancer Registries (NAACCR) in Louisville, Kentucky this year from June 21-23. The conference meetings will be held at the Hyatt Regency Louisville and the Kentucky International Convention Center. Pre- and post-conference workshops will also will available during the week of June 18-24. The conference theme this year is "***Cancer Surveillance: Keeping Pace with Policy, Science, and Technology***." The conference will feature internationally recognized speakers on this theme, exploring how public health policy, advances in medical science, and innovations in health information technology have an impact on cancer surveillance. They will also demonstrate how cancer surveillance activities inform public policy and contribute to advances in the science of cancer care and cancer control. More information about the conference and registration materials will be posted in mid-February on the conference web site at http://www.naaccr.org/EducationandTraining/AnnualConference.aspx.

It's A New Year!

With the clock already ticking away in 2011, registrars continue to conquer changes in the data collection world. CPDMS.net has been updated for 2011 NCDB submissions. Additional software updates and improvements continue to be forthcoming from the CPDMS.net support staff. There will be a conversion from CSv02.02 (currently in use) to CSv02.03 in April, which will require numerous revisions to the CS manuals and to the CPDMS.net software. Multiple Spring Training sessions are being planned and scheduled in various locales around the state, and the updated CSv2 (02.03) rules will be covered (*see training dates/locations on page 4*). Yes, it may be a new calendar year, but registrars continue to whittle away on their 2010 case-finding lists, as they look forward to 2011 changes. We are a unique breed of professionals; not only are we surviving, we are ***succeeding.***

Calendar of Events

January 31- Even year CTR CE's due
February 12-13 - NCRA CTR-Prep Workshop, Baltimore
March - NAACCR CTR-Prep Webinar Series
March 5-19 - CTR Exam "Window"
April - KCR Spring Training (*see dates and locations on page 4*)
May 15-18 - NCRA Annual Conference, Orlando FL

New NCDB Submission Schedule Begins....

All ACoS-approved programs are busily cleaning 2009 data and any 1998 cases that were changed on/after 7/1/09, in preparation for the first 2011 "Call for Data." This will be a busy submission year indeed, as multiple NCDB submissions are planned. A compilation of submissions is included below for your quick reference:

Submission Period	Case Diagnosis Years	Required if added/updated after:
Jan 1-31, 2011	2009	Submit all cases
" " "	1998	7/1/2009
Mar 1-31, 2011	2008	7/1/2009
" " "	2003	7/1/2009
May 1-31, 2011	2007	7/1/2008
" " "	2004	7/1/2005
July 1-31, 2011	2006	7/1/2007
" " "	2001	7/1/2007
Sept 1-30, 2011	2005	7/1/2006
" " "	2002	7/1/2008
Nov 1-30, 2011	2000	7/1/2006
" " "	1999	7/1/2005

(from COC/NCDB website)

NCRA Exam Readiness Webinars

A series of three webinars for registrars preparing to take the CTR Exam will begin in February 2011. At a cost of $50 each for NCRA members and $75 each for nonmembers, the NCRA series runs on February 17, 24, and March 3. Topics featured include Computers, Statistics/Epidemiology, and Exam Taking Tips. Register online at the NCRA website at www.ncra-usa.org.

KCR Education & Training 2011

SPRING TRAINING:

April 12	Lexington KY	St Joseph Hospital/Bldg D, 4th Floor, Chase Room	8:30am-4:30pm
April 14	Madisonville KY	Trover Clinic Tower, Lomon Trover Conference Room	8:30am-4:30pm
April 19	Louisville KY	Norton Audubon Hospital Community Room LL2	8:30am-4:30pm

FALL CONFERENCE:

September 8-9 - Galt House Hotel, Louisville KY

When making hotel reservations, ask for the Kentucky Cancer Registry rate. All rooms in our block are suites. The rates are: Single $101.00; Double $111.00; Triple $121.00, and Quad $131.00 per night, plus tax. For more information about the Galt House, go to GaltHouse.com or call 1-800-The-Galt.

Parking will be free for hotel guests; for those driving in daily, you will need to see Reita Pardee for a parking sticker.

Abstracting Bits & Pieces

- In-situ breast carcinoma grading, when mentioned in the pathology report, is now coded as shown in the Abstractor's Manual "Bloom-Richardson Grading for Breast Cancer" table. In-situ breast grades should fit in with either the BR Grade or Nuclear Grade columns.
- Remember to ignore "foci", "focal", or "focus" when these terms are used to identify an additional histology subtype for any cancer primary.
- CPDMS Abstractors' Manual 2010 was updated on 12/17/10. Notice the description of "Date of 1st Contact," which was taken directly from FORDS 2010…. There is no mention of pre-treatment workup or planning.
- Lymphoma in-situ is currently NOT reportable; do not abstract such cases at this time.
- CTR Exam details can be found at www.ctrexam.org.
- Watch NAACCR webinars in the comfort of your own registry office! Kentucky-based registrars are invited to visit the KCR website and watch individual topics at no local registry charge.
- Future NCRA annual conference sites have been announced:
  2011-Orlando, FL; 2012-Washington, DC; 2013-San Francisco, CA;
  2014-Nashville, TN; 2015-Las Vegas, NV; 2016-San Antonio, TX;
  2017-Washington, DC. (NCRA Board Highlights 11/13/10)

Change in Clinical Prostate Terminology for 'Apparent'

Clinical Extension codes for prostate revolve around the concept of 'apparent' versus 'inapparent' tumor. There has been a slight change in the wording of Note 2A for this field in CSv2 (02.02), when compared to the wording in the original Collaborative Staging Manual. The updated statement is as follows: "A clinically apparent tumor/nodule/mass is palpable or visible by imaging. Do not infer inapparent or apparent tumor based on the registrar's interpretation of *other* terms in the DRE or imaging reports."

How will this affect your CS Extension coding? For prostate cases where no direct mention is made of 'apparent' or 'inapparent' tumor, and there is no clinical T stage mentioned by the physician in the chart, the registrar can consider the cancer is apparent, based on chart documentation including one of the descriptions listed for Note 2A (**tumor, mass, nodule**) and code CS Extension accordingly.

When there is no mention of tumor, mass, or nodule, and there is no stage given for the case, and the physician fails to mention 'apparent' or 'inapparent' tumor, the registrar should continue to code "300" for localized, NOS (code "30" in CSv1).

When a physician stages a prostate cancer as "cT1c" and also documents a "tumor", or "mass", or "nodule" on physical exam, code CS Extension from the staging documentation. That staging element takes precedence over an inferred description.

Grading Colon and Rectal Carcinomas

Coding the grade for colorectal cancers is simple in that the CAP protocol shows only 2 potential codes: low grade and high grade. Colon carcinoma may be coded either '2' for well or moderately differentiated tumors or '4' for poorly or undifferentiated tumors. These are the only two options, and they are shown in this extract from the CAP checklist:

Histologic Grade
___ Not applicable
___ Cannot be determined
___ Low-grade (well-differentiated to moderately differentiated)
___ High-grade (poorly differentiated to undifferentiated)

This 2-code concept has confused 'seasoned' abstractors, who years ago simply coded 1, 2, 3, or 4 from the terms 'well differentiated' (1), 'moderately differentiated' (2), 'poorly differentiated' (3), or 'undifferentiated' (4) as shown on pathology reports. Those of us with many years of abstracting experience under our belts who continue to abstract 2010 cases need to take note and jump on the bandwagon! If a colon resection path report shows well differentiated adenocarcinoma, code '2' for low grade. When in doubt, go to the CAP checklist to determine the appropriate terminology/grade. The 2-Grade System is included in the 2010 Abstractor's Manual under the "Tumor Grade" data item, which is shown below.

Two-Grade System
Two grade systems apply to colon, rectosigmoid junction, rectum (C18.0-C20.9), and heart (C38.0). Code these sites using a two-grade system- Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as Low Grade, use code 2. If the grade is listed as 2/2 or as High Grade, use code 4.

Code	Terminology	Histologic Grade
2	Low grade	1/2
4	High grade	2/2

Instructions show to code "2" for low grade or "4" for high grade. The CAP extract shows that well-differentiated to moderately differentiated is coded as "Low Grade," and poorly differentiated to undifferentiated is coded as "High Grade."

Did You Know?

- The FDA has approved the use of Gardasil in the prevention of anal cancers that are linked to certain HPV types. (American Cancer Society website; article date 12/22/10)
- A series of NIH experiments on UV light exposure and melanoma has led to the discovery that interferon-gamma acts in promoting the disease. Interferon-gamma ordinarily functions in the immune system as a "communicator" between cells. (NCI website 1/20/11)
- NIH researchers recently found that gastrointestinal stromal tumors (GIST) are linked to low oxygen levels within cells. An enzyme that helps supply oxygen shuts down, leading to the O2 deficiency. (NCI website 1/20/11)

SEER Coding Questions

Review these new SINQ coding questions for ongoing education:

Question 1: Surgery of Primary Site - Brain & CNS: How should surgery be coded when the procedure is stated to be a "stereotactic CORE biopsy" of a brain tumor? See Discussion.

Discussion: The most recent version of the Brain Site Specific Surgery schema has a note that states "Assign code 20 for stereotactic biopsy of brain tumor." Does this also apply to a stereotactic CORE biopsy? SINQ 2008-1118 also states that a stereotactic biopsy should be coded as Surgery code 20.

Answer: *Assign code 20 for stereotactic core biopsy of brain tumor.*
(SINQ #2010-0059, last updated 11/29/10; 2010 SEER Manual, Appendix C)

Question 2: Primary site/Histology - Heme & Lymphoid Neoplasms: How should we code the site and histology for Langerhans cell histiocytosis? For example, Langerhans cell histiocytosis diagnosed from excisional biopsy, T8 vertebral bone. No other tissue biopsy. The doctor's confirmation is malignant, but Langerhans cell histiocytosis, NOS is listed as /1 (borderline) in ICD-O-3.

Answer: *Do not use the ICD-O-3 to look up histology codes for [hematopoietic] cases diagnosed in 2010 and later. Enter "langerhans" in the Hematopoietic DB search. The ICD-O-3 code is 9751/3 which is reportable. Next see the abstractor notes for Langerhans cell histiocytosis. The abstractor notes say lytic bone lesions are the most common primary site. Code the primary site to bone, vertebral.*
(SINQ #2010-0100, last updated 12/10/10; 2010 Heme & Lymph Manual & DB)

Question 3: Primary site/Histology - Heme & Lymphoid Neoplasms: Bone marrow biopsy on 6/18/2008 and the final diagnosis on the path report is small B cell leukemia, most consistent with mantel cell leukemia. ICD-O-3 does not list a histology code for small B cell leukemia or mantle cell leukemia. What histology code is used for this diagnosis and would the primary site be coded to bone marrow?

Answer: *Code the histology to mantle cell lymphoma and the primary site to bone marrow. Mantle cell lymphoma can present in a leukemic phase. The only code available is for mantle cell lymphoma and the only primary site that could be coded would be bone marrow. The same would be done for a case diagnosed in 2010 or later.*
(SINQ #2010-0098, last updated 12/10/10; WHO Class Hem & Lymph Tumours, 2008, pg 229; ICD-O-3)

Question 4: Primary site/Heme & Lymphoid Neoplasms: I have a question regarding Module 6/PH 24. If the lymphoma is found initially in both lymph nodes and bone marrow and we don't have the pathology available (many … class 2 cases) to determine primary site, do we automatically code this to C42.1 over C77? The abstractor's notes state it can be either bone marrow or lymph nodes. The physician only states that they are both involved.

Answer: *When you are having problems coding primary site, go to Module 7 Primary Site Rules for Lymphomas Only. See PH 32 that says to code to bone marrow when ONLY the bone marrow is involved. Since both the bone marrow and LN are involved, code to LN (specific nodes if a specific region is specified; if no region is specified, code to LN, NOS C77.9).*
(SINQ #2010-0089, last updated 12/02/10; 2010 Heme & Lymph Manual & DB)

Question 5: Reportability - Heme & Lymphoid Neoplasms: Is Thrombocytosis, NOS reportable? (It does not specify Primary, Idiopathic, Essential.)

Answer: *Unless the disease is specified as primary, idiopathic, essential, or the physician states there is a myeloproliferative neoplasm, the term thrombocytosis, NOS is not reportable. Thrombocytosis, NOS is the presence of high platelet counts in the blood. Thrombocytosis can be associated with chronic infections and other diseases as well as with myeloproliferative disease.*
(SINQ #2010-0076, last updated 12/02/10; 2010 Heme & Lymph Manual & DB)