In The Abstract

A Quarterly Newsletter from the Kentucky Cancer Registry

JANUARY 2015

INSIDE THIS ISSUE:

2015 Spring Training

KCR Spring Training is tentatively set for late April. Users may enter 2015 cases any time after the Jan. 20th update of CPDMS.net

ACoS Approved Programs

Congratulations to Jewish Hospital and St Mary's Healthcare for receiving Silver level CoC accreditation and Flaget Memorial Hospital for receiving first time accreditation on CoC survey!
Congratulations to St. Joseph Hospital and St. Joseph Hospital East! Both were awarded full CoC accreditation Silver level with no deficiencies in September 2014!

Cancer Awareness

January - Cervical Cancer Awareness Month
February - Gallbladder & Bile Duct Cancer Awareness Month
National Cancer Prevention Month
March - Colorectal Cancer Awareness Month
Kidney Cancer Awareness Month
Multiple Myeloma Awareness Month

People News

New Hires:

Bryan Baseheart	University of Kentucky
Jennye Bush	University of Louisville
Sarah Childress	Lake Cumberland Regional Hospital
Roger Chui	KCR IT Team
Amanda Coffey	Norton Healthcare
Y-Vonnie Foster (*eff Jan 26)*	Ephraim McDowell
Emily Reed	University of Kentucky

Resignations:

Sara Adams	KentuckyOne Health Lexington
Amanda Coffey	Lake Cumberland Regional Hospital
Amanda Moore	Baptist Health Louisville
Jan Penick	University of Louisville
Emily Reed	KCR

New CTRs:

Agnes Caudill	Hazard Regional Medical Center
JoHannah Cook	Norton Healthcare
Tamika Hudson	Norton Healthcare
Talisa Lewis-Best	Norton Healthcare
Susan Yunt	Norton Healthcare

Golden Bug Award

Congratulations to our latest Golden Bug winner, Frieda Herald, who identified an issue with last month's central follow up report. She also identified an inconsistency with Data Analysis Descriptive stats and graphs for Topography and Histology translations

News from *The CoC Brief*, Top 20 Articles

Prostate cancer 'could be transmitted sexually'
WebMD
From May 28: Prostate cancer might be a sexually transmitted disease caused by a common infection, according to a study. Experts say the research has limitations and is not proof, though. Scientists at the University of California found evidence of a link between prostate cancer and the STD trichomoniasis, in which a common parasite is passed on during unprotected sexual contact.

Prostate cancer patients face higher risk of second malignancies
Renal & Urology News
From July 30: Prostate cancer (PCa) patients are at increased risk for secondary primary malignancies compared with the general population, a study found. In this study of 20,558 PCa patients in Zurich, Switzerland, 1,718 developed a second primary tumor after their PCa diagnosis, most frequently lung and colon cancer (15 percent and 13 percent, respectively).

Breast cancer vaccine shows promise in slowing progress
TIME
From Dec. 3: An initial safety trial of a breast cancer vaccine has proven safe, with preliminary results suggesting the vaccine will slow cancer progression. The vaccine, which is being developed by researchers at Washington University School of Medicine in St. Louis, is meant for patients with breast cancers that express a protein found only in breast tissue called mammaglobin-A

A possible explanation for why brain tumors are more common, and more harmful, in males
Oncology Nurse Advisor
From Aug. 20: New research helps explain why brain tumors occur more often in males and frequently are more harmful than similar tumors in females. For example, glioblastomas, the most common malignant brain tumors, are diagnosed twice as often in males, who suffer greater cognitive impairments than females and do not survive as long. The researchers found that retinoblastoma protein (RB), a protein known to reduce cancer risk, is significantly less active in male brain cells than in female brain cells.

Breast cancer vaccine shows promise in slowing progress
TIME
From Dec. 3: An initial safety trial of a breast cancer vaccine has proven safe, with preliminary results suggesting the vaccine will slow cancer progression. The vaccine, which is being developed by researchers at Washington University School of Medicine in St. Louis, is meant for patients with breast cancers that express a protein found only in breast tissue called mammaglobin-A.

Coding Reminders

- Acinar Adenocarcinoma of the prostate is coded to 8140 Adenocarcinoma per MPH rule H10.
- Encapsulated follicular carcinoma of the thyroid 8335.
- Encapsulated papillary carcinoma of the thyroid 8343/3.
- There is no encapsulated code for papillary carcinoma, follicular variant, code to 8340.
- AJCC defines Tis on page 151 of the 7th edition manual as follows: "the definition of in-situ carcinoma – pTis – includes cancer cells confined within the glandular basement membrane (intraepithelial) or lamina propria (intramucosal) with no extension through the muscularis mucosae into the submucosa. Neither intraepithelial nor intramucosal carcinomas of the large intestine are associated with risk for metastasis." And, while this is derived as a Stage 0, the behavior code should be /3 since there are cancer cells in the basement membrane and beyond still without the risk for developing metastasis. This situation is unique to the colon.

(Reference: CAnswer Forum Thread: Intramucosal Carcinoma in a polyp).

Reportability Reminders

- Tectal plate lipoma of the brain is reportable.
- Dermoid cyst of brain is reportable.

References/Resources

◊ CAP protocols
◊ NCCN guidelines
◊ FORDS manual
◊ SEER manual
◊ CPDMS web help
◊ SEER educate
◊ KCR website

Calendar of Events

January 19, 2015 - Martin Luther King Holiday, KCR Office Closed
January 31, 2015 - CTR exam application deadline
February 28-March 21, 2015 - CTR exam testing window
May 29, 2015 - CTR exam application deadline
June 20-July 11, 2015 - CTR exam testing window
September 18, 2015 - CTR exam application deadline
October 17-November 7, 2015 - CTR exam testing window

SEER Coding Questions

Question
MP/H Rules/Histology--Breast: What is the histology code for invasive carcinoma of the breast, no special type? See Discussion.

Discussion
Recently pathology reports for breast primaries are no longer listing invasive ductal carcinoma as the histology on many cases if the treating physician calls the cancer an invasive ductal carcinoma. The pathology report (final diagnosis and synopsis) state this is invasive carcinoma, no special type.
Upon inquiry to the pathology department, the response received stated, In 2012, the WHO got rid of ductal carcinoma as a specific type. So what would have been called Invasive ductal carcinoma, Not Otherwise Specified (NOS), is now being called Invasive carcinoma, No Special Type (NST). In the new WHO classification, lobular, tubular, cribriform, mucinous, etc. are the special types. But ductal is gone.
Is this a change in terminology? Should these cases be coded as 8500/3 [ductal carcinoma, NOS] or 8010/3 [carcinoma, NOS]?

Answer
Code the histology to ductal carcinoma, NOS [8500/3] for invasive carcinoma, no special type. Do not code the histology to carcinoma, NOS [8010/3].
The 4th Edition of the WHO Classification of Tumors of the Breast refers to invasive ductal carcinoma as invasive carcinoma, no special type. The ICD-O-3 code remains the same as invasive duct carcinoma [8500/3]. The next revision to the MP/H Solid Tumor Rules will clarify this issue.
(SEER SINQ 2013-0170; Date Finalized 2/16/14; WHO Class Breast tumors)

Question
MP/H Rules/Multiple primaries--Colon: Does rule M7 apply here (A frank malignant or in situ adenocarcinoma and an in situ or malignant tumor in a polyp are a single primary)? Can the frank malignant adenocarcinoma be any specific type of adeno-carcinoma for this rule to apply?
A patient has 2 synchronous tumors in the ascending colon. The first is grade 3 adenocarcinoma with signet ring differentiation and focal mucinous features (8255/3). The second is grade 2-3 adenocarcinoma in a tubulovillous adenoma (8263/3).

Answer
M7 applies to this case. The frank adenocarcinoma can be a specific type of adenocarcinoma.
(SINQ 2014-0086; Date Finalized 12/18/14; 2007 MP/H rules)

Question
Reportability--GIST: The 2014 SEER Program Coding and Staging Manual and the answer to SINQ 20100014 appear to conflict with respect to reporting GIST cases. The manual states (p.5, exception 1) that we are to accession the case if the patient is treated for cancer. However, the patient in Example #7 in the SINQ discussion is receiving chemotherapy, but is deemed not reportable. This is a problematic issue in our area, as pathologists prefer using the NCCN “Risk Stratification of Primary GIST by Mitotic Index, Size and Site” table rather than stating whether the tumor is benign or malignant. Although they tell us that moderate or high risk should receive treatment, they will not characterize them as malignant.

Answer
Determining reportability for GIST is problematic because of the reluctance of pathologists to use the term "malignant" for GIST cases. If you can document the pathologist's terminology and case characteristics (e.g. treatment) that correspond to "malignant" for your registry as part of the registry's policies and procedures, you can report those cases as malignant.
The exception cited above in the SEER manual pertains to a clinical diagnosis with a negative pathology report. Normally, the negative pathology report would override the clinical diagnosis and the case would not be reportable. However, if the patient is treated for a malignancy in spite of the negative pathology, report the case.
(SINQ 2014-0088; Date Finalized 12/18/14; 2014 SEER manual)

SEER Coding Questions *(continued)*

Question

MP/H Rules/Multiple primaries--Thyroid: How many primaries should be reported when a complete thyroidectomy specimen shows two tumors: 1.8 cm papillary carcinoma with tall cell features (8344/3) and a 0.4 cm papillary thyroid carcinoma (8260/3)? See discussion.

Discussion

Is papillary thyroid carcinoma an NOS histology qualifying for rule M16, thus leading to a single primary, or would M17 apply (multiple primaries) because the histology codes are different at the second digit (8260 and 8344)? While rule M16 doesn't include papillary thyroid carcinoma in the listed histologies, it seems like it may be an NOS histology for the thyroid. In addition, code 8260/3 is listed as NOS in the ICD-O-3.

Answer

Apply rule M16 and abstract a single primary. These two thyroid tumors, one papillary carcinoma with tall cell features (8344/3) and one papillary thyroid carcinoma, fit the criteria for rule M16, although not explicitly listed there. We will clarify this in the next version of the rules.
(SINQ 2014-0083; Date Finalized 11/26/14; 2007 MP/H rules, other sites)