*A Quarterly Newsletter from the Kentucky Cancer Registry*

# In The Abstract

JULY 2016

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## KCR Fall Workshop Goes Regional

KCR is excited to announce that it will be teaming up with Indiana to offer a regional Fall Workshop this year. The first Kentucky-Indiana Regional Cancer Registrar Meeting, presented by the Kentucky Cancer Registry, the Indiana Cancer Registrars Association, and the Indiana Cancer Consortium will be held Thursday and Friday, September 8-9, 2016. The conference will be held at the Holiday Inn Louisville East located at 1325 South Hurstbourne Pkwy, Louisville KY.

This year's workshop will be the 30th annual meeting for the Kentucky Cancer Registry and what a better way to celebrate then to make this year a regional meeting! We will have national speaker Jayne Holubowsky, Training and Development Coordinator for the Virginia Cancer Registry as well as Advocacy and Technical Director for NCRA, East Region, speaking on various TNM topics. There will be presentations from both Kentucky and Indiana speakers on topics regarding lung and colorectal cancers, chronic myelogenous leukemia, and brain tumors.

We will also be offering a new Thursday morning break option. Susie Stewart, from Floyd Memorial in Indiana, is a Pilates Instructor with over 10 years of teaching experience and trained in both Mat and Reformer Pilates. She is also a Certified Breast Cancer Exercise Specialist trained through the Pink Ribbon Program, and she has offered to lead an optional exercise routine during the morning break.

The preliminary agenda has been developed and the registration materials are available on our website at *https://www.kcr.uky.edu/training*. Mark your calendar and plan to attend!

## Calendar of Events

*September 8-9, 2016 – KCR Fall Workshop/Regional Meeting in Louisville*
*September 16, 2016 – CTR exam application deadline*
*October 15-November 5, 2016 – CTR exam testing window*

# People News

**Promotions:**

| | |
|---|---|
| Tracy Mausteller | Lead Registrar, Baptist Health Louisville |
| Jodee Chumley | Cancer Registry Manager - Baptist Health Louisville |

**New Hires:**

| | |
|---|---|
| Laura Cook | University of Kentucky Healthcare |
| Teresa Ford | Baptist Health Paducah |
| Michelle Sumpter | Norton Healthcare |
| Shannon Ladd | KCR Abstractor Coordinator for Patterns of Care Studies |
| Lakisha Parris | Norton Healthcare |
| Rachel Maynard | Frankfort Regional Medical Center |
| Melissa Cromer | Lake Cumberland Regional Hospital |

**Resignations:**

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|---|---|
| Emily Reed | University of Kentucky Healthcare |
| Laura Cook | Medical Center of Bowling Green |
| Cindy Traylor | Kentucky Cancer Registry |

**Retirements:**

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|---|---|
| Sam Underwood | Taylor Regional Hospital |
| Pam Fitzpatrick | Baptist Health Lexington |

**New CTRs:**

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|---|---|
| Bryan Baseheart | University of Kentucky Healthcare |

## ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- **University of Louisville/James Graham Brown Cancer Center** received the Commission on Cancer 2015 Outstanding Achievement Award with all seven commendations, one of only 27 US health care facilities to earn this national honor for surveys performed July 1-December 31, 2015 and one of three in Kentucky. The facility also received a 3 Year Re-accreditation award from NAPBC.
- **Baptist Madisonville** on passing their recent CoC survey!
- **Baptist Paducah** on passing their recent CoC survey!
- **Taylor Regional Hospital** received 3 year with commendation accreditation, Silver Level on their April 2016 CoC survey!

# AJCC Staging Reminders

**Clinical Staging: Imaging, exam, endoscopic procedures, diagnostic biopsies**

**X = something was done (imaging, endoscopy, etc) BUT can't be assessed**

**Blank = nothing was done to assess**

**EXAMPLE: Screening colonoscopy revealed an obstructive mass in the sigmoid colon. BX obtained. Path: Invasive adenocarcinoma. Imaging revealed mass in sigmoid with no LAD or METS noted.**

**cTx cN0 cM0 cStage Unknown**

**Pathologic Staging: Clinical info + histologic exam of surgically resected specimen**

**Does your case meet criteria to be pathologically staged in one of these 3 ways ?**
- **Surgical resection per the site chapter**
- **Highest T biopsied PLUS highest N biopsied**
- **Metastatic site histologically confirmed**

**Once a case is eligible to be pathologically staged, you cannot have any blanks. The T, N and M must all have a value or an X.**

⇨ ***If your case doesn't meet at least one of the 3 criteria listed above, your pathologic staging will be blank (except for stage group which will be 99 unknown).***

⇨ ***If your case does meet one of the three criteria listed above, the pT, pN, pM and pStage group cannot be blank.***

# AJCC Pathologic Staging Examples

**#1**

**Imaging reveals a R kidney mass measuring 1.2 cm with no evidence of renal vein or IVC involvement. No LAD or METS identified. R partial nephrectomy performed. Path: RCC, 1.3 cm, confined to kidney, no nodes examined, margins negative.**

**cT1a cN0 cM0 cStage I**
**pT1a pNx cM0 pStage Unk (the N category is needed to assign the stage group)**
**[*This case meets criteria for pathologic staging described above in scenario #1]**

**#2**

**Imaging reveals R kidney mass measuring 3.9 cm with evidence of renal vein involvement. No LAD or METS identified. R partial nephrectomy performed. Path: RCC, involvement of renal vein present, margins negative, no nodes examined.**

**cT3a cN0 cM0 cStage III**
**pT3a pNx cM0 pStage III (the N category is not needed to assign the stage group, wouldn't make a difference if N0 or N1, both are Stage III)**
**[*This case meets criteria for pathologic staging described above in scenario #1]**

**#3**

**Imaging reveals LUL lung mass invading the mediastinum with bil hilar, bil mediastinal and bil supraclavicular LAD c/w regional nodal METS. Mediastinoscopy performed in which surgeon states he biopsied the mediastinal portion of the primary L lung tumor. Path: SCC. He also biopsied bil mediastinal LNs (R & L paratracheal & subcarinal) which were positive on path for metastatic SCC.**

**cT4 cN3 cM0 cStage IIIB**
**pT4 pN3 cM0 pStage IIIB**
**[*This case meets criteria for pathologic staging described above in scenario #2]**

**#4**

**MRI reveals R frontal lobe mass. CT/PET reveals Sigmoid colon thickening. No LAD or METS identified. PT taken to surgery for resection of brain mass. Path: Metastatic Adenocarcinoma c/w colorectal primary.**

**cTx cN0 pM1a pStage IVA**
**pTx pNx pM1a pStage IVA**
**[*This case meets criteria for pathologic staging described above in scenario #3]**

## More AJCC Staging Reminders

**IN-SITU/NON-INVASIVE**

**In-situ cannot be determined on imaging alone and must be confirmed microscopically. The correct AJCC clinical staging for in-situ is pTis cN0 cM0 cStage 0. The cN0 and cM0 will move down to pathologic staging if applicable. No nodes are required to be evaluated for in-situ OR Stage IA melanoma cases only, per AJCC manual.**

**Example: R breast BX showing DCIS. Lumpectomy performed. Path: DCIS. No nodes examined.**
**pTis cN0 cM0 cStage 0**
**pTis cN0 cM0 pStage 0 (You can stage this pathologically *only because* the lumpectomy was performed).**

**Example: TURBT shows L lateral wall bladder non-invasive papillary TCC. No further treatment performed, observation only.**
**pTa cN0 cM0 cStage 0**
**pTblank pN blank pM blank pStage 99/unknown. (case is not eligible for pathologic staging since a partial cystectomy or radical cystectomy was not performed).**

**MELANOMA**

**"*By convention, clinical staging should be performed after complete excision of the primary melanoma (including microstaging) with clinical assessment of regional LN.*"**
NOTE: You can use information from the resection (surgical procedures) to code your cT, unlike other sites**.**

***"Pathologic staging will use information gained from both microstaging of the primary melanoma and pathologic evaluation of the nodal status after SLN BX and/or complete regional LAD. Pathologic Stage 0 or Stage IA patients are the exception; they do not require pathologic evaluation of their lymph nodes."*****(AJCC manual, Melanoma chapter, pages 330, 338 **under stage group).**

**Example: L leg abnormal mole. PE: No LAD in groin. Shave BX: L lower leg malignant melanoma, Clark's level III, 1.05 mm in depth with ulceration, negative margins. Wide excision w/ SLN BX performed. Path: No residual melanoma. SLN negative.**
**cT2b cN0 cM0 cStage IIA**
**pT2b pN0 cM0 pStage IIA (The T2b is assigned both as cT and pT since there was evaluation of LNs performed).**

**Example: R upper arm suspicious skin lesion identified on PE. No LAD in neck or axillae. Shave BX: Superficial Spreading Malignant Melanoma, Clark's level II, 0.5 mm thickness w/out ulceration and mitosis < 1/mm2. No nodes examined.**
**cT1a cN0 cM0 cStage IA**
**pT1a cN0 cM0 pStage IA (the cN0 can be moved down since this is a stage IA melanoma and LNs are not required to be evaluated per AJCC manual).**

# SEER Coding Questions



**Question**
Reportability--Thyroid: Is a final diagnosis of "non-invasive follicular thyroid neoplasm with papillary-like nuclear features" reportable when the diagnosis comment states this tumor was historically classified as encapsulated follicular variant of papillary thyroid carcinoma? See Discussion.

**Discussion**
The term "non-invasive follicular thyroid neoplasm with papillary-like nuclear features" is now being used, instead of the previous classification of an encapsulated malignant thyroid tumor. Recent evidence supports a very minimal risk of aggressive behavior for these tumors, and pathologists in our area are no longer classifying these as malignant in the final diagnosis.

**Answer**
We are discussing this terminology change with the other standard setters and with the ICD-O-3 Implementation Workgroup. When a consensus decision is made, it will be reflected in the revised MP/H (to be known as Solid Tumor) rules. For now, you can report noninvasive follicular thyroid neoplasm with papillary-like nuclear features as a synonym for encapsulated follicular variant of papillary thyroid carcinoma and assign 8340/3. Document this in a text field.
(SINQ 2016-0040, Date Finalized: 6/22/16; ICD-O-3)

**Question**
MP/H Rules/Histology: What is the correct histology code for a NUT midline carcinoma?

**Answer**
Code histology to 8010/3.
NUT carcinoma is identified by the *NUTM1* gene rearrangement.
NUT midline carcinomas (NMC) are lethal and morphologically indistinguishable from other poorly diff carcinomas. They are epithelial tumors which can range from undifferentiated carcinomas to carcinomas with prominent squamous differentiation.
A new proposed ICD-O-3 code has been suggested for NUT tumors but it is not yet approved for implementation. Do not use the new code until it is approved for use in the United States.
(SINQ 2016-0025; Date Finalized: 6/23/16; MPH Rules/ICD-O-3)

**Question**
Surgery of primary site--Lung: Should microwave ablation be coded as treatment for lung cancer, and if so, how should it be coded?

**Answer**
Code microwave tumor ablation as surgery. For lung, assign code 15.
This question was discussed by the technical advisory group – a small group of representatives from each standard setter which meets periodically. The group agreed on this consensus answer.
(SINQ 2016-0014; Date Finalized: 3/31/16)