KENTUCKY CANCER REGISTRY

KCR NEWSLETTER

Don't be left out in the cold, STAY INFORMED!

Issue: December 2019

Calendar of Events

January 1-20, 2020: CTR exam testing window.

January 31, 2020: CTR exam application deadline.

March 6-27, 2020: CTR exam testing window.

Commission on Cancer

The Commission on Cancer (CoC) is pleased to announce that its new accreditation standards, Optimal Resources for Cancer Care (2020 Standards), are now available for download.

https://www.facs.org/-/media/files/quality-programs/cancer/coc/optimal_resources_for_cancer_care_2020_standards.ashx

CoC Online Education

- Online series with tips for each standard—*To be released early 2020 (information will be at the CoC website)*
- CAnswer Forum LIVE 2020—*Six webinars beginning in February 2020*

Available Trainings and Webinars at kcr.uky.edu

NAACCR Webinar Series 2019-2020

NAACCR presents a different webinar series throughout the year beginning in October and continuing through September of the following year. These webinars carefully review how changes to histology coding, the solid tumor rules, AJCC 8th Edition, EOD, Summary Stage 2018, and radiation coding impact specific sites. Each webinar is carefully produced and presented by full time CTR/trainers and is 3 hours in length. Recordings of the live sessions have been added to the KCR training library, along with access to quizzes, quiz answers, case scenarios, case scenario answers, and a Q&A from the live session.

Recent available trainings are:

February 6, 2020 – SSDI's: An In-Depth Look
March 5, 2020 – Abstracting and Coding Boot Camp
January 9, 2020 - Prostate
December 5, 2019 – Base of Tongue/Head and Neck
November 7, 2019 - Bladder
October 3, 2019 - Breast
September 6, 2019 - Coding Pitfalls
June 6, 2019 - Ovary
May 2, 2019 - Neuroendocrine Tumors
March 15, 2019 - Boot Camp
February 20, 2019 - Colon

The upcoming scheduled webinars are:

April 2, 2020 – Melanoma
May 5, 2020 – Central Nervous System
June 11, 2020 – Esophagus
July 9, 2020 – Navigating the 2020 Survey Application Record
August 6, 2020 – Corpus Uteri
September 3, 2020 – Coding Pitfalls

Note: Webinars will be posted to the KCR website once they are made available through NAACCR

Registrar Round-up

Karrie Ihrie – Baptist Health Louisville & La Grange

Cindy Joseph – Mercy Health Lourdes Hospital

Trish Johnson – Taylor Regional Hospital

Freida Belcher – Director, Cancer Registry – Baptist Health Cancer Service Line

Robin Centers – Manager – Baptist Health Lexington, Richmond and Corbin

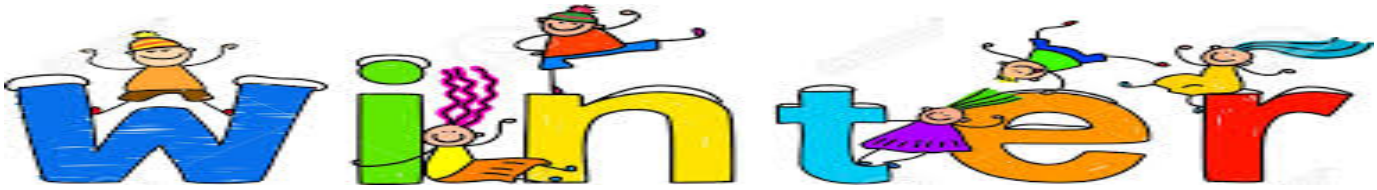
Erin Collins-Buchanan – Market Oncology Director -– Clark Regional and Georgetown Community Hospital

Jennifer Withrow – Kings Daughters Medical Center

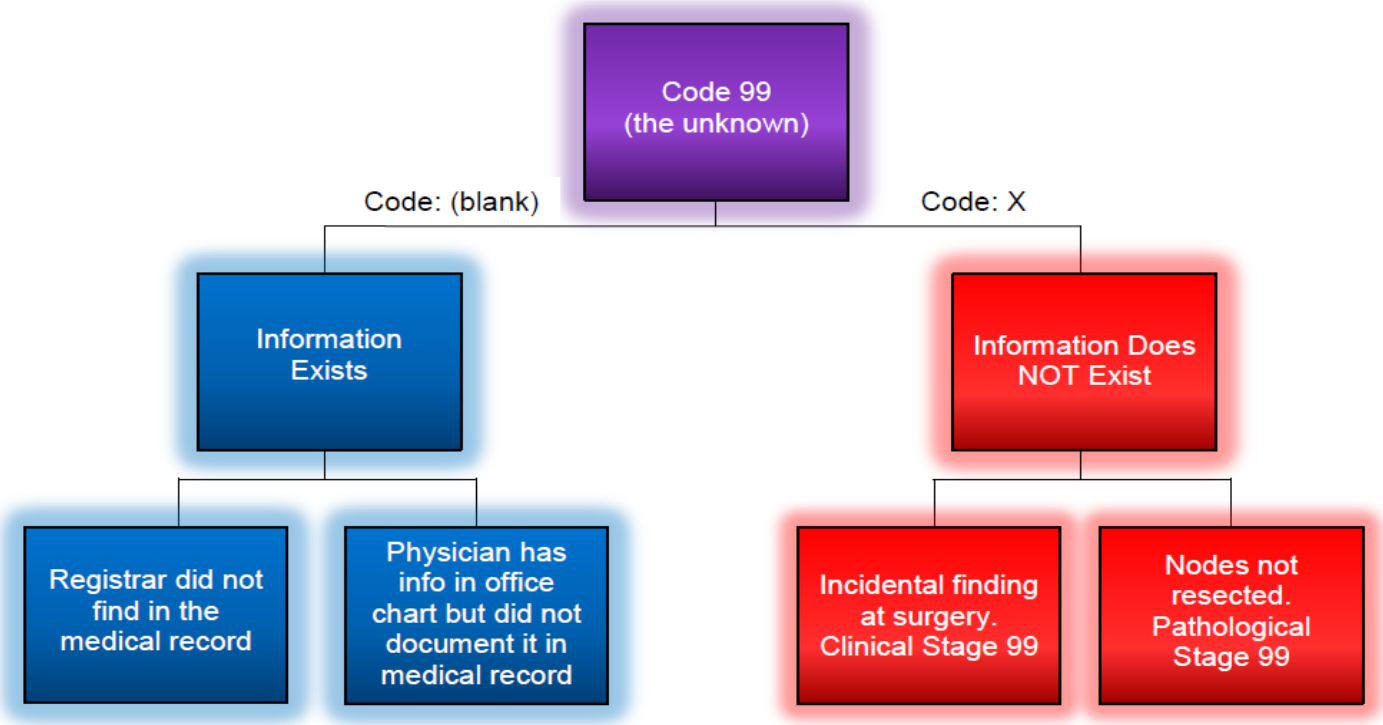
Awards & Honorable Mentions

St. Elizabeth Edgewood and Ft. Thomas received CoC Golden level of achievement, receiving all commendations and no contingencies for both programs. This makes them eligible for the Outstanding Achievement Awards that are announced in 2020!

Tips & Helpful Hints



Blank -vs- X



Use Blank: Information exists but the registrar does not have access to it. Registrar has part of a patient file but not all of it. (example: a patient is presented at your facility for a biopsy of the prostate. No information of PSA or DRE are in the file you have).

Use X: Should have, Could have and Would have but didn't.
Should have done the test because it is a standard.
Could have done the test because they had the opportunity.
Would have done the test but something unforeseen occurred (blockage and could not gain access or incidental finding).

EOD and SS2018

On September 4, 2019, NCI SEER released a new version of EOD Data. Use the link provided to view the changes and known issues in Version 1.7: https://staging.seer.cancer.gov/eod/news/1.7/

Below are some of the changes made for the more common sites. We recommend using the link provided above and reviewing the list in its entirety.

Colon and Rectum and NET Colon and Rectum Cases:

SS2018: new Note 6 added, describing invasion into pericolonic/pericolorectal tissue; Code 1, Non -peritonealized pericolic/perirectal tissues had comment about peritonealized tissue added, Pericolic/perirectal tissues invaded was added; Code 2 had Peritonealized pericolic/perirectal tissues invaded added, and Cecum (C180): Greater Omentum added

Colon and Rectum Cases:

EOD Primary Tumor: new Note 5 added, describing invasion into pericolonic/pericolorectal tissue; Code 300, Non-peritonealized pericolic/perirectal tissues had comment about peritonealized tissue added, Pericolic/perirectal tissues invaded was added; Code 400 has Peritonealized pericolic/perirectal tissues invaded add ed; minor change to Code 500 (of/through); Code 700 had 'Greater omentum' removed from Cecum (C180) as this term is part of Code 600

Lung Cases:

EOD Primary Tumor: Note 2 about Code 100 expanded, Note 3, about Code 200, and Note 4, about Code 300, added, Note 6 had 'NOS' added to what should be captured in Code 450; Code 450 modified from 'Visceral pleura (PL1 or PL2)' to 'Visceral pleura (PL1 or PL2, NOS)'

EOD Regional Nodes: Code 600 had 'Pulmonary Root' removed; Code 700 had 'Periesophageal' and 'Pretracheal' added

SS2018: Code 2 had 'Main stem bronchus less than 2.0 cm from carina' removed and 'Visceral pleura' changed to 'Visceral pleura (PL1, PL2, PL3 or NOS)'; Code 7 had 'Pulmonary root' removed from 'Distant lymph node(s), NOS' and 'Periesophageal' and 'Pretracheal' added

Breast Cases:

AJCC ID: 8540 now goes to 48.1, instead of XX
If you collect AJCC TNM fields, you should review these cases to verify you have collected the required data

EOD Regional Nodes: Note 4 expanded to define ITCs; Note 7 Intramammary and Infraclavicular moved out of the Level I and III lists and Fixed/matted Axillary was added; Code 350 word order modified for Fixed/matted Axillary and all bullets were updated for consistent formatting

EOD Mets: Code 10 list of nodes updated for consistent formatting and Fixed/matted axillary, Infraclavicular, and Intramammary were added

SS2018: Note 7 updated to define ITCs and how they should be coded; Code 3 updated for consistent formatting, Fixed/matted Axillary, Infraclavicular and Intramammary bullets modified for specificity; Code 7 updated for consistent formatting, Fixed/matted axillary, Infraclavicular and Intramammary were added

Sentinel Lymph Nodes Examined [#834] and Sentinel Lymph Nodes Positive [#835]: added to the schema

Get in SINQ

Question

Primary site/Histology--Peritoneum: What is the correct primary site code for peritoneal mesothelioma in a female? When I use C482, it seems that the fields are all geared towards primary peritoneal carcinoma with FIGO staging, etc.

Answer

For mesothelioma, NOS (9050) and epithelioid mesothelioma (9052) of the peritoneum for females, assign C481, C482, or C488 as appropriate based on the site of origin in the medical documentation. The Primary Peritoneal Ca schema is assigned and you will need to complete the SSDIs for FIGO staging, CA-125 PreTx Interpretation, and Residual Tumor Volume Post Cytoreduction.

If the histology is 9051 or 9053 with primary site of C481, C482, or C488 for females, the Retroperitoneum schema is assigned. The only SSDI for this schema is Bone Invasion. (SINQ 2019-0082; Date Finalized 12/03/2019; EOD Data/SEER*RSA v1.7)

Question

Update to current manual/Surgery of Primary Site/Surgery codes--Melanoma: Can the operative report be used to assess margins if there is no residual melanoma on the wide excision and no margins stated, or if distance is not stated on the pathology report when there is residual melanoma? See Discussion.

Answer

1. You may take margin information from the operative report if it is missing from the pathology report when assigning the surgery codes for skin.

Exception: Do not apply this to surgery codes 45-47 where specific instructions about microscopic confirmation are included

2. The rule applies to any skin malignancy for which the skin surgery codes apply.

3. SEER, CoC, NPCR, NCRA, NAACCR, and the Canadian registries participated in this decision. SEER is publishing this SINQ question for reference. (SINQ 2019-0080; Date Finalize 12/03/2019; Standard setters agreement)

Question

Solid Tumor Rules (2018)/Multiple primaries--Lung: How many primaries should be reported for a patient with a March 2018 diagnosis of non-small cell carcinoma with neuroendocrine differentiation on lung biopsy (single left upper lobe tumor only) who also has a prior history of left lung squamous cell carcinoma in 2016 (treated with chemotherapy/radiation)? See Discussion.

Answer

Abstract separate primaries according to the 2018 Lung Solid Tumor Rules. Lung Table 3 is not an exhaustive list of lung histologies and the H rules instruct you to use the tables, ICD-O and/or ICD-O updates. Per ICD-O-3, carcinoma with neuroendocrine differentiation is coded to 8574/3; whereas, squamous cell carcinoma is coded to 8070/3. These represent distinct histologies on different rows in Table 3. (SINQ 2019-0073; Date Finalized 12/03/2019; 2018 Solid Tumor Rules)

❄❄❄KCR Publications❄❄❄

Spatiotemporal Analysis of Lung Cancer Histological Types in Kentucky, 1995–2014

W. Jay Christian, PhD, MPH, Nathan L. Vanderford, PhD, MBA, Jaclyn McDowell, DrPH, Bin Huang, DrPH, MS, Eric B. Durbin, DrPH, MS, Kimberly J. Absher, MD, Courtney J. Walker, BA, and Susanne M. Arnold, MD

Full text available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482657/

Abstract

Recent metabolic and genetic research has demonstrated that risk for specific histological types of lung cancer varies in relation to cigarette smoking and obesity. This study investigated the spatial and temporal distribution of lung cancer histological types in Kentucky, a largely rural state with high rates of smoking and obesity, to discern population-level trends that might reflect variation in these and other risk factors. The Kentucky Cancer Registry provided residential geographic coordinates for lung cancer cases diagnosed from 1995 through 2014. We used multinomial and discrete Poisson spatiotemporal scan statistics, adjusted for age, gender, and race, to characterize risk for specific histological types—small cell, adenocarcinoma, squamous cell, and other types—throughout Kentucky and compared to maps of risk factors. Toward the end of the study period, adenocarcinoma was more common among all population subgroups in north-central Kentucky, where smoking and obesity are less prevalent. During the same time frame, squamous cell, small cell, and other types were more common in rural Appalachia, where smoking and obesity are more prevalent, and in some high poverty urban areas. Spatial and temporal patterns in the distribution of histological types of lung cancer are likely related to regional variation in multiple risk factors. High smoking and obesity rates in the Appalachian region, and likely in high poverty urban areas, appeared to coincide with high rates of squamous cell and small cell lung cancer. In north-central Kentucky, environmental exposures might have resulted in higher risk for adenocarcinoma specifically.