



KCR NEWSLETTER

Taking a bite out of the 2018 cases!



Issue: June 2019

33RD ANNUAL ADVANCED CANCER REGISTRAR'S WORKSHOP

WHEN:

September 12 – 13, 2019

WHERE:

Griffin Gate
Marriot Resort and Spa,
Lexington, Kentucky

TOPICS:

Calendar of Events

June 21 - July 13, 2019:
CTR exam testing window

July 4, 2019: Fourth of July
Holiday, KCR Closed

September 12 – 13, 2019:
33rd Annual Advanced
Cancer Registrar's
Workshop

September 13, 2019: CTR
exam application deadline.

**October 11 – November 2,
2019:** CTR exam testing
window

Available Trainings and Webinars at kcr.uky.edu

NAACCR Webinar Series 2018-2019

NAACCR presents different webinars 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. The available trainings are as follows:

June 6, 2019 - Ovary

May 2, 2019 – Neuroendocrine Tumors

March 15, 2019 - Boot Camp

February 20, 2019 - Colon

December 12, 2018 - Breast

October 15, 2018 - Lung

Registrar Round-up

Welcome!

Jennye Bush, Norton Health Care, Cancer Registry Coordinator, Tumor Boards
Sherisa Sayles, Norton Health Care, Cancer Registry Coordinator, Tumor Boards
Jamie Batista, Baptist Health – Lexington
Barbara Zangari, Baptist Health – Lexington
Carlee Burton, Data Management Specialist, KCR

Resignations

Susan Knight, Baptist Health Madisonville

Retirements

Larry Sutton, Baptist Health – Lexington

New Position

Robin Walls, Abstractor Coordinator Regional, KCR

New CTRs

Alison Glover, Norton Healthcare

Awards & Honorable Mentions



The combined North American Association of Central Cancer Registries and International Association of Cancer Registries meeting was held June 9th - 13th in Vancouver, British Columbia, Canada.

Presenters representing KCR were:

Elevating the Science of Cancer Research by Using the Central Cancer Registry as a Virtual Tissue Repository (VTR) - Thomas Tucker and Rachel Maynard

Getting Ready for NAACCR XML in 2020 - Isaac Hands

Influence of Depression on Treatment and Survival: A Population-Based Study for Breast Cancer Patients in Kentucky - Bin Huang

The Impact of the Delays in the Implementation of the 2018 Changes on the Timeliness of Reporting to the Central Registries - Tonya Brandenburg.

Tonya Brandenburg was also recognized as a young researcher for her original scientific research in cancer epidemiology and was 1 of 19 nominees for the Enrico Anglesio Prize!

Tips & Helpful Hints

STAGING TEXT

THE GOOD, THE BAD & THE UGLY

Staging Text serves as your stage assignment validation! During QA audits, your supporting text is used to verify the data entered. If an error is flagged your Staging Text can be used to figure out what information was used to support your coded data. Complete and well organized Staging Text will help you avoid or dispute any errors and increase your accuracy rate! It's a good thing!

THE GOOD

DO justify your answers with the information on how and where the data are found or can be located.

All	EOD PRIMARY TUMOR PERICOLID ADIPOSE TISSUE PER PATH
History and Physical	EOD REGIONAL NODES 2/14 PERICOLONIC NODES POSITIVE
X-rays/Scans/Ultrasounds	DATE REGIONAL LYMPH NODE DISSECTION 6-21-18
Scopes/Endoscopic Exams	NODES POSITIVE 02
Laboratory Tests/Markers	NODES EXAMINED 14
Operative Reports	EOD METS NONE PER SCANS
Pathology Reports	GRADE CLINICAL NO BX PERFORMED
Site Text	GRADE PATH MOD DIFFER
Histology Text	GRADE POST TX
Staging	CEA PRETREATMENT LAB 11.5
Treatment Plan	CEA PRETX INTERP ELEVATED
Miscellaneous/General Remarks	PERINEURAL INVASION NOT IDENTIFIED
	TUMOR DEPOSITS NOT IDENTIFIED
	CRM MARGINS 2CM
	KRAS NONE FOUND
	MSI NONE FOUND
	SS 2018 REG/REG NODES
	CLINICAL TUMOR SIZE UNKNWON
	PATH TUMOR SIZE 1.8CM

THE BAD

Do **NOT** just copy and paste your case data!! If that is all we wanted or needed to see we could go to the case information to retrieve it.

All	EOD--Schema Breast (00480)
History and Physical	EOD--Primary Tumor 000
X-rays/Scans/Ultrasounds	EOD--Regional Nodes 000
Scopes/Endoscopic Exams	EOD--Mets 00
Laboratory Tests/Markers	Date Sentinel Lymph Node Biopsy
Operative Reports	Date Sentinel Lymph Node Biopsy Flag 11
Pathology Reports	Sentinel Lymph Nodes Positive 98
Site Text	Sentinel Lymph Nodes Examined 0
Histology Text	Date Regional Lymph Node Dissection
Staging	Date Regional Lymph Node Dissection Flag 11
Treatment Plan	Nodes Positive 98
Miscellaneous/General Remarks	Nodes Examined 0
	Mets at DX - Bone 0
	Mets at DX - Brain 0
	Mets at DX - Liver 0
	Mets at DX - Lung 0
	Mets at DX - Distant LN 0
	Mets at DX - Other 0
	Derived Summ Stg 2018 0
	Grade/SSDI--Schema Breast (00480)
	Schema Discriminator 1

THE UGLY!

Do **NOT** just leave it blank!! This is **UNACCEPTABLE, WRONG** and it just won't fly!

All
History and Physical
X-rays/Scans/Ultrasounds
Scopes/Endoscopic Exams
Laboratory Tests/Markers
Operative Reports
Pathology Reports
Site Text
Histology Text
Staging
Treatment Plan
Miscellaneous/General Remarks

Get in SINQ

Question

Primary site--Head & Neck: Are cases with positive cervical lymph nodes that are EBV positive (EBV+) coded to the nasopharynx, and cases with positive cervical lymph nodes that are p16 positive (p16+) coded to the oropharynx, when no primary site is identified? See Discussion.

Answer:

Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes that are positive for Epstein-Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.

Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-mediated oropharyngeal carcinoma (OPC). (SINQ 2019-0031; Date Finalized 06/05/2019; SSDI Manual, Volume 1.5)

Question:

Summary Stage 2018/Extension--Prostate: Can imaging be used to code SEER Summary Stage 2018? MRI shows tumor involved the seminal vesicles and the patient did not have surgery. AJCC does not use imaging to clinically TNM stage a prostate case.

Answer:

Per Note 5 of the 2018 SEER Summary Stage Prostate chapter: Imaging is not used to determine the clinical extension unless the physician clearly incorporates imaging findings into their evaluation. This note was added to be in line with how AJCC stages; therefore, AJCC and Summary Stage agree. Do not use the MRI findings when that is all you have and the physician does not document agreement with the MRI. (SINQ 2019-0030; Date Finalized 06/05/2019; 2018 Summary Stage)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5604438/>

Question:

Solid Tumor Rules (2018)/Histology--Lung: Is histology code or the number of primaries assigned differently in SINQ 20180093 if the word 'pattern' was omitted? See Discussion.

Answer:

If the word 'pattern' was omitted, you would abstract multiple primaries per the Lung Solid Tumor Rule M6 and code histology to adenocarcinoma, acinar predominant (8551/3) and adenocarcinoma, lepidic predominant (8250/3) per Rule H4 as the word 'pattern' is not included in each histology. (SINQ 2019-0022; Date Finalized 04/16/2019; 2018 Solid Tumor Rules)

Question:

Solid Tumor Rules 2018/Histology--Brain and CNS: How is histology coded for a single meningioma tumor when the histology is a meningioma comprised of multiple specific subtypes/variants? See Discussion.

Answer:

Code the histology for the meningioma, transitional and angiomatous, WHO Grade I to Meningioma, NOS (9530/0). Since a mixed meningioma ICD-O code has not been proposed by WHO, we consulted with our expert neuropathologist.

The other option is to follow back with the pathologist and code what they feel is the predominant type. A new histology rule for coding mixed meningiomas will be added in a future update of CNS rules. (SINQ 2019-0019; Date Finalized 04/12/2019; 2018 Solid Tumor Rules; Subject matter expert)

KCR Publications

Your Hard Work Makes This Possible



Identifying Smoking Status and Smoking Cessation Using a Data Linkage Between the Kentucky Cancer Registry and Health Claims Data

Michael Shayne Gallaway, PhD, MPH; Bin Huang, DrPH; Quan Chen, DrPH; Tom Tucker, PhD, MPH; Jaclyn McDowell, DrPH; Eric Durbin, DrPH; David Siegel, MD; and Eric Tai, MD

Full text available at: <https://doi.org/10.1200/CCI.19.00011>

Abstract

PURPOSE

Linkage of cancer registry data with complementary data sources can be an informative way to expand what is known about patients and their treatment and improve delivery of care. The purpose of this study was to explore whether patient smoking status and smoking-cessation modalities data in the Kentucky Cancer Registry (KCR) could be augmented by linkage with health claims data.

METHODS

The KCR conducted a data linkage with health claims data from Medicare, Medicaid, state employee insurance, Humana, and Anthem. Smoking status was defined as documentation of personal history of tobacco use (International Classification of Diseases, Ninth Revision [ICD-9] code V15.82) or tobacco use disorder (ICD-9 305.1) before and after a cancer diagnosis. Use of smoking-cessation treatments before and after the cancer diagnosis was defined as documentation of smoking-cessation counseling (Healthcare Common Procedure Coding System

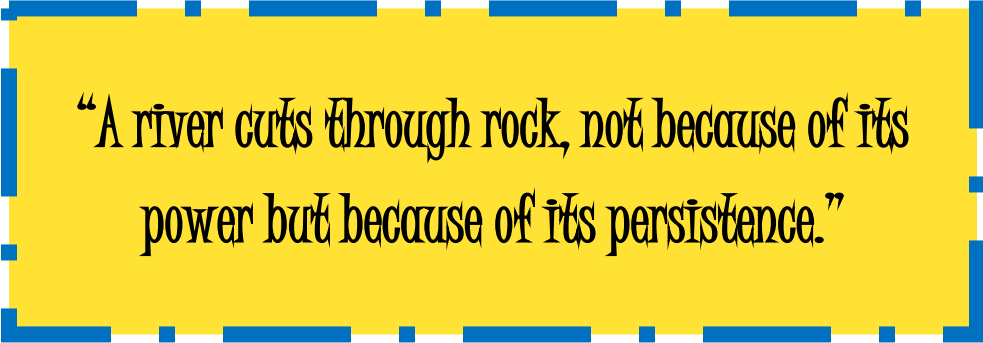
codes 99406, 99407, G0375, and G0376) or pharmacotherapy (eg, nicotine replacement therapy, bupropion, varenicline).

RESULTS

From 2007 to 2011, among 23,703 patients in the KCR, we discerned a valid prediagnosis smoking status for 78%. KCR data only (72%), claims data only (6%), and a combination of both data sources (22%) were used to determine valid smoking status. Approximately 4% of patients with cancer identified as smokers (n = 11,968) and were provided smoking-cessation counseling, and 3% were prescribed pharmacotherapy for smoking cessation.

CONCLUSION

Augmenting KCR data with medical claims data increased capture of smoking status and use of smoking-cessation modalities. Cancer registries interested in exploring smoking status to influence treatment and research activities could consider a similar approach, particularly if their registry does not capture smoking status for a majority of patients.



“A river cuts through rock, not because of its power but because of its persistence.”