KCR NEWSLETTER

Springing Forward with Knowledge

Issue: March 2020

SPRING TRAINING

WHEN:
Tuesday, April 28, 2020
2:00pm – 4:00pm
or
Wednesday, April 29, 2020
10:00am – 12:00pm

2020 Spring Training will be presented by webinar and will be recorded in case you are unable to attend one of the sessions listed above. We will present the same material at both sessions, so you only have to attend one. Please register for which day you will be attending by sending an email to Shelly Gray at sgray@kcr.uky.edu.

TOPICS INCLUDE:
Kentucky's NPCR Audit Results,
Coding Pitfalls and STORE Updates

Calendar of Events

May 25, 2020: National Holiday - Memorial Day – KCR offices closed

May 29, 2020: CTR exam application deadline.

May 31 – June 3, 2020: NCRA 46th Education Conference, Lake Buena Vista, Florida

June 26 - July 17, 2020: CTR exam testing window

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:

March 5, 2020 – Abstracting and Coding Boot Camp
February 6, 2020 – SSDI's: An In-Depth Look
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

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

Barb Fitzpatrick, Kings Daughters Medical Center
Chalon Davis, UofL Health – Jewish Hospital
Darian Cummins, Ephraim McDowell Regional Medical Center
Michelle Grantham, Taylor Regional Hospital
Danielle Price, Taylor Regional Hospital
Nicole Catlett, University of Kentucky HealthCare
Betty Wells, Baptist Health Corbin and Richmond

Nikki Murphy, University of Louisville Hospital/Brown Cancer Center

Nicole Catlett, KCR, Senior Regional Coordinator

Cynthia Thompson, Baptist Health - Lexington

Donna Lamb, Oncology Office Coordinator, Baptist Health - Louisville

Awards & Honorable Mentions

Congratulations to Baptist Health Madisonville, who received the Commission on Cancer 2019 Outstanding Achievement Award! Baptist Health Madisonville is Kentucky's oldest community hospital cancer program to consistently hold accreditation with the American College of Surgeons Commission on Cancer.

Congratulations to the cancer program at St. Claire Regional Medical Center for completing the Commission on Cancer Survey and achieving Full Accreditation with NO DEFICIENCIES!!

Congratulations to St. Elizabeth Healthcare Edgewood, who received the Commission on Cancer 2019 Outstanding Achievement Award!

Congratulations to St. Elizabeth Healthcare Ft. Thomas, who received the Commission on Cancer 2019 Outstanding Achievement Award!

Congratulations to Methodist Health Henderson for completing the Commission on Cancer Survey and achieving a three-year re-accreditation!

Cancer registrars throughout the world will join their colleagues, fellow medical professionals, and community leaders to observe the 24th annual National Cancer Registrars Week (NCRW), April 6-10, 2020. The 2020 theme, *Cancer Registrars: 2020 Vision for the Future*, reflects the critical role cancer registrars play in capturing the data that informs cancer prevention and screening programs, treatment, and research.

Key to the nation's fight against cancer is having an accurate account of cancer incidence and a clear understanding of effective treatments. NCRW provides an opportunity to acknowledge the important role registrars play in that fight. These health information professionals capture the data that guides the work of oncologists, nurses, researchers, and public health officials to ensure the best possible outcomes for cancer patients. Celebrating National Cancer Registrars Week helps to highlight the critical work of registrars.

NCRW 2020 Celebration Ideas

Innovative, yet simple and effective ways to celebrate NCRW 2020, are listed below. Use these ideas or create your own.

- Bring fresh flowers to the office at the beginning of the week and offer a celebratory breakfast one day during the week.
- Work with the management of your facility to distribute a small gift and nice letter celebrating the work of cancer registrars.
- Give a decorative gift bag with an attached personalized note of encouragement and recognition to each cancer registrar.
- Plan a potluck luncheon with NCRA members.
- Plan a departmental luncheon to conclude the week.

Tips & Helpful Hints

INTRAMAMMARY VS INTERNAL MAMMARY LYMPH NODES FOR BREAST

Intramammary LNs are found within the breast parenchyma. These are considered axillary LNs per AJCC Breast chapter. (see page 598 figure 48.2).

Internal mammary LNs are found along the sternum. These are NOT considered axillary LNs in staging. (see page 598, figure 48.2). If you have clinically apparent internal mammary LNs found on imaging this will be cN2b if pathologically confirmed pN2b (if axillary LNs are also positive then it upstages to N2c).

EOD REGIONAL LYMPH NODE NOTE IN MANUAL:
Note 5: Codes 100-200 and 350 only apply to involved axillary level I and II lymph nodes. If internal mammary, infraclavicular (subclavicular, level III axillary, apical), or supraclavicular lymph nodes are involved, codes 100-200 and 350 may not be used.

CODING TIPS

Surgery of Primary Site
SEER Coding Manual's Appendix C: Site Specific Coding Modules is a good resource for coding surgery of the primary site. The surgery codes are based on the STORE Manual and contain additional information and instructions. Here are some common coding errors.

Cystoprostatectomy

Cystoprostatectomy is surgery to remove the urinary bladder and the prostate (a combination cystectomy and prostatectomy). When coding this procedure, make sure you use the correct site-specific code. A cystoprostatectomy is coded different depending on whether the primary cancer site is bladder (71) or prostate (70).

Bladder

- 70 Pelvic exenteration, NOS
- 71 Radical cystectomy including anterior exenteration
    - For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra.
    - For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

Prostate

- 70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
- Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

Get in SINQ

Question:

Solid Tumor Rules (2018)/Multiple primaries--Corpus uteri: How many primaries are accessioned for patient with a minimally invasive endometrial adenocarcinoma arising in a polyp in 2001, followed by a metastatic poorly differentiated clear cell carcinoma of gynecologic (GYN) origin in 2019?

Discussion:

The patient has a history of a minimally invasive endometrial adenocarcinoma that was low grade and confined to an endometrial polyp in 2001. The patient underwent a total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) that entirely removed the tumor at that time.

Almost 18 years later, the patient had a left inguinal mass excision that was, Carcinoma of gynecologic origin, consistent with clear cell carcinoma. No other disease was found, the physician never indicated whether this was felt to be metastatic from the previous, low grade adenocarcinoma or not. It was only noted as, an unusual malignancy of the left lower quadrant and inguinal region of gynecologic origin. No further information was available in the medical record or from the physician on follow-up.

Although neither the Solid Tumor Rules nor the MPH Rules (still in use for the Other Sites schema) apply to metastasis, given the differences in histology and behavior of these two tumors (i.e., minimally invasive, low grade disease diagnosed in 2001 vs. higher grade, more aggressive tumor in 2019) should the current clear cell carcinoma of GYN origin really be considered the same primary as the 2001 endometrial adenocarcinoma?

Answer:

Abstract a multiple primaries using 2018 Other Sites Solid Tumor Rule M10 as these tumors are more than one year apart. This represents endometrioid adenocarcinoma (8380/3 of C541) and 18 years later, clear cell Carcinoma (8310/3 consistent with GYN (C579) primary). (SINQ 2020-0008; Date Finalized 03/13/2020; 2018 Solid Tumor Rules)

Question:

Multiple primaries--Heme & Lymphoid Neoplasms: How many primaries are accessioned for a patient diagnosed with myelodysplastic syndrome (MDS) with ring sideroblasts in 2005, and stated to have progressed to high risk disease/early evolving acute myeloid leukemia (AML) in 09/2019?

Discussion:

The bone marrow biopsy proved bone marrow with blasts comprising 15-19%. Neither the pathologist nor the physician specifically diagnosed this as AML, calling this only high risk disease or early evolving AML prior to starting the patient on Vidaza.

No further information can be obtained from the pathologist or the physician for this case. Should this early evolving AML be accessioned as an additional primary per Rule M10, or should this be considered the same MDS that is now high risk as the blast count is up to 19%, but has not yet reached the threshold of 20% blasts usually required for AML per the Hematopoietic and Lymphoid Neoplasm Database?

Answer:

Abstract a single primary as we do not abstract early/evolving AML. This is still one primary until there is a confirmed diagnosis of AML. (SINQ 2020-0012; Date Finalized 03/13/2020; Hematopoietic and Lymphoid Neoplasm Coding Manual)

KCR Publications

Smoking and Smoking Cessation Among Persons with Tobacco- and Non-tobacco-Associated Cancers.

Gallaway MS[1], Huang B[2,3], Chen Q[3], Tucker TC[3,4], McDowell JK[3], Durbin E[3,5], Stewart SL[6], Tai E[6].

Abstract

PURPOSE:
To examine smoking and use of smoking cessation aids among tobacco-associated cancer (TAC) or non-tobacco-associated cancer (nTAC) survivors. Understanding when and if specific types of cessation resources are used can help with planning interventions to more effectively decrease smoking among all cancer survivors, but there is a lack of research on smoking cessation modalities used among cancer survivors.

METHODS:
Kentucky Cancer Registry data on incident lung, colorectal, pancreatic, breast, ovarian, and prostate cancer cases diagnosed 2007-2011, were linked with health administrative claims data (Medicaid, Medicare, private insurers) to examine the prevalence of smoking and use of smoking cessation aids 1 year prior and 1 year following the cancer diagnosis. TACs included colorectal, pancreatic, and lung cancers; nTAC included breast, ovarian, and prostate cancers.

RESULTS:
There were 10,033 TAC and 13,670 nTAC survivors. Smoking before diagnosis was significantly higher among TAC survivors ($p < 0.0001$). Among TAC survivors, smoking before diagnosis was significantly higher among persons who: were males (83%), aged 45-64 (83%), of unknown marital status (84%), had very low education (78%), had public insurance (89%), Medicaid (85%) or were uninsured (84%). Smoking cessation counseling and pharmacotherapy were more common among TAC than nTAC survivors ($p < 0.01$ and $p = 0.05$, respectively).

DISCUSSION:
While smoking cessation counseling and pharmacotherapy were higher among TAC survivors, reducing smoking among all cancer survivors remains a priority, given cancer survivors are at increased risk for subsequent chronic diseases, including cancer. Tobacco cessation among all cancer survivors (not just those with TAC) can help improve prognosis, quality of life and reduce the risk of further disease. Health care providers can recommend for individual, group and telephone counseling and/or pharmacotherapy recommendations. These could also be included in survivorship care plans.