KCR NEWSLETTER

Don't FALL Back, Keep Moving Forward!

Issue: September 2019

NEW
ABSTRACTORS' TRAINING

WHEN:
November 20-22, 2019
8am – 4:30pm

WHERE:
UK Turfland Clinic
2195 Harrodsburg Road
Room T1307
Lexington, Kentucky 40504

TOPICS INCLUDE:
EOD, SSDI, Summary Stage 2018, Grade, ALCC, Therapy, Solid Tumor Rules, etc.

Calendar of Events

October 1-20, 2019: CTR exam registration period.

October 31, 2019: It's Halloween! Trick or Treat, Smell My Feet!

November 10-20, 2019: CTR exam testing window.

November 21-22, 2019: Thanksgiving Holiday. KCR CLOSED

December 1-20, 2019: CTR exam registration period.

December 23-31, 2019: Christmas Holiday! KCR CLOSED

January 1, 2020: New Year Day. KCR CLOSED

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

Available Trainings and Webinars at kcr.uky.edu

NAACCR Webinar Series 2018-2019

NAACCR presents a different webinar 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:

September 6, 2019 – Coding Pitfalls

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

The 33rd Annual Advanced Cancer Registrars' Workshop

The 33rd Annual Advanced Cancer Registrar's Workshop was held at the Griffin Gate Marriott Report and Spa in Lexington, Kentucky on September 12th and 13th, 2019. On behalf of the Kentucky Cancer Registry, thank you for a fantastic Fall Workshop! Your attendance and participation is what makes this workshop the fantastic event it is! It was exciting to see so many cancer registrars, oncology providers and other oncology professionals coming together to share knowledge and insight to make this year's workshop educational, engaging and fun!

Thanks to your feedback and suggestions, we were able to produce an excellent agenda that we believe produced a diverse and dynamic group of speakers. They represented the schemas and touched on topics that are the most challenging to registrars and presented insight within the field of oncology care and treatment.

Congratulations to Jodee Chumley, CTR, the Cancer Registry Manager from Baptist Health Louisville & LaGrange, this year's recipient of the Judith Ann Cook Excellence Award! It was an award well deserved for all her years of dedication and service to the field of cancer data and research.

We also want to extend a thank you to the facilities that helped put the swag in our bags and donated such wonderful door prizes: Baptist Health-Lexington, Bon Secours Health System, CHI Saint Joseph Health, Clark Regional Medical Center, Harrison Memorial Hospital, Markey Cancer Center Affiliate Network, Pikeville Medical Center, TJ Regional Health and UK HealthCare.

The updated workshop materials have been aggregated and we invite you to visit the KCR website to download the material.

Again, your presence helped to make this event a great success and your enthusiasm and positive spirit helped make our time together productive, educational and fun. See You Next Year!

Registrar Round-up

Katelyn Warren, Registry Supervisor, Owensboro Health
NaKisha Fields, Norton Health Care
Susan Knight, Cancer Coordinator, Baptist Health Madisonville
Angela Elsherbini, Baptist Health Paducah
Cyndee Thompson, Baptist Health Lexington
Amy Mullins, Pikeville Medical Center

Vanissa Sorrels, Owensboro Health
Cindy Joseph, Baptist Health Paducah

JoAnn Smith, Taylor Regional Hospital (October 4, 2019)

New CTRs

Katie Wilkes, Norton Health Care

Awards & Honorable Mentions

Congratulations to Taylor Regional Hospital who received ZERO deficiencies on their CoC Performance Report and received 3 year with Commendation! Way to Go Taylor Regional!!!

Tips & Helpful Hints

Colon/Rectum EOD Regional Nodes:

For Colon and Rectum *ONLY*, any unnamed nodes that are removed with a colon or rectal resection are presumed to be regional pericolic or perirectal lymph nodes and are included in the EOD Regional Nodes code 300. (NOT 800 Regional Lymph Nodes, NOS, this is a change from Collaborative Staging rules).

> **Note 2:** For Colon and Rectum ONLY, any unnamed nodes that are removed with a colon or rectal resection are presumed to be regional pericolic or perirectal lymph nodes and are included in the EOD Regional Nodes code 300 (pericolic for sites C180 - C189, C199 and perirectal for sites C199 or C209). This site-specific instruction applies only to colon and rectum tumors and was verified with subject matter experts.

NOTE: A query to review these cases: Site code in colon and rectum, EOD Regional Nodes coded 800. The cases can be reviewed and updated to 300.

Papillary Carcinoma of Thyroid:

Per the Solid Tumor Rules: Papillary carcinoma of the thyroid is coded to 8260 NOT 8050.

Other Sites Histology Rules
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H26 Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

NOTE: A query to review these cases: Site code in thyroid, Histology coded to 8050. The cases can be reviewed and updated to 8260.

Lung Cases:

Solid Tumor Rules Updated: New rule H7 (when more than one subtype of adenocarcinoma is listed in path) you NOW code the subtype with highest percentage listed NOT the mixed code 8255.

Lung Histology Rules
C340-C343, C348, C349
(Excludes lymphoma and leukemia M9590 – M9992 and Kaposi sarcoma M9140)

Rule H7 Code the histology that comprises the **greatest percentage** of tumor when two or more of the following histologies are present:

NOTE: A query to review these cases: Site code in lung, Histology coded to 8255. The cases can be reviewed and updated to most specific histology type code.

Melanoma:

Melanoma cT and pT will match as per the Melanoma chapter. Clinical staging includes all info through "complete excision/microstaging" of the melanoma. When wide excision is negative for residual melanoma your cT will come down to pT (as pathologic staging includes all info clinical and pathologic).

Melanoma In-situ and Stage IA/IB = does NOT have to have LNs evaluated so you can bring down cN0 to pN field for these cases only. If higher than stage IB and no LNS are removed for eval then you will have pNx.

Colon and Rectum EOD Primary Tumor:

300 vs 400: 300 will be used for subserosal fat invasion or when path states "non-peritonealized" pericolic tissues. 400 will be used for pericolic fat/tissue invasion. Remember that 300 is considered localized (code 1) for SS2018 and 400 is considered regional (code 2) for SS2018 and both are T3 per AJCC staging.

Note 5: Invasion into "pericolonic/pericolorectal tissue" can be either codes 300 or 400, depending on the primary site. Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Code 300 may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).

- Code 300
  - Invasion through muscularis propria or muscularis, NOS
  - Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: Posterior surface; Middle third of rectum: Anterior surface; Lower third of rectum]
  - Subserosal tissue/(sub)serosal fat invaded
- Code 400
  - Mesentery
  - Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]
  - Pericolic/Perirectal fat
- If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code 300.

Circumferential Resection Margin (CRM):

- Record in Millimeters (mm) to the nearest tenth the distance between the leading edge of the tumor and the nearest edge of surgically dissected margin as recorded in the pathology report.
- The decimal is now coded in the data item.
  EXAMPLES:
  CRM 5 cm = 5.0 cm = 50.0 mm YOU WILL ENTER 50.0 in data item.
  CRM 8 mm = 8.0 mm = 8.0 YOU WILL ENTER 8.0 in data item.
  CRM 2.1 cm = 21.0 mm = 21.0 YOU WILL ENTERE 21.0 in data item.
- If the CRM is coded to indicate margins, than your Surgery Code must indicate there was a surgery.
- If the CRM is coded to "No resection of primary site", than your surgery code must be coded "No surgical procedure of primary site.

CLL/Lymphoma Cases:

Peripheral blood involvement ONLY is NOT enough to stage Clinical Stage IV. An EOD Primary Tumor code will be added for these cases in 2020. For now, EOD Primary Tumor will be 800, SS2018 will be 7 and AJCC Clinical Stage group 99.

Tumor Size Clinical, Tumor Size Pathological and Tumor Size Summary:

If you have a clinical case only and Clinical Tumor Size is coded per imaging/PE and Pathological Tumor Size is 999 since no surgery was performed, your Clinical Tumor Size will also be coded in the Tumor Size Summary field.

Reminders:

- Reminder that Avastin, Rituxan and Keytruda are immunotherapy *NOT* chemotherapy.
- Reminder that any biopsy, FNA or excision of regional lymph nodes are to be coded as a surgery record to capture lymph node staging procedure under "scope of regional lymph node" data item. You will enter EVEN WHEN PATH IS NEGATIVE.

Get in SINQ

Question:

EOD 2018/Summary Stage 2018--CLL/SLL: Can chronic lymphocytic leukemia (CLL) be staged when diagnosed by peripheral blood and no bone marrow biopsy, and observation is employed? See Discussion.

Answer:

For EOD and Summary Stage: Peripheral blood involvement for CLL (or any lymphoma-but most commonly for CLL) can be coded. This is code 800 for 2018 EOD Primary Tumor, and code 7 for Summary Stage 2018. We have recently received confirmation that peripheral blood involvement only is not enough information to assign AJCC stage; assign code 99 for AJCC Stage Group. We will correct in the 2021 release of EOD so that peripheral blood involvement only will have its own code to derive the appropriate AJCC TNM Stage Group (99). (SINQ 2019-0065; Date Finalized 9/20/2019)

Question:

Reportability--Heme & Lymphoid Neoplasms: The term indolent systemic mastocytosis is listed in the 2018 ICD-O-3 Histology Update table with borderline behavior (9741/1). However, smoldering systemic mastocytosis is listed in the Hematopoietic and Lymphoid Database (Heme DB) as an alternate name for histology 9741/3. Are smoldering systemic mastocytosis and indolent systemic mastocytosis synonymous? If so, should smoldering systemic mastocytosis also be removed from the Heme DB alternate names listing? See Discussion.

Answer:

Smoldering systemic mastocytosis is reportable, 9741/3. Indolent systemic mastocytosis is not reportable as of cases diagnosed 2018, 9741/1.
Smoldering systemic mastocytosis and indolent systemic mastocytosis are not synonymous. Smoldering differs from indolent based on diagnostic criteria and burden of disease; indolent is low whereas smoldering is high burden of disease that can progress to aggressive systemic mastocytosis or mast cell leukemia.
We will update SINQ 20130134.
(SINQ 2019-0017; Date Finalized 4/12/2019; WHO Class Hem & Lymph Tumors 4th edition)

Question:

SS2018/Lymph nodes--Breast: Should Code 3 of the Summary Stage 2018 (SS2018) for Breast designate the intramammary and infraclavicular lymph nodes as being ipsilateral? Similarly, should Code 7 designate infraclavicular lymph nodes as contralateral/bilateral? Laterality (ipsilateral, contralateral/bilateral) is included for axillary and internal mammary nodes in the respective codes.

Answer:

Based on your question, a review of the AJCC manual was done to clarify how these nodes would be coded. A review of Extent of Disease (EOD) Regional Nodes and EOD Mets was also done. That information is correct and in line with AJCC 8th edition. We apologize that SS2018 was not updated accordingly and thank you for bringing this issue to our attention.

Per AJCC, infraclavicular and intramammary nodes are ipsilateral for the N category. Contralateral or bilateral involvement are included in the M category.

The following will be applied to the planned 2020 update of the SS2018 manual.

Code 3
Ipsilateral will be added to Infraclavicular and Intramammary
Infraclavicular (subclavicular) (ipsilateral)
Intramammary (ipsilateral)

Code 7
The following will be added under Distant lymph nodes
Infraclavicular (subclavicular) (contralateral or bilateral)
Intramammary (contralateral or bilateral)

(SINQ 2019-0016; Date Finalized 4/12/2019; 2018 Summary Stage, Breast; 2018 EOD Manual, Breast)

KCR Publications

Potential protein markers for breast cancer recurrence: a retrospective cohort study

Chunyan He · Rina Plattner· Vivek Rangnekar · Binhua Zhou · Chunming Liu · Rachel L. Stewart ·Bin Huang · Chi Wang · Thomas C. Tucker

Abstract:

Background We evaluated five key proteins involved in various cancer-related pathways and assessed their relation to breast cancer recurrence. Methods We used the Kentucky Cancer Registry to retrospectively identify primary invasive breast cancer cases (n = 475) that were diagnosed and treated at University of Kentucky Medical Center between 2000 and 2007. Breast cancer recurrence was observed in 62 cases during the 5-year follow-up after diagnosis. Protein expression or activity level was analyzed from surgery tissue using immuno-histochemical assays. Results Compared to ER+/PR+/HER2− patients without recurrence, those with recurrence had higher TWIST expression (p = 0.049) but lower ABL1/ABL2 activity (p = 0.003) in primary tumors. We also found that triple-negative breast cancer patients with recurrence had higher SNAI1 expression compared to those without recurrence (p = 0.03). After adjusting for potential confounders, the higher ABL1/ABL2 activity in primary tumors was associated with a decreased risk of recurrence (OR 0.72, 95% CI 0.85–0.90) among ER+/PR+/HER2− patients. In addition, among patients with recurrence we observed that the activity level of ABL1/ABL2 was significantly increased in recurrent tumors compared to the matched primary tumors regardless of the subtype (p = 0.013). Conclusions These findings provide evidence that the expression/activity level of various proteins may be differentially associated with risk of recurrence of breast tumor subtypes.

Full text available at:
https://link.springer.com/article/10.1007%2Fs10552-018-1099-8