KENTUCKY CANCER REGISTRY

KCR NEWSLETTER

Our actions must reflect what we learn and teach

Issue: Spring 2021

Testing Dates and Deadlines

March 5 - March 27, 2021; application deadline: February 24

June 18 - July 10, 2021; application deadline: June 4

October 15 - November 6, 2021; application deadline: October 1

Announcements!

- **SEER*Educate**
  New material available!
  https://educate.fredhutch.org/LandingPage.aspx

- ***AJCC Cancer Staging System: Cervix Uteri Protocol (Version 9)*** is now available for purchase on Amazon for just $9.99.

- **SEER Site Histology Validation List: 2022 Update**
  The SEER Site Histology Validation List has been updated to include new ICD-O-3 codes and behavior changes per the 2022 ICD-O-3 update.
  seer.cancer.gov/icd-o-3

Available Trainings and Webinars at

kcr.uky.edu

KCR 2021 Spring Training

The webinar was recorded and has been posted along with the related training materials. This webinar covers the Solid Tumor Rules and AJCC staging for lung, radiation phase and coding pitfalls.

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:

August 2020 - Corpus Uteri
September 2020 - Coding Pitfalls
October 2020 - Prostate
November 2020 - Lung
December 2020 - Thyroid
January 2021 - Treatment
February 2021 - Lymphoma
March 2021 - Boot Camp
April 2021 - Larynx
May 2021 - Pancreas

Upcoming CoC Trainings

CAnswer Forum LIVE—June 9, 2021
Rehabilitation Care Services
Oncology Nutrition Services
https://www.facs.org/quality-programs/cancer/events/ondemand/canswer-forum-live

Honoring Frances Ross

Frances Ross has been an essential part of the Kentucky Cancer Registry (KCR) since its inception. For nearly 37 years, she has led efforts in cancer surveillance operations through the promotion of uniform data standards, providing education and training, and ensuring complete, high quality and timely registry data. Frances began her career at the Markey Cancer Center in July 1981. As the very first KCR employee hired by Dr. Gil Friedell, she led the development of a data management system that permitted KCR to begin as a voluntary registry in 1984. Her efforts were instrumental to the formal establishment of KCR by the Kentucky State Legislature in 1990. She played a key role in the design and implementation of the Cancer Patient Data Management System, the expansion of KCR's data collection and data quality activities through the CDC National Program of Cancer Registries (NPCR) in 1994 and the NCI Surveillance, Epidemiology and End Results (SEER) Program in 2000. Frances has mentored cancer registrars throughout Kentucky and has fostered their dedication to standards of excellence and a sense of camaraderie among their ranks. Frances' leadership has propelled KCR to become a national model for the procurement of high-quality cancer registry data that has been extensively utilized for cancer prevention and control throughout Kentucky and a prized resource for research.

Frances' wisdom and skills have been shared with the broader cancer surveillance community through her service to the North American Association of Central Registries (NAACCR). She has served on countless committees, work groups, and two elected terms on the Board of Directors. Frances established a reputation as a frank and honest advocate for meaningful data standards and a no-nonsense pragmatic approach to cancer surveillance activities. She helped establish the NAACCR Member Recognition Award Series in 2004 and was awarded the Constance L. Percy Award for Distinguished Service in 2010 and the highly prestigious Calum S Muir Award in 2021.

After many years of dedicated service, Frances retired at the end of April. She is enjoying her first grandchild, Kaia Ann, who was born on May 6, at just the right time to welcome Frances into retirement. We relish our ongoing friendship and we wish her and her husband Ed great joy in their new role as grandparents!

We miss her greatly, but Frances' legacy lives on and shines brightly through the work of her dedicated staff and colleagues whom she mentored through the years. Importantly, Frances built and led KCR operations in the curation of high-quality data from over 700,000 cancer patients which serves as the foundation of cancer prevention and control and population-based cancer research in Kentucky. This is truly a remarkable achievement in our mission to reduce the burden of cancer in the Commonwealth!

Registrar Round-up

New Hires

LaKisha Parris, University of Louisville
Cheyenne Harbour, CHI St. Joseph Health
Patrick Thompson, CHI St. Joseph Health
Marlene Geryes, Appalachian Regional Hospital Network
Danielle Colemire, Harrison County Memorial Hospital

Departures

LaKisha Parris, Norton Healthcare
Julie Krift, Harrison County Memorial Hospital

New CTRs

Nakisha Fields, Norton Health Care

Awards & Honorable Mentions

Congratulations to University of Kentucky HealthCare, for completing the Commission on Cancer Survey!

Congratulations to Ephraim McDowell Regional Medical Center, for completing the Commission on Cancer Survey!

Congratulations to Baptist Health - LaGrange, for completing the Commission on Cancer Survey!

Get in SINQ

Question:

Primary site--Ovary: What information takes precedence for coding the primary site in cases with high grade serous carcinoma that are clinically called ovarian but on pathology, the pathologist calls the primary site fallopian tube and the gynecology oncology/managing physician continues to call the cases ovarian. Both the ovary and tube are involved. Sometimes also referred to as "tubo-ovarian."

Discussion:

Answer:

When the choice is between ovary, fallopian tube, or primary peritoneal, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal invasive serous carcinoma.

If there is no information about the fallopian tubes, refer to the histology and look at the treatment plans for the patient. If all else fails, you may have to assign C579 as a last resort. Use text fields to document the details.

For additional information, see the CAP GYN protocol, Table 1: Criteria for assignment of primary site in tubo-ovarian serous carcinomas.

(SINQ 2021-0025, Date Finalized 05/05/2021; Category Primary Site, Ovary)

Question:

EOD 2018/Lymph Nodes-EOD--Breast: Should Extent of Disease (EOD) Regional Nodes be coded as 150 (Clinical assessment only; Positive needle core biopsy/fine needle aspirate [FNA]) when the patient has a biopsy-proven, clinically apparent, movable ipsilateral axillary lymph node, but no evidence of involvement at surgery after neoadjuvant therapy? See Discussion.

Discussion:

The Breast EOD Regional Nodes notes contain new clarification regarding the clinical assessment vs. pathological assessment codes, but the new Note 2 does not specifically indicate an exception for neoadjuvant therapy. However, if the pre-treatment lymph node core biopsy proved cN1 disease, and the post-treatment resection proved ypN0 disease, should the clinical assessment code (code 150) have priority over any pathological assessment code (including 200) since the involved lymph node was only clinically positive and not pathologically positive? Should an exception be added to Note 2 to address cases where neoadjuvant therapy is given, but the clinical assessment is greater than the pathological assessment?

Answer:

The clinical assessment code takes priority over the pathological assessment code in this case because the clinical assessment was worse than the pathologic assessment. Although there was a pathological assessment, the clinical assessment is greater. According to the general coding guidelines for neoadjuvant therapy, code the worst information, which in this case is the clinical assessment.

The 2018 EOD General Instructions for EOD Regionals Nodes, instruction #4, addresses neoadjuvant therapy as follows. Neoadjuvant (preoperative) therapy: If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the most extensive lymph node involvement documented.

A new note is being included for the 2022 updates. Exception: If patient has neoadjuvant therapy, and the clinical assessment is greater than the pathological assessment, the clinical assessment code takes priority.

(SINQ 2021-0021, Date Finalized 05/14/2021; EOD 2018, Lymph Nodes-EOD, Breast)

Question:

Behavior--Breast: Should the behavior change to /3, invasive, to get a case to clear edits? The histology of this breast case is ductal carcinoma in situ (DCIS), 8500/2. Lymph nodes are positive for micro-mets (0.2 mm-2 mm). SEER Summary Stage: 3, regional lymph nodes positive. This creates an edit for SEER Summary Stage due to the behavior code of /2, in situ.

Discussion:

Answer:

Code the behavior to /3, not just to pass edits, but because this is an invasive case based on the positive lymph nodes.

For most cases, behavior is based on the primary tumor, but in situations like this where an invasive component cannot be found and there are positive lymph nodes, the /3 behavior is assigned based on the positive lymph nodes.

(SINQ 2021-0020, Date Finalized 05/14/2021; Behavior, Breast)

Tips & Helpful Hints

UPDATE to SEER Manual!!!

Source: 2021 SEER Manual
Field: Mets at Dx
Site: Lymphoma

This is a **correction** to the SEER manual. Lymphomas originating in lymph nodes (C77) could have distant metastases to any site except lymph nodes. The following corrections to the manual apply now and will appear in the next version of the manual.

Remove C770-C779 from the instruction for assigning code 8 on the following pages.

Page 135 Mets at Dx--Bone
Page 137 Mets at Dx--Brain
Page 139 Mets at Dx—Liver
Page 141 Mets at Dx--Lung
Page 145 Mets at Dx--Other

Example
Biopsy of axillary lymph node: Diffuse Large B-Cell lymphoma. Lymph nodes involved above and below the diaphragm, multiple nodules seen in lung, lesions in liver. Bone marrow biopsy positive for DLBLC. Per Hematopoietic manual, primary site would be C778 for multiple lymph node regions involved.

Mets at Dx--Bone-0
Mets at Dx--Brain-0
Mets at Dx--Liver-1
Mets at Dx--Lung-1
Mets at Dx--Distant Lymph Nodes-8
Mets at Dx--Other-1

FNA Positive Clinical Timeframe

AJCC Manual 8th Edition, Chapter 1, Pages #: 20-22

If a patient has positive lymph node involvement by FNA in clinical timeframe, no neoadjuvant therapy given but lymph nodes removed during resection of the primary tumor are negative. How to approach this scenario when coding Pathological Stage.

Remember that pathological stage = Clinical information + Op Report + Path Report. All lymph nodes from clinical staging are carried into pathological staging, especially one that was microscopically examined since there is no doubt it contained cancer. Chapter 1 of the AJCC Manual under pathological classification, Pathological N, Requirements for assigning pN category, this will explain that you can use FNA.

Sentinel Lymph Node Biopsy for Breast Only

STORE Manual, Pages: 161-171

If a sentinel lymph node bx is performed **during the same procedure** as the regional lymph node dissection, **use code 97** in the data item Sentinel Lymph Nodes Positive. Record the **total** number of positive lymph nodes biopsied / dissected (both sentinel & regional) in Regional Lymph nodes positive.

Example:

1/1/2021: Patient was diagnosed with biopsy proven right breast ca with biopsy proven right axillary lymph node involvement during clinical workup.

2/1/2021: Mastectomy with sentinel lymph node biopsy that showed involvement (2/3) and an axillary lymph node dissection was completed during the same procedure. Axillary node dissection showed no involvement (0/3).

Positive Reg Nodes: 02
Regional Nodes Examined: 06
Sentinel LNS Positive: 97
Sentinel LNS Examined: 03

NAACCR Summer Forum

NAACCR is pleased to announce the introduction of the NAACCR Summer Forum June 15-17, 2021. Due to continuing COVID-19 concerns they have developed a fully remote experience that will offer their traditional high-level educational content and member sponsored research in a new venue with plenty of opportunity to network with our colleagues and collaborators.

What is different?

- The 2021 NAACCR FORUM will take place: June 15 through June 17, 2021 (Tuesday – Thursday)
- We are reserving Friday, June 18th for the NAACCR Business Meeting, Birds of a Feather, and other networking activities.
- Educational sessions will run 1.5 hours – 2.0 hours in length with breaks in between.
- We will have a special session dedicated to interactive poster presentations.
- Mini- Forums on additional topics/special interest will be presented throughout 2021 at no additional cost
- Recordings of sessions will be available for registrants through 2021 which they can access on-demand as their schedule permits.
- Reduced cost compared to our Annual Conference.

What is the same?

We're bringing the best parts of NAACCR to the FORUM stage.

- Outstanding Plenary Sessions
- Short talks on NAACCR member-submitted content (Breakouts)
- Scientific Posters
- Opportunities for students
- Networking Opportunities
- CEUs
- Awards, recognition, and certification

The 2022 Annual Conference is scheduled for June 2022 in Boise, Idaho. In the meantime, NAACCR will continue to utilize innovative methods to deliver NAACCR's high-quality content of an in-person conference in this virtual setting. NAACCR hopes you will join them for the NAACCR FORUM and take time to learn, renew, re-focus, and set our sight on an optimistic future for us all in 2021!

QUESTIONS?

If you have any questions, please email the Summer Forum Secretariat office at

NAACCR-registration@venuewest.com

Description of a Lung Cancer Hotspot: Disparities in Lung Cancer Histology, Incidence, and Survival in Kentucky and Appalachian Kentucky

Christine F Brainson [1], Bin Huang [2], Quan Chen [3], Laurie E McLouth [4], Chunyan He [5], Zhonglin Hao [5], Susanne M Arnold [5], Ralph G Zinner [5], Timothy W Mullett [6], Therese J Bocklage [7], David K Orren [8], John L Villano [5], Eric B Durbin [9]

Abstract

Introduction: Kentucky is recognized as the state with the highest lung cancer burden for more than 2 decades, but how lung cancer differs in Kentucky relative to other US populations is not fully understood.

Patients and methods: We examined lung cancer reported to the Surveillance, Epidemiology, and End Results (SEER) Program by Kentucky and the other SEER regions for patients diagnosed between 2012 and 2016. Our analyses included histologic types, incidence rates, stage at diagnosis, and survival in Kentucky and Appalachian Kentucky relative to other SEER regions.

Results: We found that both squamous cell carcinomas and small-cell lung cancers represent larger proportions of lung cancer diagnoses in Kentucky and Appalachian Kentucky than they do in the SEER registries. Furthermore, age-adjusted cancer incidence rates were higher in Kentucky for every subtype of lung cancer examined. Most notably, for Appalachian women the rate of small-cell carcinomas was 3.5-fold higher, and for Appalachian men the rate of squamous cell carcinoma was 3.1-fold higher, than the SEER rates. In Kentucky, lung cancers were diagnosed at later stages and lung cancer survival was lower for adenocarcinoma and neuroendocrine carcinomas than in SEER registries. Squamous cell carcinomas and small-cell carcinomas were most lethal in Appalachian Kentucky.

Conclusion: Together, these data highlight the considerable disparities among lung cancer cases in the United States and demonstrate the continuing high burden and poor survival of lung cancer in Kentucky and Appalachian Kentucky. Strategies to identify and rectify causes of these disparities are discussed.

Keywords: Appalachia; Disparities; Interventions; Small cell; Squamous.