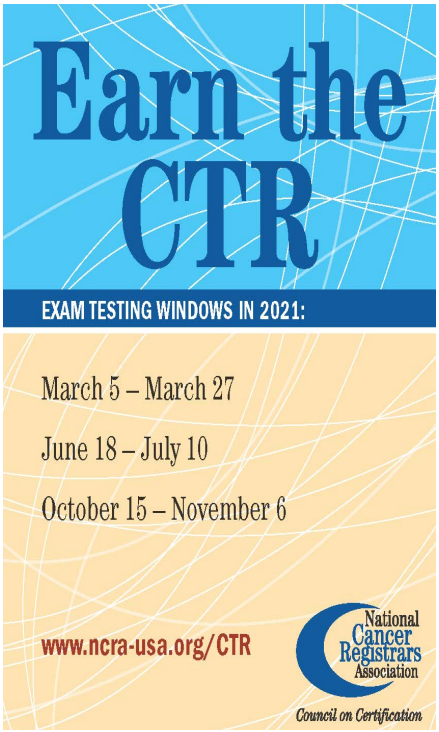
KENTUCKY CANCER REGISTRY

KCR NEWSLETTER

Don't FALL Behind, Keep-Up with the Upcoming Changes

Issue: Winter 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

CTR Re-Certification

For those CTR's whose CE cycle ends 12/31/2020, CE submissions after the deadline of 1/31/2021 are subject to a late-filing fee and possible certification revocation.

Available Trainings and Webinars at kcr.uky.edu

KCR 2020 Fall Workshop

The webinars were recorded and have been posted along with the related training materials. These webinars cover the 2021 updates.

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

Upcoming CoC Trainings

CAnswer Forum LIVE
February 10, 2021 1:00-2:00pm
April 14, 2021 1:00-2:00pm
To learn more and register:
https://www.facs.org/quality-programs/cancer/events/ondemand/canswer-forum-live

Registrar Round-up

New Hires

Cecelia Love, University of Louisville
Patricia Johnson, University of Louisville
Deborah Bradley, Norton Healthcare
Rebecca Baize, Norton Healthcare
Robin Dowell, Norton Healthcare
Amanda Kelley, Taylor Regional Hospital
Peggy Downs, Baptist Health Louisville/LaGrange
Carol McClanahan-Londak, Baptist Health Louisville/LaGrange
Carol Jones, Taylor Regional Hospital

Departures

Patricia Johnson, Taylor Regional Hospital
Marcia Withers, St. Joe's London
Amy Tompkins, University of Louisville
Courtney Sanphasiri, University of Louisville

Promotions

Jodee Chumley, Regional Manager, Baptist Health Louisville /LaGrange and Floyd

Position Change

Tonya Phelps, Norton Healthcare, Cancer Data Analyst
Sherisa Sayles, Norton Healthcare, Cancer Data Analyst

New CTRs

Elizabeth Metje, Norton Healthcare
Katie Prow, Owensboro Health
Darian Cummins, Ephraim McDowell Regional Medical Center
Paige Haydon-Lutz, KCR
Shannon Ladd, KCR

Get in SINQ

Question:

Surgery of Primary Site/Multiple primaries--Breast: Should the Surgery of Primary Site for the 2020 diagnosis be coded 51 (Modified radical mastectomy without removal of uninvolved contralateral breast) when a partial mastectomy and axillary lymph node dissection are performed for a 2011 right breast primary and a subsequent 2020 right breast primary is treated with a total mastectomy only?

Discussion:

The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2011. The separate 2020 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings.

Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. If the Surgery of Primary Site data item is cumulative, does the order of surgeries matter?

It is unclear whether this question should be directed to SINQ (for coding in a SEER registry) or to CAnswer Forum because both have addressed similar surgery related questions in the past and there is no guidance regarding this specific situation.

Answer:

Yes, assign surgery of primary site code 51 for the 2020 diagnosis in this case. Code the cumulative effect of all surgeries to the primary site. This means that for the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

(SINQ 2020-0050; Date Finalized 11/17/2020; 2018 Solid Tumor Rules, Breast)

Question:

Solid Tumor Rules (2018)/Histology--Bladder: A patient has high-grade papillary urothelial carcinoma with focal glandular and neuroendocrine differentiation followed by carcinosarcoma. Is this one or two primaries?

Discussion:

12-19-19 Transurethral resection of bladder tumor pathology revealed high-grade papillary urothelial carcinoma with focal glandular and neuroendocrine features; Pathology Overread: High-grade papillary urothelial carcinoma with focal glandular and neuroendocrine differentiation. Carcinoma invades muscularis propria pT2.

Histology 8130

01/20/20 to 07/01/20, completed 6 cycles of gemcitabine/cisplatin.
07/30/20 Robotic radical cystoprostatectomy with bilateral pelvic lymph node dissection, open ileal conduit pathology revealed carcinosarcoma, invading perivesical fat, no lymphovascular invasion, negative margins. ypT3bN0M0 disease; Pathology Overread: Carcinosarcoma arising in association with high-grade papillary urothelial carcinoma.

Histology 8980/3 or is there another histology that should be used?

Answer:

The carcinosarcoma is a separate tumor, abstract a new primary per M13. Code this primary to 8980/3.

Based on the information provided, the patient was first diagnosed with papillary urothelial carcinoma and received neo-adjuvant treatment for that specific histologic type. Subsequent resection identified carcinosarcoma arising within the papillary neoplasm. Carcinosarcoma is rare in bladder primaries and is not included in Table 2; however, it is a subtype/variant of sarcoma.

(SINQ 2020-0061; Date Finalized 01/25/2021; 2018, 2021 Solid Tumor Rules, Bladder)

Question:

Solid Tumor Rules/Multiple primaries--Lung: How many primaries should be accessioned for the following patient scenario?
1) 09/2014 Left upper lobe (LUL), unifocal, localized acinar adenocarcinoma (8550/3) treated with lobectomy.
2) 04/2016 Right lower lobe (RLL), unifocal, localized acinar adenocarcinoma (8550/3) treated with wedge resection.
3) 04/2019 (within 3 years, but masked full date) Left lower lobe (LLL), unifocal, non-small cell carcinoma (8046/3) with brain metastasis.

Discussion:

Rule M4 does not seem to apply because Note 1 defines clinically disease free to mean no evidence of recurrence in the same lung on follow-up. Patient had been disease free in the left lung after 09/2014 diagnosis. The 04/2019 diagnosis was in a different lung than the 4/2016 diagnosis.

The next applicable rule is either M11 or M14 depending on how we should compare the new 2019 tumor: to the most recent prior tumor in 2016 or to both prior tumors.

Answer:

Abstract three primary tumors according to the 2018 Solid Tumor Rules as follows :
2014: LUL, single primary using M2
2016: RLL, multiple primary; abstract second primary using M11 (different lung)
2019: LLL, multiple primary after reapplying rules using M4 when comparing to the same lung in 2014. Abstract this tumor as it has been more than three years and it appears the patient had no clinical evidence of disease in the left lung until 2019.

(SINQ 2020-0030; Date Finalized 09/11/2020; 2018, 2021 Solid Tumor Rules, Lung)

Tips & Helpful Hints

Prostate – Cores Positive and Cores Examined

SSDI Manual Pages #: 316-320

Important to remember Coding Instructions and Guidelines:

- These data items should be coded from the same test.
- Record the number of positive prostate core biopsies from the ***first*** prostate core biopsy diagnostic for cancer.
- If positive cores are identified and the number of positive cores not specifically documented, code X6.
- Number of Cores Positive must ***ALWAYS*** be less than or equal to Number of Cores Examined.
- Do not make assumptions about the number of cores positive or examined based on the number of areas biopsied within the prostate (laterality, lobes, apex, base, or mid-prostate). Several cores may be taken from each area.
- Do not include cores of other area like seminal vesicles
- Information from the gross description of the core biopsy pathology report can be used to code this data item when the gross findings provide the actual number of cores and not pieces, chips, fragments, etc.

Example 1:

- RT apex: benign prostate tissue
- RT mid: prostatic adenocarcinoma,1 of 2 cores involved
- RT base: prostatic adenocarcinoma,1 of 2 cores involved
- RT apex lat: benign prostate tissue
- RT mid lat: benign prostate tissue
- RT base lat: prostatic adenocarcinoma, 2 of 2 cores involved
- LT apex lat: benign prostate tissue
- LT mid lat: benign prostate tissue
- LT base lat: benign prostate tissue
- LT apex: benign prostate tissue
- LT mid: benign prostate tissue
- LT base: prostatic adenocarcinoma,1 of 2 cores involved

Number of Cores Examined: X6
Rationale: Number of cores taken from each area is not given. Rule states to not assume that the number of cores positive or examined based on the number of areas biopsied.

Number of Cores Positive: 5
Rationale: Though the number of cores taken from each area is unknown, the number of cores that were positive for adenocarcinoma was given.

Example 2:

- RT apex: benign prostate tissue
- RT mid: positive for prostatic adenocarcinoma
- RT base: positive for adenocarcinoma
- RT apex lat: benign prostate tissue
- RT mid lat: benign prostate tissue
- RT base lat: positive for adenocarcinoma
- LT apex lat: benign prostate tissue
- LT mid lat: benign prostate tissue
- LT base lat: benign prostate tissue
- LT apex: benign prostate tissue
- LT mid: benign prostate tissue
- LT base: adenocarcinoma,1 of 2 cores involved

Number of Cores Examined: X6
Rationale: Number of cores taken from each area is not given. Rule states to not assume that the number of cores positive or examined based on the number of areas biopsied.

Number of Cores Positive: X6
Rationale: Though 4 areas were positive for adenocarcinoma, the number of cores positive was only mentioned in one result.

Prostate – PSA Lab Values

SSDI Manual V2.0 Pages #: 300-301

Important Coding Instructions and Guidelines:

- Record the ***last*** pre-diagnosis PSA lab value that was completed within 3 months prior to diagnostic biopsy of prostate and the initiation of treatment.
- **Note**: This is a change from CSv2, where the instructions stated to code the highest PSA value within 3 months prior to diagnostic biopsy**.**

Example 1:

1/5/2018: PSA 5.8
1/29/2018: PSA 5.2
2/22/2018: Biopsy positive for adenocarcinoma
3/25/2018: PSA 5.9

Code: 5.2
Rationale: Though the PSA from 1/5/18 and 3/25/18 were higher the rules state to use the PSA lab value ***closest*** and ***prior*** to the diagnostic biopsy.

Example 2:

2/5/2018: PSA 6.8
6/29/2018: Biopsy positive for adenocarcinoma

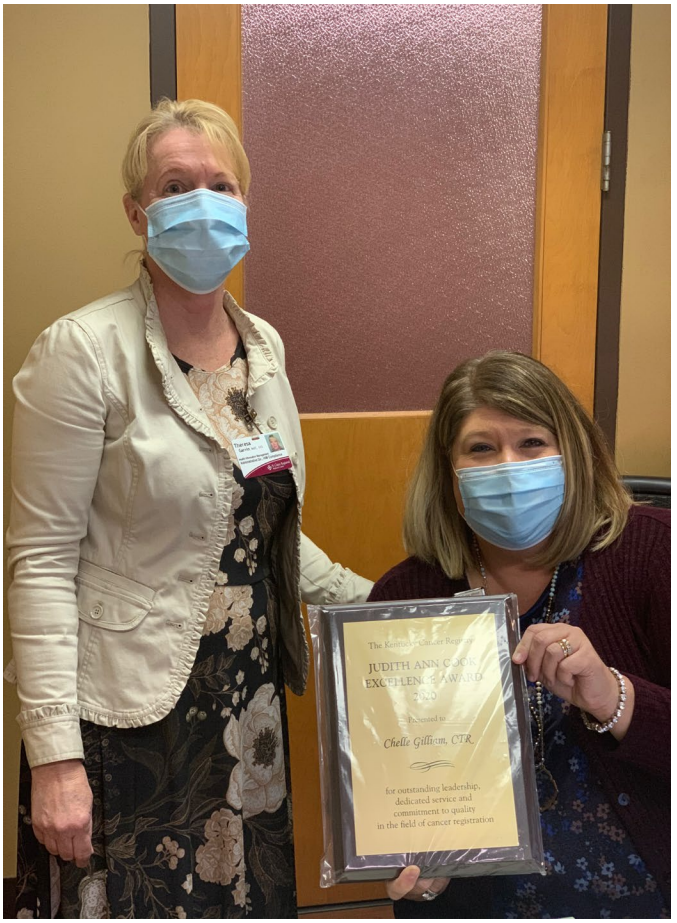
Code: XXX.9
Rationale: Though the PSA result was done prior to the diagnostic biopsy, results were obtained outside the three-month window.

The 34th Annual Advanced Cancer Registrars' Workshop

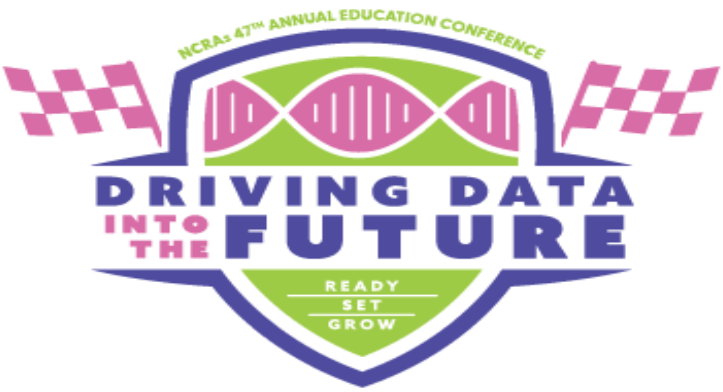
The 34th Annual Advanced Cancer Registrar's Workshop was held virtually on every Tuesday and Wednesday throughout the month of October. On behalf of the Kentucky Cancer Registry, thank you for a successful Fall Workshop! Your attendance and participation are what makes this workshop the fantastic event it is! It was wonderful to see so many cancer registrars coming together and eager to expand their knowledge and insight in cancer abstraction!

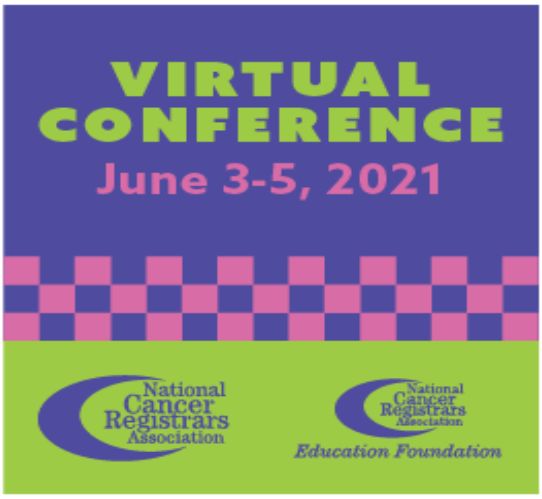
Due to the COVID-19 restrictions, we were faced with many challenges in 2020. However, regardless of the obstacles that we encountered, we feel strongly that we were still able to produce an excellent educational experience and opportunity. The materials presented covered topics that are most relevant to a cancer registrar's daily experience and gave insight within the field of cancer coding and data collection.

We again want to congratulate, Chelle Gilliam, CTR, from St. Claire Healthcare, this year's recipient of the Judith Ann Cook Excellence Award! It was an award well deserved for her outstanding dedication and service to the field of cancer data and research.



The updated workshop materials have been aggregated and we invite you to visit the KCR website to view the materials.
Again, your attendance helped to make this event a great success and your enthusiasm and positive spirit helped make our time together productive, educational and rewarding. It is our hope that we are able to put the challenges of 2020 behind us and once again come together for an in-person workshop in 2021! Until then, stay safe and stay healthy!





NCRA's 47th Annual Educational Conference Will be a Virtual Only Event

The National Cancer Registrars Association (NCRA) is holding its 47th Annual Educational Conference as a virtual only event. There will be no in-person conference in 2021.

Like many of you, NCRA is grateful for the progress made on the COVID-19 vaccines, but the timing will not ensure a safe in-person event in June of 2021. With this in mind, the NCRA Board of Directors and staff made the decision to move forward with presenting a virtual-only conference on June 3-5, 2021. NCRA is working with the J.W. Marriott in Indianapolis to reschedule a future NCRA conference in that great city.

NCRA's 2021 Virtual Annual Educational Conference will be hosted on a virtual platform to allow us to continue to offer high-quality and unique content that is the hallmark of NCRA's conference programming. In addition, the 47th Annual Educational Conference will include a virtual exhibit hall, online basket raffles, roundtable discussions, and other networking opportunities.

Registration Rates
Early rates are available to registrants whose form and payment are postmarked and/or received by March 1, 2021.

Member Rates
Before March 1, 2021: $260
After March 1, 2021: $360

Non-Member Rates
Before March 1, 2021: $360
After March 1, 2021: $460

Important Dates

- **March 1, 2021: Early-rate registration cut-off.**
- **May 14, 2021: Last date to register and cancel registration to receive a refund.**

Web-based interactive mapping from data dictionaries to ontologies, with an application to cancer registry

Shiqiang Tao [1], Ningzhou Zeng [2], Isaac Hands [3], Joseph Hurt-Mueller [3], Eric B Durbin [3,4], Licong Cui [1], Guo-Qiang Zhang [5]

Abstract

Background: The Kentucky Cancer Registry (KCR) is a central cancer registry for the state of Kentucky that receives data about incident cancer cases from all healthcare facilities in the state within 6 months of diagnosis. Similar to all other U.S. and Canadian cancer registries, KCR uses a data dictionary provided by the North American Association of Central Cancer Registries (NAACCR) for standardized data entry. The NAACCR data dictionary is not an ontological system. Mapping between the NAACCR data dictionary and the National Cancer Institute (NCI) Thesaurus (NCIt) will facilitate the enrichment, dissemination and utilization of cancer registry data. We introduce a web-based system, called Interactive Mapping Interface (IMI), for creating mappings from data dictionaries to ontologies, in particular from NAACCR to NCIt.

Method: IMI has been designed as a general approach with three components: (1) ontology library; (2) mapping interface; and (3) recommendation engine. The ontology library provides a list of ontologies as targets for building mappings. The mapping interface consists of six modules: project management, mapping dashboard, access control, logs and comments, hierarchical visualization, and result review and export. The built-in recommendation engine automatically identifies a list of candidate concepts to facilitate the mapping process.

Results: We report the architecture design and interface features of IMI. To validate our approach, we implemented an IMI prototype and pilot-tested features using the IMI interface to map a sample set of NAACCR data elements to NCIt concepts. 47 out of 301 NAACCR data elements have been mapped to NCIt concepts. Five branches of hierarchical tree have been identified from these mapped concepts for visual inspection.

Conclusions: IMI provides an interactive, web-based interface for building mappings from data dictionaries to ontologies. Although our pilot-testing scope is limited, our results demonstrate feasibility using IMI for semantic enrichment of cancer registry data by mapping NAACCR data elements to NCIt concepts.