KCR newsletter Novemeber 2018

KCR Fall Workshop 2018

On August 16-17, 2018, KCR held a Tri-State Regional Cancer Registrars' Meeting at the Crowne Plaza Airport in Louisville, Ky. The workshop was jointly conducted by the Indiana Cancer Consortium, the Ohio Cancer Incidence Surveillance System and the Kentucky Cancer Registry. Speakers included Dr. David Byrd, Chair of the American Joint Committee on Cancer (AJCC), Dr. Michael Bousamra from Baptist Health Floyd, Dr. Tim Mullett from the Markey Cancer Center Research Network, and Dr. Russel Eldridge of Baptist Health Lexington. The topics presented by these physicians included melanoma, breast, and lung cancer staging, as well as new immunotherapies and the 2018 changes to the Commission on Cancer's requirements for approved Cancer Programs.

Other highlights on the program were Dr. Eric Durbin, Director of KCR; Larry Peters from the Bone Metastases Program in Cincinnati, OH; Dr. Thomas Tucker and Rachel Maynard with the Virtual Tissue Repository in Kentucky; and Lindsey Byrne, genetic counselor with the Mount Carmel Health System of Ohio. Kentucky Cancer Registry's Tonya Brandenburg and Nicole Catlett presented a "Staging Shakedown".

Special thanks go to our sponsors: the UK Healthcare Markey Cancer Center Affiliate Network and the Norton Cancer Institute.

This year's Judith Ann Cook award for excellence in cancer registration went to Vivian Wyatt from the University of Louisville Hospital. The meeting was awarded 9.5 continuing education units from NCRA.

People News

New Hires:
Jaime Clark, Baptist Health Louisville
Jennifer Smothers, KentuckyOne Health Lexington
Mary Jo Mahoney, SEER DMS coordinator, KCR
Paige Haydon-Lutz, SEER DMS coordinator, KCR
Sarah Burke, Norton Healthcare (starts December 2018)
Michelle McCormick, QA specialist, Norton Healthcare (starts Jan 2019)
Resignations:
Keisha Sawyers, KentuckyOne Health Louisville
Jennifer Smothers, KentuckyOne Health Louisville
Karrie Ihrie, Baptist Health Louisville
Mary Jo Mahoney, Norton Healthcare
Michelle McCormick, KentuckyOne Health Louisville
Retirements:
Theresa Geoghegan, Norton Healthcare
Position changes:
Vicki Larue, SEER DMS coordinator, KCR
Debbie Thompson, Abstractor, Norton Healthcare
Promotions:
Desiree Montgomery, SEER DMS Manager, KCR
Bev Shackelford, Registry Manager, KentuckyOne Health Lexington
New CTRs:
Whitney Bryant, Murray Calloway County Hospital
Chelle Gilliam, St. Claire Medical Center

ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- Harrison County Hospital for passing CoC survey!
- King's Daughters Cancer Registry for receiving approval with full accreditation on recent CoC survey!
- Norton Healthcare for passing three surveys - NAPBC, Network & Pediatric Childrens Hospital surveys!

Coding Hints/Reminders

AJCC staging clarifications:

1. For thyroid cancers that have suspicious cytology only and then go on to have thyroidectomy, you can assign clinical AJCC staging as per Donna Gress on the CAforum this case meets eligibility for clinical AJCC staging.

2. Use of "m" descriptor for in-situ/non-invasive disease: AJCC 8th edition page 12 of general instructions states you do NOT use the "m" for multifocal in-situ/non-invasive cancers.

3. Histologies/Topographies that are reportable but NOT stageable as they are not listed in the AJCC:

    - LCIS of breast.
    - Adenocarcinoma in a Meckel's diverticulum.
    - Multiple Myeloma.

4. For 2018 cases using AJCC 8th edition: For cases that have confirmation of a metastatic site you will now bring down the cT and cN to the pT and pN field. (in 2017 you left pT and pN blank).

5. Encapsulated Follicular variant of Papillary Thyroid Carcinoma (EFVPTC) has a specific histology code that went into effect January 1, 2017. You will use code 8343/3 for invasive and 8343/2 for non-invasive.

COLON CASES
Coding Reminders/Tips/Guidelines for 2018 Cases

Topography: The OP report is your priority document for coding primary site. The surgeon has the best info NOT the pathologist. Review OP report for mention of tumor being 'identified' or 'palpated' and include this in your OP report text documentation.

Histology: Path reports are your priority documents for coding histology. Do NOT use polyp codes for any cases DX'd 2018 and later per Solid Tumor Rules.

Clinical Grade: Now coded using 4-tier system (G1, G2, G3, G4). This item can be coded from colonoscopy w/ BX that has +pathologic confirmation of malignancy OR from a polypectomy w/ cancer that is followed by a surgical resection. This item CANNOT be blank; if no BX was done of the primary site you will code this item 9.

Pathologic Grade: Now coded using 4-tier system (G1, G2, G3, G4). This item can be coded from a polypectomy that is the definitive surgical procedure OR a surgical resection of the primary site (segmental, hemi, etc). This item CANNOT be blank if no surgery was done of the primary site. You will code this item 9. If the clinical grade is higher than the pathologic grade you SHOULD code the clinical grade in BOTH the clinical & pathologic grade fields. If a patient has neo-adjuvant TX followed by resection, this item will be coded 9 as there is no pathologic grade -- only a post-tx grade to be recorded.

Post-TX Grade: Now coded used 4-tier system (G1, G2, G3, G4). If no neo-adjuvant TX given then this item will be left blank.

EOD Primary Tumor: Code the further extent of involvement by the primary tumor as documented in medical records. This could be from the clinical findings, in imaging reports, pathology report & in OP report in surgical observations with or without BX. There are no longer eval codes to designate where you are coding your info from, so just use same line of thinking as before with CS and code the cancer at its worst stage of involvement.
CODE 050 = Intramucosal (remember you must enter behavior as /3 as SEER considers 'intramucosal' to be invasive and SS2018 will be localized, code 1, BUT AJCC considers in-situ Tis).
CODE 300 Subserosal fat/adipose tissue/tissues and SS2018 will be localized, code 1.
CODE 400 Pericolic fat/adipose tissue/tissues and SS2018 will be regional, code 2.

EOD Lymph Nodes: Code regional LN involvement as documented in imaging, OP or path reports. Note for colon/rectum only: You can assume that nodes are pericolic/perirectal when removed w/ colon resection specimens and the pathology report doesn't mention anything but regional LNs. This is new with 2018 cases. The majority of cases will be coded to 300 when LNs are positive on path reports.

EOD Mets: Code distant METS as documented in the medical record. This information may be obtained from imaging reports, OP reports and path reports.

COLON CASES

Coding Reminders/Tips/Guidelines for 2018 Cases (continued)

SS2018: Code the extent of involvement as noted in the medical record. Remember there are times when EOD/AJCC will consider something to be regional and noted in the T or N category BUT SS2018 will consider them distant (Example: Colon tumor directly invading the bladder will be a EOD code 600 and AJCC T4 but SS2018 will be distant, code 7).

Clinical AJCC Staging: Uses information from imaging, PE, endoscopic procedures, staging workup PRIOR to neo-adjuvant TX or surgical resection.
-In-situ cancer diagnosed on BX will be cTis for 2018.
-Polypectomy cases FOLLOWED BY DEFINITIVE SURGERY will be coded in clinical T classification. If no residual tumor found on resection your cT also gets assigned in pT in the absence of neo-adjuvant TX.
-Polypectomy is the only surgical procedure done for a colon primary then your polypectomy information will be used in the pathologic AJCC staging classification as it was definitive surgery. Your clinical AJCC staging will therefore be blank as the cancer was diagnosed at time of definitive surgery, no clinical staging applies.
-If invasive on BX and imaging mentioned colon wall thickening with no other description to assign the extent of primary tumor, then you will have a cTX as tumor cannot be assessed clinically.

Pathologic AJCC Staging: Uses information from clinical timeframe + pathologic/surgical resections. Read the site chapters to see what surgical procedure is needed to qualify case for pathologic staging. If there is a resection after neo-adjuvant therapy then pStaging will be blank/not applicable and you will record yp Staging in post-tx staging fields.

PostTX AJCC Staging: Leave blank for cases that do not have neoadjuvant treatment.

Calendar of Events

November 22-23, 2018 KCR Offices closed-Thanksgiving
Dec 24, 2018-Jan 1, 2019 KCR offices closed-Holiday Break
January 31, 2019 CTR exam application deadline.
March 1- March 23, 2019 CTR exam testing window

SEER Coding Questions

Question

Solid Tumor Rules/Multiple primaries--Breast: How many primaries should be abstracted when papillary carcinoma is identified in two biopsies and a subsequent lumpectomy identified invasive ductal carcinoma with multifocal ductal carcinoma in situ (DCIS)?

Answer

Abstract as multiple primaries using Breast Solid Tumor Rule M12 as these are separate, non-contiguous tumors on different rows in Table 3. (SINQ 2018-0079; Date Finalized 11/15/2018; 2018 Solid Tumor Rules, Breast).

Question

Reportability/Heme & Lymphoid Neoplasms: Is monoclonal B-cell lymphocytosis reportable?

Answer

Monoclonal B-cell lymphocytosis is not a reportable condition. This term will be removed from 9823/3 since it is a /1 (has it's own code). This will become much more clear once we get the new WHO Heme terms into the database. (SINQ 2018-0050; Date Finalized 11/06/2018; WHO Class Hem & Lymph Tumors, Revised 4th ed., 2017; Heme & Lymph Manual & DB).

Question

Solid Tumor Rules (2018)/Histology--Lung: The Histology coding guidelines for lung cancer state to code histology when stated as type or subtype but not to code when described as pattern. How should the histology be coded (Adeno, NOS or Adeno, Mixed subtypes) if the College of Americal Pathologists Protocol of the pathology report lists the following: Histologic type: Adenocarcinoma, papillary (90%), lepidic (8%), and solid (2%) patterns?

Answer

The term/modifier "patterns" is no longer allowed to code a specific histology according to the Lung Solid Tumor H rules. Disregard the papillary, lepidic, and solid patterns and code histology to adenocarcinoma, NOS (8140/3). (SINQ 2018-0070; Date Finalized 11/15/2018; 2018 Solid Tumor Rules, Lung).

Question

EOD 2018/Summary Stage 2018--Head & Neck: When the reportable suspicious cytology used to code diagnosis date is a regional lymph node fine needle aspirate (FNA), should this information also be used to code positive Extent of Disease (EOD) Regional Nodes, Regional Nodes Positive, Regional Nodes Examined, and SEER Summary Stage 2018?

Answer

Use information from the suspicious cytology of the lymph node for determination of EOD and Summary Stage when there is a subsequent definitive diagnosis.

Code as follows based on the information provided.
EOD Regional Lymph Nodes: 500
Regional Nodes Examined: 95
Regional Nodes Positive: 95
SS2018: 3 (RN)

If subsequent treatment involves surgery and nodes are removed, code to the status of the surgically resected nodes. (SINQ 2018-0048; Date Finalized 11/06/2018; SEER*RSA).