KCR newsletter March 2018

KCR 2018 Fall Workshop/Regional Meeting

SAVE THE DATE!

2018 Tri-State Regional Cancer Registrars' Meeting

Presented by:

Kentucky Cancer Registry, Indiana Cancer Consortium, and Ohio Cancer Incidence Surveillance System

Thursday, August 16, 2018 8:30 AM - 4:30 PM and
Friday, August 17, 2018 8:30 AM – 12:00 PM
Crowne Plaza
830 Phillips Lane
Louisville, KY 40209

*Registration and agenda information will come out soon. We will officially begin accepting registrations for the workshop on July 2, 2018

9.5 CEUs will be awarded

For those who will need overnight accommodations, we have reserved a block of rooms at the Crowne Plaza Louisville at the rate of $119.00 plus tax. You may book your room now. The reservation link for booking your room online is:

BOOK YOUR GROUP RATE FOR THE 2018 TRI-STATE REGIONAL CANCER REGISTRARS' MEETING

The deadline for room reservations is July 15, 2018. Please make sure you mention that you are attending the 2018 Tri-State Regional Cancer Registrars' Meeting if you call in to reserve the special rate.

If you need additional information regarding the workshop, please contact Paula Cole at pcole@kcr.uky.edu or call (859) 218-3192.

We hope you all will be able to join us.

KCR 2018 Spring Training Locations

April 11, 2018 at UK Turfland Conference Room, 2195 Harrodsburg Rd., in Lexington, KY

April 17, 2018 at Baptist Health Madisonville, in the Loman Room, 200 Clinic Drive, Madisonville, KY

April 20, 2018 at Baptist Health Louisville in the Cancer Resource Center, Charles and Mimi Osborn Cancer Center, 4003 Kresge Way, Louisville, KY

Calendar of Events

May 28, 2018 KCR offices closed – Memorial Day
June 1, 2018 CTR exam application deadline
June 25 - July 14, 2018 CTR exam testing window
July 4, 2018 KCR Offices closed-Independence Day

People News

New Hires:
Tabitha Sutton - University of Kentucky Healthcare Enterprise
Beverly Shackelford - Frankfort Regional Medical Center
Michelle "Shelly" Gray - QA Manager of Abstracting and Training, KCR

Resignations:
Tabitha Sutton - King's Daughters Medical Center
Carole Miller - University of Louisville Hospital

ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- The University of Kentucky Markey Cancer Center is one of 16 accredited cancer programs nationwide to receive the 2017 Outstanding Achievement Award from the American College of Surgeons Commission on Cancer.

Coding Hints/Reminders

Helpful Hints for Coding Lung Cases

INTERPRETING IMAGING

Imaging can include both CT and PET. The uptake seen on the PET may alter the findings clinically by treating surgeon, oncologist, etc. See example below:
*Example for Interpreting Imaging: CT chest may show enlarged LNs which for lung cases CAN be used to code CSLN data item per CS manual rules. BUT, if a PET scan is performed and there is no SUV uptake seen within the LNs mentioned on CT, then the MD is using the PET to "trump" the CT and considered to be clinically cN0. PTs who have cN2 disease should NOT be taken to surgery per CP3R measures and NCCN guidelines.
*You should use *all* info available, including how was the patient treated.

AMBIGUOUS TERMINOLOGY LISTS

There are (3) Ambiguous terminology lists:
Case-finding
Multiple Primary and Histology coding
Involvement/extent of disease

CS DATA ITEMS

- "Pleural-based" is an anatomic term for location of tumor. Don't code to involvement of pleura based on this description in imaging.
- CSEXT code 410: DO NOT use due to algorithm error (See Lung coding Bootcamp Fall Workshop presentation).
- If CSLN = 600, then SS2000 = 7 distant
- If SSF1 = 020 or 030 (there is a separate tumor in a different lobe w/tumor also in same lobe), then SS2000 = 7 distant
- Tumor extending to hilum SHOULD be coded to 500 involvement of Main Stem Bronchus (MSB)/hilum less than 2 cm from carina per CAforum post. The hilum and MSB have same topography code. If a tumor extends to the hilum it is involving the MSB to get there. (see CAforum posts).

TS/EXT EVAL

When coding a case, using AJCC manual & SS2000 manual, decide what is deriving the "T" category. For lungs, Tumor Size plays a role as does extension. If the T category is based on imaging or PE, or even just coded from physician staging documentation, then the Eval code will be 0. If a biopsy proves the extension coded, then the Eval code is clinical code 1. Usually, you will find imaging results stating Tumor Size (which derives T category when no other mention of invasion noted. For example: confined to lung, code 100, eval 0, based on imaging). If imaging states invasion of rib then your Eval will be 0, unless proven by biopsy or resection to be involving the rib. In that case, the Eval code could be 1 (BX+ direct extension, NOT A MET) or 3 (resection, NOT A MET).

Coding Hints/Reminders (continued)

CSLN

- Imaging may show enlarged LNs and then usually a PET scan is performed to rule out N2 involvement as shown on CT and staging workup. If N2 nodes which are enlarged on CT do NOT show uptake on PET, then surgeons are using the PET to "override" the CT. Then usually if the patient's condition allows, surgery is an option (per CP3R measures, cN2+ should not be taken to surgery).
- Mediastinoscopy may be performed as well to rule out LN involvement. Remember, it is important to capture in text the level of LNs that are evaluated.
- Using the coding manuals, you see that the level of LN is important when assigning the "N" category.

LN EVAL

- The level of LN involved will derive the "N" category for lung cases. So, where are you coding CSLN from Imaging, this will be eval code 0. BX proven LN involvement will be code 1. Surgically/path resected w/ primary OR highest N category BX+ will be code 3.
- EXAMPLE: CT shows LUL mass w/ associated enlarged bilateral hilar and bilateral paratracheal LNs with subcarinal LAD suspicious as well. PET scan shows uptake in all mentioned LNs. Mediastinoscopy is performed path shows +R hilar LN, +L hilar LN, +R paratracheal and negative L paratracheal LNs. So, you have BX proven highest N category, N3 with +BIL HILAR LNS proven. The CSLN will be 600 and LN eval will be coded 3. If the primary is in the LUL and the R hilar LN had been negative above, unless you have resection of the primary (which in a N2+ PT the surgeon would then refer to MED ONC/RAD ONC), the CSLN will be 200 and LN eval code will be 1 BX proven, clinical N2.

METS@DX

- When reviewing imaging, terminology may be used that you should look for: "pleural studding", hypermetabolic nodes suspicious or consistent with pleural mets; these indicate MET nodules are present separate from the primary.

METS EVAL

Any BX of a metastatic site will be code 3 pathologic. AJCC agrees. Now, with CS, you have to look at what is highest "subcategory" of M1 being coded from…Imaging OR BX proven. For example, if you have a right lung cancer with +Pleural fluid from a thoracentesis and no other METS seen on imaging, then you have a pM1a. Now, if you have a right lung cancer with bone and brain METS seen on imaging, eval 0 clinical, cM1b.

SSF2

- If VPI is present on path, then pT2 (subcategory based on size), then PL1.
- If VPI is present and the tumor is stated to extend to the pleural surface path report,then pT2 (a/b based on size), then PL2. *There must be a statement on path under "extension" on CAP or other template in order to code this.
- If under VPI it says not identified, confirmed by elastin stain, + for invasion of elastic layer but not through, then pT1 (subcategory based on size). *IF elastin staining is performed it will be noted on path report. *Due to an algorithm error, you should not use CSEXT code 410 which is the correct code for this scenario, you should downcode to 100 confined to lung with note in text. *See lung coding bootcamp.

Coding Hints/Reminders (continued)

Coding FNA/needle BX/excisional BX of regional Lymph Nodes

FROM CPDMS.net web help manual:

Record the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

• The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.

• Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.

• Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

• For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9), code 9.

• For lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9), code 9.

• For an unknown or ill-defined primary (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989), code 9.

• Do not code distant lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field Surgical Procedure/Other Site.

• Refer to the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

• If the operative report lists a lymph node dissection, but no nodes were found by the pathologist, code this field 0 (no lymph nodes removed).

• If the patient has two primaries with common regional lymph nodes, code the removal of regional nodes for both primaries.

**Remember: Even if the FNA/BX/excisional BX of regional LNs are negative on cytology/pathology – You will still code as these are considered staging workup procedures that will help to derive the TX plan for the patient.

**Clinical N2 patients SHOULD NOT be taken to surgery. So, you should see evaluation of LNs (FNA, BX, mediastinoscopy) performed to rule this out. CP3R measure.

Coding Hints/Reminders (continued)

Primary intracranial and CNS tumors

Don't forget to abstract all non-malignant, primary intracranial and CNS tumors of any morphology found in the ICD-O-3 with a behavior code of /0 or /1 diagnosed after January 1, 2004. This includes Lipoma, NOS 8850/0. Topography codes included: C70.0 - C70.9, C71.0-C71.9, C72.0-C72.9, C75.1, C75.2, C75.3.

SEER Coding Questions

Question
MP/H Rules/Histology--Breast: Should encapsulated papillary carcinoma of the breast with a separate focus of ductal carcinoma in situ be coded as 8050/2 (papillary carcinoma) and staged as in situ?

Answer
For cases diagnosed prior to 2018

Code as encapsulated papillary carcinoma, 8504/3; this is a synonym for intracystic carcinoma (WHO Classification of Tumors of the Breast). Stage this case as invasive. (SINQ 2018-0006; Date Finalized 03/07/2018; ICD-O-3; WHO Classification of Tumors of the Breast)

Question
Scope of Regional Lymph Node Surgery--Lung: How do you code Regional Nodes Positive, Regional Nodes Examined, and Scope of Regional Lymph Node Surgery when a fine needle aspirate (FNA) or biopsy of supraclavicular lymph nodes is positive for a lung cancer primary? Supraclavicular lymph nodes are distant in SEER Summary Stage and regional by AJCC.

Answer
For cases diagnosed through 2017, use the Collaborative Staging (CS) system to determine regional versus distant lymph nodes. Supraclavicular lymph nodes are regional for lung in CS. Please note that Summary Stage is not the same as EOD, CS, or AJCC staging. Registrars should not use Summary Stage definitions for anything other than directly assigning the Summary Stage field. (SINQ 2017-0078; Date Finalized 01/25/2018; 2016 SEER Manual)

Question
Reportability--Kidney: Is a renal cell neoplasm stated to be multilocular clear cell renal cell neoplasm of low malignant potential a reportable tumor if the physician refers to the tumor as renal cell carcinoma in a follow-up note after surgery? If reportable, how is histology coded?

Answer
For now, report the case and code to 8310/3.
In the 3rd Ed WHO Tumors of the Urinary System, multilocular clear cell RCC is coded as 8310/3, however the recent 4th Ed WHO Tumors of Urinary System notes this term is obsolete and a synonym for multilocular cystic renal neoplasm of low malignant potential (8316/1) which would be non-reportable. Per WHO 3rd Ed these tumors never recur or metastasize which may be why the behavior code is shown as /1. The standard setters must review this terminology change in relation to reporting the case as it may impact incidence rates. (SINQ 20017-0074; Date Finalized 01/10/2018; WHO Class Urinary Tumors).