In the Abstract

KCR Newsletter

JULY 2017

SAVE THE DATE!! KCR Annual Fall Conference 2017

The Kentucky Cancer Registry Annual Fall Conference will be held September 21 & 22, 2017 at the Marriott Griffin Gate Hotel in Lexington, Ky. We have an agenda full of TNM Training. Please mark your calendars and join us!

KCR 2017 Spring Training

KCR held Spring Training webinars on Wednesday May 24, 2017 and Thursday May 25, 2017. Tonya Brandenburg discussed the rules for coding grade with many examples and answers given. She also presented the new data items for AJCC 8th edition clinical AJCC grade and pathologic AJCC grade and she reviewed the general rules for AJCC staging.

People News

New Hires:
Scott Myers, University of Kentucky
Alison Heath, Norton Healthcare
Katherine Wilks, Norton Healthcare
Valerie White, Norton Healthcare

Resignations:
Scott Myers, KentuckyOneHealth, Lexington
Carolyn Hennessey, Norton Healthcare
Heather Patton, Norton Healthcare
Lisa Witt, KCR ePath coordinator

Position Change:
Eric B. Durbin, DrPH, MS, is now the Director of the Kentucky Cancer Registry
Thomas C. Tucker, PhD, MPH, is now the Associate Director of KCR
Lisa Witt, Data Management Specialist for Cancer Research Informatics at the Markey Cancer Center

New CTRs:
Carolyn Miller, Pikeville Medical Center

Calendar of Events

September 4, 2017 KCR offices closed – Labor Day
September 15, 2017 NCRA CTR exam application deadline
September 21-22, 2017 KCR Annual Fall Conference in Lexington
October 14 – November 4, 2017 NCRA CTR exam window

ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- Methodist Henderson on passing their first CoC survey !

Job Opportunities

Norton Healthcare has an opening for a Cancer Data Compliance Specialist

Coding Histology Hints/Reminders

** When the pathology report states ‘papillary carcinoma of the thyroid,’ you should use Histology code 8260/3 per “other sites module” MP/H rule H14.

**When a colon pathology report states ‘invasive mucinous adenocarcinoma arising in a tubular adenoma,’ you should use Histology code 8210/3 per “colon site module” MP/H rule H4. Remember, it is important to capture cancers arising in polyps versus frank malignancies.

**When a definitive surgery path report for a breast cancer states ‘invasive apocrine ductal carcinoma,’ you should use Histology code 8401/3, from table 2 and MP/H rule H12. *Apocrine should be marked off of the specific types of Intraductal carcinomas (Table 1) and moved down to specific types of Duct Carcinoma (Table 2).

Recommended Internal QA Audits

Use the Data Analysis feature of CPDMS to identify the following potential errors:

1. Select in situ Breast cancers (Site code = 29 and Behavior code = 2) which have an SSF7 that is NOT equal to 999. These are incorrect, because Bloom Richardson Score/Grade pertains to invasive cancers only.
2. Select Lung cancers (Site code IN 22,23) with CS Extension code = 410. These are incorrect; Extent code 410 should not be used; change to code 430.
   ***CORRECTION: Ext code 410 derives an algorithm error; Change to code 100 confined to lung. 410 should derive a T1 based on extension only but is deriving a T2 which is the error.*
3. Select colon cases (Site code = 14) with polypectomy only (in NAACCR Therapy segment, RX Summ-- Surg Prim Site [1290] IN 26, 28, 29). Create a data list and review SSF4 and SSF6; they should both be 998 (no surgical resection performed).
4. Select all cases with Therapy type = Other and review for correct assignment of treatment type. SEER*RX may be a helpful resource here.
5. Select all prostate cases (Site code = 34) diagnosed in 2015 or 2016 (Diagnosis date BETWEEN 01/01/2015 AND 12/31/2016) and review the PSA value in SSF1. Check for rounding or decimal point errors. Use the PSA Coding Guideline on the KCR wiki page:
   https://wiki.kcr.uky.edu/registrar/lib/exe/fetch.php?media=psa_ssf1.pdf

SEER Summary Stage Reminders/Hints

There a many differences between SEER Summary Staging, AJCC and CS. It is important to use the SEER SS2000 manual when directly coding this data item. Here are just some of the discrepancies found upon review:

1. Colon Extension code 100 (intramucosal) maps to SS localized (code 1).
2. Colon Extension code 400 (invasion of subserosal fat) maps to SS localized (code 1).
3. Colon Extension code 450 (invasion of pericolic fat) maps to SS regional (code 2).
4. Lung case with separate tumor nodules in different lobe (SSF1 020 or 030) maps to SS distant (code 7).
5. Lung case with N3 involvement (bilateral hilar, mediastinal or supraclavicular LNs) maps to SS distant (code 7).
6. Breast case with N3c involvement (supraclavicular LN) maps to SS distant (code 7)
7. Bladder with common iliac LN involvement maps to SS distant (code 7).
8. Kidney with Extension code 700 (invasion of rib) maps to SS distant (code 7).

AJCC 7th Edition Staging Clarifications

cM vs pM = Timing is an important factor in assigning classification

When a patient has metastatic disease identified on imaging and has histologic confirmation performed during the workup then the pM is used in the clinical M staging classification. But, if the histologic confirmation is performed during surgical resection of the primary it should only be used in the pM classification and your cM is staged based off all clinical information prior to the surgery.

EXAMPLE
Patient presents to ER w/ abdominal pain. CT shows R colon thickening, No LAD, but numerous liver nodule suspicious for METS. CT chest shows no evidence of disease. Patient taken to OR for R Hemicolectomy and Liver BX. Path: Adenocarcinoma of Ascending colon w/ extension of serosa, 9/14 positive pericolic LNs, Margins negative. Liver BX: Positive for metastatic Adenocarcinoma.

cTx cN0 cM1a cStage IVA
pT4a pN2b pM1a pStage IVA

The NPCR.dll will now allow a cN0 in the pN choice list for these situations:

Corpus Uteri cancers, GIST tumors, Soft tissue sarcomas and Bone tumors

*Corpus Uteri – AJCC 7 chapter 36 (Corpus Uteri)

Topography codes: C54.0-C54.9, C55.9
AND these
Histology codes: 8000-8790, 8950-8951, 8980-8981, 8800, 8890-8898, 8900-8921, 8930-8931, 8933, 8935
Reason: AJCC 7 ed. Manual, page 405 states, “The pT, pN, and pM categories correspond to the T, N, and M categories and are used to designate cases where adequate pathologic specimens are available for accurate stage groupings. When there are insufficient surgical-pathologic findings, the clinical cT, cN, cM categories should be used on the basis of clinical evaluation.”

*GIST Tumors – AJCC 7 Chapter 16 (Gastrointestinal Stromal Tumor)

Topography codes: C15.0-C15.9, C16.0-C16.9, C17.0-C17.2, C17.8-C17.9, C18.0-C18.9, C19.9, C20.9, C48.0-C48.8
AND these
Histology codes: 8965, 8936
Reason: AJCC 7 ed. Manual, page 176 states, "Surgeons generally agree that nodal dissection is not indicated for GIST. In the absence of information on regional lymph node status, N0/pN0 is appropriate; NX should not be used."

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*Bone – AJCC 7 Chapter 27 (Bone)

Topography codes: C40.0-C40.9, C41.0-C41.9
AND these
Histology codes: 8800-9136, 9142-9582
Reason: AJCC 7 ed. Manual, page 282 states, "Because regional lymph node involvement from bone tumors is rare, the pathologic stage grouping includes any of the following combinations: pT pG pN pM, or pT pG cN cM, or cT cN pM."

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*Soft Tissue Sarcoma -AJCC 7 chapter 28 (Soft Tissue Sarcoma)

Topography codes: C38.0-C38.3, C38.8, C47.0- C47.9, C48.0-C48.8, C49.0-C49.9
AND these
Histology codes: 8800-8820, 8823-8935, 8940-9136, 9142-9582
Reason: AJCC 7 ed. Manual, page 293 states, "Nodal involvement is rare in adult soft tissue sarcomas. In the assigning of stage group, patients whose nodal status is not determined to be positive for tumor, either clinically or pathologically, should be designated as N0."

AJCC 7th Edition Staging Coding Exercises

CASE SCENARIO:
75 yo wf present w/ HX of SOA and cough. CT chest showed 3.5 cm LUL lung mass extending into the chest wall w/ satellite lesions throughout L lung. There was associated L hilar, L paratracheal and subcarinal LAD present. There was also a L pleural effusion. PT had a thoracentesis w/ pleural fluid cytology positive for SCC. PT expired w/ no further treatment.

What is your Topography code
c34.1
c34.0
c34.9
c34.8

What is your Histology code
8140/3
8010/3
8071/3
8070/3

What is your cT classification
cTx
cT3
cT4
cT blank

What is your cN classification
cN3
cN blank
cNx
cN2

What is your cM classification
cM1a
pM1a
cM0
cM1b

What is your pathologic Staging
pT blank pN blank pM1a pStage IV
pT4 pNx pM1a pStage IV
pT4 pN2 pM1a pStage IV
pT blank pN blank pM blank pStage 99

(Answers will be posted on KCR wiki page)

AJCC 7th Edition Staging Coding Exercises

CASE SCENARIO

35 yo wm presents w/ HX of thyroid goiter. PE reveals enlarged thyroid and no neck LAD. Thyroid US shows bil thyroid nodules. FNA was performed which was non-diagnostic. PT desired surgery after counseling and knows that he will require continuous oral hormone replacement. Path report summary: papillary carcinoma, follicular variant R lobe, 1.5 cm, with focal invasion of thyroid capsule. No LNS received with specimen.

What is your cT classification
cTx
cT3
cT1b
cT blank

What is your cN classification
cN0
cN blank
cN1a
cNx

What is your cStage group
cStage blank (99)
cStage I
cStage II
cStage IVA

What is your cM classification
cM0
cM blank
cM1
cMx

What is your pT classification
pT1b
pTx
pT2
pT blank

What is your pN classification
pN0
pNx
cN0
pN blank

What is your pStage group
pStage unknown
pStage I
pStage II
pStage blank

What is your pM classification
pM blank
cM0
pM0
cMx

(Answers will be posted on KCR wiki page)

SEER Coding Questions

Question
MP/H Rules/Multiple primaries--Breast: Is this the same primary per MP/H Rule M10? Ductal carcinoma of the left breast in 2013, treated with a lumpectomy. New tumor with ductal and lobular carcinoma in the same breast in 2016.

Answer
The 2016 diagnosis is the same primary. MP/H Rule M10 for breast cancer applies. Do not change the original histology code. Use text fields to document the later histologic type -- duct and lobular. (*SINQ 2017-0025; Date Finalized: 6/15/17; 2007 MP/H rules, Breast, M rules)*

Question
MP/H Rules/Multiple primaries--Melanoma: Is a melanoma with an unknown laterality a different laterality for the purposes of applying Multiple Primaries/Histology Rule M4? See Discussion

Discussion
8/1/2016 Left Abdomen biopsy: Early melanoma in situ (C445-2, 8720/2).
9/2/2016 Upper back: Superficially invasive malignant melanoma (C445-9, 8720/3).
Does rule M4 apply and multiple primaries should be reported or does rule M8 apply and a single primary should be reported?

Answer
Abstract multiple primaries following Multiple Primary Rule M4. Unknown laterality is a different laterality for the purposes of applying the MP/H rules for melanoma. *(SINQ 2017-0027; Date Last updated: 5/30/17; 2007 MP/H rules, Melanoma)*

Question
MP/H Rules/Histology--Brain and CNS: What is the code for an embryonal tumor with multilayered rosettes. WHO shows the code as 9478/3, but this code is not available for use in the United States.

Answer
Assign ICD-O-3 code 9392/3 until code 9478/3 is implemented in 2018. Per our expert neuropathologist, embryonal tumor with multilayered rosettes was previously called ependymoblastoma. *(SINQ 2017-0022; Date Finalized: 5/30/17; WHO class CNS tumors, pages 201, 205; Revised 4th edition).*