A Quarterly Newsletter from the Kentucky Cancer Registry
Large Hospital Edition May 2007

IN THE ABSTRACT

Spring Training Wrap-Up

Multiple Primaries/Histology Workshops have been completed this spring in Kentucky. Three separate 2-day sessions were presented in locations that were accessible by registrars throughout the commonwealth. Trainers Reita Pardee and Jan Michno explained how to follow the new rules and used exercises to illustrate new concepts. Preliminary responses were largely positive. CE credits are being requested from NCRA and will be published in the summer edition of the newsletter.

CTR Exam News

Results of the March 2007 testing period show that 124 (57%) candidates passed. Official results were mailed to all test-takers on April 9th. September 2007 candidates should visit www.ctrexam.org/ to download the current Candidate Handbook and Application and to view the detailed content outline. The current exam lasts 4-5 hours. Part I lasts a maximum of 3 hours, followed by a mandatory break. Part II lasts 1.5 hours. The 2007 MP/H Rules will be tested in 2008.

CTR Exam Preparation Workshops

- A. Fritz and Associates is considering offering an exam-prep course in August 2007. This 2-1/2 day review will cost around $375. Visit www.afritz.org/CTRws.htm to show interest in this potential repeat workshop.
- Naples (FL) Community Hospital is hosting "CTR Examination Review & Basic Skills Workshops" on August 27-28, 2007. Registration fee is $150, and deadline for registration is August 15, 2007. Contact Mary O'Leary, CTR, at learymol@bellsouth.net for more information, or visit the Florida Cancer Registrars Association online.
- NAACCR's CTR Exam Readiness Webinar Series begins July 25, 2007 at 1:00pm EST. This course consists of seven 2-hour sessions, a 1-hour review session, and a follow-up exam session. Enrollment is limited to the first twenty applicants, and the cost is $400. Visit www.naaccr.org/ for more information.
- The Indiana Cancer Registrars' Association (ICRA) will be hosting their annual CTR Exam Prep Class on July 27th in Indianapolis. Registration information will be mailed to Reita Pardee at KCR in the near future.

Online Education Center for Cancer Programs

Available online for physicians and cancer registrars alike is a series of educational presentations co-sponsored by The Commission on Cancer (CoC) and The American Joint Committee on Cancer (AJCC). Visit www.facs.org/cancer/webcast/index.html to see these fee-based offerings. From "Preparing for Commission on Cancer Survey" to "Lymphoma Staging: What Registrars Need to Know", a broad spectrum of topics is available. The education center was created to provide training on CoC/AJCC requirements, and also to offer training that does not require travel. Sessions are comprised of slides, audio, and written transcripts, and they may be viewed multiple times. Credits are available for physicians and registrars.

May is Skin Cancer Detection & Prevention Month

CoC Outstanding Achievement Award for 2006

Pikeville Medical Center's Cancer Registry has received the highest honor bestowed upon a registry following survey. Not only did they receive 3-year reapproval status, but they also received commendation in all nine areas! Pikeville is the only facility in Kentucky to be named to the award for 2006, according to the "CoC Flash". Leisa Hopkins, CTR is to be commended for receiving this most distinguished award.

Did You Know?

- The NCRA conference recently held in Las Vegas was the largest ever, with more than 1,500 attendees.
- Approximately 60% of patients diagnosed with malignant melanoma are caucasian men over 50 years of age.
- Sunscreen with a minimum SPF of 30 is now recommended for anyone expecting to be in the sun more than 20 minutes.
- The NCI estimates that about 59,940 new melanoma cases will be diagnosed in the U.S. in 2007, and approximately 8,110 deaths will be attributable to this disease.
- More pancreatic cancer resections have been performed at Johns Hopkins than at any other hospital in the world.
- Patients with GIST who underwent tumor resection followed by Gleevec were less likely to have recurrence than those who did not receive the drug, according to preliminary NCI study results.
- "The New England Journal of Medicine" reported in its April 19th issue that the drop in new breast cancer rates in 2003 may be related to the reduction in hormone replacement therapy use.
- Patients infected with hepatitis C are at higher risk of developing lymphoma.
- What You Need to Know About ™ Melanoma is an online booklet available for viewing on the NCI website.
- The International Union Against Cancer (UICC) has scheduled its 2008 World Cancer Congress for August 27-31, 2008 in Geneva, Switzerland.

Abstracting Bits and Pieces:

◊ New fields for 2007 (Multiplicity Counter, Date of Multiple Tumors, Multiple Tumors Reported as One Primary, Ambiguous Terminology Diagnosis, and Date of Conclusive Diagnosis) have been added to FORDS: Revised 2007. They are also located at the end of the MP/H Rules Manual.

◊ The new Facility Oncology Registry Data Standards (FORDS) Manual is available for order through the American College of Surgeons, at the price of $45.

◊ Complete year 2006 abstracting before beginning 2007 cases. MP/H Rules take effect with cases diagnosed 1/1/07 forward.

◊ ACoS-approved programs may resubmit NCDB data by June 1st. Remember to make corrections to online studies as well as to CPDMS.net abstracts prior to resubmission. KCR can help you with gen-edits.

◊ Routinely check your "incomplete case" list. Warnings are shown in blue, and errors are colored red. Errors must be corrected before the case is removed from the incomplete list. Incomplete cases are not counted in reports or data analysis; so they should be corrected promptly.

◊ The latest Death Clearance report consists of 2004 and 2005 deaths. An unusually large list may be the result of not completing 2004 death results last year. Check name, social security number, birthdate, or vital status before automatically updating each case.

People News

New Hires:	**Betty Baker**	**Jewish Hospital, Louisville**
	Christina Boling	**Owensboro Medical Health System, Owensboro**
	Robin Centers	**Central Baptist Hospital, Lexington**
	Erin Collins	**Central Baptist Hospital, Lexington**
	Vicky Pennington	**Norton Healthcare, Louisville**
	Courtney Redd	**Central Baptist Hospital, Lexington**
	Vanissa Sorrels	**Owensboro Medical Health System, Owensboro**
Resignations:	**JoAnn Murray**	**Owensboro Medical Health System, Owensboro**
	Brenda Priar	**Owensboro Medical Health System, Owensboro**
	Melinda Webb	**King's Daughters Hospital, Ashland**
Retirement:	**Betty Lindsey**	**Owensboro Medical Health System, Owensboro**
New CTR:	**Karen Magsig, CTR**	**Jewish Hospital, Louisville**

New Honor: Donna Schmidt, CTR, Cancer Registry Coordinator at Western Baptist Hospital in Paducah, was named to the President's Honor Roll at Santa Barbara City College, where she recently graduated from the Cancer Registry Program. Outstanding job, Donna!

ACoS-Approved Cancer Programs:

- The University of Louisville/James Graham Brown Cancer Program received notice of 3-year reapproval from the college. Congratulations to Mary Wilson, Vivian Wyatt, Rochelle Smith, and Michelle Weaver.
- Regional Medical Center of Hopkins County was awarded 3-year reapproval following their most recent ACoS survey. Stacy Littlepage, Teresa Ford, and Regina Higgins are to be congratulated.
- Lake Cumberland Regional Hospital received notification that it's new cancer program has been awarded full 3-year approval. Congratulations are extended to Shona Harper.

Golden Bug Award

Congratulations to the latest Golden Bug Winners—Toyia Redd (Lourdes Hospital, Paducah) and Marie Hall (Jewish Hospital, Louisville)!

Toyia found a bug in the latest update that required an NPI number to be entered before a new physician could be added to the MD list.

Marie discovered a percentage error in the ACoS Follow-up Report.

Thank you for continuing to call KCR with your latest bug discoveries.

Calendar of Events

May 28, 2007-Memorial Day Holiday, KCR Office Closed

June 2-9, 2007-NAACCR Annual Conference, Detroit MI

June 27-29, 2007-KCR Abstractor's Training, Lexington

July 31, 2007-CTR Exam Application Deadline

August 1-2, 2007-Survey Savvy, Chicago IL

September 6-7, 2007-KCR Fall Workshop, Louisville

September 15-29, 2007-CTR Exam "window"

Preliminary Fall Workshop Information

The 2007 KCR Fall Workshop will be held at Embassy Suites Hotel, located at 9940 Corporate Campus Drive, Louisville KY on September 6th and 7th. Suite rates are $129 with 15.01% local tax per day. All accommodations are suites and include full American cooked-to-order breakfast and a 2-hour beverage reception nightly. Call 502-426-9191 to reserve your room now.

Abstracting Text in 2007

The importance of abstracting adequate text has taken on new significance in recent years. When a registrar thoroughly documents in text what he/she has coded in the abstract, the accuracy of the coding should be higher than if there were no text. Checking codes when no text is available to "back them up" adds to the chart-pulling list, but paper charts are no longer available in many facilities. Electronic records may be perfect for home-based registrars and hospital registrars with computer access, but few cases can be QA'd by the central registry via this format. And how many hospital registries are performing QA on substantial percentage of their own abstracts?

Documenting case data in text is one solution! New registrars in Kentucky are "texting" thoroughly and with great ease, as a result of abstractor's training that has focused more and more on this part of the abstract. Read ahead to learn more about the "art" of text documentation. A sample text is included at the end of this article.

- Text documentation should be brief, yet thorough enough to allow recoding of the fields from text only. Use standard medical abbreviations (Appendix I) to save space. Do not record in full sentences.
- Include age at diagnosis, race, and sex of patient in the Physical Exam space. Also list symptoms and history of other cancers or benign CNS tumors here.
- Record x-rays/scans in chronological order - date first, then scan type, followed by results. Record positive AND negative findings.
- Record pertinent laboratory studies and be sure to show if the results are normal, elevated, positive, or not done/available.
- Report scopes in the same format as x-rays: date first, type of scope, followed by results.
- Record surgeries in the Operative Report section: date first, procedure name, then results that are pertinent. Include facility name.
- Path Reports should be documented in that section in chronological order: date first, specimen examined, and final diagnosis (including extension, nodes positive/examined, tumor size, grade….)

Abstracting Text in 2007 (continued)

- Site should include specific information on primary origin.
- Histology should correspond in words to what is coded in the abstract. If there was difficulty in assigning the histology code, this is where you should document that problem!
- Staging should include the MD's TNM-staging selection, as well as your Collaborative Staging choices and reasoning.
- General remarks should include brief treatment (chemo, radiation, hormones, etc) information, such as type and date initiated. Include names of following MD's here.
- Insert diagnosis date (DX DT) into the text box that includes that "piece of the puzzle"; it may be by scan, scope with biopsy, surgery, or a clinical diagnosis by MD.
- Include your initials at the end of each text box, as well as the date the entry was made.
- Do not include extraneous, non-cancer information, other than benign CNS syndromes that are related to benign CNS tumors.

Open Text Example

Physical Exam: 47 yo bm w/rectal bleed, abd discomfort; fam hx colon ca
jm 5/14/07

X-rays/scans: 11/15/06 cxr neg; 11/24/07 CTabd neg. jm 5/14/07

Laboratory: 11/20/06 CEA elevated. jm 5/14/07

Scopes: 11/20/06 (UL) colonoscopy (DX DT) - mass in sigmoid; "probable CA" per MD. jm 5/14/07

Operative Report: 11/22/06 (UL) sigmoidectomy; liver appears normal.
jm 5/14/07

Path Report: 11/22/06 sigmoid—well diff adenoCa, 5.0cm, extending through wall into subserosal fat; 1 out of 15 mesenteric LNs +; margins clear. jm 5/14/07

Site: sigmoid. jm 5/14/07

Histology: Adenocarcinoma, well diff. jm 5/14/07

Staging: pT3N1, mo per Dr. Mason. CSTS = 050, CS Ext = 40, CS LNs = 30, #LNs + = O1, # LNs exam = 15, CS mets = 00, SSF1 = 010
jm 5/14/07

General Remarks: chemo started 12/28/06; Dr. Dobbs' onc grp will follow; pt remains NED as of 4/28/07 OV.
jm 5/14/07

SEER CODING QUESTIONS:

The following SEER Inquiry questions have been finalized since our last newsletter. Review these scenarios as a continuing education resource.

Question 1: **CS site Specific Factor/Melanoma: What would you code as CS-SSF 1 (depth of invasion) for this melanoma? Please see Discussion.**

Discussion: The path report says "superficial spreading malignant melanoma: 2 areas of papillary dermal invasion to depth of less than .2mm." The revised CS pages include codes for "less than" a certain tumor size, but these are not included in the depth of invasion SSF. Using 999 results in an unstageable melanoma, when we know it is "less than .2mm".

Answer: *Code SSF1 019 [.19mm]. For any case with an SSF1 code in the range of 001-100, the T category will be determined using CS extension and SSF2 [ulceration]. All cases with an SSF1 code in the range of 001-100 will map to a T1 (either T1NOS, T1a or T1b).*
(SINQ #2007-1001; 2004 SEER Manual, pg C-437)

Question 2: **Primary site: For an angiosarcoma arising in the skin of the breast, is the primary site skin or breast? Treated with mastectomy.**

Answer: *Code the primary site as skin of breast when skin of breast is documented as the site of origin. According to the WHO classification of soft tissue tumors, the majority of angiosarcomas "develop as cutaneous tumors...less than one quarter present as a deep soft tissue mass."*
(SINQ #2007-1006; WHO Class Cutaneous Tumors, pg 175)

Question 3: **Histology-Prostate: Should cases of acinar adenocarcinoma of the prostate be coded as 8550/3 (acinar adenocarcinoma) when diagnosed prior to 1/1/07 only? Please see Discussion.**

Discussion: The SEER Multiple Primary and Histology manual, which went into effect 1/1/07, indicates that this histology should be coded to 8140/3 (adenocarcinoma, NOS). Does this contradict ICD-O-3? Are there other sites besides prostate where acinar adenocarcinoma (8550/3) might arise?

Answer: *Code acinar adenocarcinoma of the prostate as 8140/3 for cases diagnosed on or after 1/1/2007. Code 8550/3 (acinar adenocarcinoma) may be used for prostate cases prior to 1/1/2007 and for acinar adenocarcinoma of other sites, such as pancreas.*
(SINQ #2007-1010; 2007 MP/H Rules; ICD-O-3)

Question 4: **MP/H Rules/Multiple primaries-Bladder: The new multiple primary rule M7 states that tumors diagnosed more than three years apart are multiple primaries. Does this apply to in-situ bladder tumors? Also, does this apply to an in-situ three years after an invasive?**

Answer: *Use the rules in order. Rule M6 comes before Rule M7.*
M6 states that bladder tumors with certain histologies are a single primary. It is a single primary if there is any combination of:

- *papillary carcinoma (8050)*
- *transitional cell carcinoma (8120-8124)*
- *papillary transitional cell carcinoma (8130-8131)*

Rule M7 only applies to bladder tumors with histologies other than those listed above. If you have such a case, rule M7 applies to in-situ tumors to an in-situ three years after an invasive.
(SINQ #2007-1016; 2007 MP/H Rules, pg 314)

SEER CODING QUESTIONS (*Continued*):

Question 5: **CS Lymph Nodes-Melanoma: Should we assume that positive lymph nodes are regional if the primary site for a melanoma is not identified (i.e., C44.9)? Please see Discussion.**

Discussion: Patient has no skin lesions but 3/27 axillary LNs positive.

Answer: *Code the CS Lymph Nodes field to 80 [Lymph Nodes, NOS].*
Although it is in the CS LN field, use the code for Lymph Nodes, NOT OTHERWISE SPECIFIED when you don't know whether the nodes are regional or distant. There are separate codes to use when you definitely know that the nodes are regional.
(SINQ #2007-1019; 2004 SEER Manual, pg C-434)

Question 6: **MP/H Rules: When the pathology report from a FNA or other biopsy states a diagnosis of carcinoma in-situ and the patient for some reason must wait more than 60 days for a more definitive procedure which documents invasive carcinoma, does this have to be reported as two primaries?**

Answer: *No. When the invasive component is discovered as part of the work-up phase leading to treatment decisions, the case should not be abstracted as a multiple primary. In the rare instance when a patient has not been treated and is still having diagnostic work-up greater than 60 days after the malignancy is diagnosed, do not count the invasive diagnosis as a new primary.*
(SINQ #2007-1023; 2007 MP/H Rules)