



In the Abstract

December 2016

KCR-Indiana Regional Cancer Registrars Meeting 2016

The *first ever* Kentucky-Indiana Regional Cancer Registrar Meeting, presented by the Kentucky Cancer Registry, the Indiana Cancer Registrars Association, and the Indiana Cancer Consortium was held Thursday and Friday, September 8-9, 2016 at the Holiday Inn Louisville East. This year's workshop was also the *30th annual meeting* for the Kentucky Cancer Registry and what a better way to celebrate then to make this year the first regional meeting!

Presentation topics included lung cancer, colorectal cancer, GYN malignancies, CML, and brain cancer treatments. There were several presentations devoted to the AJCC staging system, particularly for lung and colorectal cancers, as well. Among the many highlights were an exercise break, a discussion of cancer detection by breath analysis, and examples of Indiana's use of cancer registry data by the Indiana Cancer Consortium

Congratulations to Sarah Campbell from Owensboro Health Regional Hospital for being the 2016 Judith Ann Cook Award winner!

Thank You to Marynell Jenkins and Tonya Brandenburg who Michelle Hoskins with Indiana planned this exceptional



along with workshop!

The workshop NCRA # 2016-095 CEUs 9.5 hours.

8th Edition AJCC Staging Update

In order to ensure that the cancer care community has the necessary infrastructure in place for documenting 8th Edition stage, the AJCC Executive Committee, in dialogue with the National Cancer Institute (NCI-SEER), Centers for Disease Control and Prevention (CDC), the College of American Pathologists (CAP), the National Comprehensive Cancer Network (NCCN), the National Cancer Data Base (NCDB), and the Commission on Cancer (CoC), made the decision to delay the implementation of the 8th Edition Cancer Staging System to January 1, 2018.

Clinicians will continue to use the latest information for patient care, including scientific content of the 8th Edition Manual. All newly diagnosed cases through December 31, 2017 should be staged with the 7th edition. The time extension will allow all partners to develop and update protocols and guidelines and for software vendors to develop, test, and deploy their products in time for the data collection and implementation of the 8th edition in 2018.

Calendar of Events

December 25 – January 2, 2017 KCR offices closed – Holiday Break

December 31, 2016 CTR CEU cycle ends (if you passed CTR exam in an even-numbered year, you must submit CE summary form to NCRA)

January 16, 2017 KCR offices closed – Martin Luther King Day

January 31, 2017 CTR exam application deadline

February 11, 2017 – March 1, 2017 CTR exam window

People News

New Hires:

Sharon Isaacs, Frankfort Regional Medical Center

Danielle Price, Taylor Regional Hospital

Ellen Pardue, Medical Center Bowling Green

Courtney Redd, Baptist Health Lexington

Whitney Smiley, KentuckyOne Health Lexington

Danielle Darsey, KCR, NKY Small Hospital Abstractor (*Starts 1/17/17*)

Desiree Montgomery, KCR QA Specialist (*Starts 1/9/17*)

Resignations:

Courtney Redd, KyOne Health Lexington

Celia Love, KyOne Health Lexington

New CTRs:

Beth Eberhart, Norton Healthcare

Lindsey Baker, KCR

Cindy Joseph, Baptist Health Paducah

Susan Knight, Baptist Health Madisonville

Name Changes:

Shelly Hodge, Kentucky Cancer Registry

ACoS Approved Programs

Congratulations to the following on their recent CoC survey:

- ❖ Frankfort Regional Hospital on passing their recent CoC survey !
- ❖ St. Claire Regional Medical Center on passing their CoC survey !
- ❖ St. Elizabeth Healthcare on their recent CoC survey, including an Outstanding Achievement Award for Edgewood.

Coding Hints/Reminders

****Coding 998 test not done vs 999 unknown**

You will only code a lab test 998 if stated in the record that the specific test was not and will not be performed for this patient.

If not mentioned in records, you should code 999.

998 = indicates that you KNOW that the test was not performed anywhere.

****Surgery coding for breast – partial mastectomy (20) vs lumpectomy (22 or higher)**

FORDS surgery codes are listed as partial mastectomy is a NOS code becoming more specific as you go down the codes listed below (21, 21, 23, 24). Surgeons use “catch all” terminology so you will need to read the OP reports to determine what was actually performed. A lumpectomy is a partial mastectomy (and most are coded to 22). If you have surgeons that performed quadrantectomies (24) then you may want to discuss dictation with them.

Lumpectomy is a form of “breast-conserving” or “breast preservation” surgery. There are several names used for breast-conserving surgery: biopsy, lumpectomy, partial mastectomy, re-excision, quadrantectomy, or wedge resection. Technically, a lumpectomy is a partial mastectomy, because part of the breast tissue is removed. But the amount of tissue removed can vary greatly. Quadrantectomy, for example, means that roughly a quarter of your breast was removed or a specific quadrant.

****Texting recommendations**

Include Physical Exam notes on all cases (especially noting any Tumor Size, clinical descriptions, location, Lymph Node evaluations, etc). Prostate cases: document the pre-biopsy DRE if available. If not, please note in text “preBX DRE not on chart or available in records. PostBX DRE states: ...” For Breast cases, the Physical Exam should always be put in text. Clinical exams provide information for clinical staging and should be documented.

It is important to differentiate between MD AJCC staging and CTR AJCC staging. Please include MD stage as dictated, date and location of where you found staging.

FOR EXAMPLE: Dr. House staged cT1cN0M0 Stage IA, pT1cN0M0 Stage IA on MED ONC Consult 1/1/16. Registrar stages cT1b (1.0 cm breast mass per MRI) cN0 (per PE/imaging) and cM0 (no signs and per imaging) cStage IA, pT1c (1.1 cm per path) pN0 (per path) and cM0 pStage IA.

Reportability Reminders

- ✓ Patient presents to your facility for a completion thyroidectomy where no cancer is found. This is reportable as you are performing a definitive surgery for treatment of thyroid cancer.
- ✓ Patient presents to your facility for a wide excision of a melanoma where no residual melanoma is identified. This is reportable as again, you are performing a definitive surgical treatment per NCCN guidelines.
- ✓ Patient presents to your facility where a needle biopsy of a breast mass is performed and path shows: Atypical Ductal Hyperplasia with minute foci of DCIS. This is reportable as there is in-situ cancer (although minute) present.
- ✓ Patient presents to your facility for TAH/BSO for treatment of a non-cancerous condition, but the path report shows foci of intraepithelial carcinoma in the uterus. There is in-situ disease found which is reportable.

Patient present to your facility with recently DX'd breast cancer for planned lumpectomy where no residual cancer is found. This is reportable as you are performing definitive surgery for management of breast cancer.

AJCC 7th Edition Staging Clarifications

Endometrial cases that do not have lymph nodes removed for pathologic exam will meet requirements to be pathologically staged per AJCC. In these cases where no LNs are examined, you will NOT put a pNx in pathologic staging, you will use the cN info. This is discussed in the AJCC 7th edition manual, large book page 407, under pathologic staging (last paragraph).

**This is an exception for bringing down a cN0 to the pN field to to complete pathologic stage group. A kidney case that has no LNs removed for exam during definitive surgery will still be staged pNx.*

NOTICE !!! KCR Training

CPDMS Operator's Training will be held on February 16-17 2017.

SEER Coding Questions

Question

MP/H Rules/Histology--Lung: What histology code and MP/H Rule applies to the Histologic Type described as adenocarcinoma, mixed invasive mucinous and non-mucinous which involves multiple lung tumors present in a single lobe? See Discussion.

Discussion

The patient had a lower lobectomy with final diagnosis of adenocarcinoma with the following features: Tumor Focality: Multiple separate tumor nodules in same lobe; Tumor Size: 2.6 cm, 0.7 cm, 0.3 cm and 0.1 cm in greatest dimension; Histologic Type: Adenocarcinoma, mixed invasive mucinous and non-mucinous adenocarcinoma; Histologic Grade: Moderately differentiated.

Answer

Assign histology code 8254/3.

The 2007 MP/H Lung rules do not include coding guidelines for mixed mucinous and non-mucinous tumors. Lung Table 1 (in the Terms and Definitions, pages 37-38, http://seer.cancer.gov/tools/mphrules/mphrules_definitions.pdf) is very specific about which histologies can be coded to mixed adenocarcinoma (8255/3). Mucinous is not included per the note at the end of Table 1. Per WHO 3rd and 4th Ed Tumors of the Lung, mixed mucinous and non-mucinous tumors of the lung are classified as 8254/3. Mixed invasive mucinous and non-mucinous adenocarcinoma is a synonym for BAC, mucinous and non-mucinous. (*SINQ 2016-0065; Date Finalized: 10/31/16; WHO class Lung tumors, 3rd and 4th editions*)

Question

Grade--Kidney: Should WHO/ISUP grade for renal cell carcinoma be coded for cases diagnosed 2016 and later? See discussion.

Discussion

The 2016 WHO Classification of Tumours of the Urinary System appears to be moving away from using Fuhrman grading toward using WHO/ISUP grade. These seem like similar 4 grade staging systems; however, the SEER Manual specifically states to not use the Special Grade System table for WHO/ISUP. We are seeing the WHO/ISUP grade being used on 2016 pathology reports.

Examples of new grading for renal cell carcinomas

Histologic type: Clear cell renal cell carcinoma

Histologic grade (WHO/ISUP 2016): Grade 3 in a background of 2 (of 4).

And

Histologic type: Clear cell renal cell carcinoma

Histologic grade (ISUP): Grade 2.

Answer

Do not record WHO/ISUP grade in the grade/differentiation field.

Designated fields for this grade system are being proposed for future implementation. (*SINQ 2016-0062; Date Last updated: 9/14/16; 2014+ grade instructions*)

Question

Mets at diagnosis fields--Heme & Lymphoid Neoplasms (Lymphoma): How are Mets at Diagnosis -- Bone, Brain, Liver, Lung, Lymph Node, and Other -- to be coded for lymphomas in 2016? Are they always 0 if the TNM Stage is I, II, or III? How is bone marrow involvement coded -- in which Mets at Diagnosis field?

Answer

Code all mets at diagnosis fields to 0 when the Stage is I, II, or III.

When the lymphoma is Stage IV, one of the mets at dx fields (other than Mets at Dx--Distant lymph nodes) needs to be coded to 1. Stage IV indicates that there is multiple extralymphatic organ involvement, diffuse involvement of an organ; liver, brain, lung or bone involvement, or bone marrow involvement.

*For bone, brain, liver, and lung, code these as 1 when these sites are involved and they are not the primary site. This is the same instruction for solid tumor neoplasms.

*For mets at dx--distant lymph nodes, always code to 0. For lymphomas, lymph node involvement is included in stage and not based on whether they are regional or distant.

*For mets at dx--other, code to 1 for bone marrow involvement or if there is multi extralymphatic organ involvement. (SINQ 2016-0060; Date Finalized: 9/29/16; 2016 SEER manual, section IV).

Question

First course treatment--Heme & Lymphoid Neoplasms: Are blood thinners, e.g., warfarin, coded as treatment in the Other Therapy data item for polycythemia vera and myelodysplastic syndrome? See Discussion.

Discussion

Under the hematopoietic data base, treatment for polycythemia vera shows chemotherapy, immunotherapy, and phlebotomy. Essential thrombocytopenia shows blood thinners, anti-clotting medications, aspirin, chemotherapy, immunotherapy, and other therapy (Anagrelide) (for essential thrombocytopenia only) and watchful waiting (for asymptomatic patients). Myelodysplastic syndrome shows bone marrow transplant, chemotherapy, immunotherapy, and stem cell transplant.

SEER*RX under warfarin says: Per the 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual (page 10), blood thinners and/or anti-clotting agents are to be coded as treatment (Other Therapy) for the following histologies: 9740/4 Mast cell sarcoma 9741/3 Systemic mastocytosis 9742/3 Mast cell leukemia 9875/3 Chronic myelogenous leukemia BCR/ABL 1 positive 9950/3 Polycythemia vera 9961/3 Primary myelofibrosis 9962/3 Essential thrombocythemia 9963/3 Chronic neutrophilic leukemia 9975/3 Myelodysplastic/myeloproliferative neoplasm, unclassifiable.

Answer

Based on information from the National Cancer Institute and the Food and Drug Administration, aspirin and/or other blood thinners are not valid treatment for polycythemia vera and myelodysplastic syndrome. These drugs are often given to relieve symptoms of the disease such as bone pain or side-effects of standard treatments including blood clots. The treatment information found on page 22 (2015 Hematopoietic & Lymphoid Neoplasms coding manual) will be updated and ICD-O-3 codes 9950/3 and 9975/3 will be removed from the list. SEER*RX has been updated to reflect this change. (SINQ 2016-0058)