In The Abstract

A Quarterly Newsletter from the Kentucky Cancer Registry

NOVEMBER 2011

INSIDE THIS ISSUE:

2011 Fall Workshop in Review

The KCR Silver Anniversary Fall Workshop has already come and gone….

Educational sessions presented by physician-specialists were outstanding. The Informatics Team session was appreciated by registrars who requested that a treatment report be made available. A celebratory luncheon was headlined by Lynda Douglas, who gave a humorous tribute to the KCR "pioneers." Kim Kaiser, registrar at Methodist Hospital in Henderson, received the Judith Ann Cook Excellence Award. Registry Bingo, a relaxed review of CSv2 information, rounded out the 25th Annual Advanced Cancer Registrars' Workshop program. It has been a very productive quarter century for cancer registration in Kentucky!

Cancer registry pioneers in KY with 25+ years' experience (from left to right): Reita Pardee, Frances Ross, Dr. Gilbert Friedell, Cynthia Leedham, Barbara O'Hara, Jan Michno, Bill Taylor, & Dr. Thomas Tucker

Fall Workshop CE's Approved by NCRA

The NCRA Program Recognition Committee has awarded 9 CE hours for two-day attendance at the 2011 KCR Fall Workshop. NCRA has awarded 6 CE hours for those who attended the workshop on Thursday only. **The NCRA event number for this program is 2011–182.**

People News

New Hires:

Jo Hannah Cook	Norton HealthCare, Louisville
Kimberly Kimbler	KCR Pediatrics Project Coordinator
Celia Love	KCR QA Specialist
Mariya Lozinskaya	Norton Healthcare, Louisville
Susan Yunt	Norton Healthcare, Louisville

Resignations:

Barbara O'Hara	Norton Healthcare, Louisville
Toyia Redd	Lourdes Hospital, Paducah

New CTR:

Amy Shepard, CTR	King's Daughters Hospital, Ashland

Golden Bug Award

Congratulations to our latest Golden Bug winner – Amy Shepard (registrar at King's Daughters Hospital in Ashland). Amy found a bug in the NCDB November submission report. It indicated that it included data from 2000 and 2009, but it should have included 1999 data. Jason Jacob is fixing this bug. Thank you all for alerting us to potential software errors!

Making annual NCRA Educational Conference plans?

Save these dates: April 18-21, 2012

Here's the place: Washington, DC

GenEdits for January 2012 NCDB Submission

The new GenEdits is ready to provide you with an error report for your NCDB-bound 2010 abstracts! Prior to the January 2012 submission of data to NCDB, 2010 abstracts must be run through this new GenEdits program. Besides 2010 cases, the 2012 NCDB submission will also include any previous records with changes.

This updated edits program is the first to cover the new CSv2 fields, which were first implemented with 2010 cases. The resulting edits error reports may be considerably larger than for previous years. Start NOW and clean your 2010 data ahead of the deadline. It is suggested that facilities run GenEdits on a routine basis throughout the year, so as to minimize edits errors found close to data-submission time.

Did You Know?

*University of Southern California researchers have found the genetic location of a risk factor for an aggressive form of breast cancer (ER negative) that is more prevalent among women of African descent. (NCI Cancer Center News, posted 11/2/11)

*Melanoma surveillance in the US between 2000 and 2006, as reported by the CDC, shows that melanoma incidence was higher among females, it increased with age, and it was highest among non-Hispanic whites. (CDC Website, 11/4/11)

*A new tool is available for interns, volunteers, and potential cancer registrars! Visit the Cyber Cancer Registry to develop cancer registry skills. This NPCR-sponsored interactive system is geared toward providing interested students and new registry staff with exercises in cancer registry functions.
Go to www.cdc.gov/cancer/npcr/training/ccr.htm to login and begin preparing for a career in cancer registry!

*The International Agency on Research on Cancer (IARC), part of the World Health Organization (WHO), is headquartered in Lyon, France. The next IARC conference, featuring “Emerging Oncogenic Viruses,” takes place 5/30 through 6/3/12 in Puglia, Italy.

CTR Exam Tidbits

Planning on taking the CTR Exam? Go to www.ctrexam.org/ and click on ‘Request a 2012 CTR Exam Candidate’s Handbook’ now!

Abstracting Bits & Pieces

- Attention Non-ACoS-Affiliated Hospitals! You need to run an edits program and clean up errors, too. Look for the "COC Edits Report" in cpdms.net under "Reports" then under "QA." It became available with version 6.1.30 which was released on 11/15/11. "The COC Edits report should be run and errors cleaned up for all cases from 1995 (or the registry's reference date, whichever is earlier) to present," according to KCR Director of Operations, Frances Ross. Collaborative Stage errors are high priority, and address errors are low priority. Please note that this report runs slowly, so do not be discouraged when it does not complete its mission quickly!
- A new Death Clearance report will come out in December. Complete your current list if you have not already done so. This process provides helpful follow-up information, the official cause of death code from KY death certificates, and also county of birth information.
- Code C14.8 when the physician determines the case is a "head and neck primary" and no more-precise primary site descriptions are provided. (KCR via SEER, 11/2011)
- April Fritz' Cancer CASEbook has been updated to incorporate CSv2 (02.03), 7th Edition TNM staging, the new Hematopoietic multiple primary rules, and updated exercises. Order both Volume I and II to obtain the better price. This set is invaluable to abstractors with any level of experience. (www.afritz.org/casebook.htm, 11/2011)
- All CTRs must pay a maintenance fee annually ($25 for NCRA members) in addition to the annual membership fee. Non-members pay $105 per year to maintain their CTR credential. (NCRA website 11/4/11)

Most-Missed BINGO Question!

One CSv2 question was missed by many attendees of the KCR Fall Workshop's BINGO session on day two of the meeting. "What is the name of hollow space in lung that does not contain any lung tissue?" Correct answer: Hilum. This part of the lung is defined as a triangular depression where the bronchus, blood vessels, nerves, and lymphatics enter or leave the organ. The hilum is sometimes called the root of the lung.

Many attendees incorrectly answered this question with "pleura." The pleura is a very thin membrane covering the lungs (visceral pleura) or lining the chest cavity (parietal pleura). The space between the visceral and parietal pleura is sometimes called the intrapleural space or pleural cavity.

We hope everyone enjoyed the fun and informative CSv2 BINGO presentation, complete with prize presentations! Special thanks are extended to Peggy Adamo at SEER who provided the power point and game card templates.

Checking In On Follow-Up

One of the major functions of a cancer registry is to provide lifelong follow-up information on all analytic cases. As a registry grows in size and age, pursuing timely follow-up on patients becomes more and more challenging. Follow-up procedures require increasingly longer time to complete each and every year, since more patients are added into the registry database each year.

Are the follow-up workers at your hospital fully-trained registrars? Do your follow-up staff members understand what cancer status, survival status, and recurrence mean? Do they know how to distinguish between a new primary versus a true recurrence? Are they alert to the fact that keying a "9" into survival status does not mean "unknown" – it means "dead?"

Follow-up work is careful and important work that requires training and a certain amount of oncology knowledge in order to attain accurate coding. Careless coding can send a case to the incomplete list! There has been a growing number of incorrect "9" codes keyed into survival status fields of late. Please work with your facility's follow-up staff and review the various interrelated fields that must be coded. Remind them that "9" means "dead, cause unknown" in survival status. Remind them they cannot code a patient "alive, no evidence of this tumor present" (code 1) in the survival status field if the cancer status is coded "2" (tumor present), or if "type of first recurrence" is coded "70" (since diagnosis, patient has never been disease-free). Make sure they read and refer to the Abstractor's Manual frequently for coding directions.

Sometimes follow-up staff check hospital department (e.g. Lab or X-ray) schedules to obtain the last date of contact. This method can be inaccurate, as a patient may have expired prior to the appointment and the schedule still lists the patient as being there. Obituary listings may be very helpful, but watch out for name spellings and compare patient's age and spouse or other relative's name before accepting this date as final.

Allow your follow-up specialists to take breaks from this sometimes-tedious chore. A change of pace can pay off in terms of accuracy and worker satisfaction. Above all, tell your follow-up staff how much you appreciate their hard work and attention to detail. KCR appreciates ALL of you!

Assigning CS Tumor Size/Extent Evaluation Code for Breast Primaries

For breast primaries, both tumor size and extension derive the "T" category. CSv2 (02.03) Part I Section I directs us as follows:

"For primary sites where both tumor size and extension determine the T category in TNM, select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

   Example: Tumor size for a breast cancer biopsy is 020 (maps to T1). On physical exam, there is ulceration of skin (extension code 512 maps to T4). Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from the physical examination results in a higher T category.

   Note: For breast, unless there is skin or chest wall involvement, always assign the Tumor Size/Ext Eval code based on size. If there is skin or chest wall involvement or a statement of inflammatory carcinoma (T4 disease), assign Eval code based on extension."

Breast cases are not automatically assigned a Size/Ext Eval code of 3 when tissue is examined. (CSv2 [0203] Part I Section I, page 40)

Calendar of Events

December 24, 2011-January 1, 2012 - UK Winter Holiday (KCR Office Closed)
January 11, 2012 - NCRA Collaborative Stage Webinar: Prostate
January 16, 2012 - Martin Luther King Holiday, KCR Office Closed
January 31, 2012 - Spring CTR Exam Application Deadline
February 2012 - Mini-Abstractors' Training, Norton Suburban Hospital (date to be arranged)
February 15, 2012 - NCRA Collaborative Stage Webinar: Head
March 14, 2012 - NCRA Collaborative Stage Webinar: Neck
March 3-17, 2012 - CTR Exam Window

SEER Coding Questions

Take a look at these more recently finalized SINQ coding questions for continuing education…….

Question 1: Primary site/Histology – Heme & Lymphoid Neoplasms: Which site/histology code for the following case? See discussion.

Discussion: Large mediastinal mass, cervical lymphadenopathy. (But no biopsy of either of these or statement that they are involved.)
Bone marrow biopsy – 100% cellular marrow with involvement by precursor T lymphoblastic leukemia
Peripheral Blood – Precursor-T lymphoblastic leukemia
Discharge summary and office notes – T cell acute lymphoblastic leukemia

Answer: *Code the histology Adult T cell leukemia/lymphoma 9837/3 and the primary site C77.8 lymph nodes, multiple regions. The following steps were used to find the answer: Search the Hemato DB for "T-cell lymphoblastic." The matched terms display precursor T-cell lymphoblastic lymphoma, NOS 9729/3. ALWAYS check the abstractor notes. These notes tell you that the code 9729/3 is not used for cases diagnosed 2010 and later. It refers you to 9837/3. Search the Heme DB for 9837/3 and the display is Adult T-cell leukemia/lymphoma. The primary site box refers you to Module 3 PH 11. The abstractor notes say this disease is characterized by peripheral blood involvement and widespread lymph node involvement. These characteristics are the reason WHO made the separate lymphoma and leukemia codes obsolete and now classifies the disease as a leukemia/lymphoma.*
To determine primary site, go to module 3 PH 11 as instructed in the primary site box. Let me preface the next comments with this statement – we have noted that the "warning boxes" for the lymphoma/leukemia codes do not mention both rules PH11 and PH 12 as they should. This will be corrected in the next revision.
When you go to PH 11 it tells you that for the lymphoma/leukemia codes, the primary site is coded to bone marrow when bone marrow is the ONLY site of involvement. That does not fit your case. Go on to PH12 which says to code the primary site to the lymph node region(s) when there is involvement of lymphoma nodes (there may also be involvement of bone marrow).
For lymphomas, lymph node adenopathy identified on scans is coded as positive lymph node involvement. Using that rule, you have involvement of cervical and mediastinal lymph nodes. Using Appendix C, cervical lymph nodes C77.0 are classified as the head and neck lymph node region and mediastinal lymph nodes C77.1 are in the intrathoracic lymph node region. Lymph nodes in multiple regions are coded C77.8 using rule PH30.
(SINQ 2011-107, last updated 7/21/11, 2010 Heme & Lymph Manual & DB)

Question 2: MP/H Rules/Multiple primaries – Heme & Lymphoid Neoplasms: Two separate myeloma cases. Both of these have the diagnosis of a Multiple Myeloma/Plasma Cell Myeloma, Plasmacytoma, and a Plasma Cell Leukemia. These 3 histologies were diagnosed at the same time. I've looked thru the MP Rules and Database and come up with 3 separate primaries. Am I understanding this correctly? I especially am questioning if the Plasmacytoma histology and MM/Plasma Cell Myeloma are one and the same.

Answer: *This answer assumes that the plasmacytoma is primary in bone. This is a single primary coded to multiple myeloma/ plasma cell myeloma. The steps used to determine this answer are as follows:*

***Step 1**: Search the Hemato DB for plasmacytoma. Click on plasmacytoma of bone. Display the information and check the transformation box which shows that plasmacytoma of bone transforms to multiple myeloma. That means that plasmacytoma is a chronic neoplasm and multiple myeloma is an acute neoplasm. The chronic (plasmacytoma) and the acute (MM/PM) were diagnosed within 21 days.*

***Step 2**: Go to the MP rules. Use M7: chronic and acute phase of disease diagnosed within 21 days and there is one bone marrow biopsy. Code the acute disease, plasma cell myeloma.*

***Step 3**: Now you need to determine whether plasma cell myeloma/multiple myeloma and plasma cell leukemia are multiple primaries. Search the Hemato DB for plasma cell leukemia. See the abstractor notes which say plasma cell leukemia is now listed as a variant of plasma cell myeloma 9732/3 rather than being a "stand-alone" neoplasm. So that means that you code only the plasma cell myeloma/multiple myeloma.*
(SINQ #2011-109, last updated 7/21/11, 2010 Heme & Lymph Manual & DB)

SEER Coding Questions....*continued*

Question 3: MP/H Rules/Multiple Primaries - Head & Neck: How should transformations of histology be handled? See discussion.

Discussion: A neuroesthesioblastoma of nasal cavity diagnosed in 1991 with multiple recurrences of the same histology then "recurs" in 2008 in the left orbit with biopsy histology of "Sarcoma, NOS, high grade" and resection histology of "High grade fibrosarcomatous transformation of esthesioneuroblastoma." Physicians' clinical documentation continue to refer to this as recurrence. Is this a second primary because the site and histology are now different form the original tumor? Or are histologic transformations always considered recurrences of the original tumor?

Answer: *Our current MP/H rules make this a new primary because it is a different histology. The revised MP/H rules will include tables to define tumors that de-differentiate (transform) and recur with what is seemingly a different histology. Although the rules will be changed in the future, we must use the rules in place at this time for this case. (SINQ #2011-110, last updated 7/22/11, 2007 MP/H Rules)*

Question 4: MP/H rules/Histology - Lung: How is micropapillary adenocarcinoma of the lung coded? A literature search indicates that this is a distinct subtype of adenocarcinoma of the lung with poor prognosis.

Answer: *Code this as papillary, 8260. Our expert pathologist states that the WHO notes micropapillary to be a pattern seen in papillary carcinomas, but does not specify it as a separate histologic type. (SINQ #2011-115, last updated 10/13/11, ICD-O-3, WHO Class Lung Tumors)*

Question 5: MP/H Histology - Lung: What is the histology code for "heterologous biphasic sarcomatoid carcinoma of the lung with prominent rhabdomyoblastic and adenoca differentiation?"

Answer: *Our expert pathologist recommends 8980/3 for this combination histology. He explains: The designation "carcinosarcoma" is given when the pathology shows differentiation in both the sarcomatous (rhabdomyoblastic) and carcinomatous (adenoca) elements. This is emphasized in the path for this case with the term "biphasic." The term "heterologous" means that the sarcomatous component is of a type not normal to lung. Rhabdomyoblastic means skeletal muscle differentiation, and skeletal muscle is not normally found in lung, hence heterologous. If it were smooth muscle it would be homologous, since smooth muscle is found in lung (as a part of the bronchi). (SINQ #2011-116, last updated 10/13/11, ICD-O-3, SEER expert pathologist)*