IN THE ABSTRACT

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

Did You Know?

- The latest Annual Report to the Nation mentioned a continuing decline in cancer death rates. New data showed a 2.1% decrease in mortality rates due to cancer from 2002 through 2004. This was double the rate previously reported between 1993 and 2002.
- Ixabepilone (Ixempra) was FDA-approved in October for the treatment of certain advanced breast cancer cases.
- Several studies have found genetic markers that are associated with a higher risk of developing prostate cancer. The presence of two or three of these markers leads to an additive effect on risk.
- The March 2008 CTR exam, closed-book section, will include general concepts from the MP/H rules.
- Six new ICD-9-CM codes for Non-Hodgkin Lymphoma became effective on October 1. Contact your regional coordinator to obtain an informational sheet. Additional new codes for several other malignant conditions are forthcoming.
- Obtain CE credit by reviewing the Fall 2007 Journal of Registry Management article "Revising the Multiple Primary and Histology Coding Rules" and taking the associated quiz.

Abstracting Bits and Pieces:

◊ Download the newly-available MP/H definitions and rules for Benign CNS Tumors from the SEER website. Although the rules for abstracting these tumors have not changed, the format has been converted to the same used on all other tumor types.

◊ The National Program of Cancer Registries (NPCR) wants to see better text documentation in abstracts.

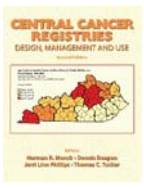
◊ Want to check your registry data with GenEDITS more frequently? Now that your central registry has made this possible on CPDMS.net, use it as often as you wish!

◊ A new KCR Follow-up Report will be ready sometime in early November.

◊ Having trouble with a case and can't reach another registrar? Check out I&R (ACoS website) and/or SINQ (SEER website).

◊ Our highest goal is to produce a quality product. The next reabstracting audit will cover year 2006 cases.

A Kentucky Connection…



Not only does the NCRA have a new reference manual with Kentucky on the cover, but one of the editors is Dr. Thomas Tucker! Copyrighted in 2007, Central Cancer Registries: Design, Management and Use, 2nd edition, is a textbook and reference book for central registries and registrars-in-training. Questions from this resource will be included in the 2008 CTR exam, along with FORDS (revised 2007). Find it on the NCRA website—NCRA Store.

People News

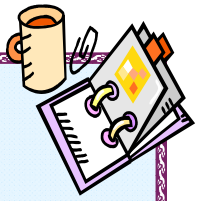
New Hires:	**Mary Jane Byrne**	**KCR, QA Manager for Field Studies**
	Michele Hoskins	**Floyd Memorial Hospital, New Albany Indiana**
	Kelly Pictor	**KCR, Casefinding Auditor**
Resignations:	**Mary Jane Byrne**	**KCR, Casefinding Auditor**
	Vince Cecil	**KCR, QA Manager for Field Studies**
	Michele Hoskins	**Norton Healthcare, Louisville**
	Kelly Pictor	**KCR, Non-Hospital Facilities Abstractor**
	Donna Tucker	**KCR, Regional Abstractor**
New CTR:	**Pam Shaw**	**KCR, Non-Hospital Facilities Abstractor**
	Barbara Fitzpatrick	**Our Lady of Bellefonte, Ashland**

Golden Bug Award

Congratulations to Freida Herald, our newest Golden Bug Award winner! Freida discovered a bug involving duplicate field names, which will be fixed on the next software release.

ACoS-Approved Cancer Programs:

- The cancer program at Medical Center of Bowling Green received notice of full three-year approval. Congratulations to Jana Thornton and Paula Alford.
- Western Baptist Hospital (Paducah) received full three-year reapproval from the ACoS. Congratulations to Donna Schmidt, Julie Welch, and Betty Copeland. Congratulations are also extended to Western Baptist's Cancer Liaison Physician, Dr. James Patrick O'Rourke, recipient of a CoC Outstanding Performance Award.



Calendar of Events

October 31, 2007 - Collaborative Staging Update

November 1, 2007 - SEER Data Submission

November 2, 2007 - NCDB "Call for Data" Deadline

November 22-23, 2007 - Thanksgiving Holiday - KCR Office Closed

December 25-January 1, 2008 - Holidays - KCR Office Closed

January 31, 2008 - NCRA Renewal Deadline

January 31, 2008 - CTR Exam Application Deadline

Continuing Education Opportunities Offered by the Kentucky Cancer Registry

The 2007-2008 Hospital Registry Webinar Course Descriptions and Hosting Facilities are shown below. (Start time: 9:00 a.m. to 1:00 p.m. EST)

Abstracting Gynecologic Cancer Incidence and Treatment Data **11/8/2007**
Host: Rhonda Paul, Norton Hospital Classroom 2, 224 Bldg on Broadway, Louisville

Hospital Cancer Registry Operations **1/10/2008**
Specific to the hospital Cancer registry including the Commission on Cancer Standards; writing, revising, and using a cancer registry policy and procedure manual; and other registry operations.
Host: Shona Harper, Lake Cumberland Hospital, Somerset

Cancer Treatment and How to Code It: Surgery, Radiation, Systemic, and Other Therapy **2/14/2008**
Host: Reita Pardee, KCR, B100 Classroom, Lexington

Abstracting Thyroid Cancer Incidence and Treatment Data **WE WILL PURCHASE CD**
Abstracting Larynx Cancer Incidence and Treatment Data **after 3/6/08**
Host: Reita Pardee, KCR, B100 Classroom, Lexington

Data Quality and Data Use **5/8/2008**
Ways to evaluate the quality of registry data and ways to use the data.
There will be discussion on using NCDB data as comparison data in registry studies.
Host: Jana Thornton, Medical Center of Bowling Green

Abstracting Upper Gastrointestinal Tract Cancer Incidence and Treatment Data **7/10/2008**
Host: Reita Pardee, KCR, B100 Classroom, Lexington

Abstracting Other Digestive System Cancer Incidence and Treatment Data **9/11/2008**
Host: Rhonda Paul, Norton Healthcare, Norton Audubon Hospital, Poplar Level Road, Community Room, Louisville

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KCR Spring Training 2008 plans are being made. The agenda will cover changes and/or additions to Collaborative Staging (national update due 10/31/07), address questions regarding the 2007 New Data Elements, and abstract cases and discuss rationale for answers using the MP/H rules. Mark your calendars early for the following dates and locations:

March 6, 2008 - Lexington - Hilton Lexington Green
March 7, 2008 - Madisonville - Trover Clinic Tower
March 13, 2008 - Elizabethtown - Hardin Memorial Hospital

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CDs of several of the NAACCR Webinars that were held in 2006-07 have been purchased by KCR. Registrars who are interested in borrowing these for review may do so by contacting their regional coordinator. Sites available include: Bladder/Ureter/Renal Pelvis, Prostate, Colon/ Rectum Incidence and Treatment Data, Abstracting Head and Neck Primaries, and Lung. CE hours may be earned following the review and completion of associated exercises.

Meningioma—Where Did It Arise?

When it comes to coding topography for meningioma cases in Kentucky, the error rate is increasing. GenEDITS revealed more "C-code errors" in 2006 than in previous years of meningioma data collection. In hopes of clarifying this site identification before the trend escalates any further, please incorporate the following information into your abstracting 'arsenal'.

"Meningioma is a tumor that arises from the meninges—the membranes that surround your brain and spinal cord", according to the MayoClinic.com website. This three-layer membrane also folds in at the level of the tentorium, and covers deeper structures in addition to the outermost "surround zone". The term "meningioma" can be broken down into the word root "mening(i)", which refers to the meninges layers around the brain or spinal cord, and "oma", which means "tumor". Meningioma , therefore, literally means "tumor of the meninges."

The correct topography code is that which identifies where the tumor originated or "arose". Thus, a meningioma found on the right frontal lobe of the brain would be assigned topography code C70.0, meninges of the brain (cerebral meninges). For a meningioma arising in the spinal cord region, the correct code would be C70.1.

Feel confident when coding your next meningioma topography code. All of the experts on-line, in medical texts and dictionaries, and in-house, agree that the origin of a meningioma is the meninges! Don't waste precious time trying to pinpoint the exact spot where it began. Your most difficult challenge is to choose between the brain, spinal cord, or "NOS" types.

One last word on benign CNS casefinding: When a new benign CNS tumor is identified only on a scan in your hospital, abstract the case. Do not forward that scan to KCR. As a follow-up to 2004 training, many of these tumors are followed for years without surgery. It is important to abstract the case upfront. If you find the case at your facility, you own it!

Collaborative Staging Update

Version 01.04.00 of the CS System will be released on October 31st. Minor changes to the current version are expected. Abstracting will continue as is until programmers nationwide can implement any necessary software changes. We anticipate CPDMS.net will be ready for the new codes sometime after the first of the new year.

Commission on Cancer Educational Activity

A free webconference entitled "Survey Pitfalls: Preventing Common Program Deficiencies" will be presented on November 16, 2007 at 11:00am EST. This one-hour-long program will be presented by Asa Carter, CTR, Manager of Approvals and Standards. No registration is required. Visit http://www.facs.org/cancer/coc/webconf6.html for more details.

KCR 2007 Fall Workshop in Retrospect…..

Evaluation forms were unanimous! The topics and speakers were great. The hotel was fantastic. We can expect a return visit to Embassy Suites.
Requested CE hours are pending NCRA approval.

Best US Hospitals in 2007

The top 50 cancer hospitals in the nation were listed in the July 23rd issue of "US News and World Report." Thirty four (34) of these programs were also ACoS-Approved Programs and most had earned commendation status. Among the top 50 was University of Kentucky Chandler Medical Center, Lexington, the only Kentucky hospital to make the 2007 list.

SEER CODING QUESTIONS:

Review these SINQ questions and answers, and make use of this guidance in future case scenarios.

Question 1: **Primary Site--Meninges: Should the primary site for a meningioma of the right frontal lobe be coded to C71.1 or C70.0?**

Discussion: In the opinion of some neurologists it is more important to capture the lobe in which the meningioma is located rather than code the primary site to meninges. Should a meningioma always be coded to meninges for primary site?

Answer: *Code the Primary Site field to C70.0 [cerebral meninges], the suggested site code for most meningiomas. Meningiomas arise from the meninges, not the brain (although they can invade brain). ICD-O-3 does not differentiate the specific location of the brain that the meninges cover. The information of interest to neurologists would have to be captured in an optional or user-defined field. (SINQ #2002-1031; ICD-O-3, pg 61)*

Question 2: **Reportability: Can a diagnosis be made based on flow cytometry alone, for example, where flow cytometry is positive, but bone marrow biopsy is negative? If so, how should diagnostic confirmation be coded?**

Answer: *The case is reportable if a recognized medical practitioner says the patient has cancer. Flow cytometry alone is not diagnostic. Flow cytometry may be supported by either a positive bone marrow or a clinician's statement. If the statement is based only on flow cytometry, code diagnostic confirmation as 8 [Clinical diagnosis only].*
(SINQ #2007-1063; 2007 SEER Manual, pgs 3, 76-77)

Question 3: **Multiplicity Counter--Lung: Primary LLL lung tumor with LUL satellite tumor. Is multiplicity counter 01 or 02? Please see discussion.**

Discussion: Example 5 in the instructions suggest that 02 would be the choice. However, lung tumors in other lobes or contralateral lung are considered metastatic and coded as 35 or 39 in CS Mets at DX. Instructions for multiplicity counter state "Do not count metastatic tumors." This would suggest 01 as the correct code.

Answer: *Code multiplicity counter as 02 [two tumors present]. According to the multiple primary rules, these two lung tumors are reported as a single primary. Record the number of tumors reported as a single primary in Multiplicity Counter.*
(SINQ #2007-1065; 2007 SEER Manual, pgs 90, C-539)

Question 4: **MP/H Rules/Histology--Breast: What is the correct histology code for this breast cancer? Please see discussion.**

Discussion: A breast tumor diagnosed in February 2007 is a single tumor with in situ and invasive components. The invasive component is diagnosed as ductal with tubular features. The only rule that applies is H9 which says 'code the invasive histology.' Is it ductal (8500) or tubular (8211)? If you continue through the H rules, then H12 does not apply, because tubular is not a type of ductal. So then you end up at H17, which would make this 8523. Which code is correct?

Answer: *Code the histology 8523 [duct mixed with other types of carcinoma]. After determining that the invasive histology is to be coded using rule H9, there is another decision to make in this case--which invasive histology should be coded? Make a second pass through the histology rules, beginning with rule H10. Stop at H17 and code 8523.*
This advanced concept of a "second pass" through the rules is discussed in an online web training session called "Beyond the Basics." Go to the SEER website to view this session:
http://www.seer.cancer.gov/tools/mphrules/training_advanced.html
(SINQ #2007-1073; Breast MP/H Rules, SEER website)

Question 5: **MP/H Rules: Is the following scenario one or two primaries?**
Renal Pelvis - Papillary transitional cell carcinoma, Invasive, 2006
Bladder - Papillary transitional cell carcinoma, Non-Invasive, 2007

Answer: *This is a single primary with renal pelvis as primary site.*
Use the 2007 MP/H rules to determine if the 2007 diagnosis is a new primary.
Use the Urinary rules, multiple tumors module. Start with rule M3. Follow the rules down to Rule M8 and stop. This is an example of implantation effect.
(SINQ #2007-1083; 2007 SEER Manual, pgs C897-898)

Question 6: **MP/H Rules--Colon: Please see discussion and confirm number of primaries and histology.**

Discussion: A patient had three tumors, left colon tumor invasive well-diff mucinous adenoca arising in tubulovillous adenoma with pericolonic subserosal fat invasion 8.5cm. An infiltrative mod-diff colonic adenoca with invasion of muscularis propia 4cm and an invasive mod-diff colonic adenoca with invasion of muscularis propria, 1/69 nodes positive. We used M8 for one primary, but M10 contradicts; and H13 coding rule 8263/3.

Answer: *Assuming that all tumors are in the left colon, there are three tumors:*
1. Mucinous adenocarcinoma arising in a villous adenoma
2. Colonic adenocarcinoma
3. Colonic adenocarcinoma

Multiple Primary Determination
In the colon MP rules go to the multiple tumors module. Start with M3. Stop at M7 and abstract as a single primary.

Histology Code
Go to the histology coding rules, multiple tumors module, and start with H15. Stop at H20 which tells you to code the most invasive tumor. Tumor 1 is the most invasive according to the definition of most invasive in the 2007 SEER Manual, page C-271. Code 8263/3 [Adenocarcinoma in tubulovillous adenoma.].
(SINQ #2007-1077; 2007 SEER Manual, pgs C-271, 303, 310)