A Quarterly Newsletter from the Kentucky Cancer Registry

In The Abstract

LARGE HOSPITAL EDITION NOVEMBER 2008

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Kentucky State Chair Honored

Daniel Kenady, MD, FACS was one of three Commission on Cancer State Chairs honored recently at the CoC Cancer Liaison Physician Breakfast. The Kentucky, California, and Nebraska State Chairs were recognized for "outstanding performance and…significant contributions to the Liaison Program in 2007." Special congratulations are extended to Dr. Kenady for this latest honor. (CoC Flash 10/08)

*** * * Fall Workshop CE Hours* * ***

The NCRA Program Recognition Committee has determined that **KCR's 22nd Annual Advanced Cancer Registrars' Workshop, *"Leaders in the Race"*** supports **8.75 CE hours**. This workshop has been assigned the following event number: **2008-159**. CTRs are advised to update the CE form accordingly.

Did You Know?

- AJCC will be releasing its Cancer Staging Manual, 7th edition and the Collaborative Staging System, Version 2 in 2009 for implementation in 2010. ("The Connection," Fall 2008)
- NCRA members can earn one CE by submitting five (CTR) exam questions with answers and references. ("The Connection," Fall 2008)
- Basic statistics terms, definitions, and graphs are available on the SEER website. Visit www.seer.cancer.gov/statistics/.
- A report on "Cancers Associated with Tobacco Use in the US, 1999-2004" has been released by the CDC. Data used in the report came from registries affiliated with NPCR and SEER. (CoC Flash 9/08)
- The National Cancer Institute has a liaison office in Brussels, Belgium. This office provides a link between the U.S. NCI and multiple European partners. (NCI website 10/08)

People News

New Hires:

Dorene Johnson	Jewish Hospital, Louisville
Cindy Hall	UK Medical Center, Lexington

New CTRs:

Leslie Baas, CTR	Kentucky Cancer Registry
Carole Miller, CTR	University of Louisville Hospital
Toyia Redd, CTR	Lourdes Hospital, Paducah
Bonnie Roberts, CTR	Owensboro Medical Health System
Shelly Scheer, CTR	University of Louisville Hospital

Pat Meade, KCR Regional Abstractor, would like to thank all of you who sent her kind wishes and expressions of sympathy at her father's recent illness and death.

ACoS Approved Cancer Programs

⇒ Jewish Hospital/St Mary's Hospital in Louisville recently received full 3-year approval for their network cancer registry program. Congratulations to Marie Hall, Amy Tompkins, and Betty Baker for their hard work!

⇒ Central Baptist Hospital in Lexington has been awarded full 3-year approval with commendation on 6 of 9 standards. Congratulations are extended to Freida Herald and her entire team!

⇒ Taylor Regional Hospital in Campbellsville recently received 3-year approval with commendation. Jennifer Smothers and Sam Underwood are to be congratulated!

Abstracting Bits and Pieces

- Use MP/H charts or tables ONLY when instructed to do so by a rule. Go through the rules FIRST….
- Abstracting is the heart of the registry. Set a weekly abstracting goal to maintain timeliness, and stick with it!
- NCRA members can now log on and participate in Discussion Forums… another membership benefit.
- Neoadjuvant treatment leads to special Collaborative Staging codes. Refer to CS Manual Part I for guidelines on when to use clinical staging and when to use pathologic staging information in coding. There are specific directions for when to use either.
- The Staging Text Box should include the TNM staging selected by MD/Registrar as well as Collaborative Staging information. Rather than just copying the CS codes from the abstract, use this box to justify your codes. *For example*, if an MD stages a case "T2" and you have NO scans or other tests to use for coding CS Extension, briefly explain the MD T-equivalent was coded in the absence of any other available studies. Use text to back up your coding!

Coding Head & Neck Lymph Nodes

Site-Specific Factors 3 through 6 for all Head & Neck sites feature coding of lymph node involvement. Carefully read the Note preceding each coding box in the appropriate Head & Neck chapter of CS Manual Part II. If you remain unsure as to which level of lymph nodes is involved (your facility's radiologist or ENT specialist may use different terminology than that printed in the SSF lists…), go to CS Manual Part I.

CS Manual Part I is an excellent "general instructions" reference for all CS data elements. In addition, there is an area in the CS Lymph Nodes section that is devoted specifically to Head & Neck Sites and Lymph Nodes. *"Coding Regional Lymph Nodes for Head & Neck Sites"* begins on page I-35 and continues to the top of page I-38. This resource is a necessary "read" for abstractors working on identifying or deciphering neck nodes. Names for nodes in Levels I through VII and "Other Groups" are spelled out. Once involved levels are identified, it becomes easy to code them "1", while uninvolved levels are coded "0". Be careful to code involvement in the correct slot.

For example, when abstracting a right tonsil case (C09.9), records indicate involvement of a single right Delphian node. CS Lymph Nodes in the Tonsil/Oropharynx Chapter in CS Manual Part II does not mention "Delphian" as a regional lymph node. You have NO IDEA as to which level this node falls into….

Go to CS Manual Part I, where on page I-38 you will see Delphian listed alongside Prelaryngeal as a Level VI node. The correct CS Lymph Nodes code would then be "12" (single positive ipsilateral regional node Level VI). SSF#3 would be coded "000" for no involved lymph nodes in Levels I, II, or III. SSF#4 would be coded "000" for no involved nodes in Levels IV, V or Retropharyngeal Nodes. SSF#5 would be coded "100" to show involvement of Level VI (1st digit in code = 1), no involvement in Level VII (2nd digit in code = 0), and no involvement of facial nodes (3rd digit in code = 0). SSF#6 would be "000" for no involvement of Parapharyngeal, Parotid, or Sub-Occipital nodes.

Suddenly, it all makes sense! Take time to review the extra-help Head & Neck Lymph Nodes information in CS Manual Part I. Your Head & Neck coding will benefit as a result.

Calendar of Events

November 3, 2008 – NCDB Call for Data ends

November 27-28, 2008 – Thanksgiving Holidays, KCR Office CLOSED

December 24, 2008 thru January 1, 2009 – UK Winter Holidays, KCR Office CLOSED

December 31, 2008 – CTR Even-Year Cycle ends

January 19, 2009 – Martin Luther King Day, KCR Office CLOSED

January 31, 2009 – Spring CTR Exam Application deadline

NAACCR Webinars in Kentucky

Four new NAACCR webinars for 2008-2009 will be hosted at several locations in our commonwealth. Each session lasts from 9am through 12pm EST, and CE's are awarded to attendees. Plan on attending one or more of these informative webinars, brought to you by the Kentucky Cancer Registry:

3/5/09 "Cancer Staging In-Depth" – Norton Audubon Community Room

6/11/09 "Collecting Cancer Data: Prostate" – Medical Center at Bowling Green (*Revised date)*

7/9/09 "Advanced Coding & Abstracting" – St Elizabeth Medical Center

8/6/09 "Collecting Cancer Data: Breast" – Western Baptist Hospital

Training Opportunities Outside Kentucky

- Principles of Oncology for Cancer Registry Professionals will be presented December 8-12, 2008 in Reno, NV by April Fritz & Associates. This class is almost full at press time. The cost is $949 per person.
- CTR Exam Preparation will be presented by NAACCR in eight weekly 2-hour webinar sessions. Beginning January 13, 2009, the subscription for this series is $400. 2009 exam changes will be covered.
- NCRA will present a CTR Exam Prep Workshop in Baltimore, MD on February 7-8, 2009. Contact lgrossman@ncra-usa.org to register. The cost is $360 for members or $395 for nonmembers.
- NCRA will present an Exam Prep Webinar on Statistics on February 19, 2009. This 1-hour presentation begins at 2pm EST and costs $50 for members, $75 for nonmembers. Contact Lily Grossman. Additional NCRA webinars are also available….

New Research at the National Cancer Institute

Two recent research topics at the NCI have relevance to the work of cancer registrars in the areas of chemotherapy drug resistance and the recurrence of cancer:

Cisplatin is a drug used to treat many types of cancer. After successful treatment with Cisplatin, tumors sometimes recur. This indicates the drug is no longer effective; cancer cells somehow become resistant to it. Researchers have found a gene that apparently contributes to this resistance. Understanding the resistance process will help scientists develop pathways to "get around" resistance and increase the effectiveness of this familiar chemotherapy agent.

NCI scientists have identified a way in which dormant metastatic cells can begin growing again after a long period of inactivity. This helps researchers understand how breast cancer, for example, can metastasize many years after removal of the primary tumor and completion of first course therapy. Preventing the switch from dormancy to renewed growth is the key question in ongoing research….

SEER Coding Questions

Review these questions recently finalized by SEER.

Question 1: **MP/H Rules--Bladder: How many primaries should be abstracted for this scenario? Please see discussion.**

Discussion: TURBT in 4/07: Lateral wall of bladder tumor was resected and path stated papillary carcinoma. Two weeks later the bladder was biopsied again and the path returned "High grade flat dysplasia/carcinoma in situ." Following the rules, this results in 2 primaries because the histology codes are 8130/3 and 8010/2. Is this correct?

Answer: *Rule M6 applies and this is a single primary.*
Flat transitional cell carcinoma and carcinoma in situ of the bladder are synonymous. See the definition of "Flat Tumor (bladder)/Noninvasive flat TCC" in the Urinary Terms and Definitions section of the 2007 MP/H Manual.
(SINQ #2008-1064; 2007 SEER Manual, pg C-898)

Question 2: **Reportability--Lung: Is carcinoid tumorlet of the lung a reportable disease? The literature on this is rather ambiguous as to whether these tumorlets (defined as <0.5 cm) are benign, such as atypical hyperplasia, or actual carcinoid tumors.**

Answer: *Carcinoid tumorlets are not reportable. The histology can be similar to typical carcinoids; however, they are <5 mm in diameter and are benign/nonreportable.*
(SINQ #2008-1076; ICD-O-3)

Question 3: **Multiplicity Counter--Thyroid: How would "multinodular carcinoma of the thyroid" be coded in the multiplicity counter field? This is a path report with no other information available at the present time.**

Answer: *Count the number of measured nodules. If the nodules are not measured, code 99 in the multiplicity counter.*
(SINQ #2008-1089; MP/H Manual, pg 340)

Question 4: **MP/H Rules: When applying the MP/H rules, what happens with metastases? Please see discussion.**

Discussion: Single lung tumors presenting in each lung but the patient also presents with bone mets? Would rule M6 apply? Or do the bone mets represent additional tumors?

Answer: *The MP/H rules do not apply to metastases. Ignore metastases when applying the rules. For the case above, use rule M6 and abstract as two primaries (right lung and left lung). The bone mets are ignored.*
(SINQ #2008-1090; 2007 SEER Manual, pg C-528)

Question 5: **First course treatment: Is the later treatment with R-ICE in the case below abstracted as first course therapy or is it second course due to progression? Please see discussion.**

Discussion: Patient was initially diagnosed with Hodgkin Lymphoma, Nodular Sclerosing on 3/3/06.
Patient received ABVD x 2 cycles. Had disease reassessed in May, 2006, no response to treatment, showed evidence of progression (new adenopathy). Patient's pathology from 3/06 was sent for consult: Diagnosis was Hodgkin with some overlapping features of B-cell Non Hodgkin Lymphoma. Treated 5/18/06 with R-ICE for NHL.

Answer: *The R-ICE treatment in this case is not part of the first course. Documentation of treatment failure and/or disease progression signifies the end of the first course of treatment.*
(SINQ #2008-1054; 2007 SEER Manual, pg 170, #2)

Question 6: MP/H Rules--Brain and CNS: Is this a single primary and what is the diagnosis date and the behavior code? Please see discussion.

Discussion: Dec. 2004 MRI of brain: Pineal region mass. The major differential consideration given patient's gender, age group, and imaging characteristics is pineocytoma. The differential includes pineoblastoma or germ cell line tumor. These are felt less likely.
Nov. 2005 MRI brain: stable exam since last MRI. No change in size.
Nov. 2007 MRI studies: pineal mass has almost tripled in size.
Dec. 2007 Surgical resection of pineal tumor: High grade (WHO Grade IV) pineal parenchymal neoplasm consistent with pineoblastoma.

Answer: Abstract as separate primaries. Complete two abstracts when a previously diagnosed non-malignant tumor transforms or progresses to a malignancy. Refer to the CDC/NPCR guidelines for Data Collection of Primary Central Nervous System Tumors, 2004. Malignant transformation is discussed on page 50. (SINQ #2008-1062; Data Collection CNS Tumors, pg 50)