In The Abstract

A Quarterly Newsletter from the Kentucky Cancer Registry

OCTOBER 2012

INSIDE THIS ISSUE:

KCR Annual Fall Workshop 2012 in Review

The 26th Annual Advanced Cancer Registrars' Workshop, "A New Day for Cancer Registry" was conducted September 6th and 7th at the Marriott Griffin Gate Resort and was very well attended. Educational presentations by physician specialists were outstanding, and April Fritz's instructional sessions enriched our understanding of CSv0204. The KCR Informatics team reviewed past, current and upcoming projects and increased our understanding of how technology is being used to aid in state cancer reporting. Marie Brown, registrar at Jewish Hospital and St Mary's Healthcare, received the Judith Ann Cook Excellence Award. A buffet luncheon was enjoyed at the Griffin Gate Mansion, and drawings for door prizes added a fun diversion during the workshop. The NCRA awarded this workshop 9.25 CEU's, program #2012-093. Kudos to Marynell Jenkins on her initial endeavor toward successfully coordinating an excellent workshop!

CPDMS.net Data Entry

Incorrect data entry practices negatively impact your registry data and negatively impact central registry data functions. Please follow these important data entry instructions to insure your registry data accuracy and integrity:

1) Deleting Patients/Cases from CPDMS.net VS Entering Key Changes

When registrars discover they have abstracted a case on the wrong patient, they SHOULD NOT Key Change the patient into someone else. This action causes multiple problems at central if the patient/case has already been uploaded. Registrars should print the case and then DELETE the patient/case from the database and re-enter it with the correct patient information (a new accession number will be assigned). *Never change an existing patient record into a different person.*

2) Patient Level Key Changes Based on Central Follow-Up Report

Do not enter patient level key changes in CPDMS.net based on the follow-up report. The correct information on patient name and SSN is conveyed in errata reports. These fields may not have been verified before the follow-up report was generated. The only fields registrars should EVER edit due to the follow-up report are follow-up fields such as date of last contact, survival status, etc.

People News

New Hires:

Sara Adams	St Joseph Hospital, Lexington
Michael Barker	Norton Healthcare, Louisville
Tonya Brandenburg	KCR Death Clearance & Data Exchange Coordinator and Non-Hospital Facilities Coordinator, Eastern KY
Teresa Ford	Lourdes Hospital, Paducah
Lowena Ginter	Highlands Regional Medical Center, Prestonsburg
Carolyn Hennessy	Norton Healthcare, Louisville
Sharlene Moore	VA Medical Center, Lexington
Courtney Redd	St Joseph Hospital, Lexington
Cindy Roberts	Frankfort Regional Medical Center, Frankfort
Tamara Schweitzer	Greenview Regional Hospital, Bowling Green
Andrea White	Central Baptist Hospital, Lexington

New CTRs:

Allissa Anderson, CTR	St Joseph Hospital, Lexington
Nicole Catlett, CTR	Baptist Hospital East, Louisville
Terri Ganote, CTR	Baptist Hospital East, Louisville
Chalon Mask, CTR	Jewish Hospital & St Mary's Healthcare, Louisville
Tammie Rogers, CTR	UK Medical Center, Lexington
Tamara Schweitzer, CTR	Greenview Regional Hospital, Bowling Green
Bonnie Still, CTR	Baptist Health, Richmond

Transfers:

Rachel Maynard, CTR	KCR Non-hospital Facilities Coordinator

Resignations:

Sara Adams	Norton Healthcare, Louisville
Teresa Ford	Regional Medical Center of Hopkins Co., Madisonville
Courtney Redd	Central Baptist Hospital, Lexington
Cindy Roberts	St Joseph Hospital, Lexington

Retirement:

Pat Meade	KCR Regional Abstractor

CoC Accreditations

The following hospital cancer programs achieved accreditation by the American College of Surgeons Commission on Cancer:

- Hardin Memorial Hospital in Elizabethtown received full 3-year accreditation with commendations.
- Jewish Hospital and St Mary's Healthcare in Louisville received full 3-year accreditation with commendations.
- Murray-Calloway County Hospital in Murray received full 3-year accreditation.

Breast Cancer Accreditations

Baptist Hospital East achieved initial accreditation of their breast cancer program by the National Accreditation Program for Breast Centers.

Abstracting Bits & Pieces

- KCR published in the November 2011 edition of *'In the Abstract'* to "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)."

  Conflicting information recently appeared in the SEER SINQ system. Frances Ross addressed this issue in a SEER Managers call. SEER agrees that head and neck cases of unknown primary site should be coded C14.8, and advised that the conflicting SINQ question has been taken down. Per the *'Data Collection Answers from the CoC, NPCR, SEER Technical Workgroup'* posted on the SEER website on 8/3/11, "Assign C14.8 based on the note in ICD-O-3. C14.8 is a more specific site code than C76.0." You can view this documentation on the SEER website at http://www.seer.cancer.gov/registrars/data-collection.html#neoplasm.

- Clarification of polycythemia reportability--Is a diagnosis of "polycythemia NOS" reportable if a patient is treated with phlebotomy? Answer: No, it is not reportable.

  According to SEER, polycythemia (also known as polycythemia or erythrocytosis) is a disease state in which the proportion of blood volume that is occupied by red blood cells increases. Blood volume proportions can be measured as hematocrit level. It can be due to an increase in the mass of red blood cells, "absolute polycythemia"; or to a decrease in the volume of plasma, "relative polycythemia."

  The phlebotomy is a treatment for the excessive blood volume; therefore, a diagnosis of "polycythemia" without one of the modifying terms listed in the Heme DB under Alternative Names is NOT reportable.
  (SINQ 20110060, last updated 6/29/12, source 2010 Heme & Lymph Manual & DB)

  You may have heard April Fritz advise, during her fall workshop hematopoietic presentation, that if a patient diagnosed with polycythemia NOS is treated with phlebotomy, consider the polycythemia to be the reportable condition. However, KCR must follow SEER rules, as published in the SINQ answer.

- The therapy report (available in the web portal) has been updated. You can now run therapy reports by patient social security number or patient name.

  Helpful reminder—When reviewing treatments found on the therapy report, remember that scope of regional lymph node surgery and surgery of other regional or distant sites details do not appear on the report. If the complete surgery details are not available in the treatment notes on the report, you need to contact the registry sharing your case to obtain complete surgery details.

  Suggestion—If you currently don't document complete surgery details in the therapy treatment notes, you may want to consider beginning that practice for ease of sharing/obtaining treatment information.

Abstracting Bits & Pieces (*continued*)

- Free education and CEU opportunities:

  KCR offers complimentary viewing of NAACCR educational webinars to Kentucky hospital registrars. The webinars are 3 hours each and are eligible for 3.0 CEU's from NCRA. To access the webinars, go to http://www.kcr.uky.edu/training. For technical assistance and password assistance contact Joel Wheeler at joel@kcr.uky.edu or (859) 219-0773 ext 283.

  The NAACCR *'Industry and Occupation Coding and Support'* training module is available on-line and is eligible for 1.5 CEU from NCRA. To access the module go to http://www.cdc.gov/niosh/topics/coding/courses/cancer.

  There are seven Collaborative Stage webinars available on the AJCC Education Portal for complimentary viewing. The CS webinars are free, but creation of an account to view the webinars is necessary for new users. If you have previously viewed an AJCC or CoC webinar through the Comm Partners Education Portal, you can begin viewing immediately by adding the CS webinars to your cart. For technical issues, such as login or account creation, contact Comm Partners at facs@commpartners.com.

  The AJCC YouTube Channel offers six short presentations that focus on specific Collaborative Stage topics. These videos are now viewable directly from the CS website. The YouTube videos are found under the education section of the Cancer Staging on YouTube tab at http://www.cancerstaging.org/cstage/education/index.html.

- The *'AJCC Cancer Staging Atlas, 2nd edition'* (for use with the 7th edition of the *'AJCC Cancer Staging Manual'* and its companion handbook) is now available. The atlas illustrates the TNM classifications of all cancer sites and types included in the 7th edition staging manual. You can order a copy at www.cancerstaging.net or directly at http://www.springer.com/medicine/oncology/book/978-1-4614-2079-8.

- NCRA's new '*Workbook for the Staging of Cancer: A Companion to the AJCC Cancer Staging Manual (7th edition)*' is now available for pre-ordering at http://www.ncra-usa.org/i4a/ams/amsstore/category.cfm?product_id=283. This manual is a tool to understanding the concepts of TNM staging, explains how to apply them in a consistent manner, and offers an overview of the AJCC staging process. Ten primary cancers are described in detail and extensive exercises are provided. Rationales for the correct answers are also included.

Coding Sentinel Lymph Node Biopsies

In the spring of 2011, the Breast Quality Measure Group (BQMG) wanted to definite a measure that would allow the CoC to track recently reported findings from an ACOSOG trial reporting that breast conservation surgery paired with a sentinel lymph node dissection for small primary breast cancers was as effective as an operation that removed axillary lymph nodes. Analysis of lymph node dissection patterns for AJCC clinically negative breast cancers that underwent surgical treatment including pathologic lymph node examination suggested that 28-29% of cases were undergoing an axillary dissection (ALND) without a preceding sentinel lymph node biopsy (SLNBx), contrary to clinical expectation. The validity of this data was questioned, focusing specifically on "Scope of Regional Lymph Node Surgery."

The CoC initiated two reviews. The first preliminary limited review concluded that SLNBx and SLNBx with ALND was under reported in "Scope of Regional Lymph Node Surgery"; this issue centers on how this data element has been defined over time and how registries have been guided to code this item, and that any erroneous data should NOT be blamed on registrars; coding directives did not provide a mechanism to report failed SLN mapping; this problem likely exists across all registry operations including hospital and central registries and impacts the CoC, SEER, NPCR, NAACCR and state central registries; and these data affect the interpretation of papers published from many registry sources.

The second review consisted of 12 CoC-accredited cancer program registries participating in a re-coding exercise. This systematic review concluded that "Scope of Regional Lymph Node Surgery" has been under-reporting SLNBx and SLNBx with ALND; the revised coding rules used in the re-coding study emphasized obtaining information from the operative report (in contrast to the standing coding rules which limited information to be drawn from the pathology report), and that the new directions were comprehensive and clear; the problem of mis-coded regional lymph node procedures exists across all registry operations; and the availability of these data in widely distributed data sets and the use of these data in published work needs to be assessed.

The CoC implemented revised coding instructions (Appendix B) beginning with cases diagnosed in 2012. The instructions are published in the *'FORDS: Revised for 2012'*. CoC use of "Scope of Regional Lymph Node Surgery" will be curtailed for cases diagnosed 2011 or earlier. This data item for cases diagnosed 2011 and earlier will be used only to identify whether or not a patient underwent regional lymph node surgery, removing any distinction between the type or extent of surgical intervention.

For cases diagnosed 2012 and forward, when coding "Scope of Regional Lymph Node Surgery," review the operative report for the surgeon's intent with regard to SLNBx. If the surgeon indicates a SLNBx procedure was attempted but mapping failed, you must code "Scope of Regional Lymph Node Surgery" to reflect that a SLN procedure was performed. "Scope of Regional Lymph Node Surgery" coding examples:

Coding Sentinel Lymph Node Biopsies (continued)

- Patient to undergo SLNBx and possible axillary dissection. The surgeon states in the operative report that SLN mapping was attempted and failed, and the patient underwent subsequent axillary dissection in the same procedure. Code 6 – SLNBx [procedure] and axillary dissection performed at the same time. Even though no SLN's were removed, the attempt to remove SLN's must be reflected in the regional lymph node surgery code as documented in the operative report.
- Patient to undergo SLNBx. The surgeon states in the operative report that SLN mapping was attempted and failed. No further lymph node surgery performed. No lymph nodes were removed. Code 2 SLNBx [procedure]. Although no SLN's (or any lymph nodes) were removed, you must code the attempt to remove SLNs as reflected in the operative report.

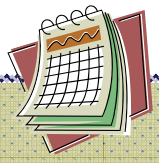
Additional codes impacted are Collaborative Stage data items "Regional Nodes Positive" and "Regional Nodes Examined."

- "Regional Nodes Positive" – When a SLNBx is attempted but no lymph nodes are removed (mapping fails) and there is no other lymph node surgery performed, code 99 since it is unknown whether regional lymph nodes are positive.
- "Regional Nodes Examined" – For the same scenario, code 96 since a SLN procedure was performed (although it failed). *Refer to CSV0204 Section 1 Part 1 General Instructions for coding Regional Lymph Nodes Examined #6.*

Be sure to read operative reports carefully to determine if a SLNBx procedure was attempted and if SLNs were removed in order to accurately code regional lymph node codes.

References:
NCDB 3/9/12 article 'Scope of Regional Lymph Node Surgery: A Review of Data Validity, Revised Coding Directives, and Agency Transition Plans"
FORDS: Revised for 2012
Collaborative Staging version 0204

Calendar of Events



November 6, 2012 - Presidential Election Day, KCR office closed
November 22-23, 2012 - Thanksgiving Holiday, KCR office closed
December 25, 2012- January 1, 2013 - UK Winter Holiday, KCR Office Closed
December 31, 2012 - CTR CEU cycle ends - CE summary forms must be submitted to the NCRA if you passed the CTR exam in an even-numbered year
December 31, 2012 - NCRA membership expires - 2013 renewal deadline is 1/31/13
January 21, 2013 - Martin Luther King Holiday, KCR Office Closed
January 31, 2013 - 2013 CTR exam application due date (2013 exams scheduled for March 9-23, 2013)

SEER Coding Questions

Take a look at these recent SINQ coding questions for continuing education…….

Question 1: MP/H Rules/Primary site: Do the answers to questions 20100025 and 20110119 contradict each other? One says to use code C68.9 and the other says to leave the primary site code as the original primary site code and not change it to C68.9. In both cases, rule M8 applies (single primary). In one case the tumors are diagnosed within a month of each other and in the other case the tumors are diagnosed more than a year apart. When the answer says "same time" or "synchronous" does this mean during the same event and if not, what is the time range for "same time" e.g. 8 months, 1 year?

Answer: *The term "synchronous" means at the same time or less than or equal to 60 days apart. The case in 20100025 was NOT synchronous. The first lesion (renal pelvis) occurred in 1/08 and the subsequent tumors were diagnosed 5/09, more than one year apart. In this case, you do not go back to change the primary site code on the original abstract. Case 20110119 WAS diagnosed synchronously, the first lesion in 11/09 and the second in 12/09, one month apart. Because the lesions were synchronous, the primary site is coded urinary system, NOS C68.9.*
(SINQ 20120048, last updated 7/17/12, source 2007 MP/H rules)

Question 2: MP/H Rules/Multiple primaries--Kidney, renal pelvis, bladder, ureter: How many primaries should be abstracted for the following scenario?
See discussion.

Discussion: Patient had TCC in situ of the renal pelvis in Oct. 2006. Then he had TCC in situ of the bladder in July, 2008. Per MP/H rule M8, this is a single primary. Then the patient has TCC in situ of the ureter diagnosed in Nov. 2009. Is this a new primary, since sequence 1 was diagnosed in Oct. 2006 (M7)? Or does the 3 year time frame start from the last recurrence (i.e., July, 2008) making this all part of the first primary?

Answer: *Abstract one primary for this scenario. The three-year time-frame starts from the date of the last diagnosis, which in this case was the July 2008 diagnosis.*
(SINQ 20120080, last updated 9/21/12, source 2007 MP/H rules)

Question 3: Reportability--Is VIN II-III reportable?

Answer: *VIN II-III is not reportable. When "VIN II-III" is stated, it is interpreted as meaning that the pathologist is not certain whether this is VIN II or VIN III. Do not report the case until/unless VIN III or carcinoma in situ is confirmed.*
(SINQ 20120081, last updated 9/21/12, source 2012 SEER Manual)

Question 4: Reportability--Heme & Lymphoid Neoplasms: Is polycythemia vera secondary to volume depletion reportable?

Answer: *No, secondary polycythemia vera is not reportable. Primary polycythemia vera is a condition in which there is an over-production of blood cells due to a neoplastic process. Secondary polycythemia vera is an over production of red blood cells caused by a co-morbidity, in this case, volume depletion.*
(SINQ 20120049, last updated 7/17/12, source 2012 Heme & Lymph Manual & DB)

Question 5: Reportability--Heme & Lymphoid Neoplasms: I would like some clarification on the term "myelodysplastic disorder." Is this a reportable term?

Answer: *Myelodysplastic disorder is a synonym for myelodysplastic syndrome (MDS). Go to the Heme DB, Abstractor Notes for MDS. Myelodysplastic disorder is a NOS term. Usually when this diagnosis is made, the physician will conduct further tests to determine a more specific disease in the Myeloproliferative Neoplasms group. Other specific histologies include: refractory anemia with unilineage dysplasia, refractory anemia with excess blasts, myelodysplastic syndrome with del(5q), childhood myelodysplastic syndrome. If a more specific disease is diagnosed, code to that specific neoplasm. If no further work-up is done or no additional information can be found, code the disease to 9989/3 for cases diagnosed 1/1/10 and after.*
(SINQ 20120040, last updated 7/12/12, source 2010 Heme & Lymph Manual & DB)

SEER Coding Questions....*continued*

Question 6: Histology/Heme & Lymphoid Neoplasms--What is the correct histology?

Discussion: CT-guided core biopsy pelvic mass positive for B-cell non-Hodgkin lymphoma; bone marrow is negative. Mediastinos copy with mediastinal and pre-tracheal lymph node biopsy is positive for follicular lymphoma grade 1 of 2. PET scan is positive for extensive metastatic disease with lymph nodes in neck, chest, abdomen, pelvis and bone involvement. Code 9695 vs 9591. Hematopoietic rules table of contents directs me to Module 8 for these histologies. Module 8 rules do not apply, so I am directed to Module 9 where the first rule that applies is PH40 which tells me to use the Heme DB to determine primary site/histology. Heme DB then tells me this is two primaries. This doesn't seem correct. Both histologies are B-cell lymphomas. Please clarify.

Answer: *Use Rule PH39 and code follicular lymphoma, grade1 – 9695/3. This is an NOS (B-cell lymphoma) and more specific histology (follicular lymphoma). The first diagnosis you have is "B-cell lymphoma." That is almost as generic as you can get. It simply states this is a lymphoma and the lineage is B-cell. The next diagnosis is follicular lymphoma, grade 1. Follicular lymphoma is a B-cell lineage. Therefore, you have B-cell (lineage) follicular lymphoma, grade 1.*
(SINQ 20120042, last updated 7/12/12, source 2010 Heme & Lymph Manual & DB)

Question 7: Multiple primaries/Heme & Lymphoid Neoplasms: Is this a single or multiple primary? Which 'M' rule would apply?
Mediastinum excision – myeloid sarcoma (9930). At the same time, bone marrow biopsy – fibrosis.
Final diagnosis: Acute myeloid leukemia with diffuse myeloid sarcoma involving right ventricle with outflow tract obstruction pericardial, pelvic, orbit, skull base, infratemporal fossa, and intracranial extradural regions diagnosed at the same time.

Answer: *There is one primary, acute myeloid leukemia. The myeloid deposits in the soft tissue (myeloid sarcoma) represent an advanced stage of disease. The myeloid cells from the bone marrow have escaped into the soft tissue and metastasized to organs. That is why your physician said acute myeloid leukemia WITH diffuse myeloid sarcoma rather than acute myeloid leukemia AND diffuse myeloid sarcoma. There is no 'M' rule that addresses this issue. There will be rules addressing leukemia/sarcoma in the revised edition of the Heme Manual. Thank you for bringing this to our attention.*
(SINQ 20120043, last updated 7/12/12, source 2010 Heme & Lymph Manual & DB)
****This is now addressed in the 2012 Heme & Lymph Manual & DB, Module 5, Rule PH 14.*

Question 8: Multiple primaries/Heme & Lymphoid Neoplasms: Do I use the physician statement and treat as a recurrence?

Patient was diagnosed with acute monocytic leukemia in 2009. In 2011, patient is found to have several masses in his cerebellum and biopsy confirms granulocytic sarcoma. Physician states this is "extramedullary relapse of leukemia." Bone marrow is negative.

Answer: *The granulocytic (myeloid) sarcoma is not a new primary. Both the acute monocytic leukemia and the granulocytic sarcoma are myeloid neoplasms. As your physician states, the granulocytic sarcoma is "metastatic" from the acute myeloid leukemia.*
(SINQ20120044, last updated 7/12/12, 2010 Heme & Lymph Manual & DB)