A Quarterly Newsletter from the Kentucky Cancer Registry
Large Hospital Edition August 2005

IN THE ABSTRACT

Historic Seelbach - Site of the 19th Annual KCR Fall Workshop

Nine presidents, famed author F. Scott Fitzgerald, and even 'the king", Elvis Presley, have all slept in the Seelbach Hotel. Now it is KCR's turn to spend some quality workshop time in this classic 100-year-old Louisville landmark. Located at Fourth Street and Muhammad Ali Boulevard, the Seelbach Hilton is within walking or trolley-hop distance of just about everything that's "happening" downtown.

"4th Street Live!" is one block north, with restaurants, cafes, and activities galore. Live musical performances are featured there on Wednesday evenings. Take a carriage ride after dusk to view beautiful lighted buildings and learn about the history of the city in the moonlight. Take the trolley to the Louisville Slugger Museum, Science Museum and IMAX, Waterfront Park and riverside restaurants, Kentucky Center for the Arts, or Slugger Field. Visit Churchill Downs' Derby Museum or go shopping at the Mall St. Matthews, Oxmoor Mall, or the Summit in eastern Jefferson County. There are lots of things to see and do in Louisville these days!

Be sure to make your hotel reservations early - by noon on August 12th - in order to obtain the workshop room rate at the Seelbach. Special tours are being offered periodically during this centennial celebration. While you're planning your city adventures, don't forget to mail your workshop registration form and check to KCR before August 20th. See you soon in downtown Louisville for the 19th Annual Advanced Cancer Registrars' Workshop.

Abstracting Bits and Pieces:

- ◊ Effective January 1, 2006, ACoS-approved hospital registries will no longer be required to follow class of case "0" patients.
- ◊ The ACoS will not require class '0" cases to be AJCC staged, beginning with 2006 cases.
- ◊ Look at the SEER website (www.seer.cancer.gov), under Data Collection Tools, to find out how to download the new SEER*Rx interactive antineoplastic drugs database.
- ◊ A brand new "melanoma" training module is available now on the SEER website (www.training.seer.cancer.gov)
- ◊ The next NCDB call for data (years 1994, 1999, and 2004) will begin in October. A CPDMS software update must be installed by your regional coordinator before you can submit your data.
- ◊ NCRA has a new online education center. Check www.creducationcenter.org for information on educational opportunities, how to get CE hours, etc.
- ◊ "Cancer-Wise" is a monthly online publication featuring news on cancer from specialists at the M.D. Anderson Cancer Center in Houston. Visit www.cancerwise.org to learn more. Dr. Sanjay Oupta, senior medical correspondent on CNN-TV, visited the center earlier this year and produced a special one-hour report on cancer as a result.

Abstracting Bits and Pieces: (*continued*)

Tips and Reminders:

Before closing out year 2004 data, make sure you have reviewed all casefinding sources. Don't forget to review autopsy reports!

Insert the Collaborative Stage Errata sheets into your CS binder and begin using them with 2005 cases. Pay special attention to prostate changes.

Abstract any missed cases from previous years as soon as they are identified. Putting them aside makes them even more delinquent!

Q &A From the NCDB

Question: A patient moved out of state and was supposed to receive radiation but he died and it is unknown if he had radiation. For Reason No Therapy, why is code 8 an invalid code if the patient dies? Is it more correct than unknown, code 9, which is accepted by the edit check?

Answer: *Once the patient has died, we know the patient will not receive the treatment in the future. If adequate follow-up has not confirmed whether it was given or not by the time the patient dies, then use unknown. If you can tell from the patient record that the radiation was to be given after some period of time, and the patient died prior to that time, you can infer that it was not given because the patient died. If the place the radiation was to be given has no record that it was given, and the patient's death did not intervene before it was to be given, then use "not given, reason not recorded". If all the record shows is that the patient was to go someplace to determine whether radiation was to be given, and follow-up has not established that it was actually planned, then record "not part of planned first course treatment". The 8s serve as follow-up ticklers, not as permanent codes, and the edits require updating them when the patient's death is known, even if you have not been able to establish whether the treatment was given.*

Calendar of Events

August 12, 2005 (noon) - Fall Workshop Hotel Reservation Deadline - Seelbach Hilton Hotel
August 17, 18, 19, 2005 - KCR Abstractor's Training - Lexington KY
August 25-26, 2005 - NAACCR CTR Exam - Readiness Institute - Nashville TN
August 29, 2005 - Fall Workshop Registration Deadline - KCR office
September 8-9, 2005 - KCR Fall Workshop - Louisville KY
September 10-24, 2005 - Fall CTR Exam
November 14-15, 2005 - Survey Savvy - Chicago IL

People News

New Hire: **Pam Shaw** **KCR Non-Hospital Facility Abstractor**

Resignations: **Karen Magsig** **Baptist Hospital East, Louisville**

ACoS Cancer Program Approvals

- University of Kentucky Hospital Cancer Registry recently "passed" their most recent survey. Congratulations are sent to Loretta Parke, Kim Ratliff, and Jennifer Halsey.
- St Joseph Hospital in Lexington received reapproval status following their survey this year. Congratulations go out to Sue Burns and Betty Lathery!

Golden Bug Award!!

Teresa Geoghegan, registrar at Norton Suburban Hospital in Louisville, wins "the bug" for reporting a follow-up physician label problem to the KCR IT department. Good eye, Teresa!

SEER CODING QUESTIONS

Questions recently finalized on the SEER Inquiry System (SINQ) are shown below. These coding directions may help you with future abstracting questions.

Question 1: What is the CS Ext Code when there are two tumors in the brain, a 3.5 cm tumor in the parietal lobe and a 3.0 cm tumor in the occipital lobe. The left occipital lesion was removed revealing glioblastoma multiforme. The neurosurgeon signed the case out as multifocal glioblastoma multiforme.

Answer: *CS Extension code is 10 [confined to cerebral hemisphere]. Record the size of the largest lesion in CS Tumor Size. Both the occipital and parietal lobes are supratentorial and confined to the cerebral hemisphere with no mention of crossing midline or involvement of ventricles.*
(SINQ #2005-1052; CS Manual, Part 1I)

Question 2: How is CS Mets Eval coded when the metastatic site is confirmed by cytology? Example: Positive pleural effusion cytology for an ovary primary.

Answer: *Code CS Mets Eval for the example above 3 [path exam of metastatic tissue] assuming there has been no pre-treatment. Positive cytology is required for confirmation of pleural effusion for an ovarian primary.*
(SINQ #2005-1054; SEER Manual 2004, pgs C-516, C-517, {Appendix C})

Question 3: Behavior/Date of diagnosis--Lung: Is Pancoast tumor benign or malignant by definition? If the pancoast tumor was mentioned prior to definitive date of diagnosis (say from a lung biopsy), can we use that prior date as the date of diagnosis (back date)?

Discussion

Pancoast tumors are neoplasms of pulmonary origin located in the superior sulcus thus typically manifesting as superior sulcus syndrome.

Answer: *Yes, Pancoast tumor is by definition malignant. It is defined as a lung cancer in the uppermost segment of the lung that directly invades into the brachial plexus (nerve bundles) of the neck, causing pain. If a Pancoast tumor was identified on imaging prior to the biopsy, the date of diagnosis should be linked to the Pancoast tumor report.*
(SINQ #2005-1059)

Question 4: A case described as "most likely cancerous" is reportable, but what about a case described as "likely cancerous"?

Answer: *"Likely cancerous" is reportable. See the 2004 SEER Manual, page 4, note under 1.b. "Most likely" appears on the reportable list. "Likely" is a form of "Most likely."*
(SINQ #2005-1079; 2004 SEER Manual, pgs 4-5)

Question 5: Multiple primaries--Lymphoma: How many primaries should be reported when there is a Marginal Zone B-Cell Lymphoma (9699/3) diagnosed in 2000, and then a Diffuse Large B-Cell Type Lymphoma (9680/3) diagnosed in 2004? Please see discussion below.

Discussion

The Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases table indicates they are most likely "D" different disease processes. As any low grade lymphoma can transform, we suspect this represents a transformation (the clinician is considering this transformed).

Answer: *Report this case as one primary according to the physician's opinion. Code the histology as 9699/3 [marginal zone B-Cell lymphoma, NOS] and code the date of diagnosis as 2000.*
Code the physician's opinion regardless of whether or not it agrees with the Single Versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases table. Use the table when the physician does not state whether or not there is a new primary.
(SINQ #2005-1083; Singl vs Sbsq Prim Lymph & Hem [2/28/2001])