IN THE ABSTRACT

New Rules for a New Year of Data

Beginning with 2007 cancer cases, registrars across the country will be using a new set of rules to determine multiple primaries and histology codes. KCR trainers, Reita Pardee and Jan Michno, have participated in two national "Train the Trainer" workshops in Potomac MD in order to prepare for this transition. With site-specific rules in a new format, choosing the correct histology code and deciding how many primaries a patient has, should become more clear-cut.

Plan ahead for KCR Spring Training which is being offered in three (3) locations:

> Lexington (Crowne Plaza/Campbell House) March 29 and 30
> Elizabethtown (Hardin Memorial Hospital) April 12 and 13
> Madisonville (Regional Medical Center) May 3 and 4

Call or email Barbara Bray to confirm the date and site your registry chooses to attend. Barbara can be reached at (859)219-0773 x 281, or bbray@kcr.uky.edu. Registrars planning to attend the Lexington workshop are eligible for a special hotel rate of $99 plus tax. To obtain this rate, call the Crowne Plaza at (859)225-4281 **no later than** Tuesday, February 27, 2007. Be sure to mention your affiliation with the KCR Spring Training Workshop. Training will take place in the back of the Conference Center, where the Fall Workshop was held.

All attendees of these workshops must download and print a copy of the "2007 Multiple Primary and Histology Coding Rules" which can be found on the SEER website (www.seer.cancer.gov) under the heading "For Cancer Registrars". Manuals **are not** being provided by KCR or any of the national organizations this year. Print out your set of rules just before the meeting you have chosen to attend and bring it to the meeting with you. Because of the new topic and extensive rules, every cancer registrar in the state should plan on attending one of these sessions. There will be no "make-up session"!

Abstracting Bits and Pieces:

◊ The correct histology code for papillary carcinoma of thyroid and kidney is <u>8260</u>, *NOT 8050*. Be very careful when coding this histology.

◊ Code TS/Ext Eval on the basis of the how the <u>farthest extent</u> of the tumor was identified. A lung primary may be described as having a pleural effusion per CT chest. Bronchoscopy with biopsy may determine the histology. The Extension code would be 72, due to the (farthest extension) pleural effusion. How was the effusion seen (evaluated)? By CT scan, so the TS/Ext Eval code would come from the <u>scan</u>, code 0.

◊ Collaborative Staging, Part I (revised) was made available for registrars to download and use, beginning in December 2006. Revisions of Parts I and II should be used henceforth. Do not use the "old" versions while abstracting anymore.

◊ Back up your abstracting codes with documentation in text! Regional coordinators will be checking abstractors' text completeness on a revised 2006 report sheet. Age, sex, race, diagnosis date, topography, histology, grade, plus Collaborative Staging information are all being checked in regards to coding and text documentation.

CTR Exam Update

The Spring 2007 CTR exam will be given between March 3rd and 17th at Multiple Laser Grade Computer Testing, Inc. facilities. The Exam Handbook and Application can be downloaded from the website (www.ctrexam.org/exam/index.htm). NCRA members pay an exam fee of $225.00 and non-members are charged $325.00. An online exam prep is available for a fee at www.creducationcenter.org/

A CTR Exam Workshop will be held in Phoenix AZ on February 10-11, 2007. Sponsored by NCRA, the workshop fee is $260.00 for NCRA members and $295.00 for non-members.

The Fall 2007 Exam deadline is July 31, 2007. Testing in the fall will take place from September 15-29, 2007. The 2007 exam consists of an 80% closed book portion, divided into 25% Registry Organization & Operations, 35% Concepts of Abstracting Coding & Followup, and 20% Data Analysis & Interpretation. The 20% Open Book portion consists of Application of Coding & Staging Principles.

Did You Know?

- Subscribe online to the *NCI Cancer Bulletin*, a weekly electronic cancer news source covering research highlights, clinical trial information, and featured articles (www.cancer.gov/ncicancerbulletin).
- NCI and the National Human Genome Research Institute announced the first three sites to be studied in a pilot phase: Lung, Brain (Glioblastoma), and Ovary. Genome changes due to these cancers will be studied and mapped in a project entitled 'The Cancer Genome Atlas". Data will help researchers develop new tools for the diagnosis, treatment, and prevention of cancer.
- Fifty percent of your hospital's 2006 cancer cases should have been abstracted and entered into CPDMS by January. What is your timeliness?
- Many large hospitals in Kentucky are using "E-path" or are in the process of implementing this time-saving software. Do you review all of your pathology departments' reports for casefinding? E-path can save you much time and energy….Call Marilyn Wooten at KCR for more information about installing E-path at your hospital.

Calendar of Events

January 31, 2007 - CTR Exam Application Deadline

February 5-16, 2007 - NPCR Reabstracting & Casefinding Audit in KY

March 3-17, 2007 - CTR Exam Testing Period

March 29-30, 2007 - KCR Spring Training - Lexington

April 12-13, 2007 - KCR Spring Training - Elizabethtown

April 23-25, 2007 - NCRA Annual Conference - Las Vegas NV

May 3-4, 2007 - KCR Spring Training - Madisonville

People News

New Hires:	Kendra Garvin	Norton Healthcare, Louisville
	Amanda Zinner	Norton Healthcare, Louisville
	Karen Magsig	Jewish Hospital, Louisville
	Carole Miller	University of Louisville Hospital, Louisville
	Shelly Scheer	University of Louisville Hospital, Louisville
	Bernice Slone	Frankfort Regional Medical Center, Frankfort
	Teresa Thomas	Samaritan Hospital, Lexington
Resignations:	Sonja Blissett	Jewish Hospital, Louisville
	Kathy Sears	Jewish Hospital, Louisville
New CTRs:	Michelle Clark, CTR	Hardin Memorial Hospital, Elizabethtown
	Marie Hall, CTR	Jewish Hospital, Louisville
	Tracy Kay, CTR	St. Claire Medical Center, Morehead
	Rochelle Smith, CTR	University of Louisville/Brown Cancer Ctr, Louisville
	Vivian Wyatt, CTR	University of Louisville Hospital, Louisville
	Melinda Webb, CTR	King's Daughters Hospital, Ashland

ACoS-Approved Cancer Programs:

- Baptist Hospital East has received notice of full three-year approval following survey recently. Congratulations are extended to Marge Constan, Tina Harper, Terri Ganote, Nicole Catlett, Christine Lapina, and Donna Lamb.
- Owensboro Medical Health System was awarded full approval of its program, following survey in September. Kudos to JoAnn Murray, Brenda Priar, and Betty Lindsey.
- Kosair Children's Hospital received full approval of its cancer program this past fall. Congratulations are sent to Michele Hoskins, Alice Dzenitis, Wendy Drechsel, Natascha Lawson, and Rhonda Paul.
- King's Daughters Hospital has been awarded three-year approval of its cancer program. A round of applause is sent to Sherrie Halstead and Melinda Webb.
- Pikeville Methodist Hospital has received full three-year approval following their recent survey. Congratulations go out to Leisa Hopkins!

Golden Bug Award

Two categories of Golden Bug Award winners have been identified for the current edition of the newsletter. Winners in the "Follow-Up Mailing Labels" category include Marge Constan (Baptist Hospital East), Vivian Wyatt (University of Louisville Hospital), and Amy Tompkins (Saints Mary & Elizabeth Hospital). Winners in the "Patient Abstract Report" category include Kristie Kneebone (Murray-Calloway County Hospital) and Stacy Littlepage (Regional Medical Center of Hopkins County). Congratulations to all of our astute Golden Bug recipients!

SEER CODING QUESTIONS:

Review these recently finalized abstracting questions from the SEER Inquiry System (SINQ).

Question 1: **CS Extenion—Lymphoma: For a lymphoma case, can CS Ext be coded 80 based on imaging or operative findings when there is no positive statement of involvement? Please see Discussion.**

Discussion: Specifically, CS Ext code 80 includes nodular involvement of the lungs. The CT report for this patient states that the lungs are nodular. Is that enough to use code 80? Can the liver be coded as involved based on the operative findings?
Scenario: The patient was diagnosed with lymphoma. The CT showed pulmonary nodules. The pt had an exploratory laparotomy with a positive mesenteric LN bx and a positive ileocecectomy. The operative findings included a nodular liver. No staging was done by the oncologist and he has the pt on CHOP-R.

Answer: *Extension code 80 can be assigned based on imaging or operative findings as in the lymphoma case described above. The fact that this extension was not based on pathological evidence is captured in the evaluation code. Assign CS/TS Ext-Eval code 0 [No staging laparotomy done. No autopsy evidence used (clinical)].*
(SINQ #2006-1036; 2004 SEER Manual, pg C-703)

Question 2: **First course treatment/Chemotherapy: Are the agents used for chemoembolization coded as chemotherapy? Please see Discussion.**

Discussion: Example: Chemoembolization was performed with adriamycin and ethiodal mixture.

Answer: *Code as chemotherapy only when a chemotherapeutic agent is used, such as adriamycin. Do not automatically code chemoembolization as chemotherapy..*
(SINQ #2006-1054; 2004 SEER Manual, pgs 189-191)

Question 3: **CS Extension—Lymphoma: Is an enlarged spleen seen on CT coded as involved for lymphoma cases? Please see Discussion.**

Discussion: CT: Retroperitoneal and diffuse inguinal lymphadenopathy, enlarged spleen, bilat pleural effusions. No physician staging.

Answer: *Do not code spleen involvement when the only evidence is an enlarged spleen. When imaging is the only diagnostic tool (no biopsy or splenectomy), spleen involvement is based on the presence of nodules and not on enlargement. Splenic enlargement alone (by physical exam or imaging) is insufficient to support involvement of spleen..*
(SINQ #2006-1071; AJCC Cancer Stage Manual, pg 400—6th ed)

Question 4: **Ambiguous terminology: Is the word "consider" an ambiguous term, or should it just be viewed as a verb meaning "believe"? Please see Discussion.**

Discussion: For example, if a physician states that the tumor is considered to be malignant, is it reportable since it does not have any modifiers?
Or is it considered not to be reportable because "consider" is not on our list?

Comment: "Considered to be" is not a term noted on the ambiguous terms for case ascertainment in the 2004 SEER manual.
Effective 1/1/1998 and later:
Comparable with and compatible with were added to consistent with but those are the only ambiguous terms that begin with "c".

Answer: *A tumor considered to be malignant is reportable. "Considered to be" is an UNambiguous term.*
(SINQ #2006-1094; 2004 SEER Manual, pg 3)

SEER CODING QUESTIONS (*Continued*):

Question 5: **Reportability—Breast: Is this case reportable? It is just so unusual. Please see Discussion.**

Discussion: Final Diagnosis (2/15/06)
Specimen designated "left breast nipple biopsy, rule out Paget's disease":
    A. Positive for malignancy, favor poorly differentiated squamous carcinoma….
    B. Central erosion/ulceration and inflammatory response.
Then she underwent areolar resection with path results on 3/3/06:
Final Diagnosis
1. Excision left nipple and areola:
    A. Subareolar abscess formation, associated with foreign body granulomatous reaction to suture material.
    B. No histologic evidence of residual malignancy of nipple epidermis….

Answer: *Yes, this case is reportable. The primary site is C500 (nipple). There was a diagnosis of malignancy on 2/15/06: "Positive for malignancy." Even though no residual malignancy was found in the later specimen, that does not disprove the malignancy diagnosed on 2/15/06.*
(SINQ #2006-1119; 2004 SEER Manual, pg 1)

Melanoma Surgery Codes

Some registrars are confused when it comes to coding surgical procedures for melanomas. Surgery codes were revised nationally several years ago in order to accommodate software that only has space for only one surgery code. For abstractors who use such software, the surgical codes within the "30 range" were created. (In Kentucky - CPDMS allows for multiple surgical treatments per case.)

Because CPDMS allows more than one surgery to be coded, it is preferable to code each of the surgeries separately. This allows a more clear and accurate portrayal of the actual surgeries a patient undergoes, and the dates of each procedure are captured.

As an example, a patient had a reported "biopsy" of a melanoma on 10/15/06 in a doctor's office. He shows up at a surgeon's office the following week, and a wide excision is planned and undertaken on 11/1/06. The wide excision has a specimen size of 2.5 cm x 3.0 cm. The scar is in the very center of the specimen, and the final diagnosis shows "no residual melanoma". Create a surgery (27) for the 10/15/06 biopsy; since there was no residual on the second path report, this biopsy was "excisional" in nature. Then, create a second surgery (46) for the 11/1/06 wide excision. With the scar in the center, margins would be greater than 1 cm, but less than 2 cm. The disease-free start date would be 10/15/06.

This process provides KCR and other national agencies with a clearer picture of what happened with this patient surgically, than would a single "collapsed" code. It is our hope that coding melanoma surgeries is now clearer for you, and we can all code them consistently.