A Quarterly Newsletter from the Kentucky Cancer Registry
Large Hospital Edition January 2008

IN THE ABSTRACT

KCR Spring Training Scheduled

Spring Training is on the calendar once again in three Kentucky locations: Lexington, Madisonville, and Elizabethtown. Check the **Calendar of Events** for specific dates and sites. This one-day-per workshop event will feature updated practical use of the MP/H Manual. Contact Barbara Bray at KCR to register. Her phone # is 859-219-0773 x 281, or email her at bbray@kcr.uky.edu.

Did You Know?

- A new study conducted by researchers at the National Cancer Institute (NCI), Ohio State University, and the Liver Cancer Institute in China identified small molecules responsible for directing gene activity which can predict if liver cancer will spread. These molecules also can predict longer or shorter survival for patients - even those with disease in an early stage.
  (Hepatology, January 7, 2008).
- Researchers at Johns Hopkins University found that HPV exposure and infection are strong risk factors for the development of oropharyngeal cancer.
  (New England Journal of Medicine, May 20, 2007.)
- Cancer Incidence in Five Continents, Volume IX, was released in November 2007 by the International Association of Cancer Registries.
  Visit http://www.iacr.com.fr/ and click on "Publications".
- Learn more about HPV vaccines and cervical cancer on the NCI website.
- National Institutes of Health (NIH) researchers have found an error in brain-specific stem cell development that causes them to become "seeds" for glioblastoma multiforme. (Cancer Cell, January 2008.)

Abstracting Bits and Pieces:

◊ Commission on Cancer Staging Rules have changed for 2008! Approved programs are referred to the special "CoC Flash", sent on December 3, 2007, for the specifics.

◊ The next CPDMS.net update will incorporate a difference in timeliness calculations.

◊ Clarifications for MP/H Rules are available for downloading from the SEER website. Rules have not changed, but wording and explanations have changed.

◊ SEER will conduct a 2008 Reliability Study later this year, focusing on the use of MP/H Rules. After data from the study have been analyzed, rules *may* change.

◊ Batch-merge conflict resolutions should be called in to Frances Ross by the date scheduled for your monthly upload.

◊ Check your database for incomplete cases. These should be completed before your facility upload date each month.

People News

New Hires:	**Mary Ellen Ford**	**KCR, Non-Hospital Facility Abstractor**
	Mary Jo Mahoney	**Norton Healthcare, Louisville**
	Kevin Moore	**University of Louisville Hospital, Louisville**
	Amy Shepard	**King's Daughters Medical Center, Ashland**
	Vicky Stratton	**Frankfort Regional Medical Center, Frankfort**
Resignations:	**Kevin Moore**	**Norton Healthcare, Louisville**
	Jennifer Halsey	**University of Kentucky Hospital, Lexington**

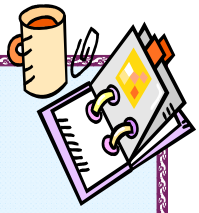
Golden Bug Award

Congratulations to Sharon Isaacs, our newest Golden Bug Award recipient! She identified a bug with the Key Change/Delete Report in CPDMS.net, where users could not view any key changes and/or deletes that were generated within the same day that the report was being run on. This has been fixed.

Also, congratulations to Bernice Slone (UK Medical Center), who has been nominated to receive a Golden Bug Award for her discovery of a problem in the data entry screen for TNM descriptor fields. Thank you for alerting the IT staff to this bug.

ACoS-Approved Cancer Programs:

Greenview Regional Hospital in Bowling Green was recently notified of its newly-approved status. Registrar Leslie Baas was pleased to report the Greenview Cancer Program received commendations in six areas. Congratulations!



Calendar of Events

January 31, 2008 - CTR Exam Application Deadline

February 19-21, 2008 - KCR Abstractor's Training, Lexington

March 6, 2008 - KCR Spring Training, Lexington (UK Samaritan)

March 7, 2008 - KCR Spring Training, Madisonville (Trover Tower)

March 13, 2008 - KCR Spring Training, Elizabethtown (Hardin Memorial)

March 1-15, 2008 - CTR Exam "Window"

April 7-11, 2008 - Cancer Registrars' Week

April 28-May 1, 2008 - NCRA Annual Conference, Minneapolis MN

CTR Exam Preparation Courses

Registrars who are planning to sit for the CTR exam this year may choose to attend an exam-prep class. The 2008 test is the first to include Multiple Primary and Histology Rules questions. Route 1 for eligibility has also changed this year. The following workshops are available for anyone interested.

- NCRA-sponsored CTR Exam Prep Workshop - February 9 & 10
  (Baltimore MD/Hampton Inn Camden Yards)
  This 2-day class will be led by instructors Donna Gress, RHIT, CTR and Louise Schuman, MA, CTR. All exam topics will be covered, and also included is an "Exam-Taking Tips" webinar, as well as access to an online study group. Go to the NCRA website to register. The cost is $360 for NCRA members and $395 for non-members.

- A. Fritz and Associates, LLC, will offer a CTR Prep Workshop in Reno NV on February 7-9, 2008. Visit www.afritz.org for contact information.

Coding Embolization

Three registry-governing agencies recently collaborated on directions in coding tumor embolization. The American College of Surgeons, National Program of Cancer Registries, and SEER sent out a memo regarding this joint effort on December 18, 2007. The categories and brief instructions are as follows:

1) Chemoembolization - tumor blood-flow is blocked by other means and then a chemotherapy drug(s) is injected into the tumor. This method allows a higher dose of chemo to directly involve the cancer for more time. It is sometimes used to treat liver primaries. Check SEER*Rx to see if the drug(s) used are truly chemotherapeutic agents. Once confirmed, code "01, 02, or 03" as indicated.
2) Radioembolization - tumor blood-flow is blocked by other means, and an injection of tiny radioactive beads or coils is directed into the tumor. Code "2" is used for radioactive implants. For the field "regional treatment modality", code "50" for brachytherapy using radioactive seeds/agents. An example of this would be Yttrium-90 microspheres used to treat liver cancer that is not surgically amenable. The microspheres physically block smaller blood vessels in the primary site, and they also give off radiation that kills cancer cells in the immediate area.
3) Other Therapy - tumor blood-flow is blocked by other chemicals and materials, such as alcohol or acrylic, not coded as chemotherapy drugs. These agents penetrate tiny tumor blood vessels, but nearby tissues are spared. Head and neck primaries may receive this type of treatment, which is coded "01" in the 'Other Therapy' field.
4) "Pre-surgical embolization of hypervascular tumors with particles, coils or alcohol" IS NOT CODED, per the memo from SEER! This type of embolization is performed so the subsequent resection is easier to perform.

NCRA Program Recognition

The NCRA Program Recognition Committee determined that **KCR's 21st Annual Advanced Cancer Registrars' Workshop** (Event No. 2007-138) supports **8.75 CE hours**. CTRs are advised to update the CE form accordingly.

CNS Quality Study

NPCR Feedback on 2004 Benign Brain and CNS Tumors

This was the first year for data collection of Benign Tumors. Results of the National Program of Cancer Registries' audit show coding problems in the area of CNS tumors. NPCR has compiled a lengthy report, which includes a set of guidelines that can be very helpful to abstractors. The guidelines, taken from the original report, are listed below. Keep a copy with your CNS book and notes for future reference.

- **NPCR Guideline**: Always use the **behavior code** listed in the ICD-O-3 unless otherwise directed by a pathologist.

- **NPCR Guideline**: Meningiomas are always coded to meninges (C70._) unless specifically directed otherwise by a pathologist.
  - ◊ Intraparenchymal meningiomas are **exceedingly rare**.
  - ◊ Meningioma can also occur as a tumor of the choroid plexus (C71.5 Brain) in **rare cases**.

- **NPCR Guideline: Nerve Sheath Tumors**
  - ◊ Malignant: all tumors are reportable. Always code to nerve of origin (**C47._** or **C72._**).
  - ◊ Nonmalignant: reportable <u>for intracranial segment of cranial nerves only</u>. Always code to the nerve of origin (**C72.2, C72.3, C72.4, or C72.5**).

- **NPCR Guideline: Germ cell tumors**: Intracranially, these tumors are usually located in the **pineal gland** (**C75.3**) and **suprasellar region** (**C71.9** Brain, NOS), and **posterior 3rd ventricle** (**C71.5**). Code to site of origin.
  - ◊ A **teratoma** (M908_) is always a germ cell tumor. It may be malignant or non-malignant. The only <u>nonmalignant</u> teratomas that are reportable are those occurring intracranially.

- **NPCR Guideline: Craniopharyngiomas** (M9350/1)
  - ◊ All craniopharyngiomas are non-malignant.
  - ◊ Very few of these tumors actually arise in the craniopharyngeal duct. Most are either suprasellar (**C71.9** Brain, NOS), or in the 3rd ventricle (**C71.5**).

- **NPCR Guideline: Choroid plexus tumors**
  - ◊ Located in the ventricular system.
  - ◊ Code to ventricle (**C71.5**) unless otherwise directed by a pathologist.

- **NPCR Guideline: Chordomas** (9370-9372) are malignant tumors so ALL chordomas are reportable. These tumors usually start in the bone at the back of the skull (**C41.0** bones of skull) or at the lower end of the spinal column (**C41.2** vertebral column). 35% occur at the base of the skull. Intracranially, the tumors occur at the clivus (bones of skull: **C41.0**), and occasionally in the parasellar and sellar area (**C71.9** Brain, NOS). All chordomas should be **coded to the bone of origin** unless otherwise directed by a pathologist.

SEER CODING QUESTIONS:

These SEER Inquiry System (SINQ) questions were finalized after our last newsletter. Please review as a means of continuing education.

Question 1: **MP/H Rules--Breast: MD states this is a bilateral breast cancer - one primary. Registrar feels this is two primaries. How many abstracts (primaries) does SEER require for this case? Please see discussion.**

Discussion: Patient has microcalcifications both breasts. Has bilateral mastectomy. Path report states Left breast multifocal DCIS predominantly micropapillary. Right breast two foci of DCIS micropapillary.

Answer: *There are two primaries in this case.*
Using the 2007 MP/H rules for breast, go to the multiple tumors module and start with Rule M4. Stop at Rule M7. Tumors on both sides (right and left) are multiple primaries.
Always use the 2007 Multiple Primary rules to determine the number of primaries.
Do not use the physician statement.
(SINQ #2007-1087; 2007 SEER Manual, pgs C691-692)

Question 2: **Type of Multiple Tumors--Lung: How do you code the Type of Multiple Tumor Reported as One Primary when only one lung tumor is biopsied? Please see discussion.**

Discussion: Rt lung with 4 tumor nodules in the upper lobe. Bx of one tumor is positive for moderately differentiated adenocarcinoma. No other work up.
Do we use code 40, since the biopsy of the tumor was invasive or do we use code 80 since we don't know the behavior of the other tumors?

Answer: *The best code to use in this case is 40 [multiple invasive]. For lung only, it is assumed that all of the tumors are the same histology and that all are invasive.*
(SINQ #2007-1088; 2007 SEER Manual, pgs 93-94)

Question 3: **Reportability--Brain and CNS: In addition to Schwannoma, are there additional types of benign tumors that arise in peripheral nerves along the spinal cord that are not reportable?**

Answer: *Reportability depends on the location of the tumor. Tumors in the following sites are reportable:*
C700 - C709
C710 - C719
C720 - C720
C751- C753
Benign and borderline tumors of the peripheral nerves (C47_), including peripheral nerves along the spinal cord, are not reportable.
(SINQ #2007-1093; 2007 SEER Manual, pg 2)

Question 4: **Histology--Lung: How is histology to be coded for a tumor that is best categorized as pleomorphic carcinoma, but the tumor shows multiple histologic components? Please see discussion.**

Discussion: Path diagnosis of lung tumor is pleomorphic carcinoma, with adenocarcinoma, squamous, clear cell, and spindle cell components. Path comment states: "While the majority of tumor displays usual adenocarcinoma-type features, elsewhere the tumor shows varying differentiation, including squamous, clear cell and spindle cell differentiation. Therefore the tumor is best categorized as pleomorphic carcinoma."
This tumor is best described by a non-specific histology. However, the MP/H Rules guide the abstractor to identify a more specific histology. If we work through the lung rules, would we end up using rule H7 and code the histology with the numerically highest ICD-O-3 code?

Answer: *Assign histology code 8022 [pleomorphic carcinoma] based on the pathologist's assessment and rule H3. He/she considered all of the histologic components and rendered a final diagnosis of pleomorphic carcinoma.*
"Components" is not a term indicative of a more specific histology. See note under rule H5.
(SINQ #2007-1099; 2007 SEER Manual, pgs C502, C529-530)

Question 5: **Reportability/Histology: Is the case below reportable? If so, what is the correct histology code? Please see discussion.**

Discussion: 08/13/2007 polypectomy final diagnosis: tubulovillous adenoma with severe epithelial atypia. Dx Comment (on same path).… atypia including focal cribiform glandular architecture (carcinoma in situ).

Answer: *This case is reportable as carcinoma in situ. The histology code is 8263/2 [adenocarcinoma in situ in a tubulovillous adenoma].*
According to our pathologist consultant, a "comment" in a path report is a part of the diagnosis - it often elaborates on or clarifies the diagnosis. Placing [carcinoma in situ] in the comment, even in parentheses, indicates that is the appropriate diagnosis for our purposes.
(SINQ #2007-1129; ICD-O-3)

Question 6: **Reportability/Primary Site--Brain and CNS: Is a chondroma, NOS or a chondroblastoma, NOS that occurs in an intracranial site or along the spinal cord reportable?**

Answer: *Chondroma, NOS or chondroblastoma, NOS occurring in intracranial sites or along the spinal cord are not reportable.*
Chondroma, NOS and chondroblastoma, NOS are benign tumors of the bone itself, not the intracranial contents.
(SINQ #2007-1092; ICD-O-3, WHO Class Bone Tumors, pgs 237-242)

Apparent or Inapparent?

Registrars, ever been coding a prostate cancer case and asked: "Is this clinically apparent or inapparent?" There is not a registrar anywhere who has not had this problem. The issue was where to look for help in a situation like this. The good news is there is actually clarification for determining whether a prostate cancer is clinically apparent versus inapparent coming with the new Collaborative Staging Manual.

When the original version of Collaborative Staging was introduced, there was confusion and misunderstanding surrounding how to handle clinical information, mainly digital rectal exam (DRE) findings, when trying to decide if a prostate cancer was clinically inapparent versus clinically apparent. In the previous SEER Extent of Disease Manual, registrars were given guidelines to use to decide in situations like these. The original version of Collaborative Staging did not give registrars these clear-cut guidelines and registrars were left to their own devices when considering documented clinical information. Subsequent versions of the CS Manual, over the last couple of years, have not offered registrars any guidelines for assigning clinical CS Extension.

The new CS version, 01.04.00, has added clarifications about determining whether a prostate case is clinically apparent versus inapparent. Simply, the notes under the prostate schema in the new CS version state the physician determines whether a prostate cancer is apparent or inapparent. He must document the DRE as normal or abnormal by dictating/recording it in the medical record or by marking the staging form. This particular point was reiterated by Donna Gress, AJCC Technical Specialist, during a recent ACoS web conference entitled, "Collaborative Staging: Staying on Top of the Latest Changes" held on January 15, 2008.

What does this mean for registrars? No more guessing. This statement takes the guesswork out of assigning clinical CS Extension for prostate cases. Registrars are no longer required to sift though rules and manuals trying to decide if the terminology used to describe the DRE makes the case clinically apparent or inapparent. If the physician states the DRE is normal or assigns cT1, then the prostate cancer is clinically inapparent. If the physician states the DRE is abnormal or assigns cT2, then the prostate cancer is clinically apparent. When no physician statement about clinically apparent or inapparent is documented, then the registrar will assign CS Extension code 30, which correlates to cT2NOS.

Now when the question of clinically apparent or inapparent comes up during the abstracting process, the registrar has to ask another question-"What does the physician say about the status of this prostate cancer?" There is always an answer to this question and the registrar can assign the CS Extension code based on the answer.

**Please remember, these clarifications are coming in the new CS version and will not be implemented in Kentucky and CPDMS.net until March 2008. Until that time, please, continue to use CS Version 01.03.00 with the prostate notes as they are currently written.