A Quarterly Newsletter from the Kentucky Cancer Registry

In The Abstract

LARGE HOSPITAL EDITION NOVEMBER 2009

INSIDE THIS ISSUE:

2009 Fall Workshop in Retrospect

KCR's annual Fall Conference, held this year at Embassy Suites Louisville, was once again a resounding success. Physicians and speakers loaded us down with information on Head & Neck tumors, current radiotherapy innovations, and Leukemia & Lymphomas. Updated CPDMS.net capabilities and plans were presented. Changes for diagnosis year 2010, including CSv2, Commission on Cancer new data items, and new SEER hematopoietic multiple primary rules were summarily reviewed. And, to help registrars acknowledge and prepare for these changes, the audience was treated to a first-class relaxation therapy experience. All in all, not a bad way to earn 9.75 CE hours!

Abstracting Bits & Pieces

- Coding "tomotherapy": A recent clarification with I&R over how to code this form of radiation therapy in the regional treatment modality field gives us current specific directions. Tomotherapy is a form of IMRT, and FORDS instructs us to use code '31.' (SEER does not collect detailed radiation information that is specified by FORDS.) When coding radiation therapy, refer to the more detailed FORDS directions and use code '31.' (I&R transaction ID 46263/Reita Pardee)
- When KCR asks hospital registrars to fix a social security number in their database, careful background detective work has already taken place. KCR linkages with the Social Security Administration and Medicare databases should support your confidence level in making the change!
- The recent statewide recoding audit on the 2nd half of year-2007 cases produced an average 96% accuracy rate. Congratulations to all!
- Get prepared to undertake new Collaborative Stage codes in 2010 by viewing NCRA or NAACCR webinars, ordering and previewing new manuals, and attending free-of-charge KCR Spring Training presentations.

People News

New Hires:

Talisa Lewis-Best	Norton HealthCare - Louisville

New CTRs:

Sarah Campbell, CTR	Owensboro Medical Health System - Owensboro
Sue Schneider, CTR	King's Daughters Medical Center - Ashland
Lisa Witt, CTR	Kentucky Cancer Registry - Lexington

Promotion: **Rachel Maynard** has been promoted to the East NHF, Death Clearance, and State Data Exchange Coordinator position at KCR. Previously, Rachel worked with West NHF, Dermatology & Urology path lab cases.

Promotion: **Lisa Witt** has recently accepted the position of Epath Coordinator for KCR. Her duties will include maintaining current Epath installations and helping with new installations, among other responsibilities. She will soon be contacting registries that already have Epath to discuss any questions or concerns that they may have, such as training needs and quality improvement. She will also be contacting registries that do not currently have Epath to discuss plans for future installation. Epath is becoming a crucial part of efficient cancer registration, so we expect to keep Lisa very busy. Please feel free to contact her at 859-219-0773 x284, or at lwitt@kcr.uky.edu.

ACoS Approved Programs

Norton HealthCare received full 3-year accreditation with commendation for their May 2009 survey. Congratulations to Barbara O'Hara, CTR and the entire Norton HealthCare registry!

Golden Bug Award

Congratulations to the latest Golden Bug winner - Marge Constan, CTR (Baptist Hospital East, Louisville). Marge discovered a CP3R report error showing stage group T1c, an impossible stage group! KCR appreciates your input whenever you spot a software bug.

Did You Know?

- Beginning in 2010, the CoC plans to "go green." Hospitals due for survey will be able to upload electronic policies, minutes and studies instead of copying and mailing large paper files. (CoC *Flash* 8/09)
- NAACCR Collaborative Stage Version 2 webinars are available for viewing by Kentucky hospital registrars. Visit the KCR website for more details.
- AJCC 7th Edition Staging Manuals are ready for purchase! The regular manual containing staging forms costs $64.95 (http://www.springer.com/978-0-387-88440-0). The thick pocket-sized handbook (without staging forms) costs $49.95 (http://www.springer.com/978-0-387-88442-4). (CoC *Flash* 9/09)
- The CSv2 manual will be available electronically and at no charge in early January 2010. Abstractors who prefer paper manuals can go to the NCRA website (www.ncra-usa.org) and pre-order a hard copy that comes in a 3-ring binder. Cost: $114 (NCRA member) or $154 (non-member). This offer is available as a "pre-order only." (NCRA website 10/29/09)
- A new cancer gene was discovered recently by Swedish researchers. The type of cancer caused by this gene, adenoid cystic carcinoma, is most often found in the head and neck and in the female breast. Researchers showed that 100% of the tumors they tested contained the gene. (Science Daily, 10/14/09)

KY Cancer Liaison Physician Wins Outstanding Performance Award

Julie McCay, MD, FCAP (Medical Center at Bowling Green) has received a Liaison Outstanding Performance Award for service in 2008. According to the Commission on Cancer, physicians were nominated for contributions in these areas: improving quality of care, contributing to accreditation status, strengthening the cancer program, demonstrating cancer control leadership, and serving as champion and role model for staff. Congratulations are extended to Dr. McCay for her exemplary service in these areas!

MP/H Rule Coding Clarification - LUNG

A single tumor in each lung is multiple primaries, according to rule M6 in the Lung Chapter of the Multiple Primary & Histology Coding Rules. The note underneath this rule states: "When there is a single tumor in each lung, abstract as multiple primaries unless stated or proven to be metastatic." However, SEER's "Beyond the Basics" powerpoint, presented at the 2007 KCR Fall Workshop, clarified that the statement should read "…unless **proven** to be metastatic."
Remove "…stated or…" from the M6 note in your MP/H Lung Chapter. The rule remains the same, but the wording will be updated when the MP/H revisions are published.

Up-and-Coming CTR Exam-Prep Activities

- **CTR Exam Prep Workshop: 1/30-31/10 Baltimore, MD**
  This two-day NCRA-sponsored workshop will be presented by Donna Gress, RHIT, CTR and Louise Schuman, MA, CTR. Registry organization, abstracting, coding, follow-up, MPH rules and more will be covered. Registration is $360 for NCRA members. Register online at the NCRA website by 1/15/10. This workshop is NOT for beginners! Location: Hampton Inn at Camden Yards.

- **Exam Prep Workshop: 1/28-30/10 Reno, NV**
  This tentatively planned workshop will be presented by April Fritz and colleagues. Visit www.afritz.org for the latest details.

- **CTR Exam Prep Webinars available through NCRA:**
  02/11/10 @ 2:00pm - "Computers"
  02/25/10 @ 2:00pm - "Statistics"
  03/04/10 @ 2:00pm - "Exam Tips"
  Register online for these webinars which are delivered via your computer desktop. Cost is $50 each (NCRA members) or $75 each (non-members). Register for all 3 and receive a 20% discount.

KCR 2010 Spring Training Schedule

March 25 & 26 - "CSv2" - Crowne Plaza Hotel, Lexington
April 1 & 2 - "CSv2" - Trover Tower, Madisonville
April 6 - "Hematopoietics & Other Changes" - Crowne Plaza, Lexington
April 8 & 9 - "CSv2" - Hardin Memorial Hospital, Elizabethtown
April 28 - "Hematopoietics & Other Changes" - Hardin Memorial, Elizabethtown
April 29 - "Hematopoietics & Other Changes" - Trover Tower, Madisonville

Calendar of Events

November 26-27, 2009 - Thanksgiving Holiday, KCR Office Closed
December 3, 2009 - NCRA CSv2 "Head & Neck" Webinar @ KCR
December 25, '09/January 1, '10 - UK Winter Holidays, KCR Office Closed
December 31, 2009 - CTR Odd-Year Cycle Ends
January 7, 2010 - NCRA CSv2 "Lymphoma/Hematopoietics" Webinar @ KCR
January 21, 2010 - NCRA CSv2 "Skin" Webinar @ KCR
January 31, 2010 - Spring CTR Exam Registration Deadline

When IS Neurofibromatosis Reportable?

The current ICD-O-3 classification lists a code for neurofibromatosis, NOS – 9540/1. There are two types of this hereditary disease, Neurofibromatosis Type I (NF1) and Neurofibromatosis Type II (NF2). During benign brain and CNS tumor training in 2004, registrars were instructed to list a patient's history of neurofibromatosis in text whenever a patient with a benign CNS tumor who also expressed this condition was abstracted. Since the 2004 training, several questions concerning NF1 & NF2 have been submitted to the SEER Inquiry System. An update and clarification is presented in this article.

NF1, also known as von Recklinghausen's disease and Elephant Man's disease, is usually characterized by skin discolorations, multiple subcutaneous lesions, and bone deformities. This type of neurofibromatosis usually presents peripherally to the CNS and as such is not reportable to tumor registries. The gene for NF1 has been located on chromosome 17, and research is ongoing.

NF2 is much less common than NF1. This form is more closely associated with tumors in the central nervous system. For example, NF2 patients develop bilateral acoustic neuromas, benign reportable tumors of the 8th cranial nerves. A more current name for these tumors is "vestibular schwannomas." Because they arise from the 8th cranial nerves, these tumors are reportable. (Benign schwannomas arising from peripheral nerves are NOT reportable.) Research continues on NF2, and the gene has been found on human chromosome 22.

The primary question becomes, when does the NF itself become reportable? SINQ question #2008-1126 addresses one such situation. In this scenario, a young patient with a history of NF1 presents with an MRI showing an optic glioma and stigmata ("…heterogeneous high T2 signal in the middle cerebellar peduncles…") of neurofibromatosis type I. Another MRI several days later showed a new mass suspicious for glioma in the hypothalamus. The questioner wondered how many cases should be abstracted for this patient?

SEER responded that neurofibromatosis is accessioned "…when there is CNS tumor – a glioma or some other intracranial/intraspinal tumor, OR one of the 'stigmata' on MRI or some other CNS study." Registrars are not to abstract cases showing peripheral nerve involvement only. Neurofibromatosis is only reported once per patient. Other neoplasms of the CNS are to be abstracted separately. For the cases in study, sequence 1 is neurofibromatosis (C72.9, 9540/1); sequence 2 is optic glioma (C72.3, 9421/3 [*per SEER, optic gliomas associated with neurofibromatosis are coded as pilocytic astrocytomas]); sequence 3 is hypothalamus glioma (C71.0, 9380/0).

In retrospect, every neurofibromatosis is not related to a benign CNS tumor! Abstract NF only when it is mentioned by a physician and seen on a CNS radiology report. This is a new concept in our benign CNS casefinding "bag of tricks." No additional benign CNS training or updates have been scheduled by the CDC, original sponsor of the 2004 training and Benign Brain Book. Please forward any future questions in this regard to your KCR regional coordinator.

(Information for this article was found on the SEER, Cleveland Clinic Neuroscience Center, and National Institutes of Health websites.)

SEER Coding Questions

The following SINQ items were finalized recently. Please review as an additional form of ongoing registry education:

Question 1: MP/H Rules - Lung: What is the diagnosis date, diagnostic confirmation and histology for the left lung mass? Scenario: PET shows a 3 cm mass in the left lung and a 2.9 cm mass in the right lung. No reportable terminology in PET. The right mass is biopsied and shows adenoCa. The left mass is not biopsied. Based on rule M6, this should be reported as two primaries. No additional information in medical record; pt expired.

Answer: *For date of diagnosis, use the date of the PET scan for both primaries. For the left tumor, assign diagnostic confirmation code 8 [Clinical diagnosis only] and assign histology code 8000/3 [malignant neoplasm]. The left lung mass is reported as a separate primary because there is one tumor in each lung. According to Rule M6, when there is one tumor in the left lung and one tumor in the right lung, each tumor is a separate primary. Tumor and mass are equivalent terms for purposes of the multiple primary rules.*
(SINQ #2009-1092; 2007 SEER Manual, pg C-496)

Question 2: Reportability - Are squamous cell carcinomas arising in a condyloma of the rectum reportable or should we assume that the site is skin of anus or perianal and not reportable?

Answer: *Squamous cell carcinoma arising in a rectal condyloma is reportable. Do not assume the site is skin of anus or perianal.*
(SINQ #2009-1094; 2007 SEER Manual, pg 1)

Question 3: MP/H Rules/Histology: Final diagnosis from a partial vulvectomy says "vulvar intraepithelial neoplasia III, basaloid type." Is this VIN III (8077/2) or basaloid squamous cell carcinoma (8083 and change the behavior code from 3 to 2)? Which Histology rule applies? It seems to me that H4 and H6 both lead to 8083.

Answer: *Assign 8077/2 [Squamous intraepithelial neoplasia, grade III] for VIN III diagnoses, regardless of the type. According to the WHO Classification of Tumours (pg 319), "VIN is predominantly of the warty or basaloid types…" Use the multiple tumors module to determine the histology code for VIN. Rule H21 applies.*
(SINQ #2009-1098; 2007 SEER Manual, pg C-1066; WHO Class of Female Gen Organ, pg 319, note 2003)

Question 4: MP/H Rules/Histology - Melanoma: Path: Melanoma in situ, lentiginous type, skin rt lower leg. Is this the same as acral lentiginous melanoma (8744)? To code 8744, do we specifically have to see the word "acral" lentiginous melanoma? Please see discussion.

Discussion: In researching this, acral lentiginous melanoma is observed on the palms, soles and under the nails.

Answer: *Assign 8742/2 [lentigo maligna] to "melanoma in situ, lentiginous type." Acral lentiginous melanoma is not the same as melanoma, lentiginous type. "Acral lentiginous melanoma," 8744, should be used only if the report states acral lentiginous melanoma or malignant melanoma, acral lentiginous type. Acral lentiginous melanoma most often occurs on the soles of the feet or the palms of the hands.*
(SINQ #2009-1100; 2007 SEER Manual, pg C-567; ICD-O-3)

Question 5: Reportability/Ambiguous Terminology - Prostate: Text from prostate biopsy states "highly suspicious for but not diagnostic of adenocarcinoma, suggest another biopsy." Is this case reportable?

Answer: *Do not report."Not diagnostic of" means that while the pathologist is seeing some features that resemble cancer, there are not enough features to feel comfortable making an unquestionable diagnosis. Watch for another biopsy of the patient in the next 3-6 months. The statement "not diagnostic of" overrules the "highly suspicious" statement.*
(SINQ #2009-1103; 2007 SEER Manual, pg 3)

Question 6: MP/H rules/Histology - Esophagus: Biopsy of esophagus – path report states "adenocarcinoma, intestinal type." There is no evidence of a gastric tumor in scans or EGD. There is a rule for colon to disregard "intestinal type" and code to adenocarcinoma (8140) but no rule for esophagus. How should histology for this esophageal case be coded?

Answer: *Follow MP/H Other Sites Rule H11 and code 8144/3 [Adenocarcinoma, intestinal type]. Adenocarcinoma, intestinal type, is called that because it resembles the normal pattern of adenocarcinoma seen in the large intestines. It is not an indication of the location of the adenocarcinoma. We find that it is not uncommon in the sinuses, stomach, lungs, cervix, and many other organs.*
(SINQ #2009-1104; 2007 SEER Manual, pg C-1064)