A Quarterly Newsletter from the Kentucky Cancer Registry

In The Abstract

LARGE HOSPITAL EDITION SEPTEMBER 2010

INSIDE THIS ISSUE:

2010 Fall Workshop ~ A Success

KCR's 24th Annual Fall Workshop entitled "Extreme Registry Makeover" earned rave reviews again this year! Held at Embassy Suites in Lexington, physician-speakers covered the topics of tumor markers and GYN cancers. Attendees enjoyed the teaching expertise of April Fritz, who just returned from training in Singapore, Malaysia, for this latest Advanced Cancer Registrars' Workshop. April led Kentucky registrars through anatomy and CSv2 coding schemas for Lung, GYN, and Breast primaries. In addition, difficult coding questions that had been submitted prior to the workshop were addressed and answered on Day #2.

The 2010 Judith Ann Cook Award for excellence in data quality was presented to Kimberly Ratliff from the University of Kentucky Medical Center cancer registry. Kim also participated in a workshop segment on improving communications within a hospital registry. Sheena Batts presented a segment featuring patient care studies.

Frances Ross and Dr. Thomas Tucker discussed "Studies Using KCR Data." The importance of collecting complete treatment information and how registry data has impacted colorectal screening in Kentucky were highlighted. Eric Durbin rounded out the program with a discussion on life after 2010 in CPDMS.net.

Fall Workshop CE Hours

The NCRA Program Recognition Committee has announced that the recent KCR 24th Annual Advanced Cancer Registrars' Workshop supports the requested **9 CE hours**. This workshop has been assigned **Event Number 2010-119**. CTRs must supply this information when providing CE information for biannual credential renewal.

People News

New Hires:

Lisa Walker	VA Medical Center, Louisville
Donna Warwick	Norton Healthcare, Louisville
Marcia Withers	Jewish Hospital, Louisville

Resignations:

Edie Moore	Pikeville Medical Center, Pikeville
Shannon Schawe	St. Elizabeth Healthcare, Edgewood

New CTRs:

Michael Anderson, CTR	St. Joseph Hospital, Lexington
Marynell Jenkins, CTR	KCR Regional Abstract Coordinator
Vicki LaRue, CTR	St. Joseph Hospital, Lexington
Mary Jo Mahoney, CTR	Norton Healthcare, Louisville
Rachel Maynard, CTR	KCR Regional Abstract Coordinator

ACoS Approved Programs

- Western Baptist Hospital received renewal of 3 year accreditation plus 8 of 8 commendations, making them eligible for the Outstanding Achievement Award. Recipients of the OAA will be notified in February 2011. Congratulations to Donna Schmidt, Julie Finke, and Betty Copeland!
- Medical Center at Bowling Green received notice of 3 year re-approval and 6 commendations following their most recent cancer program survey. Congratulations are extended to Jana Thornton, Paula Alford, and Laura Cook.

Golden Bug Award

Freida Herald (Central Baptist Hospital, Lexington) wins a Golden Bug Award for finding a bug in the NAACCR Therapy calculation for hormone therapy medically contraindicated that came out as "hormone therapy refused." Sarah Campbell (Owensboro Medical Health System) tested the 2010 software and found bugs prior to the statewide application. Thank you both for assisting our IT department in refining the CPDMS.net "product"!

Frances Ross Receives NAACCR Award

At the North American Association of Central Cancer Registries (NAACCR) annual meeting held in Quebec this June, our own Frances Ross was presented the **Constance L. Percy Award for Distinguished Service**. According to a July press release, this award "recognizes individuals who have contributed exceptional volunteer service to NAACCR during the past 12 months, or sustaining, current, and long-term contributions to the organization." Frances' participation on NAACCR committees, Board of Directors, co-chair of original multiple primary rules evaluation, and help in organizing the first Death Clearance Workshop, among other achievements, were listed as contributing factors in her nomination for this honor. Congratulations, Frances!
(*NAACCR website, press release 7/1/10*)

CoC 2010 Cancer Liaison Physician Award Winner

The Commission on Cancer announced its 2010 Outstanding Cancer Liaison Physicians in the August 31 edition of the "CoC Flash." Included in this list of extraordinary liaisons is one known to many Louisville-area registrars – Dr. Robert Martin of the Norton Cancer Institute and the University of Louisville. To be selected for this award, liaisons must excel in multiple areas, including helping with the accreditation status, providing cancer control leadership, acting as role model for staff, and improving quality of care. We join the cancer community in saluting Dr. Martin on this latest in a long list of achievements!

Robert Martin, MD, PhD, FACS

- Director, Division of Surgical Oncology
- Director of the Upper GI and HPB Multi-Disciplinary Clinic
- Academic Advisory Dean
- Associate Professor of Surgery
- University of Louisville
- CoC Liaison Physician, Norton Cancer Institute Network Cancer Program
- Medical Director, GI Surgical Cancer Unit, Norton Healthcare

Calendar of Events

September 11-25 - CTR Exam Window
October 2010 - National Breast Cancer Awareness Month
October 7, 2010 - NAACCR Webinar: Endometrium
November 4, 2010 - NAACCR Webinar: Hematopoietics
November 25-26, 2010 - Thanksgiving Holiday, KCR Office Closed
December 2, 2010 - NAACCR Webinar: Liver
December 25-January 2 - UK Winter Holiday, KCR Office Closed
January 6, 2011 - NAACCR Webinar: Brain

Surgical Approach to Primary Site Revised

Shortly after publication of the June 2010 "In The Abstract," we were made aware of another revision to the Surgical Approach field. Code number "3" has been designated now for endoscopic approach. The updated codes and descriptions were recently added to the online KCR Abstractor's Manual, and the complete surgical approach coding options are also shown below for your convenience:

Code	Definition
0	**No surgical procedure of primary site <u>at this facility</u>**; diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic
4	Endoscopic converted to open
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

2010 Brain Surgery Code Updates

The FORDS 2010 manual contains new and updated brain surgery codes. These codes can be found in Appendix B of the FORDS 2010 online manual. SEER surgery codes have not been revised for 2010, so abstractors are being instructed to follow only the latest FORDS 2010 codes. Both descriptions and codes have been updated by FORDS in an attempt to further clarify the appropriate selections for treatment coding. Below are some of the highlights:

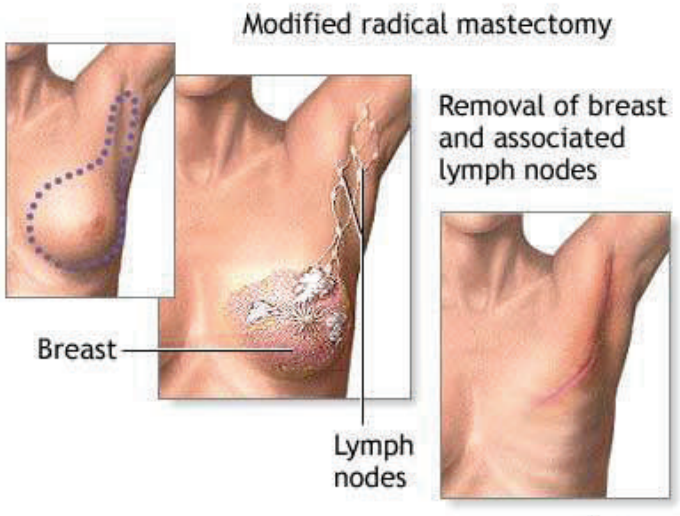
"Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields."

New codes:
- 21 Subtotal resection of tumor, lesion or mass in brain
- 22 Resection of tumor of spinal cord or nerve
- 30 Radical, total, gross resection of tumor, lesion or mass in brain

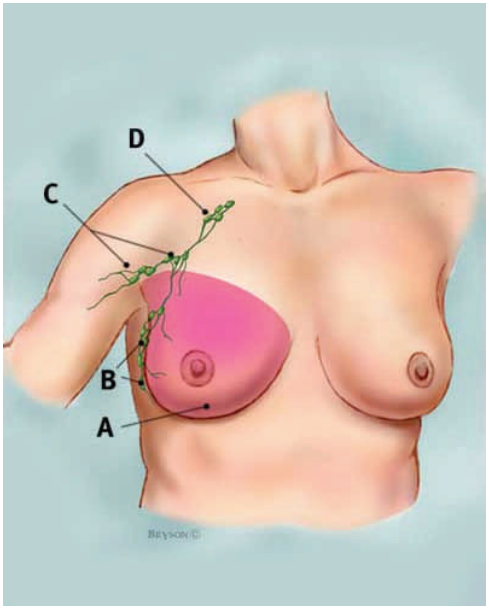
When coding CNS surgeries for 2010 cases, remember to refer to the 2010 FORDS Manual surgery codes.

Important Breast Surgery Coding Re-Directions

CPDMS.net and the CPDMS Abstractor's Manual currently contain links in Appendix G to two sets of surgery codes: the FORDS surgery codes and the SEER surgery codes. Please use only the FORDS surgery codes, which is the 2010 updated version. The SEER codes and notes are outdated and could lead to a possible miscode, for example the SEER note regarding axillary lymph nodes for code (41) Total Mastectomy, might lead to code (51) Modified Radical Mastectomy (MRM), which would be incorrect. Please code surgeries based on the operative report containing the physician's statement of the procedure performed. A MRM is a more extensive surgery and resection of the axillary contents would be clearly stated in an operative report. The CPDMS link to the SEER surgery codes will be removed.



"Simple" or "total" mastectomy



Simple or total mastectomy concentrates on the breast tissue itself:

- The surgeon removes the entire breast.
- The surgeon does not perform axillary lymph node dissection (removal of lymph nodes in the underarm area). Sometimes, however, lymph nodes are occasionally removed because they happen to be located within the breast tissue taken during surgery.
- No muscles are removed from beneath the breast.

Searching for the Standard of Care...

The Breast and Colorectal cancer site outcomes are currently being analyzed nationally as noted by the six measures of the CoC Program Practice Profile reports. Complete and precise documentation ensures reliability of the data along with accurately reflecting the quality of care our patients are receiving. Being aware of the Standard of Care (expected treatment) for these sites enables us to capture the expected treatments or document in text the consultants, referrals, or reason the treatment was not given.
The following is a list of the current cancer site measures with the standard of care:
Loco-regional invasive Breast cancer= pT1-pT3, pN0-pN1

BREAST

Breast conserving therapy, AJCC Stage I, II, III= (**breast irradiation within 1 year of diagnosis**) **RX=S-R**

- tumor greater than 10mm, hormone receptor Negative=**S-C-R**
- tumor greater than 10mm, hormone receptor Positive=**S-C-R-H**

Hormone receptor negative Breast tumors greater than 10mm, no distant mets= (**combination chemotherapy considered or administered within 4 months of diagnosis**)

- Lumpectomy=**S-C-R**
- Mastectomy=pT1c-T2, N0, Negative Margins=**S-C**
  PT1c-T3 close margins, positive margins, or positive nodes=**S-C-R**

Hormone receptor positive Breast tumors greater than 10mm, no distant mets= **(Tamoxifen or an aromatase inhibitor considered or administered within 1 year of diagnosis**)

- Lumpectomy=**S-C-R-H**
- Mastectomy=pT1c-T2, N0, Negative Margins=**S-C-H**
  PT1c-T3 close margins, positive margins, or positive nodes=**S-C-R-H**

COLON

Colon Cancer Lymph node positive-(**Adjuvant chemotherapy is considered or administered within 4 months of diagnosis.**) **RX=S-C**

- T4 tumors **=S-C-R**

Colon Cancer (**At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer**.)

RECTUM

Rectal Cancer, Stage III or AJCC T4N0M0 (**Radiation therapy is considered or administered within 6 months of diagnosis post surgical resection.**) **RX= S-R–C**

Did You Know?

- The Centers for Disease Control (CDC) offers over 100 "Health-e-Cards" for sending to friends and family. Several of the electronic cards feature cancer. Visit the website to select your free e-cards today!
- "Survey Savvy" is on the ACoS calendar for March 3-4, 2011 in Chicago. Registration is $600 and the nightly hotel rate is $149.
- Remember to report CE Hours (20 minimum) to NCRA by January 31, 2011 if your CTR cycle ends on 12/31/10.
- A new committee has been created to coordinate research on environmental and genetic factors in relation to breast cancer. The first meeting is set for Sept 30/Oct 1. (NCI website 8/16/10)
- A large research study has shown that prophylactic breast and ovarian surgery is effective in reducing risks of these types of cancer in women with inherited BRCA1 or BRCA2 genes. Results were just published in the September 1 issue of JAMA. ("Cancer Research Highlights," NCI website 9/7/10)

2011 NAACCR ANNUAL CONFERENCE

Host City: LOUISVILLE, KY

HYATT REGENCY HOTEL

June 18-25, 2011

SEER Coding Questions

Review these newly finalized SINQ coding questions for ongoing education:

Question 1: Reportability: Is this benign tumor reportable based on metastasis to a regional lymph node? See Discussion.

Discussion: "Periampullary duodenum, resection: Gangliocytic paraganglioma, with metastasis to one large periduodenal lymph node. Six other small lymph nodes negative. Comment: The primary tumor in the duodenum is made up [of] mainly endocrine cell component. This component appears to have metastasized to a periduodenal lymph node."

Answer: *This neoplasm is reportable because it is malignant as proven by the lymph node metastases. Code the behavior as malignant (/3) when there are lymph node metastases.*
(SINQ #2010-0011, last updated 07/01/10; 2007 SEER Manual, pg 1)

Question 2: Reportability - Lymphoma: Should we abstract a case of in situ follicular lymphoma? See Discussion.

Discussion: Patient with mesenteric lymphadenopathy had a biopsy. Consult supports original path findings: The histologic and immunophenotypic findings represent what has been referred to in the literature as "in situ follicular lymphoma." Oncology assessment says: At this point patient has no other obvious evidence of other disease: no heaptospleno-megaly…no peripheral adenopathy…no significant abnormalities on PET scan to suggest active lymphoma. No treatment planned at this time, just monitoring. Diagnosis date is in Dec. 2008.

Answer: *Do not report in situ lymphoma at this time. Currently, lymphoma cannot be reported with a behavior code of in situ (/2) and it would be incorrect to abstract in situ lymphoma as a /3. We will address the reportability criteria and edits to determine if and how these cases should be reported in the future.*
(SINQ #2010-0013, last updated 07/15/10; 2007 SEER Manual, pg 1, ICD-O-3)

Question 3: MP/H Rules - Multiple Primaries - Prostate: This is a MP/H question for an unusual prostate case. See Discussion. There is no information of a history of a squamous carcinoma in the urinary system that could have involved the prostatic urethra, so the MPH rules would make this a second primary with the histology of 8560/3 adenosquamous carcinoma. Is this correct?

Discussion: History: Patient was diagnosed many years ago with adenocarcinoma of the prostate and treated with hormonal and radiation therapy. The patient recently underwent a TURP and now is found to have adenosquamous carcinoma of the prostate. The Pathology comment states squamous carcinoma of the prostate is rare and is often associated with a history of hormonal or radiation therapy.

Answer: *Based on the limited information available for this unusual case, abstract a second prostate primary and code the histology as adenosquamous carcinoma. Rule M3 does not apply in this case. Apply rule M10.*
(SINQ #2010-0017, last updated 07/15/10; 2007 SEER Manual, Appendix C, pg C-1060)

Question 4: Histology - Brain & CNS: What is the correct histology and behavior code for Cystic Glioma?

Answer: *Code the histology 9380/3 [Malignant glioma; Glioma, NOS]. There is no specific code for cystic glioma.*
(SINQ #2010-0020, last updated 07/29/10; 2007 SEER Manual, Appendix C, pg C-909)

Question 5: Reportability: Is any AIN III reportable or is it not reportable if it looks like the site is skin? See Discussion.

Discussion: Physical exam states patient has a suspicious area of anal skin. Operative findings show a raised, suspicious lesion in the rt perianal region. Our interpretation of the primary site would be skin and therefore not reportable. However, path shows AIN III/SCCa with focal areas suspicious for microinvasion. SINQ #20041056 states that AIN III is reportable.

Answer: *AIN III of the anus or anal canal (C210-C211) is reportable. AIN III (8077) arising in perianal skin (C445) is not reportable.*
(SINQ #2010-0027, last updated 08/09/10; 2007 SEER Manual, pg 1)