

INSIDE THIS ISSUE:

KCR Spring Training	1
KCR Fall Workshop	1
CTR Exam Readiness Webinar Series	1
People News	2
Golden Bug Award	2
ACoS Approved Programs	2
Breast Cancer Center Accreditation	2
Norton Cancer Institute Named NCI-Designated Center	3
Outstanding Achievement Award	3
Did You Know?	3
Two New Data Fields Required by KCR	4
Calendar of Events	4
Bits & Pieces	5
SEER Coding Questions	6-7

KCR 2010 Spring Training

Event # 2010-046

18.25 CE Hours

Spring training 2010 involved three locations and many dates! Trainers Reita Pardee and Jan Michno initiated this marathon with a humorous short skit prior to the Overview. Frances Ross and Leah Driscoll completed the topics on Day 3. Multiple CSv2 sites, Hematopoietics, and FORDS changes were all covered in 3-days-per-location sessions. 2010 will be a huge year in terms of new registry manuals, codes, and data items.

KCR 2010 Fall Workshop

KCR's 24th Annual Advanced Cancer Registrars' Workshop will be held September 9-10 at Lexington's Embassy Suites, located at 1801 Newtown Pike, Lexington, KY.

A block of rooms are being held, so ask for the Kentucky Cancer Registry Workshop rate (\$135 + tax per night). ***Reservations must be made by 8/10/10 to receive this special discount rate.***

You may call direct at (859) 455-5000 to make your reservations.

The program agenda will be out sometime in July.

CTR Exam Readiness Webinar Series

NCRA is sponsoring three one-hour webinars this fall to help prepare registrars for the CTR exam in September. Each webinar costs NCRA members \$50 and non-members \$75. These are the dates and topics:

Webinar 1 (8/26/10, 2pm EDT): COMPUTERS

Webinar 2 (9/2/10, 2pm EDT): Stats & Epidemiology

Webinar 3 (9/9/10, 2pm EDT): CTR Exam Tips

Visit the NCRA website @ www.ncra-usa.org for sign-up information.

New Hires:

Anne Fields	KCR Abstractor Coordinator
Michelle McCormick	Jewish Hospital, Louisville
Edie Moore	Pikeville Medical Center, Pikeville
Sharron Pinkston	KCR Abstractor Coordinator
Cindy Roberts	St Joseph Hospital, Lexington
Leslie Tackett	King's Daughters Medical Center, Ashland

Golden Bug Award



Several software bugs have been identified by registrars during the past few weeks. Congratulations to bug award recipient Jodee Chumley (Norton HealthCare, Louisville), who found a bug in the key-change section. Congratulations are also extended to Julie Finke (Western Baptist, Paducah), who discovered a bug involving rejection of a benign CNS case in the 2010 software. Julie also identified a problem with the AJCC programming and site specific factor 25. As always, your reporting of suspected bugs in the software is much appreciated by our IT team!

ACoS Approved Programs

The cancer program at Regional Medical Center of Hopkins County has received notice of three-year approval with commendations in five standards. Congratulations are extended to Stacy Littlepage and Teresa Ford.

Breast Cancer Center Accreditation

Central Baptist Hospital in Lexington has been awarded full three-year accreditation by the National Accreditation Program for Breast Centers (NAPBC). This breast program is only the second one in Kentucky to receive NAPBC accreditation. Congratulations to our colleagues at Central Baptist Hospital!

Norton Cancer Institute Named NCI-Designated Center

Bob Shaw, President of the Norton Cancer Institute, recently announced the news of its being named as one of fourteen new sites in the National Cancer Institute's Community Cancer Center Program (NCCCP). This is quite an achievement for the Norton system. The NCCCP has created a national network of cancer centers to expand cancer research "...with a special emphasis on minority and underserved patients." The Norton Cancer Institute is the only cancer center in Kentucky which has attained the Commission on Cancer's "network status" and been named an NCCCP site. Congratulations to all of our colleagues who work in this new NCI-designated facility!

Outstanding Achievement Award

Pikeville Medical Center has been awarded a 2009 CoC Outstanding Achievement Award. One of only 82 programs in the nation to receive this honor as a result of surveys in 2009, Pikeville also received this award following their last survey in 2006. A listing of all recipients may be found in the CoC Flash – March 31, 2010. Superior work, Leisa Hopkins!

Did You Know?

- The International Agency for Research on Cancer (IARC) website has information on global cancer statistics. "GLOBOCAN 2008" was unveiled on June 1st as providing "...the most accurate assessment of the global cancer burden..." This interactive tool provides cancer incidence and mortality information by site and world-region. (www.iarc.fr/) 6/3/10
- NCI reports there is no increased risk of brain tumors developing among most cell phone users. For a small proportion of callers who use cell phones the most, there is a suggestion of increased risk in developing glioma; however, results were inconclusive. (NCI website, 5/17/10)
- Researchers at the National Cancer Institute have found that an anti-cancer drug named Perifosine may become useful in neuroblastoma cases. Studies have shown that Perifosine "dramatically inhibited neuroblastoma growth." Neuroblastoma is a common type of childhood cancer that develops from nerve tissue. (online 'Journal of NCI'~ 5/13/10)
- NCI data show that while cancer of the lower portion of the stomach has decreased overall among American adults, incidence of this type of cancer has risen among whites between the ages of 25 and 39. A study on this trend was published in the 'Journal of the American Medical Association' in May of this year. (NCI website, 5/4/10)

Two New Data Fields Required by KCR

“Place of Diagnosis” and “Reason No Non-definitive Surgery” are two new fields to be coded in the 2010 abstract. Place of diagnosis is a text description of the place where the diagnosis was made. This text box can accommodate 60 characters. Enter MD office or facility name or ID#. If the diagnosis took place outside KY, include city and/or state if there is enough space. Any information regarding the location where the diagnosis took place will be helpful. Although not required by FORDS, this new field IS required by KCR. It is located directly after class of case within CPDMS.net.

The Reason No Non-definitive Surgery field is also required by KCR. This field is used to explain why a non-definitive procedure was not created. All hospitals are now required to add the first positive non-definitive procedure for each case. These should be added even if performed at another facility. The coding structure is simple and shown in the following box:

Code	Description
0	Non-definitive surgery not performed, not applicable, or not recommended for this case. Autopsy only.
1	Non-definitive surgery performed and results diagnostic.
2	Non-definitive surgery performed but results negative.
9	Unknown if non-definitive surgery performed.

Calendar of Events



June 11	Final CPDMS.net software update to CSv2
June 14-18	IARC: Summer School in Cancer Epidemiology – Lyon, France
June 19-25	NAACCR Annual Conference – Quebec City, Quebec, Canada
August 12-14	A. Fritz CTR Prep Workshop – Reno, Nevada
August 21-22	NCRA CTR Prep Workshop – Baltimore, Maryland
Sept 9-10	KCR Annual Fall Workshop – Embassy Suites, Lexington
Sept 11-25	CTR Exam window

- ◆ FORDS class of case codes are new and different for cases diagnosed in 2010! Cases diagnosed in a hospital but receiving all of first course therapy in a staff physician's office are now considered to be class "00". These cases are not required to be TNM-staged per ACoS; however, registrars are urged to collect complete therapy information. KCR requires follow-up to be performed for this class of case. See I&R #46726, submitted 1/14/2010, for an example.
- ◆ Surgical approach must be coded for 2010 surgeries that take place at your facility. There is no code corresponding to endoscopic approach, for example cystoscopy for a TURB or TURP. When there is no specific approach code, use code '5', which is "open or approach unspecified."
- ◆ Upon receiving your facility's 2008 recoding audit results, please review any changes suggested, and call Reita Pardee promptly at 859-219-0773 x233 with your responses. We need feedback on which items have been corrected, and which ones are already correct "as is." Without feedback, calculated error rates may not be accurate in letters sent to registry supervisors.
- ◆ Please remember to download and complete your facility's ERRATA in a timely fashion! Changes to cases should be made well in advance of your facility's next scheduled date for data upload. Make sequence changes EXACTLY as is shown on the errata list. If a sequence 1 is changed to a sequence 3 and then back to sequence 2, the computer upload will NOT recognize the sequence 2. Your continued cooperation is greatly appreciated.

NCDB Call For Data Delayed Until January

The regular NCDB call for data that takes place each fall has been postponed until January 2011. Check the Commission on Cancer "Flash" for the revised 2011 schedule.

SEER Coding Questions

Review these recently finalized SINC questions as additional training:

Question 1: MP/H Rules/Histology - Breast: What is the correct histology code for this breast cancer case? Final diagnosis says “Infiltrating duct carcinoma with apocrine features.” What rule is used? See also discussion.

Discussion: I & R has conflicting answers: #25719 (dated 3/17/2008) says per rule H12, this is 8401/3, but #23347 (dated 8/12/2007) says per rule H16, this is 8523/3.

Answer: Assign histology code 8401/3 [apocrine adenocarcinoma] according to rule H12. Apocrine is a type of duct carcinoma; see table 1. Code 8401 should be listed in Rule H12. Apocrine should be removed from table 3. These corrections will appear in the 2010 version of the rules. (SINC #2009-1085, last updated 8/10/09; 2007 SEER Manual, pg C-647)

Question 2: Primary site - Breast: What is the code for this subsite: Invasive Paget Disease of the nipple with an infiltrating ductal carcinoma of the lower inner quadrant?

Answer: Code C50.9. Code the last digit of the primary site to ‘9’ for single primaries when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined. Nipple (C50.0) and LIQ (C50.3) fit this rule. This is a single primary per MP/H Breast Rule M9. (SINC #2009-1129, last updated 3/26/10; 2007 SEER Manual, pgs 70 and C-619)

Question 3: MP/H Rules/ Histology - Breast: How are the following two examples coded? (1) Infiltrating ductal carcinoma, mucinous type, and (2) Infiltrating ductal carcinoma with features of tubular carcinoma. See discussion.

Discussion: We have a difference of opinion on which rule applies. Some registrars believe that the first rule that applies for both scenarios is Rule H12 (code the most specific histologic term) because “type” and “with features of” are used in the pathological diagnosis. They are coding 8480 and 8211 respectively for the above examples. Other registrars are stopping at Rule H17, because they do not believe these are examples of duct carcinomas, since the histological code is not included in the Rule description, nor are these histologies included in Table 2. They are coding to 8523 for both examples.

Answer: Code 8523 for 1. Infiltrating ductal carcinoma, mucinous type AND 2. Infiltrating ductal carcinoma with features of tubular carcinoma. The infiltrating ductal types in Rule H12 are listed (8022, 8035, 8501-8508) and do not include mucinous or tubular. We cannot use this rule. The first rule that applies to these single tumors is H17, code to 8523. If you look up 8523 in the numerical morphology section of ICD-O-3, you will see similar examples included in the definition of this code. (SINC #2009-1130, last updated 3/10/10; 2007 SEER Manual, C-628, ICD-O-3 pg 80)

Question 4: Multiplicity Counter/Type of Multiple Tumors - Breast: How many tumors should be counted, and what is the correct code for Type of Multiple Tumors? See discussion.

Discussion: Lumpectomy path shows 2 foci of invasive ductal carcinoma, 1.5cm & 3mm sizes, and CAP summary lists “DCIS: focally seen,” no further description. Re-excision path finds a 1.5mm focus of residual invasive carcinoma, very close to the new inferior margin (so registrar assumes probably not part of the previously excised mass), and no mention of any more in-situ. Can we assume the DCIS was associated with part of the invasive tumors since not measured or described separately? If we say there are 3 tumors (for the measured invasive foci), should Type of Multiple Tumors be in situ + invasive, or just invasive?

Answer: Code 03 [3 tumors] in the multiplicity counter. Do not count the “focally seen” DCIS since it is not measured. Code 30 [in situ and invasive] in Type of Multiple Tumors Reported as One Primary. The single primary reported for this case is a combination of in situ and invasive tumors. (SINC #2009-1131, last updated 3/24/10; 2007 SEER Manual, pgs 90-91, 93-94, Note 3.a.)

SEER Coding Questions-*continued*

Question 5: Reportability/Histology - Colon: The microscopic description and the Final Diagnosis state large tubulovillous adenoma of the cecum with focal surface high grade dysplasia. The CAP protocol has histologic type as adenocarcinoma, and pT as pTis. Which has priority? Is the case reportable?

Answer: The case is reportable because carcinoma in situ is stated. Carcinoma in situ has higher priority than severe dysplasia or high grade dysplasia. Per AJCC 6th edition colon chapter, the terms "high grade dysplasia" or "severe dysplasia" may be synonymous with carcinoma in situ. Because the pathologist gave carcinoma in situ information within the CAP, (s)he is apparently defining the dysplasia as in situ carcinoma. (SINQ #2010-0002, last updated 3/24/10; 2007 SEER Manual, pg 262, Notes: Appendix C; AJCC 6th Edition Cancer Staging Manual)