

Cancer Registry Review

“Cancer Registry Review” is published by the Arizona Cancer Registry for the information and education of Arizona Cancer Registrars

Bureau of Public Health Statistics
Arizona Cancer Registry

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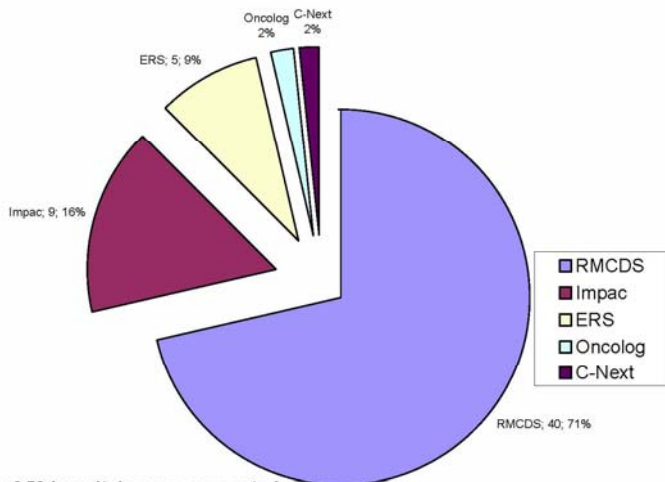
ACR ANNOUNCEMENTS

PROGRESS IN ELECTRONIC REPORTING

The summer, 2007 edition of “Cancer Registry Review” introduced the concept of ftp reporting to Arizona’s cancer data reporting facilities. FTP (short for File Transfer Protocol) is a tool that enables registrars to submit their data to the ACR electronically, eventually saving time and eliminating the need for cumbersome floppy diskettes and CD’s.

The ACR is proud to report the progress that facilities have made over the past year. Of the fifty-six (56) non-circuit riding, non-military, non-Indian Health Services hospitals in Arizona, 38 (68%) now report to us electronically. However, there is more work to do. Contact Keith Laubham at (602) 542-7314 as soon as possible in order for the ACR to meet CDC deadlines. The goal is to get all hospitals on board with electronic reporting by the end of this year.

Cancer Registry Software Vendors- Arizona Hospitals, June 2008**



** Note- A total of 56 hospitals are represented. Excludes military, VA, Indian Health Service, and ACR circuit-riding facilities. Oncolog & C-Next are the vendors for one hospital each.

Also of interest, a breakdown of the software vendors used by reporting facilities is illustrated to the left. The number of facilities using each vendor is listed, followed by the percentage.

In This Issue of Cancer Registry Review

ACR Announcements.....	1-4
Registrar Education.....	5-7
Coding Corner.....	8-14
Data Section	15-19

ACR ANNOUNCEMENTS

IN MEMORIAN



Veronica Vensor, the ACR's Data Section Manager, passed away on June 15th following injuries sustained in an auto accident. She was a valued member of our team, and her professional and personal contributions will be missed. A native of the Valley, Veronica graduated with bachelor's and master's degrees from the University of Arizona. While at the U of A, Veronica interned for the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention. Veronica began her career at ADHS in 2003 as an epidemiologist for a variety of chronic disease programs, including diabetes, cardiovascular disease, arthritis, obesity prevention, and cancer. She joined the ACR staff in 2006.

Veronica will be remembered for her knowledge and enthusiasm for her work, her upbeat and cheerful attitude, a laugh that never failed to make everyone else smile, and the pride she took in being a mother to three year-old Jasmine. In addition to her daughter, Veronica is survived by a three-year old daughter, Jasmine, her husband Miguel, father Rudy, and brother Angel. The ACR wishes to thank the registry community for their condolences and their contributions during this difficult time.

Milestones

Carmen Williams, Data Specialist, left the ACR last month to take a position in her hometown of St. Louis. The ACR wishes her luck in her new adventure.

Ardis Decker, Data Management Analyst, will be leaving the ACR to pursue an opportunity at T-Gen. Ardis will be working as Clinical Research Coordinator and Data Manager responsible for sample acquisition, regulatory and data management activities for several cancer research projects.

ACR Staff phone numbers and emails

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ACR ANNOUNCEMENTS

NAACCR Certification

The North American Association of Central Cancer Registries (NAACCR) annually reviews state data to evaluate quality, completeness, and timeliness. NAACCR uses six evaluation measures. Each measure has gold and silver standards, awarded according to degree of compliance. A registry must meet a gold or a silver standard for each of the six criteria in order to be NAACCR-certified. The ACR did not achieve certification status for 2005 data (the most recent year available for evaluation) because of lower than expected case ascertainment completeness. Arizona achieved the gold standard on four measures: Completeness of information recorded for the data items age at diagnosis, sex, race, state/province and county at diagnosis; duplicate case rate; percentage of cases passing EDITS; and timeliness. The ACR reached silver for the percentage of death certificate only cases. See the table on the next page for detailed results. Below is a brief explanation of each performance measure mentioned above and included in the table.

Completeness of Case Ascertainment

Completeness of case ascertainment is defined as the extent to which all the incident cancers occurring in a defined population of a specified geographic area are included in the registry database. It is gauged using a two-step process. First, national incidence and mortality rates are applied to Arizona's mortality rate in order to estimate the expected incidence rate. This expected rate is then compared to the actual observed incidence and mortality rate in Arizona. Arizona was not certified for 2005 data due to the shortfall on this criterion.

Completeness of Information Recorded

The data items age at diagnosis, sex, race, and state and county of residence at diagnosis are critical to a state registry's objective of generating incidence rates. Therefore, the percentage of unknown values for these items needs to be kept to a minimum.

Death Certificate Only (DCO) Cases

The percentage of death certificate only cases is one measure of data completeness. Death records with cancer listed as a cause of death are compared

against the registry's database. ACR staff members attempt to collect information from doctors and hospitals for cases that are not in the registry. If no further information can be gathered, the case is added to the registry as a DCO case.

Duplicate Primary Cases

Because several facilities may be involved in a patient's care, the ACR often receives more than one abstract for the same case. One function of the Operations Section is to consolidate multiple reports into a single record. The presence of too many duplicates artificially inflates incidence rates by overcounting cases.

The ACR emphasizes the critical need for timely data submissions on the part of reporting facilities, as well as prompt responses to DCO requests.



ACR ANNOUNCEMENTS

NAACCR Registry Certification on Quality, Completeness & Timeliness of 2005 Data					
Arizona Cancer Registry					
Registry Element	Gold Standard	Silver Standard	Actual Measure*	Measurement Error Allowed	Standard Achieved
Completeness of case ascertainment	95%	90%	88.2%	1.0%	Not achieved
Completeness of information recorded					
Missing/unknown "age at diagnosis"	<=2%	<=3%	0.0%	-0.4%	Gold
Missing/unknown "sex"	<=2%	<=3%	0.0%	-0.4%	Gold
Missing/unknown "race"	<=3%	<=5%	2.0%	-0.4%	Gold
Missing/unknown "State/Province & county"	<=2%	<=3%	0.1%	-0.4%	Gold
Death Certificate only cases	<=3%	<=5%	3.8%	-0.4%	Silver
Duplicate primary cases	<=1 per 1000	<=2 per 1000	0.1 per 1000	-0.4 per 1000	Gold
Passing EDITS	100%	97%	100.0%	Not applicable	Gold
Timeliness	Data submitted within 23 months of close of accession year				Gold
Certification Status					Not Achieved

Upcoming Awareness-Related Events

July

UV Safety month



Prostate Cancer Awareness Ribbon

September

- ◆ National Ovarian Cancer Month
- ◆ Childhood Cancer Month
- ◆ Gynecologic Cancer Awareness Month
- ◆ Prostate Cancer Awareness Week (Sept. 14-20)
- ◆ Prostate Cancer Awareness Month
- ◆ Leukemia and Lymphoma Awareness Month
- ◆ Take a Loved One for a Check-up Day (Sept. 16)



Ovarian Cancer Awareness Ribbon

REGISTRAR EDUCATION

CTR EXAM

FALL 2008 Testing Window:

September 13- 27, 2008

Application Due by:

July 31, 2008

September 2008 CTR Exam Readiness Webinar Series

The NAACCR CTR Exam Readiness Webinar Series offers real-time interactive instruction with a live and experienced instructor. This course consists of eight two-hour sessions and a short post-exam follow-up session. The series includes lectures, Q&A sessions, study materials, quizzes and a timed practice test. The ACR will not be hosting the series this year. Course cost is \$400. Classes will be held on Tuesdays from 10 a.m. to noon Arizona time (1 to 3 ET) beginning July 22nd. Go to the NAACCR Web site at <http://www.naaccr.org> to view the course syllabus and to register.

NCRA CTR Exam Prep Workshop

NCRA will be sponsoring a CTR exam preparation workshop in Baltimore, Maryland on Saturday, August 2nd and Sunday, August 3rd. Cost is \$360 for NCRA members and \$395 for non-members. Go to <http://x01.us/ncra/pdfs/education/LOandagenda.pdf> and to http://x01.us/ncra/pdfs/education/NCRA_CTR08.08.pdf for more details.

CTR Eligibility

As you are probably aware, NCRA now requires a higher level of education for registrars who wish to take the CTR exam than in the past.

The eligibility routes to taking the Certified Tumor Registrar (CTR) examination have changed. These changes are part of the NCRA Council on Certification's focus on requiring a minimum of an Associate's degree in an allied health field by 2010 as recommended by the Frontline Workers in Cancer Data Management: Workforce Analysis Study of the Cancer Registry Field.

In 2008, **Eligibility Route 1** will require two semesters/three quarters of college-level courses in Human Anatomy and/or Physiology, in addition to two years of full-time or equivalent experience in the cancer registry field. A college-level course is defined as coursework eligible for college credit. The course must be completed (not audited) with a passing grade.

In 2009, candidates will need to meet additional formal education requirements in order to qualify for **Eligibility Route 1**. Eligibility Route 1 will require a minimum of 12 credit hours of college education that includes two semesters/three quarters of Human Anatomy and/or Physiology, one semester of Medical Science/Biology, and a college-level course in Medical Terminology. A minimum of two years of full-time (24 months or 3,900 hours) or equivalent experience in the cancer registry field is also required.

In 2009, **Eligibility Route 2** will require successful completion of an NCRA-approved Cancer Information Management Associate's degree **OR** an NCRA-Accredited Formal Education Program **AND** successful completion of a minimum of an Associate's degree or equivalent (four semesters/six quarters).

In 2010, **Eligibility Route 1** will be eliminated, meaning that all candidates must apply through another route and have a minimum of an Associate's degree.

Additional information regarding eligibility and the CTR exam can be found at the Council on Certification Web site at <http://www.ctrexam.org/eligibility/index.htm>. Specific eligibility questions should be forwarded to the NCRA Office at (703) 299-6640.

Detailed information on the different routes to eligibility may be found at <http://www.ctrexam.org/>

(Continued on page 6)

REGISTRAR EDUCATION

(Continued from page 5)

This fall, the Maricopa Community Colleges system will offer several courses that will help aspiring CTR's meet the new eligibility requirements. The courses are listed below. Go to the Maricopa Community Colleges' web site, www.maricopa.edu, for details on schedules and to register.

Introductory Biology for Allied Health

4 Credits
BIO156 20046-99999

Human Anatomy and Physiology I

4 Credits
BIO201 20066-99999

Human Anatomy and Physiology II

4 Credits
BIO202 20056-99999

Experience NCRA's 2008 Conference on CD

Unable to attend NCRA 2008, but don't want to miss out on all of the knowledge to be had? Most sessions from the Annual Educational Conference will be available on CD for \$95 (including shipping). The recorded sessions consist of digitally captured video and audio, so you can view and listen to a presenter and see the corresponding slide or Power Point visual at the same time. You may earn CE's towards CTR maintenance by completing the viewing certificate included on the CD (additional CE fees will be required).

Order your copy at <http://www.ncra-usa.org/store/index.htm#multi9>.



NAACCR Webinar Series for 2008-2009: Save the Dates

10/2/2008	Bladder
11/6/2008	Coding Pitfalls
12/4/2008	Leukemia, Lymphoma, and Other Hematopoietic Malignancies
1/8/2009	Measuring and Minimizing the Disclosure Risk of a Cancer Data Public Use File (Central Registry)
2/5/2009	Pharynx
3/5/2009	Cancer Staging In-depth
4/2/2009	Central Nervous System
5/7/2009	Using the National Death Index in Registry Mortality Ascertainment Activities (Central Registry)
6/4/2009	Prostate
7/9/2009	Advanced Coding & Abstracting
8/6/2009	Breast
9/3/2009	Assessing and Using Cancer Data (Central Registry)

FYI-

"The Staging of Cancer, A Retrospective and Prospective Appraisal" was published in the May/June 2008 CA: A Cancer Journal for Clinicians. This article describes the history of cancer staging, the principles of TNM staging, its use as a clinical tool, and the incorporation of prognostic factors into future staging systems. The article is available at no cost at <http://caonline.amcancersoc.org/cgi/content/full/58/3/180>

REGISTRAR EDUCATION

Multiple Primary and Histology Rules Coding Reliability Study Announcement

The following announcement was distributed by SEER on 7/1/08:

Mark your calendar now for the 2008 Multiple Primary and Histology Coding Reliability Study. Important dates

8/25/08 8 a.m. ET Website open for participants to register and do practice cases

9/8/08 8 a.m. ET Website open for participants to do study cases

9/22/08 8 a.m. ET Website closed

What does the study involve? The primary sites included in the study are: breast; colon; lung; kidney; bladder, ureter and renal pelvis; head and neck; brain; melanoma of skin, and other sites. You will be assigned four of these sites and will complete four cases for each site – a total of 16 cases. For example, you may be assigned four breast cases, four kidney cases, four lung cases and four melanoma cases. When you complete the 16 cases, you may request an additional set of 16 study cases. You will be assigned 16 additional cases from sites other than those in your first set of 16. No more than 32 study cases can be coded by a single participant.

What data items will you code? For each case you will answer the question: Is this a multiple primary? (Yes/No) For each primary, you will code the following data items: Histology and behavior

When and where will the study take place? This study will be conducted on the SEER website. You will need Internet access to be able to participate. The reliability study will open for participants to register and code the **practice cases** at 8 AM Eastern time on Monday, August 25. The website will be open for participants to do the **study cases** at 8 AM Eastern time on Monday, September 8. The website will be closed at 8 AM Eastern on Monday, September 22.

How do you sign up? The website will be available for registration at 8 AM Eastern time on August 25, 2008. Go to the website <https://reliability.seer.cancer.gov> to register for the study. If you participated in the 2008 CS Reliability study, use the same username and password that you used for the CS Reliability study. Click the [Reset Password](#) button if you have forgotten or lost your password. Otherwise, request a new account by clicking the

[request one from the administrator](#) link. Enter your name, a username of your choice, and a password that you can remember. Your username must be at least four characters long and may be alpha, numeric, or alphanumeric. The password must be at least six characters in length and may be alphabetic, numeric, or alphanumeric. You will also be asked to enter a contact telephone number and email address.

A registration confirmation will be sent to your email address. Please keep this confirmation for reference. Click on the link in the email (or if that doesn't work with your email, copy the entire URL and paste it into your browser) to confirm your email address. We will approve your account within one business day. You will receive an email that tells you your account was approved and you can log in.

How do you log in? Go to <https://reliability.seer.cancer.gov> and enter your username and password. Choose "New Study" from the drop down list. You will be prompted to enter your demographic information. This information **must be completed before you will be allowed to access the study**. If any of the items are incomplete, an error message will appear in red on the top of the page. Please read the error message and fill in the missing information.

Who will show you how to use the software? After you log-in to the website, you will be able to download a **User Guide**. SEER also provides four practice cases. The website will open August 25, 2008 at 8 AM Eastern to allow participants to work on practice cases before the actual study begins. We recommend that you code the practice cases to become familiar with the study site and the software before doing the study cases.

Important: Please remember that you must answer the demographic questions before you can access any of the cases.

How will the study results be used? The results of the 2008 study will be compared to the results of the first MP/H reliability study conducted in 2006. The 2006 study led to some important revisions prior to the 2007 implementation of the rules. The 2008 study will evaluate those revisions and identify any new areas that may need revision. Educational materials will be developed based on study results.

Please take advantage of this opportunity to evaluate the 2007 MP/H rules.

SEER will request continuing education units from the National Cancer Registrars Association. For further information, please contact Peggy Adamo at adamom@mail.nih.gov.

CODING CORNER

Reportability/Class of Case

CNS Hemangiomas

The following question and answer was obtained from the “Brain Tumor Registry Reporting Training Materials: Collection and Coding Clarifications for Central Nervous System (CNS) Tumors” section of the National Program of Cancer Registries web site (<http://www.cdc.gov/cancer/npcr/training/btr/clarification.htm>):

Question

Are non-malignant blood vessel tumors occurring in CNS sites reportable?

Answer

YES: The CNS site/histology listing includes blood vessel tumors under several categories including meninges (C70.0 -C70.9), brain (C71.0-C71.4 and C71.7-C71.9), (excluding ventricle), spinal cord (C72.0), cauda equina (C72.1), cranial nerves (C72.2-C72.5), cerebellum (C71.6) and other nervous system (C72.8-C72.9).

These tumors include:

- 9120/0 Hemangioma, NOS
- 9121/0 Cavernous hemangioma
- 9150/0 Hemangiopericytoma, benign
- 9150/1 Hemangiopericytoma, NOS
- 9161/1 Hemangioblastoma
- 9120/3 Angiosarcoma
- 9130/3 Hemangioendothelioma
- 9150/3 Hemangiopericytoma

Cancer-Directed Surgery with Negative Findings

Question

Patient was diagnosed with melanoma (unknown where or when). He had an excision (unknown where or when) and is now at my facility for lymph node surgery. Sentinel node was negative. Is this case reportable? If so, what would be the class of case?

Answer

According to FORDS 2007, page 27, “Relationships Among Surgical Items,” ...”Surgical Procedure of Primary Site, Scope of

Regional Lymph Node Surgery, and Surgical Procedure/Other Site record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events.”

In other words, the excision of the sentinel node is considered cancer-directed surgery per FORDS. Report the case as a class of case 2.

Case Reportability when there is Conflicting Info in the Record

The discharge diagnosis of the discharge summary is the only place in the patient’s record that mentions a definitive diagnosis of pituitary adenoma. Nothing else in the patient’s record- e.g., MRI, CT, endocrine and neurology consults- uses definitive terms for the abnormality. Is this case reportable?

Report the case if there is a definitive term any-place in the record. Page 4 of the SEER Program Coding and Staging Manual 2007 states:

If one section of the medical record uses a reportable term such as “apparently” and another section of the medical record uses a term that is not on the reportable list, accept the reportable term and accession the case.

Exception: Do not accession a case based only on suspicious cytology. The case is accessioned if proven by positive cytology or other diagnostic methods including a physician’s clinical diagnosis.

Cancer Identification

Primary Site Coding

Ovary vs. Peritoneum

It can be difficult to decide whether to code primary site to the ovary or to the peritoneum. The following question submitted to SEER’s Inquiry System gives some guidelines for making this distinction.

(Continued on page 9)

(Continued from page 8)

SINQ # 20041013

Question

Primary Site--Ovary/Peritoneum: Should this field be coded to ovary or peritoneum when the bulk of the tumor is in the peritoneum and there is only surface involvement of the ovary?

Answer

If it is not clear where the tumor originated, use the following criteria to distinguish ovarian primaries from peritoneal primaries:

The primary site is probably ovarian, unless:
Ovaries have been previously removed
Ovaries are not involved (negative)
Ovaries have no area of involvement greater than 5mm.

- Descriptions such as "bulky mass," "omental caking," probably indicate an ovarian primary.
- Descriptions such as "seeding," "studding," "salting" probably indicate a peritoneal primary.

Blood Vessel Tumors in CNS Sites

The following question and answer was obtained from the Brain Tumor Registry Reporting Training Materials: Collection and Coding Clarifications for Central Nervous System (CNS) Tumors section of the National Program of Cancer Registries web site (<http://www.cdc.gov/cancer/npcr/training/btr/clarification.htm>):

Question

Should blood vessel tumors occurring in CNS sites be coded to blood vessel or CNS?

Answer

They should be coded to the CNS site in which they occur. This follows the same rationale that if you have a lymphoma of the brain, it is coded to brain, not lymph node. Example:
Patient is diagnosed with a hemangioblastoma of the right temporal lobe of the brain. Site code: "C71.2"; histology code: "9161/1"; Laterality: Right only.

Lymphomas

Question

Lymphoma was diagnosed by a liver biopsy. Lymph nodes in the mediastinum, periaortic region, mesentery and pelvis were seen on imaging studies. Bone marrow biopsy was negative.

An organ and different lymph nodes are involved. How would "Primary Site" be coded in this case--Unknown primary site (C80.9) or lymph nodes of multiple regions (C77.8)?

Answer

The SEER Program Coding and Staging Manual (2007) states on page 72 that if lymphoma is "...present in extranodal organ(s)/site and non-regional lymph nodes, consult the physician to determine the primary site. If a site cannot be determined, code 'Primary Site' to Lymph Node, NOS (C77.9)."

Also, "Code unknown primary site (C80.9) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma."

Question

Patient has a cutaneous lymphoma. Is the site code "C77.9?"

Answer

Cutaneous lymphoma is site coded to skin, "C44.____." Reference: FORDS 2007, page 10.

Histology Coding

Micropapillary carcinoma of Thyroid

There has been some confusion about the use of the term "micropapillary" in describing histology for thyroid cancers. SEER provides an explanation of this term:

SINQ 20071076

Question

MP/H Rules/Histology--Thyroid: Regarding rule

(Continued on page 10)

CODING CORNER

(Continued from page 9)

H15, is the mixed code “8340” [Papillary carcinoma, follicular variant] used when there are subtypes of these histologies described, such as a tumor diagnosed with follicular and papillary microcarcinoma or should “8341” [Papillary microcarcinoma] be used?

Answer

For coding purposes, this is a papillary and follicular combination that would be coded to the combination code “8340/3” [Papillary carcinoma, follicular variant].

For thyroid cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult, usually less than 1 cm. in diameter.

The Role of Comedonecrosis when Coding Histology

Question

Ductal carcinoma in-situ, comedo type, is coded as “8501/2” in the ICD-O-3. Is DCIS with comedonecrosis considered the same thing as comedo type DCIS?

Answer

I&R 23607

8/30/2007

If a pathology report states “DCIS cribriform and solid architectural patterns, clear cell features, focal central comedonecrosis,” is it coded “8500/2?”

Comedonecrosis is a type of necrosis occurring with glands in which there is a central luminal inflammation with deviated cells, usually occurring in the breast in intraductal carcinoma. You would ignore the comedonecrosis when coding.

Coding Histology with Multiple Specimens

Question

The patient has a multifocal in situ breast cancer removed in two settings:

Surgery 1 reveals a maximum size 3.5 mm in situ duct carcinoma, papillary and micropapillary

types. Surgery 2 reveals 0.1 and 0.5 cm DCIS. Surgery 2 was the most representative tumor specimen, by a small amount.

I went with M11 (“Multiple intraductal and/or duct carcinomas are a single primary”) and H29 (“Code the histology with the numerically highest ICD-O-3 code”), so I came up with the histology code of “8507/2.” The thing that I am not sure about is that page 13 of the manual says to go with the most representative tumor specimen. This would make the histology code “8500/2.”

Answer

No. Use the histology from specimen 2 (8500/2), even though it is less specific, because there is more tumor tissue from the second surgery. The question/answer below from the SEER Inquiry system illustrates a similar situation.

SINQ 20071027

Question

MP/H Rules/Histology--Breast: Which report and diagnosis should be used to code the histology if an excisional biopsy that removes the majority of the tumor has a diagnosis of "carcinoma," and the subsequent lumpectomy diagnosis is "microscopic residual disease consistent with infiltrating duct carcinoma"?

Answer

Code histology for this case to “8010” [carcinoma]. The histology is coded from the pathology report with the most representative specimen (the most tumor tissue) even when the most representative specimen has a less specific histology.

Number of Primaries

You may now download the entire, up-to-date Multiple Primary and Histology Rules Coding Manual as a single .pdf document. The updates, which were issued on 5/6/2008, include the incorporation of the Benign Brain & CNS rules and the replacement pages released on 1/8/08 and 2/8/08 into the main manual. Also included are the updates needed to ensure that the manual sections are accessible to individuals who use screen readers.

(Continued on page 11)

(Continued from page 10)

Go to <http://www.seer.cancer.gov/tools/mphrules/download.html> for complete information.

Order Divider Tabs for your Multiple Primary and Histology Coding Rules Manual

Order from <http://www.ncra-usa.org/store/index.htm#pubs12>. Cost is \$20 for NCRA members, \$25 for non-members.

Recurrence vs. New Primary: Non-Invasive Bladder Cancer Diagnosed Prior to 1/1/2007

There has been confusion about how to handle multiple occurrences of non-invasive bladder cancer for cases diagnosed prior to 2007.

Label *19c from FORDS 2004 states, in part: "Invasive bladder cancers, (C67.0-C67.9) with histology codes 8120-8130...a single abstract is required for the first invasive lesion only."

A couple of registrars questioned whether this rule also applies to non-invasive papillary and transitional cell carcinomas, as the rule specified only invasive lesions. SEER clarified this issue: If the first tumor was non-invasive and the subsequent tumors were all non-invasive they would be recurrences.

Endometrioid Carcinoma of Endometrium and Ovaries

Question

Patient had both ovaries involved with endometrioid adenocarcinoma. The endometrial cavity contains an exophytic tumor; path showed endometrioid adenocarcinoma. The endometrial tumor has superficial myometrial invasion (less than 1/3). The physician refers to this as two separate primaries. How many primaries are there?

Answer

The first question is whether the ovary tumors are the same, or different primaries. Using the Multiple Tumors module for "Other Sites," you

can rule out M3 thru M6 right away. Rule M7 states that "Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single primary." Endometrioid adenocarcinoma (8380/3) falls within this histology code range. So, the ovary tumors are a single primary.

The second question is whether the endometrial tumor is a separate primary from the ovary. This requires another pass through the rules ("Other Sites" chapter, Multiple Tumors module). Rules M3 through M10 don't apply to this particular situation. Rule M11 states: "Tumors with ICD-O-3 topography codes that are different at the second and/or third characters are multiple primaries." The site code for endometrium is "C54.1," while the site code for ovary is "C56.9," so they are different at the third character. The endometrium tumor is a separate primary from the ovary tumor. You will need to prepare two abstracts.

Multiplicity Counter

Sextant Needle Biopsy of Prostate

Question

Patient had sextant prostate biopsies positive for tumor in different areas of the prostate. How is "Multiplicity Counter" coded?

Answer

Code "99" for "Multiplicity "Counter" when cancer is found in multiple areas during biopsy. It still is not known if there are multiple tumors or a large single tumor. It is also possible that the cancer is clinically inapparent and only found on biopsy.

Source: Carol Johnson, SEER

Multiplicity Counter/Date of Multiple Tumors

I&R 27067

Question

Biopsies of two liver lesions on 8/16/07 revealed hepatocellular carcinoma in both lesions. Treatment plan documented on 9/10/07 was liver transplant with chemoembolization and/or radiofrequency ablation as a "bridge to transplant."

(Continued on page 12)

CODING CORNER

(Continued from page 11)

The patient underwent chemoembolization of the two hepatocellular cancers on 9/19/07.

A total hepatectomy with liver transplant was performed on 2/19/08. The pathology report stated:

- 4 cm. necrotic mass in segment ii- No residual hepatocellular carcinoma
- 2 cm. mass in segment iii- Hepatocellular carcinoma, grade 3/4
- 0.7 cm. mass, segment viii- Consistent with treated hepatocellular carcinoma
- 0.5 cm. mass, segment iva- Consistent with treated hepatocellular carcinoma

Is “Multiplicity Counter” coded “02” or “04?” Is “Date of Multiple Tumors” “8/16/07” or “2/19/08?” Can these fields be updated, or do you use the first date and number that multiple tumors were recognized?

Answer

Update “Multiplicity Counter” to “04.” Leave the date as 8/16/07 because multiple tumors were confirmed on this date (earliest date).

Stage of Disease

The following information was taken from: Gress, DM. The Inquiry and Response System: Improving Collaborative Staging. J Reg Mgmt. 2007; 34(4): 164-166. Copyright (C) 2007 National Cancer Registrars Association's Journal of Registry Management (Alexandria, VA). www.ncra-usa.org

Colon: CS Extension for Intramucosal Tumors

“If a lesion is confined to the mucosa or is intramucosal, the appropriate code maps to Tis. Intramucosal includes the lamina propria and confined to the muscularis mucosae. Staging is based on outcomes. Since neither intraepithelial (in situ) nor intramucosal tumors have a significant potential for mets, they are grouped together as Tis because that most closely predicts their outcome.

Use the malignant behavior code (/3) for intramucosal tumors. The behavior is not based on

stage, which is grouped with the in situ.

It is important not to make the stage (Tis) match the behavior code.”

Lung: CS Lymph Nodes

When coding “CS Lymph Nodes,” use the nodal chain farthest from the primary site. There is no preference given to either clinical or pathologic information. The priority of involved nodes is a common problem for lung cases, since many times the farthest nodes are evaluated by imaging.

Previous Editions of the Cancer Staging Manual Available for Free Download

Past editions (1st through 5th editions) of the AJCC Cancer Staging Manual are now available for download at no charge. Visit the AJCC Web site at <http://www.cancerstaging.org/>, and click on the link underneath “News” on the left side of the page.

First Course of Treatment

Surgery of Primary Site Coding

Simple Mastectomy vs. Modified Radical Mastectomy

Earlier this year, ACR staff conducted a quality assurance review that focused on the “Scope of Regional Lymph Node Surgery” field for cases where patients underwent simple mastectomies. The review revealed that for cases diagnosed from 1998 through 2007 (2007 data incomplete), approximately 28% had more than one lymph node removed. By definition, a simple mastectomy does not include lymph node removal; the FORDS 2007 definition on page 269 states: “A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.”

The ACR recommends that registrars review these items and perform a data clean-up as necessary.

(Continued on page 13)

CODING CORNER

(Continued from page 12)

For future reference, if a first course surgery procedure is described in the operative report as a simple mastectomy and regional lymph nodes are removed, code the procedure as a modified radical mastectomy (Surgery of Primary Site codes 50-63).

Surgery Codes- Brain/Meninges

The June edition of the CoC's "Flash" includes the College's interpretation of the meanings of several brain surgery codes. Specifically:

Code "20"- Local excision (biopsy) of lesion or mass

Use this code to describe excision (removal) of the primary tumor or "debulking" (less than full removal of the tumor). Most primary brain surgery is code "20."

Code "40" Partial resection

Use this code to describe a partial resection of a lobe

Code "55" Gross total resection

Use this code to describe gross total resection of a lobe. This is a less common form of surgical treatment.

Do not use the College's definitions at this time. Rather, continue coding surgery for brain tumors as you have always done, until directed otherwise. This issue will be clarified by other standard setters.

Surgical Margins of the Primary Site

TURB's and TURP's

There has been contradictory information about how to code the "Surgical Margins" field for transurethral resections of the bladder and prostate. "Surgical Margins" should be coded to "9" for these procedures. The following query was recently submitted by ACR staff to the Commission on Cancer's I&R:

Question

I&R #20648 states code "7" is used if the pathologist states the margins cannot be evaluated.

#17460 states if a patient has a TURP or TURB and the path does not mention margins, code "7" would be used. Is "7" or "9" used for transurethral resections?

Answer:

Use code "9" if surgery to the primary site was performed but the margin status was not stated in the pathology report. This instruction for coding was clarified by a curator and this option will be added to the next revision of FORDS.

Note from ACR: If nothing is stated in the pathology report about the surgical margin, use code "9." If the pathologist specifically states that the margins are not evaluable, use code "7."

Coding Treatment for Tumor Embolization Procedures

Question

How do you code an embolization of the renal artery veins done to shrink the tumor before a nephrectomy?

Answer

Based on the info you have provided, don't code the procedure. The embolization guidelines state that you code embolization as chemotherapy, radiation, etc. depending on the agents used. They also instruct registrars not to code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol, as these pre-surgical embolizations are typically performed to make the resection of the primary tumor easier.

CoC-Approved Programs

Updates to Standards

Standard 3.3: 2008 Abstracting Timeliness

Standard 3.3 from Cancer Program Standards 2004: Revised Edition reads: "For each year between surveys, 90 percent of cases are abstracted within six months of the date of first contact." Since 2004, the CoC has been flexible in the interpretation of this standard during on-site

(Continued on page 14)

CODING CORNER

(Continued from page 13)

surveys. The College has advised all cancer program surveyors to review this standard as written. In other words, when the surveyor comes to your facility, he or she will calculate the rating for Standard 3.3 based upon the charts reviewed, and if the program is current at the time of survey.

Here is the rating scenario for 2008 surveys based upon the 25-case review for all programs:

(1+) More than 90% of the cases reviewed were abstracted within 6 months from the date of first contact (month to month, not date to date) AND the program is current on the day of survey.

(1) 90% of the cases reviewed were abstracted within 6 months from the date of first contact (month to month, not date to date) AND the program is current on the day of survey.

(5) Less than 90% of the cases reviewed were abstracted within 6 months from the date of first contact (month to month, not date to date) AND/OR the program is NOT current on the day of survey.

Standard 5.2 Clinical Trials Accrual Rating

Standard 5.2 states: “As appropriate to the category, the required percentage of cases is accrued to cancer-related clinical trials on an annual basis.” In the past, the College allowed surveys to round up the percentages. For instance, if the program required 2 percent enrollment based upon the category and they documented 1.76 percent enrollment, the program would have been rated as compliant. Starting in 2008, surveyors are required to use the exact percentage and not to round up when determining compliance or commendation.

Standard 2.10 Cancer Registry Data Quality Control

Registrars in CoC-approved programs will need to revise their quality control plans to include a review of the accuracy of the Collaborative Stage derived stage compared with extent of disease information found in the medical record. A sample Collaborative Stage Quality Control process has been developed by ACoS staff, and is available through the Best Practice Repository that can be found at <http://www.facs.org/cancer/coc/>

[bestpractices.html](#). Look for 2.10 Collaborative Stage Quality Control Policy.

Tumor Registrar Position Verde Valley Medical Center

There is an open position for a tumor registrar at Verde Valley Medical Center/Sedona Campus. The position is full time (40 hours/week), day shift. A position description and application are available online at www.nahealth.com. If you have questions, please contact Theresa Neuhaus in Human Resources at 928-639-6365 or tn15561@nahealth.com

DATA SECTION

Your Data Hard at Work!

MESOTHELIOMA IN ARIZONA,

1995-2005

Veronica M. Vensor & Chris Newton

Introduction

Mesothelioma is a form of cancer found in the mesothelium. The mesothelium is a protective sac that covers most of the body's internal organs. Between 2,000 and 3,000 people are diagnosed with mesothelioma in the United States each year. Men are more likely to develop mesothelioma than are women. It is more common in older adults; most people with mesothelioma are 65 and older, although it may be diagnosed at any age. Most cases of mesothelioma begin in the pleura or the peritoneum. Mesothelioma that occurs in the tissue surrounding the lung is called pleural mesothelioma. Mesothelioma that occurs in the tissue surrounding the abdomen is called peritoneal mesothelioma. Pleural mesothelioma is the most common form. Mesothelioma can also occur in the linings around the heart or the testicles.

Risk Factors

Mesothelioma is linked to asbestos exposure. Asbestos is a group of minerals that occur naturally as strong, flexible fibers. Asbestos has been used in many industrial products, such as cement, brake linings, roof shingles, flooring, textiles, and insulation. During the manufacturing process tiny particles of asbestos float in the air and may be inhaled or swallowed. It can take as long as 40 years to develop mesothelioma.

People who work with asbestos are at risk of developing mesothelioma, as 70 to 80 percent of mesothelioma cases come from asbestos exposure. Also, family members and others living with asbestos workers may be at risk of developing mesothelioma. Many industrialized countries now limit asbestos use and have laws to protect exposed workers.

Other possible risk factors include exposure to simian virus 40 (SV40), radiation, and asbestos-like material:

SV40: Simian virus 40 is a virus originally

found in monkeys. People may have been exposed to SV40 through polio vaccinations between 1955 and 1963. Once it was found that SV40 was linked to certain cancers, the virus was removed from the vaccine. More research is needed to determine if SV40 increases the risk of developing mesothelioma.

Radiation: Thorium dioxide is a radioactive substance used with X-rays to diagnose health conditions from the 1920's to the 1950's. Once thorium dioxide was found to cause cancer, it was no longer used. Some research has linked thorium dioxide to mesothelioma.

Asbestos-like minerals: Zeolite is a naturally occurring asbestos-like mineral linked to mesothelioma cases in Turkey. Family history has also been shown to play a role in mesothelioma occurrence in the same region of Turkey where zeolite is used.

Mesothelioma in Arizona

From 1995-2005, 556 Arizona residents were diagnosed with mesothelioma. The number of cases per year ranged from 41 in 1997 to 61 in 2004 (See Table 1, page 16). Most cases were male (78.6% - See Table 2), White non-Hispanic (89.7% - See Table 3) and age 70 or older - 61.4% - See Table 4). The median age of cases was 73 years. The primary sites of most cases were of the pleura and lung (88.3%), followed by the peritoneum and digestive system (9.4% - See Table 5).

(Continued on page 16)

DATA SECTION

Your Data Hard at Work!

Table 1

Diagnosis Year	Case Count	% Cases
1995	44	7.9
1996	43	7.7
1997	41	7.4
1998	54	9.7
1999	47	8.5
2000	52	9.4
2001	43	7.7
2002	51	9.2
2003	60	10.8
2004	61	11.0
2005	60	10.8
Total	556	100.0

Table 2

(Continued on page 17)

Sex	Case Count	% Cases
Male	437	78.6
Female	119	21.4
Total	556	100.0

Table 3

Race-Ethnicity	Case Count	% Cases
White Non-Hispanic	499	89.7
White Hispanic	40	7.2
All Other Races	12	2.2
Unknown Race	5	0.9
Total Cases	556	100.0

Table 4

Age Group	Case Count	% Cases
Under 50 yrs	23	4.1
50-54 yrs	23	4.1
55-59 yrs	30	5.4
60-64 yrs	63	11.3
65-69 yrs	76	13.7
70-74 yrs	102	18.3
75-79 yrs	110	19.8
80-84 yrs	81	14.6
Over 85 yrs	48	8.7
Total	556	100.0

Table 5

Primary Site	Case Count	% Cases
Peritoneum, retroperitoneum & Digestive System	52	9.4
Ill-defined and unspecified	8	1.4
Male genital system	1	.2
Pleura, Lung, & Other Respiratory System	491	88.3
Soft tissue incl heart	4	.7
Total	556	100.0

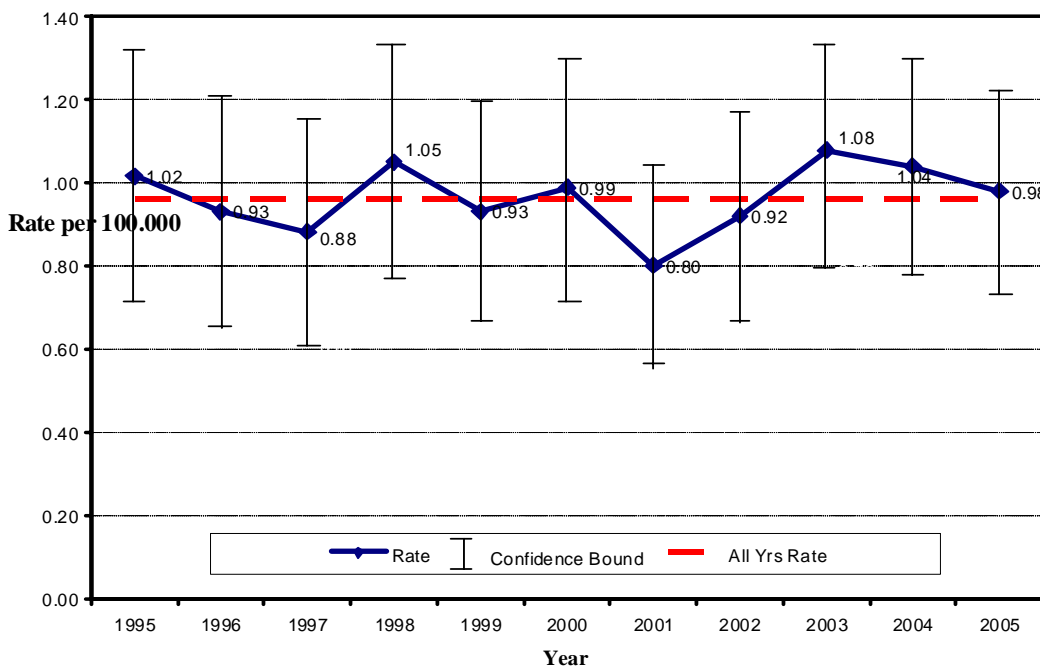
DATA SECTION

Your Data Hard at Work!

Incidence, 1995-2005

The rate of new mesothelioma cases in Arizona bounced around between 1995 and 2005. However, changes in the yearly mesothelioma rates, when compared to the overall time period rate (0.96 cases per 100,000 residents), are not significant as the overall rate falls within the confidence bound of the yearly rates (See the graph below). These rates are also not significant when compared to the U.S. national rate of 1.0 case per 100,000 residents (CDC analyzed cases 1999 – 2002), since they also fall within the bounds of each diagnosis year’s mesothelioma rate.

Age Adjusted Rates of Mesothelioma, Arizona 1995-2005



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DATA SECTION

Your Data Hard at Work!

Report Issued by ACR in May, 2008 Public Health Evaluation of Indoor Air Quality, Self-Reported Illnesses, and Tumors: Corona Del Sol High School, Tempe Arizona

In March of this year, the Superintendent of Tempe Union High School District (TUHSD) contacted the ACR to request assistance in addressing a perceived excess of brain tumors among students and staff at Corona del Sol High School. Approximately eight (8) to twelve (12) brain tumors had been noted in the last few years.

The concerns about tumors arose in conjunction with concerns about air quality, including stagnant air, excess carbon dioxide (CO₂), wet and moldy carpets around drinking fountains, and other ventilation system problems.

The ADHS agreed to review cancer case reports in the cancer registry and to analyze inquiry forms that school staff or parents completed and returned to the ACR. ACR staff reviewed the returned inquiry forms to verify whether the reported tumors were benign or malignant, and also examined other factors such as patient's age, gender, and type of cancer.

Seventy-two (72) tumors or cancers were identified from the inquiry forms. Thirty-eight (38) of the 72 met the criteria for reportability. Eight were benign tumors, and five were malignant brain tumors (a total of 13 of the 38 reportable cases). Dr. Stephen Coons from Barrows Neurological Institute reviewed the report. He concluded that the histologies for the benign tumors are unrelated, and so they should be considered different diseases. He noted that four of the five malignant brain histologies are considered to arise from one (glial) cell lineage.

The review panel and the ACR concluded that a pattern of disease could not be identified, and that the tumor and cancer findings are not indicative of a link to environmental factors. For several reasons, the ACR staff determined that a cancer rate calculation would not be appropriate in this situation. It is likely that students who attended the

school soon after it opened in the 1970's did not have an opportunity to complete and return the inquiry form. Also, the number of cancers reported per diagnosis year is small. The small number of cases per year may result in unreliable rates. Additional reasons include the inability to assess exposures outside of the school, and the lack of a defined geographic area for analysis.

The complete report may be viewed at <http://azdhs.gov/phs/oeH/pdf/finalcoronareport.pdf>.

ACS Releases Cancer Facts and Figures 2008

The American Cancer Society's (ACS) annual cancer statistics report finds that death rates from cancer in the United States have decreased by 18.4 percent among men and by 10.5 percent among women since mortality rates began to decline in the early 1990s. Society epidemiologists predict that in the U.S. in 2008 there will be 1,437,180 new cancer cases (745,180 in men and 692,000 in women) and 565,650 cancer deaths (294,120 among men and 271,530 among women). The findings come from "Cancer Statistics 2008," published in the March/April issue of CA: A Cancer Journal for Clinicians; they are also available in the 57th edition of its companion publication, Cancer Facts & Figures 2008 (http://www.cancer.org/docroot/STT/stt_0.asp)

Each year, *Cancer Facts & Figures* features a Special Section highlighting one aspect of cancer prevention, early detection, or treatment. In recent years, the section has focused on tobacco, obesity, infectious causes of cancer, environmental pollutants, and cancer-related pain. The Special Section of Cancer Facts and Figures 2008 is "Insurance and Cost-Related Barriers to Cancer Care." About 47 million people in the U.S. are uninsured. Minority populations and/or those with low income are disproportionately represented in this category. Recognizing that reducing barriers to cancer care is critical in the fight to eliminate suffering and death due to cancer, the ACS and its sister advocacy organization the American Cancer Society Cancer Action Network (ACS CAN) are

(Continued on page 19)

DATA SECTION

Your Data Hard at Work!

(Continued from page 18)

working together to bring the need for meaningful healthcare reform to the forefront of public and political debate. One important goal of this campaign is to educate Americans about the extent of the access to care problem and to motivate them to take action in support of change. The Special Section provides an overview of systems of health insurance and describes the impact of being uninsured or underinsured on cancer prevention, diagnosis, treatment, and outcome.





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Cancer Registry Review

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