OCTOBER 2017 E-Tips	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

Histology Issues:

-Code histology for Pan IN-III to 8148/2 glandular intraepithelial neoplasia, gr III, for cases diagnosed 2007 or later.

-Pituitary adenoma has its own histology code of **8272/0** NOT 8140/0.

Coding Issues:

TS Clinical and **TS Pathological** and **TS Summary** are ALL required by SEER. Please be sure your software allows you to complete all of these fields.

For more information on coding these fields, please visit-
https://seer.cancer.gov/manuals/2016/SPSCM_2016_Revised_Coding_2017.pdf

Reportability Issues:

A brain or a CNS neoplasm identified only by diagnostic imaging is reportable.

- ✓ **Neoplasm** and **tumor** are **reportable** terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1.
- ✓ **Mass** and **lesion** are **not** reportable terms for brain and CNS because they are **not** listed in ICD-O-3 with behavior codes of /0 or /1

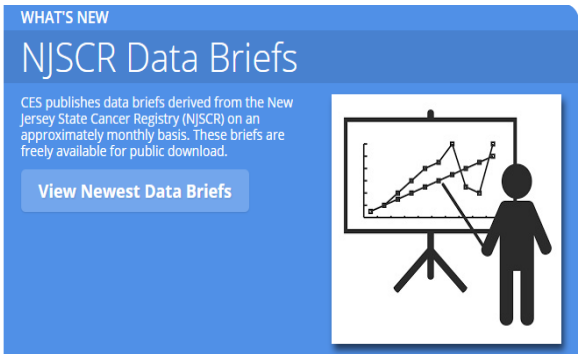
Testis- Mature teratoma/Immature teratoma (SINQ 20140064)

Mature teratoma in an adult (post-puberty) is reportable because it is malignant (9080/3); however, **mature teratoma in a child is benign** (9080/0). You may use 2011 or 2012 as the date of this change.

If the teratoma had an immature component, make it a /3 behavior code according to ICD-O. Per SINQ, 20110045 **immature teratomas** of the testis or ovary are reportable. http://seer.cancer.gov/seerinquiry/index

Check out the CDC's new video about cancer registries! It's available on the CDC web page at https://www.cdc.gov/cancer/index.htm or https://youtu.be/oasCxJP3sNw

Don't forget to look for our new Data Brief on thyroid cancer incidence in NJ! https://www.nj.gov/health/ces/briefs.shtml



Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

September 2017 E-Tips	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

Recent quality review revealed multiple errors in the recording of Lymph-Vascular Invasion (LVI), especially in noninvasive and in situ tumors.

What is the Lymph-Vascular Invasion field?

This field records the presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor and surrounding tissues in the primary site. It is noted microscopically by the pathologist.

The presence of LVI may affect a patient's prognosis.

Other names for LVI are vascular invasion, blood vessel invasion and lymphatic invasion. It does not include perineural invasion.

Information to code this field can be taken from any specimen from the primary tumor (biopsy, resection).

Code 0 when the pathology report indicates no LVI. This includes in situ carcinoma and noninvasive carcinoma.

Code 1 when the pathology report indicates LVI or a physician's statement indicates LVI is present.

Code 8 for the following: Hodgkin's and Non-Hodgkin's lymphoma, leukemias, hematopoietic and reticuloendothelial disorders, myelodysplastic syndromes, myeloproliferative disorders.

Code 9 for the following: when there is no microscopic exam of primary tissue specimen; the only specimen is cytology or a FNA; primary site is unknown, LVI not mentioned on pathology report, pathologist states insufficient tissue to determine LVI.

Did you know SEER posts its most recent questions to SEER SINQ?

You can read the most recent questions asked by your fellow registrars right after they are answered here: https://seer.cancer.gov/seerinquiry/index.php

Here are some examples:

SINQ question 20170050, do not code **medical marijuana** as treatment. Enter the information in a text field. Medical marijuana is used to treat side effects (like nausea, vomiting and pain) and to stimulate appetite.

SINQ question 20170034, use surgery code 45 for a person having a unilateral breast simple mastectomy with tissue expanders and **AlloDerm or an acellular dermal matrix**. The tissue expander indicates preparation for an implant. AlloDerm comes from human tissue donors with cells removed and sterilized to promote regenesis and decrease rejection. It also provides an additional layer of tissue between the skin and the implant. The AlloDerm is not coded because it is not the principle element of reconstructive procedure. The principle elements would be tissue from the patient and/or prosthetics (e.g., gel implants).

National Cancer Registrars Association

NCRA CEs are due in December. Odd years are due!

2017 ORANJ Annual Meeting Registration is open!
https://www.oranjonline.com/

Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

August 2017 E-Tips Grade	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

Common Grade Error: FIGO

Do not use FIGO (female gynecologic sites) grade to code the grade/differentiation field. For a diagnosis that includes commonly used differentiation term *with* a FIGO grade, such as "Moderately differentiated, FIGO grade II," disregard the FIGO grade and code the Grade, Differentiation field according to the term "Moderately differentiated." Note that FIGO grade is something completely different from FIGO stage.

WHO Grade for Malignant and Non-malignant CNS tumors is NOT the same as ICD-O-3 grade/differentiation. Code the WHO grade in SSF 1. WHO grade 1 is non-malignant. WHO grade 2 can be non-malignant or malignant. WHO grades 3 & 4 are always malignant. Pathologic confirmation is required for a WHO grade. If the tumor was *pathologically confirmed* but the WHO grade is not known, use Table 56.3 in AJCC 7th ed, page 598 for specific histologies with *assigned* WHO grade. If the tumor is diagnosed by radiology only (no pathologic confirmation), don't use the Table and assign WHO grade 9. Anaplastic is synonymous with undifferentiated and assigned grade/differentiation of 4.

"New Prostate Grading System" - SINQ Question 20170036

Grade--Prostate: How are the prostate-related fields completed when documentation in pathology reports only includes one of the new grade groups?

Discussion

Our pathologists have starting to use a new prostate cancer grading system that was adopted by WHO in 2016. The new grading scheme correlates with the prior Gleason grading scheme as follows:
Grade Group 1 = Gleason score 6 or less
Grade Group 2 = Gleason score 3+4=7
Grade Group 3 = Gleason score 4+3 = 7
Grade Group 4 = Gleason score 8
Grade Group 5 = Gleason score 9-10
Our pathologists are no longer dictating the Gleason Primary and Secondary Pattern values nor the Gleason's Score. Reverse correlation from the new grade groups to the required patterns and score are difficult with Grade Groups 2 and 3 needing to be distinguished from one another and Grade Group 5 including two unique scores.
The prostate-related fields include:
Collaborative Site Specific Factor 7: Gleason's Primary Pattern and Secondary Pattern Values on Needle Core Biopsy/TURP
Collaborative Site Specific Factor 8: Gleason's Score On Needle Core Biopsy/TURP
Collaborative Site Specific Factor 9: Gleason's Primary Pattern and Secondary Pattern Values on Prostatectomy/Autopsy
Collaborative Site Specific Factor 10: Gleason's Score on Prostatectomy/Autopsy

Answer

When **all you have** is the **grade group**, you may use the following table to convert the Prostate Grade Groups to the appropriate code for the indicated fields.

Grade Group	Gleason Score	Gleason Pattern	SSF7	SSF8	SSF9	SSF10	Grade/diff
Grade Group 1	6 or less	<=3+3	099	999	099	999	1
Grade Group 2	7	3+4	034	007	034	007	2
Grade Group 3	7	4+3	043	007	043	007	2
Grade Group 4	8	4+4, 3+5, 5+3	999	999	999	999	3
Grade Group 5	9-10	4+5, 5+4, 5+5	099	999	099	999	3

https://seer.cancer.gov/seerinquiry

July 2017 E-Tips	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

Confirmation Emails for Data Submissions

After you transmit data to the NJ State Cancer Registry you will get an e-mail from Jamal Johnson stating the name of the file submitted and number of records it contained. You must read it carefully. It is very important for you to e-mail a confirmation to njscrdat@doh.nj.gov stating that the file name and number of records sent is correct or incorrect. It is not unusual for there to be discrepancies which can result in missed cases. Also, the e-mail from Jamal may say that the file was "rejected" for some reason.

When We Need to Reach You

Please remember to send an update to your hospital's State representative with any changes in your contact information. This includes changes with registry and administrative staff, phone & fax numbers, mailing and e-mail addresses, outsourcing agencies, etc.

Cancer in North America (CiNA): 2010-2014

The 27th edition of the publication Cancer in North America (CiNA): 2010-2014 is now available on the NAACCR web site. Please visit https://www.naaccr.org/cancer-in-north-america-cina-volumes/ for free access/downloading of the publication.

Cancer Incidence & Mortality in New Jersey, 2010-2014

Our annual cancer report, Cancer Incidence & Mortality in New Jersey, 2010-2014, is now available on our website, http://www.nj.gov/health/ces/reports.shtml. Also, recently updated for 2017 on the Cancer Surveillance Unit homepage is the Lifetime Risk of Being Diagnosed with Cancer http://www.nj.gov/health/ces/public/surveillance-unit/

Common Edit Errors

Edit: RX Date Radiation, Rad--Location of RX (COC)
Error: If RX Date Radiation Flag = 10, then Rad--Location of RX must = 9
Rad--Location of RX (1606): '0'
RX Date Radiation (1486): 'Y: M: D:'
RX Date Radiation Flag (1494): '10'

Type of reporting source is required by the State. Hospitals should submit with code "1".
Error: Type of Reporting Source not valid, Type of Reporting Source (563): '<BLANK>'.

For Hematopoietic cases:
Error: Regional Nodes Positive and Examined must both = 99 for this schema.

June 2017 E-Tips **Pancreas Reportability Clarifications**	***New Jersey State Cancer Registry*** ***Cancer Epidemiology Services*** ***www.state.nj.us/health*** ***(609) 633-0500***

The updated NJSCR reportable list includes a number of benign sounding pancreatic tumors. For example, pancreatic neoplasia III (PanIN III) is reportable as of 2016. Some questions have been received regarding when these tumors become reportable - when a physician makes a clinical diagnosis of a pancreatic tumor with terms that include high grade dysplasia or when the tumor is resected and there is pathology to confirm the diagnosis? The case then becomes reportable with the diagnosis date as the first date the reportable term was used.

The latest version of the NJSCR reportable list included IPMN (Intraductal Papillary Mucinous Neoplasm) but did not include the statement of with *high* grade dysplasia. A revision will be posted to include this new terminology which has been reportable since 2013. IPMN with *low* grade dysplasia is NOT considered a reportable diagnosis. If clinical documentation or imaging states pancreatic "mass" or "tumor" or "neoplasm" without the reportable terminology (IPMN, ITPN, etc.) then the case is not reportable. If the patient proceeds with a diagnostic work up or surgical resection of the tumor and the diagnosis returns with a reportable diagnosis, the case then becomes reportable with the diagnosis date as the first date the reportable term was used. Please note the "ALL SITES" portion at the beginning of the reportable list for reportable terms that can be found in multiple sites of the body.

Diligent case finding practices including pathology, radiology and discharge/disease index along with appropriate physician follow back will assist in finding all reportable cancer cases. Physician follow back should be performed on any suspicious cases for all sites.

The following Q&A may be helpful and can be found on the SEER Inquiry System at https://seer.cancer.gov/seerinquiry

SINQ Question: 20130070

Question: Reportability--Is "intraductal papillary mucinous neoplasm with low grade dysplasia" (also called IPMN adenoma) reportable?

Answer: Intraductal papillary mucinous neoplasm (IPMN) of the pancreas with *low grade* dysplasia, also referred to as IPMN adenoma, is not reportable. IPMN of the pancreas is reportable when stated as "IPMN with *high-grade* dysplasia," or "IPMN with an associated invasive carcinoma," or "IPMN with an associated in situ carcinoma."

SINQ Question: 20140070

Reportability--Pancreas: Is this reportable? Is this benign? If reportable, what histology code and behavior code should be used? A final pathology diagnosis reads: "Cystic pancreatic endocrine neoplasm (CPEN)".

Answer: "Cystic pancreatic endocrine neoplasm (CPEN)" is reportable. Assign 8150/3 based on the information provided. We consulted our expert pathologist and he states, "Since metastases have been reported in a few, and all the rest of the pancreatic endocrine tumors are now designated malignant, …we are safe considering them /3 until proven otherwise. Since most of them are non-functioning, [assign code] 8150/3 unless specified as to G1 (8240/3) or G2 (8249/3)."

SINQ Question: 20160050

Reportability--Appendix: Is a mucinous cystic neoplasm with high grade dysplasia of the appendix reportable? The language appears similar to the mucinous cystic neoplasm of the pancreas with high grade dysplasia (8470/2), which was clarified to be reportable in 2014.

Answer: WHO does not list MCN as a histology for the appendix. This case should be clarified with the pathologist. For pancreas specifically, the term "mucinous cystic neoplasm (MCN) with high grade dysplasia" replaced the term "mucinous cystadenocarcinoma, noninvasive" according to WHO. MCN with high grade dysplasia of the pancreas is reportable because it is used in place of the now obsolete terminology. If we did not make the new terminology reportable, trends over time could be affected.

May 2017 E-Tips Confidentiality & the Cancer Registry: What You NEED to Know	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

As Cancer Registry professionals, we have a responsibility to safeguard the confidentiality and security of the data we work with. Below are some surprising truths behind common myths in patient confidentiality.

MYTH #1: **HIPAA doesn't apply to Cancer Registries.**

While cancer registry reporting for public health is exempt from the Privacy Rule, hospitals and healthcare providers are "covered entities" under HIPAA and therefore MUST comply with the Privacy Rule for the release and confidentiality of Protected Health Information (PHI).

MYTH #2: **Confidentiality only applies to patients.**

Although we normally think of patient information when it comes to confidentiality, it is also important to protect the identity of physicians, institutions and other health care providers. This includes caseloads and treatment/referral patterns of individual providers.

MYTH #3: **Name and Social Security Number are the only fields that need to be protected.**

PHI and Personal Identifying Information (PII) are not limited to the patient's name and Social Security Number. They include any data that might be used, independently or in combination with other information, to identify an individual. This may include any dates pertinent to patient care, such as diagnosis dates or other unique characteristics.

MYTH #4: **Reports with data in graphs and tables are not considered confidential.**

Summary data (such as data presented in a table), may violate confidentiality standards when data are being reported for small groups, i.e. where the number of cases are low. When presenting summary data, it is good practice to suppress the information when the number of cases in each category is fewer than 5. In some instances, it may be necessary to suppress the data when the count is fewer than 10. NJSCR suppresses counts fewer than 5 for our incidence data, and fewer than 10 for our mortality data.

MYTH #5: **Patient-level data can be published if the identifiers are removed.**

De-identified individual level data can be released under certain circumstances, but you should discuss this with your facility's compliance or privacy officer before making the information publicly available, this includes sharing the information at meetings beyond your immediate staff area. Recall Myth# 3, the absence of a name does not necessarily ensure an individual cannot be identified. Care must be taken to ensure individuals cannot be identified using a combination of unique characteristics which, when taken individually, are not independently identifying, but when combined provide a means of identifying an individual. A Record Uniqueness Program is available through NAACCR to test individual-level data.

Resources:

NAACCR Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, Management, Security and Confidentiality of Data, Subsection 6.3: Data Use and Release. www.naaccr.org

NAACCR *HIPAA Resources for Cancer Registries* https://www.naaccr.org/hipaa-resources-cancer-registries/

National Institute of Standards and Technology (NIST) *Guide to Protecting the Confidentiality of Personally Identifiable Information (PII).* http://nvlpubs.nist.gov/nistpubs/Legacy/SP/nistspecialpublication800-122.pdf

Integrity in Action: Safeguarding Confidential Information. Leading Edition – E-Newsletter for Purdue University Supervisors. http://www.purdue.edu/hr/LeadingEdition/LEdi_104_confidentiality.html

Cancer Registry Management Principles and Practices for Hospital and Central Registries. 3rd edition. Chapter 6: Health Information Privacy and Security.

NAACCR Record Uniqueness Program https://www.naaccr.org/analysis-and-data-improvement-tools/#UNIQUENESS

April 2017 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
www.state.nj.us/health
(609) 633-0500

Have you visited our website lately?

Check this out!

- Monthly Cancer Data Briefs- For nearly a year now our researchers have posted informative one page reports on our New Jersey residents with various cancers.
- Recently released reports- derived from data submitted to the NJ State Cancer Registry.
- The updated New Jersey State Cancer Registry list of reportable diseases and conditions.
- The updated ICD-10 casefinding list for 2017 for IT Departments.

http://www.state.nj.us/health/ces/

Resources for Registrars

- AJCC has a presentation on when to use blanks, 88's and x's. The link is: http://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx.
- Registry Best Practices (NCRA). **FREE** videos in preparing site specific cancer registry abstracts. Presentations are intended to help your abstracting process become more efficient and accurate. http://www.cancerregistryeducation.org/best-practices

Colon Coding Clues

- Page 64 of the SEER Summary Staging Manual 2000 contains a table of the layers for each anatomical site of the digestive system. This is useful in understanding the depth of invasion.
- The MP/H chapter on colon is specific to C180-C189. Rectum, rectosigmoid and anus are covered by the "other sites" rules.
- AJCC Tis, stage group 0 for colon cancer covers more than *in situ* (intraepithelial); it also includes the invasion of the lamina propria (intramucosal) [AJCC Cancer Staging Manual 7th Edition, page 155]. In SEER Summary Staging Manual 2000, (page 88) intramucosal is considered localized, **not** *insitu*. Behavior code is 3 for intramucosal tumors.
- Radiosensitizing or radioprotectant chemotherapy agents should *not* be coded as chemotherapy *treatment* when given in combination with radiation therapy *with the intention of enhancing that treatment*. Typically the agents (for ex., xeloda/capecitabine) are given at a much lower dosage than that given to treat cancer patients.

Grade

The special grade system rules for sarcoma do NOT include the primary site of bone.

In the terminology section for solid tumors, intermediate "differentiation" is assigned grade code 2, but intermediate "grade" is assigned grade code 3 (with the exception of breast and prostate). http://seer.cancer.gov/tools/grade

Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

March 2017 E-Tips Did You Know?	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

NAACCR NEWS

NAACCR is providing a free webinar called "Understanding Population-Based Cancer Registries Course". Complete a quiz and print a certificate when you're done. https://education.naaccr.org/population-based

NAACCR's *What You Need to Know for 2017* was updated in March 2017. There are no reportability changes in 2017, thus registries continue to use the 2007 MP/H rules and transmit cases in the Version 16D metafile.

Common errors with address at diagnosis impact geocoding. This is used to analyze cancer cluster concerns.

- Be careful not to transpose zip codes. A missing or incorrect directional prefix (N, NE) or a missing or incorrect street type (Trail, Terrace) is problematic.
- Record a full P.O. box (including city and zip code) in the *supplemental* address field. Look through all sources to find the patient's street address. Put the P.O. Box in the street address field *only* if there is absolutely no other address information available. Do not leave address at diagnosis field blank.
- If a person is homeless and has no usual residence, use the street address of the shelter or diagnosing facility and then write "HOMELESS" in the supplemental field. If a patient is living in a jail, rehab, nursing home, etc at the time of diagnosis, the street address of the facility is to be put in the address fields. The name of the facility should be entered into the supplemental address field. Don't abbreviate. For example, spell out "Martin Luther King" Blvd rather than writing "MLK" Blvd.

CODING CLUES

Diagnostic confirmation code 3 can be used for hematopoietic cases diagnosed 2010+ with histologic confirmation and *positive* immunophenotyping, genetic testing, or JAK2 confirmation.

The histology code for micropapillary carcinoma or papillary microcarcinoma of the thyroid is 8260/3; not 8341/3. It means that the papillary portion of the tumor is minimal or occult and was found incidentally. It does not refer to a specific histologic type. See SINQ 20150023.

Noninvasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) is a synonym for encapsulated follicular variant of papillary thyroid carcinoma (EFVPTC). Code as 8343/2. If invasive code as 8343/3. Reportability of **NIFTP** as a new term for **EFVPTC** will be effective January 1, 2017.

The codes and instructions in the *2016 SEER Program Coding and Staging Manual* remain in effect for 2017.

Revised coding instructions are posted on the SEER website for the data items listed below. There are no changes to codes or code definitions.

Tumor Size – Clinical
Tumor Size – Pathologic
Tumor Size – Summary

Mets at Dx – Bone
Mets at Dx – Brain
Mets at Dx – Liver
Mets at Dx – Lung
Mets at Dx – Distant Lymph Node(s)
Mets at Dx – Other

February 2017 E-Tips "Type of Reporting Source"	*New Jersey State Cancer Registry* *Cancer Epidemiology Services* *www.state.nj.us/health* *(609) 633-0500*

Type of reporting source* is a required data field for two of our federal funding agencies, the Centers for Disease Control and Prevention's National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program. The field is utilized by staff at the NJSCR, the Cancer Epidemiology Service, and researchers.

For the central registry this variable codes the source used to abstract the majority of information on the tumor being reported. The code in this field can be used to explain why information may be incomplete on a tumor. This field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. The field can also be used to monitor changes in trends in reporting sources.

SEER rules state that the central registry should code the source that provided the *best* staging and treatment information used to abstract the case. Abstractors working in hospitals should always be coding a "1" for type of reporting source with the exception of cases diagnosed at autopsy (code 6).

	Type of Reporting Source Codes
1	Code 1 is used for a NAACCR abstract submitted to NJSCR from a **hospital**, whether or not the patient was only seen in their radiation therapy department or outpatient surgery. Lab only cases (class of case 43) reported by a hospital should also be coded as 1.
2	Code 2 is used for cases submitted by **independent radiation** or **medical oncology** facilities.
3	Code 3 is used for cases submitted by **independent labs**.
4	Code 4 is used for cases submitted by **private physician offices**.
5	Code 5 is used for cases submitted by **nursing homes** and **hospice** facilities.
6	Code 6 is used for cases diagnosed at **autopsy only**.
7	Code 7 is used for **death certificate only** cases. Code 7 is coded at the central registry only.
8	Code 8 is used for cases submitted by **independent outpatient surgery centers**

***Please note that this field is not to be confused with "case finding source".** Case finding source codes the facility's earliest source of identifying information. This data item will help reporting facilities in prioritizing their case finding activities. Case finding source is intended to code the source that first identified the tumor.*

SEER CODING MANUAL

Section 2 Information Source (Pages 26-28)

https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

NAACCR STANDARDS & REGISTRY OPERATIONS MANUAL

Volume 2 Version 16 Data Standards & Data Dictionary, Chapter 10: Data Dictionary

http://datadictionary.naaccr.org/?c=10

Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

JANUARY 2017 E-Tips

*****NEW*** NCRA CTR CE Requirement**

New Jersey State Cancer Registry
Cancer Epidemiology Services
www.state.nj.us/health
(609) 633-0500

https://www.ncra-usa.org/files/public/CatA-CTR-FAQ.pdf

Category A Requirement for CTR Continuing Education

WHAT: CTR credentialed individuals are required to comply with a new continuing education standard as set forth by NCRA's Council on Certification. At least four (4) of the required 20 CE hours must fall within "**Category A**" which covers the specific topic(s) of: directly assigned stage and/or site specific coding principles.

WHO/WHEN: All current CTRs will be required to comply with this mandatory CE policy. The **Category A** requirement goes into effect for CTRs whose CE Cycle ends 12/31/2017.

HOW: The **Category A** CE's are to satisfy at least 4 of a CTR's 20 CE minimum. CTRs that completed **Category A** CE's in 2016 will be allowed to use those CE's to fulfill the requirement. You are encouraged to tailor your CEs to the role you perform in your daily work. **Category A** CE's are to be submitted along with other completed CEs during the CE Cycle.

A CTR may complete training(s) from any provider(s) on **Category A** topics to attain required CE content. To qualify for CE's, content must improve or expand the existing base of knowledge or skills of the CTR.

Examples of typical activities for Category A credit

- **Directly assigned stage**

  SEER Summary Stage

  Activities under this topic may include materials that define directly assigned SEER Summary Stage, including guidelines and code structure (in situ, localized, regional by direct extension, regional lymph nodes, regional by direct extension and regional lymph nodes, regional NOS, and distant).

  AJCC Clinical and Pathologic TNM Staging

  Activities under this topic would define the TNM categories and stage group requirements for clinical and pathologic staging, anatomy (e.g. prostate), regional lymph nodes, metastatic sites and prognostic factors (e.g. Gleason score, Prostate-specific antigen).

- **Site specific coding**

  Activities under this topic may include training relevant to specific site (e.g. prostate) requirements for coding (e.g. number of cores examined/positive, clinical staging procedure).

National Cancer Registrars Association
Council on Certification

UPDATED 12/04/2016

ADDITIONAL INFORMATION ON CTR Continuing Education can be found at http://www.ncra-usa.org. Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.