

OCTOBER 2015 E-Tips

ORANJ Annual Meeting

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

This October Atlantic City was host again to approximately 120 CTRs and other cancer registry personnel for the 2015 ORANJ Education Conference.

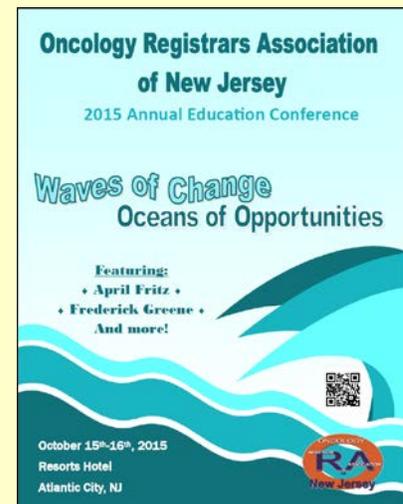
Attendees had the opportunity to hear presentations on topics such as:

- ❖ The “TNM 8th Edition” and “What’s New for 2016?”
- ❖ Information on breast, ovarian and HPV- related cancers, and
- ❖ “Innovations in Radiation Oncology Treatments” and how to code Radiation Treatment.

The conference featured April Fritz and Dr. Frederick Greene as well as other known names in the Cancer Registry field.

Some important notes taken from the presentations included:

- ❖ Standard setting organizations have agreed to continue to collect biomarkers and prognostic factors via SSFs as they are currently collected when staging is moved to directly coding TNM. (*Summary Staging 2016 & SEER Educate, Marilyn Hansen*)
- ❖ Hospital Registrars will be responsible for recording the physician assigned stage. Programs will receive a deficiency on Standard 5.6 if derived values are detected. (*Summary Staging 2016 & SEER Educate, Marilyn Hansen*)
- ❖ ICD-O-3 has been revised. Effective 01/01/14 and 01/01/15. Read revisions carefully. Some changes have been pushed back to 2017 (*Summary Staging 2016 & SEER Educate, Marilyn Hansen*)
- ❖ ICD-10 Chapter II contains neoplasms- Malignant (C) and Benign, Borderline, in situ (D) (*ICD-10, Susan Scully*)
- ❖ Annual Data Reviews can include running queries on cTis, Surgical margins for TURBT, review of Class 10 and 20 cases to see if more information is available to update, review of C80.9 to see if a specific site is now available. (*Quality Assurance of Oncology Data, Carolyn Ingram*)
- ❖ Use text to document “Pt declined to give race”, or “Pt declined to give SSN” to support unknown codes. (*Quality Assurance of Oncology Data, Carolyn Ingram*)
- ❖ Minimally invasive surgical options are evolving and not widely practiced. (*HPV-Related Head & Neck Cancer, Yekaterina Koshkareva, MD*)
- ❖ In the US between years 1988 and 2004, the incidence of HPV-positive oropharyngeal squamous cell carcinoma increased from 0.8/100,000 to 2.6/100,000 (225%) (*HPV-Related Head & Neck Cancer, Yekaterina Koshkareva, MD*)
- ❖ Aromatase inhibitors and Tamoxifen are not effective in women who have an ER negative and a PR negative cancer. (*Breast Cancer Updates, William Holaday, MD*)
- ❖ HER2 Receptor positive breast cancers grow faster and are more likely to spread. (*Breast Cancer Updates, William Holaday, MD*)
- ❖ Factors used to determine and tailor the treatment of breast cancer include, age/health of patient, stage of breast cancer, tumor markers, genetic characteristics of cancer cells, cell grade and genetic testing. (*Breast Cancer Updates, William Holaday, MD*)
- ❖ Maybe it isn’t really an unknown primary. Read the chart including consults, ask the pathologist, see how patient is treated, follow back to primary physician, use suggested site codes, access death certificate. (*Unknown Primaries, April Fritz*)



Carolyn Ingram, CTR from Precyse and Manager of the Tumor Registry at New York Presbyterian Hospitals of Columbia & Cornell has provided her full presentation “Common Radiation Treatment Coding Questions”. Please see the attachment included in this email.

Questions regarding the Presentations at ORANJ 2015 can be sent to your facility’s State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

It is the policy of Cancer Epidemiology Services (CES) to encourage research use of New Jersey State Cancer Registry (NJSCR) data for the purpose of determining the incidence and etiology of malignant neoplasms and/or evaluating measures designed to eliminate, alleviate, or reduce the impact of cancer.

CES collaborates with many researchers to facilitate cancer research using the NJSCR. Below is a sample of some of the special studies currently under investigation at NJSCR. **Please visit the NJSCR website, http://www.state.nj.us/health/ces/sp_studies.shtml for additional studies and more information.**



Women's Circle of Health Study

The Women's Circle of Health study is a collaboration of several institutions, including the Rutgers Cancer Institute of New Jersey, Roswell Park Cancer Institute, the New Jersey Department of Health, Rutgers School of Public Health, and Mount Sinai School of Medicine. The study aims to evaluate factors explaining the earlier age at diagnosis and the more aggressive nature of breast cancer in African-American women, compared to Caucasian women. Participants are asked to complete an interview, which includes answering questions regarding demographic, medical, reproductive, lifestyle and diet histories, measuring body size such as weight, height, waist and hip circumferences, providing a saliva sample, and filling out a questionnaire about usual dietary intake.

Improving Patient Access to Quality Cancer Treatment (IMPACT)

The New Jersey State Cancer Registry (NJSCR) is collaborating with Rutgers Cancer Institute of New Jersey in a study to ask eligible patients about their current health status, care they were provided during cancer diagnosis and treatment and experiences after completing cancer treatment. We are interested in learning more about the experiences of cancer patients in order to improve access to quality cancer care and learn more about quality of life and the diagnosis. Cancer sites include female breast, prostate, colorectal and cervix; patients must speak English; diagnosis of their primary cancer must be between 2012 and 2014. Patients will be asked to complete one survey by mail.

Medullary Thyroid Carcinoma Surveillance Study: a Case-Series Registry

The Medullary Thyroid Carcinoma Surveillance Study is being conducted by the New Jersey State Cancer Registry (NJSCR) in collaboration with United BioSource Corporation to identify possible risk factors for developing medullary thyroid cancer (MTC), including history of treatment with liraglutide, a prescription medicine for type 2 diabetes. This study is taking place in more than 20 states across the country and involves a telephone interview with adults who have been diagnosed with MTC.

Survivorship Care Experiences of Oral Cancer Survivors in the SEER Registry: A Pilot Study

The New Jersey State Cancer Registry (NJSCR) is collaborating with Rutgers Cancer Institute of New Jersey on a study of survivorship of individuals diagnosed with oral and oropharyngeal cancers. The purpose of this study is to identify unmet support needs, get a better understanding of follow-up care experiences, and quality of life of oral and oropharyngeal cancer survivors. Eligible individuals must speak English, and will be asked to complete two surveys via a dedicated website.

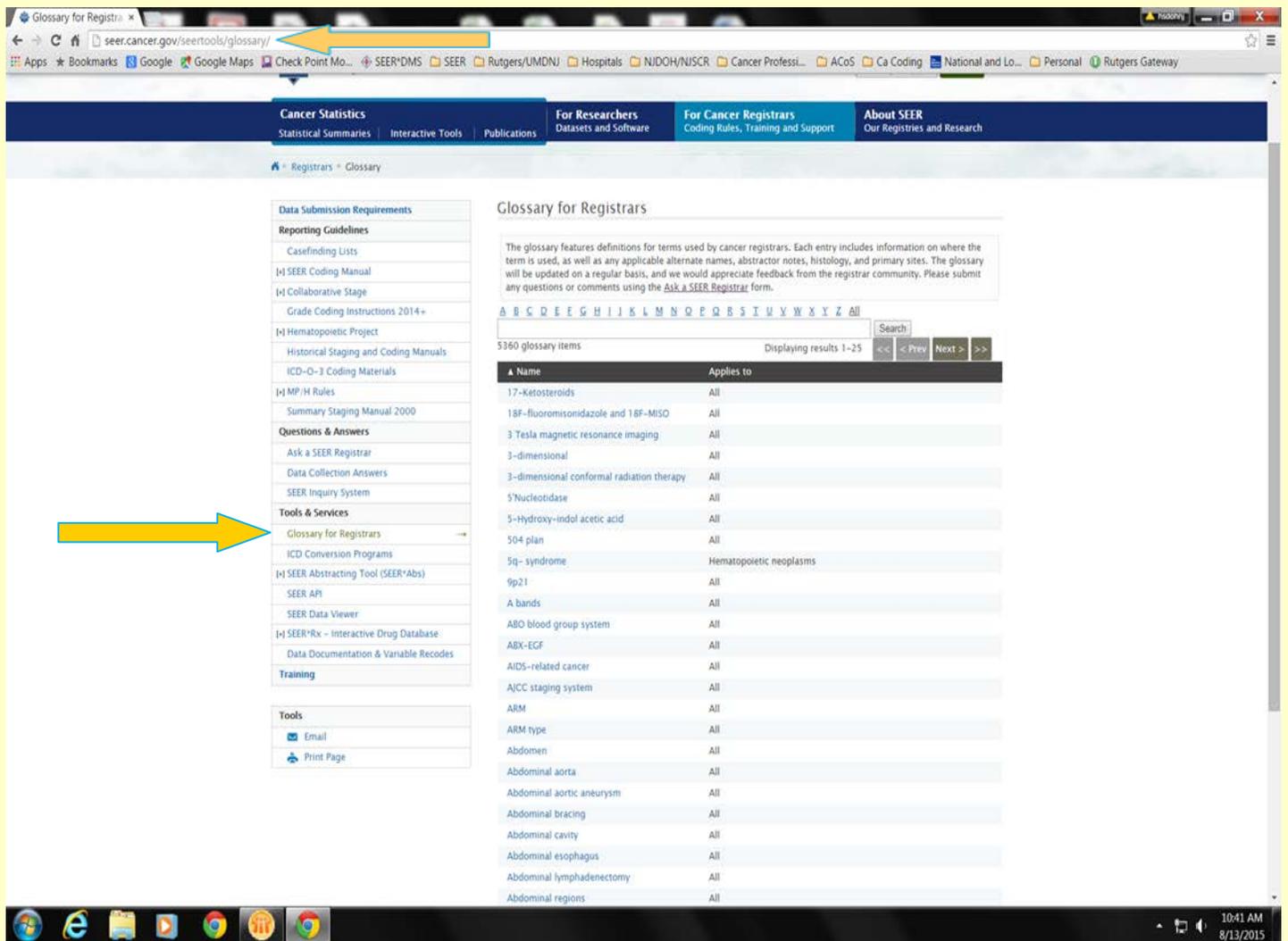
Epidemiologic Study of Hepatocellular Carcinoma

The purpose of the study is to investigate how dietary, physical activity and certain medical factors may cause liver cancer. New Jersey and Connecticut residents newly diagnosed with hepatocellular cancer are eligible for the study. Telephone interviews are conducted to collect information on demographics, physical activity, medical history and lifestyle factors. Information on dietary habits are collected through food frequency questionnaires. Saliva samples are collected for genetic testing related to immune and other cell functions, and for analysis of hepatitis B and hepatitis C virus infections.

The **Glossary for Registrars** is an interactive web-based tool with over 5,000 terms defined for cancer registrars.

Use the glossary to find definitions for **anatomy terms, cancer-related terms, common diseases (and not-so-common diseases), physiology terms, surgical procedures, other treatment procedures**, and much more.

The glossary can be accessed directly from the SEER website (<http://seer.cancer.gov/seertools/glossary/>). It can also be accessed by clicking on linked terms in the Hematopoietic database and SEER*Rx.



Questions regarding the *Glossary for Registrars* can be sent to your facility's State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

Colon Rules H4 and H5 contain specific histology information. Follow the Histology rules appropriately and when instructed to STOP at rule H4 or H5, code the colon histology pertaining to the case.

Rule H4

Note 1: It is important to know that the adenocarcinoma originated in a polyp.

Code **8210** (adenocarcinoma in adenomatous polyp), **8261** (adenocarcinoma in villous adenoma), or **8263** (adenocarcinoma in tubulovillous adenoma) when:

- The final diagnosis is adenocarcinoma in a polyp
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report.
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp *or*
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp *or*
- There is documentation that the patient had a polypectomy

Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.

When the microscopic description indicates a colon tumor is "tubulovillous," but the final diagnosis only states "adenocarcinoma," the histology is coded 8263/3 (adenocarcinoma in a tubulovillous adenoma)

For cases diagnosed 2007 or later, the MPH Rules for colon specifically state that "other parts of the pathology report" may be used to identify a tumor arising from a polyp, adenomatous polyp, villous adenoma, or tubulovillous adenoma. This is a site-specific exception to the general rule to code only from the final diagnosis. (*SEER Sinq 20071026*)

Rule H5

Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:

- Mucinous/colloid (8480) or signet ring cell carcinoma (8490) *or*
- Adenocarcinoma, NOS and the microscopic description documents that 50% or more of the tumor is mucinous/colloid *or*
- Adenocarcinoma, NOS and the microscopic description documents that 50% or more of the tumor is signet ring cell carcinoma

Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing extra-cellular mucin comprising more than 50% of the tumor.

Note that "mucin-producing" and "mucin-secreting" are not synonymous with mucinous.

Questions regarding Colon MPH Rules codes can be sent to your facility's State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

CODING UPDATES FOR ICD-O-3
EFFECTIVE JANUARY 1, 2014

This information was originally reported in the September 2013 E-tips.

36 new terms have been added to existing codes in ICD-O-3 for use in the USA and Canada beginning with cases **diagnosed on or after 01/01/2014**.

The list below represents some of the changes made to the ICD-O-3 codes for diagnosis 01/01/2014 and forward. A complete list can be found in at <http://www.naaccr.org/LinkClick.aspx?fileticket=u7d3sB71t5w%3d&tabid=126&mid=466> or the *Journal of Registry Management* 2013 Volume 40 Number 3 (pg 140-143). Also reference your ICD-O3 First Revision (WHO 2013) book.

The terms for 2014 are additions (synonymous terms) to existing codes so there should be no problems with invalid codes or edit conflicts. ***Italics indicate a new reportable term.***

New preferred term **8150/0** Pancreatic endocrine tumor, benign (C25._)
Move former preferred term to synonym 8150/0 Islet cell adenoma (C25._)
New related term 8150/0 Pancreatic microadenoma (C25._)

New preferred term **8150/1** Pancreatic endocrine tumor, NOS (C25._)
Move former preferred term to synonym 8150/1 Islet cell tumor, NOS (C25._)

New preferred term 8150/3 Pancreatic endocrine tumor, malignant (C25._)
Move former preferred term to synonym 8150/3 Islet cell carcinoma (C25._)
New related term 8150/3 Pancreatic endocrine tumor, nonfunctioning (C25._)

New preferred term 8154/3 Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)
New related term 8154/3 Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term 8154/3 Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term 8154/3 Mixed acinar-endocrine-ductal carcinoma

New related term 8201/3 Cribiform comedo-type carcinoma (C18._,C19.9, C20.9)
New synonym 8201/3 Adenocarcinoma, cribriform comedo-type (C18._,C19.9, C20.9)

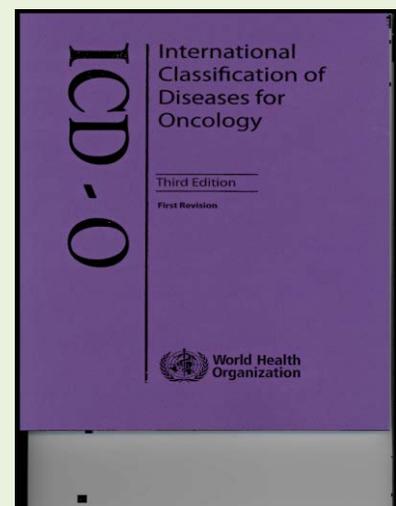
New term 8213/3 Serrated adenocarcinoma

New related term 8240/3 Neuroendocrine tumor, grade 1
New related term 8240/3 Neuroendocrine carcinoma, low grade
New related term 8240/3 Neuroendocrine carcinoma, well-differentiated

New preferred tem 8244/3 Mixed adenoneuroendocrine carcinoma
Former preferred term to synonym 8244/3 Composite carcinoma
New synonym 8244/3 Combined/mixed carcinoid and adenocarcinoma

New related term 8490/3 Poorly cohesive carcinoma

New related term 9474/3 Anaplastic medulloblastoma



The most current version of ICD-O-3:
(WHO 2013)

***NOTE:** It is important to understand that **cancer registry reportability rules based on behavior code still apply**. The addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable, with the exception of benign and borderline tumors of the central nervous system.

Questions regarding new ICD-O-3 codes can be sent to your facility's State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

May 2015 E-Tips
Prostate Grade Coding

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

Do not reply to this email address

The relationship of Gleason score to grade changed for **1/1/2014+** diagnoses in order to have the grade field in sync with AJCC 7th ed.

Prostate (excluding lymphomas)

Use the highest Gleason score from the biopsy/TURP OR prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began.

Use the table below to determine grade.

	Description					
Gleason	CS Code	Grade Code 2014+	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy).

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

ADDITIONAL INFORMATION ON CODING PROSTATE GRADE CAN BE FOUND AT <http://seer.cancer.gov/tools/grade/> or contact your State Representative.

Quarterly Hospital Quality and Completeness Report

Purpose: To aid in **evaluating the quality, timeliness, and completeness of the data** you collect and submit to NJSCR.

Quarterly reports will be received by Registrars in **April, July, October, and January**.

Report Date	Accession Year Included	Cut-off Date for Data Submission
April 2015	2014	March 31, 2015
July 2015	2014	June 30, 2015
October 2015	2015	September 30, 2015
January 2016	2015	December 31, 2015

This report is designed to be used as a **quality improvement tool by your facility’s Cancer Registry, Cancer Committee and administration**.

Beginning with the 2014 accession year, NJSCR will use the Quarterly Hospital Quality and Completeness Report to identify those facilities which are eligible for the ***NJSCR Award for Excellence in Timely Cancer Case Reporting***.

Use the data to assess your registry’s progress toward achieving the Award for Excellence.

There will be **three levels of awards: Gold, Silver and Bronze**.

Benchmarks are derived from standards of the NAACCR and the SEER Program of the National Cancer Institute.

Awards will be given in October of each year. Recipients will be recognized at the annual meeting of the Oncology Registrars Association of New Jersey.

Complete usage instructions will accompany the Quarterly Report and a copy of the usage instructions will be provided on the NJSCR website, <http://www.state.nj.us/health/ces/njscr.shtml>

Questions regarding the Quarterly Hospital Quality and Completeness Report can be directed to your NJSCR representative at 609-633-0500.

Does your facility have a staffing change? Please contact your NJSCR Hospital Representative to provide any updated information on Registry, Medical Records, Administrative or other cancer directed department changes.

March 2015 E-Tips

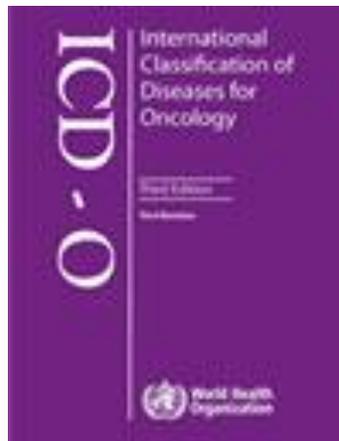
Electronic ICD-O-3

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

International Agency for Research on Cancer, **World Health Organization**

ICD-O-3 online now makes available ICD-O-3 and ICD-O-3.1 as fully searchable electronic resources.

The alphabetical index of the printed book has been replaced with an efficient search tool to enable the user to quickly identify specific entities. In addition, the online format has enabled WHO/IARC to enhance the listings with useful definitions of entities from the WHO/IARC Classification of Tumours series and other sources. Further information on the use of ICD-O-3 online can be found here.



<http://codes.iarc.fr/>

The third edition of ICD-O (ICD-O-3) has been available in printed format since 2000. In September 2011, following approval by the WHO/IARC Committee for ICD-O-3, the classification was updated with a number of new or modified codes and terms (ICD-O-3 First Revision, or ICD-O-3.1). The printed version of the first revision was published in 2013 and is available from WHO press.

The AJCC has created a **Curriculum for Registrars** in an effort to assist in the transition to directly assigning AJCC TNM. It is designed to provide education in a step-wise learning environment complete with additional resources to reinforce the information. **Webinars are included** with interactive quizzes to prompt discussion and serve as a self-assessment.

There is no charge for anyone to view the modules in the Curriculum. There are 4 Modules. Each Module is broken up into 7 lessons.

Module I- Introduction for both staff assigning stage and those who use or process data.

Module I been posted. Lessons can be viewed now. The live webinar is scheduled for 2/24/15.

Subsequent Modules will follow:

Module II- Beginning- Learning the basic rules (scheduled 3/15/15)

Module III- Intermediate- Nuances and exceptions (scheduled 5/15/15)

Module IV- Advanced- Complex cases (scheduled 7/15/15)

Please visit <http://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx> for registration and additional information.