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:

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 http://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.
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.

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**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](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).

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**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.
**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" - SINOQ 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.

<table>
<thead>
<tr>
<th>Grade Group</th>
<th>Gleason Score</th>
<th>Gleason Pattern</th>
<th>SSF7</th>
<th>SSF8</th>
<th>SSF9</th>
<th>SSF10</th>
<th>Grade/diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade Group 1</td>
<td>6 or less</td>
<td>&lt;=3+3</td>
<td>099</td>
<td>999</td>
<td>099</td>
<td>999</td>
<td>1</td>
</tr>
<tr>
<td>Grade Group 2</td>
<td>7</td>
<td>3+4</td>
<td>034</td>
<td>007</td>
<td>034</td>
<td>007</td>
<td>2</td>
</tr>
<tr>
<td>Grade Group 3</td>
<td>7</td>
<td>4+3</td>
<td>043</td>
<td>007</td>
<td>043</td>
<td>007</td>
<td>2</td>
</tr>
<tr>
<td>Grade Group 4</td>
<td>8</td>
<td>4+4, 3+5, 5+3</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>999</td>
<td>3</td>
</tr>
<tr>
<td>Grade Group 5</td>
<td>9-10</td>
<td>4+5, 5+4, 5+5</td>
<td>099</td>
<td>999</td>
<td>099</td>
<td>999</td>
<td>3</td>
</tr>
</tbody>
</table>

[https://seer.cancer.gov/seerinquiry](https://seer.cancer.gov/seerinquiry)

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


Cancer Incidence & Mortality in New Jersey, 2010-2014


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.

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

**Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.**
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 HIPAA Resources for Cancer Registries [https://www.naaccr.org/hipaa-resources-cancer-registries/](https://www.naaccr.org/hipaa-resources-cancer-registries/)


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 in situ. 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](http://seer.cancer.gov/tools/grade)
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 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          | Mets at Dx – Bone |
| Tumor Size – Pathologic        | Mets at Dx – Brain |
| Tumor Size – Summary           | Mets at Dx – Liver |
|                                | Mets at Dx – Lung |
|                                | Mets at Dx – Distant Lymph Node(s) |
|                                | Mets at Dx – Other |

Questions can be sent to your facility’s State Representative or by calling 609-633-0500. DO NOT REPLY to this email. Please report any changes in email address to harrine.katz@doh.nj.gov
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 is also used to monitor the success of non-hospital case reporting and follow-up 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).

<table>
<thead>
<tr>
<th>Type of Reporting Source Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>2 Code 2 is used for cases submitted by independent radiation or medical oncology facilities.</td>
</tr>
<tr>
<td>3 Code 3 is used for cases submitted by independent labs.</td>
</tr>
<tr>
<td>4 Code 4 is used for cases submitted by private physician offices.</td>
</tr>
<tr>
<td>5 Code 5 is used for cases submitted by nursing homes and hospice facilities.</td>
</tr>
<tr>
<td>6 Code 6 is used for cases diagnosed at autopsy only.</td>
</tr>
<tr>
<td>7 Code 7 is used for death certificate only cases. Code 7 is coded at the central registry only.</td>
</tr>
<tr>
<td>8 Code 8 is used for cases submitted by independent outpatient surgery centers</td>
</tr>
</tbody>
</table>

*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)

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.
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).