



## OCCR NEWSFLASH

Oklahoma Central Cancer Registry

Winter Issue

January 2015

### Farewell to Our Colleague *By Marva Dement, BBA, BS, CTR*

Anne Pate, the Chronic Disease Service Surveillance and Evaluation Administrative Program Manager, resigned her position with OSDH effective January 7, 2015, after 10 ½ years.



She received her BS degree in Secondary Science Education from Taylor University, MPH in Epidemiology of Microbial Diseases from Yale University and her PhD in Occupational and Environmental Health from the University of Oklahoma Health Sciences Center. She was originally hired at the OSDH as a Cancer Epidemiologist.

Anne has accepted a position with Southwestern Oklahoma State University in Weatherford, OK as an Assistant Professor. She will be teaching Health Applications, Data Analysis, Health Information Research, Clinical Practicums, Allied Health Careers and Health Statistics. She states that the people who are part of the OCCR are some of the best in the world and that her life has been made better for having had the opportunity to work side-by-side with them.

### Happy Retirement! *By Paula Marshall, BBA, CTR*

Yes, sad but true! Delores Greene will retire from the Oklahoma State Department of Health, Oklahoma Central Cancer Registry, on February 27<sup>th</sup>, 2015. She has been with the OCCR nine years, first as a Regional Consultant and in 2009 became the Education / Compliance Specialist. As the Education Specialist, Delores has been instrumental in coordinating / scheduling all the NAACCR, NCRA and CTR Readiness webinars for all registrars in Oklahoma as well as educating.

Delores started her journey as a tumor registrar at Midwest Regional Medical Center's Cancer Registry in 1988 and became a Certified Tumor Registrar in 1992. She worked at MWC Regional Hospital 14 years before moving on to the cancer registry at INTEGRIS Baptist Medical Center in 1997.

Traveling, taking road trips with her sister and friends, going on cruises, and spending time with her grandson are just a few of the items on her "retirement agenda." She does plan to keep her certification current and work from home 1-2 days a week abstracting.

Delores feels truly blessed and proud to call herself a registrar. She has made a lot of friends working in this profession and has enjoyed learning from physicians as well as fellow registrars. There are probably very few registrars that haven't met or had the privilege to work with Delores. She has generously contributed to the cancer registry world a great deal of wisdom, knowledge and advice. The OCCR wishes Delores well and much happiness on her retirement which is very much deserved.



#### Special points of interest:

- *Reportability and Code Changes Effective in 2015*
- *New Staging Requirements*
- *New Oklahoma CTR*
- *Mercy Health Center Profile*
- *Cancer Registry Training Sites*

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## Reportability and Code Changes Effective in 2015

By Delores, Greene, CTR

Effective with the 2015 cases, code 8240/1 for Carcinoid tumor, NOS of appendix (C18.1) will become obsolete. Carcinoid tumors of the appendix (C18.1) must be coded to 8240/3 effective with cases diagnosed 01/01/2015. This will be reportable and must be coded with a behavior code of 3.

There are two pancreatic tumors, uncertain behavior and malignant enteroglucagonomas (8157/1 and 8157/3) must be coded as uncertain behavior and malignant glucagonomas (8152/1 and 8152/3, respectively), effective for cases diagnosed 01/01/2015. Code 8157 is obsolete in 2015.

| TERM                             | Pre - 2015 Codes (Obsolete in 2015) | 2015 and later Code |
|----------------------------------|-------------------------------------|---------------------|
| Carcinoid tumor, NOS of Appendix | C18.1, 8240/1                       | C18.1, 8240/3       |
| Enteroglucagonoma, NOS           | 8157/1                              | 8152/1              |
| Enteroglucagonoma, malignant     | 8157/3                              | 8152/3              |

## Staging Requirements for 2015

1. Collaborative Stage, Version 02.05 remains in use as the primary staging system for all cancers.
2. Directly assigned SEER Summary Stage 2000 is required from all facilities.
3. Directly assigned AJCC TNM (Clinical and Pathologic) is:
  - a. Required from CoC accredited hospitals
  - b. As available from non CoC Facilities and small providers

In addition to the staging data items, CDC/NPCR has determined it necessary for NPCR Funded registries to capture all modes of treatment and their associated dates for all cancers. Treatment dates are important for evaluating clinical versus pathologic AJCC stage.

## SEER Summary Staging by Delores Greene, CTR

### What? Why? Where? When?

**What is SEER Summary Staging?** SEER Summary Staging is the most basic way of categorizing how far a cancer has spread from its point of origin or primary site. Summary Stage provides a standardized measure of anatomic extent of disease for cancer surveillance programs with longitudinal stability for population based cancer registries. Summary Stage applies to every anatomic site and includes staging criteria for lymphoid and myeloid neoplasms and for pediatrics. Summary Stage allows use of all information available in the medical record. It is a combination of the most of clinical and pathological documentation of the extent of the disease.

**Why Summary Stage?** The basis of Summary Stage has not changed since the 1950's. Basic concepts of in-situ, localized, regional and distant stage are used with the definitions "frozen in time" allowing assessment of long term trends without edition-to-edition variation that confounds trend analysis using multiple editions. Summary stage applies to every anatomic site, including lymphoid and myeloid neoplasms (lymphoma and leukemia). Summary stage also can be applied to pediatric cancers. *Continued on page 3*





## SEER Summary Staging , continued

**Where can you find “Stage” information?** Use available diagnostic workup. You are looking for the same information used with coding Collaborative Staging and TNM Staging. Priority order for determining best information is Pathological, Surgical and Clinical. Don’t forget to DOCUMENT test results (Negative or Positive).

|                         |                               |                             |
|-------------------------|-------------------------------|-----------------------------|
| Admission Note (s)      | Diagnostic Imaging Report (s) | Treatment Records           |
| History and Physical    | Reports from Scopes and Scans | Specialty Lab Test/Markers  |
| Discharge Summary       | Operative Report (s)          | Physician Progress Note (s) |
| Consultation Report (s) | Pathology Report (s)          | Cytology Report (s)         |

**When will SEER Summary Stage be implemented?** Starting with 2015 Diagnoses all reporting facilities will be required to assign directly coded SEER Summary 2000. The SEER Summary Staging Manual is located at <http://seer.cancer.gov/tools/ssm/>. Make sure you put this link in your favorites for easy access. **Every case abstracted must have the SEER Summary Stage assigned and the Collaborative Staging Completed (CS).**

It is highly recommended you read the first 15 pages in the SEER Summary Staging Manual. You will find detailed General Instructions for using the manual, Guidelines for Summary Staging and How to Assign Summary Staging.

There are six main categories in summary stage and the regional stage is subcategorized by the method of spread.

| Code | Definition                                                                                        |
|------|---------------------------------------------------------------------------------------------------|
| 0    | In situ                                                                                           |
| 1    | Localized only                                                                                    |
| 2    | Regional by direct extension only                                                                 |
| 3    | Regional lymph nodes involved only                                                                |
| 4    | Regional by BOTH direct extension AND lymph node involvement                                      |
| 5    | Regional NOS (Not Otherwise Specified)                                                            |
| 7    | Distant site (s) Node (s) involved                                                                |
| 8    | Not Applicable (Benign/Borderline Brain/CSN only) Not in manual                                   |
| 9    | Unknown if extension or metastasis (unstaged, unknown or unspecified) Death certificate only case |



SEER Summary Staging continued on page 4



## SEER Summary Staging, continued

When reviewing a case for staging three of the SEER Summary stage, categories can be ruled out quickly: in situ, distant and localized.

- Rule out in situ stage: Carcinoma and melanoma are the only type of cancer that can be classified as in situ. Only carcinoma's have a basement membrane. Sarcoma's are never described as in situ. A pathologist must examine the primary organ and state the tumor is in situ. If there is any mention of invasion or extension to, nodal spread or metastatic spread the case is not in situ.
- Rule out distant disease: If metastases can be documented then there is no need to spend time trying to identify localized or regional disease. Hematopoietic disease's such as leukemia's and multiple myeloma's are considered disseminated or distant at time of diagnosis.
- Rule out localized stage (confined to organ of origin): In order for a lesion to be classified as localized it must not spread beyond the boundaries of the organ. It is important to know and recognize the names of the different structures within an organ (such as lamina propria, myometrium, muscularis) so a description of invasion or involvement of these structures will not be interpreted as regional. If still in the organ of origin (Blood vessel invasion, Perineural lymphatic invasion or Vascular invasion) does not change the stage (localized). Does indicate the potential for spread.

If in situ, localized and distant stage is ruled out then the stage is regional. Review documentation prior to assigning the regional stage.



## New CTR in Oklahoma, Aleisha Williams

By Kaela Barger, RHIA

OCCR would like to introduce Oklahoma's most recent CTR, Aleisha Williams! Aleisha is a graduate of the University of Central Oklahoma with a Bachelor's degree of Science in Public Health and is currently working toward her MBA in Health Care at SNU. While doing her undergrad internship at INTEGRIS Cancer Institute, she had the opportunity to learn about cancer registry and has now been a cancer registrar at the very same facility for 1 year. As a hospital cancer registrar Aleisha enjoys the knowledge that she gains about cancer as well as the variety of tasks available to her.

When asked about her advice to others planning to take the CTR exam Aleisha responded, "The advice that I would share with others that are planning on sitting for the CTR exam is to study as much as possible. The longer you study, the less stressful it will be. Do not try and cram the month before the test because there is too much information that needs to be covered. Also, if there is an area that is less familiar, study that more. If it is not something you use in your current job, whether you work for the central or hospital registry, then it might need to be studied more."

OCCR congratulates Aleisha on her outstanding accomplishment!



## Some of Oklahoma's Finest Cancer Registrars

By Christina Panicker, MBA, CTR and Kaela Barger, RHIA

One of the greatest benefits of the OCCR is the opportunity to interact with facilities and cancer registrars all over Oklahoma. We learn that many facilities have their own culture, personalities and unique methods of accomplishing their goals or streamlining processes. OCCR would like to interview registries in order to better understand those we work with as well as share the information so that others may learn and become familiar with their fellow Oklahoma cancer registry departments. This issue's featured facility is Mercy Health Center of Oklahoma City.

In keeping with the tradition of excellence of Mercy Health Center, the Mercy Cancer Registry does not disappoint. They were first accredited by the COC in 1971 and, since then, have maintained this credential. The team abstracts and impressive average of 1,840 cases per year. Currently, the cancer registry department includes two certified tumor registrars with almost twenty years of combined experience, two registrars working towards their CTR, and two registrars who work on follow up.

One of the major challenges, necessary for every hospital cancer registry, is case finding. Over the years the cancer registry has strived to identify every cancer case diagnosed and or treated at Mercy Hospital. This includes running a report utilizing the reportable codes against the disease indices, which has been a staple in case finding for Mercy's Cancer Registry. Implementation of a new process allows the cancer registry access to the Medical Oncologists' daily schedules and the Radiation Oncologists' Documents Module to review End of Treatment Summaries. This process has helped identify cases that receive cancer treatment only at Mercy. Reports can also be created utilizing EPIC (health care software) to print a daily insight report allowing select departments, specific to cancer, to identify cases as well.

In order to gain better insight of their department, Abby Williams, BS, CTR was generous enough to answer a few questions about cancer registry at Mercy.

Q: What is one thing you look forward to in your department?

A: Abby Williams states that she personally enjoys abstracting the individual cases each day, but there are many other projects that need to be accomplished. "I've heard Tumor Board is also enjoyable for our newest member Judy Myers."

Q: Is there a tradition for which your department is known?

A: When we moved to our current location, we were given a "blessing of the hands" as a way to bless the efforts we would make for our cancer patients in all the areas the patient would be associated with: Nurse navigation, psychosocial, nutrition, chemotherapy infusion, radiation all of it. I was personally inspired and moved by this ceremony and I hope we will do it again when we move to our cancer center that will be free standing from the hospital (under construction now). Anytime Mercy has something new there is always a "blessing ceremony" which I'm sure is rooted in the Catholic heritage, but it's also empowering.

OCCR would like to thank Mercy Cancer Registry for their willingness to participate in this article. Their readiness in helping the Oklahoma Central Cancer Registry is always greatly appreciated.

Would you like to see your registry featured in a future OCCR Newsflash? Let us know. We would love to hear from you. Express your interest by emailing [LeslieD@health.ok.gov](mailto:LeslieD@health.ok.gov).



Back row, left to right, Judy Myers, BS, and Barbara Murray, CNMT, CTR. Front row, left to right, Darlene Scott, Abby Williams, BS, CTR, and Stacey Hibbetts.



## New Death Clearance Process

By Jessica Taylor

OCCR routinely performs a linkage with mortality files, called “death match”, which utilizes death certificate information to update the cancer registry database. If OCCR has death information but no related case in our database, the death clearance process is performed by contacting the facility where the patient died or was last seen. This past November, many of you assisted in the death clearance process by providing information on over 300 patients. This was a great undertaking and OCCR appreciates your help! In hopes of reducing the burden on facility registrars as well as OCCR, we will be performing death clearance on a quarterly basis. Letters will be sent within the next month requesting information on patients who were listed as dying at your facility between January and June 2013. If you have any questions regarding this process please contact Jessica Taylor at [jessicat@health.ok.gov](mailto:jessicat@health.ok.gov).

## NAACCR Cancer Registry and Surveillance Webinars

The first Thursday of each month, from 8-11a.m., OCCR provides the NAACCR Cancer Registry and Surveillance Webinars for free to all Oklahoma cancer reporters.

In Oklahoma City, the webinars are hosted at the OU Medical Center, Samis Education Center, next to Children’s Hospital, 1200 Children’s Avenue, basement level B, conference room C.

Hosting in Tulsa will be St. John Medical Center, Mary K. Chapman Health Plaza, 1819 E. 19th Street, in the Newman Room at the end of the lobby area.

If you plan to attend a webinar, please register by emailing [LeslieD@health.ok.gov](mailto:LeslieD@health.ok.gov). Once you have been registered, you will receive an email with webinar information and handouts.

2/05/2015 Collecting Cancer Data: Uterus  
3/05/2015 Abstracting and Coding Boot Camp: Cancer Case Scenarios  
4/02/2015 Collecting Cancer Data: Stomach and Esophagus  
5/07/2015 Collecting Cancer Data: Larynx and Thyroid  
6/04/2015 Collecting Cancer Data: Pancreas  
7/09/2015 Survivorship Care Plans  
8/06/2015 Collecting Cancer Data: Central Nervous System  
9/03/2015 Coding Pitfalls



## 2015 CTR Exam Dates Announced

NCRA has announced the 2015 CTR Exam Dates. To learn more, including exam details and how to request a copy of the 2015 CTR Exam Handbook & Application, visit [www.ctrexam.org](http://www.ctrexam.org).

February 28 - March 21, 2015      Application deadline: January 31, 2015

June 20 - July 11, 2015              Application deadline: May 29, 2015

October 17- November 7, 2015      Application Deadline: September 18, 2015

Please let OCCR know if you are interested in the NAACCR CTR Exam Readiness Webinars.



## RMCDs Corner

By Paula Marshall, BBA, CTR

ATTENTION! If you have not converted your RMCDs system to NAACCR v14.0 2014/CS Version 020550 please contact me ASAP. NAACCR v15.0 has been released and the system must be in v14.0 before converting to the new v15.0. Please contact Paula with any questions.



### RMCDs Abstracting Shortcut Keys

The following is a list of keyboard shortcuts for quick reference: (Items in **Alt** represent keys. If two are listed in sequence, it indicates that you are to hold down the first while pressing the second)

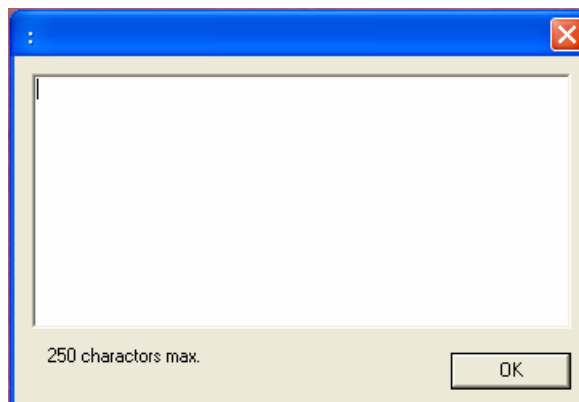
- Tab** or **Enter** Move to the next field
- Shift Tab** Move to the previous field
- Alt N** Move to the next page
- Alt R** Move to the previous page
- Alt S** Save the current case, but do not exit the case
- Alt X** Exit the current case (it will ask you if you want to save if you have not done so)
- Alt C** Allows you to select a different screen to abstract in (must also use **Alt H** to change screen)
- Alt H** Changes to the screen that you selected using **Alt C**
- Alt D** Marks the case as deleted
- Alt P** Pulls up the list of print options
- Alt E** Pulls up the error report option
- Alt T** Pulls up the treatment page (FORDS only)
- Alt Q** Pulls up the subsequent treatment page (FORDS only)



When you are in a text box you will see a T next to the line the cursor is on. If you click on the T you will get a free text box. This box provides you with the ability to have word wrap.

At the bottom of the box you will see the maximum number of characters that are available for the text box. This number is consistent with the field size in the NAACCR layout.

Once you are finished typing, click the 'OK' button and the text will appear in your abstract.





Registrars, April 6-10, 2015 is YOUR week! For more information, including ways to celebrate this important event, go to <http://www.ncra-usa.org/i4a/pages/index.cfm?pageid=3876>.

## Training Sites

*Compiled by Delores Greene, CTR*

**SEER's Training Web Site:** SEER's Training Web Site was developed to provide web-based training modules for cancer registration and surveillance, but can be used by anyone. <http://training.seer.cancer.gov/>

### ICD-O-3Errata and Clarifications:

It is very important to examine the errata pages and update printed copies of the International Classification of Diseases for Oncology, third edition. The printed versions of ICD-O-3 do not include these changes and must be updated manually.

<http://training.seer.cancer.gov/coding/structure/errata.html>

### SEER\*Educate:

This comprehensive training platform is tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts. <https://educate.fhcrc.org/LandingPage.aspx>

### Hematopoietic Training:

Online training with a CEU certificate for those who successfully complete a quiz after each presentation.

<http://seer.cancer.gov/tools/heme/training/>

### SEER Self Instructional Manuals for Tumor Registrars:

Instructional manuals that can be downloaded or you can order the manuals on CD-ROM. <http://seer.cancer.gov/training/manuals/>

**American College of Surgeons (ACS) Cancer Program Education Portal:** This site holds a wealth of educational opportunities for individuals involved in cancer care.

<http://eo2.commpartners.com/users/acsnew/index.php>

### National Program of Cancer Registries (NPCR) Training:

*Cyber Cancer Registry* is an interactive virtual registry system. *Brain Tumor Registry Reporting Training Materials* covers data collection for benign, borderline and malignant central nervous system tumors.

<http://www.cdc.gov/cancer/npcr/training/index.htm>

### American Joint Committee on Cancer:

Dedicated to supporting cancer registrars in the transition to directly assigning AJCC TNM stage.

<https://cancerstaging.org/CSE/Registrar/Pages/default.aspx>

### Florida Education:

Florida has approved use of their Educational Website by other NPCR States.

<http://fcds.med.miami.edu/inc/teleconferences.shtml#y2013>

### Quizlet Cancer Registry Structure & Management

This site has flashcards, lessons and tests.

<http://quizlet.com/16682004/cancer-registry-structure-management-flash-cards/>





## News You Can Use

### New Diagnostic Technology May Improve Detection of Certain Bladder Cancers

Author Claire Turmelle, Submitted by Judy Hanna, HT (ASCP)



Patients with known or suspected bladder cancer will now have access to improved diagnostic tools at the Stephenson Cancer Center through a new technology that uses blue light rather than the standard white light.

White light cystoscopy has been the gold standard for visualizing suspicious lesions for certain bladder tumors. However, when used on its own, harder-to-see tumors can often be missed. The blue light technology works by exploiting fluorescent properties of naturally occurring molecules in malignant tissues.

The Stephenson Cancer Center is one of a select number of centers nationwide, and the only one in the state of Oklahoma, offering the new diagnostic technology.

"Bladder cancer is difficult to detect and has a high rate of recurrence. An inaccurate diagnosis can result in incomplete treatment, which may lead to serious complications and a lower chance of survival for patients with potentially aggressive tumors," noted Michael Cookson, M.D., chair of the Department of Urology. "This new technology represents an important advancement in diagnostic technology, enabling more accurate diagnosis of bladder tumors compared to the standard technique."

Bladder cancer is the second most prevalent and the sixth most commonly diagnosed cancer in the United States. The American Cancer Society estimates that 72,570 new cases of bladder cancer are diagnosed in the U.S. each year, and between 50 to 80 percent of patients will have their bladder cancer recur, making it the highest recurrence rate of any form of cancer.

"The availability of this new technology is in keeping with our commitment to advancing patient care through science and innovation," said Cookson, who participated in the initial clinical trials that led to the approval of this technology. "Patients with known or suspected bladder cancer can now undergo diagnostic procedures at the Stephenson Cancer Center administered by physicians who have been specially trained in the use of this innovative technology."

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OCCR Staff will be out of the office on  
Monday, January 19th and  
Monday, February 16th, 2015

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