OKLAHOMA CENTRAL CANCER REGISTRY

OCCR NewsFlash

FEBRUARY 2016

AJCC TNM 7th Edition and SEER Summary Stage 2000 Training to be held in OKC April 27th - 28th, 2016

By Raffaella Espinoza, MPH

The Centers for Disease Control National Program for Cancer Registries (CDC-NPCR) require all cancer cases diagnosed in 2016 to have AJCC TNM and Seer Summary Stage assigned. In support of this transition to directly assigned AJCC stage, the OCCR will be hosting state-wide **AJCC TNM 7th Edition and SEER Summary Stage 2000 training** for all Oklahoma cancer reporters to attend.

The OCCR has invited a nationally recognized trainer to lead the AJCC cancer stage training which will include basic rules for assigning cancer stage and rules pertaining to specific common cancer sites. Case scenarios will be provided to aid the participants in practical application of cancer staging. The training will be tailored for an audience that includes the experienced cancer registrar to the cancer reporter who is unfamiliar with AJCC cancer staging.

The **AJCC TNM 7th Edition and SEER Summary Stage 2000 training** will be held on April 27th-28th at the Oklahoma Health Care Authority building in Oklahoma City. FREE registration and continuing education credits will be offered. More information on where and how to register will be disseminated as OCCR finalizes details. Please mark your calendars; we hope to see you there!

In the meantime, the National Cancer Registrars Association's Center for Cancer Registry Education has created a series of 10-minute PowerPoint presentations on complicated TNM staging issues. Topics to be covered include *Ambiguous Terminology*, the *Use of "Blank" and "X" for Stage Categories T, N, and M*, *Staging Neo-Adjuvant Treatment*, *Colon-Anatomy*, *Colon-Depth of Invasion* and *Clinical T, N,M for Ovary*.
http://www.cancerregistryeducation.org/best-practices.

Let it snow, let it snow, let it snow!

INSIDE THIS ISSUE:

By Judy Hanna, HT(ASCP)

Mark your calendars! April 11-15, 2016 is National Cancer Registrars Week (NCRW). This event was established by the National Cancer Registrars Association as an annual celebration to recognize and promote the work of cancer registry professionals.

The OCCR would like to extend our sincere appreciation to the registrars who work so diligently to report cancer data. Thank you for being the HERO in fighting the battle to prevent cancer in Oklahoma!

"I think a hero is any person really intent on making this a better place for all people" – Maya Angelou

All cancer registrars are invited to meet and take a group photo with Governor Fallin in honor of NCRW at the State Capitol in the Blue Room on April 6th at 9 a.m.

ICD-10 and Cancer Registry

By Kaela Howell, RHIA

If you're in any profession related to healthcare you are certainly aware of the major conversion to ICD-10 that was implemented last October. Almost every health field has or will be affected and cancer registry is no exception. Unless your facility was dual coding before October, registrars may not feel the shift for a little while longer, so there's still time to get ready! Although we are not on the front lines of this conversion, we should be aware of a few things.

As hospitals continue to use ICD-10, cancer registries will have to refine some of their processes to include ICD-10 codes in their case finding to be able to query. Registrars only need to know a portion of the new codes, mostly those located within Neoplasms section. This section contains codes C00-D48. The registry has already been using ICD-10 (with a few modifications) for almost 20 years for reporting cause of death and topography. If you look over the C codes for ICD-10 you'll notice that they're comparable to the topography codes within the ICD-O Manual. Further comparison of ICD-O and ICD-10 can be found within the introductory portion of your ICD-O Manual.

Be aware that the new coding system is more specific, which can result in more codes. For example, one code in ICD-9 may need 5 codes in ICD-10 to cover the original definition. The specificity of the codes can be used to the registrars' advantage. Although they should not be used as the only reference for information, these codes can differentiate between laterality as well as the gender of the patient for certain sites. Our profession is always evolving but the good news is that cancer registry can approach this major change as an adjustment instead of an overhaul. ICD-10 casefinding lists for Clinical Modification and Cause of Death codes can be found on the SEER website at

http://seer.cancer.gov/tools/casefinding/.

Newly Reportable Conditions/Tumors

By Susan Nagelhout, CTR

The following tumors are required to be reported by **ALL** Oklahoma facilities for cases diagnosed 1/1/2016 and after:

1. Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2).
2. Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._)
3. Cystic pancreatic endocrine neoplasm (CPEN). Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).
4. Mature teratoma of the testes in adults is malignant and REPORTABLE as 9080/3, but continues to be non-reportable in prepubescent children (9080/0). The following provides additional guidance:
    - Adult is defined as post puberty
    - Pubescence can take place over a number of years
    - Do not rely solely on age to indicate pre or post puberty status. Review all information (physical, history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
    - Do not report if unknown whether patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.
5. Laryngeal intraepithelial neoplasia*, grade III (LINIII) (8077/2), C320-C329.
6. Squamous intraepithelial neoplasia*, grade III (SINIII) (8077/2), except Cervix and Skin

***According to FORDS 2016, LIN III and SIN III are not reportable for Commission on Cancer (CoC facilities). These tumors are, however**, considered reportable by the Centers for Disease Control National Program for Cancer Registries (CDC-NPCR) and **MUST** be reported to the Oklahoma Central Cancer Registry (OCCR) by all Oklahoma facilities.

When Physician and Registrar Staging Don't Jibe

By Jessica Taylor

Physicians are responsible for documenting physician-assigned clinical and pathologic stage in the patient medical record. Hospital registrars are responsible for recording the physician-assigned stage in the registry database. The Commission on Cancer provides specific instructions on steps the registrar should take if the physician-assigned staging is not consistent with documentation or if staging cannot be found.

If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of a stage. However, it is outside the realm of the responsibility of the registrar to educate the physician. If physician-assigned stage cannot be found in the medical record, the registrar should assign the stage and record it in the registry database.

In both of these instances, the hospital registry should inform the registry physician advisor and refer identified documentation issues to the Cancer Committee for quality improvement activities. The NAACCR 2016 Implementation Guidelines can be found at: http://www.naaccr.org/standardsandregistryoperations/implementationguidelines.aspx.

CDC - NPCR SSF Requirements for Diagnosis Year 2016

By Paula Marshall, BBA, CTR

Beginning with cases diagnosed on or after January 1, 2016, the OCCR will follow the data collection requirements as set forth by our funding source, CDC-NPCR. Please make note of the changes listed below.

Required Site-Specific Factors (SSFs)

SSFs necessary to derive SS2000 or AJCC-TNM (for Collaborative Stage) are no longer required for cases diagnosed in 2016; however, site-specific factors that impact AJCC-TNM Stage Group assignment, or that are prognostic factors of interest, remain important to collect for cancer surveillance.

SSFs that will be required by CDC-NPCR are listed in Tables 2 and 3 below.

Table 2: SSFs Required for Directly Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Appendix	SSF11	Histopathologic Grading
GISTPeritoneum	SSF 5 and 10	Mitotic Count; Location of Primary Tumor
GISTEsophagus, GISTSmallIntestine, GISTStomach	SSF 6	Mitotic Count
GISTAppendix, GISTColon, GISTRectum	SSF 11	Mitotic Count
MycosisFungoides	SSF 1	Peripheral Blood Involvement
Placenta	SSF 1	Prognostic Scoring Index
Prostate*	SSF 1, 8 and 10	PSA Lab Value, Gleason Score
Testis	SSF 13, 15, 16	Post Orchiectomy AFP, hCG, and LDH Range
BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, MelanomaCiliaryBody, MelanomaIris, Nasopharynx, Peritoneum, PeritoneumFemaleGen, PharyngealTonsil, Stomach	25	*Schema Discriminator*

*NOTE: NPCR will continue the requirement for Gleason Score data using SSF 8 and 10 in order to accurately determine the AJCC stage group for prostate cancer cases.

Requirements continued on next page

February is National Cancer Prevention Month

CDC - NPCR SSF Requirements, continued from page 4

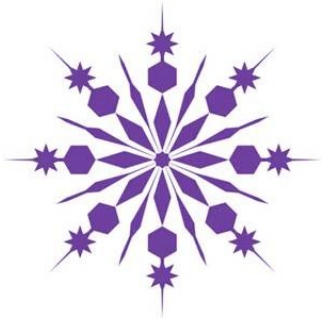
Table 3: SSFs required by NPCR (but not for AJCC Staging)

Site (CS Schema)	SSF	Description
Brain, CNSOther, IntracranialGland	1	*Who Grade*
Breast	1	*ERA*
	2	*PRA*
	8	*HER2: IHC Value*
	9	*HER2: IHC Interpretation*
	11	*HER2: FISH Interpretation*
	13	*HER2: CISH Interpretation*
	14	*HER2: Result of other test*
	15	*HER2: Summary Result testing*
	16	*Combination of ERA, PRA and HER2 Testing*

Newly Required Data Collection Variable for 2016

CDC-NPCR has added one newly required data collection variable for 2016:

Tumor Size Summary – Captures single best tumor size from information available.



Web Plus Changes

By Paula Marshall, BBA, CTR

Over the years we have observed staff turnover, frustration with the edits, and less time allocated for abstracting. The OCCR decided to make some changes to Web Plus in order to simplify abstracting on your part and I'm sure everyone will be quite pleased!

What are the changes?

- New display type is labeled Low Volume Facility
- The Collaborative Staging (CS) section has been removed
- CS variables are no longer required to be coded
- Same look just less variables
- No longer required to run the CS Edits

When you click "Save", the edits will run automatically and you are still required to clear any errors before the case can be "Released."

When will changes take place?

- All cases MUST be released no later than January 22nd, 2016
- Non-released cases will be lost once the change takes place
- Low Volume Facility display type available on January 29th, 2016

The new display type, "Low Volume Facility," is now available. If you did not receive an email announcing the changes or a copy of an electronic Web Plus Manual, please contact paulam@health.ok.gov.

Reportable Benign/Borderline Intracranial and Central Nervous System (CNS) Tumors: Part One

By Susan Nagelhout, CTR

Non-malignant primary intracranial and central nervous system tumors became reportable effective with diagnosis on or after January 1, 2004. ICD-O-3 behavior code of 0 or 1 are required for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central parts of central nervous system (72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2), and pineal gland (C75.3).

In addition, two additional ambiguous terms that constitute a diagnosis were established for non-malignant primary intracranial and CNS tumors: neoplasm and tumor.

Oftentimes, it is difficult to ascertain the exact location of the primary tumor. The following definitions and descriptions are presented to aid the reporter in determining location of tumor and establish if the tumor is reportable.

Meningioma:

Meningiomas typically arise from the meninges, which cover the brain and spinal cord. Although intracranial meningiomas are referred to as brain tumors, they do not arise from brain tissue. Meningiomas arising from the meninges covering the brain are reportable and are coded to primary site C70.0. Meningiomas arising from the meninges covering the spinal cord are reportable and are coded to primary site C70.1.

Rarely, meningiomas arise from within the bones of the skull. These are primary intraosseous meningiomas. These benign tumors are coded to primary site C41.0 and thus are not considered reportable for benign tumors. An example of an intraosseous meningioma is a “sphenoid wing meningioma”.

Benign/Borderline Spinal Cord Tumor:

Benign spinal cord tumors are reportable if they are stated to be “intradural” or “of the nerve root” or “intramedullary”.

Spinal tumors can be divided into three categories: extradural, intradural extramedullary, intramedullary.

- *Extradural tumors* typically arise from the osseous spine, intervertebral discs or adjacent soft tissues. Examples of benign extradural spinal tumors are hemangioma, osteoid osteoma and osteochondroma. These tumors are *NOT* reportable as they do not arise from the nerve root.
- *Intradural extramedullary tumors* arise inside the dura but outside the spinal cord. Examples of benign/borderline intradural extramedullary tumors are meningioma (C70.1), schwannoma (C72.0) and neurofibroma (C72.0). These tumors ARE reportable as they do arise from the nerve root.
- *Intramedullary tumors* arise from cells within the spinal cord. These tumors are very rare. Examples of benign/borderline intramedullary tumors are hemangioblastoma, cavernoma and ganglioglioma. These tumors ARE reportable and would be coded to site C72.0.

Stay tuned for Part Two of Reportable Benign/Borderline Intracranial and Central Nervous System Tumors in the next OCCR newsletter.

FACILITY SPOTLIGHT

ProCure Proton Therapy Center

By Jessica Taylor

This quarter the OCCR shines the spotlight on ProCure Proton Therapy Center.

ProCure Proton Therapy Center opened in 2009 and administers proton therapy as treatment for both benign and malignant conditions. Proton therapy is an advanced form of radiation which precisely targets tumors, reducing damage to healthy tissue near the tumor. Because of the precision of this type of radiation therapy, it allows higher, more effective doses of radiation. It is particularly useful for treating tumors around critical organs/regions of the body as well as for children and young adults.

ProCure does not house a "cancer registry" but one person ensures the data is captured and sent to the OCCR. Dulce Bramblett accepted a position with ProCure in February 2013 as cancer registrar for their Oklahoma City, OK and Somerset, NJ facilities. She performs all casefinding and case abstracting and produces reports as needed. She has also been assisting the research department at ProCure with follow-up for more than two years.

Dulce's journey as a cancer registrar began in 2002. She was employed at Deaconess Hospital for 19 years and during that time she began working with their cancer registry in 2002. She attended the 5-day SEER Principals of Oncology for Cancer Registry Professionals taught by April Fritz, learned on-the-job with tremendous support by fellow registrars, and obtained her CTR in 2004. Dulce has also worked as a cancer registrar and coordinated compliance with the American College of Surgeons Commission on Cancer standards. Since becoming a Certified Tumor Registrar, she has worked part-time for cancer registries at St. Anthony Shawnee, OU Medical Center and Kforce, and eventually worked full-time for Kforce as a remote abstractor. Her responsibilities included performing quality assurance on abstracts which she really enjoyed.

Dulce and Odie

When asked what the favorite part of her job was she replied, "I enjoy the precision required for abstracting and the challenges of utilizing all available resources to ensure each case is abstracted to the best of my ability. The diversity of cases seen at ProCure allows me to continually expand my knowledge."

Dulce states that her biggest challenge as a registrar is staying current with coding rules from all the different standard setters. As a member of the Oklahoma Cancer Registrars Association [OCRA] executive committee since 2009, Dulce has worked closely with registrars from other facilities, and has come to rely on those friendships. Dulce states, "My secret weapon is the support of a few amazing registrars who I consult with case questions. We're in this together and supporting each other is key!"

In 2014 ProCure Proton Therapy Center treated 334 patients with approximately 15% coming from countries outside the U.S. The top primary sites in 2014 were: Prostate, Brain/CNS and Lung, with prostate representing about 46% of the 334 cases abstracted. Dulce does a fantastic job, reporting an average of 340 cases per year!

Collaborative Stage Transition

By Paula Marshall, BBA, CTR

As a reminder, the initial change in 2016 will be focused on the transition to directly assigned TNM stage, but will not eliminate all the variables collected under CS. Both directly assigned SEER Summary Stage 2000 and AJCC-TNM Clinical and Pathologic Stage are now required for all cases except for those cases where stage is not applicable. Effective with cases diagnosed in 2016, the Collaborative Stage Data Collection System will no longer be used for deriving stage; however, the CSv2 items and algorithm will remain in place for coding historical cases diagnosed from 2004-2015. The existing CSv2 fields will also continue to be used for capturing required SSFs for 2016 diagnosis forward. In particular, most Site Specific Factors (SSFs) will continue to be required, as they are either:

*A critical component of stage assignment
*Essential to understanding the cancer (predictive or prognostic factors)

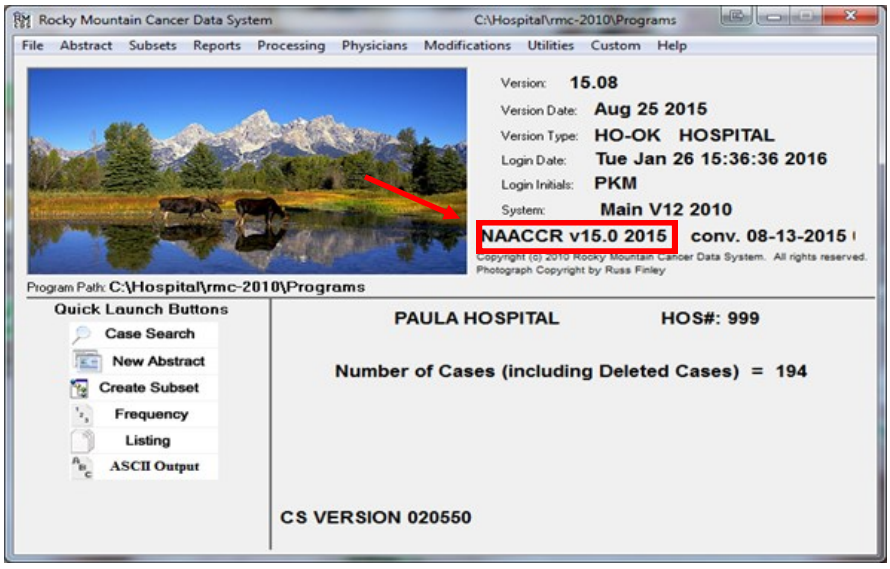
New AJCC T, N, and M Categories to Be Implemented in 2016:

The primary considerations when assigning AJCC staging classifications are timeframe and criteria. The clinical staging (or classification) timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. Within the clinical staging timeframe, criteria include physical exam, imaging, endoscopies, and diagnostic biopsies. It is important to emphasize that the mere existence of a pathology report that includes microscopic assessment does not exclude it from the clinical staging criteria. If the assessment was a part of the diagnostic workup, it has occurred within the clinical timeframe and can be used for clinical staging.

The pathologic staging/classification timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery. Within the pathologic staging timeframe, criteria include all of the clinical staging criteria, operative findings from the surgeon, and the pathology report for the resected specimen. Observations, from the surgeon in the operative findings that are not accompanied by a biopsy are included in the pathologic staging criteria (e.g., observation of extension without a tissue sample for pathologic review). Similarly, involvement found on imaging is considered in the pathologic staging criteria even in the absence of tissue biopsy.

Rocky Mountain Cancer Data System (RMCDS) Corner

By Paula Marshall, BBA, CTR



The OCCR is currently using NAACCR format Version 15. If you have not converted the RMCDS system at your facility, please contact me as soon as possible. The OCCR is no longer accepting files in version 14 and you will be asked to resubmit any files sent in version 14 files. To locate the current NAACCR version of the RMCDS system, please see the example to the left.

2016 National Conferences

By Christina Panicker, MBA, CTR

Cancer registrars have two excellent educational opportunities available in 2016! April 10-13, NCRA will be hosting its 42nd Annual Educational Conference in Las Vegas, NV at the Westgate Las Vegas Resort Hotel. Click here for more details.

June 11-17, NAACCR will hold its Annual Conference in St. Louis, MO. The theme of the conference is "Gateway to Cancer Discoveries." To learn more about the conference click here.

NAACCR St. Louis 2016

Are you Compliant?

By Leslie Dill

Ready or not, compliance letters are scheduled to be mailed by mid-February. Compliance Specialist, Susan Nagelhout, is currently preparing a letter for each reporting facility. The letter will contain facility-specific information to complete the following fields:

Expected Number of Cases	Cases Received	Cases Needed to be Compliant	Compliant? Yes or No

Below is a schedule that can be used this quarter to keep track of reporting dates and ensure that cases are being reported to OCCR within 180 days of diagnosis.

Month of Diagnosis	Month Due to OCCR	Date Submitted to OCCR
August 2015	February 2016	
September 2015	March 2016	
October 2015	April 2016	
November 2015	May 2016	
December 2015	June 2016	

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Upcoming Webinars

By Leslie Dill

The following NAACCR webinars will be presented in Oklahoma City and Tulsa at no cost to registrars. If you are interested, please email SusanN@health.ok.gov for registration and details.

March 3, 2016 - Abstracting and Coding Boot Camp
April 7, 2016 - Collecting Cancer Data: Ovary
May 5, 2016 - Collecting Cancer Data: Kidney

2016 CTR Exam Dates Announced

By Leslie Dill

NCRA has announced the 2016 CTR exam dates. To learn more, including exam details and how to request a copy of the 2016 CTR Exam Handbook & Application, visit www.ctrexam.org.

2016 Testing Dates:

February 27 - March 19; application deadline = January 29
June 18 - July 9; application deadline = May 20
October 15 - November 5; application deadline = September 16

Please email SusanN@health.ok.gov if you are interested in participating in the 2016 CTR Exam Readiness Webinars. OCCR strives to purchase and provide these webinars when an interest is shown and funding is available.

We're on the Web!
http://occr.health.ok.gov

Oklahoma State Department of Health
Creating a State of Health

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