

May 2016 E-Tips

Assistance for AJCC/TNM questions

sent to CAnswer Forum

New Jersey State Cancer Registry

Cancer Epidemiology Services

www.state.nj.us/health

(609) 633-0500

Do not reply to this email address



Beginning May 16, 2016 additional help will be available for AJCC questions sent to CAnswer Forum.

If you have a **AJCC related question for CAnswer Forum**, please submit it to CAnswer Forum as instructed on the website, <http://cancerbulletin.facs.org/forums/>

If your question is not answered within **15 business days**, please send the question to OPS.NJSCR@doh.nj.gov. **Please include in your email:**

- Your question
- Your name
- Your email address
- The date it was initially sent to CAnswer Forum

Your question will be reviewed. If it is determined there is no answer posted on the forum, the question will be submitted to an additional CDC address that will be monitored for question submissions.

When an answer is received, it will be forwarded to you.

This new procedure was developed by members of the CDC Division of Cancer Prevention and Control, Cancer Surveillance Branch. It is **specifically designed for AJCC/TNM questions only**.

Please contact Heather Stabinsky at NJSCR with questions, heather.stabinsky@doh.nj.gov

April 2016 E-Tips

Notable Details

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

CODING GRADE/DIFFERENTIATION

Per SEER Instructions for Coding Grade for 2014+:

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

FIGO GRADE cannot be used to assign Grade/Differentiation.

WHO (CNS Tumors) cannot be used to assign Grade/Differentiation.

WHO/ISUP (bladder/renal pelvis) cannot be used to assign Grade/Differentiation.

PROSTATE SSF 1/SSF 2

Record the highest PSA value prior to, and closest to, diagnostic biopsy of prostate and initiation of treatment in the range 001 to 979.

SSF 1 is a 3-digit field with an **implied decimal point between the second and third digits**. A PSA lab value 98.0 ng/ml or greater should be coded 980.

- Example PSA 12.6= SSF 1 **126**
- Example PSA 8.4= SSF 1 **084**
- Example PSA 126.5= SSF1 **980**

Results for SSF1 and SSF2 should be from the same test. (CS v02.05, Section 2)

CODING PRIMARY SITE

Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site (SEER Program and Coding Manual, pg 75)

BREAST SURGERY CODES

A **total (simple) mastectomy** removes all breast tissue, the nipple, and the areolar complex. **An axillary dissection is not done.** (SEER Program Coding Manual, Breast: Appendix C)

A sentinel node biopsy can be performed. Apply appropriate 40 surgery code.

SEER SUMMARY STAGE

SEER Summary Stage 2000 is required to be reported starting with NAACCR v15 (and subsequently v16). NAACCR #759

(NAACCR 2015 Implementation Guidelines and Recommendations)

TNM EDITION

TNM Edition # is required to be reported starting with NAACCR v15 (and subsequently v16). NAACCR #1060

(NAACCR 2015 Implementation Guidelines and Recommendations)

BRM/IMMUNOTHERAPY DRUGS

Beginning with diagnosis 1/1/2013, the following drugs moved from chemotherapy categorization to BRM/Immunotherapy. (seer.cancer.gov, SEER Rx)

- Rituxan
- Avastin
- Erbitux
- Perjeta
- Herceptin
- Compath

ADDITIONAL INFORMATION ON CODING RULES CAN BE FOUND AT <http://seer.cancer.gov>. Questions can be sent to your facility's State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

January 2016 E-Tips

Coding Total (Simple Mastectomy)

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

A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex.

An axillary dissection is not done.

40 Total (simple) mastectomy, NOS

41 WITHOUT removal of uninvolved contralateral breast

43 Reconstruction, NOS

44 Tissue

45 Implant

46 Combined (tissue and implant)

42 WITH removal of uninvolved contralateral breast

47 Reconstruction, NOS

48 Tissue

49 Implant

75 Combined (tissue and implant)

[SEER Note: "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

Question: 20091076- Surgery of Primary Site/Scope Regional LN Surgery--Breast: How should these fields be coded when a sentinel lymph node dissection removes one-to-three axillary lymph nodes and a total/simple mastectomy is done?

Answer- Assign code 41 [Total (simple) mastectomy, NOS WITHOUT removal of uninvolved contralateral breast] for Surgery of Primary Site. Assign code 2 [Sentinel lymph node biopsy] for Scope of Regional Lymph Node surgery. **Code 41 applies to a total/simple mastectomy with any number of sentinel lymph nodes removed -- as long as all of the nodes removed are designated as sentinel nodes.**

Question: 20120019- Surgery of Primary Site/Scope Regional LN Surgery--Breast: How are these fields coded for breast cases diagnosed 2011 and later when the patient has a simple mastectomy with removal of seven sentinel lymph nodes? See Discussion.

Discussion- Per SINQ 20091076, the correct codes would be 41 [simple mastectomy] and 2 [sentinel lymph node biopsy only] when the patient has any number of sentinel nodes removed, as long as they are designated as sentinel nodes. Under the mastectomy codes in the 2011 SEER Manual, Appendix C, Breast Surgery Codes, the SEER Note states that code 41 [simple mastectomy] includes the removal of one to three axillary lymph nodes. A simple mastectomy with four or more axillary lymph nodes is coded to 51. Does the lymph node count for code 51 include both sentinel and axillary lymph nodes? Or does code 51 refer to strictly the count of axillary lymph nodes, separate from the count of sentinel lymph node(s) biopsied?

Answer- First, make sure that the seven lymph nodes removed were actually designated to be sentinel nodes and not a combination of sentinel nodes and other regional nodes. Code sentinel nodes only when the nodes are stated to be sentinel nodes or when the surgical procedure includes the injection of dye to identify sentinel nodes.

If all seven nodes removed are sentinel nodes, follow the instructions in SINQ 20091076 and assign codes 41 [simple mastectomy] and 2 [sentinel lymph node biopsy only].

The guideline [Appendix C: Breast] does not pertain to nodes designated as sentinel nodes. A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex. An axillary dissection is not done.

ADDITIONAL INFORMATION ON CODING TOTAL (SIMPLE) MASTECTOMY CAN BE FOUND AT <http://seer.cancer.gov/manuals/2015/appendixc.html>.
Questions can be sent to your facility's State Representative or by calling 609-533-0500. DO NOT REPLY to this email.

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.

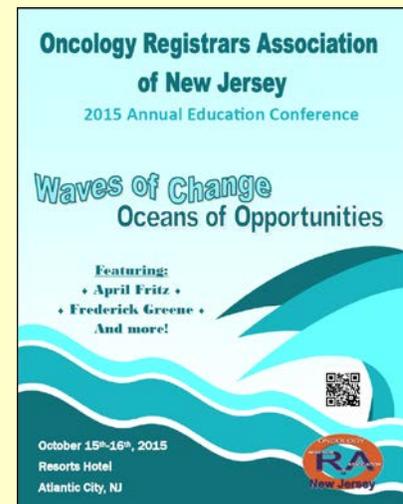
Attendees had the opportunity to hear presentations on topics such as:

- ❖ 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.

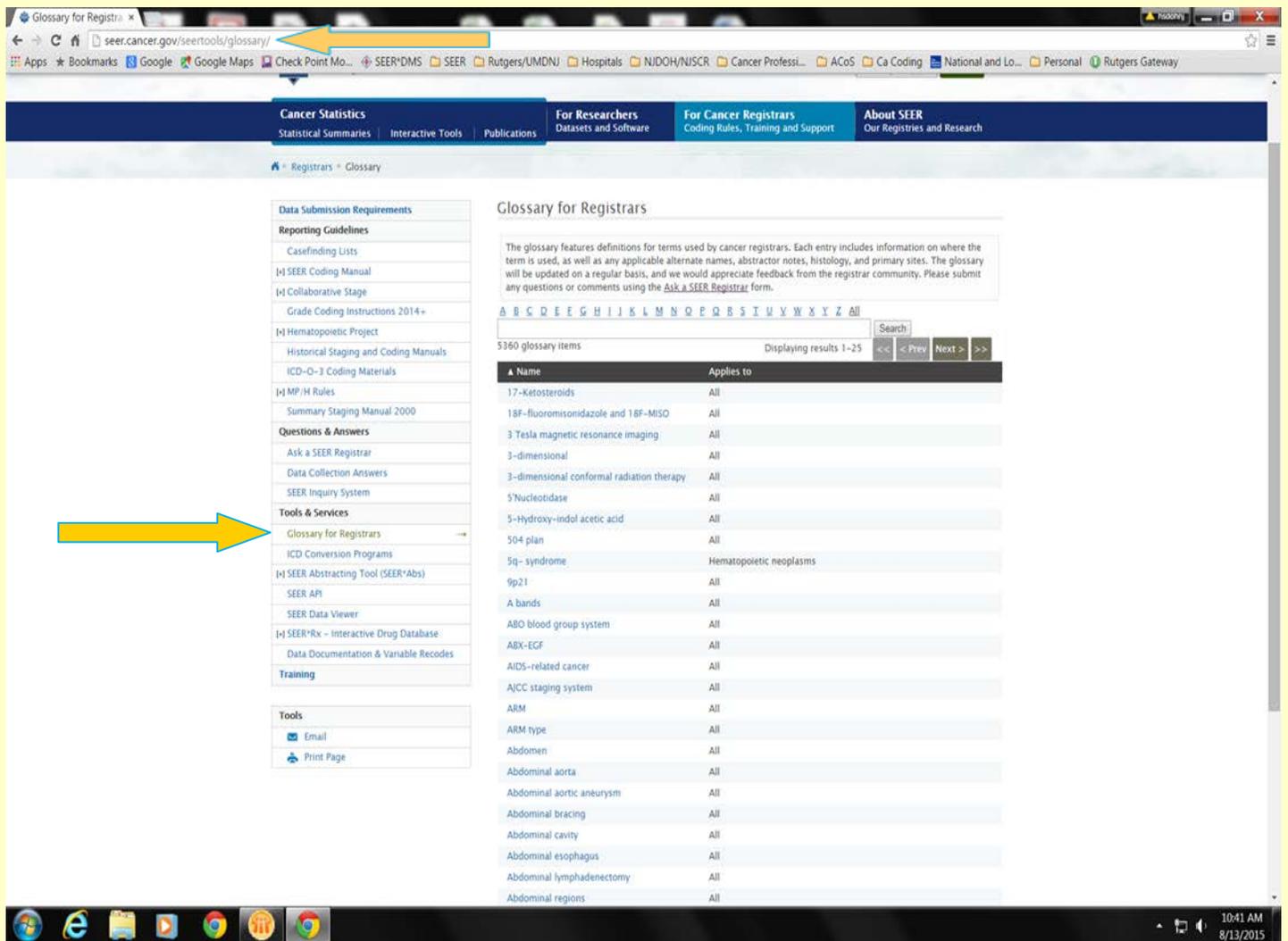
Epidemiologic Study of Hepatocellular Carcinoma

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.

JULY 2015 E-Tips
COLON HISTOLOGY RULES

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

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)

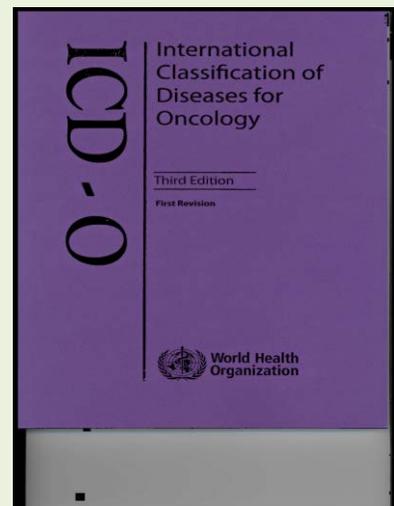
New term 8213/3 Serrated adenocarcinoma

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.