DECEMBER 2018 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

CERVICAL LYMPH NODES AND UNKNOWN PRIMARY TUMORS OF THE HEAD AND NECK

In AJCC 8th edition, a new chapter was introduced for situations when there are positive cervical nodes and the primary tumor is not evident (occult tumor) but the primary tumor is suspected to be from the head and neck region (primary sites C00-C14, C30-32). "Positive cervical nodes" is an overall term used for the head and neck regional lymph nodes, which include Levels I-VII, and other groups.

This section pertains to cases diagnosed 1/1/2018 and later. Previous instructions were to code these types of cases to C14.8.

If the differential diagnosis includes non-head and neck sites, the primary site should be coded to C80.9. Ex. Path states metastasis to cervical lymph node, could be from head and neck primary, lung primary or gynecological primary. Code C80.9.

	EBV Positive	EBV Negative	EBV Unknown
P16 Positive	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C10.9 Oropharynx (Schema ID 00100: Oropharynx HPV-Mediated (p16+))	C10.9 Oropharynx (Schema ID 00100: Oropharynx HPV-Mediated (p16+))
P16 Negative	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)
P16 Unknown	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)

Choosing the correct primary site depends on whether the Epstein-Barr Virus (EBER test) is done and is positive. If it is EBV positive the primary site is C11.9, Nasopharynx, NOS. The AJCC Nasopharynx chapter will be used.

If the p16 test for Human Papilloma Virus (HPV) is done and is positive (and the EBV is negative or unknown), the primary site is C10.9, Oropharynx, NOS. The AJCC HPV-Mediated (p16+) Oropharyngeal Cancer chapter will be used. Note: p16 is a surrogate marker for HPV and is the only test that can be used for this discriminator.

If the neck node has not been tested or is negative for both HPV and EBV, the primary site will be coded to C76.0 and the AJCC Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck chapter will be used.

Further instructions and examples can be found in the Site-specific Data Item (SSDI) Manual.
https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

ANY QUESTIONS?

The following question was recently submitted to SEER from our central registry.

Question: **What is the difference between 'Ask a SEER Registrar'** (AASR) and submitting a question in **SEER SINQ** (SS)?

Answer: AASR is for anyone to use. AASR questions are answered by NCI SEER staff who specialize in the particular topic of the question. The answer is returned to the author of the question. AASR questions are usually answered within a week, sometimes within a day.

In contrast, questions can be submitted to SINQ only by designated registrars in SEER registries. The questions are answered by a trained contractor and reviewed by NCI SEER staff. The answers are then reviewed by the designated registrars in the SEER registries. All reviewer comments are taken into consideration before the SINQ answer is finalized. Once the answer is final, it is available to everyone via the SINQ database on the SEER website. Certain AASR questions are added to SINQ to make the information available to the cancer registry community. These AASR questions in SINQ go through the same review process as other SINQ questions. The review process takes time, so questions submitted to SINQ take longer to answer, sometimes a month or more.
https://seer.cancer.gov/

UNKNOWN DATE OF DIAGNOSIS

The NJSCR's QI Workgroup recently reviewed 332 cases submitted by NJ hospital cancer registries with a date of first contact in 2016 and an unknown date of diagnosis.

It is very important to do everything possible to determine the year of diagnosis. Cases with an unknown year of diagnosis cannot be transmitted to NCI SEER.

For analytic cases, the year of diagnosis cannot be blank or unknown. The date of diagnosis should be estimated if an exact date is not available. For guidelines on estimating the date of diagnosis see:
https://seer.cancer.gov/archive/manuals/2016/SPCSM_2016_maindoc.pdf page 68-72
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx page 120

Consulting with the managing physician for information regarding the date of diagnosis is also recommended. If there is no information about the date of diagnosis, use the date of first contact as the date of diagnosis. This should be used as a last resort when all other resources have been exhausted.

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

NOVEMBER 2018 E-Tips

New Jersey State Cancer Registry
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Do You Need CEs?

SSDI 2018 Coding Exercises Now Available in SEER*Educate!

Site Specific Data Items (SSDI) replaced the Collaborative Stage Site Specific Factors effective with cases diagnosed 1/1/2018. SEER*Educate has made 85 practice cases available from the Training Menu in the Practical Application section.

The National Cancer Registrars Association (NCRA) awarded continuing education (CEs) credits for each set of 5 cases. **These were approved as Category A CEs.**

https://educate.fredhutch.org/LandingPage.aspx

The Term "Recurrence"

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. **The ONLY exception** is when **a pathologist compares slides** from the subsequent tumor to the "original" tumor and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".
https://seer.cancer.gov/tools/solidtumor/General_Instructions_STM.pdf (pg 9)

Correction:

On the current NJSCR reportable list, under the Soft tissue heading is **Angiomyxoma** (+), listed as reportable. This is a ***not*** reportable condition and will be removed when the list is updated in the future. Another non-reportable term in ICD-O-3 is Aggressive Angiomyxoma which has the same histology code, 8841/1.

Reserve your space!

NJSCR Presents: **Spend the Day at the Registry**

Date: December 6, 2018

Location
135 E. State Street
Trenton, NJ 08608

*awarded **5.5 CE hrs** by NCRA (0 category A)*

Follow link below for registration form:

https://www.nj.gov/health/ces/documents/Brochure%20revised%20AGAIN%202%20for%202018%20dates.pdf

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Coding Corner: ANAL CANCER

Reportable Diagnosis:
Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211).

Code 8077/2 (Squamous intraepithelial neoplasia, grade III) for in situ squamous intraepithelial neoplasia grade III in the anus (AIN III).
https://seer.cancer.gov/tools/solidtumor/Other_sites_STM.pdf (pg 6)

Do Not Report:
AIN III (8077) arising in perianal skin (C445).
https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf (pg 7)

In the absence of any additional information about the primary site, assign the codes listed for these primary sites.

Primary Site	Code
Anal margin	C445
Anal verge	C211

Anal cancer cases in the U.S. have been increasing over several decades. Infection with human papillomavirus (HPV) is the major risk factor for anal cancer.
The skin around the outside of the anus is called the perianal area. Tumors in this area are *skin* tumors, not anal cancer.
https://www.cancer.gov/types/anal
Anal warts (condyloma acuminata) are caused by the human papilloma virus (HPV). Left untreated, warts may lead to an increased risk of anal cancer in the affected area.
https://www.fascrs.org/patients/disease-condition/anal-warts-0
For additional information on anal cancer, visit
https://www.cancer.gov/types/anal

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

OCTOBER 2018 E-Tips

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Did you know?

IMPORTANT 2018 BREAST CHANGES! Effective with cases diagnosed 1/1/2018 and later.

Mammary carcinoma is a synonym for "carcinoma no special type" (NST)/duct carcinoma, not otherwise specified (NOS), 8500. It will no longer be coded as carcinoma NOS, 8010.

DCIS/Carcinoma NST in situ has a ***major*** classification change. **Subtypes/variant, architecture, pattern, and features *ARE NOT CODED***. The majority of in situ tumors will be coded to DCIS 8500/2.

Example: What histology would be assigned? Path says histologic type: ductal carcinoma in-situ. Architectural pattern: Comedo, Cribriform, Micropapillary, Solid. Tumor Grade: histologic grade 2. Nuclear Grade 2.
Answer: 8500/2, Subtype, variant, architecture, pattern and features ARE NOT CODED.

Rule M8 Breast Multiple Primary Rules:
Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than five years after the original diagnosis ***or last recurrence.***

Note 2: Clinically disease-free means that there was no evidence of recurrence on follow-up.
- Mammograms are NED
- Scans are NED
- Tumor biomarkers are NED

Note 3: When there is a **recurrence less than or equal to five years of diagnosis, the "clock" starts over.** The time interval is calculated from the date of last *recurrence.* In other words, the patient must have been disease-free for greater than five years from the date of the *last recurrence*.

Note 4: When it is unknown/not documented whether the patient had a recurrence, use date of diagnosis to compute the time interval.

https://seer.cancer.gov/tools/solidtumor/Breast_STM.pdf

Punctuation in Demographic Information:

First name NAACCR Item #: 2240
Last name NAACCR Item #: 2230

Blanks spaces, hyphens, and apostrophes are allowed; do not use other punctuation. Do not use parentheses, periods, etc., in next of kin fields either.

Example:
Mc Donald: Recorded with space as Mc Donald
O'Hara: Recorded with apostrophe as O'Hara
Smith-Jones: Janet Smith marries Fred Jones and changes her last name to Smith-Jones
https://seer.cancer.gov/archive/manuals/2016/SPCSM_2016_maindoc.pdf pg 30 &31

NJSCR Cancer Reporting Rules (a.k.a. "Regs")

The administrative code defining cancer reporting rules in New Jersey, N.J.A.C. 8:57A, was readopted with amendments effective July 17, 2018. Below are highlights of some of the more significant amendments. For full-text of the readopted rules, please visit https://www.nj.gov/health/ces/.

2018 Renewal Highlights

Old Rules	New Rules
List of reportable diseases and conditions was included in the rules as N.J.A.C. 8:57A-1.11.	The reportable list is now a separate document and can be found on the NJSCR web site at https://www.nj.gov/health/ces/.
Timing for reporting to NJSCR was within 6 months of diagnosis or 3 months of discharge, whichever is sooner.	New reporting timeframe is within 6 months of date of first contact at the reporting facility.
Electronic reporting by labs was not required.	Electronic pathology (E-path) reporting by labs (independent and hospital-based) is required as licenses become available.
NJSCR staff must be given access to medical records as requested.	Remote access to medical records must be provided, if available. If remote access is not available, then records must be sent in electronic format approved by NJSCR.
NJSCR was not permitted to release treatment information back to a facility.	Facilities may request and receive treatment information reported by another facility for patients already reported by that facility. Treatment information will be limited to date and type of treatment. Location of treatment will not be released.
Physicians, dentists, other health care providers and clinical laboratories were allowed to report to NJSCR on paper.	Physicians, dentists, other health care providers and clinical laboratories are now required to report to NJSCR electronically.
No-cost registry software, Rocky Mountain Cancer Data System, was available through NJSCR.	The NJSCR now offers the CDC suite of Registry Plus products at no cost.

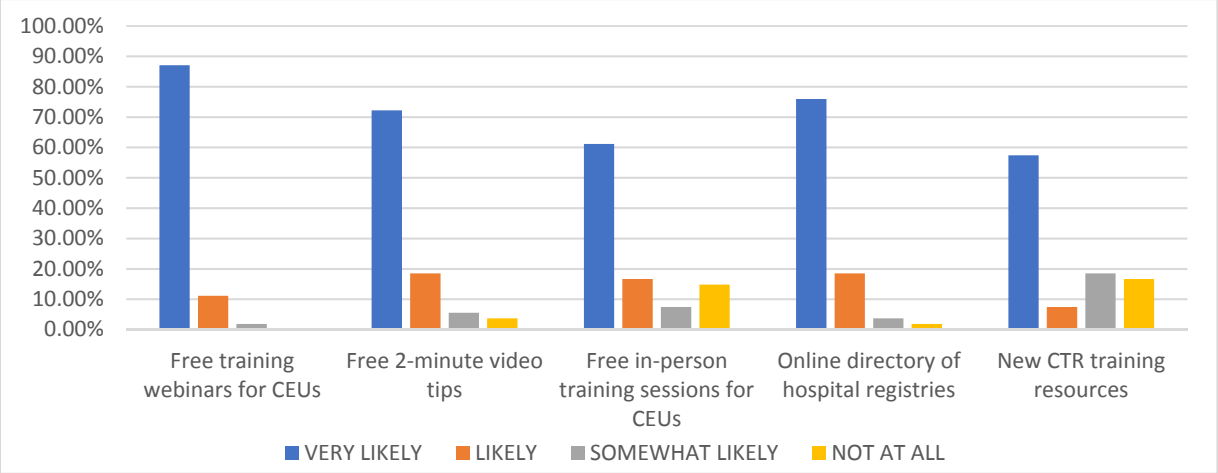
Questions can be sent to your facility's State Representative or by calling 609-633-0500. DO NOT REPLY to this email.

SEPTEMBER 2018 E- Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

2018 Hospital Needs Assessment Survey. We Asked. You Answered!

Thank you to everyone who participated in the 2018 Hospital Needs Assessment Survey! Your responses will help NJSCR to plan activities and programs for the coming year. Fifty-four registrars from hospitals throughout the State responded to the brief survey.

1. **How important are each of the following NJSCR resources to your registry work?**
   The top results, in order of importance, were (1) Reportable List; (2) Follow-up Reports; (3) E-tips Newsletter; and (4) NJSCR Program Manual.
2. **How likely would you be to use the following resources if provided by NJSCR?**



Great news! NJSCR will soon be offering the recorded NAACCR Cancer Registry and Surveillance Webinar Series (a $1,440 value!) to New Jersey hospital cancer registrars free of charge! More information to come.

3. **Would you like NJSCR staff to visit your facility?**
   Half of all respondents indicated they would like NJSCR to visit their facility to present to their cancer committee or meet with their leadership. To arrange a visit to your facility, please contact your NJSCR hospital representative.

Early/evolving melanoma -IMPORTANT REPORTABILITY CHANGE FOR 2018!

SINQ 20180029:
Question: Reportability—Skin. Is **early/evolving** lentigo maligna reportable?
Answer: **Early/evolving** lentigo maligna is ***not*** reportable. As of 1/1/2018 diagnoses, **none of the early/evolving melanoma types are reportable.**
https://seer.cancer.gov/seerinquiry/index.php?page=search_results&records=n&search_results_show=first&search_type=quick_search&search_within_results=0&quicksearch=20180029&Question_1=1&Question_3=1&search_display_format=1

Examples:
Early/evolving melanoma in situ NOS is not reportable (starting 1/1/18)
Early/evolving melanoma in situ, lentigo maligna type, is not reportable (starting 1/1/18)
Early/evolving melanoma in situ (insert other type, i.e. superficial spreading) is not reportable (starting 1/1/18)

Lentigo maligna: Is a specific histologic type of in situ melanoma. It appears as a brown or black mottled, irregular, lesion with increased numbers of scattered atypical melanocytes in the epidermis. It usually occurs on the face.
Lentigo maligna melanoma: Is an invasive melanoma that begins as lentigo maligna, but usually after many years the dermis is invaded by the tumor. Once invasion has occurred, the lesion is called lentigo maligna melanoma.
Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or “severe melanocytic dysplasia.” **Not reportable.**
https://seer.cancer.gov/tools/solidtumor/Melanoma_STM.pdf

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

August 2018 E- Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

A recent **review of 1,550 analytic bladder cancer** cases diagnosed in 2016 and submitted from fifty-eight (58) NJ hospital cancer registries was conducted. The review focused on the data items: grade and SSF 1 (WHO/ISUP Grade).

A summary of the review revealed the following:

BLADDER GRADE

GRADE CORRECT	GRADE INCORRECT	TOTAL
676 (43%)	874 (57%)	1550

SSF 1 (WHO/ISUP GRADE)

SSF1 CORRECT	SSF1 INCORRECT	TOTAL
1463 (94%)	87 (6%)	1550

Rules for coding bladder grade for histologies 8130 and 8120 with diagnosis date 01/01/2014 through 12/31/2017:
In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

	Grade/differentiation field	CS SSF 1 WHO/ISUP Grade
WHO/ISUP Grade **specified**	Code 9	Code grade as appropriate Low Grade (010)/High Grade (020)
WHO/ISUP Grade **not specified**	Code grade based on 2-grade system Low Grade (2)/High Grade (4)	Code grade as appropriate Low Grade (010)/High Grade (020)

For **Grade/Differentiation** if WHO/ISUP grade is specifically stated you do not code the field with the grade, code 9. If the grade is given and WHO/ISUP is not stated, code the grade in the field as appropriate.
For **CS SSF 1** (WHO/ISUP Grade) if the WHO/ISUP grade is specifically stated you code the field with the appropriate code. If the grade is given and WHO/ISUP is not stated, assume it is WHO/ISUP and code the grade in the field as appropriate.

In situ and/or combined in situ/invasive components:
o If a grade is given for an in-situ tumor, code it. Do NOT code grade for dysplasia such as high-grade dysplasia.

o If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown (**SEER 2016 Manual, Page 97, 7a/FORDS 2016 Manual, Page 12, 7a)**

The **Cancer Schema List for the EOD Data v1.3** is available on the National Cancer Institute Seer Registrar Staging Assistant site. This includes an Extent of Disease Schema List which can be used to search for required data items by a specific site. Extent of Disease (EOD) consists of three data items that describe how far that cancer has spread at the time of diagnosis. Within the list you will find the name of the data item, if it is used for staging, NAACCR item number and who it is required by. By clicking on the NAACCR Item number, they provide you with a description of the data item. These are effective for cases diagnosed in 2018 or later. https://staging.seer.cancer.gov/eod_public/list/1.3/

2018 Diagnosis Year Cancer Reporting

Check our website for:

- Important information for registrars regarding 2018 cases
- Seer Summary Stage comparison, 2000 vs 2018
- 2018 New Required data Items for Hospitals
- NJSCR 2018 Reportable Cancer List

https://nj.gov/health/ces/reporting-entities/njscr/

NJSCR will celebrate its 40th Anniversary in October!
Visit our exhibit at the ORANJ annual meeting in Atlantic City

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

July 2018 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

Text Documentation Instructions

The NJSCR requires the submission of text information to validate coded data items. Text is used for quality control purposes to justify codes for various data items. Text is also used to identify errors, to determine multiple primaries and to resolve discrepancies in data submitted on the same patient by multiple facilities.

All cancer registry software must include specific fields, which have been designed to record text information. These fields are transmitted to the NJSCR along with the other required data fields when you make your monthly electronic submission. Please refer to the table in Appendix D, Table of Required Data Items, for the maximum number of characters per field. Please refer to Appendix F for a list of recommended abbreviations. Recording text information should include but not be limited to the following:

- Record text to support primary site, laterality, histology, grade, stage, treatment codes, relevant SSDIs and dates of tests.
- Record text to justify any unusual information about the case that could result in potential questions, e.g., unusual site/histology combinations, such as age/site combinations, gender/site combinations, name/gender combinations, pediatric age.
- Record text to clarify modifications or dates on the abstract.
- If limited information is available in the medical record about a case, utilize the text field to state that limited information was available in the medical record.

See Section III of the NJSCR Program Manual, which is currently under revision, for more specific and detailed information at https://www.state.nj.us/health/ces/documents/proc_manual2015.pdf .

This is an example of an abstract on a NJ resident (class of case 10) submitted to the NJ State Cancer Registry by a NJ hospital.

What's Missing?

[redacted] NA 09-23-2016 C629-2 9061/3

DX Proc PE
pe

XRay/Scan
us

DX Proc OP
sx

Surg Txt
SX

DX Proc Path
9/30/2016 [redacted] S16-[redacted] Left testicle Seminoma

Site Title
LEFT TESTIES

Hist Title
SEMINOMA, CLASSIC TYPE

Staging Txt
Dr. B[redacted] (S16-[redacted]) Stage I

Remarks
active smoker of 1/2 ppd for 15+ years, no ETOH, ex-drug use

Usual Occup
cook

Usual Industry
[redacted]

Place Of DX
[redacted]

SEER INQUIRY SYSTEM

Question: 20180010

Is Diagnostic Confirmation coded as 5 (positive laboratory test/marker study) or code 8 (clinical diagnosis only) for a case that has a positive JAK2 mutation, and based on the results of the JAK2, the physician diagnosed the patient with polycythemia vera? There were no blood smears or bone marrow biopsies done.

Answer: Assign diagnostic confirmation code 8 for a clinical diagnosis only. Code 5 is not correct in this case because JAK2 is not definitive for any specific hematopoietic neoplasm. The physician uses JAK2 info combined with all of the other facts for the case to make the diagnosis. https://seer.cancer.gov/seerinquiry

NJSCR Offers Student Clinical Hours

Are you a CTR student and need clinical hours? **NJSCR offers *Student Visit* days** for cancer registry students interested in gaining central registry experience and fulfilling their remaining clinical practicum requirement. NJSCR will provide a customized framework to familiarize students with central registry research and operations, a sample of hands on work experiences, and several tools to prepare for the CTR exam. If interested in attending our *Student Visits*, and have approximately 80 hours of clinical hours already completed, please email OPS.NJSCR@doh.nj.gov to arrange a visit.

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

June 2018 E-Tips

New Jersey State Cancer Registry
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Treatment of glioblastoma multiforme (GBM) with the Optune System is coded as "Other Tx". GBM cancer cells divide quickly. Optune is a wearable and portable, FDA-approved device indicated to treat GBM in adult patients 22 years of age or older. It creates low intensity wave-like electric fields which are delivered by adhesive patches called transducer arrays. The patches are applied to the scalp in the location of a GBM tumor and are connected to the device and battery. This interferes with cancer cell division; either slowing or stopping cancer cells from dividing. The device is worn for at least 18 hours per day and keeping one's head shaved is recommended. https://www.optune.com/therapy
Per CAnswer Forum, this therapy does not fit the description of Surgical Procedure to Primary Site, Radiation therapy, or Systemic therapy. Code it as Other Tx, 1. http://cancerbulletin.facs.org/forums

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According to 2018 Solid Tumor Manual adenocarcinoma arising in an adenomatous polyp should be coded to 8140 starting in 2018.

Low Grade Appendiceal Mucinous Neoplasm (LAMN) 8480/1
According to the Solid Tumor Manual this is not reportable (see page 11, Table 2: ICD-O Histology/Morphology Not Reportable for Colon, Rectum, and Appendix)
https://seer.cancer.gov/tools/solidtumor/Colon_STM_Draft.pdf
If COC wants the case, abstract as required, but do not send to the NJSCR until 2018 rules are finalized and **if** there is a change on p11. According to AJCC 8 it is considered pTis (LAMN), (STAGE 0).

When coding **diagnostic confirmation** for hematopoietic and lymphoid neoplasms use **code 3** only for 2010 and later diagnosis year with positive histology PLUS ***positive*** immunophenotyping or genetic studies (can be found in the heme database). Assign **code 1** for neoplasm microscopically confirmed and immunophenotyping, genetic testing, or JAK2 is done but ***negative*** (non-diagnostic) for the neoplasm being abstracted.
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

CDC's Division of Cancer Prevention and Control has introduced new updates to the United States Cancer Statistics: Data Visualizations tool, a user-friendly product that allows cancer surveillance data to be directly and more easily accessible by the public and cancer control planners. Data displays on national and state incidence, death, and trends are available as maps and bar charts with interpretive text when users scroll over each graphic. Users can customize displays of overall and cancer-specific statistics, download data tables, and share each page via social media. 2015 cancer data are scheduled to be added this summer. The direct link to access the application is:
https://gis.cdc.gov/grasp/USCS/DataViz.html

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The final 2018 Solid Tumor Breast Rules have been posted and now may be used for cases diagnosed 1/1/2018 forward.
IMPORTANT INFORMATION: Major changes have been made to the 2018 Breast rules regarding histology coding. These comprehensive changes reflect WHO 4th Ed Breast Tumors and the 2018 In situ Breast CAP Protocol and Invasive Breast Carcinoma CAP Protocol. The editors of the 2018 Breast rules strongly recommend you read the Breast Terms & Definitions AND the Breast H Rules as they provide detailed instructions for coding breast histologies.

Final Solid Tumor Breast Rules may be accessed at the following link:
https://seer.cancer.gov/tools/solidtumor/
Educational modules are being developed for each revised set of site rules and an email notice will be sent once they are available. Please direct questions concerning the breast rules to Ask A SEER Registrar.
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Look forward to a list of **2018 data items** that will be required by the NJSCR, including a 2018 reportable list.

Have you visited our website lately? Explore and learn! You won't be disappointed! For researchers, cancer reporting entities and the public:
http://www.nj.gov/health/ces/

Spend the Day at the Registry- Time to register!
135 E. State Street, Trenton, NJ 08608
*Awarded **5.5 CE hrs** by NCRA (0 category A)*
July 18, 2018 or December 6, 2018
To register call Maria Rolon at 609-633-0500

SSF 12- Number of Prostate Cores Positive
SSF 13- Number of Prostate Cores Examined

A recent review of a sample of 2016 prostate cancer cases submitted to NJSCR revealed a total accuracy rate of **46%** for these data items.

Note:
*Do not make assumptions on the number of cores based on the number of anatomic locations- **Several cores may be submitted per site**.
*Fragments are **NOT** synonymous with cores. Do **not** count them as cores.
*If number of cores not specifically documented, **code 991**.

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

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces

May 2018 E-Tips

Hematologic Transplant and Endocrine Procedures

NJ State Cancer Registry hematopoietic case review revealed that often allogenic stem cell transplant is being coded as "12" (bone marrow transplant, allogenic) rather than "20" (stem cell harvest/transplant and infusion).

SINQ Question 20180012: What is the correct code to use for allogenic stem cell transplant?

Answer: Code an allogenic stem cell transplant as 20 (Stem cell harvest (stem cell transplant) and infusion) in Hematologic Transplant and Endocrine Procedures in the 2016 SEER Manual.

Background: This data item records systemic therapeutic procedures including bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Important Definitions:

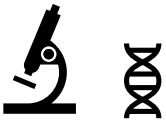
- **Bone marrow transplant (BMT)**: Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.
- **BMT Allogeneic**: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.
- **BMT Autologous**: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.
- **BMT Syngeneic**: Bone marrow received from an identical twin.
- **Conditioning**: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.
- **Hematopoietic growth factors**: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.
- **Non-myeloablative therapy**: Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.
- **Peripheral Blood Stem Cell Transplantation (PBSCT)**: Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.
- **Rescue**: Rescue is the actual BMT or PBSCT done after conditioning.
- **Stem cells**: Immature cells found in bone marrow, blood stream, placenta, and umbilical cords. The stem cells mature into blood cells.
- **Stem cell transplant**: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells.
- **Umbilical cord stem cell transplant**: Treatment with stem cells harvested from umbilical cord blood.

https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf
https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20180012&type=q

STUMP
"Smooth muscle tumor of uncertain malignant potential" is not reportable.

NJ State Cancer Registry-Quality Lung Review revealed multiple errors in date of diagnosis. In many cases, the lung cancer was clinically diagnosed via imaging prior to the biopsy date. Frequently the date of the biopsy was recorded instead. Code the month, day and year the tumor was first diagnosed clinically or microscopically. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis. *Example:* Microcalcifications suspicious for malignancy of breast on mammography, 2/13/16. Biopsy positive for ductal carcinoma, 2/28/16. Date of dx is 2/13/16.
https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

The **Summary Stage 2018** manual and the revised **Hematopoietic Manual and Database** are now live on the SEER website.
Please submit your questions to Ask a SEER Registrar.
There is now a new category for Summary Stage 2018.
https://seer.cancer.gov/registrars



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

April 2018 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

2018 Solid Tumor Rules (formerly MP/H rules) draft versions POSTED!

The National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program Solid Tumor Task Force is posting draft versions of the 2018 Solid Tumor Coding Rules so that registrars may assess the revised rules prior to the final rules being posted. Solid Tumor site rules will be marked as "Draft" until they are finalized. Site specific draft rules will be posted as they complete formatting. ***Prior to reviewing the draft rules, it is highly recommended that registrars read the 2018 Solid Tumor Rules Implementation Statement.***
The Solid Tumor rules may be accessed on the seer.cancer.gov website: https://seer.cancer.gov/tools/solidtumor/

SEER Extent of Disease (EOD) 2018 Manual POSTED!

EOD has been posted on the SEER website. This electronic manual contains more than just the SEER EOD codes and will be important for abstracting your 2018 and forward cancer cases.

When you open the link, you will see a list of schemas. It is important to read the EOD 2018 general instructions before using the schema specific EOD rules. Once you open a schema, you will see some notes that apply to the schema and then a list of **SEER data items collected for this schema**. The manual currently includes EOD Primary Tumor, EOD Regional Nodes and EOD Mets data items, as well as SEER Summary Stage 2018 (SS2018), Grade Clinical, Grade Pathological, and Grade Post Therapy as well as several others. To see the notes and codes for the data item, click on the data item to open it.

Everything within the schema only applies to that schema. Some errata have already been identified to the EOD v1.0 manual and are detailed on the website. No date for the release of the next version has been given.

EOD is required for all New Jersey facilities. Please see the links below for more information.
General instructions: https://seer.cancer.gov/tools/staging/2018-EOD-General-Instructions.pdf
Schema list: https://staging.seer.cancer.gov/eod_public/home/1.0/
Errata: https://staging.seer.cancer.gov/eod/news/1.0/

It doesn't *sound* reportable. Is it?

SINQ Question: 20140058 , Reportability--Pancreas: Is a solid pseudopapillary neoplasm of the pancreas reportable?
Answer:
Solid pseudopapillary neoplasm of the pancreas is reportable. According to the WHO classification, it is a "low-grade malignant neoplasm…[which] frequently undergoes hemorrhagic-cystic degeneration and occurs predominantly in young women."
Assign topography code C25 with the appropriate 4th digit. Code the histology as 8452/3.
https://seer.cancer.gov/seerinquiry/

According to the hematopoietic database, *systemic* mastocytosis is reportable. Mastocytosis by itself (not reportable) is a disorder caused by the presence of too many *mast cell*s in the body. To be reportable, it must state *systemic* mastocytosis (9741/3). Mast Cell Activation Syndrome is also not reportable. Malignant mast cell tumor or malignant mastocytoma is reportable.
https://seer.cancer.gov/seertools/hemelymph

Did you know?

CyBorD is a three-drug combination with *bortezomib* (Velcade), *cyclophosphamide* and *dexamethasone* used for multiple myeloma. **Code as *multiple* agent chemotherapy and hormonal treatment**.

Reserve your space!
NJSCR Presents:

Spend the Day at the Registry

Dates
July 18, 2018
October 4, 2018
December 6, 2018

Location
135 E. State Street
Trenton, NJ 08608

*awarded **5.5 CE hrs** by NCRA (0 category A)*
Register for this event here.

March 2018 E-Tips

News from the Standard Setters

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

News from SEER/NCI

- **Radiation Treatment Volume** for I-131 treatment for thyroid is no longer coded to "33" (Whole Body), it should be coded to "50" (Thyroid).
  http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/radiation/77471-coding-i-131-thyroid-ablation-rt-volume-current-coc-position-and-rationale

- **PUVA** is coded as "other treatment" with code 1 when used for skin primaries such as melanoma and mycosis fungoides. PUVA is a combination of photosensitizing agent Psoralen (P) with exposing the skin to the long wave Ultra Violet A radiation (UVA). Psoralen can be taken orally or applied to the skin. See SEER Rx and SEER SINQ links here for more information:
  https://seer.cancer.gov/seertools/seerrx/rx/53c44b06102c1290262dcc2a/?regimen_field=score&rx_type=drug&drug_offset=0&regimen_offset=0&q=PUVA&limit=25&drug_field=score&search_mode=&drug_direction=UP&regimen_direction=UP&mode=

  https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20110082&type=q

- **Prostate-reportability/date of diagnosis:** You may be seeing more use of **PI-RAD** (Prostate Imaging Reporting and Data System) categories on scans.
  - **SINQ 20170023:** Is PI-RADS 5 diagnostic of prostate cancer, and if so, can we use the date of the impression on the scan that states PI-RADS category 5 as the diagnosis date?
    ***Updated answer*:** PI-RADS categories *4 and 5* are reportable, unless there is other information to the contrary.
    PI-RADS 4: high (clinically significant cancer is likely to be present)
    PI-RADS 5: very high (clinically significant cancer is highly likely to be present)
  - Use the date of the scan as the date of diagnosis. Keep in mind that we *cannot* use BI-RADS (Breast Imaging Reporting and Data System) categories for a breast diagnosis because those definitions are slightly different, per SINQ 20010094, but we *can* use LI-RADS category 5 (Liver Imaging Reporting and Data System) for a hepatocellular carcinoma diagnosis, SINQ 20160008.

https://seer.cancer.gov/seerinquiry/index.php?page=search_results&records=n&search_results_show=first&search_type=quick_search&search_within_results=0&quicksearch=20170023&Question_1=1&Question_3=1&search_display_format=1

News from CDC/NPCR

- **Here's a link** to the first combined Public Use Dataset that puts together cancer data from the CDC-NPCR and SEER with instructions on how to obtain access to the data. The dataset covers 100% of the cancers diagnosed in the U.S. https://www.cdc.gov/cancer/npcr/public-use/

News from NCRA

- 2017 Salary Survey Results
  http://www.ncra-usa.org/Portals/68/PDFs/2017SalarySurvey_color.pdf?ver=2018-03-09-165728-913

Other News

- Benign and borderline tumors of the ovary are not reportable. An updated 2018 list will be available soon.
- NAACCR Standards Volume II, Data Standards and Data Dictionary, Version 18 is available on the NAACCR website. https://www.naaccr.org/data-standards-data-dictionary/

AJCC TNM 8th Edition Updates

-Is the AJCC errata the same information that was corrected on the replacement pages? ***Yes***
-It seems there are two documents posted with changes to the breast chapter. Is one more pertinent than the other? ***They have the same content. The document posted in November was the Word version of the breast chapter. In January we updated the file with the PDF version that's formatted like the book. If you access the download link from your email, it will take you to the book-formatted PDF.***
-Can you give us an anticipated release date of an updated 8th Edition that includes all the errata? ***The third printing should be available from Springer sometime during the week of 3/12/18. Amazon stock will arrive in late April. We'll consider the loose-leaf suggestion.***

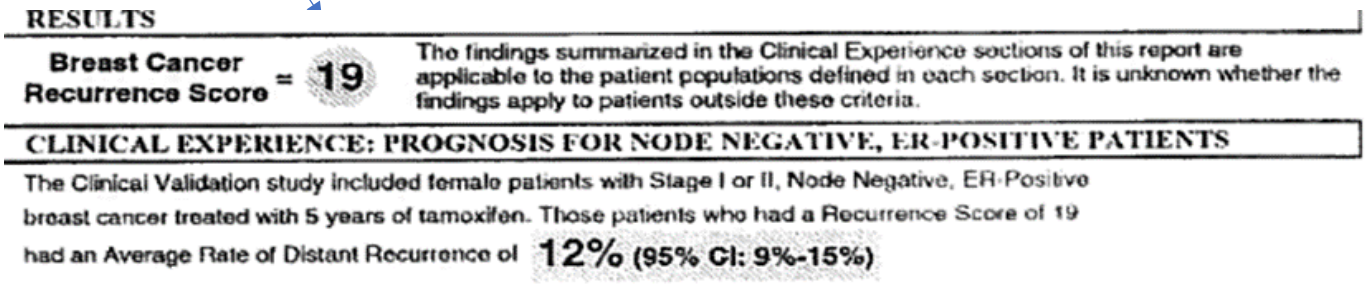
*Per **Laura Meyer Vega, PMP**, American College of Surgeons AJCC 8th Edition Project Manager (3/14/18)*

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

February 2018 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces/
(609) 633-0500

SSF 23 Multigene Signature Results: For the Oncotype DX test record the breast cancer recurrence score which ranges from 1-100. Code the actual score with leading zeros. The score can be found in the circle as seen below. Code the score in preference to the risk assessment of low, intermediate or high. Do not record the average rate of distant recurrence. In the example below the number 19 should be recorded as 019.
For 2018 (assume this is invasive) Oncotype Dx Recurrence Score-Invasive =019, Oncotype Dx Risk Level-Invasive = 1 [Intermediate risk (recurrence score 18-30)]. https://www.naaccr.org/2018-implementation/#SSDIGRADE



RESULTS

Breast Cancer Recurrence Score = 19

The findings summarized in the Clinical Experience sections of this report are applicable to the patient populations defined in each section. It is unknown whether the findings apply to patients outside these criteria.

CLINICAL EXPERIENCE: PROGNOSIS FOR NODE NEGATIVE, ER-POSITIVE PATIENTS

The Clinical Validation study included female patients with Stage I or II, Node Negative, ER-Positive breast cancer treated with 5 years of tamoxifen. Those patients who had a Recurrence Score of 19 had an Average Rate of Distant Recurrence of **12% (95% CI: 9%-15%)**

- **2018 Cases Submission** Please do not include any 2018 diagnosis year cases in your file submissions. Any submission that contains 2018 diagnosis year cases will be rejected in total and will need to be resubmitted. Consult with your software vendor on the best way to keep 2018 cases out of your submission files. You may also want to delay resolving edits on your 2018 cases until your version 18 upgrade is complete. Your facility's timeliness will not be affected as long as all 2018 cases are submitted to NJSCR no later than July 1, 2019.

- **The NAACCR Site-Specific Data Items Task Force** (SSDI TF) is posting draft versions of the SSDI and Grade manuals for review and comment. In addition to helping to refine the materials before they are posted in final form, the draft manuals may be helpful to registrars and others who are seeking information about how the SSDIs and grade will be collected for cases diagnosed 1/1/2018 and later. https://www.naaccr.org/2018-implementation/#SSDIGRADE . Please use this link to CAnswer Forum to post questions and provide comments on the manuals. http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018). Release of the final version of the Manuals is scheduled for May 2018.

- **New case finding changes** came out in November 2017. Find them at: https://seer.cancer.gov/tools/casefinding/changes.html

- **Commonly seen error**: Folfox contains oxaliplatin, 5-FU and leucovorin. It is coded as *multiple* agent chemo.

- **SINQ Question: 20170034 Answer updated!**

A unilateral breast simple mastectomy with tissue expanders and Alloderm, acellular dermal matrix which comes from human tissue donors with cells removed and sterilized to promote regenesis and decrease rejection, is coded as 43, Reconstruction, NOS. The tissue expander indicates preparation for reconstruction. Alloderm "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 procedures. The principle elements would be tissue from the patient and /or prosthetics, (e.g. gel implants.) https://seer.cancer.gov/seerinquiry/index.php

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

January 2018 E-Tips

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

The Guidelines for ICD-O-3 Histology Code and Behavior Update for cases diagnosed 1/1/2018 forward have been released and are now available on the NAACCR website. The update includes links to tables listing new codes and other changes and is available in two formats: .pdf and Excel. The NAACCR ICD-O-3 Implementation Work Group strongly recommends all users read the guidelines which contain valuable information related to the 2018 update. https://www.naaccr.org/2018-implementation/#Histology

New Jersey is a SEER state and Extent of Disease *must* be coded for cases diagnosed in 2018 even though CoC is not requiring **SEER EOD** to be coded. *(NAACCR 2018 Implementation Webinar, Session 2)*

NJSCR will be hosting periodic Student Visit days for cancer registry students who have completed 80 hours of clinical practicum or are nearing the end of their training and need to complete a central registry experience requirement. NJSCR will provide a customized framework to familiarize students with central registry research and operations, a sample of hands on work experiences, and several tools to prepare for the CTR exam. The first session will be held on March 27th, 2018 in Trenton, NJ. Spots are limited to four students a session. If interested in attending-please email OPS.NJSCR@doh.nj.gov to reserve a spot.

World Cancer Day 2018

February 4th is an international event called World Cancer Day, created to unite the world in the fight against cancer. The goal is to raise awareness through education in order to prevent cancer deaths and promote research. For more information on spreading the word and creating global awareness of the disease go to: http://www.worldcancerday.org **#ICanWeCan**

Date of Diagnosis Clarification

Do not use cytology as a basis for diagnosis when ambiguous terms are used. Ambiguous cytology is not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

"Ambiguous" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc. Do not use ambiguous cytology alone for case ascertainment.

Example: Cytology suspicious for malignancy 01/12/2016. Diagnosis of carcinoma per biopsy on 02/06/2016. Record 02/06/2016 as the date of diagnosis.

https://seer.cancer.gov/manuals/2016/SPCSM_2016_maindoc.pdf

Surgery of Primary Site- Breast

Revised Answer for SINQ 20150024:

When a patient has a lumpectomy and an additional margin excision during the same procedure assign **code 22**.

Assign **code 23** when a patient has a lumpectomy and an additional margin excision during a separate procedure.

According to the CoC, "Re-excision of the margins intraoperatively during same surgical event does not require additional resources; it is still 22. *Subsequent re-excision* of lumpectomy margins during separate surgical event requires additional resources: anesthesia, op room, and surgical staff; it qualifies for code 23."

https://seer.cancer.gov/seerinquiry/index.php?page=view&id=20150024&type=q

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