

Coding EOD Primary Tumor for Lung

Specific information about visceral pleura invasion is captured in codes: **450** (PL1, PL2, or NOS) and **500** (PL3). Elastic layer involvement has prognostic significance for lung cancer. **Visceral Pleura invasion is NOT localized.** Do not code 300 with Visceral pleura invasion. Penetration of the visceral pleura indicates a progression of invasion, even in small (≤ 3 cm) tumors, and indicates a less favorable prognosis. Visceral pleural invasion is considered present both in tumors that extend to the visceral pleural surface (type PL2 invasion), and in tumors that penetrate beyond the elastic layer of the visceral pleura (type PL1 invasion). Further invasion, which extends to the parietal pleura, is also described as type PL3 invasion.

Coding EOD Primary Tumor for Prostate remember....

Code 120: Tumor identified by needle biopsy (clinically inapparent/not palpable) Ex: elevated PSA

Code 150: Incidental histologic finding (for example, on TURP), number of foci or percent of involved tissue not specified (clinically inapparent/not palpable)

* https://staging.seer.cancer.gov/eod_public/list/1.7/

This is different than pre-2018 CS Prostate coding!

Tips for coding Grade**General guidelines:**

- Clinical grade and Pathologic grade MUST NOT BE BLANK for all sites.
 - Clinical grade is recorded for cases where a histological (microscopic) exam is done and tissue is available and grade is recorded. This includes FNA, biopsy, needle core biopsy, etc.
 - Pathological grade is recorded for cases where a **surgical resection has been done.**
 - For bladder, a TURB qualifies for a clinical grade **ONLY**.
 - If the **clinical grade is the highest grade identified**, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade

Kidney:

- **The Fuhrman grade is no longer used for coding grade for Kidney cancers.**
 - The WHO/ISUP grade is now used. If the Fuhrman grade is documented, code 9.

Breast:

- **Breast Priority order for Grade:**
 - Invasive cancers: codes 1-3 take priority over A-D.
 - In situ cancers: codes L, M, H take priority over A-D.

Urinary:

- **Kidney Renal Pelvis, Bladder, Urethra, Urethra-Prostatic:** Priority order for codes:
 - **Urothelial cancers:** use codes L, H and 9
 - If only G1-G3 are documented, code 9
 - **Adenocarcinomas and Squamous Cell Carcinomas:** use codes 1-3, 9
 - If only L or H are documented, code 9

*<https://www.naaccr.org/SSDI/Grade-Manual.pdf>

Coding EOD Primary Tumor for Colon/Rectum

*Invasion into "pericolonic/pericolorectal tissue" can be either **codes 300 or 400**, depending on the primary site.*

Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Code 300 may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).

Code 300

Invasion through muscularis propria or muscularis, NOS Non-peritonealized pericolonic/perirectal tissues invaded **[Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: Posterior surface; Middle third of rectum: Anterior surface; Lower third of rectum] Subserosal tissue/(sub)serosal fat invaded**

Code 400

Mesentery, Peritonealized pericolonic/perirectal tissues invaded **[Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface] Pericolonic/Perirectal fat**

If the pathologist does not further describe the "pericolonic/perirectal tissues" as either "non-peritonealized pericolonic/perirectal tissues" vs "peritonealized pericolonic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code 300.

*[https://staging.seer.cancer.gov/eod_public/input/1.7/colon_rectum/eod_primary_tumor/?breadcrumbs=\(~schema list~\),\(~view schema~,~colon_rectum~\)](https://staging.seer.cancer.gov/eod_public/input/1.7/colon_rectum/eod_primary_tumor/?breadcrumbs=(~schema list~),(~view schema~,~colon_rectum~))

Social Security Number Coding

If a Social Security number (SSN) is not available in any part of the medical record, including hospital billing system, code the SSN field unknown (999-99-9999). If an unknown SSN is coded, the reason it is unknown must be documented in "Remarks" text section.

- Please use the following format: "No SSN –" followed by the reason.
- **Acceptable reasons for no SSN include:** "patient refused", "undocumented resident," and "foreign resident." Example: No SSN- foreign resident. **"Not available" is not an acceptable reason.**
- **For Partial SSN Coding:** If your registry reporting software will not allow you to code a partial SSN in the data field (ie. 999-99-1234), code the SSN as 999-99-9999 in the data field.
 - In the Remarks text field, write "No SSN- partial only" followed by the 4 digits you have been provided with.
*<https://www.state.nj.us/health/ces/documents/2018%20NJSCR%20Program%20Manual%20FINAL.pdf>

Abstracting a Bladder case? Remember these guidelines!**Uncertain about behavior code for Bladder?****Code the behavior as malignant /3, not in situ /2, when:**

The only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen **AND** the physician's TNM designation is not available,

OR

the pathology report says the submucosa is invaded with tumor,

OR

the pathology report does not mention whether the submucosa is free of tumor or has been invaded by tumor.

Code the behavior as in situ /2 when:

The TNM designation is Ta for TURB with no muscle in the specimen.

OR

The pathology report says the submucosa is free of tumor.

*https://seer.cancer.gov/manuals/2018/AppendixC/Coding_Guidelines_Bladder_2018.pdf (page 5)

Bladder Grade Guidelines**Priority order for codes:**

- Urothelial cancers: use codes L, H and 9
 - If only G1-G3 are documented, code 9.
- Adenocarcinomas and Squamous Cell Carcinomas: use codes 1-3, 9
 - If only L or H are documented, code 9.

G3 includes undifferentiated and anaplastic.

Clinical Grade:

- **A TURB qualifies for a CLINICAL GRADE ONLY.** A TURB does not qualify for a surgical resection.

Pathological Grade:

- A cystectomy or partial cystectomy must be performed.
- Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the code that was identified during the clinical tumor frame for both the clinical grade and the pathologic grade.
- If a resection is done of a primary tumor and there is no grade documented from the surgical resection, use the grade from the clinical workup.
- If a resection is done of a primary tumor and there is no residual cancer, use the grade from the clinical workup.

* <https://www.naaccr.org/SSDI/Grade-Manual.pdf> (page 96)

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

Coding grade for Breast primary!

Priority order for codes:

Invasive cancers: codes 1-3 take priority over A-D

- If a resection is done of a primary tumor and there is no grade documented from the surgical resection, use the grade from the clinical workup
- If a resection is done of a primary tumor and there is no residual cancer, use the grade from the clinical workup.
- If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a clinical grade and code appropriately per clinical grade categories for that site, and then code unknown (9) for pathological grade, and blank for post therapy grade.

*<https://www.naaccr.org/SSDI/Grade-Manual.pdf> Grade 12

In situ cancers: codes L, M, H take priority over A-D

Staging CLL/SLL

Question: EOD 2018/Summary Stage 2018--CLL/SLL: Can chronic lymphocytic leukemia (CLL) be staged when diagnosed by peripheral blood and no bone marrow biopsy, and observation is employed?

Answer: For EOD and Summary Stage: Peripheral blood involvement for CLL (or any lymphoma-but most commonly for CLL) can be coded. This is code 800 for 2018 EOD Primary Tumor, and code 7 for Summary Stage 2018. We have recently received confirmation that peripheral blood involvement only is not enough information to assign AJCC stage; assign code 99 for AJCC Stage Group. We will correct in the 2021 release of EOD so that peripheral blood involvement only will have its own code to derive the appropriate AJCC TNM Stage Group (99).

*<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20190065&type=g>

Who Can Stage?

Only managing physician may assign patient stage in the medical record.

- If the physician incorrectly assigns the stage, the registrar may correct if certain they have appropriate data.

Registrar may:

- Document physician stage in registry.
- Assign AJCC stage in abstract database.
- Ensure all appropriate stage classifications are in abstract (c, p, yc, yp)
- Only document what is found. A registrar may not group stage if information is unclear.

Pathologist/radiologist may:

- Provide T, N, M information but they may NOT assign stage group.

Strive for accuracy over completeness!

*"AJCC 8th Edition General Rules" Louanne Currence, RHIT, CTR. 2019 ORANJ&MNYCRA Regional Conference

Timing for Clinical staging!

Code with understanding and practicality

Can imaging after systemic treatment be counted in cTNM staging?

*****Clinical timeframe*****

From date of diagnosis before ANY treatment starts or decision for watchful waiting or supportive care. Should be done within 4 months of diagnosis date or to date of cancer progression. Whichever is *shorter*.

Question:

Patient was diagnosed with prostate cancer. 3/6/18 DRE showed large tumor mass crossing the midline and prostate biopsy positive for adenoca w/ extraprostatic extension. 2/23/18 CT of abd/pelvis shows L pelvic sidewall and R external iliac chain lymphadenopathy which is suspicious for mets.

3/19/18 the patient sees the doctor who orders a PET scan and Lupron shot.

The patient had the Lupron shot on 3/28/18.

The patient had the PET scan on 3/30/18 which showed left common iliac lymph node suspicious for mets.

AJCC 8th edition states- clinical classification is based on evidence acquired from the date of diagnosis until initiation of primary treatment.

Can I use the PET scan to code distant lymph node mets even though it was done AFTER treatment started? Is there a time limit for using the imaging after treatment starts?

Answer:

There isn't a strict time frame, but two days after the shot the scan can definitely be included as there wouldn't be an effect yet.

*<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/83919-imaging-after-systemic-therapy-starte>

September 2019 E-Tips

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

The New Jersey State Cancer Registry (NJSCR) is dedicated to compiling complete, current, and high-quality data on cancer in the State of NJ. The data collected by the NJSCR can be useful for describing cancer patterns in the population, discovering causes of cancer, planning programs for people affected with cancer, and other related research. Beginning with accession year 2014, the New Jersey State Cancer Registry developed criteria for the Award for Excellence in Timely and Complete Cancer Reporting requires that the facility meet the certain benchmarks. These benchmarks were derived from standards of the North American Association of Central Cancer Registries (NAACCR) and the Surveillance, Epidemiology and End Results Program of the National Cancer Institute (NCI/SEER).

The benchmark for Race is currently <5% for Bronze recognition, <4% for Silver, and <3% for gold.

Race is an important element in the analysis and utilization of cancer registry data.

Look for RACE documentation

- All resources in the facility, including the medical record, face sheet, physician and nursing notes, photographs, and any other sources, must be used to determine race.
- Do not use patient name as the basis for coding race.
- Code race using the highest priority source available.

Sources in Priority Order:

- The patient's self-declared identification
- Documentation in the medical record
- Death certificate
- Patient photographs may be used with caution to determine race in the absence of any other information

https://seer.cancer.gov/manuals/2018/SPCSM_2018_maindoc.pdf

Circumferential Resection Margin (CRM) SSDI

The CRM can be referred to as: Circumferential radial margins, Circumferential resection margins, Mesenteric (mesocolon) margin, Radial margin, Soft tissue margin.

Record in millimeters to the nearest tenth the distance between the leading edge of the tumor and the nearest edge of surgically dissected margin as recorded in the pathology report.

- If the CRM is 2 mm, code 2.0
- If the CRM is 2.78 mm, code 2.8

Code	Description
0.0	Circumferential resection margin (CRM) positive Margin IS involved with tumor Described as "less than 0.1 millimeter (mm)" (Note 7: margins of 0-1 mm are recorded by the pathologist as involved.)
0.1-99.9	Distance of tumor from margin: 0.1- 99.9 millimeters (mm) (Exact size to nearest tenth of millimeter)
XX.0	100 mm or greater
XX.1	Margins clear, distance from tumor not stated Circumferential or radial resection margin negative, NOS No residual tumor identified on specimen
XX.2	Margins cannot be assessed
XX.3	Described as "at least" 1 mm
XX.4	Described as "at least" 2 mm
XX.5	Described as "at least" 3 mm
XX.6	Described as "greater than" 3 mm
XX.7	No resection of primary site Surgical procedure did not remove enough tissue to measure the circumferential or radial resection margin (Examples include: polypectomy only, endoscopic mucosal resection (EMR), excisional biopsy only, transanal disk excision)
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Circumferential or radial resection margin not assessed or unknown if assessed



Oncology Registrars Association
of New Jersey
&
Metropolitan New York Cancer Registrars
Association
Present:

"Rolling the Dice on Change"

2019 Regional Educational Conference
October 17th & 18th, 2019
Tropicana Casino
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Earn
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Wednesday, October 16, 2019 – CTR Exam Prep Educational Seminar
<https://www.oranionline.com/education/educational-events/>

[https://staging.seer.cancer.gov/eod_public/schema/1.7/colon_rectum/?breadcrumbs=\(~schema_list~\)](https://staging.seer.cancer.gov/eod_public/schema/1.7/colon_rectum/?breadcrumbs=(~schema_list~))

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

August 2019 E-Tips

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

SEER Advanced Topics for Registry Professionals Workshop 2019

The recorded sessions from the 2019 SEER Advanced Topics for Registry Professionals workshop is now available on NCRA's Cancer Registry Education website.

Click on the link below (or copy into your browser) to find the recorded sessions on the SEER training page. Scroll down the page to the SEER *Archived Sessions* section and the workshop is the first product listed. You will need to add this to your cart and check out (no payment required) to view the recorded sessions. You will be required to sign in, so if you don't have an account established you will need to create an account to view the recordings. The recorded sessions will load into My Learning Activities (menu tab on website) and you can view immediately or go back to view at any time.

If you have problems logging into the system, please contact our membership department at info@ncra-usa.org or 703-299-6640 ext. 310.

Instructions:

1. Go to www.cancerregistryeducation.org/SEER (Make sure you are using Chrome or Firefox)
2. Login using your NCRA login
3. Find "2019 Workshop: SEER Advanced Topics for Registry Professionals" activity and click "Add to Cart" button.

The activity will automatically load into the "My Learning Activities" page on the website. You can access the activity at any time by going to the "My Learning Activities" page.

NEW 2018 Prostate EOD!

- Serum PSA does not equal free PSA or Precursor PSA. **DO NOT record** free PSA or precursor PSA in PSA LAB Value field.
- Do not make assumptions about the number of cores positive or examined based on the number of areas biopsied within the prostate.
- For Gleason pattern, **code the pattern that reflects the highest or most aggressive score** regardless if the pathologist provides an overall pattern in a final summary.
- If neoadjuvant therapy was given, code Gleason Pathological score= **X9**.
- **Do not code the Gleason Tertiary pattern of the biopsy.** Record the tertiary pattern documented on the prostatectomy or autopsy only.

*[https://apps.naaccr.org/ssdi/schema/prostate/?breadcrumbs=~schema list~](https://apps.naaccr.org/ssdi/schema/prostate/?breadcrumbs=~schema%20list~)

Bladder tumor size?

Tumor Size/Bladder: The 2018 SEER Coding and Staging Manual says to use imaging over physical exam as priority for determining tumor size. If a bladder tumor is 4 cm visualized on cystoscopy, and is 2.8 cm on CT scan, which should be used as the clinical size? Is cystoscopy (endoscopy) a clinical exam or imaging?

Answer

For the case described here, use the size from the CT scan. Physical exam includes what can be seen by a clinician either directly or through a scope. A tumor size obtained visually via cystoscopy is part of a physical exam. **Therefore, the imaging (CT) tumor size is preferred.** Use text fields to describe the details.

*<https://seer.cancer.gov/seer inquiry/index.php?page=view&id=20190046&type=q>

National Accreditation Program for Rectal Cancer (NAPRC) Tips and Hints

- **95% of all new rectal cancer patients MUST have their biopsy confirmed by an appointed pathologist before the start of any treatment.** If done outside the report/slides must be reviewed and documented in the medical record.
- **95% of all new rectal cancer cases MUST be staged before the start of definitive treatment and must be documented in the medical record.**
- **NAPRC Standard 1.5: RC MDT/Cancer Conference Minutes:** Each year the **2** monthly meetings/cancer conferences must be documented along with documented compliance with the required standards.
- **NAPRC Standard 2.3: MRI Reporting (Standardized):** **90%** of new rectal cancer cases who have not had treatment yet must have an MRI of the rectum performed and the report must be read by an appointed radiologist of the RC MDT. **95%** of new rectal cancer cases who have not had treatment, the MRI reports must be standardized and must contain all required elements for staging. **20%** of cases will be randomly audited at the survey (max 100 cases)
- **NAPRC Standard 2.4: CEA Labs: For 75% of new rectal cancer cases** who have not had treatment yet; they must have a CEA (Carcinoembryonic Antigen) level drawn and this must be documented in the medical record. **20% of cases will be randomly audited at the survey (max 100 cases)**

*NAACCR 2018-2019 Webinar Series "A Registrars Defense to ACoS Accreditations"

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

MAJOR SOLID TUMOR RULE CHANGE ANNOUNCED BY SEER

The new lung H rule address tumors with multiple types of adenocarcinoma and percentages of each type listed in the diagnosis. The original H rule instructed registrars to code adenocarcinoma, mixed types (8255/3). *Per our lung expert, ICD-O code 8255/3 is strongly discouraged.* The new H rule provides instructions on coding the histology comprising the greatest percentage of tumor. Lung Table 2 (Combination histology codes) has also been updated to reinforce the new H rule.

Important: We strongly suggest you review lung cases diagnosed 1/1/2018 forward with code 8255/3 to determine if a specific histology code can be assigned based on the new H rule. By coding a specific histology rather than the mixed histology, you will be able to assign stage.

Lung M rule:

A rule was added to address separate non-contiguous tumors, one with a combination code from Table 2 and one with a single histology from Table 3.

A comprehensive change log has also been posted for reference. The updated rules published July 2019 apply to the following sites **only:** Breast, Colon/Rectum, Head & Neck, Lung, Kidney, Malignant CNS, Non-malignant CNS, Urinary

The Solid Tumor Manual can be accessed at: seer.cancer.gov/tools/solidtumor

Submit questions concerning the Solid Tumor Rules to Ask A SEER Registrar:
seer.cancer.gov/registrars/contact.html

Melanoma

- Breslow thickness can be rounded! Measurements given in the hundredths of millimeters should be rounded to the nearest tenth. Code the greatest measured thickness regardless of if it from the biopsy of excision.
- **ULCERATION CAN ONLY BE CONFIRMED BY MICROSCOPIC EXAMINATION.** Do not use the findings from a physical exam to code ulceration.
- Another term from Mitotic rate is mitotic figures or mitoses. Code the highest mitotic rate regardless if it is on biopsy or excision. If no mitoses are documented, it cannot be assumed mitoses were absent.
- If there is no mention of LDH, code 9.

*<https://apps.naaccr.org/ssdi/list/>

Ovary

- **Two New histologies for 2018:**
 - Low Grade Serous Carcinoma 8460/3
 - High Grade Serous Carcinoma 8461/3
- Serous Tubal Intraepithelial Carcinoma (STIC) 8441/2 always arise in the fallopian tubes. This histology currently does not have an AJCC ID and is not eligible for staging. Code stage group 88, Summary Stage 0, EOD 000. If you find metastatic disease of invasion code behavior 3.
- Do not attempt to code FIGO stage based on T, N, & M.
- If Stage group stated is not specified as FIGO, assume FIGO stage and code it.

*<https://apps.naaccr.org/ssdi/list/>

*NAACCR 2018 Webinar series

Lung only has 2 SSDI's!

Separate Tumor Nodules

- Separate tumor nodules in contralateral lung are not coded in this SSDI data item.
- Second primary tumor also called synchronous primary tumors (not the same histology as primary tumor) are not coded in this field.

Visceral Pleura Invasion

- **PL0-** Tumor that is surrounded by lung parenchyma or invades superficially into the pleural connective tissue beneath the elastic layer but falls short of completely traversing the elastic layer of the pleura.
 - **PL1-** Tumor that extends through the elastic layer.
 - **PL2-** Tumor that extends to the surface of the visceral pleura.
 - **PL3-** Tumor that extends to the parietal pleura or chest wall.
 - *An FNA is **not** a histologic specimen and is not adequate to assess pleural layer invasion. If only an FNA is available, code 9.*
 - Code 9 if there is microscopic confirmation and there is no mention of visceral pleural invasion.
 - A tumor described as being “contained within visceral pleura” is not describing a tumor that involves the visceral pleura.
- Atelectasis can be caused by multiple causes. For staging, atelectasis must present with an obstructing tumor to be utilized for staging.

*<https://apps.naaccr.org/ssdi/list/>

* “Let’s Unite N’ Gather” Colleen M. Grosso

Coding for FNA in Diagnostic/Staging Procedure Field

According to FORDS & STORE: Surgical Diagnostic and Staging Procedure Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease. Surgical Diagnostic and Staging Procedure (NAACCR Item #1350, FORDS, page 138) and STORE, page 148, states that brushings, washings, cell aspiration and hematologic findings (peripheral blood smears) are recorded as positive cytologic diagnostic confirmation in the Diagnostic Confirmation (NAACCR Item #490).

Page 143 (STORE), Diagnostic Confirmation. Coding instructions indicates to Code 1 when the microscopic diagnosis is based on (tissue specimens) from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy. Use code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

Yes, the cell aspiration (code 2) in FORDS/STORE does refer to Fine Needle Aspiration (FNA). **Bullet #6 states to code (cell aspirations) as positive cytologic diagnostic confirmation in the data item Diagnostic Confirmation (NAACCR Item #490).** These are not considered surgical procedures and should not be coded in this data items. **Code 1 refers to (tissue aspirations).**

Code 1 Positive histology Histologic confirmation (tissue microscopically examined).

Code 2 Positive cytology Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).

<http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/surgical-diagnostic-and-staging-procedure/80559-coding-for-fna-in-diagnostic-staging-procedure-field> !

Neuroendocrine Tumors

- No SSDI's for Neuroendocrine Tumors!
- Somatostatin Analog treatment Lanreotide (LAR) and Sandostatin are ancillary agents for NETs. They relieve symptoms but do not kill the cancer cells.
- In the Pancreatic Neuroendocrine Tumor (pNETS) category be sure to pay attention to **Insulinoma's!** A functional Insulinoma is considered malignant due to more hormones. Code 8151/3.

GRADE!

The Mitotic rate and/or the Ki-67 index are needed to determine the grade for neuroendocrine tumors.

Check out page 55 of the NAACCR grade manual for more information!

<https://www.naacccr.org/SSDI/Grade Manual.pdf?v=1527608547>

***NAACCR 2018-2019 Webinar Series on Neuroendocrine Tumors**

Text is important!

NAACCR has recommendations for abbreviations in the data dictionary Appendix G. Text is required to support the coded information.

Adenopathy: ADENOP

Carcinoma: CA

Cancer: Spell out, do not abbreviate

Grade: GR

Malignant Melanoma: Spell out, do not abbreviate

Sentinel lymph node biopsy: SLNBX

<http://datadictionary.naacccr.org/?c=17>

Congrats!



The External Quality Improvement (EQI) Team at the New Jersey State Cancer Registry won 1st place for their poster titled, "Quality Insiders: A Central Registry's Quality Improvement Plan" at NCRA's 45th Annual Conference in Denver, Colorado.

The team consists of (left to right) Frances Krol, Amy Cass, Adrian Botchway, Maryanne Burhenne, and Harrine Katz.

You can view their poster abstract in the next issue of The Journal of Registry Management.



Hematopoietic & Lymphoid Neoplasms

- Baby aspirin is coded as other treatment for essential thrombocythemia.
- If there is no mention of B symptoms and/or HIV status in the medical records code **unknown**.
- Waldeyer’s ring, thymus, and spleen are considered nodal. Do not use E suffix.
- **REMEMBER!** Pathologic staging for Hematopoietic and lymphoid neoplasms requires a Staging Laparotomy.
- **The following histology’s have Mets at DX field always coded to 8:**
 - Any case coded to primary site: C420, C421, C423, C424
 - Plasma cell Myeloma 00821
 - Plasma Cell Disorders 00822
 - HemeRetic 0083

Bulky Disease

- **Hodgkin Lymphoma (HL)**
 - If mediastinal, Bulky is defined as greater than 1/3 the size of the cavity.
 - If not mediastinal, “Bulky” is defined as greater than 10cm.
- **Non- Hodgkin Lymphoma (NHL)**
 - Definition varies based on histology.
- **Look for physician statement of “Bulky”**
- **Stage 2 Bulky is a new stage category for 8th edition.**
- **Make sure you read the summary of changes in your AJCC Staging Manual**
- **Any extralymphatic involvement with nodal disease above and below the diaphragm is Stage IV.**

Question!

If there is no clinical information available and all that is available is the post-neoadjuvant information, is it better to code EOD unknown (999) or use the post-neoadjuvant information to code EOD?

Answer!

Code EOD Primary Tumor using the post neoadjuvant information for this case. Since the only information you have is the post neoadjuvant, code that. EOD combines clinical and pathological information.

Wondering what radiation fields must be filled out when “No Radiation” or “Unknown” if Radiation done?

Radiation items carried over from FORDS to STORE:

- Reason for No Radiation [1430] (required 2003+)
 - RX Summ-Surg/Rad Seq [1380]
- Rad—Location of RX [1550] (Required 2003 +)
 - Date Radiation Started [1210]
 - RX Date- Radiation Flag [1211]
 - Date Radiation Ended [3220]
 - RX date Rad Ended Flag [3211]

If No Radiation:

- Phase 1 Radiation Primary Treatment Volume is coded 00
- Phase 1 Radiation treatment Modality is coded 00
- All other “Phase” radiation fields may be blank.

Check out SEER Educate for 2018 EOD Training

<https://educate.fredhutch.org/Assessments/PracticalApplicationTests.aspx>

Sources:

*NAACCR 2018-2019 Webinar Series
 Hematogenic & Lymphoid Neoplasms

*SEER Inquiry System:

<https://seer.cancer.gov/seer inquiry/index.php?page=view&id=20190027&type=q>

*NAACCR 2018-2019 Webinar Series Abstracting and Coding Boot Camp

Radiation			
Phase Fields	Phase 1	Phase 2	Phase 3
Rad Primary Treatment Volume	00		
Radiation to Draining Lymph Nodes		Will pass edits	
Rad Treatment Modality	00	If unknown if radiation was done Code 99 is only required in volume and modality	
Ext Beam Rad Planning Technique			
Dose per Fraction			
Number of Fractions			
Total Dose			
Summary Fields			
# of Phases of Rad Tx to this Volume	00	If 00 or 01, then phase II can be blank If 00, 01, or 02, then phase III can be blank	
Rad Treatment Discontinued Early	00		
Total Dose	000000		
Radiation/ Surgery Sequence	0		

ER and PR Total Allred Score

The total Allred Score uses IHC to determine the percentage of cells that test positive for the hormone receptors, Estrogen Receptor (ER) and Progesterone Receptor (PR). The intensity is how well the receptors show up after staining. The clinician's interpretation takes priority. If the physician does not state what the Allred score is and both Positive cells % and intensity are available, then the registrar can calculate it. This information is combined to score on a scale from 0 to 8. Find your percentage in the positive cells' column for your proportion score, followed by finding your intensity score based on information provided in interpretation. Add the proportion score to the intensity score to find your total Allred score.

Proportion Score	Positive Cells, %
0	0
1	<1
2	1 to 10
3	11 to 33
4	34 to 66
5	≥67

Intensity	Intensity Score
None	0
Weak	1
Intermediate/Moderate	2
Strong	3

- Example:
 ER Positive 100% nuclear staining, strong average intensity **Allred Score: 08**
 PR Positive 10% nuclear staining, moderate average intensity **Allred Score: 04**

*Abstracting and Coding Boot Camp NAACCR 2018-2019 Webinar Series

* <https://www.naacccr.org/SSDI/SSDI-Manual.pdf?v=1533680119>

Testis

- If post-orchietomy AFP lab values remain elevated, use lowest post-orchietomy AFP lab value prior to adjuvant therapy.
- Adjuvant therapy for testicular cancer takes 3 months to decide. This is still considered first course therapy.
- When coding EOD primary tumor remember that code 100 and 150 are for PURE SEMINOMAS ONLY.

*Testis NAACCR 2018-2019 Webinar Series

Grade 2018 Coding Exercises Now Available in SEER*Educate

With diagnosis year 2018, we now have to code three Grade fields instead of one. In fact, Grade now has its very own manual!

Log in or sign up at SEER*Educate today by visiting <https://educate.fredhutch.org/> and Learn by Doing!

Free CE's available!

SEER*Educate is funded by Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI) and the Fred Hutchinson Cancer Research Center. (NCI Contract Number HHSN261201800004I)

SEER Releases New Cancer Statistics Review (CSR) and Latest SEER Data

The SEER Cancer Statistics Review (CSR), 1975-2016, published by NCI's Surveillance Research Program, was released on April 15, 2019. The updated Cancer Statistics Review presents the most recent cancer incidence, mortality, survival, and prevalence statistics.

New materials posted include:

- [Cancer Statistics Review 1975-2016](#)
- [Cancer Stat Fact Sheets](#) (now including [female breast cancer subtypes!](#))
- [SEER*Explorer](#) (now with stats by subtype for breast, esophagus, lung, and thyroid!)
- [The Cancer Query Systems](#)
- [Cancer Statistics Animator](#)
- [SEER Incidence Data, 1973-2016](#)
- [Specialized Databases](#)

*Noone AM, Howlader N, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2015, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2015/, based on November 2017 SEER data submission, posted to the SEER web site, April 2018.

Basics of External Beam Radiation Therapy (EBRT) & Coding Implications by Wilson Apollo, MS, CTR, RTT

What is the difference between IMRT and 3D conformal?

ANSWER: The main difference between IMRT and 3D-Conformal plans is that when the latter is used, the MLC leaves remain stationary. It still uses multiple fields as with IMRT, and each field conforms to the shape of the target as seen from various angles, but the collimator leaves are static through the duration of treatment.

How do we code the field External Beam Planning Technique if the radiation oncologist just calls it AP/PA?

ANSWER: The term AP/PA refers to the direction of the radiation beam only. It provides no information whatsoever on the planning technique code that should be used. AP/PA means that the patient was irradiated with the gantry @ 0 degrees and @ 180 degrees.

What is Gamma Knife and how do you code it?

ANSWER: Gamma Knife SRS can target multiple CNS lesions in a single session. Regardless of the number of lesions treated in a single session, abstract as a single phase. Code the maximum prescribed dose use. Remember that Gamma Knife is EBRT and you should code the dose/fx and total dose in cGy.

Coding Tips for Colon 2018:

Do **not** use histology codes: 8210, 8260, 8261, 8263, 8264 for C18.0-C20.9.

Types of Polyp, Treatment and Stage:

Sessile polyp- Colonoscopy is done giving it a Clinical T. The surgical Resection is treatment.

Pedunculated polyp- Snare polypectomy is the treatment. This would give you a pathologic T. No clinical stage.

Note: Component is not equivalent to subtype or variant. Component is **ONLY** coded when the pathologist specifies the component as a second carcinoma.

NEW Priority Order for Coding Primary Site

Resected cases:

- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection:

- Endoscopy report
- Pathology report

Predominantly is more than 50% which is important for coding the subtype!

Confused on Anastomotic sites. Recurrence or Same Primary?

Solid Tumor Rules for Colon:

M7: Abstract multiple primaries when a subsequent tumor arises at the anastomotic site AND: • One tumor is a NOS and the other is a subtype/variant of that NOS OR • The subsequent tumor occurs greater than 24 months after original tumor resection OR • The subsequent tumor arises in the mucosa

<https://fcds.med.miami.edu/downloads/Teleconferences/2018/2018%20Updates%20Appendix%20Colon%20Rectum%20NET.pdf>

Colon 2019 NAACCR 2018-2019 Webinar Series

<https://seer.cancer.gov/manuals/2018/appendixc.html>

COLON CANCER AWARENESS MONTH

ScreenNJ, developed by Rutgers CINJ & NJ Dept of Health, is a collaborative initiative across the state aimed at reducing cancer incidence and mortality through outcomes-oriented, evidence-based cancer prevention screening programs. You can use (www.screennj.org) to find local colorectal cancer screening programs and info about the types of testing and benefits.

What is CEA? CEA is a glycoprotein produced by adenocarcinomas and is measured in blood, plasma or serum. CEA is a prognostic marker for adenocarcinomas of the appendix, colon and rectum is often used to monitor response to treatment.

Q: "If the patient has a polypectomy followed by definitive surgery, can a higher CEA reported after the polypectomy but before the resection be coded?"

A: Record the highest CEA lab value in the medical record prior to treatment or polypectomy. If the tumor was in the polyp, do not use the post-polypectomy CEA even if it is higher. In this situation, the polypectomy would be treatment. If the tumor is a frank adenocarcinoma and the polypectomy only removed a portion, then the post-polypectomy CEA can be used.

SEERSINQ20061101

CELEBRATE APRIL 8-12, 2019

NATIONAL CANCER REGISTRARS WEEK!

<http://www.ncra-usa.org/About/NCRA-News/ArtMID/9659/ArticleID/906/Start-Planning-Your-NCRW-2019-Celebrations>

APR 8-12 2019
NATIONAL CANCER REGISTRARS WEEK
CANCER REGISTRARS:
 Capturing the Picture of Cancer



Some Highlights from the January 24, 2019 ORANJ Meeting

(Next month we will provide notes from Basics of External Beam Radiation Therapy & Coding Implications)

Bladder Cancer: Navigating SEER Coding Rules- Presentation by Heather Stabinsky

- EOD Is based on a combined clinical and operative/pathological assessment and priority goes to pathology in a discrepancy.
- Information for EOD from surgical resection after neoadjuvant treatment can be used ONLY if the extent of disease is greater than pretreatment clinical information.
- There are many different descriptive terms for noninvasive papillary transitional cell carcinoma. See Bladder- EOD Primary Tumor for a list of definitive statements and inferred terms.
- Common iliac lymph nodes are coded in REGIONAL LYMPH NODES (Code 700) for bladder BUT are considered distant lymph nodes in SEER Summary Stage. If common iliac nodes are involved for bladder, code them in EOD Regional Nodes. Do not code them in EOD Mets. If common iliac nodes are involved for bladder, code 7 (Distant) in SEER Summary Stage 2018.
- Priority order for coding Bladder- Grade:
Urothelial cancers: use codes L, H, 9 (if only G1-G3 are documented, code 9)
Adenocarcinoma and Squamous Cell Carcinomas: use codes 1-3, 9 (if only L or H are documented, code 9).

Lymph-vascular Invasion (LVI)-

Lympho-vascular invasion is an indicator of prognosis. It indicates the presence or absence of tumor cells in lymphatic channels (*not* lymph nodes) or blood vessels within *the primary tumor* as noted microscopically by the pathologist.

Information to code this field can be taken from any specimen from the primary tumor (biopsy *or* resection).

Use “code 0-Not present/Not identified” for cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

Do not code perineural invasion in this field.

For 2018 cases treated with neoadjuvant therapy, refer to table below from the STORE 2018 manual, p 153.

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	Code LVI to:
0 - Not present/Not identified	0 - Not present/Not identified	0 - Not present/Not identified
0 - Not present/Not identified	1 - Present/Identified	1 - Present/Identified
0 - Not present/Not identified	9 - Unknown/Indeterminate	9 - Unknown/Indeterminate
1 - Present/Identified	0 - Not present/Not identified	1 - Present/Identified
1 - Present/Identified	1 - Present/Identified	1 - Present/Identified
1 - Present/Identified	9 - Unknown/Indeterminate	1 - Present/Identified
9 - Unknown/Indeterminate	0 - Not present/Not identified	9 - Unknown/Indeterminate
9 - Unknown/Indeterminate	1 - Present/Identified	1 - Present/Identified
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	9 - Unknown/Indeterminate

https://www.facs.org/~media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx

**Check this out!****Articles citing NJ State Cancer Registry data:**

<https://www.futurity.org/9-11-responders-head-and-neck-cancers-1959872/>

https://www.eurekalert.org/pub_releases/2019-01/ru-wtc011619.php

<https://www.njtvonline.org/news/video/colorectal-cancer-rise-among-adults-nj-50/>

<https://nibiz.com/rutgers-njdoh-chosen-to-participate-in-prostate-cancer-study/>

New in SEER*Educate! Earn and Learn.

2018 Solid Tumor Rule Coding Exercises are now available! This is a great way to earn CEs and learn how to apply the 2018 Solid Tumor Rules. Use the 2018 Solid Tumor coding rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward.

Please note that two remaining sites, Cutaneous Melanoma and Other Sites are currently under revision. Continue to use the 2007 General Instructions, 2007 Other Sites, and 2007 Cutaneous Melanoma for cases diagnosed 2007-2020.

Your Participation is Needed! March 1 to April 15, 2019.

Complete the 2019 EOD/SS/SSDI Reliability Study!

NCRA has approved 10 CEs for completion of ten cases. The objectives of this study are to determine training needs. Go to [SEER Reliability Studies Site](#) during this period. The study will assess how well registrars assign EOD Primary Tumor, EOD Regional Nodes, EOD Mets, SS2018, Grade, SSDIs, Regional Nodes Positive and Tumor Size.

IS THIS REPORTABLE?

Atypical small acinar proliferation (ASAP) PIN 4- is not **reportable**. Patients with ASAP found on prostate needle biopsy will likely undergo another biopsy. <https://seer.cancer.gov/seerinqury/index.php?page=view&id=20180094&type=q>

Primary hepatic neuroendocrine tumor (PHNET)- PHNET is **reportable** as are other digestive system NETs. There is no specific histology code for PHNET. SINQ 20180097 suggests we use histology code 8240/3. For more details see: <https://seer.cancer.gov/seerinqury/index.php?page=view&id=20180097&type=q>

Neuroendocrine microtumor- is **reportable**. "Microtumor" refers to the size/amount of NET and not to a histologic type. Per SINQ 20180096 <https://seer.cancer.gov/seerinqury/index.php?page=view&id=20180096&type=q>

Monoclonal B-cell lymphocytosis (MBL)- According to SINQ 20180050 monoclonal B-cell lymphocytosis is **not reportable**. This term will be removed from 9823/3 since it is a /1 (has its own code). MBL is a condition in which a higher than normal number of identical B cells are found in the blood. Lymphocytosis by itself and without further specification means an increase of lymphocytes. This can be caused by many different factors. Monoclonal B-cell lymphocytosis is a condition that resembles chronic lymphocytic leukemia (CLL) and is defined as the presence of CLL-phenotype cells in the peripheral blood in the absence of other features of CLL or SLL. But follow up should be conducted to assure that this has not evolved into a lymphoma.

<https://www.cancer.gov/publications/dictionaries/cancer-terms/def/monoclonal-b-cell-lymphocytosis>

<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20180050&type=q>

New Treatment for Gastroenteropancreatic Neuroendocrine Cancers

Peptide Receptor Radionuclide Therapy (PRRT) is a radiopharmaceutical (nuclear medicine therapy) that travels throughout the body looking for a somatostatin receptor within neuroendocrine tumors (NET). NETs that form in the midgut area, from the jejunum to the ascending colon, are the most common cancerous NET. These tumors overexpress receptors for a hormone called somatostatin.

Once absorbed into the tumor the radioactive material starts to break down and kill tumor cells. PRRT was approved in 2018 to treat gastroenteropancreatic neuroendocrine tumors in adult patients. It uses lutetium Lu 177 dotatate, which is being studied in the treatment of other types of cancer. Infusion is typically given every 8 weeks for a total of 4 doses. Look for the drug LUTATHERA®.

According to SINQ 20180106 it is to be coded as Other Therapy, code 1.

<https://seer.cancer.gov/seerinqury/index.php?page=view&id=20180106&type=q>

<https://www.cancer.gov/news-events/cancer-currents-blog/2017/new-treatment-neuroendocrine-tumors>

<http://cinj.org/rutgers-cancer-institute-new-jersey-and-robert-wood-johnson-university-hospital-are-first-state>

NJSCR Presents: Spend the Day at the Registry

Please join the New Jersey State Cancer Registry for this full-day interactive workshop designed to give hospital registrars a better understanding of the central cancer registry. Meet the NJSCR staff and see first-hand how your data becomes part of our research and publications. Topics covered include data linkages and follow-up, special studies, death clearance and quality control.

135 E State St. Trenton NJ 08608

Earn 5.5 CEs!

To register for this informative event, visit:

<https://www.state.nj.us/health/ces/documents/Brochure%20revised%20for%202019%20dates.pdf>

