

OCCR NEWSFLASH

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Winter Issue

Hematopoietic Database (HemeDB)

Web Based Hematopoietic Database (HemeDB)

By Delores Greene, CTR

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The web-based HemeDB has several benefits over the software version of the HemeDB. Updates are automatic so users do not have to install anything to access the latest versions. It allows access from any computer or device with an internet connection. The web-based version of the HemeDB is the preferred method to access the current data. If you need the software version because of limited internet access, it is still available for now, but may be phased out in the future. Note that the coding information in the software version of the database can get out-of-date; be sure to check that you have the correct version (Version 2.2, released February 25, 2013). A new User's Guide was posted at <http://seer.cancer.gov/tools/heme/> to help give specific information about the use of the web-based searching mechanism and to describe the various features of the online database.

Software Revisions (version 2.2)

The title was modified to help the user see more clearly which database they are accessing, the 2012 or the 2010 database. Create a shortcut to your desktop for <http://seer.cancer.gov/seertools/hemelymph/>.

Data Revisions

These data changes are reflected in both the web-based database and the stand-alone software.

2012 Data

- o No new diseases were added.
- o Lists of alternate names were reviewed in all entries and many alternate name lists were modified by either adding new alternate names, correcting names already in the list, or removing alternate names.
- o If an ICD-O-3 morphology code was listed as obsolete but did not reference the active code, the active code was added.
- o Several entries were missing the appropriate Module Rule. These have been added.
- o The names of several diseases were modified in order to correct them.
- o Several entries had Definitive Diagnostic Methods added.
- o Several entries had Primary Site added where they were previously blank.
- o Several entries had Corresponding ICD-9 and/or ICD-10 codes added.
- o Abstractor Notes were reviewed and modified.
- o The Primary Site for ICD-O-3 Morphology code 9734/3 was corrected to read "N/A - See Abstractor Notes and Module 2", where before it had read to see Module 7.

2010 Data

- o Several of the diseases had additional primaries added to their "Same Primaries" field.

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February 25, 2013

The Hematopoietic Manual and the corresponding database are to be used for coding cases diagnosed January 1, 2012 and forward. The changes made do not require registrars to recode old cases.



Educational Presentations HemeDB

Educational presentations are provided by SEER at <http://seer.cancer.gov/tools/heme/training/>. After watching each presentation, you can take a quick quiz which has been approved by NCRA for continuing education. A CEU certificate is available for those who successfully complete each quiz. You are encouraged to view the presentations in the following order:

- Background
- Disease Presentations and Diagnostic Process
- Lineages Part I
- Lineages Part II

There are 9 archived modules from the 2010 Coding Rules which are still available for review at <http://seer.cancer.gov/tools/heme/training/archive.html>.

NOTE: Presentations will be added in the future to cover the upcoming 2014 revisions to the Hematopoietic Coding Manual and Database.

Instructions for Coding Grade for 2014+

By Delores Greene, CTR

The CoC-SEER-NPCR Technical Working Group has drafted a set of instructions that are simpler and are the same among all 3 groups. CoC-SEER-NPCR will incorporate these instructions into their respective coding manuals for 2014. A memo from the CoC-SEER-NPCR Technical Working Group can be accessed at <http://seer.cancer.gov/tools/grade/grade-2014-release-memo.pdf>.

Hematopoietic and Lymphoid Neoplasms Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms:

1. Determine the histology based on the current [Hematopoietic and Lymphoid Neoplasm Manual](#).
2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current [Hematopoietic and Lymphoid Neoplasm Manual](#).

Solid Tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example, Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

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Some Specific Histologic Terms Imply a Grade Code the Grade Shown below (6th digit)

Carcinoma, undifferentiated (8020/34)
 Carcinoma, anaplastic (8021/34)
 Follicular adenocarcinoma, well differentiated (8331/31)
 Thymic carcinoma, well differentiated (8585/31)
 Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
 Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
 Undifferentiated sarcoma (8805/34)
 Liposarcoma, well differentiated (8851/31)
 Seminoma, anaplastic (9062/34)
 Malignant teratoma, undifferentiated (9082/34)
 Malignant teratoma, intermediate type (9083/32)
 Intraosseous osteosarcoma, well differentiated (9187/31)
 Astrocytoma, anaplastic (9401/34)
 Oligodendroglioma, anaplastic (9451/34)
 Retinoblastoma, differentiated (9511/31)
 Retinoblastoma, undifferentiated (9512/34)



Photo by Jessica Taylor

Special Grade System Rules

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. The complete instructions for coding grade can be found at <http://seer.cancer.gov/tools/grade/>.

Quality Improvement Project

By Jessica Taylor

All grantees funded by CDC's National Program of Cancer Registries (NPCR) are expected to meet established NPCR standards. The standard for Data Completeness/Timeliness/Quality states to "...annually increase the number of urologists, dermatologists, gastroenterologists, medical oncologists, radiation oncologists, hematologists, and independent surgeons that report to the central cancer registry, as required by state law."

The OCCR has begun a special Quality Improvement Project that is aimed at improving this standard. The QI group decided to focus on increasing the number of Oklahoma gastroenterologists that report to the OCCR. First we compiled information from the Oklahoma Medical Licensure Board (OMLB), state and local associations as well as physician specialty associations to develop a comprehensive list of all gastroenterologists who practice in Oklahoma.

Our next step will be to identify which gastroenterologists are already reporting via the registrar. In order to do this, an OCCR consultant may contact you to obtain a list of those for whom you are reporting cancer cases, as to eliminate their name from our list. An introductory letter and questionnaire will then be sent to the gastroenterologists who have never reported to the OCCR. Once a response is received we will determine if the physician should be reporting and begin training accordingly.

The OCCR would like to thank you in advance.

Reminder: Benign Tumor Reporting

By Marva Dement, BBA, BS, CTR

Public Law 107-260, the Benign Brain Tumor Cancer Registries Amendment Act, requires programs participating in the National Program for Cancer Registries (NPCR) to collect data on benign and borderline tumors of the central nervous system in addition to the previously required data on malignant tumors. Likewise, the National Cancer Institute's (NCI), Surveillance, Epidemiology, and End Results (SEER) Program and the American College of Surgeon's Commission on Cancer began requiring that these tumors be reported. **Beginning with tumors diagnosed on or after January 1, 2004**, reportable tumors required to be abstracted include non-malignant primary intracranial and central nervous system tumors in ICD-O-3 with a behavior code of /0 or /1 (benign and borderline, or "non-malignant") regardless of histologic type for topography codes C70.0 – C72.9, C75.1-C75.3.

Collaborative Stage v0205 *By Paula Marshall, BBA, CTR*

The changes in CSv0205 primarily clarify coding instructions and correct the algorithm's mapping to AJCC to SEER Summary Stage values. There are no major changes in design, structure, or function of the Collaborative Stage (CS) algorithm in v0205. There are no new obsolete tables or codes.

CSv0205 is required for use with cancer diagnosed 1/1/2014 and later. CSv0205 may be used for cases diagnosed before 1/1/2014 that are identified after the upgrade to your software. Data should be transmitted in the North American Association of Central Cancer Registries (NAACCR) version 14.0 layout.

Some site-specific factors (SSFs) have been discontinued, but will not be obsolete.

Important to Note:

- Discontinued SSFs are NOT involved in stage calculation
- Discontinued SSFs have NEVER been required by a Standard Setter
- Codes used in discontinued SSFs are NOT obsoleted codes
- Discontinuing these SSFs is not intended to affect existing data collected for these SSFs



The coding instructions and any other documentation related to the coding structure for the discontinued SSFs will remain unchanged from this point forward. Coding instructions will not be included in the manual for CS 02.02; abstractors must refer to prior versions of the manual for information. If a facility or registry wishes to continue collecting data for these SSFs, it is the responsibility of the facility or registry to collaborate with its software vendor to maintain the discontinued SSFs.

To see a complete list of discontinued SSFs follow the link below:

<https://cancerstaging.org/cstage/about/news/Documents/list-disc-ssf.pdf>



Collaborative Stage Edits *By Christina Panicker, MBA, CTR*

Edits are necessary to provide quality data. Their purpose is not to frustrate the abstractor but to provide accurate data that is complete and thorough. There are special lookup features within the abstracting software itself that provide information regarding each specific field. In addition, review of the Collaborative Staging Manual will give the abstractor a better understanding of the CS fields and will assist in correcting any edits.

Collaborative Staging is a part of the abstraction process that often gives registrars difficulty. Many of the data fields are interrelated and an error on one of the codes will trigger an edit on other CS fields. For example, in the prostate schema there are many CS data fields that are related to whether or not the patient had a prostatectomy. If one code is incorrect, all of the corresponding fields will also appear on the edit summary page.

When correcting the edits for prostate, remember that all of the following fields are interrelated:

- **CS Site Specific Factor 3** CS Extension-Pathologic Extension
- **CS Site Specific Factor 4** Prostate Apex Involvement
- **CS Site Specific Factor 9** Gleason Primary Pattern and Secondary Pattern Values on Prostatectomy/Autopsy
- **CS Site Specific Factor 10** Gleason Score on Prostatectomy/Autopsy
- **CS Site Specific Factor 11** Gleason Tertiary Pattern Value on Prostatectomy/Autopsy

When edits require reviewing multiple fields, some may try to fix the edits by changing the codes until the edits go away. This technique does not solve the problem appropriately. The solution is to determine the relationship among data items and codes and review any coding instructions given for that field. The Collaborative Staging manual can help make the abstracting process smoother. Remember, correcting edits not only improves our data quality but can be an effective learning tool.

Be on the Lookout for...

Heads Up for Bladder

By Amanda E. Moran, RHIA, CTR

Please remember when you are completing a bladder abstract that a **TURBT** is to be coded with "1" for CS Tumor Size / Ext Eval and "27" for the Surg Prim Site code located in the First Course of Treatment box. This information is according to FORDS Appendix B: Site-Specific Surgery Codes.



Pathology Lab Search

By Judy Hanna, HT (ASCP)

As the Pathology Data Specialist for OCCR, I am always on the lookout for pathology laboratories that have not been identified to report cases to the Central Registry. There are currently several out-of-state path labs reporting to OCCR as well as labs within the state. It is very difficult to identify out-of-state labs being used by facilities to diagnosis Oklahoma cases that should be reported to the Central Registry. I would like to request if you come across the name of a pathology laboratory you are not familiar with, please send me the name and location and I will contact the laboratory. Thanks for your help! Please submit to judyh@health.ok.gov.

Double Duty

By Amanda E. Moran, RHIA, CTR

According to FORDS, palliative care is provided to prolong a patient's life by controlling symptoms, to alleviate persistent pain or to make the patient comfortable. Palliative care is not used to diagnose or stage the primary tumor. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes will indicate when they are performed for palliative purposes.

To properly code palliative care, go into the "First Course of Treatment" page and complete the coding for the type of palliative care that was given to the patient (chemo, radiation, etc.). Then, put a 1-9 code next to the "Palliative Procedure" box to indicate what type of palliative care was given to the patient. To see the 1-9 choices available, just click on the "Help" or "Look Up" box on your screen.



Upcoming NAACCR Webinars

By Leslie Dill

The next two webinars presented by NAACCR will be:

Collecting Cancer Data: Treatment Data Feb 6

Abstracting and Coding Boot Camp Mar 6
(Cancer Case Scenarios)

Two facilities will host the webinars, one in OKC and the other in Tulsa.

OKC location: OU Medical Center, Samis Education Center, next to Children's Hospital, 1200 Children's Ave, OKC, Basement Level B-Conference Room C.

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

If you would like to register to attend, please email Delores Greene, CTR, at DeloresG@health.ok.gov.

For EVERYTHING you do, Oklahoma registrars, OCCR thanks YOU!



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