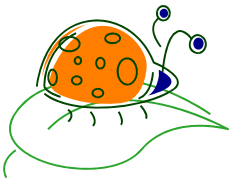
OCCR NEWSFLASH



Oklahoma Central Cancer Registry

Oklahoma State Department of Health

Spring/Summer Issue

May 2011

Charlotte Murphy Retiring

By Leslie Dill

June 30, 2011, we must say good-bye and congratulate a dear friend and co-worker, Charlotte Murphy, on her retirement. Instrumental in the development of the Oklahoma Central Cancer Registry, Charlotte began working for OCCR in 1998 and will be retiring after 26 years in Health Information Management,19 of those years specifically in the cancer registry field.

Over the years, Charlotte has been a member of several professional organizations such as American Health Information Management Association (AHIMA), Oklahoma Health Information Management Association from 1976 - present, National Cancer Registrars Association, and the Oklahoma Cancer Registrars Association (OCRA) for six years, having served as Program chairman and Nominating Committee Chairman. Charlotte also served as an Oklahoma Cancer Registrar representative on the Cancer Triad 1996 - 2000, which was the precursor to the establishment of the Oklahoma Comprehensive Cancer Network (OCCN).

Charlotte will have plenty to keep herself busy. She plans to continue her volunteer work as a client advocate at Gateway Women's Resource Center in Yukon, and as a prison ministry volunteer with the Oklahoma Jail and Prison Ministry of the Baptist General Convention of Oklahoma (BCGO). Like a lot of retirees, travel is on her to-do list and will include touring with the Capital Baptist Association Singin' Seniors Choir, as well as visits to family in Colorado, Missouri, Texas and North Carolina. Charlotte also plans to complete a second Bachelors degree (BA in Christian Studies) at OBU. At the top of her list is spending time with her 5 grandchildren who live in Chickasha and who participate in sports, academic and church activities.

While it will be sad to see her go, OCCR wishes Charlotte a VERY HAPPY RETIREMENT!

CoC Awards for 2010 Surveys

By Leslie Dill

The CoC's Outstanding Achievement Award is designed to recognize cancer programs that strive for excellence in providing quality care to cancer patients, and is granted to facilities that demonstrate a Commendation level of compliance with seven standards that represent six areas of cancer program activity: cancer committee leadership, cancer data management, clinical management, research, community outreach, and quality improvement.

We are pleased to announce that two Oklahoma facilities have been granted awards as a result of CoC surveys performed during 2010. The recipients are: CoC New Program Outstanding Achievement Award Recipients Surveyed in 2010-VA Medical Center of Oklahoma City; CoC Outstanding Achievement Award Recipients Surveyed in 2010-Southwestern Regional Medical Center of Tulsa.

OCCR congratulates the cancer registry programs at BOTH of these facilities! Well done!

Inside this issue:

Coding Breast Cancer	2
RMCDS Updates	4
Hematopoietic Database	5
Coding Breast Subsites	6
CSv2 to CSv3	6-9
RMCDS & CS 02.03 Conversion	7
Compliance Reporting	9

Coding Breast Cancer

By Delores Greene, CTR

Coding Primary Site

When the path report shows both invasive and in-situ tumor in different subsite of the same breast, code to the subsite that has the invasive tumor.

When the path report shows multifocal tumors within one quadrant, code to the specific quadrant. Do not code C509 (breast NOS).

When there is a single tumor that is overlapping two subsites and the subsite in which the tumor originated can't be determined code to C508. Or, if a tumor is in the 12, 3, 6 or 9 o'clock position use C508 (overlapping lesion).

When there are multiple tumors (two or more) in at least two quadrants code to C509 (breast NOS).

Grade

When coding the grade for breast cancer use the following priority order: 1) Bloom-Richardson (Nottingham) Scores 2) Bloom Richardson Grade 3) Nuclear Grade 4) Terminology and 5) Histologic Grade as shown in table.

Code	Bloom Richardson (Nottingham) Scores	Bloom Richardson Grade	Nuclear Grade	Terminology	Histologic Grade
1	3-5 points	Low Grade	1/3, 1/2	Well	I/III or 1/3
2	6, 7 points	Intermediate Grade	2/3	Moderately Differentiated	II/III or 2/3
3	8, 9 points	High Grade	2/2, 3/3	Poorly	III/III or 3/3

Determining the correct grade is important because it plays a role in how the cancer will be treated and in determining the patient's prognosis. When the biopsy shows a Nottingham score of 7 and the formal resection shows a Nottingham score of 4, which score should you use? The one where more tissue was resected or the one with the higher score? You should always code the highest score recorded, regardless if it is from the biopsy versus the formal resection. See Multiple Primary Histology Manual (MPH) Rule G, ICD-O3, p. 21.

Histology

Ductal Carcinoma in-situ arises in the lining of the milk ducts, and does not invade nearby tissues. See Table 1 on page 49 of the MPH Manual.

When there is an intraductal and two or more histologies present, use code 8523/2 (intraductal mixed with other types of carcinoma). See page 50 in Table 3 of the MPH Manual.

Ductal Carcinoma are invasive cases and ductal in origin, accounting for the majority of invasive breast cancers. See Table 2 on page 49 of the MPH Manual.

Continued on page 3

2011 CTR Testing Window

Fall CTR Exam: September 10-24, 2011

Coding Breast Cancer, continued from pg 2

When there is a tumor with ductal carcinoma and any of the histologies listed on page 50 of the MPH Manual, use code 8523/3 (infiltrating duct mixed with other types of carcinoma).

Paget Disease is an uncommon type of cancer that forms in or around the nipple with more than 95% of people with Paget's disease of the nipple also having underlying breast cancer. With Paget's Disease, the underlying tumor is either ductal carcinoma or ductal carcinoma in-situ which will be coded as one primary. See rule M9 of the MPH Manual. When Paget disease is present and in-situ with the underlying tumor being intraductal carcinoma code 8543/2 (MPH rule H24). If there is Paget's disease (NOS) and the underlying tumor is intraductal, code 8543/3 (MPH rule H25). Or, if you have Paget Disease and the underlying tumor is invasive ductal, code 8541/3 (MPH rule H26).

Inflammatory Carcinoma is characterized by diffuse erythema and edema (peau d'orange) involving more than 1/3 of the breast. Inflammatory carcinoma in one or both breast is a single primary. Use rule M2(MPH Manual) if there is a single tumor present and rule M6 (MPH Manual) if multiple tumors are present.

Only use code 8530 (inflammatory carcinoma) when the final diagnosis of the pathology report specifically states inflammatory carcinoma. See rule H13 (MPH Manual) if a single tumor is present and rule H22 (MPH Manual) if multiple tumors are present.

Regional Nodes

There are three levels of regional lymph nodes for the breast:

Level I nodes are the low axillary and intramammary.

Level II nodes are the mid axillary, interpectoral, and Rotter's.

Level III nodes are the high axillary, apical and intraclavicular.

Distant Metastasis

The four major sites for metastatic involvement for the breast are: Bone, Lung, Brain and Liver.

Disseminated Tumor Cells (DTCs) found in the bone marrow and Circulating Tumor Cell (CTCs) found in the blood stream and not considered distant disease.

Questions and Answers

Case Scenario :

A patient had a biopsy of the lung showing adenocarcinoma, received neo-adjuvant chemotherapy, followed by resection of the tumor which showed the histology to be mucinous carcinoma.

Question:

Would it be appropriate to code the adenocarcinoma as the histology since the patient had neo-adjuvant chemotherapy which would have altered the histology to mucinous? Or, should this case be coded to mucinous since this histology came from the definitive surgical resection and not the biopsy as stated in the MPH rules?

Answer:

According to *Carol Johnson* the lung revisions have not been completed yet, but for the other sites the physician experts say to code both the histology and grade before treatment. *April Fritz* said this case should be coded to adenocarcinoma even though it is more generic, because of the potential that the treatment might alter the histology.

This rule will be announced in the revised rules soon per Carol Johnson.

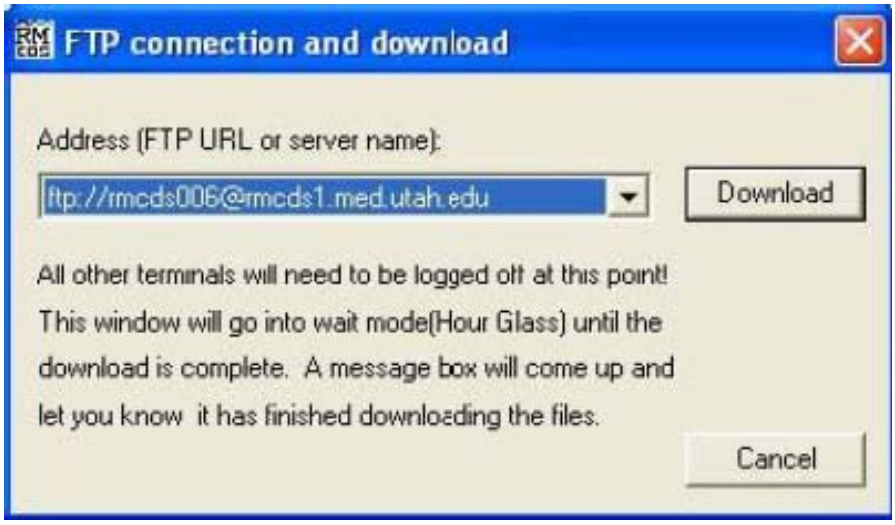
This question was submitted by Dulce Bramblett. I want to thank Dulce for sharing her question. If you have a question you would like to share please send to deloresg@health.ok.gov.

RMCDS Software Updates

By Paula Marshall, BBA, CTR

It is recommended that registrars update programs about once a month to stay current. Updates are free and available 24 hours a day. To use the automatic update, an active connection to the internet must be available.

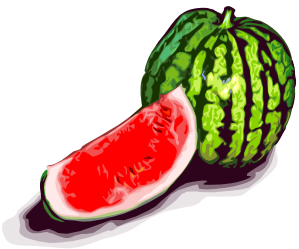
To run the automatic update, from the Main Menu click on "File" and choose "Software Updates." This will open a new window called "Process updates to the software." The Main Menu will close. The default option is "FTP update done automatically" but it is recommended to select the last option labeled "Alternate Automatic Download." Next click on the "Run" button and a new window will open.



Your facility FTP address should be listed in the box. The number following *rmcds* is your 3-digit hospital number assigned by OCCR. **If your RMCDS software is installed on a network, make sure that all other terminals are logged off of RMCDS before continuing.** Click on the "Download" button. An hourglass will appear until the files have successfully been copied onto the computer. This may take anywhere from 5 to15 minutes according to the size of the file.

Once the download is complete a message will appear stating that the FTP download is complete. Click "OK," then some screens will flash up while the programs are updated. File names will scroll as this happens. Once the update is complete, a message window will appear; Click "OK." A new login screen will appear prompting the user to enter their initials and password to open RMCDS. Please note the date to the right of Version date. The date should have updated and should be no more than a few days prior to the current date. If this date was not updated then the revision was not successful and must be run again. If the date is current then all of the RMCDS programs will been updated.

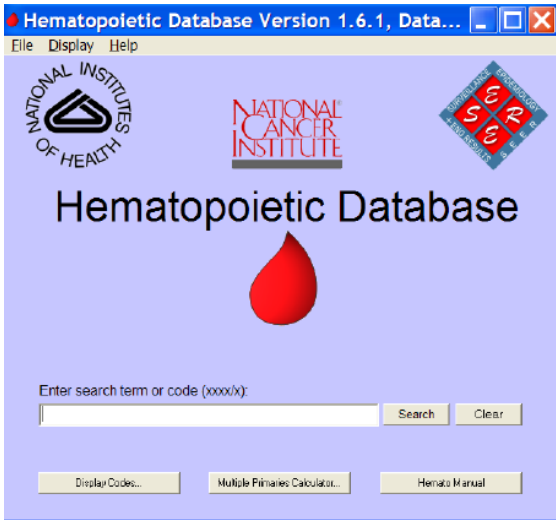
NAACCR Webinars: May-July 2011



Date	Time	Topic	OKC	Tulsa
5/5/2011	8-11 a.m.	Collecting Cancer Data: Prostate	Deaconess Hospital	St. John Medical Center
6/2/2011	8-11 a.m.	Best Practices for Developing and Working w/ Survival Data	Central Registry only	
7/7/2011	8-11 a.m.	Complete Case Identification and Ascertainment	Deaconess Hospital	St. John Medical Center

Hematopoietic Database Replaces ICD-0 Manual

By Beth Watwood, RHIA, CTR



With all of the changes taking place in Cancer Registry, it can be difficult keeping track of all the new rules and manuals! The Hematopoietic Database now replaces the ICD-O Manual for hematopoietic and lymphoid neoplasm cases diagnosed beginning January 1, 2010. The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual is embedded in the database.

Prior to using the manual or database, registrars should view the educational presentations on the SEER website: http://seer.cancer.gov/tools/heme/index.html. This is also the site where the database can be downloaded for free.

All About the WHO

By Amanda E. Moran, RHIA, CTR

In 1993, the World Health Organization (WHO) ratified a new comprehensive classification for central nervous system neoplasms. The tumor classification dictates the choice of therapy for the patient and predicts the patient's prognosis. The WHO has the following four categories of tumors:

Grade I tumors are slow-growing, nonmalignant and associated with long-term survival.

Grade II tumors are relatively slow-growing but sometimes recur as higher grade tumors. They can be malignant or nonmalignant.

Grade III tumors are malignant and often recur as higher grade tumors.

Grade IV tumors reproduce rapidly and are very aggressive malignant tumors.

When abstracting primary tumors of the brain or spinal cord (C71.0-C72.9) do ***NOT*** record the WHO grade as the tumor grade/differentiation. Pathologists do not always describe the grade or differentiation for CNS tumors. When the tumor's grade or differentiation is not described, registrars should assign code 9. Registrars should also code 9 for the grade/differentiation for nonmalignant CNS tumors.

If the differentiation is expressed in terms instead of in numbers, the three-grade coding system should be used (see FORDS manual, pgs 11-12). In this case, low-grade tumors (well to moderately differentiated) should be assigned a grade of 1 which is code 2. Medium grade tumors (moderately undifferentiated and relatively undifferentiated) should be assigned a grade of 2 which is code 3. High-grade tumors (poorly differentiated to undifferentiated) should be assigned a grade of 3 which is code 4.

The WHO grade is recorded in the CS Site Specific Factor #1. At this time, this is not a required data item by OCCR, but it will be required starting with January 2011 cases.

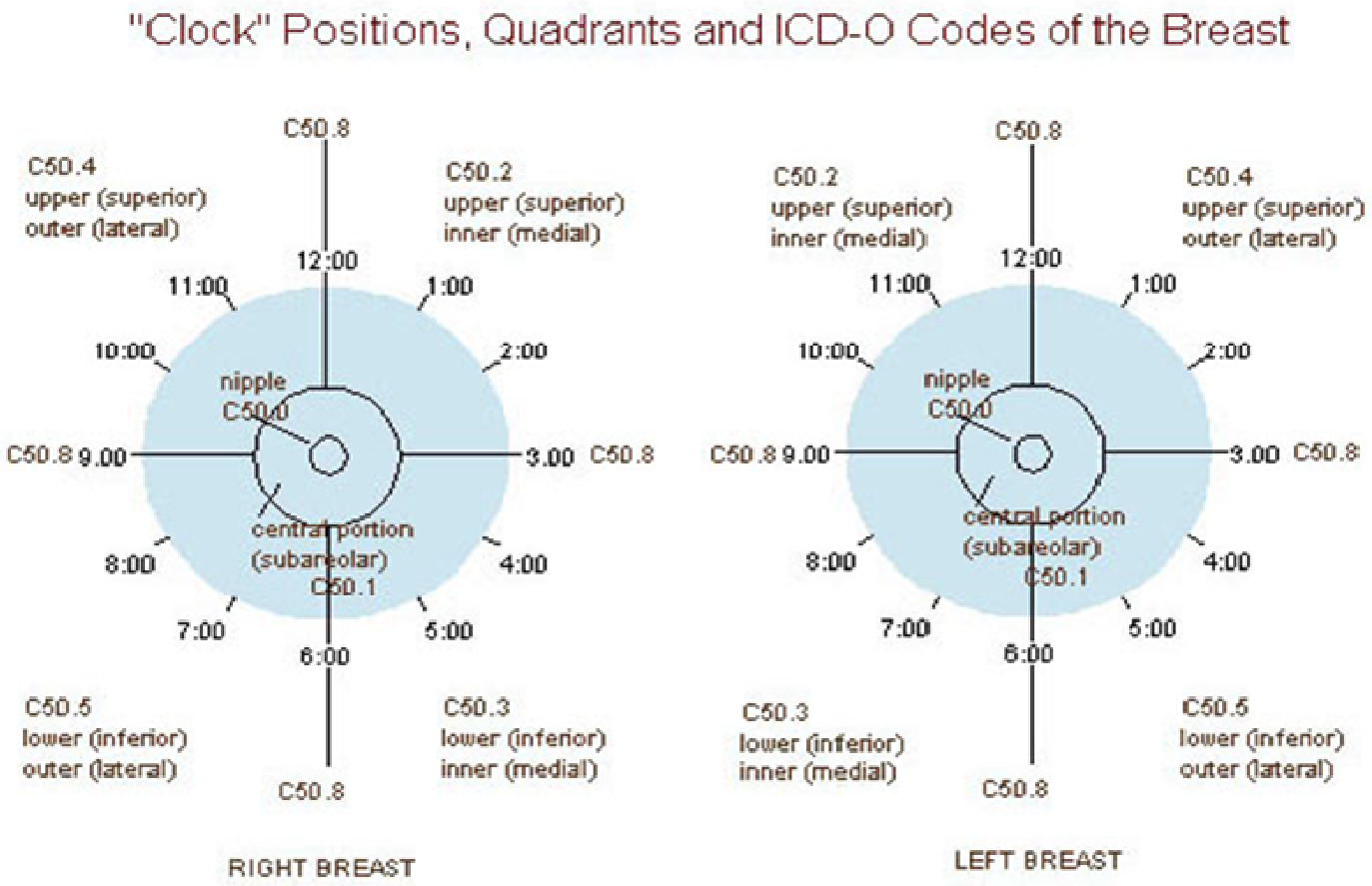
Primary Site Breast-Coding Subsites

By Beth Watwood, RHIA, CTR

The purpose of this article is to review proper coding of the quadrants of the breast. The specific subsite information may be found in numerous places within the medical record so it is important that registrars carefully review documentation in order to apply the appropriate code. Sometimes this may be mentioned in the mammography, ultrasound, or MRI reports or could be mentioned on the biopsy or surgery reports. It is always best to code the more precise quadrant rather than coding Breast, NOS- C50.9.

A great place to review anatomy of the breast is the SEER Training website http://training.seer.cancer.gov. Below are a couple of excerpts from the Breast Training Module from SEER that can be very useful tools when abstracting Breast cases.

Note: C506 is the code for axillary tail or tail of breast.



For more about breast coding subsites, continue reading on page 7.

Primary Site Breast-Coding Subsites, cont'd

ICD-O-3 Site Codes

In the second and third editions of ICD-O, cancers of the male breast are coded using the schema for tumors of the female breast.

C50.0	Nipple
C50.1	Central portion of breast
C50.2	Upper-inner quadrant of breast (UIQ)
C50.3	Lower-inner quadrant of breast (LIQ)
C50.4	Upper-outer quadrant of breast (UOQ)
C50.5	Lower-outer quadrant of breast (LOQ)
C50.6	Axillary tail of breast
C50.8	Overlapping lesion of breast
C50.9	Breast, NOS (excludes Skin of breast C44.5); multi-focal neoplasm in more than one quadrant of the breast.

RMCDS and CS 02.03 Conversion

By Paula Marshall, BBA, CTR

A number of registrars have asked about the conversion from CS 02.02 to CS 02.03. This conversion is necessary in order to code 2011 data accurately and generate the derived values. Instructions and tables were made available to the vendors in early 2011, however a program to test the conversion was not part of the release. This meant that each vendor had to write their own conversion program using their own interpretation of the instructions and tables. RMCDS did create their own conversion program several months ago, but to use it only for testing. Basically, this conversion has not been released because there is no way to independently confirm that their procedure is correct. CDC is currently writing a conversion program that will be available in early May for vendors to test their conversion procedures. Therefore, it will be late May or June before RMCDS will be performing conversions on the RMCDS systems. Information about how to convert your RMCDS system will be made available to you as soon as possible. We apologize for any inconvenience this delay may cause.

Social Security Number Sleuth

By Charlotte Murphy, RHIA, CTR

How would two unrelated persons, from different cities, have the same Social Security Number? Spouses are sometimes reported with the same SSN. Forty-five instances of this have been identified in the Oklahoma Central Cancer Registry database. The circumstance cited in the first sentence, however, is quite perplexing, and will be the subject of some sleuthing during the next few weeks.

CSv2 02 03 Reporting Requirement

By Paula Marshall, BBA, CTR

CDC-National Program of Cancer Registries (CDC-NPCR) is the funding source for the OCCR and we will follow the requirements and recommendations listed below:

CDC-NPCR requires the use of Version 02.03 of the Collaborative Stage Data Collection System (CSv2) for cancer cases diagnosed on or after January 1, 2011. CDC-NPCR requires the collection of CSv2 data items needed to derive SEER Summary Stage, SSFs for Breast, Brain/CNS/Intracranial, and SSF 25 for applicable sites (schema discriminators). CDC-NPCR requires, as available, the collection of CSv2 data items needed to derive AJCC-7 TNM Stage. CDC strongly encourages NPCR registries to collect additional CSv2 data items.

2011 Required Input Items for all sites:

Item	Item Name
1200	RX Date – Surgery
1201	RX Date – Surgery Flag
1210	RX Date -- Radiation
1211	RX Date – Radiation Flag
1220	RX Date – Chemo
1221	RX Date – Chemo Flag
1230	RX Date – Hormone
1231	RX Date – Hormone Flag
1240	RX Date – BRM
1241	RX Date – BRM Flag
1250	RX Date – Other
1251	RX Date – Other Flat
1430	Reason for No Radiation

2011 Required As Available Input Items for all sites:

Item	Item Name
135	Census Tract 2010
367	Census Tr Certainty 2010
441	Grade Path Value
449	Grade Path System
820	Regional Nodes Positive
830	Regional Nodes Examined
2840	CS Regional Nodes Eval
2860	CS Mets Eval
3400-3430	Derived AJCC-7 TNM and Descriptors

2011 Site Specific Factors for selected primary sites (not required to derive Summary Stage) but required by CDC-NPCR

SSF 1 Brain, CNS, Other, Intracranial Gland (WHO Grade Classification)

SSF15 Breast – HER2 Summary Result of Testing

SSF16 Breast – HER2 Combination of ER, PR, and HER2

If you or your cancer registry program have something to celebrate — passing the CTR exam, recognition from CoC for an outstanding survey, birth of a child or grandbaby, etc.— please forward it to OCCR so that we can include it in our next newsletter. Likewise, if there are other things that you would like to see included in the OCCR Newsflash, please send an email to LeslieD@health.ok.gov.

CS Data Collection System (CSv2 02.03)

By Paula Marshall, BBA, CTR

The fourth production release of the Collaborative Stage Data Collection System is now available. This new version includes updates to the schemas resulting from the table proof-reading and validation project. Some of the changes include:

- Myeloma Plasma Cell Disorder: A new schema for Multiple Myeloma and Plasma Cell Disorders has been added to the CS schemas. These cases were formerly part of the HemeRetic schema.
- Site-Specific Factors: Site-specific factors have been added or modified for the following schemas: 1) Bile Duct Intrahepatic 2) Kaposi Sarcoma and 3) Testis.
- Schema Discriminator (SSF 25): For those schemas that previously accepted blanks as a valid SSF25 value, these schemas will no longer accept blanks and will now require the new codes of 981 or 982.

OCCR requires the use of version 02.03 of the Collaborative Stage Data Collection System (CSv2) for cancer cases diagnosed on or after January 1, 2011. Some registrars may have completed abstracting 2010 cases while others are on schedule with the June, 2011, deadline. Whatever your status, please make note that **OCCR will not accept any 2011 data that has not been coded with the new CS 02.03**. If you have converted to the new CS 02.03 version we will accept your 2011 data submissions, however we will not be able to process your data until we have converted our database.

OCCR Compliance Reporting Calendar

By Leslie Dill

May is already here and according to the OCCR Compliance Reporting Calendar (to the right), reporters should be abstracting November 2010 cases now. If this is not the case, we strongly recommend that you call your consultant immediately and formulate a plan to get your 2010 cases submitted to OCCR by August 2011.

Keep in mind that Compliance Specialist, Delores Greene, CTR, will be sending out the quarterly compliance letters in June.

Month of Diagnosis	Month of Receipt By OCCR
January 2010	July 2010
February 2010	August 2010
March 2010	September 2010
April 2010	October 2010
May 2010	November 2010
June 2010	December 2010
July 2010	January 2011
August 2010	February 2011
September 2010	March 2011
October 2010	April 2011
November 2010	May 2011
December 2010	June 2011

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

Oklahoma State
Department of Health

SAVE THE DATE! SAVE THE DATE! SAVE THE DATE!

September 29 & 30, 2011

The Oklahoma Cancer Registrars Association (OCRA) Fall Conference will be hosted at Rose State College in Midwest City on Thursday and Friday, September 29th &30th. For more details as they are announced go to : www.ocra-ok.org/education.asp.

We acknowledge the Centers for Disease Control and Prevention (CDC) and the National Program of Cancer Registries (NPCR) for its support and the distribution of this newsletter under cooperative agreement #U58/DP000834-03 awarded to Oklahoma. Its contents are solely the responsibility of the authors and do not represent the official view of CDC.

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