ALABAMA CANCER REGISTRARS ASSOCIATION

ACRA REMINDER

Summer 2012

A Message from our President,

Priscilla Foster, CTR, CPC, AAS

Well what can I say? The year is over half-way behind us and our Annual conference is only a few months away. The board has been meeting and we are working diligently on the upcoming meeting. The meeting is scheduled for Thursday and Friday, October 11 and 12, 2012. The title for the conference is ***"Cancer Registrar's United for the Cause".*** We have some great speakers lined up and we have heard your requests for conference topics. To start off we have Carol Hahn's Johnson from SEER, who will come and speak to us on the Hematopoietic New Database and changes, Cynthia Boudreau will give us an educational overview on The New Standards and the Quality of our Data, we have topics on Informatics, HIPPA Cancer Registry Compliance and an ICD-10 overview, just to name a few. So we are planning to have a great meeting and we look forward to seeing everyone in the fall. Stay tuned to the website (www.alabamacra.org) in the next couple of weeks for location and hotel information.

In April, I had the opportunity to attend NCRA's National meeting "***United We Stand"***. The meeting was a really good meeting. The topics ranged from "Fighting a Smarter War on Cancer to Csv2 Reliability Study Results to Updates from the Surveillance Summit Work Groups. There were so many topics of discussion in those three days until it was a little hard keeping up. Some of us from our State and other states had the opportunity to participate in the **"Walk on the Hill",** the ACRA was well represented by Judy Lang, Yolanda Graham-Gaston, Lelia Edwards and myself to participate in this historic event. We visited Congresswoman Terri Sewell's office where we were supposed to meet with her but due to scheduling conflicts we were unable to meet with her (but we did see her a couple of times) we met with her assistant who was very knowledgeable on the topic of screening patients for cancer since a close relative of his had experienced a challenge with cancer. We attended and gained some valuable information on upcoming changes that may affect patient care if funds are cut from the budget. So far this hasn't happened so we trust God that CDC and all other government funded cancer programs will not experience a budget cut in any area, that affects the cancer patients. I would like to thank the association for allowing me to represent us at this years meeting. Some of the information and topics presented at the meeting included the following:

Carol Hahns Johnson spoke on the Hematopoietic Database How Does it Help? The information that she presented focused on the new download that is available to us to download at (http://seer.cancer.gov/tools/heme/download.html, so if you haven't already downloaded this very valuable tools for work you can do so on the SEER website. The platform as well as the appearance of the database has changed. There are abstractor notes with a list of specific sites and definitive diagnosis methods which is done or performed with genetic or immunophenotyping. She also mentioned that the ICD-9 and ICD-10 codes will be located in the hematopoietic database. The example given was if the code in ICD-9 is 201.9 (Hodgkin's disease unspecified then the corresponding ICD-10 code C81.9 Hodgkin's disease unspecified.

Cynthia Boudreau and Lisa Landvogt presented an overview on the 2012 Commission on Cancer – Best Practice Repository: Why Re-Invent the Wheel? They presented information on how these practices were developed for the new Cancer Program Standards; these practices are located on the Commission on Cancer's website at www.socialtext.net/cancer_standards/coc_best_practices_repository. The information was developed for use by Surveyors, Cancer Program Administrators, Cancer Registrars, Assigned Coordinators, Consultants and the CoC staff. The contributors who help develop these practices are the Accredited Cancer Programs, outstanding Achievement Award Recipients, Consultants, CoC Staff, Surveyors and National Organizations.

We all were challenged with CAP electronic Cancer Checklists (eCC) which is a Means to Enhanced Cancer Registry Services and Efficient Use of Resources. The checklists can have a positive impact on the Cancer Registrar and the Cancer Registry Program. This is a way for the pathologist to use the eCC and engage the registry vendors to provide synoptic processing to the pathologist and help improve the functions of the path reports. This tool is used to enhance and advance cancer reports with great benefits for the hospital and the state cancer registries. The checklists also help to provide and understanding the relationship between the eCC Rules-Based software for Collaborative Stage, and the CS Stage Algorithm.

I could go on and on but time or space will not permit me to do so. There were so many presentations and lots of speakers with a wealth of knowledge and information for us to absorb. The meeting provided lots of changes and updates for us to embrace. So whether it's COC Standards, Collaborative Staging updates, Hematopoietic changes, Cap guidelines, etc. this information helps us as professional registrars to stay abreast and it challenges us to do the very best that we can to make a difference in the collection of cancer data to help the physicians in their use of our data as they continue to research and provide the best in cancer patient's care that they can. So, let us continue to do our part as we as Cancer Registrar's are focused and "United for the Cause."

Education Committee July 2012

One of ACRA's goals is to provide you with innovative education to promote excellence in expertise in cancer data collection and management. In doing so, we would like to focus on the 2012 FORDS changes. Some of these changes will have a direct impact on patient care and outcome. Everyone is encouraged to become familiar with Fords 2012, especially the Preface and review Appendix C for an overview of the 2012 changes.

The most substantial changes are to coding instructions:

- **Grade**: See *Section I (Morphology: Grade)* for new instructions for determining which Grade items require coding, depending on the type of case. Grade items include cell lineage for hematopoietic and lymphatic tumors, *CS* special grade items, *Grade Path System* and *Grade Path Value*, and *Grade/Differentiation*.

- **Sentinel Lymph Node Biopsy**: See the item descriptions in *Section II* for *Scope of Regional Lymph Node Surgery* and *Scope of Regional Lymph Node Surgery at This Facility*. These items are **to be coded from the operative report**, **not** from the pathology report. The operative report will designate the surgeon's planned procedures as well as a description of the procedure that was actually performed. The operative report takes precedence when attempting to distinguish between SLNBx and regional dissection or a combination of these two procedures. Remember that the surgeon sees and does the surgical procedure and the pathologist only sees what has been given to him/her. **Specific additional instructions are provided for breast primaries.** Sentinel lymph node biopsies for breast cancer have been significantly under-reported, therefore new instructions and clarifications have been designed to guide the coding for this data element for implementation for cases diagnosed January 1, 2012 and after. See the link below for more information about this important change. Neither CoC nor other standard setters are asking registries to recode cases diagnosed prior to 2012, due to the large number of cases affected. http://www.facs.org/cancer/ncdb/scope-regional-lymph-node-surgery.pdf

Other major changes in **FORDS: Revised for 2012** include the following:

- The Multiple Primary data items are now defined in **FORDS** rather than in the SEER Multiple Primary and Histology coding manual.

Instructions to code repeat surgeries cumulatively are clarified. **Repeated surgeries**. Often a patient undergoes more than one first course surgical event that is coded in the same surgery item. The instructions for coding these surgeries have been clarified in this volume. Each subsequent surgery of the type that is coded in the same item as the original must be coded to show the *cumulative* effect of the all first course surgeries of the type. For example, if a sentinel lymph node excision is followed at a later time with non-sentinel regional lymph node surgery, use the code that represents that action (7) to record the second surgery. Do not rely on your registry software to compute that from individual descriptions of the operations. It is the final cumulative code that will be submitted to NCDB and central registries.

New codes were added to the two items, *Radiation/Surgery Sequence* and *Systemic/Surgery Sequence*.

Radiation/Surgery Sequence. A new code 7 was added to this item for use when a surgical procedure was followed by radiation, and then another surgical procedure was performed. Networks are reminded that *Facility Identification Number (FIN)* and *Archive FIN* apply to the hospital, not to the full network, in registry data. *Archive FIN* is the facility's FIN at the time the cancer was first accessioned by the facility, and is only different from the *FIN* if a change in FIN is caused by a hospital merger.

Systemic/Surgery Sequence. A new code 7 was added to this item for use when a surgical procedure was followed by systemic therapy, and then another surgical procedure was performed, followed by systemic therapy, then another surgical procedure was performed.

Multiplicity Counter. Added new codes 00 and 89 (Both initially were added to the *SEER Multiple Primary and Histology Coding Rules* for use in 2011, but were not identified in the list of changes to that manual when the update was distributed that year). Note also that some site- and histology-specific instructions also have changed since that manual was produced.

All items in **FORDS** are required for CoC accredited cancer programs. Supplementary references that are necessary for coding AJCC, collaborative stage, multiple primaries and histologies, hematopoietic tumors, and systemic agents.

Pat Caldwell

Education Committee Chair

Save the Date

ACRA Annual Meeting

October 11th & 12th, 2012

YES WE DO!!! ACRA needs you to seek an office and serve your organization. The deadline is approaching and we need some names on those ballots!

Please send your nominations to me my email diane.lolley@stvhs.com or call me @ 205-939-7242 for offices listed below. Thank you!

Eligibility: Only an active member with at least one-year active membership in good standing shall be eligible to hold office. To be eligible for the offices of President-Elect and Vice President, a member must have served at least one term on the Board of Directors or as a Chair of Standing Committee prior to nomination.

Board Description:

President-Elect: Shall assist the President in his/her duties throughout the year; shall keep informed regarding proceedings of ACRA; and, shall succeed to the office of the President at the conclusion of his/her term of office. The President-Elect shall appoint the Standing Committee Chairs for his/her term of office. The President-Elect shall appoint the Standing Committee Chairs for his/her term of office immediately after installation as President.

Vice President: Shall assume the duties of the President in his/her absence and is responsible for the quarterly newsletter sent to the membership.

Secretary: The Secretary shall keep a permanent record of all meetings of ACRA and shall present them at the following meeting; shall carry on official correspondence of the organization under direction of the President; shall provide annual maintenance and oversight of the ACRA electronic library including collecting and tracking ACRA thumb drives from out-going board members and re-distributing them to in-coming board members after copying and/or archiving data from the past year to CD (or laptop).....

Treasurer Elect: This individual will serve one year as an apprentice to the Treasurer, supporting annual budget oversight and development, and act as an assistant to the Treasurer as well as in the Treasurer's absence. This position will provide the opportunity for orientation, education and training prior to succeeding to the office of Treasurer. This individual will serve as internal auditor for the association. As Treasurer the second year:

Treasurer: The Treasurer shall receive all annual dues; collaborate with the Membership Chair to maintain a current, up-to-date and accurate membership roster. The Treasurer shall provide on-going assessment of the Association's annual budget and maintain a detailed spreadsheet of all revenues and expenses. The Treasurer shall receive and pay all bills as authorized by the President; shall purchase and pay for sympathy gifts when ACRA members experience the loss of a family member.....

Parliamentarian/Historian: Shall be informed on *Robert's Rules of Order, Newly Revised;* shall advise the presiding officers on points of Parliamentary law; shall give similar advice to the Board of Directors, when they request it; and shall decide points of order when challenged by members of ACRA. The Parliamentarian/Historian shall keep and record the history of ACRA.

Diane Lolley

Nominating Committee Chair

Hospital News

Gadsden Regional Medical Center is very excited to announce the delivery of our new Xoft, electronic brachytherapy system. This equipment will allow Dr. Harrision and our cancer center staff to deliver radiation treatment more efficiently to many existing patients as well as provide treatment not previously available in Northeast Alabama.

Electronic brachytherapy will be used in place of conventional external beam radiation therapy in some cases, and will allow safer cancer treatment and more patient convenience.

There are four treatment areas where Xoft might be an option.

1) **Selected Breast Cancer Patients**
a. Conventional Treatment Time: 35 days of external beam radiation
b. Xoft Treatment Time: 10 treatments in 5 days.

2) **GYN**
a. Conventional Treatment: Patients must travel to Birmingham for proper treatment.
b. Xoft Treatment: Now patients can stay in Northeast Alabama to have the same treatment.

3) **Skin**
a. Conventional Treatment: 30 days of external beam radiation
b. Xoft Treatment: 9 days over the course of 3 weeks.

4) **IORT** (Intra Operative Radiation Therapy)
a. Currently being performed in academic medical centers, and leading community hospitals
b. Gadsden Regional has the capability to deliver this same treatment option.

I fully expect Xoft to continue to expand their line of applicators which would give our hospital even more options of treatment delivery in the future.

We expect our first patient to be treated in about 2 months.

George Harrison, M.D.

Alabama Statewide Cancer Registry Update

Death Clearance

Thank you all for your timely response to the 2010 death clearance follow back. We are currently preparing for the last mail out for 2010. If you have received a follow back letter pertaining to a patient that was not diagnosed or treated at your facility, please provide the name of the **primary care physician** that you have on file so that additional follow up efforts can be made. The ASCR must have a 3% rate or less for Death Clearance cases in order to receive gold certification from the North American Association of Central Cancer Registries. If you have questions, or need assistance with this process, please contact me at (334) 206-2088 or Ashley.Grunewald@adph.state.al.us.

Reminder

2011 Data Close-out letters are due August 15th, 2012

Alabama Profile in Cancer in North America: 2005-2009

The North American Association of Central Cancer Registries (NAACCR) had recently published *Cancer in North America: 2005-2009*. The publication includes cancer statistics by registry and as combined information in a three volume set that is available free of charge through the NAACCR Web site at the following link: http://www.naaccr.org/DataandPublications/CINAPubs.aspx.

Below is the Alabama specific information. Due to the impact of Katrina, only first half of the 2005 data was counted in the publication. In this newsletter, we only present 2006-2009 data in Data Quality Indicator. As you can see, the percentage of missing race and DCO only cases is increasing , which indicates more efforts need to be put into those areas.

Data Quality Indicators (2006-2009)

Indicators (%)	2006	2007	2008	2009
Met Inclusion Criteria for Combined Rates	Yes	Yes	Yes	Yes
Completeness of Case Ascertainment	95.7	98.4	100.2	98
Missing Race	0.5	1	1.2	1.6
Missing Sex	0	0	0	0
Missing County	0.5	0.3	0.2	0.7
Missing Age	0	0	0	0
Death Certificate Only Cases	0.9	0.9	2.3	2.5
Passing Edits	100	100	100	100

Site-Specific Microscopic Confirmation (2005-2009*)

Cancer Site	% Micro. Confirm	Cancer Site2	% Micro. Confirm3
All Sites	93.9	Prostate	96.4
Oral Cavity & Pharynx	98.0	Testis	98.9
Esophagus	96.7	Bladder (incl. in situ)	98.7
Stomach	96.6	Kidney & Renal Pelvis	92.2
Colon & Rectum	96.7	Brain & Other Nervous System	88
Liver	70.1	Thyroid Gland	99.4
Pancreas	81.1	Hodgkin Lymphoma	97.0
Lung & Bronchus	90.3	Non-Hodgkin Lymphoma	97.0
Melanomas of the Skin	98.8	Multiple Myeloma	85.9
Female Breast (excl. in situ)	97.7	Leukemias	87.8
Cervix uteri	97.3	Brain & ONS1 benign/borderline	59.0
Uterus Corpus & Uterus NOS1	98.1	Breast in situ	100
Ovary	92.4		

Tips for Coding Biopsies and Wide Excisions for Melanoma

NAACCR Webinar Collecting Cancer Data: Melanoma of Skin

Generally, if a melanoma of the skin is suspected, a physician will try to excise the tumor. The tumor may be excised using a standard excisional technique, a punch biopsy, or shave biopsy. For the initial excisional biopsy the physician will usually try to remove the entire tumor, but leave very close margins. This will allow mapping of the lymphatics in the future. If the tumor is very large or in a place that makes an excisional biopsy difficult, the physician may just take a sample of the tumor to confirm that it is melanoma.

If the suspicious lesion is found to be melanoma, the physician will go back and perform a wide excision. Based on depth of invasion, ulceration, mitotic rate, and other factors, the physician will try to get a margin of healthy skin not involved with melanoma. For example, if the melanoma has a Breslow's depth of 1cm the physician may want to get a 1cm margin of healthy tissue surrounding the tumor.

Below are tips for coding melanomas of the skin that are diagnosed first by a biopsy and then receive a wide excision. This document does not contain suggestions for coding other common surgical procedures for melanoma such as a Mohs surgery or amputation.

Diagnostic Staging Procedure

If the tumor is very large or in a site that is difficult to biopsy, the physician may choose to take a sample of the tumor rather than remove the entire tumor. If this is done, the margins on the specimen sent to pathology will be grossly positive. This would be coded as a diagnostic staging procedure code 02.

Excisional biopsy

If a physician suspects melanoma, they will probably try to remove the entire lesion. This may be done as a standard excisional biopsy, punch biopsy, or a shave biopsy. Regardless of the approach, this procedure should be coded using the surgery code 27.

If the margins of the biopsy are microscopically positive or there is no information about the margins, assume it was an excisional biopsy.

Wide Excision

Following the excisional biopsy the patient will probably have a wide excision. A wide excision removes a margin of healthy tissue from around the melanoma site. If the margin of healthy tissue is 1cm or less, code this procedure using codes 30-33. Codes 30-33 would also be used if the margin of healthy tissue is not stated. *Even though these codes reflect two procedures, the date of surgery when assigning codes 30-33 is the date of the wide excision.*

Code 30 is used when wide excision (or re-excision) follows the original biopsy (excisional or incisional), and the wide excision path report describes the closest clean margin = 1 cm or less, or does not describe the margins at all. There are few specific codes in series 30:

- **Code 31** is used if the original excisional biopsy was a shave biopsy.
- **Code 32** is used if the original excisional biopsy was a punch biopsy.
- **Code 33** is used if the original biopsy was incisional and then a wide excision was done (the incisional biopsy was coded as a diagnostic staging procedure).

If your facility only codes one surgery for each abstract (i.e. hospital only reporting to the state cancer registry), use the code for the most definitive procedure.

Codes 45-47 are used when the margins are negative, they are microscopically confirmed, AND

- **Code 45** is used if the patient has a wide excision and the margins are more than 1cm, but it is not documented if they are more or less than 2cm's.
- **Code 46** is used if the patient has a wide excision and the margins are more than 1cm and it is documented that the margins are equal to or less than 2cm's.
- **Code 47** is used if the patient has a wide excision and the margins are more than 2cm's.

When is it ok to choose a lower histology code?

From the 2007 Multiple Primary and Histology coding rules.
Submitted by Mark Jackson

Priority order for using Documents to Code Histology
Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:
a. From the **most representative** tumor specimen examined
b. From the **final diagnosis**

Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.

Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.

Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.

2. Cytology report.

3. When you do not have either a pathology report or cytology report:
a. Documentation in the medical record that references pathology or cytology findings
b. From mention of type of cancer (histology) in the medical record

Example : A biopsy of the Pancreas shows Neuroendocrine carcinoma (8246/3). A later resection of the tumor has the final diagnosis as Islet cell carcinoma (8150/3). Code the histology to the lower code of 8150/3

Upcoming NAACCR Webinars

Collecting Cancer Data: : ICD-10-CM and Cancer Surveillance: Cullman County Health Department— August 2012, TBA from 9:00 am to noon for more information call Diane Hadley at 256-775-8970.

Mobile County Health Department—August 2012, TBA, for more information call Mark Jackson at 251-433-7809.

Live Webinars held in Montgomery, Alabama

Collecting Cancer Data: Hematopoietic Diseases— August 2, 2012 1:00 to 4:00 pm

Collecting Cancer Data: Coding Pitfalls: September 6th, 2012 1:00 to 4:00 pm for more information call Tara Freeman at 334-206-7035.

Questions & Answers from NAACCR Webinars

Collecting Cancer Data: Lower Digestive System

Q: If you have a mucinous adenocarcinoma in a tubular adenoma, what histology code do you use?

A: Per colon MPH rule H4, code mucinous adenocarcinoma in tubular adenoma to 8210/3.

Q: For an anal canal primary, would EXTERNAL iliac lymph node involvement be coded in CS Lymph Nodes or in CS Mets at DX?

A: External iliac lymph nodes are distant lymph nodes for the anus and anal canal.

Collecting Cancer Data: Lung

Q: -Pleural effusion not biopsied; what are the guidelines?

A: Per Note 1 preceding the codes in the CS Mets at DX code table for lung: "Most pleural and pericardial effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathologic examinations of pleural and/or pericardial fluid are negative for tumor, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the tumor should be classified as M0."

ALABAMA CANCER REGISTRY ASSOCIATION

Basket Drawing

The Ways and Means Committee is bringing back the basket drawing to raise money for the organization.

WHEN: Thursday, October 11th and, Friday 12th 2012

WHERE: NOT FINILIZED as of date.

HOSPITAL/INDIVIDUAL NAME_____

Contact name _____

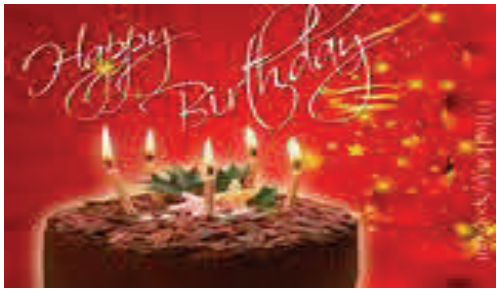
Contact phone number _____

Type of basket _____

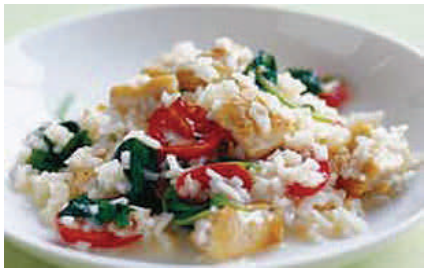
Please call or email completed form to:

Paula Wyatt at 256-494-4466
paula_wyatt@gadsdenregional.com

Alabama Cancer
Registrars Association



July	August	September
8 — Shirley Williams	2 — Jacqueline Miles	15 — Joan Baucom
18 — Rekha Khatri	8 — Lelia Edwards	22 — Cindy Johnson
19 — Barbara Roberts	12 — Kathy Hawkins	28 — Cynthia Dixon
19 — XJ Shen	13 — Denita Austin	
23 — Carol Kennemur	17 — Barbara Yarber	
	27 — Connie Jenson	



Chicken and Spinach Risotto

Main Ingredients:

1 TBSP Olive oil

1 lb. boneless skinless chicken breasts, cut into bite sized pieces

4 cups baby spinach leaves, washed, dried

1 1/2 cups instant white rice, uncooked

1 cup grape or cherry tomatoes

1 can (10-1/2 oz.) condensed chicken broth

1/2 cup water

1/4 cup grated parmesan cheese

Directions:

HEAT oil in large deep nonstick skillet on medium heat. Add chicken; cook 10 min. or until chicken is cooked through, stirring frequently.

ADD spinach, rice, tomatoes, broth and water; mix well. Bring to boil. Reduce heat to low; cover. Simmer 5 min., stirring occasionally.

STIR in the Parmesan cheese.