

Tennessee



Cancer Registry

Inside this Issue

- 2** What's the Answer
- 2** Helpful Hints
- 3** News & Information
- 4** Fun Page
- 5** Selected References &

TCR Communicator

From the Director, Dr. Martin Whiteside

It is a time of vacationing and also preparing for the beginning of school, but life continues on in the field of cancer registration! Surveys and data submissions will soon be upon reporting facilities, and we here at the Tennessee Cancer Registry (TCR) are cognizant that our data submissions to the Centers for Disease Control & Prevention (CDC) and the North American Association of Central Cancer Registries (NAACCR) will soon be here, as well.

We have essentially completed the processing of the 2005 Hospital Discharge Data System summary (HDDS) and found that it will be a very valuable tool to assure completeness of Tennessee's cancer data. In this pilot project, we sent out 4,025 total follow-back forms on patients that did not link to our main database of reported cancer patients and netted 494 new cases for a positive missed cases ascertainment rate of 12.3%. The 2006 HDDS have been processed and were sent out at the end of July 2008. This time, we will be using both the inpatient and outpatient files of the HDDS to identify possible missed cases, rather than just the inpatient file as we did for the 2005 HDDS. We are sure that this will be a valuable casefinding tool for hospital reporting facilities to assure completeness of case ascertainment, since on average it appears that about 12% of all inpatient cancer patients are currently being missed.

We continue to look forward to working with you all on the vital task of determining the cancer burden in all Tennesseans!

Fall Events

The TCR will present CDC audit results, along with highlights of web-based training modules, that will be available during the upcoming year, at the 26th Annual Tumor Registrars Association of Tennessee Educational Conference

September 24-26, 2008

For registration information and details, visit the TRAT web-site at:

<http://www.trat-tn.org/news.asp>

The 2006 Death Clearance process has begun. Letters were sent to facilities and physicians asking for information concerning individuals whose death certificate listed a reportable diagnosis as a cause of death. The Death Clearance process is a valuable casefinding tool and is also used to update the TCR records.



What's the Answer?

***Question 1:**

A patient was originally diagnosed with transitional cell carcinoma (ca.) of the bladder in January 2008. In June 2008, the patient returns and is diagnosed with transitional cell carcinoma in a different subsite of the bladder. How many primaries does the patient have?

Answer:

It depends on the behavior of each tumor and the order in which they occurred. If the first tumor was in-situ and the second tumor invasive, we would abstract both tumors as independent primaries according to rule M5 (“An invasive tumor following a

in-situ tumor more than 60 days after diagnosis are multiple primaries”).

If both tumors were invasive, we would create a single abstract according to rule M6 (“Bladder tumors with any combination of the following histologies: papillary carcinoma, transitional cell carcinoma, or papillary transitional cell carcinoma are a single primary”).

If the first tumor was invasive and the second tumor was in-situ, we would create a single abstract according to rule M6. (Rule M5 would not apply in this situation,

because the invasive tumor preceded the in-situ tumor.)

If the both tumors were in-situ, we would create a single abstract according to rule M6.

Question 2:

A patient was originally diagnosed with invasive transitional cell ca. of the bladder in 2001. He had a TURBT showing recurrent invasive transitional cell ca. of the bladder in 2003 and again in 2006. In February 2008, his TURBT shows invasive papillary urothelial ca. of the bladder. How many

primaries does the patient have?

Answer:

The patient has one primary, according to rule M6 (“Bladder tumors with any combination of the following histologies: papillary carcinoma, transitional cell carcinoma, or papillary transitional cell carcinoma are a single primary”).

Note: Urothelial and transitional are equivalent terms.

Helpful Hints

GYN SITES

**For all GYN sites, if the diagnosis is “papillary serous adenocarcinoma” the histology code would be 8460/3 using “Other Sites” rule H2, H11, & H23 of the 2007 Multiple Primary and Histology Coding Rules—this is a single histology.

For all GYN sites, if the diagnosis is “papillary AND serous adenocarcinoma” the histology code would be 8323/3 (mixed variant) using “Other Sites” rule H5, H11, & H23 of the 2007 Multiple Primary and Histology Coding Rules

LYMPHOMAS: Grade/Unknown primary site

***For anaplastic large cell lymphoma, T cell, which code is assigned for grade?

Assign the code for T-cell. For lymphomas, the cell type (T, B, etc) is always coded rather than a term such as anaplastic.

Also, if the anaplastic large cell lymphoma was T cell and null cell, what code would be assigned, since T cell and Null cell have different codes.

When you have T-cell and Null-cell, assign the code for T-cell. Null-cell essentially means that no cell type was identified. Any given cell type takes precedence over Null-cell.

****If the primary site for lymphoma is unknown or not given:

- a. Code retroperitoneal lymph nodes if described as retroperitoneal mass
- b. Code inguinal lymph nodes if described as inguinal mass
- c. Code mediastinal lymph nodes if described as mediastinal mass
- d. Code mesenteric lymph nodes if described as mesenteric mass
- e. If the primary site is unknown code Lymph Nodes, NOS (C779)

Exception: Code unknown primary site (C809) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma.

MELANOMA: Unknown primary site

****Code metastatic melanoma with "no skin lesions" to C44.9 [Skin, NOS]. ICD-O-3 does not list a suggested site code for 8720/3 because melanoma can arise in other parts of the body. However, C44.9 [Skin, NOS] is the default when the primary cannot be determined.

CODING POLYPS

***** In addition to the colon, polyps may be found in other anatomical sites of the human anatomy, such as the uterus and esophagus. See MP/H Rules ‘Other Sites’ H3, H12 & H25 (It is important to know that the adenocarcinoma originated in a polyp.)

Example: Portions of the tumor appear to arise in an endometrial polyp. Final Dx - Endometrial adenocarcinoma, High grade. Code primary site to C541/endometrium and code histology to 8210/adenocarcinoma in a polyp. Based on Rule H12.

LEUKEMIA: Coding Extension

*****For Leukemia, the **CS Extension** may be coded as localized (**10**) if the diagnosis is stated as (**single/solitary/unifocal/isolated/mono-ostotic**) and the **histology is one of the following:**

- Plasmacytoma, NOS (M-9731/3)(solitary myeloma)
- Plasmacytoma, extramedullary (M-9734/3) (not occurring in bone)
- Mast cell sarcoma (M-9740)
- Malignant histiocytosis (M-9750)
- Histiocytic sarcoma (M-9755)
- Langerhans cell sarcoma (M-9756)
- Dendritic cell sarcoma (M-9757, M-9758)
- Myeloid sarcoma (M-9930)
- NA L L

For all other Leukemia histologies, including some of the above, the CS extension should be coded as systemic disease (poly-ostotic), code (**80**).



News & Information

Text Writing

Text is a required data item on all abstracts submitted to the TCR. It must justify the coding for the following: primary site, histology, grade, behavior; CS tumor size, extension, lymph nodes, Mets at diagnosis, treatment information and any edits that have overrides.

The Central Registry uses text to perform visual edits, make decisions about how to handle multiple abstracts submitted for a single patient and merge information submitted by different facilities on the same case. Without text, it is difficult to decide whether the patient has a single malignancy or multiple primaries. It is important to be specific regarding what tissues or organs are involved.

General statements such as 'localized,' 'regional,' and 'distant' are not specific and should never be used to justify the stage. While reviewing a medical report, think location, size, extent of disease, lymph nodes, distant mets, histology, grade, date of and procedure performed. Please discontinue use of N/A or None. If not applicable, text fields may be left blank. If a specific procedure is performed, provide text from the final diagnosis, final impression or assessment paragraphs of any given report.

For example, do not text the word "colonoscopy" by itself in the scopes text field. Rather, text the final assessment from that procedure i.e. location of tumor, size of tumor, in a polyp, etc.

Almost all reports can be reduced into a few words that justify the coding. Please refer to the Text Writing section in the Tennessee Cancer Registry Abstracting and Coding Manual, which can be found on the Tennessee Cancer Registry Web-site. It contains common abbreviations and examples of appropriate text for several different primary sites. **BEWARE** of cutting and pasting. Text fields allow only a certain number of characters to be transmitted to the central registry, even if it allows the abstractor to type several characters beyond the cut-off point.

If there are any questions concerning appropriate text, please contact your TCR Regional Coordinator for assistance.

NOTE: All overrides must have a statement that documents the reason for the override.

Example: Primary/Site histology conflict – primary site and histology conflict was reviewed and Per Dr. _____, this site _____ is an unusual site for histology _____, but it is correct.

Benign Blood Vessel Tumors

***** Non-malignant blood vessel tumors are reportable if they occur in CNS sites. The tumors should be coded to the CNS site in which they occur, not the blood vessel. Sites included are listed below:

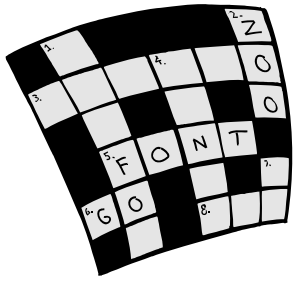
Meninges	C70.0 – C70.9	These tumors include: 9120/0 Hemangioma, NOS 9121/0 Cavernous hemangioma 9150/0 Hemangiopericytoma, benign 9150/1 Hemangiopericytoma, NOS 9161/1 Hemangioblastoma 9120/3 Angiosarcoma 9130/3 Hemangoendothelioma 9150/3 Hemangiopericytoma
Brain	C71.0 – C71.4 C71.7 – C71.9 (excluding ventricle)	
Spinal cord	C72.0	
Cauda Equina	C72.1	
Cranial nerves	C72.2 – C72.5	
Cerebellum	C71.6	
Other Nervous system	C72.8 – C72.9	

Terms and Definitions

Contiguous Tumor- A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.

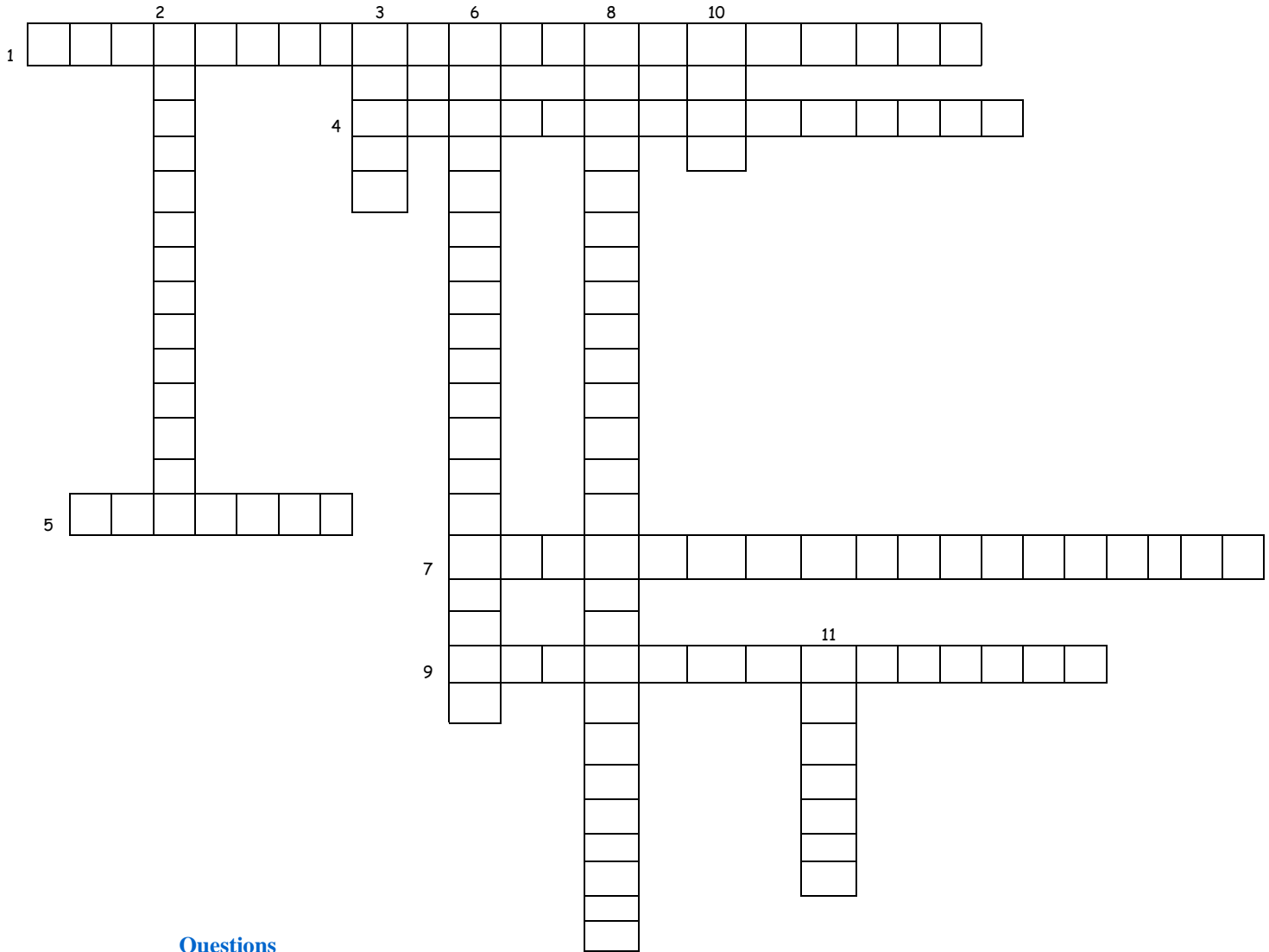
Multicentric, multifocal, and polycentric (often used as synonyms) - The tumor has multiple centers. The foci of the tumors are not contiguous.

Surgery of Primary Site – Surgical procedure that removes and/or destroys tissue of the primary site, performed as part of the initial diagnostic and staging work-up or first course of therapy.



Fun Page

Crossword Puzzle



Questions

ACROSS	DOWN
1. 8070/3	2. 8140/3
4. C24.0	3. C18.0
5. C67.9	6. 9670/3
7. 8050/3	8. 9961/3
9. 8982/0	10. C44.3
	11. C40.0

Crossword Puzzle Answers

- | | | |
|--|--|-------------|
| 1. SQUAMOUSCELLCARCINOMA
2. ADENOCARCINOMA
3. CECUM
5. BLADDER
8. AGNOGENICMYELOIDMETAPLASIA | 4. COMMONBILEDUCT
6. LYMPHOCTYLIMPHOMA
7. PAPILLARYCARCINOMA
9. MYOEPIITHELIOMA
10. CHIN | 11. HUMERUS |
|--|--|-------------|

Selected References and Resources

- * Reference: Johnson CH, Peace S, Adamo P, Fritz A, Percy-Laurry A, Edwards BK. *The 2007 Multiple
** Primary and Histology Coding Rules*. National Cancer Institute, Surveillance,
***** Epidemiology and End Results Program. Bethesda, MD, 2007
- *** Reference: SEER SINC Web Site: www.seer.cancer.gov/seerinqury
- **** Reference: Johnson CH, Adamo M (eds.), *SEER Program Coding and Staging Manual 2007*.
National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007
- ***** Reference: *Facility Oncology Registry Data Standards (FORDS): Revised for 2007*, Commission
Cancer of the American College of Surgeons; Chicago, IL., 2007
- ***** Reference: Collaborative Staging Task Force of the American Joint Committee on Cancer.
Collaborative Staging Manual and Coding Instructions, version 01.04.00. Jointly
published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of
Health and Human Services (Bethesda, MD), 2004.
NIH Publication Number 04-5496. Incorporates updates through October 31, 2007
- ***** Reference: United States. Department of Health and Human Services, Centers for Disease Control
and Prevention. Collection and Coding Clarifications for Central Nervous System
(CNS) Tumors. 27 March 2006. 31 July 2008. <[http://www.cdc.gov/cancer/npctr/
training/btr/clarification.htm](http://www.cdc.gov/cancer/npctr/training/btr/clarification.htm)

Please e-mail Anne Llewellyn, if you would like to submit a question for
“What’s the Answer” on page 2.

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