



Call for Remaining 2006 Diagnosed Cases

The deadline for submitting 2006 diagnosed cases is July 1, 2007. Thanks again for all your hard work throughout the year! If you are unable to meet the deadline, please call KCR and give us a timeline when you plan to send in all your 2006 diagnosed cases. If we do not hear from you by June 30, 2007, the Administrators of facilities will receive a delinquent letter in July. Below is the reporting schedule for 2006 diagnosed cases.

Month of Diagnosis	Due to KCR by:
January 2006	July 2006
February 2006	August 2006
March 2006	September 2006
April 2006	October 2006
May 2006	November 2006
June 2006	December 2006
July 2006	January 2007
August 2006	February 2007
September 2006	March 2007
October 2006	April 2007
November 2006	May 2007
December 2006	June 30, 2007

Reminders for Reporting 2007 Diagnosed Cases

As you all begin abstracting your 2007 diagnosed cases, the following are a few changes to keep in mind:

- ✓ Use the new MP/H Coding Rules for all cases diagnosed January 1, 2007 and forward.
 - http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf
- ✓ Make sure your software (ROCKY, Abstract Plus...) has been updated to include the new 2007 NAACCR Data Items. Additional information will be provided in an upcoming newsletter regarding new required data items.
- ✓ Submit your cases using NAACCR Version 11.1 after running NAACCR Version 11.1 Edits for all 2007 diagnosed cases
- ✓ Look for new updates to the KCR manual (to be posted soon)
 - <http://www2.kumc.edu/kcr/downloads.htm>

Questions & Answers

Frequently Asked Questions about the MP/H Coding Rules

(<http://www.seer.cancer.gov/tools/mphrules/faq.html>)

The following is a list of “frequently asked questions” about the new MP/H Coding Rules. Again, these new rules are to be used on all cases diagnosed January 1, 2007 and forward. The SEER website has a lot of great training materials on the MP/H Rules that you can check out (<http://www.seer.cancer.gov/tools/mphrules/>) or feel free to contact KCR with any questions.

1. When will the new MP/H Rules Manual be available?

The 2007 Multiple Primary and Histology Coding Rules Manual is already available on the SEER Web site (http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf). The MP/H manual is available only in electronic format and will not be published in hardcopy. The manual will be incorporated into the 2007 SEER Program Coding and Staging Manual.

2. How will the new MP/H Rules Manual be distributed?

The manual will not be printed or distributed by SEER, CoC, or NPCR. You can download the entire manual to your desktop or print it, if that is your preference. Another option is for the registrar to select the format they prefer to use (text, matrix, or flowchart) and only download or print the one format. Be sure to download the Instructions and all of the documents associated with each set of site-specific rules, no matter which format you prefer.

3. Do I have to use all three sets of documents (Equivalent Terms and Definitions, Multiple Primary Rules, and Histology Coding Rules)?

Yes, all three sets of site-specific documents must be used together. The site-specific Equivalent Terms and Definitions and the associated charts, tables, and illustrations contain important information that sets the stage for applying the new rules. The Multiple Primary Rules are used to determine the number of abstracts to prepare, and the Histology Coding Rules provide instructions for coding site-specific histology.

4. Do I have to use all three formats (text, matrix, and flowchart)?

No, most registrars will find that they have a preference for one format. The rules are identical across the three formats. There is no need to switch from one format to the next. Pick one format and stick with it.

5. Is there any reason we cannot apply the new rules to older cases diagnosed before January 1, 2007?

Using the rules early would cause some problems. There are some changes in site groupings that may effect how cases are processed and grouped in analysis with regard to the multiple primary rules. More importantly, the histology rules will effect changes in old versus new cases for coding site-specific histology.

6. Are the 2007 MP/H Rules for 2007 cases only? What about old cases with residual or metastatic disease who come to my facility after January 1, 2007?

The key is in the date of diagnosis. Use the new rules for tumors diagnosed January 1, 2007 and after. Use the old rules for tumors diagnosed before January 1, 2007.

7. How are the physicians going to be educated about multiple primary rules?

The rules will actually be more closely aligned with how physicians view new primary versus recurrence than in the past. The AJCC disease-specific site teams and specialty physicians were active in creating and approving the timing restrictions outlined in the new rules. Furthermore, based on the expected outcome from the statistical review of the new rules, we do not expect this to be an issue of any significance.

8. How do we inform pathologists that we will be coding from final diagnosis?

Were your pathologists aware that you coded from the micro before? Pathologists were surprised when they learned that registrars have been incorrectly using the details described in the microscopic for coding and support the use of coding from the final diagnosis. The micro describes everything the pathologist sees (pieces of the puzzle) and not the overall impression of the tumor. When the pathologist dictates the final diagnosis they are describing their overall interpretation and using their expertise to make the diagnosis.

9. When the final diagnosis, addenda, or a comment states "see microscopic description", can I use information from the micro section to code the histology?

No. Unless otherwise stated in a set of site-specific rules, the histology is coded using the final diagnosis, only. When the final diagnosis, addenda, or a comment instruct the reader to reference another part of the pathology report, this reference may be used only to clarify the final diagnosis and should not be construed as instruction to use anything noted in the microscopic description.

10. What if the pathologist and clinician do not agree on the diagnosis?

Use the priority lists provided in the rules to determine which diagnosis is the most appropriate to use with the new rules.

11. Do these rules change how we need to handle casefinding?

The Multiple Primary and Histology Coding Rules do not change any of the rules, guidelines, or instructions for casefinding, case ascertainment, case reportable criteria, staging, treatment, sequence number, etc.

12. What is the expected effect on counting of incidence cases?

The MP/H Rules development team worked closely with epidemiologists and statisticians from NIH, Emory University, and NCI, who carefully reviewed and compared outcomes from using the old rules versus new rules side-by-side and one rule at a time. We found nothing to indicate that we might expect a significant change in case counts or incidence rates. Most changes were measured in 100ths of one percent change. The technical documents describing the statistical review highlight differences and will be posted and made available for people who are interested in learning more about these details.

13. When an excisional biopsy removes the majority of the tumor with a diagnosis of "carcinoma" and the subsequent lumpectomy diagnosis states "microscopic residual consistent with infiltrating duct carcinoma", which report and diagnosis should be used to code the histology?

The 2007 Breast Histology Rules instruct the registrar to code the histology from the pathology report with the most representative specimen (the most tumor tissue) even when the most representative specimen is less specific. The histology would be coded to carcinoma in this case.

14. When the pathology report from a colon resection states "adenocarcinoma with features of mucinous (or signet ring cell) carcinoma", but the report does not state the exact percentage of mucinous (or signet ring cell) carcinoma, can you use terms such as "features" or "type" to imply majority of tumor (greater than 50%)?

No. The new rules specifically instruct the registrar to code the histology to "adenocarcinoma, NOS" when the percentage of mucinous or signet ring cell carcinoma is unknown. See the MP/H Rules Manual for the Colon Histology Rules.

15. When the microscopic description indicates a colon tumor is "tubulovillous", but the final diagnosis only states "adenocarcinoma", can you code histology as "adenocarcinoma in a tubulovillous adenoma"?

Yes. This is an example of a site-specific exception to the general rule to code only from the final diagnosis. The Colon Histology Rules specifically state that "other parts of the pathology report" may be used to identify a tumor arising from a polyp, adenomatous polyp, villous adenoma, or tubulovillous adenoma.

16. When the pathology report from a FNA or other biopsy states a diagnosis of carcinoma in situ and the patient for some reason must wait more than 60 days for a more definitive procedure which documents invasive carcinoma, does this have to be reported as two primaries?

No. When the invasive component is discovered as part of the work-up phase leading to treatment decisions, the case should not be abstracted as a multiple primary. In the rare instance when a patient has not been treated and is still having diagnostic work-up greater than 60 days after the malignancy is diagnosed, do not count the invasive diagnosis as a new primary.

17. The term "nodule" is not included as an Equivalent Term along with tumor, mass, lesion, and neoplasm in the 2007 Lung Multiple Primary Rules. Why not?

The term "nodule" is used by radiologists to describe many types of abnormalities in the lung, not necessarily a malignancy or a primary tumor. Therefore, "nodule" is not an equivalent term for tumor, mass, lesion, or neoplasm.

18. When a term is used that is not included on the ambiguous terms list, can I use it?

No, only use the terms specifically listed in a rule or note. The presence or absence of term modifiers such as "highly likely" or "likely" are acceptable equivalents for "most likely".

MP/H Coding Rules Training Resources

Were you unable to attend any of the MP/H Coding Rules trainings or attended but are looking for additional information? Here are a few additional training resources to check out:

- Overview of new MP/H Coding Rules and Web Casts: (<http://www.seer.cancer.gov>)
- SEER's Training Web Site: MPH Coding Rules Informational Module
 - http://training.seer.cancer.gov/module_mph_cr/00_mph_cr_home.html
- MP/H Rules Manual
 - <http://www.seer.cancer.gov/tools/mphrules/download.html>

Upcoming Trainings & Conferences

- ❖ NAACCR CTR Exam Readiness Webinar Series-starting 7/25/07
(http://www.naacr.org/index.asp?Col_SectionKey=10&Col_ContentID=473)
- ❖ Kansas Cancer Registrars Association (KCRA) Annual Meeting
 - September 20-21, 2007: Wichita, Kansas
- ❖ North American Association of Central Cancer Registries (NAACCR) "Webinar" series
(<http://www.naacr.org/filesystem/word/Hosp%20webinar%20sched.doc>)
 - June 14, 2007 Abstracting Lung Cancer Incidence and Treatment Data
 - September 13, 2007 Abstracting Breast Cancer Incidence and Treatment Data
 - October 11, 2007 Abstracting Melanoma Cancer Incidence and Treatment Data
 - November 8, 2007 Abstracting Gynecologic Cancer Incidence and Treatment Data
 - December 6, 2007 Hospital Cancer Registry Operations

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We're on the web!
www2.kumc.edu/kcr

The Kansas Cancer Registry (KCR) , under the direction of Dr. Sue Min Lai, has expanded in recent years to collect and maintain a population based longitudinal database of all Kansans diagnosed with cancer.

KCR is the only population-based source of information on cancer incidence in the State of Kansas. It provides information on the occurrence of cancer, stage at diagnosis, survival and sub-populations affected by different types of cancer. Registry information can be used by researchers to evaluate the effectiveness of new treatments and by public health professionals to implement and monitor prevention efforts.

Thanks to facilities across the state of Kansas who report cancer cases, KCR has quality data to help in the fight against cancer.

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