Kansas Cancer Registry Newsletter

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New Cancer Drug Shows Promise

The experimental drug Abiraterone has been shown to reduce the size of prostate cancer tumors in men who have been unresponsive to other types of therapies. 70% to 80% of men showed lower PSA (prostate specific antigen) levels and tumor shrinkage after receiving the drug treatment. Although the drug is in early clinical trials and is not yet approved for use by the US Food and Drug Administration, it gives hope for the future health of prostate cancer patients. This year alone, 186,320 new cases of prostate cancer will be diagnosed in the United States and 28,660 men will die of the disease this year. For more information about this new drug visit the American Cancer Society Website.
http://www.cancer.org/docroot/NWS/content/NWS_1_1x_New_Prostate_Cancer_Drug_Shows_Promise.asp

CS Coding Clarification for Bladder Cases

A coding issue which needs clarification involves *in situ* bladder cases.

Example: When the pathology report indicates either a definite statement of noninvasion, inferred noninvasion from the microscopic description, or other phrases of carcinoma *in situ*, use the behavior code of 2.
Note: CS Extension codes 01, 03, and 06 should reflect *in situ* carcinomas. (For more information, see Note 6 for Bladder CS Extension at http://web.facs.org/cstage/bladder/Bladdercsextensiontable.html.

Incidentally, if the Bladder CS Extension code is 10, the behavior code may be 2 (*in situ*) or 3 (invasive). **If the Bladder CS Extension code of 15 or greater is used, the behavior code MUST be 3 (invasive) and NOT 2 (*in situ*).** For complete explanation please refer to the collaborative staging manual (http://www.cancerstaging.org/cstage/index.html)

Race and Ethnicity

When abstracting cases, please be sure to read and obtain any information you can pertaining to the race and ethnicity of the patient. For our purposes, KCR considers both of these as critical data items. Example: 01 for “White,” 02 for “Black,” and 03 for “American Indian, Aleutian, or Eskimo.” Note: “White” includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

Ethnicity is a code identifying persons of Spanish or Hispanic origin, and these persons may be of any race. Example: 0 for "Non-Spanish; non-Hispanic," 1 for "Mexican (includes Chicano)," 2 for "Peurto Rican," and 3 for "Cuban." If ethnicity is not documented in the chart, and the patient has an English or other non-Spanish name, code 0 rather than 9.

For a complete listing of acceptable race and ethnicity codes, please refer to the KCR Coding and Information Manual (Section 1, Page 9) which can be downloaded from our website using your hospital password.

Laterality

- The following sites are considered paired organs and the laterality should be coded as 1-9. This listing includes only major categories. Code laterality for all subheadings included in the ICD-O-3 under these headings, unless specifically excluded.
- Exclusions should be coded as "0". If the site is not listed below, code laterality as "0".

ICD-O-3	Paired Organ Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping Lesion of Tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid

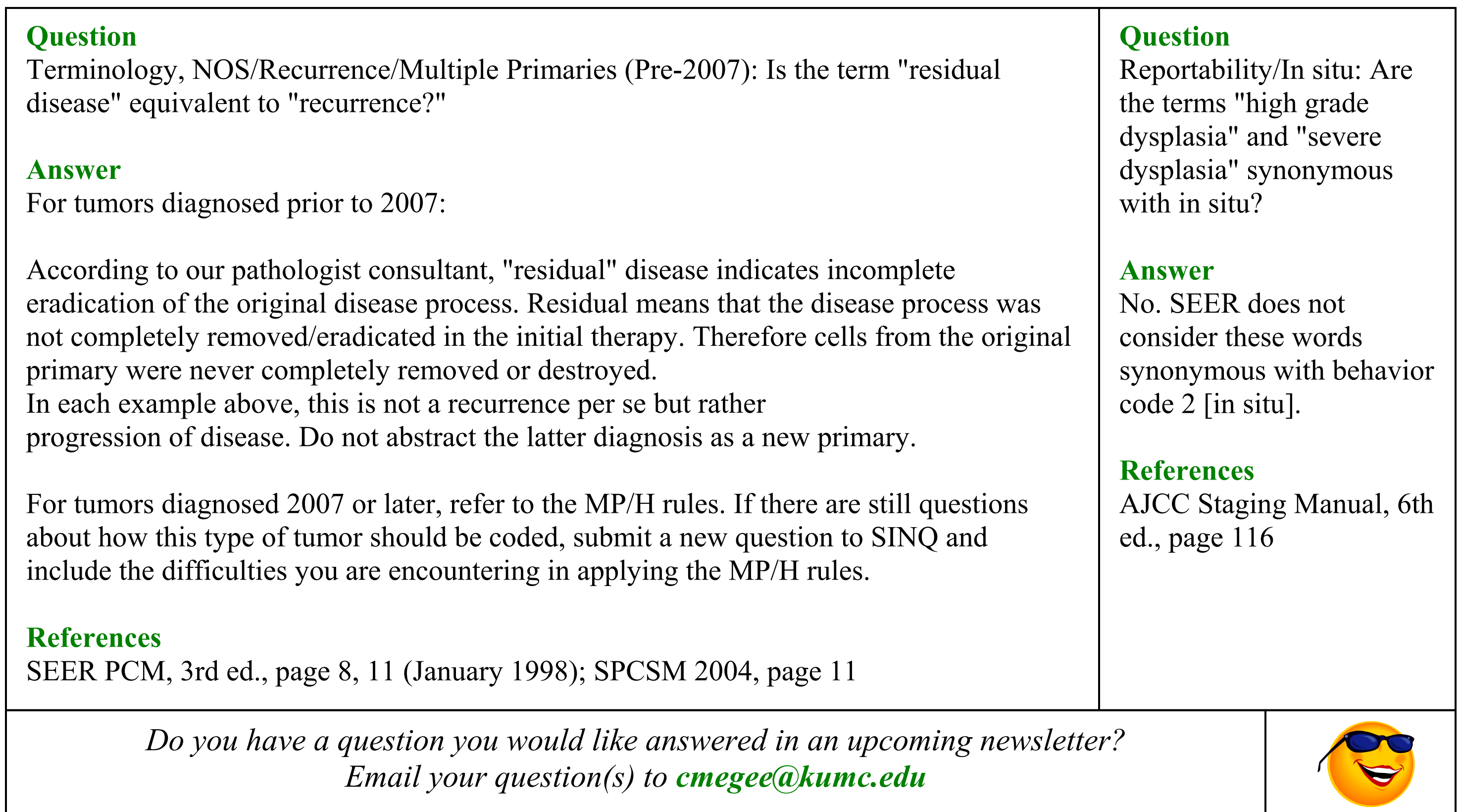
ICD-O-3	Paired Organ Site
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral Meninges, NOS **(cases diagnosed 01/01/2004 and forward)**
C71.0	Cerebrum (cases diagnosed 01/01/2004 and forward)
C71.1	Frontal Lobe **(cases diagnosed 01/01/2004 and forward)**
C71.2	Temporal Lobe **(cases diagnosed 01/01/2004 and forward)**
C71.3	Parietal Lobe **(cases diagnosed 01/01/2004 and forward)**
C71.4	Occipital Lobe **(cases diagnosed 01/01/2004 and forward)**
C72.2	Olfactory Nerve **(cases diagnosed 01/01/2004 and forward)**

C44.2	Skin of external ear	**C72.3**	Optic Nerve **(cases diagnosed 01/01/2004 and forward)**
C44.3	Skin of other and unspecified parts of face (midline code “9”)	**C72.4**	Acoustic Nerve **(cases diagnosed 01/01/2004 and forward)**
C44.5	Skin of trunk (midline code “9”)	**C72.5**	Cranial Nerve, NOS **(cases diagnosed 01/01/2004 and forward)**
C44.6	Skin of upper limb and shoulder	**C74.0-C74.9**	Adrenal gland
C44.7	Skin of lower limb and hip	**C75.4**	Carotid body

Adapted from the FORDS Manual - 2007: http://www.facs.org/cancer/coc/fords/2007/fordscorrected0707.pdf

Questions & Answers

From the SEER Inquiry System: http://seer.cancer.gov/seerinquiry/



Question
Terminology, NOS/Recurrence/Multiple Primaries (Pre-2007): Is the term "residual disease" equivalent to "recurrence?"

Answer
For tumors diagnosed prior to 2007:

According to our pathologist consultant, "residual" disease indicates incomplete eradication of the original disease process. Residual means that the disease process was not completely removed/eradicated in the initial therapy. Therefore cells from the original primary were never completely removed or destroyed.
In each example above, this is not a recurrence per se but rather progression of disease. Do not abstract the latter diagnosis as a new primary.

For tumors diagnosed 2007 or later, refer to the MP/H rules. If there are still questions about how this type of tumor should be coded, submit a new question to SINQ and include the difficulties you are encountering in applying the MP/H rules.

References
SEER PCM, 3rd ed., page 8, 11 (January 1998); SPCSM 2004, page 11

Question
Reportability/In situ: Are the terms "high grade dysplasia" and "severe dysplasia" synonymous with in situ?

Answer
No. SEER does not consider these words synonymous with behavior code 2 [in situ].

References
AJCC Staging Manual, 6th ed., page 116

Do you have a question you would like answered in an upcoming newsletter?
Email your question(s) to ***cmegee@kumc.edu***

Updating Your Contact Information

If there is any change in your facility’s contact information, **email (vhundley@kumc.edu)** or **fax (913-588-7384)** using the **Contact Information Form** posted on KCR website (http://www2.kumc.edu/kcr/downloads.htm).

Reporting Schedule

Month of Diagnosis	Due to KCR by:
January 2008	July 2008
February 2008	**August 2008**
March 2008	September 2008
April 2008	October 2008
May 2008	November 2008
June 2008	December 2008
July 2008	January 2009
August 2008	February 2009
September 2008	March 2009
October 2008	April 2009
November 2008	May 2009
December 2008	June 2009

Are You Current?

- Please submit your cases using NAACCR Version 11.2 after running NAACCR Version 11.2 Edits.
- Use Multiple Primary and Histology Coding Rules Manual (released January 01, 2007) (http://www.seer.cancer.gov/tools/mphrules/mphrules_manual_01012007.pdf) on all cases diagnosed January 1, 2007 and forward
- Use Collaborative Staging & Coding Manual, Version 01.04.00 (**released October 31, 2007**) (http://www.cancerstaging.org/cstage/index.html) to calculate collaborative stage on cases currently being abstracted. Please check this site regularly for updates

Upcoming Trainings & Conferences

- The Kansas Cancer Registrars Association (KCRA) Annual Meeting is September 18-19, 2008 in Kansas City, KS
- NAACCR CTR Exam Readiness Webinar Series-starting 01/08/08 (http://www.naaccr.org/index.asp?Col_SectionKey=10&Col_ContentID=473)
- North American Association of Central Cancer Registries (NAACCR) "Webinar" series – go to http://www.naaccr.org/filesystem/pdf/Hospital_course_decription_rev10-30-07.pdf for more information
    - September 11, 2008: Abstracting Other Digestive System Cancer Incidence and Treatment Data

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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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Thank you to all KCR staff members who contributed to the publication of this newsletter.