



## Pancreatic Cancer Awareness Month

November is National Pancreatic Cancer Awareness Month. Researchers still do not know exactly what causes most cases of pancreatic cancer. There are risk factors that can increase your chance of having this cancer. Some of the risk factors are:

- 55 years and older (men have this cancer slightly more often than women)
- Smoker
- high-fat diets
- obesity
- diabetes

It is hard to find this cancer at an early stage. The physician can't see or feel tumors during a routine physical exam because of the location of the pancreas. Tumor marker levels such as the CEA may be higher than normal in people with pancreatic cancer but the cancer is usually advanced by the time the levels become high. There are no other tests that can easily find this cancer early in people without symptoms. Here is a list of common symptoms: jaundice, pain in the abdomen or in the middle of the back, weight loss, digestive problems, blood clots.

References: <http://www.cancer.org/docroot/home/index.asp>

## Coding Caution



### Prostate Grade

Example: Biopsy of the prostate revealed Adenocarcinoma Gleason's score 4+3=7, high grade

**The grade should be coded 3 for this example.** The Gleason score takes priority over the terminology. There is a chart in the FORDS Manual (page 15) that converts the Gleason score to the appropriate grade. The highest grade for prostate is grade 3.

## Abstracting Questions and Answers

Questions adapted from: [www.web.facs.org/coc](http://www.web.facs.org/coc) Commission on Cancer

### Question

How is non-secretory pancreatic endocrine tumor with positive lymph nodes on excision indicating a malignant tumor coded? Pathologist indicated it was not an exocrine tumor.

### Answer

There are several cell types in the the islets and each produces a different hormone. The custom has been to name the tumors by their hormone production, e.g. insulinoma, glucagonoma, etc. Occasional tumors do not produce any hormone (at least one that can be determined or measured). These tumors are called non-functioning endocrine tumors. Most of the endocrine tumors in the pancreas are islet cell tumors. Code as islet cell.

### Question

What histology code is used for "pancreatic adenocarcinoma, ductal type with mucinous differentiation?"

### Answer

We would follow rule H13 and code 8480/3 for mucinous adenocarcinoma.

### Question

Is well differentiated pancreatic endocrine tumor reportable? If yes, how is it coded?

### Answer

The pancreas can have endocrine as well as exocrine tumors. Please review this case with the diagnosing pathologist. The use of the phrase "well-differentiated" would lead to the possibility that this is a malignancy and then it is coded 8000/3 for malignant tumor. But with just the use of the word "tumor," we are unsure if the pathologist meant malignancy.

### Question

Is the "Sister Mary Joseph" lymph node considered regional or distant involvement for pancreatic cancer? The patient has a carcinoma involving the tail of the pancreas and the "Sister Mary Joseph" node was biopsied for diagnosis. Pathology showed MD adenoca consistent with pancreatic origin.

### Answer

A Sister Mary Joseph nodule/node is an metastatic umbilical node or nodule first recognized by her as a surgical assistant in the 1920's as a sign of poor prognosis. This is usually considered a distant node, but it is important to verify the location with the pathologist or surgeon.

### Question

If a patient had biopsy-proven lymphoma of the pancreas and inguinal lymph node as well as radiographic evidence of mediastinal lymph node involvement, is the primary site c77.9 unknown primary, c77.8 multiple lymph node involvement or c25.9 pancreas?

### Answer

Code the primary site as C25.9 pancreas. This case would be stage IIIIE due to the involved lymph nodes on both sides of the diaphragm and the extralymphatic involvement of the pancreas.

### Question

### Answer

*Do you have any questions that you would like answered in an upcoming newsletter?  
Email your question(s) to: [awagner2@kumc.edu](mailto:awagner2@kumc.edu)*

## Reporting Schedule

Month of Diagnosis	Due to KCR by:
January 2009	July 2009
February 2009	August 2009
March 2009	September 2009
April 2009	October 2009
<b>May 2009</b>	<b>November 2009</b>
June 2009	December 2009
July 2009	January 2010
August 2009	February 2010
September 2009	March 2010
October 2009	April 2010
November 2009	May 2010
December 2009	June 2010

## Are You Current?

- ❖ **Please submit your cases using NAACCR Version 11.3A after running NAACCR Version 11.3A Edits.**
- ❖ Use Multiple Primary and Histology Coding Rules Manual (released January 01, 2007) ([http://www.seer.cancer.gov/tools/mphrules/mphrules\\_manual\\_01012007.pdf](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 the site regularly for updates

## Upcoming Trainings and Conferences

- ❖ The Kansas Cancer Registrars Association (KCRA) Annual Meeting: October 15-16, 2009, Hays, KS
- ❖ **NAACCR Webinar Series 2009-2010**  
Look for more information about webinar dates in upcoming newsletters!

To register or obtain more information about the webinars, please feel free to contact Mrs. Ashley Wagner at 913-588-4728 ([awagner2@kumc.edu](mailto:awagner2@kumc.edu)).

## Case-Finding List

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0 - 208.9	Malignant neoplasms <b>except 173.0-173.9</b>
225.0 - 225.9	Benign Brain and Other Parts of Nervous System
227.3 & 227.4	Benign Pituitary Gland and Craniopharyngeal duct (227.3), Pineal Gland (227.4)
230.0 - 234.9	Carcinoma in situ ( <b>Except 232.0 – 232.9 and 233.1</b> )
237.0, 237.1, 237.5, 237.6, 237.70, 237.71, 237.72, 237.9	Neoplasm of Uncertain Behavior Endocrine Gland and Nervous System – Includes Pineal Gland, Brain, and Spinal Cord, Meninges and Neurofibromatosis
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3) Extramedullary plasmacytoma (9734/3)
<b>238.71</b>	Essential Thrombocythemia (9962/3) Essential Hemorrhagic Thrombocythemia Essential Thrombocytosis Idiopathic (Hemorrhagic) Thrombocythemia Primary Thrombocytosis
<b>238.72</b>	Refractory anemia (RA) (9980/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS)
<b>238.73</b>	Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with excess blasts-2 (RAEB-2) (9983/3)
<b>238.74</b>	Myelodysplastic syndrome with 5q deletion (9986/3) 5q minus syndrome NOS Chronic myeloproliferative disease (9960/3) Myelosclerosis with myeloid metaplasia (9961/3) Refractory cytopenia with multilineage dysplasia (9985/3) Therapy-related myelodysplastic syndrome (9987/3)
<b>238.75</b>	Myelodysplastic syndrome, unspecified (9989/3)
<b>238.76</b>	Myelofibrosis with myeloid metaplasia (9961/3) Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis
<b>238.79</b>	Lymphoproliferative disease (chronic) NOS (9970/1) Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) J5511 NOS (9960/3) Panmyelosis (acute) (9931/3)
273.2	Gamma heavy chain disease; Franklin's disease (9762/3)
273.3	Waldenstrom's macroglobulinemia (9761/3)
288.3	Hypereosinophilic syndrome (9964/3)
<b>289.83</b>	Acute myelofibrosis (9931/3)
<b>795.06</b>	Papanicolaou smear of cervix with cytologic evidence of malignancy (without histologic confirmation) (positive Pap smear)
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
V58.0	Admission for radiotherapy
V58.11 – V58.12	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V76.0 - V76.9	Special screening for malignant neoplasm
V86.0	Estrogen receptor positive status [ER+] (new code)
V86.1	Estrogen receptor negative status [ER-] (new code)

## Welcome

We would like to give a warm welcome to our new Medical Information Specialist. Patricia Montez, RHIT she joined KCR at the end of October!

### Updating Contact Information!

Please visit our website ([www2.kumc.edu/kcr/downloads](http://www2.kumc.edu/kcr/downloads))

Submit the updated form to Victoria Hundley (*Email: [vhundley@kumc.edu](mailto:vhundley@kumc.edu); Fax: 913-588-7384*)

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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