

Montana Central Tumor Registry Newsletter



Update on Collaborative Stage (CS) Transition

Between now and January 1, 2016, registries will be transitioning into collecting directly coded AJCC stage (both clinical and pathological TNM). In addition, registries will also continue collecting Summary Stage with tumor size and lymph nodes (positive and examined).

The initial change in reporting for cases diagnosed on or after January 1, 2016 will be focused on the transition to directly assigned TNM stage, but will not eliminate all CS variables. In particular, many of the Site Specific Factors (SSF) will continue to be required as they are critical for stage assignment or are essential to understanding the cancer. Teams of experts are evaluating what SSF's will be required.

The MCTR will require reporting of Collaborative Stage for all cases diagnosed through 2015. In addition, the MCTR highly recommends reporting AJCC and Summary Stage beginning with cases diagnosed in 2014 when it's available. They will then be required for 2016 diagnoses when Collaborative Stage is no longer required. This overlap of reporting will be a learning period for registries. Here's a timeline from 2014-2017 to show requirements.

**Montana Central Tumor Registry
Staging Requirements 2014-2017**

Stage Type	Year of Diagnosis			
	2014	2015	2016	2017
CS	Required	Required	Not required	Not required
AJCC TNM	Recommended	Recommended	Required 7th Ed	Required 8th Ed
Summary Stage	Recommended	Recommended	Required	Required

The MCTR, in cooperation with the CDC, will be making training materials available to registrars as they are developed. Initial training materials will also be made available to the MCTR at the NCRA annual meeting in June 2014. Other organizations such as the Commission on Cancer and the NCI are also producing relevant materials for registrars to address training needs and questions.

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Meet the Registrar



Deanna Kliewer
Frances Mahon Deaconess Hospital, Glasgow

Hello! I am Deanna Kliewer and I have been the tumor registrar at Frances Mahon Deaconess Hospital in Glasgow, MT since 1982. I have been an employee at FMDH for 32 ½ years. I am the Health Information Manager Assistant Manager of the Health Information Management

Department at FMDH. I have been coding since 1982 and received the CCS certificate in 2004. I code inpatient, outpatient procedure, outpatient surgery and ER records. I also am a HIM charge analyst among other duties.

I have been married to my husband, Jon, for 30 years. He is a farmer and rancher. We have two children, Whitney and Ethan. Whitney graduated from the University of Montana with a music degree and is a first year band teacher for 5th through 12th grades and also teaches piano lessons. Ethan graduated from the U of M College of Technology with a two year carpentry degree and now works with his father on our farm and ranch and also doing some carpentry work with plans to return to the U of M COT for a welding technology degree next fall.

I have really enjoyed my job while at FMDH learning lots of new things with all the changes that have transpired throughout the years and this past year with the technology of the electronic record.

In my spare time, I enjoy reading, Bible study and spending time with my husband working with him on the farm and ranch.

Grade 2014 Coding Instructions (see e-mail attachment)

The coding of grade/differentiation has become more complicated over time and standard setters had different rules. Beginning with 2014 cases, the rules for coding grade have been consolidated and agreed upon by all parties to simplify rules for coding grade.

No codes have been added or deleted. The most substantial change to grade codes was to the prostate. Note that beginning with 2014 cases, Gleason Scores 2-6 are now coded grade=1, Gleason Score 7 is coded to

grade=2, and Gleason Scores 8-10 are coded grade=3.

Please see the attached document [Instructions for Coding Grade for 2014+](#). These instructions will be incorporated into the MCTR 2014 Reporting Manual which is expected to be completed by August 2014.

National Cancer Registrars Week

This year symbolizes the 18th annual National Cancer Registrars Week (NCRW), April 7-11, 2014. Montana cancer registrars play a vital role in capturing the cancer data that impacts cancer research, cancer prevention, and treatment programs.

This year's theme is *Steadfast in an Evolving Environment*. The theme acknowledges registrars who are committed to staying current in the rapidly changing worlds of cancer diagnosis, treatment, and data management.

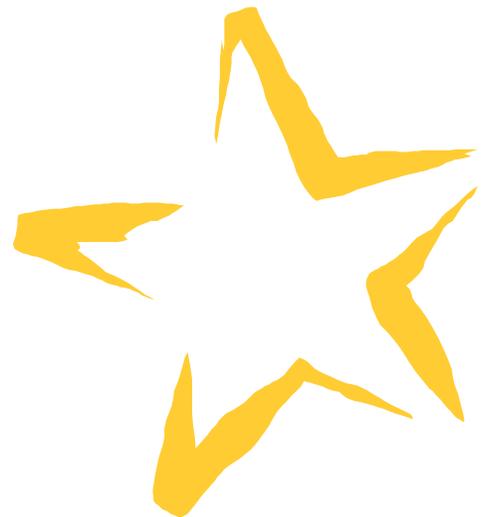
Take this opportunity to reflect on your role as a cancer registrar in partnering with the medical community for a cancer-free tomorrow. Visit the NCRA website for ideas to promote your registry at www.ncra-usa.org/ncrw.

Save the Date
Montana Cancer Registrars Association Spring Meeting
May 8-9, 2014
Fairmont Hot Springs

Certificate of Excellence Recipients

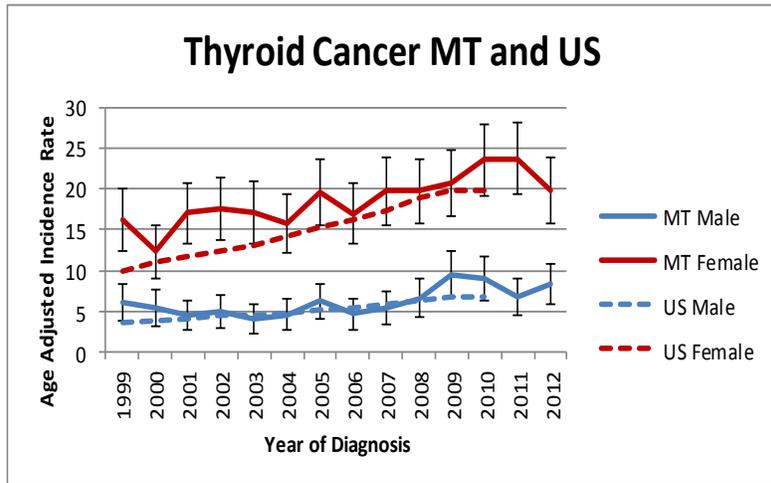
The following facilities received a certificate for the 2013 Fourth Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Yellowstone Dermatology	Billings
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Helena Dermatology	Helena
Associated Dermatology	Helena
Dermatology Associates	Kalispell
Hospitals:	
Big Sandy Medical Center	Big Sandy
Billings Clinic	Billings
St. Vincent Healthcare	Billings
Teton Medical Center	Choteau
Glendive Medical Center	Glendive
Sletten Cancer Center	Great Falls
Kalispell Regional Medical Center	Kalispell
Central Montana Medical Center	Lewistown
Phillips County Hospital	Malta
St. Patrick Hospital	Missoula
Clark Fork Valley Hospital	Plains
St. Joseph Medical Center	Polson
St. Luke Community Hospital	Ronan
Broadwater Health Center	Townsend



Increased Incidence of Thyroid Cancer in MT and US

The increased incidence of thyroid cancer appears to be associated with an “epidemic of diagnosis” and not disease, according to a new study. An increase in thyroid cancer previously has been reported, largely due to the detection of small papillary cancers, a common and less aggressive form of the disease, according to the study background.



MT data per MCTR 1999-2012
 US data per USCS 1999-2010. <http://apps.nccd.cdc.gov/uscs/>

The authors, Louise Davies, MD, MS, of the VA Medical Center in White River Junction, VT, and H. Gilbert Welch, MD, MPH, of the Dartmouth Institute for Health Policy & Clinical Practice in Hanover, NH, analyzed data for patients with thyroid cancer diagnoses between 1975 and 2009 in nine areas of the country using the Surveillance, Epidemiology, and End Results (SEER) Program.

Since 1975, the incidence of thyroid cancer has nearly tripled from 4.9 to 14.3 per 100,000 people, with virtually the entire increase due to papillary thyroid cancer (from 3.4 to 12.5 per 100,000 people). The absolute increase in thyroid cancer among

women (from 6.5 to 21.4 = 14.9 per 100,000 women) was almost four times greater than for men (from 3.1 to 6.9 = 3.8 per 100,000 men). The mortality rate has remained stable since 1975 at about 0.5 deaths per 100,000 people, according to the results.

The authors suggested that the jump in incidence is due to an increase in diagnosis and possibly overdiagnosis of papillary thyroid cancer, which can be present in patients without symptoms. Overdiagnosis occurs when a person is diagnosed with a condition that causes no symptoms and may cause them no eventual harm.

Response to overdiagnosis could ultimately include active surveillance without treatment of the asymptomatic cancers, relabeling some of them as other than cancer, and more closely investigating risk factors for cancer, the authors wrote in the study. They also suggest that physicians explain to patients that many of these small cancers will never grow and cause harm to the patient, although it is not possible to know which diagnosed cancers will fall into that category.

“We found that there is an ongoing epidemic of thyroid cancer in the United States. It does not seem to be an epidemic of disease, however. Instead, it seems to be substantially an epidemic of diagnosis: thyroid cancer incidence has nearly tripled since 1975, while its mortality has remained stable,” the authors concluded. The study was published in *JAMA Otolaryngology—Head & Neck Surgery* (2014; doi:10.1001/jamaoto.2014.1).

Source: OncologyNurseAdvisor February 28, 2014