

Montana Central Tumor Registry

Newsletter



New AJCC T, N, and M Categories Implemented 2016

The primary considerations when assigning American Joint Committee on Cancer (AJCC) staging classifications is timeframe and criteria. The clinical staging timeframe includes information obtained from the time of diagnosis throughout the diagnostic workup and ends at the initiation of definitive treatment. The pathologic staging timeframe includes information obtained from the moment of diagnosis and throughout the diagnostic workup (i.e., all information from clinical classification), the operative findings and pathology report from the definitive surgery.

According to the AJCC manual and trainings, the appropriate T, N, and M categories should be assigned based on the above AJCC rules. This may entail allowing, e.g., the pathologic staging M category to be properly assigned as cM1. However, cancer registry abstracting software is currently set up to code two separate and mutually exclusive clinical and pathologic strings of T, N, M, and stage categories, with an implied “c” in the clinical TNM string, and an implied “p” in the pathologic TNM string. Upon abstraction, the registrar has no way of recording the appropriate M category for the pathologic stage if it is cM1. This discrepancy between registry software data items and AJCC staging classification rules causes a dilemma for registrars when abstracting the T, N, and M data items and results in inconsistent coding practices and data loss.

As a result, this issue will be addressed upon implementation of NAACCR version 16-compliant software with the addition of new AJCC T, N, and M categories for the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. The new categories have been generated by adding the prefixes of ‘c’ and ‘p’ to existing valid clinical and pathologic T, N, and M categories respectively, and by modifying, adding, and deleting specific existing categories newly prefixed with a ‘c’ or ‘p’. For example, the addition of pTis to the clinical classification T category will enable its use for in situ patients in accordance with the AJCC rules (serves as a reminder that the in situ diagnosis cannot be made on imaging alone).

The new category options will be implemented for cases of all diagnosis years abstracted using NAACCR version 16-compliant software. Conversion of historical data for the diagnosis years of 2015 and earlier is being done for consistent viewing, abstraction, and editing of the data across all diagnosis years.

AJCC has updated the “Explaining Blanks and X” presentation, and added a new presentation “AJCC T, N, and M Category Options for Registry Data Items in 2016.” These are available on the AJCC website under the [Cancer Staging Education – Registrar – Presentations tab](#). In addition registrars are encouraged to review the [AJCC Curriculum for Registrars](#), which provides further details about the new categories as well as comprehensive instruction on AJCC staging

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www.cancer.mt.gov

Radioactive Seed Localization (RSL)

Source: <http://www.nebraskamed.com/article/65/radioactive-seed-gives-new-options-for-breast-cancer-patients>

What used to begin with the sometimes painful placement of a wire in the patient's breast to mark the location of the tumor can now be done with a much more precise and less painful method.

Doctors call it radioactive seed localization, or RSL. The process uses a thin needle to place a tiny radioactive seed directly on the cancerous lump. It acts as a beacon on which the surgeon can hone in; removing the lump, the seed and ideally, cancerous tissue in the margins around the lump.

"This allows us to have a procedure that is less painful and allows patients to avoid the likelihood of a second operation to clear more cancer," explained Edibaldo Silva, MD, PhD, surgical oncologist at The Nebraska Medical Center.

"It's a seed implanted in the breast. I was thinking it would be something big when I first heard about it," said Briggs. "But Dr. Silva explained and said it's no bigger than a pencil lead."

The previous and still most common approach to marking a breast cancer tumor with a wire requires the patient to have the wire placed in the breast in the morning, and then have lumpectomy surgery later in the day.

"RSL is an easier procedure," said Dr. Silva. "We can place the seed the day before surgery, and then the patient can return for surgery first thing the next morning does not have to wait around all day with the wire in place."

RSL also provides a level of accuracy not typically found with the wire method.

"The surgeon can map the location of the tumor and the margins in a way that is uniform in all directions," Dr. Silva said. "That's something that can't be done with a wire. Most importantly, the surgeon can find the least difficult and most direct approach to the area in question. That also allows the scar to be placed in the most cosmetically preferable place."

The radiation in the seed is not dangerous. It gives off only enough radiation to act as a marker for the surgeon.

"There is zero chance of it causing any radiation damage," said Dr. Silva. "In fact, the radiation dose given to a patient when they have the seed in place is many, many times less than what you would subject yourself to on an airplane trip from Omaha to New York."

Use of the radioactive seed is highly regulated. The medical center works closely with nuclear regulatory officials to account for the safety and location of all radioactive material.

The radioactive seed is strictly used for tumor marking. It does not replace radiation or chemotherapy as a method of treating the cancer. Do not code as treatment.

Bladder and Grade

SEER Sinq Question: 20150062 References Source 1: **2014+ Grade Instructions**

Question Grade--Bladder: How is Grade coded for the following cases diagnosed 1/1/2014 and later?

- 1) Low grade urothelial carcinoma, invasive carcinoma not identified (8120/2)
- 2) Papillary urothelial carcinoma, high grade, no evidence of invasion (8130/2)

Discussion The rules for coding Bladder Grade appear to have changed over time. SPCM 2013 Appendix C instructions state that Grade should be coded to 9 for urothelial carcinoma in situ (8120/2) and to 1 or 3 for non-invasive papillary urothelial carcinoma (8130/2). When the grade instructions were removed from Appendix C in 2014, these site specific instructions for in situ bladder cases were no longer included. Thus the two grade system, found in SPCSM 2014+ Grade/Differentiation Coding Instructions for Solid Tumors, is being used to code grade for both the in situ and invasive urothelial malignancies stated to be "low grade" (code 2) or "high grade" (code 4). See also, SINQ 20150022. Please clarify the current grade instructions for in situ and invasive urothelial carcinomas of the bladder.

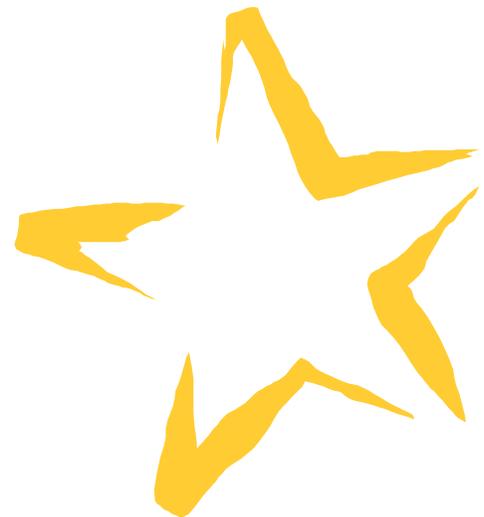
Answer Follow the instructions in the 2014+ Grade Coding Instructions to code grade for cases diagnosed 2014 and later, <http://seer.cancer.gov/tools/grade/> Instruction #4.a. states to code grade for in situ tumors when grade is specified. This instruction applies to bladder cases, as well as other in situ tumors. See the note below the table in instruction #7.

1. Assign grade code 2
2. Assign grade code 4

Certificate of Excellence Recipients

The following facilities received a certificate for the 2015 Third Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
MT Skin Cancer & Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Associated Dermatology	Helena
CPG Dermatology	Missoula
Hospitals:	
Billings Clinic	Billings
St. James Hospital	Butte
Teton Medical Center	Choteau
Pondera Medical Center	Conrad
Rosebud healthcare Center	Forsyth
Frances Mahon Deaconess Hospital	Glasgow
Glendive Medical Center	Glendive
Benefis-Sletten Cancer Center	Great Falls
St. Peter's Hospital	Helena
Kalispell Regional Medical Center	Kalispell
Central Montana Hospital	Lewistown
Livingston Memorial Hospital	Livingston
Providence St. Patrick Hospital	Missoula
Providence St Joseph Medical Center	Polson
Ruby Valley Hospital	Sheridan
Broadwater Health Center	Townsend
Pathology:	
Yellowstone Path Institute	Billings
Northern Plains Pathology	Great Falls
St. Patrick Hospital Pathology	Missoula



ICD-O-3 Changes

Below are some changes for ICD O-3 for 2016 required by the Centers for Disease Control and Prevention (CDC). It is the terminology and/or reportability that has changed (not the codes).

In 2014 and 2015 SEER added new reportable histology terms to their Program and Coding Manual. These terms had not been included in any ICD-O-3 errata or implementation guide and therefore were not addressed throughout the cancer surveillance community. CDC has reviewed the terms (reportable according to SEER) and made the following decisions:

1. Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2) and is REPORTABLE.
2. Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._) and is REPORTABLE.
3. Based on expert pathologist consultation, metastases have been reported in some CPEN cases. With all other pancreatic endocrine tumors now considered malignant, CPEN will also be considered malignant, until proven otherwise. Most CPEN cases are non-functioning and are REPORTABLE using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, grade 1 (assign code 8240/3) or neuroendocrine tumor, grade 2 (assign code 8249/3).
4. Laryngeal intraepithelial neoplasia, grade III (LINIII) (8077/2), C320-C329) is REPORTABLE.
5. Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2), except Cervix and Skin, is REPORTABLE.
6. Mature teratoma of the testes in adults is malignant and REPORTABLE as 9080/3, but continues to be non-reportable in prepubescent children (9080/0). The following provides additional guidance:
 - Adult is defined as post puberty
 - Pubescence can take place over a number of years
 - Do not rely solely on age to indicate pre or post puberty status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
 - Do not report if unknown whether patient is pre or post pubescence. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.

While there has not been an official errata to address these histology terms, CDC recommends adding them to your ICD-O-3 Manuals.

Word Search

- | | |
|-----------------------|---------------|
| AmericanCancerSociety | Metastatic |
| Awareness | Ovarian |
| Believe | Pancreatic |
| Support | Prostate |
| Radiation | RelayFor Life |
| Chemotherapy | Skin |
| Cancer | Survivor |
| Bone | Testicular |
| Breast | Uterine |
| Cervical | Physician |
| Childhood | Nurse |
| Celebration | Testing |
| Colorectal | Teams |
| Cure | Family |
| Colon | Friends |
| Hope | Community |
| Kidney | Advocacy |
| Lung | Network |
| Leukemia | Education |
| Luminaria | |
| Lymphoma | |
| Melanoma | |

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