Delaware Cancer Registry

Q & A FROM OUR STANDARD SETTERS

The following guidance from cancer registry standard setters was compiled and presented to the Delaware Cancer Registrars Association in 2011-2012.

CA?nswer FORUM

Polypectomy/SSF4

If a patient had a polypectomy that removed all of his cancer, and there was no colon resection, should SSF4 "Tumor Deposits" be coded 999? The polypectomy resected the cancer even though there was no colectomy, so 998 doesn't seem correct.

Use code 998. Even though the polypectomy removed the cancer, it was not a surgical resection of the primary site. The presence of tumor deposits is identified by examining pericolic adipose tissue after surgical resection. When a patient has a polypectomy, this is not done.

Colleen G. Sherman, RHIA, CTR
New York State Cancer Registry
CTAP Team

Visceral Pleura Invasion NOS

Should SSF2 be coded to 020 when there is a statment of 'visceral pleural' invasion but no further information, no mention of the elastic layer and no indication that elastic stains were done? Wouldn't this be a better code than 040? In a previous example given in a Forum post, the answer was to code 040 for a case that involves the visceral pleura but does not describe the elastic layer. But, the instructions in Part 1, Section 2 for lung say to use 040 when 'invasion of the pleura is stated but it is unknown if it is visceral or parietal or it is uncertain if elastic stains have been done to identify VPI.'

There has been a lot of discussion regarding how to code visceral pleural invasion without histologic confirmation. We have conferred with AJCC physicians and they state that there must

be histologic confirmation of pleural invasion to code SSF2. Notes indicating this have been added for v02.04, which will be released in 2012.
For your case, you have a statement of "visceral pleural invasion," but there is no indication if this is pathologically confirmed or is based on imaging. Since you do not have a pathologic confirmation of elastic stain involvement, you cannot use code 020. (Note 2: Code results as stated on the pathology report. Code 998 if no pathologic examination of pleura.)
If your pathology report confirms visceral pleural invasion but there is no mention of elastic layer, then use code 040. If your visceral pleural invasion is based on imaging, code 998 for no histologic examination.

Jennifer Ruhl, RHIT, CCS, CTR
CTAP Team Member

Standard 1.11 Cancer Registrar Education

Standard states that all "noncredentiald staff, including the following: . . . . Management or supervisory personnel" must participate in 1 cancer-related educational activity other than cancer conferences. The registry is under the management of the Cancer Services Manager. The registry consists of 1 CTR and 1 follow-up clerk. Must the manager of the cancer service line participate in the educational requirement?

This standard includes management or supervisory personnel of the cancer registry department. If your manager is under the budget of the cancer registry departement, then yes, he/she must participate in an educational activity for Std 1.11. If the Cancer Services Manager is not, he/she should participate in educational activities that are part of Standard 1.10.

Vicki Chiappetta, RHIA, CTR
Technical Specialist,
Accreditation and Standards

The 2009 Standard 7.2 states that for a commendation the CTR must attend a national meeting once every 3 years, but the 2012 Standard 1.11 says that a CTR must attend a national or regional meeting once every 3 years. If our next survey is for the years 2011, 2012, 2013 which set of Standards will be used 2009 or 2012 CoC Standards?

2012 standards will apply to the years 2012 and 2013.

Vicki Chiappetta, RHIA, CTR
Technical Specialist,
Accreditation and Standards

Kidney Parenchyma

We have a patient that had renal cell ca of the left kidney. In CSV2 Schema for Kidney parenchyma SSF1 it says "as documentent in path". However in CSV2 Part1 Section 2 page 1-2 104, it says that source documents can be path, imaging, surgical observation or other statements in the medical record. This patient did not have a resection of the kidney so we coded this SSF as 998 "no surgical resection of the primary site". We do have imaging that shows invasion into the perinephric fat, which according to part 1 section 2 we can use imaging as a source document. We ran into the same problem for SSF2. Are SSF1 and SSF2 just based on path reports?

12-20-10 12:24 PM #2 AGFritz

Both KidneyParenchyma SSF 1 and 2 are based on pathology reports only. The descriptions of these two SSFs have been modified in CS version 0203 documentation to indicate path report only.

SSF-10 HER-2 by FISH

I have a case where the HER-2 Fish testing was completed three different times with three different values and three different pathologic interpretations.

HER-2 (FISH) = 2.4, positive.
HER-2 (FISH) = 1.10, negative.
HER-2 (FISH) = 1.93, equivocal.

There was also one HER-2 IHC test which was negative, 1+. In the end the medical oncologist is considering the patient HER-2 negative. How should I code the value for SSF-10? Should I code the negative value for this particular case? I have made sure to record all tests and values in the NotePad.

02-04-11 08:23 AM

Since your physician is treating this patient as being HER2 negative, you need to record the HER2 negative information. The applicable site specific factors for FISH are 10 and 11. For SSF 10, the format is to record the actual number. In this case, you would record the 1.10 (110) in SSF 10 and then negative (020) in SSF 11.

For SSF's 8 and 9, you can also record that information with the 1+ and the interpretation of negative. Record the 1+ (010) in SSF 8 and the negative (020) in SSF 9.

Breast SSF-7 Nottingham Score

I have a path report that states "Nottingham Score: 3,2,1"
Can I add the values for the final score?

08-10 08:25 AM #2 **Ruhlj** CTAP Team Member

According to the CS Manual, Part I, Section II in the Section "Site-Specific Factor 7-Nottingham or Bloom-Richardson (BR) Score/Grade," on pg. 1-2-74, the Nottingham Score is made up of three different factors: degree of tubule formation, mitotic activity and nuclear pleomorphism. Examples of this include a Score of 3 (1+1+1). If your pathology report documents the 3, 2 and 1, they are probably reporting the following: degree of tubule formation (3), mitotic activity (2) and nuclear pleomorphism (1). Based on the instructions, you would add these three for a final total of 6. Record this as 060 in SSF #8. If possible, double check with the pathologist to make sure this is what they mean.

NAACCR

The COC, NPCR, SEER Technical Workgroup

How do we code PUVA – (psoralen) and long-wave ultraviolet radiation (UVA) when used for melanoma? Code PUVA as "Other treatment" with Code 1-Other.

Can we assign laterality for sites other than those listed in the paired sites table? CoC and SEER had different instructions in 2009. Starting with the 2010 FORDS, CoC permits coding of laterality for non-paired organs. SEER has always allowed coding of laterality for non-paired organs

Are bladder papillary urothelial neoplasms of low malignant potential (PUNMLPs) reportable? No, these are not reportable. PUNLMPs are pre-malignant growths in the upper urinary tract(renal pelvis, ureters, urinary bladder, part of the urethra).

Should aspirin and phlebotomies still be coded as treatment for hematopoietic neoplasms? Yes, continue with current instructions.

What are the equivalent terms to be used for behavior of /2? The list of terms synonymous with "in situ" was reviewed. The term non-invasive will be dropped from the list. Otherwise the list will remains as written in the FORDS and the SEER manual.

How should high intensity focused ultrasound (HIFU) used to treat prostate cancer be coded? Assign surgical code 17 – other method of local tumor destruction. HIFU, sometimes called FUS or HIFUS, is a high intensity focused ultrasound that heats and destroys tissue.

NPCR

SEER-CoC-NPCR Ad Hoc Committee

Second Primary Identified Post Neoadjuvant Therapy A case was presented with a patient treated with neoadjuvant therapy for rectal cancer. During AP resection a second primary was discovered in the descending colon. The neoadjuvant chemotherapy should be recorded for both primaries and reflected when completing the collaborative staging elements.

Coding Cisplatin Cisplatin used for radiosensitization should not be coded to chemotherapy IF it is to be used for radiosensitization only.

When to report Carcinoids of the Appendix Although carcinoid tumors of the appendix are usually not reported unless they are "Reportable by Agreement", the Committee agreed that there is an exception if a pathologist has identified metastatic lesions/nodes directly related to the carcinoid of the appendix. This would result in a behavior code to /3 and the case must be abstracted and reported. The mets may be found at the same time as the primary carcinoid or may occur years later.

SEER

Question: 20110128

Question

Histology/Primary site--Heme & Lymph Neoplasms: Bone marrow biopsy shows diffuse infiltration by B-Cell lymphoma/leukemia, consisting of medium-sized cells with Burkitt morphology.

Flow cytometry - No evidence of leukemia or lymphoma.

What is the histology?

Also, what is the primary site?

Answer

Code a single primary, histology is diffuse large B-cell lymphoma 9680/3.

The steps to getting this answer are: Step 1: Look up diffuse B-cell in the Hemato DB. The first matched term is DLBCL 9680/3.

Step 2: Look at the alternate names. One of the alternate names is "B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma."

Code the primary site to bone marrow using rule PH32.

Question: 20110006

Reportability/Heme & Lymphoid Neoplasms: Are all stages of CLL reportable? We have a few cases where the physician notes the patient has Stage 0 CLL (increasing leukocytosis). When we Googled CLL Stage, we found Stage 0, I, II, III, and IV. CLL Stage is not mentioned in the new hematopoietic rules (database or manual).

Answer
Yes, all stages of CLL are reportable. CLL has a unique staging system. Since the Hematopoietic DB and Manual do not address stage, we did not include this information in the abstractor notes.

Question: 20100101

Multiple primaries--Heme & Lymphoid Neoplasms: Patient was diagnosed in the blast phase of CML by bone marrow biopsy 4/2010, failed gleevac and progressed to the accelerated phase of CML in 10/2010. I am assuming this is NOT a new primary as this is not addressed in the hematopoetic rules. If I am incorrect, what am I missing?

Answer
You are correct. If you notice, CML-blast phase, and CML-accelerated phase are synonyms for CML (the same disease). The gleevac is given to prevent or delay progression to the accelerated phase.