April 2017 Quarterly

OHIO CANCER INCIDENCE SURVEILLANCE SYSTEM

OCISS Newsletter

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OCISS Updates

National Cancer Registrars Week, April 10-14, 2017

This year's National Cancer Registrars Week (NCRW) will be celebrated on April 10-14, 2017. The theme for this year's NCRW is *Cancer Registrars: Putting the Pieces Together*, reflecting cancer registrars' roles in compiling the critical information needed to support effective cancer treatment and research, with the goal of preventing cancer and finding a cure.

OCISS celebrates all of you and the excellent work you do to identify and abstract cancer cases for your facilities and report these cases to OCISS. Ohio cancer incidence data provide the means to identify geographic, behavioral, biological and other patterns of disease, including disparities by age, gender, race, and ethnicity as well as the ability to determine whether rates of cancer incidence, stage and diagnosis, and mortality in Ohio and its communities are comparable with other state, community and national rates. This information is used by programs at the Ohio Department of Health as well as our external partners to develop, implement and subsequently evaluate comprehensive cancer prevention, early detection and control programs.

OCISS data were key to the development of *Ohio's Comprehensive Cancer Control Plan 2015-2020*. OCISS data were most recently included in the Cancer in Ohio 2016 publication.

These publications would not be possible without the important work that cancer registrars do!

Death Clearance

OCISS is in the process of reviewing death certificates for 2015 and identifying persons who died with a cancer diagnosis but not reported to OCISS. We will follow the same process as last year – uploading partially-completed abstracts into Web Plus for users to review and update on-line.

Note that most death certificate follow-back requests are not cases that your hospital missed reporting or were cases that you were required to report. Most of the time they are persons who had their cancer diagnosis and treatment elsewhere. However, because the death occurred at your hospital and the death certificate was completed at your hospital, we would expect that there is some mention of the person's cancer in the medical record at your facility. At minimum, OCISS needs confirmation of the cancer diagnosis and a date of diagnosis, even if estimated. We appreciate your assistance.

NAACCR v 16

NAACCR released a new set of edits (NAACCR v 16D) in early February. OCISS has reviewed the edits and is in the process of getting them installed. We will make them available on the OCISS website as well as on the Web Plus log-in page to share with your software vendor. Most of the changes are corrections to edits that were already in place.

Some of you have asked about abstracting cases for 2017. NAACCR has informed us that we should wait until the NAACCR v 16D edits are in place before receiving 2017 cases. The edits are currently expected to be available in Web Plus by mid-April. We will notify you of the exact date when known.

Abstracting Tips from NAACCR Webinars

NAACCR Webinars are posted in Web Plus. Each provides three hours of continuing education (CE) credit. CEs are available for three years after the 'live session' is presented. NAACCR's ***site-specific*** webinars that cover Category A topics meet the Category A requirements for CTR continuing education (*source*: NCRA's "Category A FAQ" and email communication from NAACCR).

The following are abstracting tips, with a focus on AJCC TNM staging, from the last few months of NAACCR webinars. Please refer to the specific webinars for more information.

Tip: you can now stream the webinars directly in your internet browser instead of downloading the large WebEx .arf extension recording file. After you click on the "Webinar" link for a specific webinar and see the list of webinar-related documents, click on the video thumbnail that is on top of the page.

Melanoma (October 2016 webinar)

- ◊ MP/H M4 for melanoma only applies to *paired* sites, so this rule does not apply to non-paired skin sites C444, C448 and C449. (This has been confirmed with SEER.)
- ◊ TNM pathologic **stage 0** and **stage 1A** for *melanoma of the skin* are an **exception** to Chapter 1 rules. For these stage groups, pathologic evaluation of lymph nodes is ***not*** required for staging, and clinical node status can be used in pathologic staging [AJCC Cancer Staging Manual 7th Edition, pages 326 and 336, fine print underneath the stage group tables].
- ◊ Number of lymph nodes is required in order to assign cN1-3. Therefore, if imaging does not indicate number of nodes involved, assign cNX.
- ◊ If melanoma is identified by metastatic disease and a primary skin tumor cannot be found, assign T0.
- ◊ Distinction between micro– and macrometastases is whether they are clinically detectable (macro-metastases) or only evident after lymph node biopsy or complete lymphadenectomy (micrometastases).
- ◊ Cases with distant metastases and an elevated lactate dehydrogenase (LDH) are assigned M1c *regardless of the site* of the distant metastases. It is recommended that serum LDH be confirmed using 2 or more tests >24 hours apart to rule out a false positive test [AJCC Cancer Staging Manual 7th Edition, page 334].

Hematopoietic and Lymphoid Neoplasm (November 2016 webinar)

- ◊ Hematopoietic, reticuloendothelial, immuneproliferative, and myeloproliferative neoplasms such as acute myeloid leukemia do not have AJCC staging schema. Clinical and pathologic T, N, M and stage groups are all 88 for these cancers.
- ◊ T, N, and M values are not defined for Hodgkin and non-Hodgkin lymphoma in the AJCC Cancer Staging Manual [7th edition, page 611]. NPCR, CoC, and SEER have all agreed that "88" should be entered.
- ◊ For Hodgkin and non-Hodgkin lymphomas, clinical staging includes history, physical exam, imaging, blood test, and/or bone marrow biopsy. Pathologic staging is reserved for patients who undergo a staging laparotomy. This procedure is seldom done due to improvements in diagnostic imaging, so it is rare to have pathologic staging for a lymphoma case.
- ◊ The "E" designation in Hodgkin and non-Hodgkin lymphoma stage groups is for involvement of *extra-lymphatic* sites (e.g. GI tract, bone, CNS, liver, kidney, etc.). This is coded in the TNM Clin / Path Descriptor fields. Do not use the "E" designation for involvement of *extranodal lymphatic sites* such as spleen, thymus, lingual and palatine tonsil, Waldeyer's ring, Peyer's patches, and lymphoid nodules of appendix.
- ◊ Bilateral lymph node regions such as cervical, infraclavicular, epitrochlear, popliteal, among others, count as **two** lymph node regions if **both** sides are involved.
- ◊ Stage group should be classified as "A" or "B" based on absence or presence of defined constitutional symptoms. Other symptoms such as chills, pruritus, alcohol-induced pain or fatigue are not included in the classification [AJCC Cancer Staging Manual 7th Edition, page 608].

Lung (December 2016 webinar)

- In cases where the primary tumor is not resected, pathologic classification and staging for lung cancer can be met if the M1 category of the tumor is confirmed microscopically OR if *both* the highest T ***and*** the highest N categories are confirmed microscopically [AJCC Cancer Staging Manual 7th Edition, pages 11 and 257].
    - Current registry software do not have clinical T and clinical N (except cN0) in the drop down menus for the pathologic T and N fields, contrary to the special rule in Table 1.7 of the AJCC Cancer Staging Manual for cT cN pM1 pathologic stage IV. At this time, registrars should leave pT and pN fields blank in cases where pathologic staging criteria is *only* met by microscopic confirmation of distance metastasis [CAnswer Forum http://cancerbulletin.facs.org/forums/node/68189].
- TX N0 M0 is occult carcinoma stage, and TX in this case means there are microscopic findings but no visible tumor. If TX is used to mean tumor cannot be assessed, it is used in association with N1-3 or M1 [pop quiz #2 in webinar; also see AJCC's disease site webinar on lung for further clarification].
- The terms adenopathy, enlargement and mass alone are **not** used to indicate lymph node involvement for *AJCC staging* of lung primaries [webinar Q&A; also see AJCC's disease site webinar on lung for further clarification].

AJCC Staging (January 2017 webinar)

- *NOTE:* The Q&A document for this webinar includes corrections to the PowerPoint slides and Quiz #2.
- General rules: clinical staging includes some kind of clinical exam, while pathologic staging includes additional information from resection of the primary tumor and lymph nodes [AJCC Cancer Staging Manual 7th Edition, pages 9-11].
- Do not use clinical values in pathologic data items or pathologic values in clinical data items ***unless*** there is a rule that allows this. Examples: cM can be used in pM data item for cases with pathologic T and N (Table 1.7), pTis cN0 cM0 are used for both clinical and pathologic stage group 0 (Table 1.8) [ibid, page 11-12].
- Some stage groupings require subcategories. If the subcategories are required for a unique stage group but the subcategories cannot be assigned, the stage group must be 99 (example: melanoma of the skin requires subcategories of T1-4 in order to assign stage if N0 and M0). However, if subcategories for T, N, and M are ***not*** required for assigning a stage group, then a stage group can still be assigned (example: breast).
- AJCC Staging tells a story about the patient's diagnosis and treatment. Blank T, N, and M fields indicate the rules for classification have ***not*** been met. Do not use X to represent no surgical resection. See AJCC's presentation on "Explaining Blanks and X, Ambiguous Terminology and Support for AJCC Staging" and NCRA's staging short "Assigning AJCC TNM Stage: Blanks, X, Unknown, and T0" for more information.

Colon (February 2017 webinar)

- Page 64 of the SEER Summary Staging Manual 2000 contains a table of the layers for each anatomical site of the digestive system. This is useful in understanding the depth of invasion.
- The MP/H chapter on colon is specific to C180-C189. Rectum, rectosigmoid, and anus are covered by the general instructions and other site rules.
- AJCC Tis, stage group 0 for colon cancer covers more than *in situ* (intraepithelial); it also includes the invasion of the lamina propria (intramucosal) [AJCC Cancer Staging Manual 7th Edition, page 155]. In contrast, for SEER Summary Stage 2000, intramucosal is considered localized, **not** *in situ* [SEER Summary Staging Manual 2000, page 88]. Behavior code is 3 for intramucosal tumors.
- There is an errata for Figure 14.3 in the AJCC Cancer Staging Manual 7th Edition (pg 153). The corrected image should have T3 at the top of the right side of the figure instead of T4b. Errata for the 7th edition can be found here: https://cancerstaging.org/references-tools/deskreferences/Pages/AJCC-7th-Ed-Cancer-Staging-Manual.aspx.

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Ask OCISS

Q. A patient is diagnosed with metastatic melanoma but no primary site is found. Is the case reportable to OCISS?

A. If the patient has a documented history of melanoma, because MP/H rules do not apply to any tumor stated to be metastasis, subsequent melanoma in brain, lung, liver, etc, would not represent a new primary [MP/H Rules 2007 page 11]. An exception could be if the histology of the metastatic melanoma is different from the original melanoma primary, and M5 may apply and the case considered a new primary with skin, NOS as primary site (this was clarified through SEER Ask a Registrar).

If there is no information on a previous melanoma, report as a skin, NOS primary.

Please send your questions to OCISS@odh.ohio.gov with **Ask OCISS** in the subject field.

Reminder about Brain Cancers

In reviewing cases for a data request, OCISS recently discovered cases of meningioma where the primary site was coded to something other than meninges (C70.0, C70.1, C70.9). These cases passed edits because the over-ride for site/type had been set to "1". Although referred to as brain tumors, meningiomas arise from the meninges, so the primary site should be coded to meninges [SINQ20021031, SINQ20110127].

We also found benign/borderline brain cancer cases with SEER Summary Stage codes 0 (*in situ*), 9 (unknown), or blank. These cases should have been coded to 8 (not-applicable). Instructions for coding SEER Summary Stage 2000 for benign/borderline brain cancers is found in the FORDS manual [FORDS 2016, page 173].

Calendar of Events / Save the Date

April 27, 2017
12:00 - 1:30pm
OPCC Distress Screening Webinar
1.5 CEs submitted to NCRA for cancer registrars

May 5, 2017
CRACO-MiCRA 2017 Spring Regional Conference
Columbus, Ohio
http://www.miregistrars.org/conference.htm

May 16, 2017
Massachusetts Cancer Registry Educational Workshop
Boston, MA
Event is free and will be webcast, PDF of event announcement

June 17-22, 2017
NAACCR 2017 Annual Conference "Breaking Barriers in Cancer Surveillance"
Albuquerque, New Mexico
https://www.naaccr.org/naaccr-2017-annual-conference/