Alabama Department of Public Health
Alabama Statewide Cancer Registry

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CENTRAL REGISTRY UPDATE

From the Director, Tara Freeman

It is hard to believe we are in the year 2017. This year alone we have had promotions as well as hired additional staff. Crystal Jones is now serving as the Data/Education Coordinator and we have hired a new Follow-back Coordinator as well as an Administrative Assistant to assist Justin with research projects. Now that we are fully staffed we can further increase our efforts in acquiring additional cases and serving our reporting facilities.

We will be sending out facility close-out letters for 2016 at the end of July. Please return it to your Regional Coordinator by the due date indicated. If you are experiencing any problems with closing out 2016 please notify us so we can work with you to achieve compliance.

The 2016 metafile is beginning to appear to be a lesson on learning the alphabet. We have gone through A, B, C, D, and now we are finalizing E. The transition to AJCC and directly coded Summary Stage has presented a number of edit errors that have required the release of multiple metafiles. The hope is we are down to the last one and future metafiles will not require as many changes as the ones we've had this year. A V17 metafile will not be released. A number of registrars have asked if 2017 cases can be transmitted to the state. If your facility has received all first course of treatment on a patient who has been diagnosed in 2017, you are welcome to submit the case to ASCR as long as you have updated your software to V16d. If you happen to have any cases that were somehow transmitted to ASCR and you would like to submit an update, remember to utilize the ASCR Online Data Revision Form located on the WebPlus home page (https://webplus.adph.state.al.us/WebPlus/logonen.aspx).

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Collaborative Stage Data Collection System

The Collaborative Stage Data Collection System Version 02.05 will continue to be used for cases diagnosed 2004-2015 and for the collection of a few Site-Specific Factors (SSFs) for cases diagnosed 1/1/2016 and forward. In addition to the SSFs, Regional Nodes Positive and Examined and Lymph-vascular Invasion will continue to be required. All other CS input data items are no longer required. The transition from Collaborative Stage has simplified the collection of SSF's. See below for a summarization of the changes.

Data Items no longer Required (Required historically for cases diagnosed 2004-2015)	Specific Data Items with Continuing Requirement (Required for cases diagnosed 2004+)
CS Tumor Size [2800]	Regional Nodes Positive [820]
CS Extension [2810]	Regional Nodes Examined [830]
CS Tumor Size/Ext Eval [2820]	Lymph-vascular Invasion [1182]
CS Lymph Nodes [2830]	CS Site-specific Factors [2861-2880,2890-2930]
CS Lymph Nodes Eval [2840]	
CS Mets at DX Data Items [2850-2854]	
CS Mets Eval [2860]	
CS Version Derived [2936]	
Derived AJCC-6 Data Items [2940-3000]	
Derived SS and Flag Data Items [3010-3050]	
Derived AJCC-7 Data Items [3400-3430]	

Table 1. CDC NPCR SSFs Required for Directly-Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Appendix	SSF11	Histopathologic Grading
GISTPeritoneum	SSF 5 and 10	Mitotic Count; Location of Primary Tumor
GIST Esophagus, GIST Small Intestine, GIST Stomach	SSF 6	Mitotic Count
GIST Appendix, GIST Colon, GIST Rectum	SSF 11	Mitotic Count
MycosisFungoides	SSF 1	Peripheral Blood Involvement
Placenta	SSF 1	Prognostic Scoring Index

Table 1. CDC NPCR SSFs Required for Directly-Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Prostate	SSF 1, 8 and 10	PSA Lab Value, Gleason Score
Testis	SSF 13, 15, 16	Post Orchiectomy AFP, hCG, and LDH Range
BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, Melanoma CiliaryBody, MelanomaIris, Nasopharynx, PharyngealTonsil, Stomach	25	*Schema Discriminator*

Table 2. CDC NPCR SSFs required by NPCR (but not for AJCC Staging)

Site (CS Schema)	SSF	Description
Brain, CNS Other, Intracranial Gland	1	WHO Grade
Breast	1 2 8 9 11 13 14 15 16	*ERA* *PRA* *HER2: IHC Value* *HER2: IHC Interpretation* *HER2: FISH Interpretation* *HER2: CISH Interpretation* *HER2: Result of other test* *HER2: Summary Result* *testing* *Combination of ERA, PRA and HER2 Testing*

ADPH National Achievement

The Alabama Department of Public Health has achieved National Accreditation status. We met the necessary criteria that are assessed when our performance is measured against a set of standards that are nationally recognized, practice focused, and evidence based. Public health accreditation means we have an ongoing commitment to performance management and quality improvement to improve the health of our state. We are so proud to be a part of this achievement!

Ask a SEER Registrar

It is better to ask questions than to know all of the answers. ~James Tucker~

Question

MP/H Rules/Histology--Breast: Given that the current MP/H rules do not recognize specific types of lobular carcinoma, should the histology for an invasive pleomorphic lobular carcinoma be coded to 8022/3 [pleomorphic carcinoma] or 8520/3 [lobular carcinoma]? See Discussion.

Answer

Code the histology to 8520/3 [lobular carcinoma].

The 4th Edition of the WHO Classification of Tumors of the Breast now describes five variants of invasive lobular carcinoma. These variants are solid type, alveolar, pleomorphic, tubulolobular, and mixed-type. WHO has not yet proposed new ICD-O codes be assigned to these variants. The upcoming solid tumor (MP/H) revisions will include instructions on coding these variants.

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Question

MP/H Rules/Histology--Thyroid: When is 8341/3, papillary microcarcinoma coded? The code description in ICD-O-3 is followed by (C739), yet there are two SINQ answers that tell us specifically to not use this code for thyroid primaries. Even the first revision of ICD-O-3 still carries the (C739) as part of this code, which goes against SINQ 20110027 and 20081127.

Answer

Per the WHO Tumors of Endocrine Organs, for thyroid primaries/cancer only, the term micropapillary does not refer to a specific histologic type. It means that the papillary portion of the tumor is minimal or occult (1cm or less in diameter) and was found incidentally. WHO does not recognize the code 8341 and classifies papillary microcarcinoma of the thyroid as a variant of papillary thyroid and thereby should be coded to 8260. If the primary is thyroid and the pathology states papillary microcarcinoma or micropapillary carcinoma, code 8260 is correct.

Question

MP/H Rules/Multiple primaries--Thyroid: How many primaries should be reported when a complete thyroidectomy specimen shows two tumors: 1.8 cm papillary carcinoma with tall cell features (8344/3) and a 0.4 cm papillary thyroid carcinoma (8260/3)? See discussion.

Answer

Apply rule M16 and abstract a single primary. These two thyroid tumors, one papillary carcinoma with tall cell features (8344/3) and one papillary thyroid carcinoma, fit the criteria for rule M16, although not explicity listed there. We will clarify this in the next version of the rules.

Staging- Did You Know?

Green is the source of rule

If you have a question about coding stage after reviewing site specific rules, use the general rules in front of the manual.

Staging 2017 slides -Blanks vs X

"If rules for classification have not been met, leave T,N and M fields blank (99 for stage group)".
"Leave the T and N blank if the rules for classification of the T value have not been met".
"If rules for N have been met, but the rules for T have not been met, leave both blank".
"If rules for T have been met but rules for N have not been met, assign the appropriate T value and X for N value.

Staging 2017 slides cM in pM data – "cM values may be used in the pM data item if pT and pN are not blank". "If pT and pN are blank, cM may not be used in the pM data item".

Staging 2017 slides pM Values in cM data items – "If distant mets is pathologically confirmed prior to treatment, A pM value is assigned. The pM value is also entered into the cM data item".

Staging 2017 slides In Situ – "By definition in situ indicates there is no spread to regional/distant organs or lymph nodes. In order to code the pTis, a pathologist must review the entire tumor under a microscope.

Staging 2017 slides Distant mets – M1 "If patient has distant mets, patient will have a stage regardless of T&N.
Prostate PSA –" When looking at stage grouping table, "no PSA" equals "any PSA".

Staging 2017 slides TNM descriptor – "Y classification during or after initial multimodality therapy. Pathologic staging only".

Staging slides 2016 Use of ambiguous terminology by resource

Ambiguous Terminology	Terms Used	Comments
Reportability	Yes	A list of reportable and non-terms is available in FORDS.
MP/H Rules	Yes	A list of terms that can be used to describe a histology is available in the MPH manual. May not be used to determine multiple primaries.
Hematopoietic DB	No	See Hematopoietic Database and Manual.
Summary Stage	Yes	Involvement and non-involvement terms available in manual.
CS – Pre 2016 diagnosed cases	Yes	A list of terms is available in CS manual.
AJCC	No	Involvement should be based on physicians interpretation or registrars professional judgment.

Staging Practice Quiz

A patient has a CT one week after his segmental resection for colon cancer that shows metastasis to the liver. The metastasis was not identified prior to surgery and the metastasis was never histologically confirmed. What values would you enter in the cM and pM data items?

Data Item	Value
Clinical M	
Pathologic M	

Clinical M0 Pathological M= cM1a

Coding Moment – New Fields for Cases diagnosed 2016 and greater

Mets at Diagnosis BBDLLO

- Mets at Diagnosis – Brain
- Mets at Diagnosis – Bone
- Mets at Diagnosis – Distant Lymph Nodes
- Mets at Diagnosis – Liver
- Mets at Diagnosis – Lung
- Mets at Diagnosis – Other

Code Values

- Code 0 – None, no metastases
- Code 1 – Yes, distant metastases
- Code 2 (Mets at Dx – Other) – Generalized metastases such as carcinomatosis
- Code 8 – Not applicable
- Code 9 – Unknown is involved metastatic site – Not documented in patient record

Coding Tips

- Involvement may be single or multiple
- Involvement may be clinical or pathologic
- Code even if there was preoperative systemic therapy
- Code for all solid tumors, Kaposi sarcoma, Unknown Primaries and Other/Ill-defined Primaries
- Code for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

Take Notice: Important Coding Instructions

Mets at Diagnosis - Bone • Do **NOT** code bone marrow involvement in this fieldvi

Mets at Diagnosis - Brain • Do **NOT** Code involvement of spinal cord or other parts of the CNS in this field

Mets at Diagnosis - Lung • Do **NOT** code pleural or pleural fluid involvement in this field
- Do not assign code 1 for a lung primary with multifocal involvement of the same lung
- Use of Code 1 – indicates lung is primary site and there are mets in the contralateral lung

Mets at Diagnosis– Distant Lymph Nodes • Use AJCC TNM to determine regional vs distant
- Assign Code 0 for unknown primaries, unless lymph nodes are stated to be distant lymph nodes
- Placental lymph nodes for placenta primaries are distant lymph nodes (M1) are recorded in this field
- Do not code for reginal lymph node involvement
- Code 0 for all lymphomas. – Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811- 9818, 9823, 9827, 9837 (All Sites)

Mets at Dx – Other
- Code 1 includes bone marrow involvement for lymphomas – Does not include lymphomas or lymphoma/leukemias where primary site is C421
- Code 2 when the patient has carcinomatosis

Small Hospitals

I want to thank all small hospitals for their hard work, and timely responses.

Reminders:

Text is required for tumor data, procedures and treatment, including dates.
Please note in text: age, sex, and race of patient as well if they had a history of cancer or other diagnosis. If you have any questions or concerns, please contact Kandice Abernathy via telephone 334-206-2088 or via email Kandice.Abernathy@adph.state.al.us

Education Corner

South Region Webinar Schedule

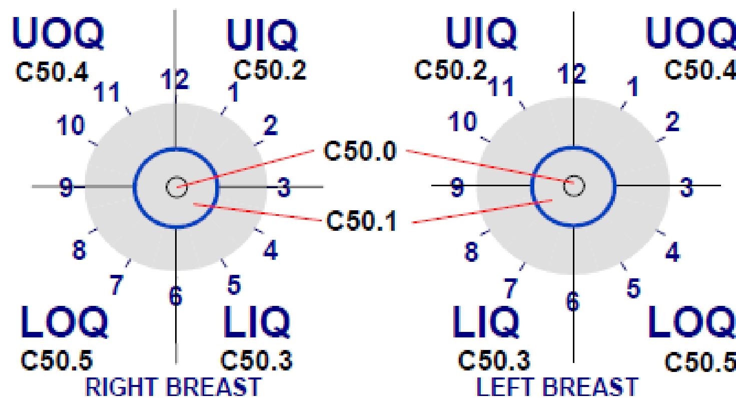
Webinar	Date
Lung	July 17
AJCC Staging	July 17
Colon	Aug 21
Abstracting and Coding	Aug 21
Multiple Primary & His-	Sep 18
Liver & Bile Ducts	Oct 16
Central Nervous System	Oct 16
Coding Pitfalls	Nov 13

North Region Webinar Schedule

Webinar	Date	Place
Lip and Oral Cav-	July 20	Cullman County
Liver and Bile	August TB	Cullman County
Hospital Cancer Registry Opera-tions	September TBD	Cullman County
Central Nervous	October TBD	Cullman County
Coding Pitfalls	November TBD	Cullman County

Please contact Diane Hadley for specific dates.

Remember to code the breast according to the quadrant of the correct laterality. C50.9 should only be used when the quadrant or anatomical clock position is not specified.



Epi Corner

Top 10 Cancers Sites in Alabama in 2014 by Sex						
Males				Females		
Rank	Site	Rate		Rank	Site	Rate
1	Prostate	107.4		1	Breast	120.8
2	Lung and Bronchus	87.0		2	Lung and Bronchus	48.3
3	Colon and Rectum	52.3		3	Colon and Rectum	37.7
4	Urinary Bladder	32.9		4	Corpus Uteri	19.3
5	Melanoma of the Skin	25.0		5	Melanoma of the Skin	14.9
6	Kidney and Renal Pelvis	22.5		6	Thyroid	13.9
7	Oral Cavity and Pharynx	20.5		7	Non-Hodgkin Lymphoma	13.6
8	Non-Hodgkin Lymphoma	19.0		8	Kidney and Renal Pelvis	12.3
9	Pancreas	14.2		9	Ovary	11.7
10	Liver	9.9		10	Pancreas	11.0

Rates are per 100,000 and age-adjusted to the 2000 US (19 age group) standard.

Rates are for malignant tumors only except for Urinary Bladder which includes in situ cases.

Standard Occupational Classification (SOC) for Medical Registrars

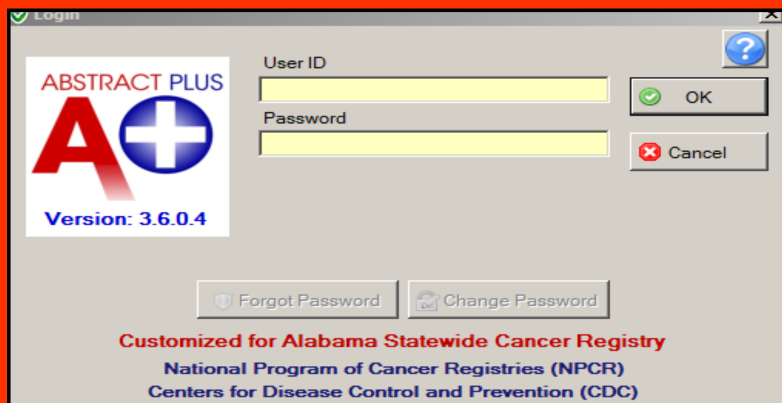
Job Classification "Medical Registrar" Recommended by U.S. Bureau of Labor Statistics

After 10 years of hard work, NCRA is proud to announce interim approval by the U.S. Bureau of Labor Statistics for a new Standard Occupational Classification of "Medical Registrar". Our hard work has paid off! NCRA created and advocated for the new job classification entitled "Medical Registrar". NCRA's next step is to look at the details of the Bureau's recommendations to make sure important features of the job classification include the details that NCRA recommended. NCRA will submit comments as needed to ensure the description is accurate. More information coming soon from NCRA. Stay tuned! NCRA has prepared materials to help its members and other medical registrars understand the importance and the process for establishing a distinct detailed SOC occupation code for "Medical Registrars".

http://www.ncra-usa.org/i4a/pages/index.cfm?pageid=4174

What Version of Abstract Plus Are You Working In?

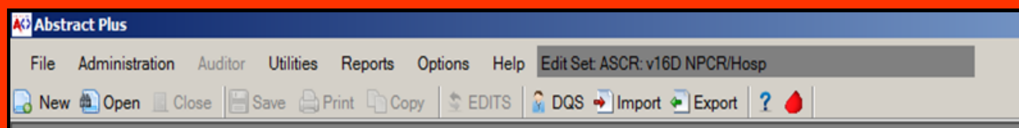
Abstract Plus has version 3.6 is now up to its 4th update. Are you operating in the newest version?



Please contact Melissa McNeil at 334.206.5557 or Melissa.mcneil@adph.state.al.us, I'll be happy to assist you in getting version 3.6.0.4 ready.

We have gotten a lot of questions about whether you should upgrade your system. The answer is "YES" and here is why:

- Edits that run in version 3.6.0.4 fixed a lot of issues we were having in the previous version. Many facilities reported that they received no edits in Abstract Plus, but got numerous edits when uploading the exported files to Web Plus. By upgrading you will fix this issue. The most recent edit set is: ASCR: V16D NPCR/Hosp



- Abstract Plus 3.6.0.4 will allow you to abstract 2017 cases. In the previous versions Abstract Plus would grey-out areas such as the Site Specific factors and not allow you to input information. That issue has been resolved in the updated version.
- When abstracting a 2016 case, the abstractor was unable to fill in the TNM fields and the edit report would not produce an edit for the 2016 case.

To avoid these errors update your Abstract Plus to version 3.6.0.4. Download the link at: https://ftp.cdc.gov/pub/NPCR-AP-UPDATES/AbstractPlus/customizations/V160/Index.html

Scroll down the page and locate the State/Region Specific Customization for the Alabama Statewide Cancer Registry to download the Patch that will update Abstract Plus to 3.6.04.

State/Region Specific Customization
Download your State/Region specific customization from below.

State/Region	Download Link
Alabama Statewide Cancer Registry	Installing Abstract Plus Version 3.6 with NAACCR 16.0 from scratch Click here to download Abstract Plus Setup File Upgrading existing Abstract Plus from version 3.5 to 3.6 with NAACCR 16.0 Click here to download Abstract Plus Updater Tool The following Patch includes the following updates: 06/08/2017 : Alabama has released new EDITS (Version D) Please download Abstract Plus 3.6 Patch below. Please read instruction before you apply patch. Click here for instructions on how to apply above patch Click here to download Abstract Plus 3.6 Patch

Meet Our New Staff

Meet Kelsey Thomas

My name is Kelsey Thomas, and I am an Administrative Assistant for the Alabama Statewide Cancer Registry. I am 27 years old and I am from Montgomery AL . I graduated from Jefferson Davis high school and my hobbies include spending time with family and working out. I previously worked with Vital Statistics with the State of Alabama. I will bring to ASCR an enthused personality with a hard-working drive that enables us to get the job done.

Meet Cassandra Reynolds

Hello my name is Cassandra Reynolds. I am a resident of Union Springs in Bullock County. I am the new Follow-Back Coordinator for the Alabama Statewide Cancer Registry. I have been working with the Department of Public Health for 11 years. I currently hold a Bachelor degree in Elementary Education and a Masters in Information Technology specializing in Assurance and Security. I have been with the Cancer Registry for 4 months. Thus far I have enjoyed working with a great group of people. In my spare time I like spending time with my family, relaxing, and being the best aunt that I can be to my one and only niece who recently just turned 4. This coming fall she will start Pre-K. I am looking forward to working with facilities and making ASCR the best.

NCRA Conference DC- 2017

NAACCR GOLD CERTIFICATION

Thank you for your commitment to submitting timely, complete, and quality data. Your commitment to excellence is what enabled the ASCR to achieve the highest NAACCR standards and receive Gold Certification for our 2014 data submission. We have been able to achieve this level of excellence since data year 2004. This November, we will submit 2015 data – the 24-month data submission to the North American Association of Central Registries (NAACCR) and the Centers for Disease Control and Prevention (CDC). Our completeness rate is significantly lower compared to previous years. Please assist the ASCR in reaching a 95% completeness rate with 2015 data by submitting all of your 2015 cases and responding to all follow back requests on pathology reports and death clearance.

Meaningful Use

The Alabama Statewide Cancer Registry has declared readiness for Meaningful Use Stage 3 to capture provider EHR reporting periods beginning May 1, 2017. ASCR will be able to meet the 2015 Edition CEHRT criteria, including incorporation of the updated Cancer Implementation Guide HL7 CDA Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1, DSTU Release 1.1 - US Realm (http://www.hl7.org/implement/standards/product_brief.cfm?product_id=398).