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Fellow Registrars,
World Cancer Day will be observed on February 4th again this year. Resources can be found on the World Cancer Day website: http://www.worldcancerday.org/

DUE DATES

Large hospitals (>500 cases/yr) are to report July 2016 cases by Feb. 15 and smaller facilities (<300 cases /yr) report the 3rd Quarter of 2016 by April 15, 2017.

EDUCATION

NAACCR Webinars

Live: February 2, 2017, 8-11 a.m., **Collecting Cancer Data: Colon.** To attend the live broadcast in Columbia, sign up here: http://www.signupgenius.com/go/30e0e49a4a82caafa7-naaccr13

Live: March 2, 2017, 8-11 a.m., **Abstracting and Coding Boot Camp: Cancer Case Scenarios.** To attend the live broadcast in Columbia, sign up here: http://www.signupgenius.com/go/30e0e49a4a82caafa7-naaccr14

NAACCR Recordings: Earn 3 CEs by viewing recorded webinars. Check out our Education and Training page to find out how you can receive access to the recorded NAACCR Webinars. http://mcr.umh.edu/mcr-education.php

GoToMeeting

***Upcoming*:** February 8, 2017, 10-11 a.m., **Bladder Surgery Codes & MPH Rules.** Sign up here: http://www.signupgenius.com/go/30e0e49a4a82caafa7-gotomeeting0208

***GoToMeeting Recordings*:** Previous GoToMeeting presentations are posted to the MCR website as recordings. http://mcr.umh.edu/mcr-education.php

Fundamentals of Abstracting Workshop

Fundamentals of Abstracting Workshop is a day and a half-long course held in Columbia, MO at the Missouri Cancer Registry and Research Center. This is a free class and which is geared toward new abstractors who are not familiar with the abstracting process. The MCR Abstract Code Manual is reviewed in detail. Students also get hands-on experience working through cases using Abstract Plus software and the manual. For those not familiar with the nuances of abstracting Missouri cases, this workshop is a great place to learn, practice and get your questions answered.

- ***Date & Time*:** Monday 03/27/2017, 1-5 pm & Tuesday 03/28/2017, 8 am - 4 pm
- ***Location*:** Missouri Cancer Registry and Research Center - Columbia MO (Clark Hall, MU campus) Room 426.
- ***Sign up*** by clicking on the following link: http://www.signupgenius.com/go/30e0e49a4a82caafa7-fundamentals2.

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Basic Registry Training

A two-day course which presents an overview of staging formats, different types of treatment (surgery radiation & chemo), central registry background, ACoS requirements, case finding, follow-up, statistics, etc. and provides a general overview of what a cancer registry is. The audience includes RHIT students as well as new registrars.

- ***Date & Time:*** Monday 03/06/2017, 8-4 pm & Tuesday 03/07/2017, 8-4pm
- ***Location:*** North Kansas City Hospital, 2800 Clay Edwards Drive, North Kansas City, MO, 64116. (Frontier Room)
- ***Sign up*** by clicking on the following link: http://www.signupgenius.com/go/30e0e49a4a82caafa7-basic

MCR Help-Line

Reach us at 1-800-392-2829 during regular office hours, or leave a message; a member of our QA team will return your call within one business day.

Massachusetts Free Educational Webcast

Save the Date Tuesday May 16, 2017 8am – 4pm
Once again the Massachusetts Cancer Registry and Dana-Farber institute will sponsor a free all-day webcast. An agenda and links will be posted here when available. You can listen to any or all of the presentations from your computer or device. In the past, many of the presentations have been NCRA pre-approved for continuing education credits.

MCR NEWS

Web Plus is open in v16

As of 1/12/17, Web Plus is available for upload of cases in v16. Only v16 case files will be accepted now. If you are still in v15, hold cases, upgrade your system and then send them by Feb. 15 in v16. This month, separate files should be sent for 2016 and pre-2016 cases and should contain a maximum of 250 cases. Registrars new to MO reporting and others who have been requested to send their 10 first cases or small files separately for closer QA feedback should continue to do so.

2017 Requirements

NAACCR recently released the publication *What You Need to Know for 2017*. Adoption of new ICD-O-3 codes will continue to be postponed. The previously published crosswalk to use when registrars encounter new codes in use by pathologists is again provided (Appendix A). NPCR and MCR will have **no changes in reportability or required fields**. CoC has not yet announced whether they will change their requirements. The 2007 MP/H rules will continue to be in effect. NAACCR will release a v16D edit metafile in February and MCR will customize it for vendor use with 2017 case reporting software.

Debra Douglas – Full Retirement

Veteran QA staff member Debra Douglas decided to start the New Year off by moving from partial to full retirement! We wish her all the best as she enjoys each day with her husband and extended family. Her MCR QA duties have been split among existing staff until we can open another QA position.

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MCR Audit of Benign Tumors

MCR conducted an audit of all benign/borderline intracranial neoplasms in our database for 2015 and would like to share our findings with you so that together we can continuously improve. Overall, our findings were in line with those reported by other states.

- SEER Summary Stage should be coded 8
  Registrars were required to code SEER Summary Stage beginning with cases diagnosed January 1, 2015 and to use SEER Summary Stage code 8 for benign/borderline brain/CNS tumors. Due to an apparent oversight, code 8 was omitted from the *SEER Summary Staging Manual 2000*; however, this instruction is documented in the *SEER Program Coding and Staging Manual 2015* on page 102 and FORDS 2016 page 173. It was communicated by MCR in our Oct. 2016 Monthly Update. Despite the late clarification of this rule, an MCR review of cases diagnosed in 2015 revealed only 16% were coded to a value other than 8. They have been corrected in the MCR database. You might consider a query of your database if you feel this is an important correction for you to make for your own purposes. Please make a note to code 8 on future cases.

- Meninges Primary Site should be coded C70.0 or C70.1
  The review of cases diagnosed in 2015 revealed less than 1% incorrectly coded to a site other than meninges (C70.x). MCR had provided webinar education and QA feedback on this in previous years and it seems to have been effective. Thank you for being attentive to this! Within the meninges, please remember, if a specific area within the cranium is mentioned on imaging (right frontal region, left cerebral hemisphere, posterior fossa) that is a clue the tumor is in the cranium and the primary site should be coded to cranial meninges (C70.0) not meninges, NOS (C70.9). Similarly, if imaging shows, for instance, an enhancing T2 vertebral body mass, the primary site would be spinal meninges (C70.1) not meninges, NOS (C70.9).

- Pituitary Adenoma Histology should be coded to 8272
  7% of pituitary (C75.1) adenomas were coded to an improper histology code such as 8140/0, Adenoma, NOS.

- Acoustic Neuroma Primary Site should be C72.4
  17% of acoustic neuromas (9560) were improperly coded to Cranial Nerve, NOS (C72.5). While this is significantly lower than the error rate reported by another NPCR state, we would appreciate your attention to this detail in future reporting.

ABSTRACTING TIPS

CORRECTION to MCR TNM Quick Reference Guidelines published last month!

Additional clarification has been made this month in national level training and discussion causing one of the TNM Quick Reference tips that we attached last month to change.

- When there is no resection of the primary site, a pathologic stage cannot be assigned unless there is biopsy of both the highest T and highest N.

Please replace any saved documents with the revised document attached to this email.

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2017 in situ TNM

Heads up that while physicians may be using the AJCC 8th edition in 2017, registrars will still assign 2017 stage according to the 7th edition. This may require some translation on our part. For instance, the new AJCC rules on assignment of T for in situ cases (news release by AJCC before the NAACCR decision to delay registry conversion) may result in this scenario:

- Case being abstracted: 2017 diagnosed melanoma in situ.
- MD says clinical Tis N0 M0 based on a biopsy because he is using AJCC 8th ed.
- Registrar cannot code cIS in the field TNM Clin T because registries are staying in AJCC 7th edition in 2017 and the only software choice available (by 7th edition rules) is pIS.
- AJCC 7 pIS will still be correct for the abstract in 2017. Donna Gress will be covering this in education throughout the year.

Use of c0 in the Pathologic N Field should be Rare

The "T is the driver", if you have a T number then you must have something in the N field (either a number or an X) or if T is blank, then N must be blank. Per Donna Gress and the CA Answer Forum, we cannot use the c0 in the pathological N category except in rare situations. If there was not at least one LN removed, then use pX in the N category unless an exception is stated in the chapter rules. There are very few chapters with this exception. One example is melanoma skin: It states in the chapter-pathologic stage 0 and IA patients are the exception; they do not require pathologic evaluation of their lymph nodes. In this particular case you can use c0 in the pathologic N category to complete the stage. However, this type of exception will not happened often. Refer to AJCC Manual, 7th ED. Table 1.6 stating the N classification rules located in the general rules section. You may see physicians use c0 as a working stage, but the above rules govern how we are supposed to enter it into our software. There is not yet an edit for this.

TNM for Kidney Cancer, No LN Removed

According to national subject matter experts, when we have a pT3 kidney cancer with no LN removed (not required for path classification) and no mets, we can assign pT3pNxcM0 with group stage III. We can assign a stage group in this case because the status of the lymph nodes does not impact the stage group. This will pass v16 edits. The AJCC 7th ed. only specifies N0 or N1 for Stage III, but can be interpreted as “any N” since in this situation N has no impact. That correction has been made in the AJCC 8th ed. errata for Chapter 60 p.774. http://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

Prolactinoma – Diagnostic Confirmation

When abstracting pituitary prolactinomas, do not assign diagnosis confirmation code 7 (imaging) when elevated prolactin levels have been documented. This subtype of pituitary adenoma cannot be diagnosed solely from imaging reports. In symptomatic patients, serum prolactin levels are measured and MRI is done to confirm the presence of the pituitary tumor. When prolactin levels are elevated, enter code 5 (lab tests) for diagnostic confirmation. If prolactin levels are normal or not measured and the physician’s diagnosis is prolactinoma, confirmation code 7 may be used.

Skin Codes

When abstracting skin primaries arising in post-auricular skin, assign topography code C44.4 (scalp), NOT code C44.2. The post-auricular skin is located **behind** the ear and is not the same thing as posterior auricular skin which is on the back side of the ear. Similarly, pre-auricular skin is located in front of the ear and is coded to C44.3 (skin of face), not to C44.2 (skin of ear).

STANDARD SETTER NEWS

From NAACCR and NCRA

NACCR has had several registrars contact us and ask if the NAACCR webinars meet the Category A CE requirement which requires that 4 of 20 hours of CE credits include topics related to staging. They sent the question to the NCRA Council on certification and received the following response:

> NAACCR Webinars covering Category A topics would meet the Category A CE requirement expect for a webinar, for example, that does not cover a specific site.
> For more information about the Category A requirement see https://www.ncra-usa.org/i4a/pages/index.cfm?pageID=4270

CDC Resources for Cervical Cancer Awareness

CDC's ***Inside Knowledge* campaign** is increasing efforts to inform women about cervical cancer risks, screening tests, and prevention. Initiatives include a **video public service announcement** featuring actress Cote de Pablo describing her cervical cancer scare, and ads on sites including Google, YouTube, and Facebook. You can share information about **cervical cancer** by encouraging women in your networks to take the new ***Inside Knowledge* cervical cancer quiz,** posting the new Facebook and Twitter **graphics** featuring quotes from **cervical cancer survivors,** and sharing a link to updated **fact sheets.** Or you may order **free print materials.**

REGISTRY TO RESEARCH

Researchers Define Optimal Time to Rectal Cancer Surgery Following Chemoradiotherapy (NCDB data)
http://www.healio.com/hematology-oncology/gastrointestinal-cancer/news/in-the-journals/%7Bfa046a65-32f1-4bc6-a347-932ff80a83dd%7D/researchers-define-optimal-time-to-rectal-cancer-surgery-following-chemoradiotherapy

Association of Delayed Adjuvant Chemotherapy with Survival After Lung Cancer Surgery (NCDB data)
http://jamanetwork.com/journals/jamaoncology/article-abstract/2595781

Black Heterogeneity in Cancer Mortality: US-Blacks, Haitians, and Jamaicans (Florida registry data)
https://moffitt.org/media/5773/3-347-pinheiro.pdf

Trends and Patterns of Disparities in Cancer Mortality Among US Counties, 1980-2014 (various sources)
http://jamanetwork.com/journals/jama/fullarticle/2598772

Radiation Therapy for Malignant Phyllodes Tumor of the Breast: An Analysis of SEER Data
http://www.sciencedirect.com/science/article/pii/S0960977616302661

Exploring the Relationship between Patient Age and Cancer-Specific Survival in Papillary Thyroid Cancer: Rethinking Current Staging Systems (SEER data)
http://ascopubs.org/doi/full/10.1200/JCO.2016.68.9372

Impact of Number of Lymph Nodes Examined on Staging and Survival of Resected NSCLC (SEER data)
http://ascopubs.org/doi/full/10.1200/JCO.2016.67.5140

How Many Lymph Nodes Are Enough? Assessing the Adequacy of Lymph Node Yield for Papillary Thyroid Cancer (NCDB data)
http://ascopubs.org/doi/full/10.1200/JCO.2016.67.6437

Minimal Loss of Lifetime for Patients with Diffuse Large B-Cell Lymphoma in Remission and Event Free 24 Months after Treatment: A Danish Population-Based Study (Danish Registry)
http://ascopubs.org/doi/abs/10.1200/JCO.2016.70.0765?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

Impact of Ethnicity on the Outcome of Men with Metastatic, Hormone-sensitive Prostate Cancer (SEER data)
http://onlinelibrary.wiley.com/doi/10.1002/cncr.30503/full

Effectiveness of Adjuvant Chemotherapy After Radical Nephroureterectomy for Locally Advanced and/or Positive Regional Lymph Node Upper Tract Urothelial Carcinoma (NCDB data)
http://ascopubs.org/doi/full/10.1200/JCO.2016.69.4141

RESOURCES/ RESEARCH OF INTEREST

More Patients with Rectal Cancer Are Candidates for a Watch-and-Wait Approach
http://www.practiceupdate.com/c/48702/32/1/?elsca1=emc_conf_ASCOGI2017During-1&elsca2=email&elsca3=practiceupdate_onc&elsca4=201705_ASCOGI2017During-1&elsca5=conference&rid=NTU2MjE4MTE1NjYS1&lid=10332481

Leading Edge Radiosurgery Is Demonstrated Safe and Effective as Upfront Adjunctive Therapy in Newly Diagnosed Glioblastoma
http://www.practiceupdate.com/c/46749/2/12/?elsca1=emc_enews_daily-digest&elsca2=email&elsca3=practiceupdate_onc&elsca4=oncology&elsca5=newsletter&rid=NTU2MjE4MTE1NjYS1&lid=10332481

Surgical Treatment of Salivary Malignant Tumors
http://www.oraloncology.com/article/S1368-8375(16)30242-1/fulltext

Laparoscopy Helpful to Prevent Futile Primary Cytoreductive Surgery in Patients with Advanced Ovarian Cancer
http://ascopubs.org/doi/full/10.1200/JCO.2016.69.2962

Diagnostic Accuracy of Multi-parametric MRI and TRUS Biopsy in Prostate Cancer (PROMIS): A Paired Validating Confirmatory Study
http://www.sciencedirect.com/science/article/pii/S0140673616324011

Bilateral Oophorectomy and Breast Cancer Risk in BRCA1 and BRCA2 Mutation Carriers
https://academic.oup.com/jnci/article-lookup/doi/10.1093/jnci/djw177

Prevalence of Differentiated Thyroid Cancer in Autopsy Studies Over Six Decades: A Meta-Analysis
http://ascopubs.org/doi/full/10.1200/JCO.2016.67.7419

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Current Management of Low Risk Differentiated Thyroid Cancer and Papillary Microcarcinoma
http://www.sciencedirect.com/science/article/pii/S0936655516304800

EGR2 Mutations Define a New Clinically Aggressive Subgroup of Chronic Lymphocytic Leukemia
http://www.nature.com/leu/journal/vaop/ncurrent/full/leu2016359a.html

Vulvar and Vaginal Melanoma: A Unique Subclass of Mucosal Melanoma Based on a Comprehensive Molecular Analysis of 51 Cases Compared with 2253 Cases of Nongynecologic Melanoma
http://onlinelibrary.wiley.com/doi/10.1002/cncr.30473/full

Older Lung Cancer Patients Face Significant Treatment Burden
http://www.medicalnewstoday.com/releases/315119.php

Wishing you a wonderful month,

Nancy H. Rold, CTR
Operations Manager
Missouri Cancer Registry and Research Center

Some General Guiding Principles for TNM fields - an MCR Quick Reference using our notes from various sources	
If…	**….Then**
If case has met the classification rules for clinical staging	then the cT and cN can be numbers or "x" (not blank) and the cM can be 0 or 1
If case has NOT met the classification rules for clinical staging (such as an incidental finding of cancer without clinical workup)	then the cT, cN, cM must be blank and group stage 99
If case has met the classification rules for pathologic staging	then the pT and pN can be numbers or "x" (no nodes pathologically assessed) and the pM can be 1 (IF biopsy of mets site positive) or cM0 or cM1 to finish the group stage
If case has NOT met the classification rules for pathologic staging	then the pT, pN, pM must be blank and group stage 99
The "T is the driver" -- if you have a T number	then you must have something in the N field (number or "X")
~~**If case meets the chapter's highest "T" category via biopsy of another organ**~~ **If there is no primary site resection and only have biopsy of highest T category**	~~then you might be able to describe pT4. (But without pathologic LN exam, you may get pT4 pNx, group stage 99).~~ then case does not qualify for pathologic staging (must have BOTH bx of highest T AND highest N to qualify)
If case is Unknown Primary T0, but described as a probable primary by the treating physician (Example probable melanoma OR probable lung)	then pN may be used for assigning pathologic nodes with path proof of involvement
If no resection, but the HIGHEST T and N can be confirmed microscopically	then pT/pN may be assigned
The "T is the driver" -- if you leave the T blank	then N and M must be blank
If pT and pN are blank	then you cannot use a cM value for the pathologic M data item. Use pM blank and path stage 99
If case has a positive biopsy of a metastatic site	then you can always use a pM value in the pM data item
If pM1 applies	then clinical and pathologic group stage may be IV regardless of "c" or "p" status of T and N
pM0 is not used because even an autopsy does not sample all possible tissue	

If behavior is 2 - in situ	then use pTis for clinical staging (it cannot be dxd by imaging alone), cN0 (LNs are not usually resected), cM0. Same for pathologic stage. EXCEPTION: Bladder with TURB only - clinical fields: pTis cN0 cM0 Stage 0is and pathologic fields: pT blank pN blank pM blank stage 99 (Note: this is for 2016 cases)