The Sentinel

The Newsletter for the Association of North Carolina Cancer Registrars

Sept/Oct 2005

Message from our President:

Elizabeth Tucker, CTR

So much has happened since our last newsletter! The fall meeting was a wonderful education opportunity! Each speaker provided such pertinent information, that regardless of the level of experience, there was information to be gleaned by everyone. I especially appreciate speakers who provide actual pictures of staging examples or procedures. Thank you again to all of you who worked so very hard to plan and provide this meeting for our organization.

In the last newsletter, I referenced that I was preparing for our ACoS survey. My hair may be slightly whiter, but thanks to a wonderful staff we did well. Deborah Carrethers worked extremely hard to bring our registry into compliance with the abstracting rule Standard 3.3. The week before survey, we found out that the CoC has decided not to enforce that standard! In October of last year, an employee resigned, so Deborah accepted the responsibility of abstracting all of our 1100 cases. She only works part time, so that was some feat! Deirdra Greene who came to the registry from Pathology was a quick learner and was wonderful in keeping the follow-up percentages on target as well as being part of the team doing what was needed to prepare us for survey!

Dr. Greene was our surveyor. He was very thorough in checking the quality of abstracting, staging and the physician's signature on the staging form. If you remember, each standard states that documentation must be provided to the surveyor on the day of survey to validate the SAR. In the past we have used notebooks that were very complete, very valuable, and extremely time consuming in preparation. In the four surveys that I have participated in, these notebooks were rarely reviewed. I decided this year to do storyboards. Each Standard was represented by a storyboard, and in some cases such as Clinical Management and Community Outreach more than one board was developed. This enabled Dr. Greene to view how we had met each standard in a visual as well as written format. In our final session with Dr. Greene, he did a very thorough presentation on the C3PR: Colon Study on Stage III cases done by the CoC. It was wonderful because our physicians sat in on the presentation. Dr. Greene was very helpful in explaining to then how very important completing follow-up requests can be in obtaining complete information. We were very pleased with our results, receiving a 3 year accreditation with accommodation.

I will be attending the CoC Surveyors Training meeting the first of November. If any of you have questions regarding your survey, please feel to call me. At this meeting, we will receive new information regarding the standards, the interpretation of standards and any revisions to the requirements. The revisions made to the standards can be found at http://www.facs.org/cancer/coc/standardsclarifications

Inside This Issue:

Please send any ideas & or articles for the Sentinel to:

Adaline Brown – Sentinel Editor
Moses Cone Regional Cancer Center
501 N. Elam Avenue
Greensboro, NC 27403
Phone (336) 832-0832 / Fax (336) 832-0841
Adaline.brown@mosescone.com

President's letter cont'd from page 1,

If you have recently passed the CTR exam please let me know. We want to celebrate with you.

Don't forget that data for 1989, 1994, 1999, and 2004 must be submitted to the NDCB by November 18 to be in compliance with Standard 3.6. To be eligible for accommodation it must be without error. USE THOSE EDITS!

If you have any news in your department or ideas concerning 'how to' in registry work share it! Adaline and I look forward to hearing from you!

Elizabeth Tucker, CTR
President

2005– 2006ANCCR Board

2005-2006 ANCCR Board: Pictured from left to right: Blanche Sellars, Tina Harkey, Deborah Carrethers, Judy Robertson, Inez Evans, Paige Tedder (hiding beside Inez), Adaline Brown, Cathy Rimmer, Deborah Thorne, Leta Vess and Carol Burke. Missing from picture are: Elizabeth Tucker, Carol Dickinson, Melissa Pearson, Sherilyn Breitenbach.

President: Elizabeth Tucker, CTR etucker@hprhs.com **Immediate Past President:** Melanie Rogan, CTR mrogan1@triad.rr.com **Vice President & Program Chair:** Carol Burke. CTR carol.burke@pardeehospital.org **Secretary**: Leta Vess, CTR lvess@firsthealth.org **Treasurer**: Deborah Thorne, CTR deborah.thorne@wilmed.org **Ways & Means:** Tina Harkey ccatxh@MSJ.ORG **Grants & Vendors:** Paige Tedder, CTR pdtedder@northeastmedical.org **New Registrar Training:** Melissa Pearson melissa.pearson@ncmail.net **Bylaws**: Vacant	**Education**: Inez Evans, RHIT, CTR ievans@wfubmc.edu **Historian**: Sherilyn Breitenbach sherilyn.Breitenbach@rexhealth.com **Membership**: Deborah Carrethers, CTR dgcarrethers@novanthealth.org **Nominating**: Blanche Sellars, CTR annie.sellars@rexhealth.com **Publications**: Adaline Brown, RHIT, CCS, CTR adaline.brown@mosescone.com **Web Site Coordinator & ACCCC Liaison:** Cathy Rimmer, BA, MDiv, CTR ccrimmer@novanthealth.org **NCRA Liaison:** Carol Burke, CTR carol.burke@pardeehospital.org **Central Cancer Registry Liaison:** Carol Dickinson, CTR carol.dickinson@ncmail.net

2005 ANCCR State Meeting

Our 2005 annual ANCCR meeting is over for another year. It was well attended with 127 people registered over the three-day period. The Holiday Inn Crabtree Valley was the perfect location (except for the lack of Ladies Rooms on the first floor), not only for our meeting, but also for the gala of shops located just across the street at the Crabtree Valley Mall. We hope each of you filled out an evaluation form so that we can learn how and where to improve for next year, and also to let ANCCR know the topics of interest to you and your registry. Thank you to everyone that helped to make this meeting a success.

When Adaline asked us to write a short article about the meeting, we were a bit stymied about which direction to go with it. Should we write an overview, touching on the speakers and topics, attendance, etc.? Or maybe a more personal view of the meeting, like what new officers were elected, what kind of "stuff" was won in the silent auction (especially by that Judy Robertson who won the raffle prize AGAIN!), and, my personal favorite, what desserts were served at lunch. But we finally hit on the idea of writing about what went into putting on the annual ANCCR meeting. So here we go!

Something that might be unique in our situation this year is that this was a first for all of us on the Planning Committee, with the exception of regulars Carol Burke and Deborah Carrethers. Susan Brossoie was the first to get roped into saying yes. She then dragged me (Sheri) in, and the two of us strong-armed Eileen Morgan from Duke into agreeing to help. Then I asked Blanche Sellars, who is my co-worker at Rex, if she would help on the committee, and she was delighted *(bless her heart).*

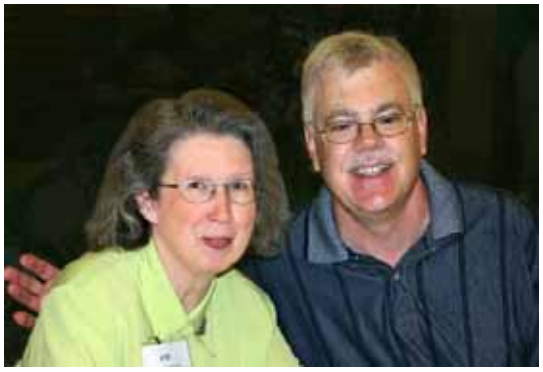
And that was the beginning! Finding the hotel was the first and most time consuming task, we found. Susan, Blanche and Sheri came up with the hotels; we all visited them together; and Carol and Deborah, along with the approval of the executive board, chose one. The rest of the duties were divvied up between mostly Susan and Sheri. We were given a handout that pretty much explained what needed to be done, so it wasn't difficult. Everyone worked as a team, and we can't say enough about the help that Carol and Deborah gave us. We never felt that we were being left on our own to sink or swim. One SOS call to Carol, and she was all over it *(bless her heart).*

If any of you get the opportunity to help plan an ANCCR meeting, JUMP ON IT! It will be an experience that you will truly appreciate in spite of the sacrifice of time that is involved. You will be able to meet and work with so many other ANCCR members, as well as learning all those behind-the-scene "things" that need to happen in order to pull a meeting of this magnitude together. We at Rex had to be ready for survey in July and then for the meeting in September, so I won't lie and say that this summer was a stroll in the park for us, but if we were asked to help host the meeting again, say three or four years from now, after we're off Prozac, we'd be delighted to say yes! Meanwhile, all our best wishes go out to Leta Vess and Pinehurst along with the new Planning Committee who have been handed the torch for hosting the 2006 meeting. Leta, you're going to have a blast! (*Bless her heart, we'll be praying for her.)*

Sheri Breitenbach, CTR
Blanche Sellars, CTR
Rex Cancer Registry
Raleigh, NC

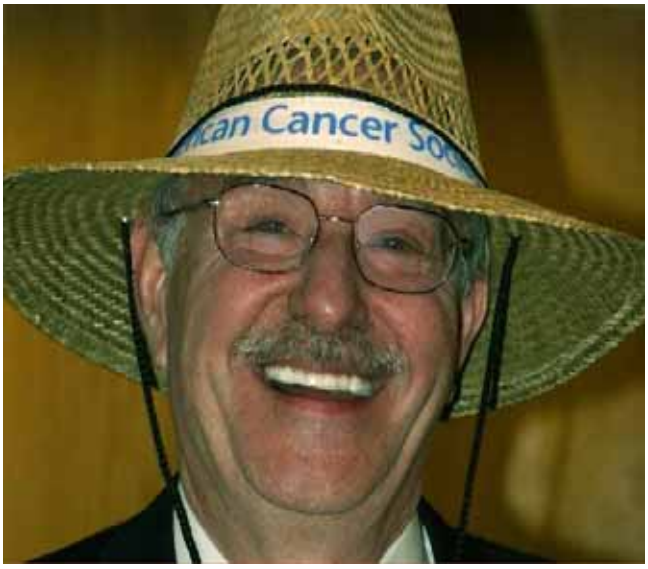
2005 ANCCR State Meeting Photos

Forum Panel: Diane Cleveland, Carol Dickinson, Cathy Rimmer



Judy Robertson and Cyrus Simpson

Susan Brossoie



Dr. Frederick Greene

Silent Auction Bidding

LUNA M. WOODS *AWARD*

This award was established on April 22, 1993 and named in honor of **Luna M. Woods**, **CTR** *(Certified Tumor Registrar)*. The **Tumor Registrars Association of North Carolina** (*TRANC*) is a non-profit educational organization that was begun under the inspiration and leadership of Mrs. Woods, Chief Registrar at Duke University Medical Center, Durham, North Carolina on June 28, 1977 with consultation from Mr. Willard Webber, Cancer Program Advisor, of the American College of Surgeons. The first annual TRANC meeting was held at Moore Memorial Hospital in Pinehurst on September 21, 1977 with twenty-eight cancer registrars present. On November 16, 1995, the name *TRANC* was changed to the **Association of North Carolina Cancer Registrars** (*ANCCR*).

The **Luna M. Woods Award** reads:

The Luna M. Woods Award which was established and named in honor of the founder of TRANC is hereby proudly presented to: _____ who has demonstrated dedication, educational leadership, extraordinary enthusiasm, tireless commitment, professional achievement or outstanding and attentive faithful service that benefited the Tumor Registrars Association of North Carolina (Association of North Carolina Cancer Registrars) and the tumor registry profession.

Signed/dated by: _____ current President of ANCCR

The *first* Luna M. Woods Award was presented on April 22, 1993 at the TRANC 1993 Spring meeting in Raleigh to **Luna M. Woods, CTR.**

The *second* LMW Award was presented on September 23, 1993 to **Carol Dickinson, CTR** (Quality Control Manager, North Carolina Central Cancer Registry) at the TRANC 1993 Fall meeting in Burlington

The *third* and *fourth* LMW Awards were presented on September 15, 1994 to **Cathy Rimmer, CTR** (Cancer Data Program Coordinator, Forsyth Memorial Hospital, Winston-Salem) and to **Judy Robertson, CTR** (Tumor Registry manager, Duke University Medical Center) at the TRANC 1994 Fall meeting in Greensboro.

The *fifth* LMW Award was presented on April 20, 1995 to **Judy Wazenkewitz, CTR** (Tumor Registrar, Gaston Memorial Hospital, Gastonia) at the TRANC 1995 Spring meeting in Hickory.

Continued on page 2

The *sixth* LMW Award was presented on October 6, 1995 to **Linda Mulvihill, CTR** (Quality Control, Central Cancer Registry) at the ANCCR 1995 Fall meeting in New Bern.

The *seventh* LMW Award was presented on April 9, 1997 to **Tim Aldrich, PhD** (Director, North Carolina Central Cancer Registry) at the ANCCR 1997 Spring meeting in Charlotte.

The *eighth* LMW Award was presented on September 8, 1999 to **Judy Robertson, CTR** (Quality Control, North Carolina Central Cancer Registry) at the ANCCR 1999 Fall meeting in Raleigh.

The *ninth* and *tenth* LMW Awards were presented on September 25, 2003 to **Annie Blanche Sellars, CTR** (Cancer Registrar, Rex Cancer Center), and to **Gloria Regan, CTR** (Rapid reporting, UNC Lineberger Cancer Center) at the ANCCR 2003 Fall meeting in Hendersonville.

The *eleventh* LMW Award was presented on September 16, 2004 to **Inez F. Evans, CTR** (Manager, Cancer Registry, WFUBMC) at the ANCCR 2004 Fall meeting in Charlotte.

The *twelfth* LMW Award was presented on September 13, 2005 to **Frederick Greene, MD** at the ANCCR 2005 Fall meeting in Raleigh.

For further information about ANCCR, please go to our web site *www.ncregistrars.com*.

Submitted by Judy, Robertson, CTR (ANCCR Historian*) 8/15/05.*

Dr Frederick Greene accepting Lou Woods Award

President, ANCCR
C/o J. Robertson
3719 West Cornwallis Road
Durham, NC 27705

Re: Luna Woods Award

It is my pleasure to nominate Rick Greene, MD for the Luna M. Woods award.

Dr. Greene, among other things, is a Surveyor for the Commission on Cancer and visits many of us at our hospitals during a crucial and stressful time. Even though, due to conflict of interests, I have never had him for a surveyor, others tell me that he makes a difficult time much easier. He is also a strong supporter of the Cancer Registrar, always mentioning during the survey how valuable our services are.

Dr. Greene is also active in NCRA and ANCCR, often speaking at our meetings. He is very supportive of our profession, our organizations and of the individual Cancer Registrar. It is very important for our profession to have someone of such high caliber on our side.

During the past few years, I have been preparing my hospital for its first survey. Dr. Greene is Chief of General Surgery for the healthcare system that my hospital belongs to and on several occasions, I have asked Dr. Greene for his advice. He has always been there to support me and has been a great help to me during this time. He even came to my hospital during National Cancer Registrars week and gave a talk on TNM staging to my physicians. I can tell you that brought me up a few notches in their opinions.

Please consider Dr. Rick Greene for the Luna Woods Award.

Respectfully submitted,

Deborah Hummert, RHIT, CTR
Cancer Registrar
Union Regional Medical Center
Monroe, NC

Additional Comments from Debbie Hummert: I think anyone who knows Dr. Greene or who have had him survey their facility would agree with me that he deserves recognition from our society. I was sorry that I could not be there to award him this honor in person but I know Sharon did a good job. Thanks for the opportunity to be able to bestow this award on someone so worthy of it.

LUNA M. WOODS AWARD

1. Award established April 22, 1993

2. Named in honor of Luna M. Woods, CTR, foundress of Tumor Registrars Association of North Carolina (TRANC).

3. Nomination "form" may be in writing or may be electronic (e-mail)

4. Nominator must be an ANCCR "member-in-good-standing" (defined as being a member for at least one calendar year).

5. Nominee need not be a member of ANCCR.

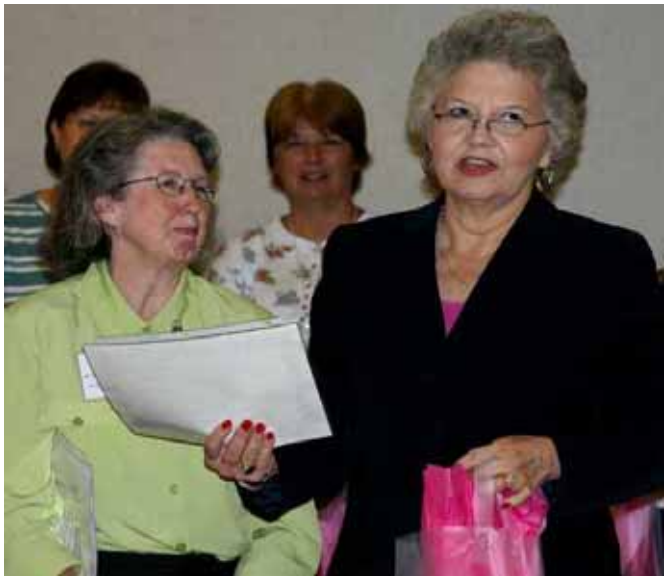
6. Deadline for submission: the nomination form must be received by the ANCCR Historian at least two (2) weeks before the ANCCR meeting.

7. Nomination "form" must give as many details as possible why the nominee deserves this award.

8. Approval must be 100% from the four (4) elected Board members:

President
Vice-President
Secretary
Treasurer

End of report/Judith Robertson (revised 3/05).



Judy Robertson honored after serving as historian for over 20 years

Educational Information Article submitted by Inez Evans (Education Chair)
Article reprinted from website.

Your imagination runs wild! Robots passing you in the hall on their way to surgery, etc....

Here is an article from http://psa-rising.com/med/surgery/robotic_laparoscopic04.html:

Robotic-Assisted Surgery Improves Outcomes for Radical Prostatectomy Patients

October 18, 2004 /New Orleans/ Robotic surgery for prostate cancer has equivalent surgical outcomes to the open approach with less blood loss, shorter hospital stay, faster recovery, and minimal use of narcotic medication during the recovery period, according to a study presented Oct 11 at the 2004 Clinical Congress of the American College of Surgeons.
In the first 300 men who underwent robotic-assisted radical prostatectomy at Urology Centers of Alabama, Birmingham, the average blood loss was less than 50 mL, which is 300 to 2000 mL less than the typical amount of blood lost during standard open surgery.
The patients did not have to undergo blood donation procedure prior to or during surgery for retransfusion.
The men were hospitalized for only one day following the operation, compared with a two- to three-day hospital stay after conventional open surgery.
Quality of life questionnaires showed that men returned to independent activity of daily living (IADL) in 7-10 days versus the four to six weeks for traditional open surgery.
In addition, up to 80 percent of the men did not take any narcotic medication during their perioperative period.
"It is extremely rare for a patient to have almost any type of surgery these days without the use of some form of narcotic agent," Vipul Patel, MD, director of minimally invasive surgery at Urology Centers of Alabama, said. "That is why its amazing that patients are able to undergo major prostate cancer surgery without the use of any postoperative narcotics."
"The minimally invasive nature of the robotic surgery along with the use of anti-inflammatories and the ON-Q subcutaneous pump [I-flow Corporation, Newport Beach, CA]," Patel reported, "have allowed us to achieve non-narcotic radical prostatectomy in 80 percent of patients. Of that number, 20 percent do require narcotics, but the use is extremely limited - usually one or two pills maximum."

Contrast with traditional surgery

For many years, radical prostatectomy for prostate cancer has been done by means of an operation that requires a six- to eight-inch incision in the lower abdomen and blunt dissection, meaning surgeons use their fingers to locate and manipulate the prostate gland before excising and removing cancerous tissue.
In the last few years, many surgeons have switched to the laparoscopic approach, which involves making a series of small incisions in the abdomen and introducing instruments that allow surgeons to see inside the abdominal area in order to dissect and remove prostate tissue. The surgical robot is called daVinci ® [Intuitive Surgical, Sunnyvale, CA] and provides the surgeon with magnified 3D vision and miniature articulating robotic writed instrumentation.

The addition of the surgical robot as an assistive device to perform laparoscopic radical prostatectomy increases precision. "Using traditional laparoscopic instrumentation is challenging, It’s like operating with chopsticks. The vision is two-dimensional and the movements are counter-intuitive also. There's articulation of the ends of surgical instruments. Whereas with the robot, you have a 'wrist' that can turn 360 degrees, which makes it easier to suture," Dr. Patel said.
The robot improves magnification of the laparoscopic surgical field by a factor of 10 and provides three-dimensional vision, which allows surgeons to see small vessels and close them with sutures. Consequently, there is less loss of blood and a 0-1 percent need for trans-fusions.
"Robotic prostatectomy makes a good surgeon even better because it enhances what you can do. It improves your ability to see the surgical field and allows increased surgical precision. This is important when attempting to remove the prostate while preserving the delicate nerves necessary for continence and potency," Dr. Patel said.
The study included men who had undergone robotic radical prostatectomy in the past two years. Oncologic outcomes were very favorable with a low positive margin rate. The clinical literature indicates that laparoscopic and open radical prostatectomy produce the same degree of cancer control as measured by postoperative levels of prostate specific antigen (PSA), an enzyme produced by the prostate gland that is elevated in the presence of cancer, and survival rates.
"A small number of series of clinical investigations have indicated that PSA levels and survival rates after laparoscopic prostatectomy are equivalent to the rates achieved with open operation," Dr. Patel explained.
Robotic-assisted radical prostatectomy is not yet widely available. The daVinci ® Surgical System is frequently used by surgeons to perform heart surgery and general laparoscopic procedures, such as gallbladder removal, treatment of gastroesophageal reflux disease, and gynecologic treatment. However, only about 100 centers in the United States and Europe offer robotic-assisted prostate surgery, according to Dr. Patel. The surgical robot also is expensive; the device costs approximately $1.3 million.

How many robotic operations has a doctor done?

Surgeons must be trained in the use of the robot. The training sounds quite minimal -- it usually involves attending a two-day course, observing about four surgical operations, and performing two procedures under supervision.
The newness of robotic surgery and this short period of training clashes with one of the main rules of cancer patient self-care -- choose a doctor (whatever the procedure) who has a lot of experience and a good, long track record.
"There's a great deal of adaptation in using robotics to perform surgery," Dr. Patel said. "For the first time, surgeons are not standing next to or actually touching the patient. They're sitting at a console and are connected to the robot by wires. They're not even scrubbed or in a surgical gown. That approach takes a bit of getting used to," he added.
The demand for robotic-assisted radical prostatectomy is growing. Dr. Patel and his colleagues perform eight to 10 robotic procedures a week, largely as a result of word of mouth by patients, he said. Men are flying in for the procedure from as far away as India and parts of Europe.
"We thought we would maybe perform 50 cases a year with the robot, but now we're estimating over 300 a year, and all because patients come in and say they want it. I think the addition of robotic assistance to prostate cancer surgery has really helped to decrease patient morbidity without sacrificing functional or oncologic outcomes. As larger series with long term data are published, we will begin to see the true efficacy. It definitely has the potential to become a standard of care in the future," Dr. Patel concluded.

More information about Dr. Vipul Patel

Other recent results from robotic prostate surgery

Robotically assisted laparoscopic prostatectomy: An assessment of its contemporary role in the surgical management of localized prostate cancer. **Am J Surg**. 2004 Oct;188(4 Suppl 1):63-7, J. A. Smith Jr., Vanderbilt University Medical Center, Nashville, Tennessee. Found no difference in immediate side effects: "no difference was seen in postoperative pain, length of stay, or requirement for blood replacement. However, the most important outcome measures are tumor control, continence, and sexual potency. The outstanding visibility and precision afforded by the robotic approach may offer advantages in each of these areas."
Robotics in urology. **Curr Opin Urol**. 2004 Mar;14(2):89-93. A. K. Hemal and M. Menon, Vattikuti Urology Institute K-9, Henry Ford Health System, Detroit, MI. " The impact of robotics is ... very promising. However, controlled clinical trials and comparisons from various centers are needed. Other important concerns are the cost and training implications. Future application may also allow integration of pre- and intraoperative imaging in the management of urological diseases. In the not too distant future, newer robotic instruments will be added to the armamentarium for performing different urological procedures. "
The technique of apical dissection of the prostate and urethrovesical anastomosis in robotic radical prostatectomy. BJU Int. 2004 Apr;93(6):715-9 Menon M, Hemal AK, Tewari A, Shrivastava A, Bhandari A**.** Vattikuti Urology Institute, Henry Ford Health System, Detroit, MI "Over 550 robot-assisted radical prostatectomies have been undertaken using Vattikuti Institute Prostatectomy (VIP) technique in patients with localized carcinoma of the prostate. *We present a critical analysis of the first 120 procedures by one surgeon (M.M.)* at our institution using this newly developed technique of urethrovesical anastomosis preceded by dissecting the apex of the prostate.... "All but 24 patients had their catheter removed 4 days after surgery, as indicated by a cystogram. The catheter was removed successfully at 7 days in the remaining 24 patients who had a mild leak on cystography. Two patients had urinary retention within a week of removing the catheter and had to be re-catheterized. Continence was evaluated using standardized criteria before and after the procedure. The patients also replied to a mailed validated questionnaire survey; 96% were continent at 3 months and the remaining 4% used a thin pad for security."

Edited by J. Strax, Oct 18, 2004

Answer for Collaborative Staging Schema raised during Panel discussion at Fall meeting: Question-What staging schema do you use if you have a case of lymphoma of the brain (and no lymphoma anywhere else in the body) Answer: (Per Valerie Vesich at ACOS CoC, you would code the primary site as Brain, but use the Lymphoma CS staging schema.

Message from Linda Mulvihill: "Thanks to everyone for the poster that ANCCR members signed at the fall meeting. I have it hanging on my office wall. I was touched by all of the people who expressed their appreciation. I miss everyone, but I do like my new job."

Hospital Profile

FirstHealth Moore Regional Hospital
PO Box 3000
Pinehurst, NC 28374

The Cancer Registry at FirstHealth Moore Regional Hospital, then known as Moore Memorial Hospital, was started back in the dim mists of time by Sister Anne Marie, who was a charter member and first treasurer of the Tumor Registrars Association of NC, later to become the Association of North Carolina Cancer Registrars.

She started with some index cards and a desk in a corner of the medical records department. Now we have all the requisite electrical equipment and a lovely office near the main hospital entrance with a whole wall of windows overlooking begonias, crepe myrtles and other kinds of greenery. There are bird feeders and a birdbath so we can enjoy watching the lively antics of the birds and observing the seasons change.

The Cancer Registry at MRH is part of the Oncology Service Line and our cancer program is very much a team effort. We were approved as a Community Hospital Cancer Program in 1995; the registry was staffed by one supervisor, one registrar and a part time follow up technician; the analytic caseload that year was 832. Approval as a Community Hospital Comprehensive Cancer Program came in 1999; registry staffing was up to 3.5 and the analytic caseload was 901. The new facility for the cancer program opened in December 2000 and we moved into our new office space in February 2001.

Our most recent survey was May 18, 2005 when Dr. Frederick Greene came to check us out. We received notification on July 12 that we were awarded a 3-year approval with commendation. We met all the available commendation standards so are hoping we will receive an Outstanding Achievement Award. We have maintained our staffing at 3.5 FTE's and our 2004 analytic caseload was 1041.

Elaine Rahal, CTR, has been with the MRH registry since 1992. Her prior training was in histopathology and her experience and knowledge of that subject is very valuable to our work. In 2000, she switched from full time registrar to part-time follow-up technician. She has two children, Reno (25) and Laura (21) and one 5-year-old grandson, David, who adores his Nana. Elaine is looking forward to participating in a mission trip to Kenya in January.

Leta Vess, CTR, entered the wonderful world of cancer registry in 1997 after working briefly in medical records processing and became supervisor in January 1999. She is very detail oriented (not to say nit-picky!) and is proud of the contributions cancer registrars make to cancer research. She says her co-workers make being a supervisor easy and her boss and the entire oncology service line make maintaining our ACoS approval relatively pain-free. Her three children are Joe (26), Katharine (23) and Mary Frances (16). Katharine is a Peace Corps volunteer in Ukraine.

Debbie Greenspon, CTR, with a background in accounting, began in the registry in 1998 as the follow up technician and then moved to a registrar position. She has very good organizational skills that help our registry run smoothly. She has completed her AA degree and is working on a Bachelor's degree at Oregon State University via the Internet. Her husband, Andy, works in the MRH Imaging Dept. and they have 4 cats and a sailboat. Debbie is also an excellent photographer.

Carla King, RHIT, CTR, worked in medical records in many capacities, including supervising and coding, at MRH for 14 years and transferred to the Cancer Registry in 1999. Her thorough knowledge of medical records science and hospital procedures is very helpful to registry operations. She has twin sons, James and William (23) and a daughter, Christa (10). She and her family are avid Carolina Panthers fans.

Even though we live here in Pinehurst, "the home of American golf," none of us or our spouses plays the game. However, Carla's daughter is learning to play and enjoys it very much. In addition to having a first class hospital, Moore County and the Sandhills area is also known for equine activities, including harness racing, steeplechases, and dressage events. There are a number of horse farms and training facilities and many horse trainers from the Northeast and Canada winter here with their horses. Northern Moore County is part of the famed Seagrove pottery area. So come to play golf, shop for pottery, see the horses or just relax.

FirstHealth Moore Regional Hospital Cancer Registry Employees

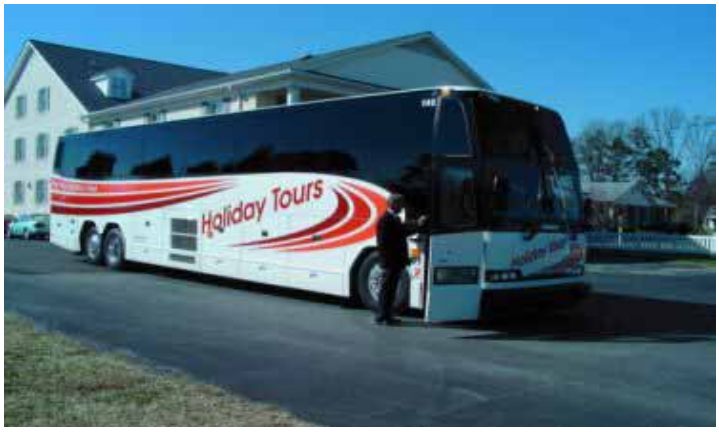
Pictured from left to right are: Elaine Rahal, Debbie Greenspon, Leta Vess, Carla King

NCRA ANNUAL MEETING MAY 4-7, 2006 Washington, DC

Too far to drive, too close to fly? Want to avoid heavy traffic, endless hours in an airport, lost luggage, high parking fees, airport shuttle costs?

If you would be interested in traveling to Washington on a “deluxe motor coach” with fellow NC Cancer Registrars, then read on. The cost would be about $120 per person. There are a lot of details to be worked out, so at this point I simply need to know how many people are interested.

Please complete the information below and return to Leta Vess, lvess@firsthealth.org, or Leta Vess, Cancer Registry, FirstHealth Moore Regional Hospital, PO Box 3000, Pinehurst, NC 28374. I will then contact those interested with more information closer to the event.



Deluxe Prevost Motor coaches,
the safest Motor coach on the road today
Courteous, Professional Travel Associates,
ready to help with all your travel needs
Professional, Safety Focused Motor coach Drivers,
committed to safe and pleasant travel
Premium Video Systems,
our fleet is video equipped for your enjoyment

NAME:

ADDRESS:

PHONE & EMAIL:

Letter from Editor:

I can't believe it's been a year since I first started publishing the newsletter. It's hard to imagine that the holidays are just around the corner, not to mention winter time. (Hopefully, this is not going to be a harsh winter due to fuel costs) It has been a challenging but fun year. One of the most challenging issues I want to tackle in the upcoming issues is to bring you informative issues with articles that you can use in your everyday work. I would like to challenge all the registrars to write an article for one of the upcoming issues and submit it for publication. It can be from an individual or an entire registry can help out with the article. There is no limit to the number of articles you can submit. Let's help each other out with all our knowledge and expertise! You can even get your doctors to submit articles that they have either written on or would be willing to write about.

Don't forget to send me your hospital profile. If you didn't get one at the fall meeting or have misplaced your copy, please either call or e-mail me. My phone number is (336) 832-0832 and my e-mail address is adaline.brown@mosescone.com. We want to ensure that all your hospital information is correct before putting the information in the updated hospital book coming out next year. If your hospital has not been profiled in the newsletter, please let me know if you are willing to do an article for your hospital.

It's time again to renew both your NCRA and ANCCR membership. NCRA membership is $85 ($80 + $5 CE fee). This year you don't have to wait for your 2006 membership to come thru the mail. You can renew online at http://www.ncra-usa.org.
ANCCR dues are $25 and must be paid before December 15th in order to avoid a late penalty of an additional $25. **Note**: There will be **no exceptions for the $25 penalty this year**. You can download an ANCCR membership form at: http://www.ncregistrars.com.

The deadline for submission of articles for the Nov/Dec issue is Nov. 23rd. If you have any ideas or articles of interest for the holiday season, please send them to Adaline.brown@mosescone.com.

Give yourself a break this holiday season and start shopping early and above all else make some time for yourself!

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Reminders and Updates

- Seer Reliability CS Study Test: November 7th (8:00am) thru November 28th (8:00am)
- 2005 ANCCR Annual Meeting Presentations available at: http://www.ncregitrars.com. Currently under "Calendar of Events" but will be moving to "Members Only Section" in the near future. CE information for the fall meeting will be posted on the website.
- Survey Savvy Workshop: November 14-15, Chicago, IL
- Seer Melanoma Web-Based Training Module available at http://training.seer.cancer.gov.
- Varian and Onco Log have merged.
- HIGHLIGHTED version to the FORDS manual and updates of changes as of 10/11/05 available at: http://www.facs.org/cancer.coc/fords manual.html
- Replacement pages for Collaborative Staging Manual Part 1, Version 01.00.00 incorporating minor page corrections thru July 15, 2005 available on the AJCC website: http://www.cancerstaging.org.

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