The Sentinel

The Newsletter for the Association of North Carolina Cancer Registrars

Fall 2014

Message from the President:
Leta Vess, BA, CTR

Hello, ANCCR members,

The 2014 ANCCR meeting in beautiful New Bern was very informative and fun despite the rainy weather. Thank you to Ann Murphy and Doris Jones of the CarolinasEast Cancer Registry for putting together such a great meeting. It is a treat to have an opportunity to meet people new to cancer registry in NC and renew acquaintances with those we see only once or twice a year. Plans are already being made for next year's meeting to be held in the Raleigh/Research Triangle area.

I would also like to thank the members of ANCCR for the opportunity to serve as president of our great organization. I look forward to working with the other elected officers: Joanne Essick, Vice President; Kelly Lowrance, Treasurer; Linda Lucas, Secretary. The other board members are listed on the ANCCR website, www.ncregistrars.com, and they are to be congratulated as well for volunteering their time and energy to ANCCR.

As you read the reports from the various committees in this issue of the Sentinel, please know that ANCCR welcomes your participation as well as your comments and suggestions. Please contact any of the officers or board members to volunteer or to share your thoughts.

Best wishes for a peaceful November.

ANCCR's Executive Board 2014-2015

President: Leta Vess, CTR lvess@firsthealth.org **Immediate Past President:** Ann Murphy, CTR amurphy@carolinaeasthealth.com **Vice President:** Joanne Essick, BA, CTR jessick@armc.com **Secretary:** Linda Lucas, CTR llucas@novanthealth.org **Treasurer**: Kelly Lowrance, RHIT, CTR kalowrance@novanthealth.org **Ways & Means:** Kimberly Bobbitt and Kisha Raynor, CTR kisha.raynor@carolinashealthcare.org **Grants & Vendors:** Paige Tedder, CTR Paige.tedder@carolinashealthcare.org Kathleen Foote, CTR Kathleen.foote@rexhealth.com **Program Coordinator**: Deborah Carrethers,CTR dgcarrethers@novanthealth.org **Bylaws:** Adaline Brown, RHIT, CCS, CTR abrown@certicode.com	**Membership:** Vickie Gill, RHIA, CTR vagill@novanthealth.org **Education**: Jenean Burris, RHIT, CTR jburris@wakehealth.edu **Educational Scholarship:** Inez Inman, BS, RHIT, CTR iinman@wakehealth.edu **Historian**: Deborah Poovey, RHIT, CTR dpoovey@catawbavalleymc.org **Nominating**: Blanche Sellars, CTR annie.sellars@rexhealth.com **Publications**: Inez Inman, BS, RHIT, CTR iinman@wakehealth.edu **Web Site Coordinator:** Cathy Rimmer, BA, MDiv, CTR ccrimmer@novanthealth.org **A4C Liaison:** Leta Vess, CTR lvess@firsthealth.org **NCRA Liaison:** Melanie Rogan, CTR melanie@ers-can.com **Central Cancer Registry Liaison:** Melissa Pearson, CTR Melissa.pearson@dhhs.nc.gov

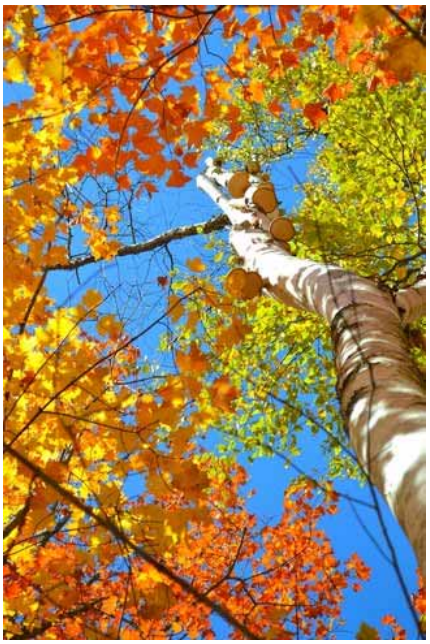
2015 ANCCR Fall Meeting
Raleigh, NC

2015 NCRA Educational Conference
San Antonio, TX
May 20-23

2015 NAACCR Annual Conference
Charlotte, NC
June 13-19

2016 NCRA Educational Conference
Las Vegas, NV
April 10-13

2017 NCRA Educational Conference
Washington, DC
April 5-8



TREASURER'S REPORT
Net Worth – As of 9/16/14

Account	Balance
ASSETS	
Cash and Bank Accounts	
ANCCR Checking	**18,373.40**
Money Market	**30,796.23**
Shares Account	**60.26**
TOTAL ASSETS	**49,229.89**
LIABILITIES	**0.00**
OVERALL TOTAL	**49,229.89**

BYLAWS REPORT

Adaline Brown, RHIT, CCS, CTR

The purpose of bylaws is to allow the ANCCR executive board and members of our organization to understand the rules, policies, and procedures. Bylaws provide consistency to help ANCCR function in accordance with its purpose and function. The ANCCR board felt that the following proposed bylaws were necessary in order to keep up with the times.

ANCCR Current Bylaws:

PROPOSED CHANGE – Passed at the ANCCR Fall Meeting 2014

1. Elections shall be by ballot. The Nominating Committee shall be responsible for the preparation of the ballots and distribution of ballots at least 60 days prior to the Annual Meeting.
2. Election shall be by a plurality of the votes cast by the active and associate members. In case of a tie, the election shall be decided by lot.
3. The Nominating Committee Chair and two (2) members of the Nominating Committee shall count ballots.
4. Elected officers shall assume office following their installation.

GRANTS AND VENDORS

Paige Tedder, RHIT, CTR

We have 10 vendor tables this year. Three Commercial Vendor fees of $900. Four Non-Profit vendor fees of 345.00. Four additional lunches purchased $72.00. We also provided free vendor tables to Pfizer for providing lunch Wednesday, Amgen who gave $1300.00 and Genomic Health who will bring a speaker and gave $1000.00. ERS and RCA also donated $500.00 each.

TOTAL VENDOR FEES: $1317.00
TOTAL DONATIONS: $3,300.00 plus lunch and speaker

EDUCATION REPORT

Jenean Montgomery Burris, RHIT, CTR

The new academic year has begun at Davidson County Community College! There are seven students that are preparing to graduate in May who will need places to complete their required 160 hours of hands-on experience during the Spring semester. The students are located around the state, with one out-of-state student from Virginia.

160 Clinical Hours required include:

84 hours	*Data Collection(Abstracting) including ICD-O-3 Coding, Staging (CS, AJCC TNM, SEER Summary), Treatment*
	**minimum of 30 abstracts to be completed*
13 hours	*Follow-up*
10 hours	*Cancer Committee Activities*
9 hours	*Reporting*
8 hours	*Required Files (Suspense, MPI, P&P, etc)*
8 hours	*Quality Control*
8 hours	*Quality Management Studies*
7 hours	*Casefinding*
5 hours	*Cancer Conference*
3 hours	*Legal/HIPPA*
3 hours	*Central Registry Operations*
2 hours	*Electronic Medical Reporting (EMR) Training*

Between September 2013 and September 2014 there have been 22 people, in North Carolina, to pass the CTR exam! Congratulations to the new Certified Tumor Registrars! The next CTR exam will be given October 18-November 8, 2014.

ICD-10 REMINDER for those CTRs that also hold RHIT/RHIA credentials!!!

AHIMA Certified Professionals can begin earning ICD-10-CM/PCS specific CEUs during the period of January 1, 2011 thru December 31, 2015. This is the new deadline, due to delay in implementing ICD-10. There are several online CEU opportunities offered through AHIMA to meet the requirements.

RHIT – 6 CEUs required
RHIA – 6 CEUs required

WEB SITE AND A4C REPORT

Cathy Rimmer, BA, MDiv, CTR

Web Site Report

The job posting listing is current. Recorded copies of the NAACR webinars are uploaded to the web site when they become available. Members who register for the "Members Only" section, once you register your information, you will be sent a link in the email you have provided. You must click on the link in the email and follow the instructions to complete the registration process. The web site will be updated with the new board after the election.

For members – use the Board member listing to contact specific board members about issues instead of using the "contact us" form on the web site. All those "contact" questions are routed to Cathy Rimmer – who in turn must route them to the appropriate board member. So, for example, for questions regarding membership, contact the membership chair listed under the Board members. There is an email link to the Board members. This will expedite answers to your questions.

NC Advisory Committee on Cancer Control and Coordination

My term ended in August as the ANCCR representative to the A4C.
I served 9 years. The Board nominated Leta Vess to be my replacement.
This nomination was submitted to the Governor for approval.
Once approved, Leta Vess will attend the meetings and give updates to the ANCCR board and membership.

MEMBERSHIP

Vickie Gill, RHIA, CTR

There were 118 ANCCR members as of September 2014.

ANCCR membership renewal for 2014-2015 is due by December 1, 2014. You can download the membership application from ANCCR's website (ncregistrars.com) under the About ANCCR tab.

NCRA LIAISON REPORT
Melanie Rogan, CTR

2015 NCRA Conference to be held in San Antonio, TX – May 20-23, 2015

Chufar Annual Conference Scholarship
The scholarship provides financial support to an NCRA member with no available funding to attend the annual conference. To be eligible, members must complete an application and write a 500-to750-word essay. The 2015 theme is: Beyond Collaborative Stage: What Impact Will the Transition to AJCC Stage and NCI Summary Stage in 2016 Have on Cancer Registrars. The deadline to submit the application for the scholarship is December 11, 2014.

WAYS AND MEANS REPORT
Deirdra Greene and Deborah Carrethers

Thanks to everyone for participating in For What's in the Box and the $100 in the Frame raffle. Ways and Means raised over $400 this year.

The new Ways and Means Chair persons for the upcoming year are Kimberly Bobbitt and Kisha Raynor.

NOMINATING COMMITTEE REPORT
Blanche Sellars, CTR

Election results at the ANCCR Fall Meeting:

President:	Leta Vess, CTR
Vice-President:	Joanne Essick, BA, CTR
Secretary:	Linda Lucas, CTR
Treasurer:	Kelly Lowrance, RHIT, CTR

REPORT FROM THE NC CENTRAL CANCER REGISTRY
Melissa Pearson, CTR

Staging: Focus on the Timing Rules
Preparing for the transition to directly coded AJCC TNM and Summary Stage, Article 2, October 2014
Melissa Pearson, CTR, NC Central Cancer Registry

Once the order in which the events in the case took place and the answers to the critical questions listed in Article 1 are known, the timing rules can be applied. The timing rules include several key words or concepts that will be discussed in more detailed in this article. These concepts are not necessarily described in detail in the AJCC Cancer Staging Manual and can often cause problems when staging cases.

Please note that the following information is based on the general rules only. There may be site specific rules that vary from the general rule and take precedence over the general rule. Before staging a case, be sure to review the site specific chapter thoroughly for any site specific exceptions.

In addition, this article focuses only on the terminology and concepts specified in the timing rules only. There are many components to staging such as which procedures can qualify for clinical or pathologic staging, how to assign the stage group, special classifications and rules for cases treated with neoadjuvant therapy, etc. Some of these concepts will be highlighted in future articles or webinars.

Clinical Stage Timing Rule, AJCC Manual p.4
"Clinical staging includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within 4 months after the date of diagnosis, whichever is shorter, as long as the cancer has not clearly progressed during that time frame."

The clinical stage timing rule STOPS when any one of the following occurs:

1) Definitive treatment begins

"Definitive treatment" is a key phrase in the definition and encompasses many facets of the treatment decision. Definitive treatment includes all methods of treatment given as part of the first course of treatment plan or established protocol. In addition to surgical resection, chemotherapy, radiation therapy, and hormone therapy, "definitive treatment" also includes the following:

- No treatment
    - Active surveillance, watchful waiting, no treatment recommended
    - Patient or family refuses treatment
    - Patient dies before treatment begins
- Maintenance treatment (if given as part of planned first course of treatment)

- Palliative care (if given as part of the planned first course of treatment).

In these cases, only the information defined prior to making the decision for palliative care or no active treatment may be used for assigning the clinical stage. Any information obtained after the decision for active surveillance or palliative care may not be used in assigning the clinical stage.

Definitive treatment also includes situations where the patient received "neoadjuvant treatment". Neoadjuvant treatment is given as a first step to shrink a tumor before the main treatment, which is usually surgery. Methods of therapy given prior to surgery usually include chemotherapy or radiation therapy but can also include hormone or immunotherapy. Any information obtained after neoadjuvant treatment began may not be used in assigning the clinical stage.

2) 4 months after the date of diagnosis, whichever is shorter

The next section of the clinical stage timing rule states: "or within 4 months after the date of diagnosis, whichever is shorter."

This segment is probably the most misunderstood section of the timing rule. Most cancer diagnoses will have a treatment plan developed and initiated as quickly as possible after the diagnosis is confirmed. However, there are cases where it is not possible to obtain enough information to determine the date that definitive treatment began or there is an unusual delay in the start of the planned treatment. It would be very difficult to evaluate and compare the clinical stage across a spectrum of cases if the information included was based on infinite amount of time into the future, especially given the fact that the cancer is likely to continue growing and spreading over time if not treated. This segment of the timing rule provides a stopping point in which information may be used for assigning the clinical stage. In cases such as these, only the information available within four months after diagnosis can be used to assign the clinical stage.
If the date that definitive treatment began IS known, then that date must be compared to the 4 month mark to determine which date occurred first. Did the 4 month mark occur first or did the date definitive treatment began occur first? Keep in mind that "definitive treatment" includes no treatment and the various other choices discussed above. In these cases, only the information available within that shortest date from diagnosis can be used to assign the clinical stage.

Examples:

Example 1		**Example 2**	
Date of Diagnosis:	04/12/2014	Date of Diagnosis:	04/12/2014
4 month from Dx mark:	08/12/2014	4 month Dx mark:	08/12/2014
Date definitive treatment began:	06/05/2014	Date definitive treatment began:	10/17/2014
Shortest date from diagnosis:	06/05/2014 (date treatment began)	Shortest date from diagnosis:	08/12/2014 (4 months after dx date)
Cutoff for including information for clinical staging:	06/05/2014 (date treatment began occurred first)	Cutoff for including information for clinical staging:	08/12/2014 (4 months after dx date occurred first)

3) Clear progression of disease

The last section of the clinical stage timing rule states: "as long as the cancer has not clearly progressed during that time frame."

In determining what information can be included in the clinical stage, the abstractor must also make sure that the disease status did not change during the clinical stage timing rule time frame. This is not a common occurrence and can be difficult to remember to make that differentiation. In order for there to be a "progression" there must have been a previous evaluation, assessment or statement that established the initial status of disease involvement. For example, in March there was no evidence of involvement of a particular site/organ. Now in April, things have changed and further evaluation now shows clear evidence involvement. To take this one step further, this progression of disease had to have occurred in the time frame between the date of diagnosis and the cutoff date for including information for clinical staging (defined above). In these cases, only the information available prior to the documented progression of disease and prior to the initiation of definitive treatment can be used to assign the clinical stage.

Caution: If the findings from a particular imaging scan are negative, the patient may be sent for a more sensitive imaging scan or the same imaging may be performed but with a different contrast that will allow certain structures to be seen. This is not progression of disease when the intent is to establish the initial status of disease.

But what about….

…Clinical staging workup that is done after the surgical resection?

It is quite common for staging to be completed after the surgical resection. Clinical staging workup done after the surgical resection can be included in the clinical stage if it is clear that any positive findings are not due to progression of disease and it is within 4 months of diagnosis. If we were to always stop at the time of surgery without regard to what is happening in the workup of the patient, then very important information would be left out of the clinical stage.

Example:

05-31-20xx, Right hemicolectomy: Adenocarcinoma, 4/21 positive lymph nodes. During surgery, surgeon states liver and other abdominal organs are normal on the intraoperative examination.

D/C summary: Adenocarcinoma right colon pT3 pN2 cM0. Complete staging with a scan and CEA.

07-09-2013, CT C/A/P: Lesion in liver suspicious for mets.

07-19-2013, Oncology Consult: CT C/A/P revealed liver mets. This would be mets from the known colon cancer. Patient is candidate for liver resection after chemo.

In the case above, M1a should be entered as the cM value. If it is clear this was not due to progression, and the staging tests were not done until after surgery, this information should be included in the clinical stage. Remember, staging is used for patient care, and vital information should not be excluded. The cM1a allows this case to correspond to the patient's survival.

…Clinical staging workup that is done before a definitive diagnosis is made?

Think about why the physician is ordering additional workup or what information is being taken into consideration when selecting the appropriate surgical treatment. More than likely, this was due to a suspicion of cancer. If there was suspected cancer, then this information (imaging, physical exam, etc.) can be used to assign the clinical stage. This is different from the cancer being found incidentally during a surgery for other reasons and there wasn't a suspicion of cancer before the surgery. To eliminate the use of clinical information obtained before the diagnosis date when there is a suspicion of cancer would eliminate a vast amount of useful information.

Example: Scans prior to surgery show a 2cm kidney tumor with no adenopathy or mets. "Tumor" is not a definitive diagnostic term. The kidney is resected and findings are consistent with renal cell carcinoma. The patient is not actually diagnosed with cancer until the surgery. The information from the pre-surgical scans can be used to assign the clinical stage (cT1a cN0 cM0).

Summary…Before attempting to assign the clinical stage:

- Determine the date that definitive treatment began. The first step in definitive treatment may not be a surgical resection.
- Compare the date that definitive treatment began to the 4 month mark from the date of diagnosis. Determine which one of those two points is shorter. Any information obtained after that shortest point may not be used in assigning the clinical stage.
- Determine whether or not there was clear evidence of progression before initiation of treatment. Any information obtained after there is documented progression of cancer and prior to the initiation of definitive treatment may not be used in assigning the clinical stage.
- Remember that it is not uncommon for staging workup to be completed after surgery and there may be applicable clinical information available before a definitive diagnosis is made.

Pathologic Stage Timing Rule, AJCC Manual p.4

"Pathologic staging includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within 4 months after the date of diagnosis, whichever is longer, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame."

Once the key words and concepts for the clinical stage timing rule are understood, the timing rule for pathologic staging becomes easier to understand as well. Remember that there may be site specific rules that vary from the general rule and take precedence over the general rule. Before staging a case, be sure to review the site specific chapter thoroughly for any site specific exceptions.

The pathologic stage timing rule STOPS when any one of the following occurs:

1) Completion of definitive surgery as part of the first course of treatment

In the clinical stage timing rule, the criteria for when clinical staging stopped included the initiation of all methods of definitive treatment. Pathological staging; however, relies heavily on what is learned about the cancer during surgery. Therefore, the focus of the pathologic stage timing rule is on information gained through the completion of definitive surgery. Therefore, the pathologic timing rule specifically states that information gathered up through and including the most definitive surgical resection can be used for assigning the pathologic stage.

2) 4 months after the date of diagnosis, whichever is longer

Just as with the clinical stage timing rule, this segment of the pathologic stage timing rule provides a stopping point in which information may be used for assigning the pathologic stage.
The date that the definitive surgery was performed must be compared to the 4 month mark to determine which date occurred last. Did the definitive surgery occur last or did the 4 month mark occur last? Because pathologic staging relies heavily on the findings from the surgery in the first course of treatment, it is important that the timing rule allow that information to be included should it occur more than 4 months from the date of diagnosis. Therefore, the timing rule specifies that information through whichever one of these dates occurred last can be used. In these cases, the information available through that last or furthest date from the date of diagnosis can be used to assign the pathologic stage.

3) Initiation of systemic or radiation therapy

The timing rule goes on to state "as long as…" There are situations in which the timing rule may stop prior to that furthest date (the definitive surgical resection or the 4 month mark).

If, at any point, the patient receives treatment other than surgery, the pathologic stage timing rule stops. This other treatment may be given before or after the planned surgical resection. Any information obtained after the initiation of systemic or radiation therapy cannot be used to assign the pathologic stage.
Note regarding neoadjuvant treatment: If the patient receives systemic or radiation therapy prior to surgery, the findings from the surgical resection cannot be used to assign the pathologic stage (pTNM). The information obtained from a surgical resection performed AFTER the patient receives neoadjuvant systemic or radiation therapy may be eligible for the post-therapy or ypTNM stage. Staging of neoadjuvant cases will be discussed in a separate article.

4) Clear progression of disease

Just as with the clinical stage timing rule, information obtained after there is clear progression of disease cannot be used to assign the pathologic stage. Again, this is progression of disease that would have occurred in the time frame between the date of

diagnosis and the cutoff date for including information for pathologic staging (defined above).

Summary…Before attempting to assign the pathologic stage:

- Determine the date of the most definitive surgery in the first course of treatment.
- Compare the date of the most definitive surgery in the first course of treatment to the 4 month mark from the date of diagnosis. Determine which one of those two points is longest. Any information obtained after that longest point may not be used in assigning the pathologic stage.
- Any information obtained after the initiation of systemic or radiation therapy cannot be used to assign the pathologic stage (pTNM). If the patient receives neoadjuvant therapy, the findings from the surgical resection may be eligible for the post-therapy or ypTNM stage.
- Determine if there was clear evidence of progression during the timeframe defined above. Any information obtained after there is documented progression may not be used.

A special thank you to those who reviewed this article and brought to light some areas of confusion and misunderstanding. This article started out as 2 pages and continued to grow as I tried to clarify some of these issues. It just goes to show how complex staging really is. And, as we have been spending countless hours trying to get a handle on Collaborative Stage over the last 10 years, AJCC staging has continued to evolve. There are many concepts that have changed. A very good point was made in the October NAACCR webinar. Remember that the manual was written for physicians. And, it was written with rules that are more flexible than we are used to seeing in Collaborative Stage. The physician has to be given the flexibility to use his/her expertise to make a determination as to the stage. Unfortunately, that means that we, as cancer registrars, will not have the very finite, specific rules we are used to. There will always be a lot of “what if’s” that will trip us up. It may be helpful to think about what the goal of staging is and what information the stage is intended to convey. We must rely on indications from the physician and look at each situation individually to make certain decisions as to the stage.

Next article: Staging classifications for certain procedures: biopsies, intra-operative findings, etc.
Future articles: Stage grouping, Staging in situ cases, Staging cases with neoadjuvant treatment.

EDUCATIONAL SCHOLARSHIP
2014 Theme - Winner: Lori Boice, RHIT, CTR

How Has the Cancer Registry Profession Evolved and What Does the Future Hold

Although I am a relative newcomer to the field of cancer registry compared to those who are celebrating with NCRA their 40th anniversary, I have witnessed and adapted to a number of significant changes in the profession. Along with those changes, I have marched forward into the future of personalized medicine.

In 2006 when I first stepped enthusiastically into cancer registry (I'd had my goals set on this since attaining my RHIT in 1997), we still pulled paper charts according to terminal digit filing, still had managing physicians completing AJCC staging on paper forms, and were just dipping our toes into an electronic Radiation Oncology management software tool. Fortunately, it didn't take me long to get the knack for learning my way around the paper chart to find the critical data required for entry into and reporting from a registry database because close on the heels of this was the introduction of the new Multiple Primary and Histology coding rules in 2007. As I continued to hone my skills as a newly certified registrar in 2007, life events in 2008 took me away from the mainstream of registry work. Still holding onto the desire to be a force in the fight against cancer, I was determined to keep up my skills even in the face of more new and updated rules in 2010 – the AJCC 7th Edition Cancer Staging Manual, the typical updates to the FORDS Manual, and a major overhaul of the Collaborative Stage Data Collection System. To achieve this I subscribed to many webinars presented by the standard setters and attended local and regional cancer registry educational seminars that dealt with these changes. In addition to these resources, I landed an adjunct faculty position at a community college teaching a course in Cancer Information Management. The performance of these duties required me to not only know basic cancer biology, but to stay up-to-date on the general rules of cancer case-finding and reportability. Continuing in this manner to keep my skills current lasted until 2010 when I was awarded a CTR credential preferred position in a teaching institution involved with supporting multi-disciplinary cancer researchers, a position I currently hold. In order to meet the expectations of the position, I am required to know and understand: which histologies are malignant vs non-malignant; to interpret and apply the appropriate rules of data collection to disease diagnosis, treatment, and staging; to know which biological marker test results are currently used in clinical practice and to translate this knowledge into the parameters the researcher desires that will yield compliant tissue samples from the institution's biobank.

My responsibilities in supporting cancer researchers have raised my awareness of the "personalized medicine" concept. Being a project coordinator in NCI's project, The Cancer Genome Atlas (TCGA), highlights the importance of understanding DNA errors responsible for causing cancer. As time goes on, more of these genome errors are detected and, in response, laboratory tests to identify them and agents to interrupt their propagation are discovered. These data then become critical for registrars to collect in an effort to show trends in early detection and efficacy in targeted therapeutics. Ultimately, science may rely on some of this data to use in cancer prevention. Because of this cascade in discovery, cancer registrars will need to be attuned to the language of genomics, the crux of personalized medicine.

For me to have come to where I am from where I started, it was crucial that NCRA, national standard setters, and state cancer registry organizations supported me in delivering new-found knowledge about cancer and kept pace by guiding the collection and dissemination of accurate and complete data that has driven cancer discoveries for decades. Through continued learning,

along with the brilliant science being conducted, I am committed to providing reliable data so that cancer may become a more manageable, less devastating disease.

HOSPITAL PROFILE

FirstHealth Moore Regional Hospital

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 electronic 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. For the past several years, we have enjoyed watching the antics of a family of hawks who have nested on the roof of the hospital.

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 7, 2014, when Dr. Frederick Greene came to check us out. A few weeks later we received notification that we were awarded a 3-year certification with gold

level commendation. We met all the commendation standards so are hoping we will receive an Outstanding Achievement Award. The FHMRH Cancer Program has received the Outstanding Achievement Award every time we have been eligible.

We recently took on the additional responsibility of doing the state reporting for the two other hospitals in the FirstHealth system: Richmond Memorial Hospital in Rockingham and Montgomery Memorial Hospital in Troy. Fortunately we were given an additional .5 FTE to accomplish this task. So we now have 4 FTEs and our 2013 caseload was 1497 cases, 1298 of which were analytic.

Elaine Jones, 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; now she has returned to full time status and is doing the state reporting for our sister facilities as described above. Elaine has two children, Reno and his wife Wendy, who live nearby, and Laura and her husband Jose, who live in the Atlanta area. She has two grandchildren, David, 14, and Aulani, 8, both of whom love their Nana!

Leta Vess, BA, 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 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 not as difficult as it could be. Leta's three children are Joseph and his wife Emily, who live in Washington, DC, Katharine, who lives in Pinehurst and Mary Frances, who lives in Madison, WI and works for everyone's favorite EHR software, Epic!

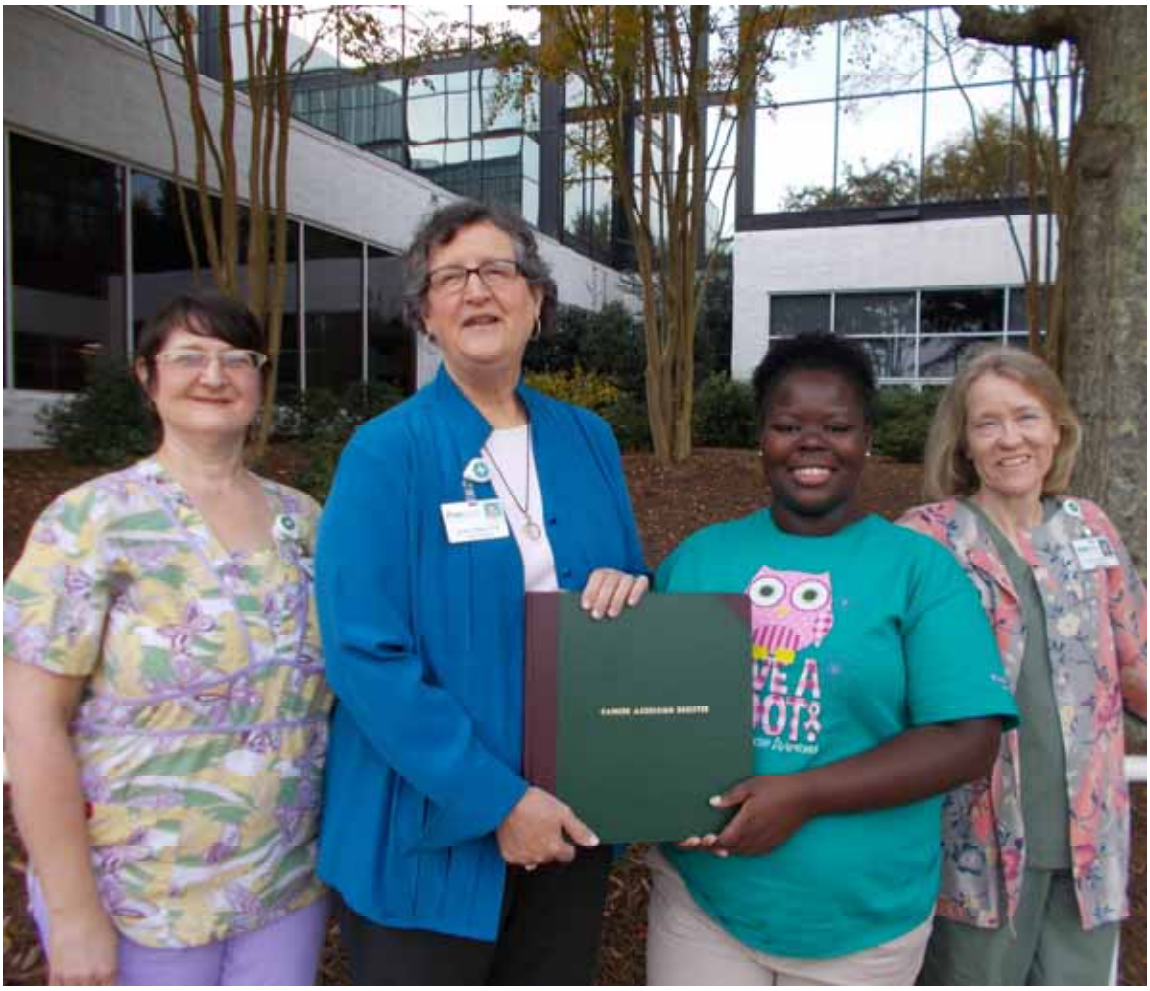
Desiree Montgomery, CTR, joined the FHMRH Cancer Registry in January 2012. She is a proud graduate of East Carolina University with a BS degree in Health Education and Promotion. We rely on Desiree for many things but her ability to use the latest electronic technologies is what we really appreciate. Desiree keeps busy playing with her 4 nieces and nephews, volunteering in her community and working on a Masters degree in Public Health.

Cathleen Cheyney, CTR, came to the FHMRH Cancer Registry in May, 2012 from Patient Accounts where she was a commercial biller. Her understanding of insurance and billing stuff is most helpful to all of us. Cathleen is also a CNA. She has an Associate Degree and is working on a Bachelors Degree. Her daughter Ashley lives in Reno NV and daughter Megan is a junior at Western Carolina University where she is majoring in Forensic Science and has been on the Dean's List every semester.

Desiree and Cathleen both took the CTR exam as soon as they were eligible and passed, much to everyone's delight and no one's surprise.

Even though we live here in Pinehurst, "the home of American golf," we are not golfers. However, there are over 40 golf courses in Moore County, so we are surrounded by lots of beautifully landscaped greens. In addition to being the home of a first class hospital, Moore County and the Sandhills area are also known for equine activities, including harness racing, steeplechases, and dressage events. 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.

Left to right: Cathleen Cheyney, Leta Vess, Desiree Montgomery, Elaine Jones.
Our office windows are behind Cathleen and Leta's heads.
We are holding the Cancer Accession Register from May 1985 with handwritten entries: name, address, sex, race, code number of first primary cancer and subsequent primary cancer, site, histologic description, physician, hospital number, date of diagnosis and date of death.



News – Facts – Articles – Updates
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Deadline for the next issue of *The Sentinel* is Febuary15, 2015.

Fall Splendor

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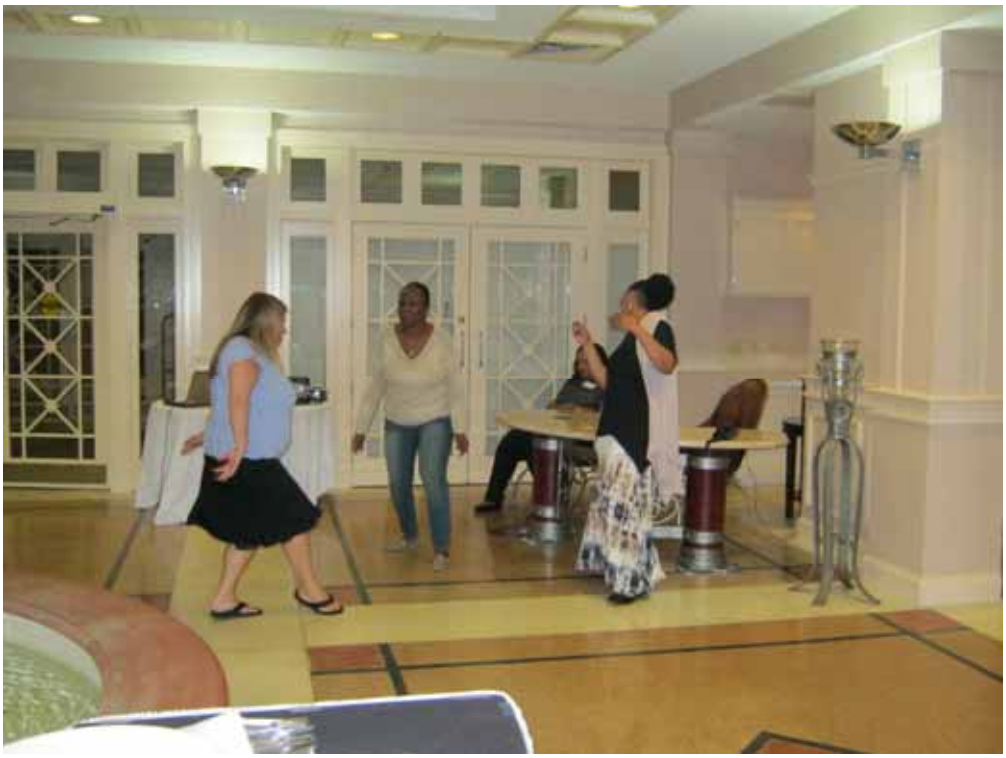
Photos from the ANCCR Fall Meeting in New Bern:

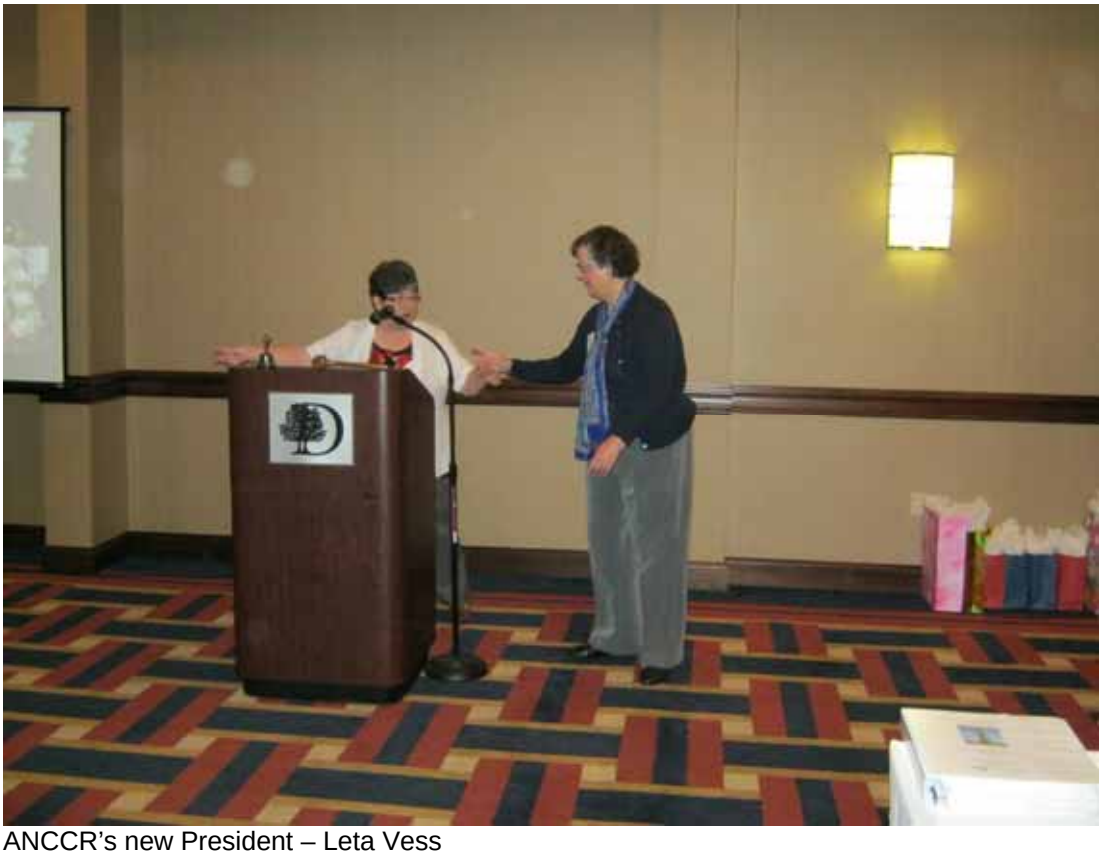

Left to right: Angela Rodriguez, Carrie Cerny, Melanie LaRusso, Kathy Foote, Jane Brown, Kim Swing, Ruth Maranda, Emily Urban, Blanche Sellars, Jennifer McLean

Board Recognition

Dancing at the Social



Showing How It Is Done



ANCCR's new President – Leta Vess

President Plaque to Ann Murphy

Survivorship Story – Beth Kaufman, Speaker