The Sentinel

The Newsletter for the Association of North Carolina Cancer Registrars

Fall 2016

Message from the President:

Jenean Montgomery Burris, RHIT, CTR

Fall President's Message

Happy Fall ANCCR members:

It's September! It is the time of year to start thinking about pumpkin spice everything, crisp, cool evenings, football, and our 1st ever Carolinas Regional Registrars Conference. It is right around the corner, September 21-23, 2016. The speakers that have been lined up are fantastic. We will have Steven Peace, CTR to help answer all of our AJCC staging questions, there will be a FORDS update by Dr. Rick Greene, a presentation highlighting the NC & SC Cancer Registry Data Uses, an in depth talk about coding radiation treatment and many more exciting presentations. And don't forget a social where we can eat, drink, and be merry! We can complain about discuss all the new changes, meet some new registrars and have a great time!

Don't forget to bring items for the silent auction, worth $15-$20, items can be wrapped or unwrapped. The wrapped items should be wrapped according to season/theme. I won an amazing Halloween themed dining table ensemble at the state meeting last year and it was wrapped in spider web wrapping paper! I love it! And this year you better believe I am going all out on wrapping the item I am bringing.

Enjoy the end of the Summer, stay safe. I hope to see you all at the Carolinas Regional Registrars Conference!

ANCCR's Executive Board 2016-2017

President: Jenean Burris, RHIT, CTR jburris@wakehealth.edu **Immediate Past President:** Leta Vess, BA, CTR **Vice President:** Kelly Lowrance, RHIT, CTR kalowrance@novanthealth.org **Secretary:** Kim Greene, RHIT, CTR kgreene@novanthealth.org **Treasurer**: Jennifer Mitchell-McLean, CTR jennifer.mclean@dm.duke.edu **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@unchealth.unc.edu **Program Coordinator**: Deborah Carrethers,CTR dgcarrethers@novanthealth.org **Bylaws:** Adaline Brown, RHIT, CCS, CTR abrown@certicoderegistry.com	**Membership:** Vickie Gill, RHIA, CTR vagill@novanthealth.org **Education**: Inez Inman and Jenean Burris **Educational Scholarship:** Inez Inman, BS, RHIT, CTR iinman@wakehealth.edu **Historian**: Deborah Poovey, CTR dpoovey7@gmail.com **Nominating**: Farrah Scodius, BS, CTR farrah.scodius@unchealth.unc.edu **Publications**: Inez Inman, BS, RHIT, CTR iinman@wakehealth.edu **Web Site Coordinator:** Cathy Rimmer, BA, MDiv, CTR ccrimmer@novanthealth.org **A4C Liaison:** Desiree Montgomery desiree.montgomery@unchealth.unc.edu **NCRA Liaison:** Melanie Rogan, CTR melanie@ers-can.com **Central Cancer Registry Liaison:** Melissa Pearson, CTR Melissa.pearson@dhhs.nc.gov

Upcoming Educational Meetings

Carolina's Regional Registrars Conference

Where: Embassy Suites
5400 John Q. Hammons Dr NW
Concord, NC

When: September 21 -23, 2016

Cost *(Full three day registration)*: $150.00 members (NC & SC)
$175.00 non-members

Hotel (*per night*): $169.00 plus tax
Online Hotel Booking:
http://embassysuites.hilton.com/en/es/groups/personalized/C/CLTCCES-ACR-20160920/index.jhtml
http://www.embassysuitesconcord.com/

NCRA Educational Conference

2017 - April 5-8, Gaylord National, Washington, DC
2018 - May 20-23, Sheraton New Orleans, New Orleans, LA
2019 – May 19-22, Sheraton Denver Downtown Hotel, Denver, CO

MEMBERSHIP
Vickie Gill, RHIA, CTR

As of August 16, 2016, there are 143 paid ANCCR members.

NOMINATING COMMITTEE
Farrah Scodius, BS, CTR

Thank you to all who have participated in this year's ANCCR election. We sincerely admire and appreciate your dedication to the ANCCR organization! We are excited and honored to announce the following officers for the 2016-2017 term. Congratulations on this great achievement!

President:	Jenean Burris, RHIT CTR
Vice-President:	Kelly Lowrance, RHIT CTR
Secretary:	Kim Greene, RHIT CTR
Treasurer:	Jennifer McLean, CTR

Kindest regards,

Farrah Scodius, ANCCR Nominating Committee (Chair)
Carrie Cerny, ANCCR Nominating Committee
Breanna Marcum, ANCCR Nominating Committee
Blanche Sellars, ANCCR Nominating Committee

WAYS AND MEANS
Kimberly Maloney-Bobbitt and Kisha Raynor

Ways and Means will be doing a silent auction with wrapped and unwrapped gifts. We are asking that donated gifts be worth $15-$20. Please wrap the donated items according to the season. We will be selling arts and crafts this year as well doing the $100 bill silent auction.

REPORT FROM THE NC CENTRAL CANCER REGISTRY
Melissa Pearson, CTR

Finally! The roll-out to NAACCR Version 16 has begun!

After you convert to NAACCR Version 16, you may want to run a few reports on your 2015 and 2016 stage data before creating the submission file to ensure SS2000 and AJCC TNM was assigned appropriately on all cases.

AJCC TNM 7th Edition Training

The American Joint Committee on Cancer began a series of webinars on the five most common site chapters for the AJCC 7th edition staging in July 2016. These webinars are not intended to be a comprehensive discussion of all TNM rules but provide information on the uniqueness, differences, exceptions or special concerns for each of these disease sites. The focus is on AJCC TNM staging only and do not address how to incorporate rules from other manuals into the abstract such as the MP/H rules.

The NC CCR would like to highly encourage everyone who will be working with AJCC staging (either through abstracting, quality control, data requests, etc.) to attend these webinars. If you can't attend the live session, the recorded session can be viewed on the AJCC website.

Just as with the AJCC Curriculum that was offered last year, there are some things that are not necessarily considered changes but were never really explained clearly in the past. As a result, we will find a few things that we may have to start doing differently. Do not take for granted that just because you have been "doing AJCC Staging for years" that there is nothing that can be learned. These webinars are a great way to reinforce the fundamentals and check that AJCC TNM is being assigned correctly.

These webinars are FREE but you must register to attend. To register, go to the AJCC website using the link below. And, as with the AJCC Curriculum, there are pre- and post- quizzes that you will need to take.

https://cancerstaging.org/CSE/Registrar/Pages/Disease-Site-Webinars.aspx

Disease Site Registration (Free)	Live Webinar Date
Melanoma (Recording Only)	July 27, 2016
Lung (Recording Only)	August 10, 2016
Breast (Recording Only)	August 31, 2016
Colorectum (Recording Only)	September 7, 2016
Prostate	September 21, 2016

AJCC TNM 7th Edition Reference

As an additional abstracting resource, the CCR will be creating a "highlights" document from each webinar. These documents will summarize the significant points made during the webinar and are designed to complement (not replace) what you will learn from listening to the entire webinar session.

In addition, a brief comparison of the major differences between AJCC TNM and SS2000 has been included. As you know, AJCC TNM and SS2000 do not always align. For example, what may be classified in the T or N category in AJCC may be classified as distant in SS2000.

The highlights from the melanoma and lung webinars are provided below. The CCR will be sending out an email with all 5 sites after the last webinar is presented. We hope you will find these notes helpful as you transition to directly assigned AJCC TNM and SS2000.

2016 AJCC Disease Site Webinar Series – Melanoma

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)

General Information:

- All information contained in this document is based on the AJCC Cancer Staging Manual 7th Edition.
- Only site-specific rules and staging issues relevant to Melanoma are included. Any site-specific rules in the Melanoma Chapter take precedence over the General Rules in Chapter 1.
- Do not use ambiguous terminology to determine involvement when assigning the T, N or M value.
- Online resources:
    - https://cancerstaging.org
    - https://cancerstaging.org/CSE/Registrar/Pages/Disease-Site-Webinars.aspx
    - https://cancerstaging.org/CSE/Registrar/Pages/default.aspx
- Check the NCCN guidelines for recommended work up and treatment to help determine if more information is expected.
- Regional Lymph Nodes for Melanoma:
    - Defined by the drainage areas for the primary site. Usually confined to 1 or 2 contiguous nodal basins. Midline tumors may drain in 2 different directions.
    - If melanoma is found in the lymph nodes only, and the primary site cannot be found, and there is no other evidence of mets, consider the involved nodes as regional. The T would be a T0. (See section titled: Metastatic Melanoma from an Unknown Primary Site)

Clinical Classification

- Includes information from time of diagnosis up until definitive treatment is started.
- Clinical stage is assigned based on information obtained prior to cancer directed treatment and is not changed on the basis of subsequent information obtained from pathologic exam of resected tissue or from information obtained after initiation of definitive therapy.
    - For melanoma, the initial procedure, even if it results in a complete excision (margins are negative), is not considered definitive treatment.
    - For melanoma, a definitive *surgical* procedure would be the re-excision or wide excision (usually surgical codes 36-60) following that initial procedure. All information prior to the re-excision or wide excision is included in the clinical stage.
    - For melanoma, do not change the cT value based on any findings from the re-excision or wide excision.
- cT category
    - An initial biopsy or initial excision of the primary tumor is required to assign the cT. This can be a shave bx, shave exc, punch bx, incisional bx, excisional bx, complete excisional bx or microstaging.
    - Even if the procedure results in a complete excision (the margins are negative), the findings from this initial procedure are used to determine the cT value.
    - Only include the information from this initial procedure in the cT data item.
    - Do not assign the T category based on Clark level or on extension into other structures. The T category is based on the Breslow depth ONLY.
    - Ulceration:
        - Determined by histopathologic exam only.
        - Must have a clear statement from a histopathologic evaluation of the ulceration status (present or not present).
        - Cannot presume no ulceration if no mention of ulceration on the path report.

- cN category
  - Site-specific rule for melanoma: the cN is limited to the physical exam and imaging findings only. A biopsy of the nodes (even for the purpose of staging or to plan definitive treatment) *is not included in assigning the cN*.
  - Therefore, the cN value cannot include subcategories (a, b, ITCs, etc.).
- cM category
  - No site-specific rules. Follows general rules in Chapter 1. Only an H&P is needed. If there are no signs or symptoms of mets, assign cM0.
  - Involvement of skin and/or subcutaneous tissue beyond first nodal drainage area is considered distant mets.
  - M1c – must have elevated serum LDH (recommended to have multiple tests for verification)

Pathologic Classification

- Includes all information from time of diagnosis (including the information used to assign the clinical stage), PLUS the surgeon's operative findings, PLUS the findings on the pathology report from the definitive surgical resection. This is the general rule for all sites.
  - For melanoma, there must have been a wide excision or re-excision (usually surgical codes 36-60) for the case to meet the pathologic stage criteria.
  - For melanoma, the initial procedure (this can be a shave bx, shave exc, punch bx, incisional bx, excisional bx, complete excisional bx or microstaging) is NOT considered definitive surgical treatment.
- pT category
  - If a re-excision or wide excision is done, use the findings from that excision PLUS the findings from the initial procedure to determine the pT value.
  - Use the deepest report of Breslow's Depth from all procedures. Do not add the depths from multiple reports together. Physicians try to avoid transecting the tumor so that is why most of the tumor is attempted to be removed in the initial procedure to get an accurate measurement of depth.
  - Example:
    - Shave exc: 1.1mm invasive malignant melanoma
    - Re-Exc: No residual melanoma identified
    - cT data item: cT2A
    - pT data item: pT2A
      - The findings from the initial procedure are added to the findings from the re-excision to determine the pT. Since there is no residual on the re-exc, the cT and pT values are the same.)
  - Do not assign the T category based on Clark level or on extension to other structures. The T category is based on the Breslow depth ONLY.
  - Ulceration:
    - Determined by histopathologic exam only.
    - Must have a clear statement from a histopathologic evaluation of the ulceration status (present or not present).
    - Cannot presume no ulceration if no mention of ulceration on the path report.

2016 AJCC Disease Site Webinar Series – Melanoma

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)

- pN category
  - At least 1 node must be microscopically examined to assign the pN. This includes a sentinel node biopsy, partial lymphadenectomy or complete lymphadenectomy.
    - EXCEPTION: Stage 0 and IA does not require the nodes to be biopsied or resected.
  - Include the findings from the pathology examination PLUS the information from the physical exam and imaging.
  - Site-specific rule for melanoma: ITC are considered positive nodes for determining the N category.
  - Definitions of terms from the N2c and N3 categories:
    - Satellite: tumors around a primary tumor
    - In transit: tumors between primary tumor and nodal basin
- pM category
  - Requires a positive biopsy or resection of metastatic tissue.
  - Involvement of skin and/or subcutaneous tissue beyond first nodal drainage area is considered distant mets.
  - M1c – must have elevated serum LDH (recommended to have multiple tests for verification)

Stage Grouping:

- The ulceration status (or mitotic rate for T1 lesions) must be known in order to assign the clinical and/or pathologic stage group for localized lesions.
  - There are no stage group categories for T1 NOS, T2 NOS, T3 NOS or T4 NOS.
  - The subcategory of "a" or "b" must be specified for the T category to assign the stage group.
- For the pathologic stage group:
  - Stage 0 and IA does not require the lymph nodes to be biopsied or resected to assign the pathologic stage group.
    - Use the cN and cM to assign the pathologic stage group for Stage 0 and 1A.
    - Example: pT1A cN0 cM0 for a pathologic stage group of 1A.
  - The N subcategory of "a" or "b" must be specified for pN1 and pN2 in order to assign the pathologic stage group.

Differences between AJCC and Summary Stage:

AJCC	Summary Stage
T category: References Breslows Depth.	Codes 1 and 2 (Local and Reg by D.E.): References Clarks Level and layer of the dermis.
T category: Ulceration and Mitotic rate a factor. Ulceration status (or mitotic rate for T1 lesions) must be known to stage group the case.	Codes 1 and 2 (Local and Reg by D.E.): Ulceration and Mitotic rate are not a factor.
N category: Defined by the drainage areas for the primary site.	Code 3 (Regional LN): References specific lymph node chains based on primary site.
N category: Includes satellite lesions/nodules or in-transit metastases, regardless of distance from the primary lesion.	Code 2 (Regional by D.E.): Only satellite lesions/nodules that are $\leq$ 2cm from the primary lesion are considered Reg by D.E.

2016 AJCC Disease Site Webinar Series – Lung

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)

General Information:

- All information contained in this document is based on the AJCC Cancer Staging Manual 7th Edition.
- Only site-specific rules and staging issues relevant to Lung are included. Any site-specific rules in the Lung Chapter take precedence over the General Rules in Chapter 1.
- Do not use ambiguous terminology to determine involvement when assigning the T, N or M value.
- Online resources:
    - https://cancerstaging.org
    - https://cancerstaging.org/CSE/Registrar/Pages/Disease-Site-Webinars.aspx
    - https://cancerstaging.org/CSE/Registrar/Pages/default.aspx
- Check the NCCN guidelines for recommended work up and treatment to help determine if more information is expected.
- AJCC applies to the following histologies: Non-small cell, small cell and carcinoid (8000-8576, 8940-8950, 8980-8981)
- It is critical to understand lung anatomy to assign stage (see additional notes on following pages).

Clinical Classification

- Based on findings from the clinical evaluation, including: physical exam, imaging studies, laboratory test, bronchoscopy, thoracoscopy, mediastinoscopy, exploratory thoracotomy, ultrasound directed biopsies.
- Clinical findings are often missed when assigning the stage for lung cancer. As a result, cases are under-staged. Reports that describe a pleural effusion or lymph node involvement or vocal cord paralysis may not specifically state that this involvement is consistent with the lung cancer. These terms may not stand out as involvement that will affect the stage that is to be assigned. It is important to understand what clinical findings can affect the stage and what exceptions there are for considering this for staging. Review clinical evaluations carefully for mention of:
- Pleural effusion or pericardial effusion (usually tumor related but refer to physician judgment)
- Atelectasis or obstructive pneumonitis (bronchopneumonia is not the same condition)
- Distance from the carina (assume it is > 2cm away if a resection is done)
- Laryngeal nerve involvement / vocal cord paralysis
- Rib invasion (direct extension)
- Superior vena cava obstruction
- Great blood vessels and arteries
- Pain in shoulder, inner arm and hand (possible cause: Pancoast Tumor)
- Lymph node involvement
- Review the section titled: **"Additional Notes Regarding TNM Descriptors"** at the end of the Lung chapter for specific staging instructions on many of the conditions listed above.

Pathologic Classification

- Pathological staging is based on information from clinical staging PLUS surgeon's operative findings, PLUS the pathology report from the resected specimen, including lymph nodes.
- pT: Resection of the primary tumor (or biopsy adequate to evaluate the highest T category).
- pN: Removal of at least one node (or biopsy adequate to evaluate the highest N category).

2016 AJCC Disease Site Webinar Series – Lung

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)

T category:

- The T category is based on a combination of the:
    - size of the tumor
    - location of the tumor
    - conditions associated with tumor involvement
    - direct invasion of other structures.

- TX has two meanings for lung:
    1. Occult carcinoma: There were microscopic findings but no visible tumor (cTX cN0 cM0)
        - For example: Sputum cells or bronchial washings were positive but the primary tumor in the lung could not be seen on imaging or bronchoscopy.
        - The only evidence of cancer is from the positive sputum or washings. Workup did not reveal any lymph node or distant involvement (cN0 cM0).
        - This is the definition of an occult carcinoma and in lung is assigned cTX cN0 cM0.
        - *Text must specify the positive findings from the sputum or washings to justify this TNM combination.*
        - Don't misinterpret lack of information available to the registrar as occult.
        - In contrast, a T0 would be used when there was lymph node or distant involvement (N1-3 or M1) and evaluation did not reveal the primary tumor in the lung (T0).
    2. Tumor cannot be assessed
        - The physician may assign a TX when there was lymph node or distant involvement (N1-3 or M1) because the physician was not able to assess the tumor in the lung.
        - The evidence of cancer is from the evidence of positive nodes or distance mets.
        - In this situation, you cannot have a TX with an N0 M0. The TNM values of TX N0 M0 would be saying there was nothing to indicate any evidence of cancer. If that is the case (there is no evidence of cancer), then this is not a reportable case.

- Multiple Primary Tumors (less common) versus Tumor Spread
    - The instructions for how to stage multiple tumors can be found in the section titled: **"Additional Notes Regarding TNM Descriptors"** at the end of the Lung chapter.
    - The instructions for how to determine the number of primary cancers to abstract can be found in the MP/H rules. Follow the MP/H Rules to help you determine whether to consider multiple lung tumors as one primary or as separate, independent primaries.
    - Example: MP/H Rule M1, Note 2: Use this rule and prepare one abstract when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung.
    - For multiple tumors in the lung considered to be a single primary according to the MP/H rules, AJCC instructs us to use the largest diameter or most extensive invasion to assign the T category.

- Be sure to look for and document all aspects of tumor involvement, including conditions associated with tumor involvement mentioned above. When using a TX N0 M0 for lung, text must clearly state the reason for using the TX (occult versus not assessed).

2016 AJCC Disease Site Webinar Series – Lung

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)

Stage Grouping:

- There are no stage group categories for T1 NOS and T2 NOS.
- The subcategory must be specified for T1 and T2 tumors in order to assign the stage group.

Differences between AJCC and Summary Stage:

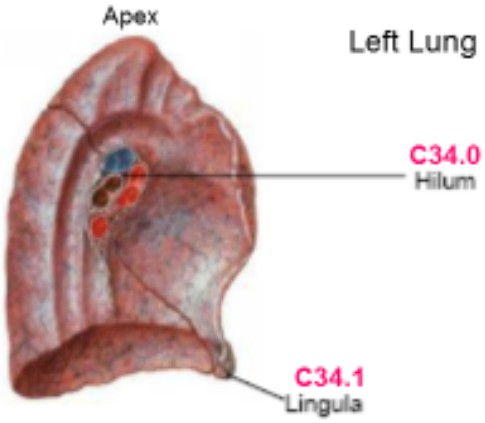
AJCC	Summary Stage
T Category: Direct extension to the following areas fall under the T4 category but is coded as Distant (code 7) in SS2000: • Heart • Vertebral body • Separate tumor nodule(s) in a different ipsilateral lobe.	Distant: Direct extension to the following areas fall under the T4 category but is coded as Distant (code 7) in SS2000: • Heart • Vertebra(e) • Separate tumor nodule(s) in different lobe
N Category: Do NOT use ambiguous terms to determine lymph node involvement.	Reg to LN: The terms "enlarged" and "lymphadenopathy" can be interpreted as regional lymph node involvement for lung primaries in SS2000. *However*, keep in mind that if the physician doesn't feel these are involved for assigning the N category to N1-3, then they shouldn't be considered involved for assigning SS2000 either. These ambiguous terms would only be used in the absence of any other documentation.
N Category: Contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, and ipsilateral or contralateral supraclavicular lymph nodes are considered Regional and assigned to N3.	Distant: Cervical NOS, contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, and ipsilateral or contralateral supraclavicular lymph nodes are considered Distant and assigned to code 7 in SS2000.

Hilum, Hilus, and Hilar

- Hilum = another word for Hilus
  - General: A depression or fissure where vessels or nerves or ducts enter a bodily organ
  - Specific: Entry point in each lung for the bronchi, nerves, lymph vessels, arteries and veins which supply air and oxygen for the respiration process

- Hilar
  - Generally refers to lymph nodes in or "near the hilum"
  - Perihilar, infrahilar, soft tissue mass
  - Should not be coded to C34.0
  - Staged in N category

- If the only description of a lung mass is a "hilar mass", then code to C34.0



Graphics source: Mediclip, Williams and Wilkins. No permission needed. 11

The use of the word hilum, hilar and hilus could be referring to the location of the primary tumor or to the lymph nodes in or near the hilum.

For the lung, the term hilum is the area surrounding where the bronchus enters the lung and then subdivides into the lobar bronchi. Notice the location of the hilum in the diagram above. It is in the center of the lung (from top to bottom).

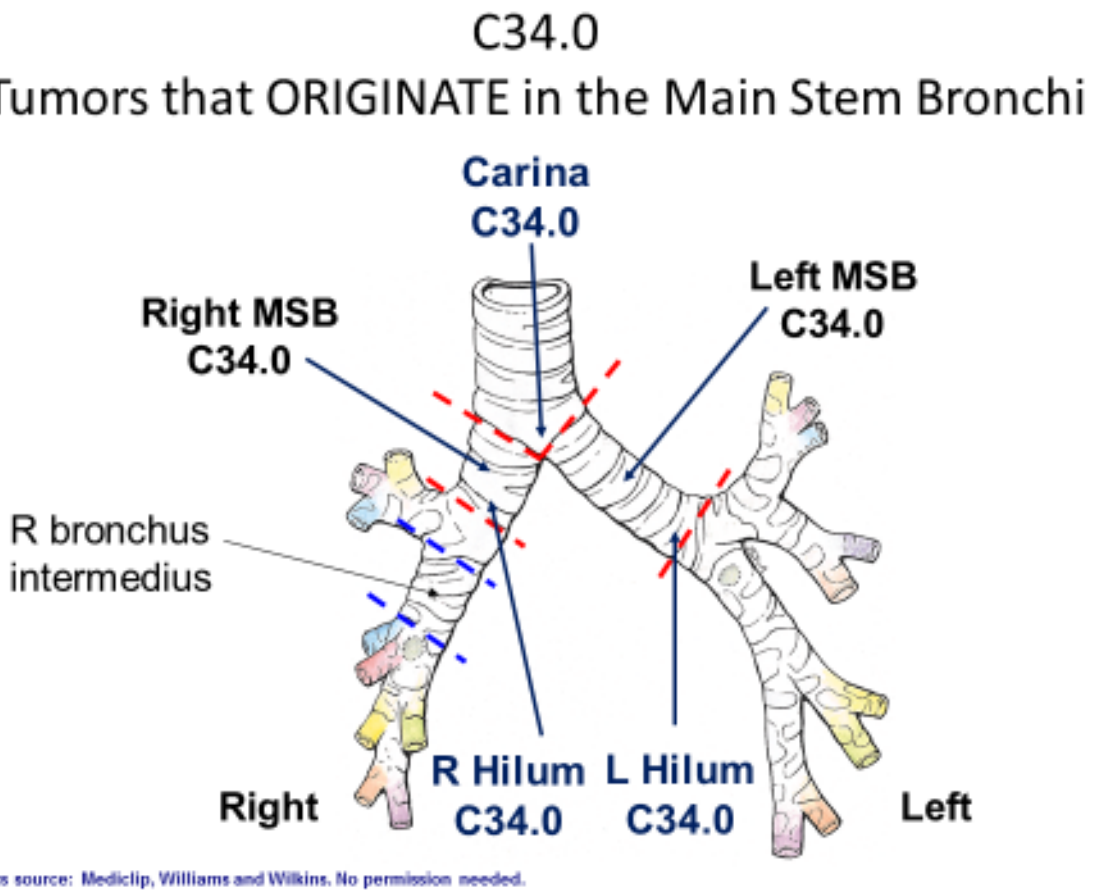
For the lymph nodes, the term hilar is referring to lymph nodes in or near the hilum. For example, a mass may be described as hilar, perihilar, infrahilar, etc. This description is usually describing involvement of the lymph nodes in or near the hilum. Along with the description of the lymph nodes, there should also be a description of a *separate* primary lung tumor.

The clinician may use these terms interchangeably. In reading the medical record, determine if the description is of a hilar mass only. Or, if the description is of a hilar mass PLUS a separate mass in the lung.

- If there is only a description of a single mass and it is described as hilar, then consider this to be referring to the primary tumor in the lung.
- If the description is of a hilar mass PLUS a separate mass in the lung, then consider the hilar mass to be referring to lymph nodes in the area of the hilum. Use the information related to the primary lung tumor to stage the case.

2016 AJCC Disease Site Webinar Series – Lung

Highlights of the AJCC Webinar (N.C. Central Cancer Registry, August 2016)



Graphics source: Mediclip, Williams and Wilkins. No permission needed.

It is important to understand the anatomy of the bronchi and pay attention to any reference to involvement of the bronchi in the record. C34.0 is used to code tumors that originate in the:

- main bronchus,
- carina, or
- hilum.

Even though these share the same ICD-O-3 code, these are 3 distinct areas within the lung. This distinction is important for staging as the T category varies depending on location and distance from the carina.

- Carina: A downward and backward projection of the lowest tracheal cartilage, forming a ridge between openings of right and left bronchi
- Main bronchi: Large air tube that begins at end of trachea and branches into the lungs. The MSB stops where the upper lobe of each lung starts (at the hilum where it enters into the lung parenchyma).
- Lobar bronchi: Secondary division of main bronchi that supply lobes of lungs; superior, middle and inferior
- Bronchioles: Smallest bronchioles that connect terminal bronchioles to alveolar ducts.

2016 EDUCATIONAL SCHOLARSHIP WINNER

"How Does Education, Networking, and Professional Development Work Together to Create an Exceptional, Well-Rounded CTR Professional?"

Being a well-rounded cancer registrar who excels at their profession requires several key components: education, networking, and continuing education. Education provides the foundation of oncology knowledge essential to the profession. Networking with other registrars as well as various other oncology professionals enables discussion of topics that require clarification and encourages growth and camaraderie, both as a registrar and as an individual. Finally, professional development keeps things relevant and interesting, enabling registrars to continually be engaged in the growth process. If one is not growing, then they are essentially dying. However, it is through the interaction of these three components that a truly exceptional and well-rounded registrar emerges and thrives.

Critical to this formula for success is the building that each does on the other. While one can have these individual components solidly in place, it is imperative that the next step of integration is taken. Failure to put forth effort to stay on top of relevant changes frequently will mean becoming antiquated in the field in a very short time period. An example of this is the recent elimination of collaborative stage in favor or AJCC stage. A deep knowledge base is necessary to comprehend the scope of these changes, while continuing education is necessary to understand the implementation process, and a network to ask questions to is requisite as well. Integration of these components allows for the sharing of current knowledge and disposition of outdated practices in the rapidly changing landscape of oncology.

These characteristics are the minimum expectation of all CTR's. Extensive cancer knowledge, intense attention to detail, good judgment, and a desire to serve the public are qualities a CTR should have before they ever start in the field. An exceptional CTR takes these qualities much further, always going the extra mile (or two!). That may involve putting forth funds from her own pocket to attend an educational/networking meeting, or it may involve digging deeply for extra resources for a particularly difficult case. She values personal relationships with providers that stand as resources to draw upon. She may write articles and presentations, or she may volunteer for leadership positions within the field. An exceptional CTR consistently demonstrates a dedication to her field that goes above and beyond what is expected or necessary.

It would be precocious to claim that any of these qualities have made myself a good CTR, as I have just earned the credential within the past three months. What I can say is that when I look at the exemplary ANCCR CTR's that I have been fortunate enough to have either been directly supervised or mentored by, or at least to have been privileged to learn from in some capacity, I have a clear idea of the kind of CTR I hope to be. Melissa Pearson, Leta Vess, Cathleen Cheney, Allen Austin, Martha Shackelford, Kathi Foote, Farrah Scodius, Lisa Ganem, Angela Rodriguez, and Mary Maul have all provided invaluable learning experiences and networking opportunities to me, without which I would likely not be in the field today.

From these mentors I have learned the value of professional interaction between education, networking and continuing education that continually provides avenues for growth of the skills essential to tumor registrars. I have learned that a well-rounded CTR has a strong knowledge base and thoroughly understands the rules and principles, but also has the ability to interpret those rules and principles and make judgment calls when necessary. However, I have learned that most important is the registrar's personal commitment to the pursuit of constant learning, implementation, and excellence in the field. These qualities, developed through education, networking, and continuing education, make an excellent and well-rounded cancer registry professional and I certainly aspire consider myself part of that elite category someday.

Laura E. DeFino-Coscia, CTR
NC Central Cancer Registry