The Sentinel

The Newsletter for the Association of North Carolina Cancer Registrars

Fall 2020

Message from the President:
Paige Tedder, RHIT, CTR

Happy Fall!

I hope everyone is out enjoying these cooler temperatures with the season change. We've seen many changes over the past year due to the pandemic.

I thought I would take a few minutes to reflect on one positive thing that have happened in 2020. NCRA hosted the first ever virtual National meeting Sept 21-23. I thought they did a fantastic job pulling that together in just a few months and I hope they plan to make this an option for upcoming years. The topics were interesting, and the speakers did a great job hosting virtual sessions. The staff here at Atrium especially appreciated the flexibility of watching sessions at their convenience. There also is the option to go back and watch session again for areas that need further clarification.

Here in NC plans are already being made for next year's meeting to be held in Flat Rock Fall 2021. Our hope is to be able to offer virtual sessions as well but more to come on that later.

I want to thank you for the opportunity to serve as your ANCCR President again in 2021. I look forward to working with the other elected officers: Kisha Raynor, Vice President; Laura Alberti, Treasurer; and Amy Arnold, Secretary in 2021. The other board members are listed on the ANCCR website www.ncregistrars.com.

If anyone is interested in volunteering, please let me know. If you have any questions or concerns, please feel free to email me at Paige.tedder@atriumhealth.org.

I hope everyone has a Happy Halloween and Thanksgiving!

Paige Tedder

ANCCR's Executive Board 2020-2021

Office	Name	Email
President	Paige Tedder, RHIT, CTR	paige.tedder@atriumhealth.org
Immediate Past President	Kelly Lowrance, RHIT, CTR	kalowrance@novanthealth.org
Vice President	Kisha Raynor, CTR	kisha.raynor@carolinashealthcare.org
Secretary	Amy Arnold, CTR	amyarnold@registrypartners.com
Treasurer	Laura Alberti	
Committee	**Name**	**Email**
Bylaws	Adaline Brown, RHIT, CCS, CTR	abrown@q-centrix.com
Education	Kimberly Swing, CTR	kimberly.swing@duke.edu
	Karen Knight, CTR	karen.knight@duke.edu
Educational Scholarship	Inez Inman, BS, RHIT, CTR	iinman@wakehealth.edu
ANCCR Resource Manual	Ruth Maranda, LPN, CTR	ruth.maranda@dhhs.nc.gov
Facebook Administrator	Angela Rodriguez, CTR	angela.rodriguez@mercy.net
Grants & Vendors	Melanie Rogan, CTR	mrogan@mycrstar.com
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	Kim Maloney Bobbitt, BS, CTR	kmaloney-bobbitt@novanthealth.org
Liaisons	**Name**	**Email**
A4C Liaison	Kathleen Foote, CTR	kathleen.foote@unchealth.unc.edu
NCRA Liaison	Angela Rodriguez, CTR	angela.rodriguez@mercy.net
NC CCR Liaison	Melissa Pearson, CTR	melissa.pearson@dhhs.nc.gov

ANCCR Elections Results:

President: Paige Tedder, CTR
Vice-President: Kisha Raynor, CTR
Secretary: Amy Arnold, CTR
Treasurer: Laura Alberti

Upcoming Annual Educational Conferences

ANCCR Educational Fall Meeting

2021 – Flat Rock, NC

NCRA Educational Conference

2021 - April 14-17, Indianapolis, IN
2022 - April 6-9, Washington, DC

TREASURER REPORT
Christine Smith, CTR

ANCCR 2020 Third Quarter Treasurer Report
Beginning Balance 07/01/2020:

Checking	18,394.33
Money Market	21,607.21
Total	40,001.54

Deposits:

July	1,402.93
August	100.00
September	0.00
Membership dues income July-Sept	0.00
Total	1,502.93

Expenses:

Bank Statement Charges	
August: Paypal Chargeback fee for refunds	35.00
Total	35.00

Ending Balance 09/30/2020:

Checking	19,862.26
Money Market	21,608.84
Total	41,471.10

WEB SITE REPORT
Cathy Rimmer, BA, CTR

NAACCR Webinars are added to the member's only section when files become available.

Most common questions under Contact Us:
- Becoming a CTR
- Questions about dues
- How to login to Member Only

A link to the NCRA website will be added to help those that are inquiring about a career change.
A button will be added: Becoming a CTR.

BYLAWS Update – Complete Bylaws on the ANCCR website.
Adaline Brown, RHIT, CCS, CTR

Optional Virtual Meetings may be held at the discretion of the ANCCR Board.

MEMBERSHIP
Jenean Burris, RHIT, CTR

There were 156 ANCCR members as of 7/21/2020. As of 10/21/2020, there are 8 members that have paid their membership fee for 2021.

It's that time of year again! **NO**, not Thanksgiving. **NO**, not Christmas. It's time to send in your ANCCR membership dues! Please send the membership application and a check or money order for $25.00 to:

Jenean Burris
2197 Fisher Ferry St
Thomasville, NC 27360

Membership application found on ANCCR's website at:
https://www.ncregistrars.com/content/membership-application

A4C Liaison
Kathleen Foote, CTR

A4C General Session met virtually on Friday, August 7, 2020

Dr. Steve Patierno, Deputy Director DCN and Dr. Karen Whitfield, WFBMC have been appointed co-chairs of A4C.

Cancer Snapshots – nearing end of current cancer plan. Each subcommittee reviewing data captured and evaluation of outcomes on activities. The new cancer plan emphasis on reducing cancer disparities & achieving cancer health equity. Discussion on how subcommittees can collaborate with other each other; coordinate activities.

Announcements/Updates

- Successfully secured CDC colorectal cancer grant for next 5 yrs.
- Mobile screening initiatives to address rural cancer disparities. Reach out to screen underserved, uninsured & Medicaid patients.
- New study LDLCS under 55 yrs – target 40 yrs+ PPD; secondary screening and smoking cessation; also targe Native American population in western part NC.
- Updating educational materials on Radon.

Care & Treatment Subcommittee met virtually on Friday, August 7, 2020

Dr. Dan Carrizosa appointed Chair.

Community Cancer Network Regional Meetings – plan to expand network. Western mtg had 14 different agencies represented and identified top barriers as health insurance & transportation; group listed 20 additional resources to address. Eastern mtg had 12 agencies represented and identified insurance, navigational deficiencies, awareness of health care and transportation. Discussed how to connect resources & networking of organizations.

A4C Care & Treatment Subcommittee Snapshot

- Vision – Create a North Carolina where state of the art cancer care is accessible, equitable and supported life-long through a coalition between patients, providers, caregivers, community services and state/local government.
- Priority Areas – Cancer Care; Cancer Survivorship; Patient Navigation; Achieving Health Equity.
- Intervention/Strategy Activities –
    - Patient-centered Cancer Care Education & Promotion
    - Plan & conduct training on "Role of Primary Care and Family Practice Doctors in Oncology and Patient-centered care" for providers in rural parts of the state.
    - Explore ways of getting Onco-Primary Care message to providers across the state.
    - Publish information quarterly on educational webinars, national cancer organization links and cancer care resources; patient navigation; survivorship educational opportunities.
    - Support & promote annual Cancer Survivorship Summit.

Save the Date 10-29-20. NCCARE360 is the first statewide coordinated care network to electronically connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. NCCARE360 is a result of a public-private partnership between the NC Department of Health and Human Services and the Foundation for Health Leadership and Innovation (FHLI). I think this has information that we can use in the Care and Treatment Subcommittee as we look at our future strategies.

Lung Cancer Awareness Month

Social Media Messages
NCDOH Memo
Resource List
TV Slide

EDUCATION REPORT
Kimberly Swing, CTR and
Karen Knight, CTR

Educational Opportunities:

NCRA Center for Cancer Registry Education - http://www.cancerregistryeducation.org/
Access to high-quality educational programming to support both seasoned professionals and those new to the field, included are programs related to AJCC 8th Edition. Most are fee based.

NCRA Registry Resources - http://www.cancerregistryeducation.org/rr
A series of informational abstracts and presentations that show registrars how to use these important resources, these site-specific abstracts provide an outline to follow when determining what text to include. FREE

SEER Educate - https://educate.fredhutch.org/LandingPage.aspx
Improve technical skills through applied testing on the latest coding guidelines and concepts. Complete practice abstracts and earn up to 20 CE credits per cycle. FREE, Casefinding and Grade exercises are now available as well.

NCRA's Mini-Learning Shorts- Great guide for new registrars-
http://www.cancerregistryeducation.org/best-practices?fbclid=IwAR1bfhzNf844uTRZKbhelHvK0G2MSBumllQH0o4K1hYqe46BmmmxPrnIVfY and
http://www.cancerregistryeducation.org/introduction-to-the-cancer-registry

https://education.naaccr.org/freewebinars - NAACCR Talks are free webinars on topics of concern to the NAACCR membership. View recordings of the live webinars for no charge.

Tumor Talk- sign up to receive webinar invitations presented by Himagine Solutions at https://himaginesolutions.com/himagine-tumor-talk-webinar/ view previously recorded webinars at https://himaginesolutions.com/previous-webinars/

Registry Partner's Coding Break- Educational presentations on YouTube created by Registry Partners https://www.youtube.com/channel/UCFePdWVva8gfosv7jL11tyQ

Register today for CAnswer Forum LIVE Webinar: https://www.facs.org/caforumlive 1 CE hour awarded

- CAnswer Forum LIVE—December 9, 2020

AJCC:
View recordings of the live webinars for no charge.

7th Edition Webinars - https://cancerstaging.org/CSE/Registrar/Pages/Seventh-Edition-Webinars.aspx
8th Edition Webinars- https://cancerstaging.org/CSE/Registrar/Pages/8thEditionWebinars.aspx
Disease Site Webinars - https://cancerstaging.org/CSE/Registrar/Pages/Disease-Site-Webinars.aspx
AJCC Curriculum - https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx
Registrar's Guide to Chapter/AJCC TNM Category Options
https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx

ANCCR Association of NC Cancer Registrars http://www.ncregistrars.com/

NAACCR Cancer Registry & Surveillance Webinar Series

For the 20-21 season, NAACCR is not allowing sharing of the webinars as we did in 2020 due to the COVID-19 virus. The NC Central Cancer Registry has volunteered to pay for one subscription for the 20-21 NAACCR webinar series with money received for participation in their new pilot Patterns of Care Study. After the LIVE version, the webinar links will be placed on the ANCCR website as soon as they become available.

NAACCR webinar schedule:

11/05/20- Lung
12/03/20 - Thyroid
1/7/21- Treatment
2/4/21- Lymphoma
3/4/21- Abstract and Coding Boost Camp
4/1/21- Larynx
5/6/21- Pancreas
6/17/21- Kidney
7/8/21- Quality in COC Accreditation
8/5/21- Breast
9/2/21 Coding Pitfalls

Coding, Staging and Abstracting Resources:

*Online version of IDC-O-3
http://www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577
the new version, ICD-O-3.2, is recommended for use from 2020.
*SEER 2018 updated case finding list- https://seer.cancer.gov/tools/casefinding/
*ICD-O-3 coding table for new terms- effective 10/1/20-9/30/21-
https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20200930.pdf, 2021 ICD-O-3 Coding Updates- https://www.naaccr.org/icdo3/
*SEER RX- https://seer.cancer.gov/seertools/seerrx/
*SEER*RSA- https://staging.seer.cancer.gov/
* EOD 2018 General Coding Instructions- https://seer.cancer.gov/tools/staging/eod/general-instructions.pdf
*Ask a SEER Registrar- https://seer.cancer.gov/registrars/contact.html
*CAncer Forum- http://cancerbulletin.facs.org/forums/help
*Hematopoietic and Lymphoid Neoplasm Database- https://seer.cancer.gov/seertools/hemelymph/
*Solid Tumor Rules- https://seer.cancer.gov/tools/solidtumor/
*NAACCR- Site specific data items (SSDI/GRADE)- https://apps.naaccr.org/ssdi/list/
*STORE- https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/store_manual_2018.ashx
-revised manual to be released on 11/1/20.
***AJCC- Errata for 8th edition AJCC https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx AJCC to Release Version 9 Cervix Uteri Cancer Staging System on Amazon Kindle** Version 9 of the American Joint Committee on Cancer (AJCC) Cancer Staging Protocol for the Cervix Uteri site will be available for purchase for $9.99 exclusively on Amazon Kindle starting October 25, 2020.*
*Informational Abstracts- http://www.cancerregistryeducation.org/rr
*NCI Cancer Types- https://www.cancer.gov/types
* RQRS User Guide-
https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/rqrs_userguide.ashx

*CTR Guide to Coding XRT- https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/case_studies_coding_radiation_treatment.ashx - Revised Guide to be released 1st quarter of 2021
*NCDB- The Corner Store- https://www.facs.org/quality-programs/cancer/news
*American College of Surgeons- Subscribe to the newsletter *The Brief* at http://multibriefs.com/optin.php?ACSORG or view articles at http://multibriefs.com/briefs/ACSORG/index.php

Coding Tips:

From 2020 NAACCR Prostate Webinar:

PSA LAB VALUE:
• Record the last pre-diagnosis PSA value prior to biopsy and/or initiation of treatment and no earlier than ~ 3 months before dx
• Change from CSv2 – coding the highest value within 3 months
• Record to the nearest tenth in nanograms/milliliter
• Micrograms per liter (ug/L) = nanograms per milliliter (ng/ml)

AP/PA?

• Regarding Planning Technique code when stated as AP/PA?
- "Normally, in this day in age, that would be 3D. If you have a really old-fashioned approach it could be 2D. But as long as the patient underwent a CT Simulation AP/PA is still considered a 3D technique." Dr. Brabham NCRA 2020 Conference.
• Clarification: What is the correct External Beam Radiation Planning Technique code, when planning technique stated as "AP/PA" on the treatment plan?
-Code 01-External beam, NOS or Code 04-Conformal or 3-D conformal therapy?

Electronic Brachytherapy

•Clarification on coding electronic brachytherapy:
•Modality code: 02, External beam, photons.
•Planning technique: 02, low energy x-ray/photon therapy.

The Brief 2019 Update

• If dose/fraction and total dose is provided in Gy or cGy units for any brachytherapy procedure, capture this information in your abstract. Do not use codes 99998 or 999998 if this information is found in treatment summary!
• If brachytherapy is only mode of treatment and dose is not provided in cGy, code to 999999 for total dose.
•You cannot, however, add dose from EBRT phase to that of brachytherapy phase to get total dose!

Instructions for coding multiple phases for radiation treatment:
• When a radiation treatment summary has multiple PHASES (aka delivered prescriptions):
A. Code the phases from the earliest to latest start date.
B. If there are multiple phases with the same start date, code the phases from highest to lowest total dose.
C. If there are multiple phases with the same start date and same total dose, then any order is acceptable.

SBRT

•SBRT treats very small volumes, typically limited to ~ 5 cm.

• Given its limitations, it cannot target the primary volume and regional lymph nodes within the same irradiated volume.
• When SBRT used, code “Radiation to Draining Lymph Nodes to 00, No RT to draining lymph nodes.

Note: If treatment summary refers to IMRT, VMAT, SBRT, code to SBRT (06, Stereotactic radiotherapy or radiosurgery, NOS).

If the RT treatment summary refers to beam energies, such as:
• 6X or 6MV,
• 10X or 10MV,
• 12X or 12MV,
• 15X or 15MV,
Then the treatment modality will always be 02, external beam, photons (a Linac was used to deliver the EBRT treatment).

Preliminary Results of Two Large Immune Therapy Studies Show Promise in Advanced Cervical Cancer

Targeted Oncology: Genetic Testing Should Be Considered for All Patients With Pancreatic Cancer

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REPORT FROM THE NC CENTRAL CANCER REGISTRY
Melissa Pearson, CTR

Staffing Updates:
ClarLynda Williams-DeVane has been appointed as the new Director of the State Center of Health Statistics, to which the Central Cancer Registry reports. Dr. Williams-DeVane's background is as a health disparity informaticist and has spent her career focused on how data can be used to achieve health equity. We welcome her to the State Center!

The NC CCR has been designated a
CDC-NPCR REGISTRY OF DISTINCTION
for its Submission of Data in November 2019!

The NC CCR has received the HIGHEST recognition awarded from the CDC National Program of Cancer Registries for meeting the standards for Data Completeness and Quality since the awards program began. The NC CCR has been a Registry of Excellence (8 years) or a Registry of Distinction (3 years) for the past 11 years. Note: for the 3 years of Registry of Distinction, the Registry of Excellence recognition was suspended due to delayed implementation of Collaborative Stage in 2010/2011 and v18 in 2018.

Meeting these standards means that our data will be included in the *United States Cancer Statistics* (USCS) report and other analytic data sets. This also means that the residents of NC will hopefully benefit in the long run from research and studies conducted using this data.

NAACCR GOLD CERTIFICATION 12 YEARS IN A ROW!

The NC CCR has been awarded GOLD CERTIFICATION by NAACCR for its 2017 data!
Cancer registries that meet the Gold Standard for Registry Certification have achieved the highest NAACCR standard for complete, accurate, and timely data to calculate standard incidence statistics for the year reviewed. NAACCR began the certification program in 1999 (1996 data) and the NC CCR has been awarded gold or silver certification since 2000 (1997 data) and has received GOLD certification for the past **12** years in a row!

NAACCR FITNESS FOR USE RECOGNITION (NEW!)

NAACCR has announced a new Fitness for Use for Survival & Prevalence Recognition for registries that meet the inclusion requirements for the *CiNA Survival* and *CiNA Prevalence* Volumes of the CiNA Monograph and the related *CiNA Survival* research dataset. The 2020 Recognition was for 2009-2015 data.

This Recognition is based on meeting the following criteria:

- Meet the CiNA incidence criteria for all relevant years, and

- Either meet the SEER standards for follow-up or ascertain deaths through the study cutoff date. The NC CCR met this criteria through its linkages with the National Death Index and the Social Security Death Index and the NC Death File to obtain vital status and cause of death data.

These achievements exemplify the progress achieved in creating a national system of cancer surveillance. We commend all who are involved in the collection, analysis, and reporting of cancer incidence and mortality data.

Death Certificate Only (DCO) Cases Reach Record Lows!

Speaking of death data…A few years ago, we started a concerted effort to follow-back on potentially missed cases identified from death certificates. And it shows!

Did you know?
Death certificates can have an "assumed" Cause of Death. In some cases, the Cause of Death is never proven or confirmed. And, the Cause of Death may be assigned by a physician who has no relationship with the patient. This is especially true in Hospices or nursing homes.

How is the Cause of Death determined in these situations?
If the physician has no direct knowledge of the patient, this history may come from the medical record or even input from facility staff and family members based on their knowledge of the patient's health history.

What does that mean for cancer data?
The Cause of Death on a death certificate must be considered carefully. It is why:

- these cases are identified separately in our data.
- our standards require that we have less than 3% of the death certificate only cases.
- we put so much effort into investigating these cases.
- the CCARM states that reporting cases identified by death certificate only is an exception to the eligibility rules and are to be reported regardless of the reason for the visit.

Just like weighing the value of microscopic versus clinical diagnostic confirmation, the more definitive confirmation you have, the more weight that diagnosis is given. Our goal is to obtain any evidence beyond the death certificate that this patient did indeed have cancer.

For example, a patient comes to the Emergency Department for reasons unrelated to cancer, but the record says the patient has a history of cancer. Even though there are no details on the cancer, meaning the abstract will contain mostly unknowns, that statement of cancer gives weight, albeit minutely, to the cause of death recorded on the death certificate. We now have some evidence beyond the death certificate that this patient did indeed have cancer.

So, how about those record lows?
The increase in our follow-back efforts and successful response rate is directly reflected in our data with our DCO counts dropping below 1% in 2015. This is well below the required 3% mark. This means we are getting better at finding evidence beyond the death certificate that the patient had cancer. And that would not be possible without your help in investigating your records and sending in an abstract when there was any mention of cancer…even though it may have been mostly unknowns! Thank you!

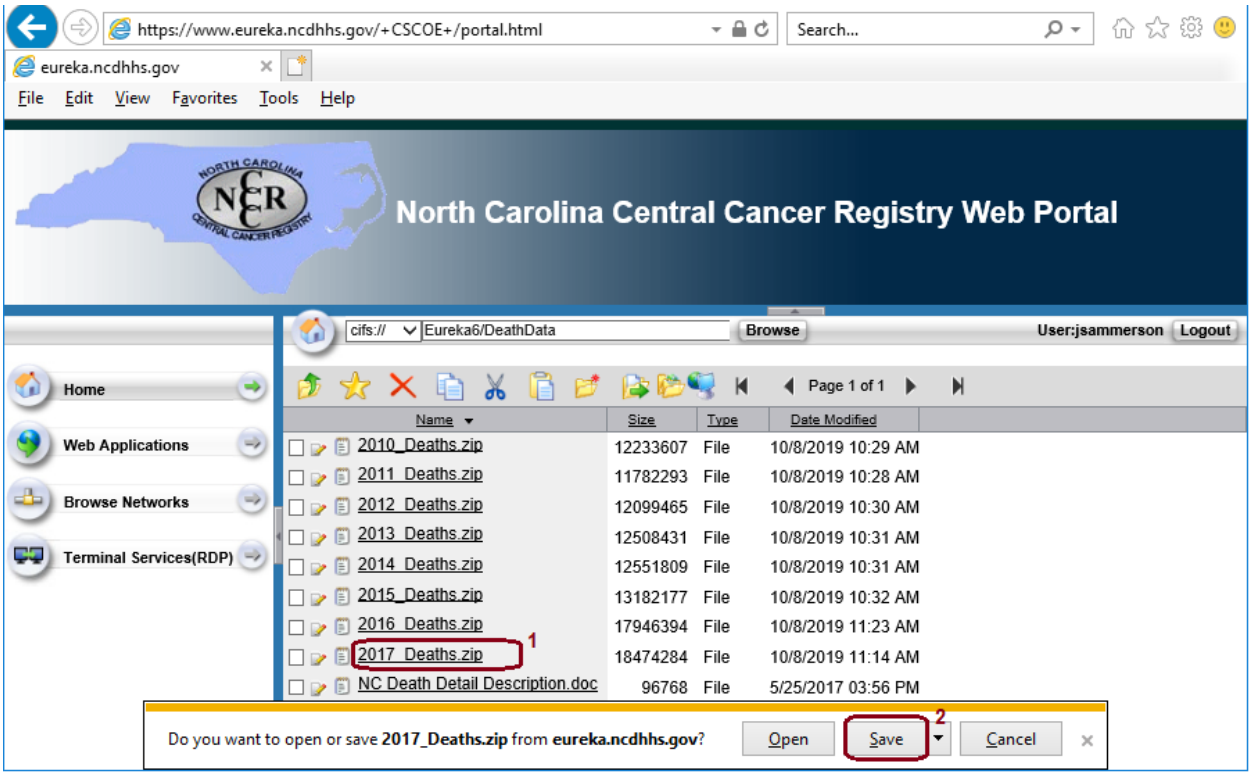
Year of Death	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NAACCR Certification	SILVER	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	GOLD	Awarded in 2021
DCO % at certification	3.9	2.1	2.9	2.2	1.8	2.1	2.3	1.9	1.2	1.2	0.9	1	0.8	0.8
Current # of DCO cases	1499	913	1191	1024	926	1054	1172	1035	771	657	565	414	422	498

Want to Update YOUR Death Data using NC Vital Records data?

During the Panel Discussion on the Panoramic View of Cancer Surveillance at the NCRA Virtual Conference, a question came up about obtaining death data for updating vital status in the abstract.

We've got you covered for your NC residents! The NC CCR provides access to the NC Death File to all facilities. This file is obtained from the NC Vital Records department and contains all deaths that occurred in NC. In addition, NC Vital Records has a data exchange agreement with other states. So, it also includes death information for NC residents who died out of state. This is captured in the "DeathState" field in the death file. Unfortunately, it does not include that small percent of patients who have moved out of state and now have residency other than NC.

These annual death files are posted on our WebPlus portal each year. An email is sent to all facility contacts announcing the availability of the current year's file. Vendors are also notified of its availability. It is recommended that you first work with your vendor to discuss options for automatically importing the death data into your database. If you find you need to download the file, contact your CCR Staff Representative to obtain full instructions.



COVID-19 Proposed Data Items to the STORE 2021

The National Cancer Database (NCDB) is introducing four new variables in 2021 to measure the impact on patient outcomes. The first three data items denote patient testing and status for the Sarscovid2 virus, and the fourth item denotes any treatment effects from hospital service disruptions related to the COVID-19 pandemic (for diagnosis effective 1/1/2020 through 12/31/2021).

- 3943: NCDB--SARSCoV2--Test
- 3944: NCDB--SARSCoV2--Pos
- 3945: NCDB--SARSCoV2--Pos Date
- 3946: NCDB--COVID19--Tx Impact

COVID-19 TEXT IS STILL REQUIRED!

Make sure any text related to COVID-19 specifically includes the word "COVID-19"!

The CCR is still relying on **TEXT!** The standard use of the word "COVID-19" in the text will allow us to identify and isolate these cases for further evaluation. Below is the CCR's guidance on how to standardize this documentation in the text.

Lab Text	Date and results of COVID-19 and antibody testing (both positive and negative)
Treatment Text	If treatment is delayed, modified or not given due to COVID-19, add that detail to the corresponding treatment text field
Remarks Text	Record COVID-19 related ICD-10 codes specified in the medical record

FAQ's:

1. What if the patient tests positive for COVID after the case has been submitted to the CCR?
   Answer: For now, just add the information to the text using the above guidelines. Modifying text only will not prompt a correction record so that update will not be sent to the CCR. We are still trying to figure out some of these finer details. Stay tuned for more instructions!

2. If treatment is delayed, when do I submit the case to the CCR?
   Answer: Please wait until ALL first course of treatment data items can be coded before submitting the case to the CCR. Keep in mind, the treatment does not need to be completed. Only the start date and type of treatment needs to be known to complete the required data items in the abstract.

If you have other ideas, please share! You are seeing these cases much sooner than we are, and your feedback is very helpful to us!

Conversion to Version 21

Soon, you will be getting your software upgrade to Version 21. We don't want to add any unnecessary disruption to your normal upload routine as that creates the potential for missed cases. Therefore, we are asking that you continue uploading your submission files as usual, regardless of the version. Currently we are accepting both v18 and v21 file formats.

As always, make sure your file, regardless of version, passes all edits in the appropriate version of the NC edit metafile. Work with your vendor to make sure you understand how to run the appropriate NC edits on your cases. We will be running all files (v18 and v21) through the appropriate edits upon upload. Any files with edit errors will be rejected.

Once we have an idea of when all NC facilities will be able to convert to v21, we will announce when we will stop accepting v18 formats. All vendors are included on these announcement emails and will receive this information as well.

Ruth Maranda, LPN, CTR
NC CCR Education and Training Coordinator

Interesting news from AJCC. Looks like this may lead to different AJCC Chapters having different effective dates (as opposed to the current edition in which the same effective date applies to all chapters). And hopefully there will be an option to get the content without having to purchase each update.

AJCC Moving from Editions to Versions in 2021

Source: Cancer Programs News: August 6
https://www.facs.org/quality-programs/cancer/news/080620

The American Joint Committee on Cancer is making an important change to how it updates and releases Cancer Staging content beginning in 2021. The AJCC will be shifting from a *Cancer Staging Manual* to a *Cancer Staging System* and moving away from *editions* to *versions,* which better align with software development and how users are increasingly consuming AJCC content. Version 9 of the Cervix Uteri Cancer Staging System will go into effect January 1, 2021.

For more than 40 years and eight editions the AJCC has published its AJCC TNM Cancer Staging System in printed books. Since then, the way information is produced, consumed, and disseminated has changed dramatically. The workflow of AJCC users has changed, and increasingly the expectation is that AJCC content is in the software products they use every day. In 2017, the AJCC made its content available for software developers as XML code for the first time. Over the subsequent years, the AJCC has made a concerted effort to better align content curation with modern software development practices.

- Cervix Uteri will be the first cancer to be updated in this model of versions
- Version 9 of the Cervix Uteri Cancer Staging System will be released in the coming months
- Version 9 of Cervix Uteri will go into effect for those cancers diagnosed starting January 1, 2021
- The Version 9 content shall replace the 8th Edition Cervix Uteri content from the Staging Manual
- Version 9 Cervix Uteri tables will be available to licensed software developers by August 1, 2020
- Physicians, registrars, and other users of the AJCC content will be able to **purchase** an electronic version of the new Cervix content (including tables, notes, and illustrations) in the coming months; final details will be provided before September 2020.
- Other disease sites will be updated to Version 9 of the Cancer Staging System in the coming years
- Updated Version 9 disease sites will go into effect on January 1 following their release

Clarification on Clinically Staging CLL/SLL (9823)
Farrah Scodius, BS, CTR
NC CCR Sr Quality Management Specialist

Ahhh, the great debate! This article should be appropriately titled, “Please Don’t Shoot the Messenger!” The 2018 changes brought some gray areas but none more so than how to correctly code the 2018 AJCC TNM clinical group stage for CLL/SLL (9823) and depending on the presentation or the presenter, it seems that we find ourselves asking the question, “Do I assign a clinical stage group of 99 or 4?”

Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) had previously been an easy-peasy-lemon-squeezy group stage of 88 for those cases diagnosed prior to 2018. Enter 2018 and CLL/SLL finds itself added to Chapter 79, Hodgkin and Non-Hodgkin Lymphomas of the 8th edition of the AJCC Cancer Staging Manual which now requires a value for the clinical stage other than the trusted 88.

Changes are like waves in the sea…..
In a July 2020 Q&A document of an in-depth hematopoietic webinar, the standard setters were called to end the debate. Both Donna Gress and Jennifer Ruehl contributed their valuable input and offered the following clarification:

QUESTION: If peripheral blood is the only site of involvement with no other sites of involvement, would you recommend assigning AJCC Clinical Stage Group 1?

Donna Gress Answer: No. If you do not have any information that matches the AJCC staging, then it should be coded to 99 since STORE does not allow it to be left blank.

QUESTION: What would SEER Summary stage be coded to if only peripheral blood is involved? And finally, what would Mets at Dx Fields be coded to if only peripheral blood involved?

Per CAnswer forum dated 7/15/2020 responded by Jennifer Ruhl:
“Yes, I did present that a lymphoma (usually CLL/SLL) with peripheral blood involvement only (diagnosed via peripheral blood smear with no other evidence of disease, or no further information) was a Stage IV.

When we developed all the information for EOD, Summary Stage and AJCC 8th edition, this was the impression that we were under. We learned this was wrong. Donna learned shortly after the NCRA conference in Denver from some of the AJCC physicians who worked on the lymphoma chapter, that this was not the case. She contacted me about this.

AJCC: A lymphoma with only peripheral blood involvement is unknown stage for AJCC (99).

EOD: For those who are doing EOD, there is a new code that has been added to the lymphoma EOD Extension that is for peripheral blood involvement only, and which will derive the appropriate TNM stage as unknown. New notes have also been added. (This will be available after your 2021 software updates, available in late Fall 2020).

SS2018: Summary Stage will continue to be 7. For bone marrow involvement, CLL/SLL is staged per lymphoma, AJCC Chapter 79. Lugano Stage IV involves bone marrow and will always be Stage IV. Summary Stage will continue to be 7.

So, there you have it-if you have a CLL/SLL (9823) case that has diagnostic workup including a positive bone marrow sample, code the AJCC TNM clinical stage to 4. If you have a CLL/SLL (9823) case that has diagnostic workup of only a peripheral blood sample, code the AJCC TNM clinical stage to 99. SEER Summary stage will continue to be 7 (distant) for both scenarios.

AJCC TNM Stage Group 4	AJCC TNM Stage Group 99
CLL/SLL (9823) AJCC CHAPTER 79 (LYMPHOMA) POSITIVE BONE MARROW	CLL/SLL (9823) AJCC CHAPTER 79 (LYMPHOMA) POSITIVE PERIPHERAL BLOOD ONLY

Annnd, I can't leave without some additional gentle reminders regarding CLL/SLL:

- In order to assign a pathological stage group, the case must fulfill the rules for pathological classification. Chapter 79 (Lymphoma) states that a staging laparotomy must be performed with the explicit intent to assess the extent of abdominal disease or to define histologic microscopic disease extent in the abdomen. If this procedure was not performed, assign the AJCC TNM Pathological Stage Group to 99.
- CLL does transform! Diffuse large B-cell lymphoma is listed as the single transformation for CLL/SLL.
- Diagnostic confirmation: Code 1 "positive histology" includes a peripheral blood smear.
- Review Module 3 of the SEER Hematopoietic manual to assign primary site. PH5 states:

  Code the primary site to bone marrow when the bone marrow or peripheral blood is involved.

  If you have a positive blood or bone marrow sample, STOP right here! There is even a great scenario given: *Positive peripheral smear for CLL with clinical lymph node involvement. No bone marrow biopsy done. Code primary site to C421 since the peripheral blood is involved.*
- Please include all lab text including the results of the peripheral blood smear if performed with the lymph node aspiration or lymph node surgery. Yes, I know, you want to code the primary site to C77 but help me to help you! □

References:

https://www.nccn.org/patients/guidelines/content/PDF/cll-patient.pdf
https://seer.cancer.gov/seertools/hemelymph/51f6cf59e3e27c3994bd5447/?q=9823
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf
AJCC Cancer Staging Manual, 8th ed.

The 2020 Commission on Cancer Lecture --"Cancer Care: Medicine Meets Math"

By Frederick L. Greene, MD FACS
Levine Cancer Institute
Charlotte, NC

For 32 years, exemplary leaders in cancer management and research have presented the Commission on Cancer (CoC) Lecture to large auditoriums in a variety of American College of Surgeons Clinical Congress venues. Although the current global pandemic has necessitated a virtual, computer-assisted meeting to maintain social distancing, the CoC Lecture this year given by Professor Sir Murray Brennan, MD, FACS of the Memorial Sloan Kettering Cancer Center, New York, was no less impactful and has a message for all those involved in cancer care, especially cancer registrars.

In his lecture, "Cancer Care: Medicine Meets Math," Dr. Brennan enumerated the difficult issues faced by all Americans, and especially those with cancer, relating to health care economics. He argued that over diagnosis, leading to potential over treatment, contributes to the high cost of cancer care in the United States, especially for breast and prostate cancer.

Dr. Brennan then asked the seminal question, "Does over investigation change outcomes?" Aggressive approaches to cancer diagnosis may correlate with increased relative survival, possibly because those who undergo regular screening generally take better care of their health. But Dr. Brennan showed data suggesting increased diagnosis of early-stage cancer does not substantially influence disease-specific survival.

He urged us to "look at the math" very carefully, and to consider another fact: over treatment is not without risk. Radiation therapy for early-stage breast cancer, for example, increases risk for heart disease, pulmonary embolism and future cancers in other sites.

Relating to clinical trials, we are admonished to look with a critical eye at small increases in progression-free survival. Professor Brennan reminded us that the "p" value is not the overarching consideration if the total benefit to patients is small.

Dr. Brennan introduces the terms "silent neglected majority (or minority)," to describe the fraction of patients in the treatment arm of a trial who would have had a positive outcome, even if they had been controls. These people may be pleased with their outcome, he said, but it is important to recognize they are subject to whatever side effects may be associated with the treatment. These need to be considered, because they may be substantial enough to negate some or all of the benefit to those whose outcome was improved by treatment. He used the example of his own past trials that test the practice of aggressive margin resection for adenocarcinoma of the pancreas to illustrate the principle, showing that even though margins might be negative, this approach has had no effect on overall outcomes for the vast majority of patients.

Dr. Brennan also warned us against "focusing on the wrong end of the curves" when looking at trial results. Rather, we should be vigilant in finding ways to determine beforehand which patients truly need and will benefit from a given cancer treatment strategy. We need to have greater reliance on prognostic indicators such as nomograms and support of artificial intelligence. Our lecturer told us that "cancer care has evolved from being discipline-specific, to organ-specific, to disease-specific, to molecular-specific, to pathway-specific."

As a true champion of the randomized controlled trial concept, Dr. Brennan urged us to look carefully at the important and meaningful endpoints of every trial. No matter the trial result, we need to accurately predict individual outcomes using prognostic indices. We must select patients for trials based on molecular diagnostics. We must evaluate technology for its benefit for the individual patient and for society. Finally, in trials, we must use surrogate indicators that accurately determine response, efficacy and disease progression.

The wisdom shared in this 2020 Commission on Cancer lecture by a true giant in cancer care will give us a road map forward and, importantly, will always remind us to consider the math.

The NCRA Call for Nominations deadline has been extended to 11/04/2020. ANCCR is full of so many wonderful volunteers. Please consider nominating yourself or another worthy member for one of the following positions and let's show NCRA how great NC is!
President Elect/Secretary
Junior Treasurer
Education Board Director
Recruitment and Retention Board Director
Advocacy and Technical Practice Board Director (West, Midwest and East)
Council on Certification Administrator
Council on Certification Representatives
Nominating Committee (West, Midwest and East)
Please click this link to view more information and to access the nominating forms. You will be happy that you did!!
https://www.ncra-usa.org/Member.../Nominations-and-Elections [ncra-usa.org]

Thank you!
Melanie Rogan
NCRA Nomination Chair 2020-2021