The Sentinel

The Newsletter for the Association of North Carolina Cancer Registrars

Spring 2020

Message from the President:
Paige Tedder, RHIT, CTR

Hello Everyone,

I hope that everyone enjoyed Cancer Registry week April 6-10 while sheltering in your home. I also hope that this newsletter finds you and your family in good health. Sheltering in place, practicing social distancing, and use PPE equipment to go grocery shopping is new to all of us. Like everyone else, I have had moments of being stressed and overwhelmed by these changes. I am trying to get outside daily for a walk or to work in the yard. We are all finding ourselves worried that ourselves or our family members will get sick and how we would cope with the unknown. As most of you know, my youngest daughter should give birth to her first child in the next month. The thought of her entering the hospital during a pandemic makes me anxious. I am filled with sadness at the thought of not being present for the birth and not being able to see my granddaughter for days maybe weeks after her birth. What helps me is to keep what is important in perspective. I remind myself that my daughter's healthy, the baby's healthy, and she has a supportive husband who will be allowed to shelter at the hospital with her. These days shall pass and we will all learn to adapt to our new normal; whatever it may be.

These times have also led to new work challenges. As most registrars work from home, not much has changed from that perspective. However, how we handle cancer conferences and committee meetings have changed. At Atrium, we have decided not to postpone any usual activities and to use Skype to keep connected. So far this month, we have had QI Committee, NAPBC, Cancer Committee and 23 weekly Cancer Conferences via Skype with no major problems. Dr. Greene is continuing his weekly chart review virtually via Skype. There have been some bumps in the road but overall things have went smoother than we anticipated. In fact, our attendance for these meetings has been much higher than in person. We have even talked about leaving some of these virtual as it is much more convenient for members to attend.

The pandemic has also led to postponements of meetings like NCRA. Our state meeting has been moved to October. It has encouraged us to think outside the box and to offer an option for registrars to attend via in person or virtually so that those who are immunocompromised or with low facility budgets can still attend and receive CE's.

In conclusion, while these times can be challenging, it also can be filled with positive change. I hope to see everyone at the State Meeting in Flat Rock on October 14-16th. Updated info is posted on the ANCCR website.

Stay safe.
Paige

ANCCR's Executive Board 2020

Office	Name	Email
President	Paige Tedder, RHIT, CTR	paige.tedder@atriumhealth.org
Immediate Past President	Kelly Lowrance, RHIT, CTR	kalowrance@novanthealth.org
Vice President	Angela Rodriguez, CTR	angela.rodriguez@mercy.net
Secretary	Amy Arnold, CTR	amyarnold@registrypartners.com
Treasurer	Christine Smith, CTR	jamstribe@aol.com
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
	Allison Shelor, CTR	allison.shelor@unchealth.unc.edu
Historian	Deborah Poovey, CTR	dpoovey7@gmail.com
Membership	Jenean Burris, RHIT, CTR	jburris@wakehealth.edu
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Program Director	Kelly Lowrance, RHIT, CTR	kalowrance@novanthealth.org
Publications	Inez Inman, BS, RHIT, CTR	iinman@wakehealth.edu
Web Site Coordinator	Cathy Rimmer, BA, MDiv, CTR	ccrimmer@novanthealth.org
Ways & Means	Kisha Raynor, CTR	kisha.raynor@carolinashealthcare.org
	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

Upcoming Annual Educational Conferences

ANCCR Educational Fall Meeting

2020 – Oct 14-16, Flat Rock, NC
Re-scheduled from Sept 23-25, 2020
The Lodge at Flat Rock

NCRA Educational Conference

2020 – Sept 20-23, Orlando, FL
Re-scheduled from May 31-June 3, 2020
2021 - April 14-17, Indianapolis, IN
2022 - April 6-9, Washington, DC

TREASURER REPORT
Christine Smith, CTR

ANCCR 2020 First Quarter Treasurer Report

Beginning Balance 01/01/2020:		
	Checking :	29,580.05
	Money Market:	21,603.98
	Total:	51,184.03
Deposits:		
	January	0.00
	February	525.00
	March	0.00
	Membership dues income Jan-March	525.00
Expenses:		
2020 Fall Meeting Deposit		750.00
Bank Statement Charges		0.00
Total Deposits		525.00
Total Expenses		
Ending Balance 03/31/2020:		
	Checking:	26,431.58
	Money Market:	21,605.60
	Total:	48,037.18

MEMBERSHIP
Jenean Burris, RHIT, CTR

There are 127 ANCCR members as of 4/20/2020.

WAYS AND MEANS
Kisha Raynor, CTR
Kim Maloney Bobbitt, BS, CTR

The Ways and Means Committee would like for you to think of what we can do for the ANCCR Fall Meeting in Flat Rock, NC! The jewelry sale did well last year so that may be done again.

WEB SITE REPORT
Cathy Rimmer, BA, CTR

NAACCR Webinars postings are up-to-date.

A4C Liaison
Kathleen Foote, CTR

A4C General Session met virtually on Friday, March 6, 2020

New lung cancer screening guidelines developed.

A4C writing grant for Colorectal Cancer. ACS in partnership with NC community health center association. Launched yearlong colorectal cancer screening learning initiative. December article evaluated the collaborative module successful in increasing colorectal screening rate.

Stomach Cancer - Discussion on higher than average rates for stomach cancer and African American population higher mortality rate.

HPV Vaccination & Cervical Screening – 2019 learning collaborative noted early data showing significant increase in prevention quality measures.

A4C Care and Treatment Subcommittee met virtually on Friday, March 6, 2020

Update on the Community Cancer Network Pilot – Breast & Cervical program, focus on women, increase awareness, connect with communities w services/departments to address barriers. Starting in 3 regions – Eastern (Pitt County), NW (Guildford), and SE (Cumberland, Sampson, Roberson). Currently sending out invitations in regions identified. Implement March 27th Cumberland, then April 15th Guilford.

NCONA Annual Conference, "Navigating Health Disparities in North Carolina" scheduled for Friday, March 20, 2020 in Chapel Hill

Cancer Survivorship Summit Plans, Friday May 1 and Saturday May 2, 2020, Winston-Salem.

2020-2025 NC Cancer Plan Update – going through review process to ensure latest information is incorporated into plan; after approval add graphics; expect release Fall 2021.

Care and Treatment Subcommittee
NC Advisory Committee on Cancer Coordination and Control

News Flash
Please share this News Flash with your staff and coworkers. It has upcoming information on training opportunities and information sources on cancer care and treatment best practices. The News Flash is compiled by the Care and Treatment Subcommittee of the N.C. Advisory Committee on Cancer Coordination and Control. It supports the efforts to reduce the effects of cancer in North Carolina that are outlined in "A Call to Action: North Carolina Comprehensive Cancer Control Plan." For more

information, contact the N.C. Comprehensive Cancer Control Program at (919) 707-5320 or http://publichealth.nc.gov/chronicdiseaseandinjury/cancerpreventionandcontrol/acccc.htm.

In-Person Training Opportunities

3rd Annual North Carolina Adolescent and Young Adult Oncology Symposium Adolescent and Young Adult Cancer: Survivorship
Friday, Apr 24, 2020 7:30 A.M. – 4:30 P.M.
North Carolina Biotechnology Center, 15 T W Alexander Dr., Research Triangle Park, NC
Speakers: Dr. Brad Zebrack
Dr. Kevin Oeffinger

Healing the Healer: Restorative Practice for Providers
April 24, 2020 12:30 P.M. - 4:15 P.M.
Northwest AHEC, 475 Deacon Boulevard Winston Salem, NC
Speaker: Paige Bentley

Webinar Training On-Line Training

Power of Meditation, Speaker: Elizabeth Morse
Breath Prayer, Speaker: David Carl
Opening the gift of healing touch, Speaker: Jean Pruett
Spirituality and Healing, Speaker: David Carl
End of Life Care-Online webinar, Speaker: Vicki T. Dougherty
Opioids in the Elderly: Trends and New Guidelines-Online Course, Speaker: Dr. Jennifer Gabbard
Caregiver Support Video Series
Cancer Survivorship E-Learning Series for Primary Care Providers
GW Cancer Center's Online Academy 10 Modules

Information/Resources

Latest information on COVID-19 - ncdhhs.gov/coronavirus or cdc.gov/coronavirus
A targeted therapy for triple negative breast cancer may lie existing drugs
Breast Cancer Index and Extended Endocrine Therapy Benefit
Study Examines Prostate Cancer Treatment Decisions
Single PSA Test May Reveal Long-Term Prostate-Cancer Risk
Never too late to quit—protective cells could cut risk of lung cancer for ex-smokers
National Vaccination Program Leads to Marked Reduction In HPV Infections
Psychedelic Drug Eases Cancer Patients' Distress Long Term
Thyroid cancer, genetic variations and cell phones linked in study
U.S. reports no new deaths tied to vaping, lung illness cases rise to 2,711
Everything we think we know about drinking water may be wrong
Screening Mammography Visits Useful for Smoking Cessation, Lung Cancer Screening Referrals
Designer probiotic treatment for cancer immunotherapy
Is Proton Therapy Safer than Traditional Radiation?

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=IwAR1bfhzNf844uTRZKbhelHvK0G2MSBumIlQH0o4K1hYqe46BmmmxPrnIVfY 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/

Register today for CAnswer Forum LIVE Webinar:
https://www.facs.org/caforumlive
The American College of Surgeons (ACS) Cancer Programs is applying for continuing education credits from the National Cancer Registrars Association (NCRA) for all upcoming 2020 CAnswer Forum LIVE webinars. Mark your calendars for these upcoming events:

- CAnswer Forum LIVE—May 6, 2020
- CAnswer Forum LIVE—June 10, 2020
- CAnswer Forum LIVE—August 5, 2020
- CAnswer Forum LIVE—October 14, 2020
- 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 - https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx
AJCC TNM Category Options - https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx

http://www.ncregistrars.com/

ANCCR purchased subscriptions to the NAACCR Cancer Registry & Surveillance Webinar Series.

Each webinar is three hours (3 CE's) and will be presented on the first Thursday of each month. After the LIVE version, a link to the webinar will be available to ANCCR members on the ANCCR website, as soon as it is available each month. The sessions are 9:00 am – 12:00 pm.

Host sites:

- Wake Forest Baptist Medical Center, Winston-Salem, NC
  Contact: Jenean Burris: jburris@wakehealth.edu
- Carolinas Medical Center, Charlotte, NC
  Contact: Paige Tedder paige.tedder@carolinashealthcare.org
- UNC Rex Hospital, Raleigh, NC
  Contact: Kathleen Foote Kathleen.foote@unchealth.unc.edu
- Vidant Medical Center, Greenville, NC
  Contact: Merrill Bright Merrill.bright@vidanthealth.com

NAACCR webinar schedule:

5/7/20	Central Nervous System
6/11/20	Esophagus
7/9/20	Navigating the 2020 Survey Application Record (SAR)
8/6/20	Corpus Uteri
9/3/20	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/
*IDD-O-3 coding table for new terms- updated 8/22/18- https://www.naaccr.org/wp-content/uploads/2018/08/Updated-8-22-18-ICD-O-3-alpha-table.pdf
*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/2018-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

*AJCC- Errata for 8th edition AJCC https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx
*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
*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: Fred Hutch Cancer Surveillance System:
https://www.fredhutch.org/content/dam/www/research/divisions/public-health-sciences/epidemiology/css/2019-09%20Registrar%20PIP%202019%20Sept%20Issue.pdf

Tips for coding primary site for Lymphomas:

* If it is clear that a specific lymph node chain is the primary site, code the primary site to that lymph node chain. For example, assume the only area of involvement is the Parotid lymph nodes. The primary site will be C77.0 (Lymph nodes of head, face and neck) because the parotid lymph nodes are located in this region. Code C77.0 can represent that either more than one lymph node in the parotid chain is involved or more than one chain in the same region is involved. As long as all involved nodes are in the same region, that ICD-O-3 site code may be used. When a mass is identified as retroperitoneal, mesenteric, inguinal, mediastinal, or pelvic and is consistent with lymphoma, code to the specific lymph node site: retroperitoneal or mesenteric (C77.2), inguinal (C77.4), mediastinal (C77.1), or pelvic (C77.5).

* For C77.8 to apply, the lymph nodes involved must be in different regions (i.e., have different ICD-O site codes) when you look them up in the ICD-O-3 or in Heme Manual, Appendix C (Lymph Node/ Lymph Node Chain Reference Table) and the physician does not indicate in which node/region the lymphoma arose. For example, if the physician does not indicate where the lymphoma arose, but both axillary (C77.3) lymph nodes and inguinal (C77.4) lymph nodes are involved, the primary site is coded to C77.8 because axillary and inguinal have different topography codes.

*In the following situations, use code C77.9 for the primary site:

If it is not clear what the primary site is, the lymphoma is known to have risen in the lymph nodes and there is no documentation of which lymph nodes are involved.

If the medical record only states that the patient has lymphoma, NOS without indicating specific details (i.e., history only cases).

If the only documentation we have in the medical record is a lymph node biopsy that confirms lymphoma pathologically, the primary site is coded to C77.9 rather than C80.9. In this situation, we don't know whether there are other areas of involvement yet. However, we know that at least one lymph node was biopsied and involved, so the site code of C80.9 (unknown primary) would not be appropriate in this situation. While it is true we don't know exactly what the primary site is (one chain, multiple chains, lymph nodes or extranodal sites, etc.), we are instructed to use C77.9 (lymph nodes, NOS) in this situation.

*If there are multiple areas of involvement, the clinician may choose to biopsy a particular lymph node because it is the most accessible. Do not automatically code primary site to the lymph biopsied, unless it is the only chain involved or it is stated to be the primary site, of course. That was the first TIP we discussed.

*If there is involvement of an organ (extranodal site) only or an extranodal PLUS involvement of the organ's regional lymph nodes only, code the primary site to the organ (extranodal site).

Examples:

Code primary site to C16.9 (stomach, NOS) if there is no involvement other than the stomach.

Code primary site to C18.7 (sigmoid colon) if only the sigmoid colon and the pericolic lymph nodes are involved.

*If it is suspected that the lymphoma is extranodal, or there is involvement in multiple organs without information to identify the primary site, or the physician does not document the site, code primary site to C80.9 (Unknown primary site). However, keep in mind that if lymph nodes are known to be involved, the primary site cannot be C809. Rule PH27 (Code primary site to unknown primary site (C809)) confirms there must be no evidence of neoplasm in the lymph nodes, and that, "If lymph nodes are involved, see Rule PH22," which indicates we are to code primary site to C77.9.

For example, if diffuse large B-cell lymphoma is found in the femur and in the soft tissue of the anterior chest wall but all CT scans are negative for lymphadenopathy, and the physician did not identify the primary site, we are to code the Primary Site field to C80.9 (Unknown primary site). Diffuse large B cell lymphoma can be either nodal or extranodal. This case is likely extranodal because there is no evidence of lymph node involvement. Given there are multiple areas of extranodal involvement and the extranodal site of origin is unknown, code the Primary Site to C809.

The rule, that allows us to use the C80.9 site code for lymphomas, took effect with the implementation of the ICD-O-3 and with cases diagnosed on or after 1/1/2001.

EDUCATIONAL SCHOLARSHIP
Inez Inman, BS, RHIT, CTR

ANCCR has designated funding for an educational scholarship for an ANCCR member to attend the ANCCR annual educational meeting in September 2020 in Flat Rock, NC.

The purpose of the scholarship is to provide financial assistance to a member who may not otherwise have the opportunity to attend ANCCR's annual meeting. The scholarship covers the full conference registration fee, mileage and hotel room for three nights at the conference hotel. ANCCR members wishing to apply for the scholarship must complete an application and submit at least a 500 word essay on the 2020 topic.

2020 Education Scholarship Essay Topic:
"How has the 2018 changes affected your cancer registry – the workflow, staffing, cancer committee discussions?"

Please send the essay with your completed application (see below) to:
Inez Inman, BS, RHIT, CTR
Cancer Registry, CCC, 2nd floor
Wake Forest Baptist Medical Center
Medical Center Blvd.
Winston-Salem, NC 27157

Deadline is Friday, August 28, 2020. The winning essay may be reprinted in The Sentinel following the ANCCR annual educational meeting.

2020 Education Scholarship Essay
"How has the 2018 changes affected your cancer registry – the workflow, staffing, cancer committee discussions?"

APPLICATION

Your name:

_____

Your title/department:

_____

Facility's name:

_____

Facility's address:

_____

Phone number:

_____

Email address:

_____

STATEMENT:
I sign this statement in good faith that I would not be able to attend the ANCCR annual educational meeting in Flat Rock, NC without this funding.

Signature:

_____

Your manager, supervisor, director's printed name:

_____

Manager, supervisor, director's signature:

_____

REPORT FROM THE NC CENTRAL CANCER REGISTRY
Melissa Pearson, CTR

Staffing Updates: Amy McClam joined the CCR in April. Amy will be primarily working with physician offices as part of our physician office recruitment effort.

We want your corrections!

We would like all facilities to get back into the routine of submitting their Modified Record files along with their New Case Record files. Some facilities were having problems getting the Modified Record file to pass edits. We think most of those issues have been resolved. Therefore, we are now requiring that Modified Record files also pass all edits before being submitted. This will also help us identify any remaining issues.

Make sure you are using the required naming convention and correct extension based on file type:

New Case Files (Record Type A):
.XAA (upper or lower case)
Example: 2020-03-20_HealthyHospital_153.XAA

Modified Records (Record Type M):
.XMO (upper or lower case)
2020-04-01_HealthyHospital_21.XMO

Create BOTH files, clear ALL edits & send BOTH files each time you upload to the CCR!

Update on the Iredell County Thyroid Investigation

Several community meetings have been taking place in Iredell County. The most recent one was held on January 9th lead by Senator Vicky Sawyer, Representative John Fraley and the Iredell County Health Department. A few staff from the CCR attended the meeting and brought back the following summary particularly as it relates to the CCR's role in cancer cluster investigations.

Senator Vicky Sawyer started the meeting with her personal reaction to the situation and her appreciation for the cancer registries in NC. She was angered and scared and felt her family was at risk. She acknowledged that she has since worked more closely with the Central Cancer Registry. She shared what she has now learned as a result of taking the time to find out how cancer reporting, and cluster investigations, are conducted. Her initial response was to place blame on the State of NC, specifically, the Central Cancer Registry for not identifying the possible cluster. **She has since concluded that the NC Central Cancer Registry is one of the best in the United States.**

Senator Sawyer also shared that thyroid cancer is increasing everywhere and the reason is unknown. However, there have been several articles weighing the need for screening which can increase the identification of indolent cancers and possibly help explain this increase. Although she understands that the CCR looks at county codes, not zip codes, and must suppress low counts that can possibly identify patients, she still feels that some work is needed to improve the turnaround time for data. She has introduced Senate Bill 297 to help speed up this process, stating "two years is too long." An advisory panel has been formed and includes representation from the CCR.

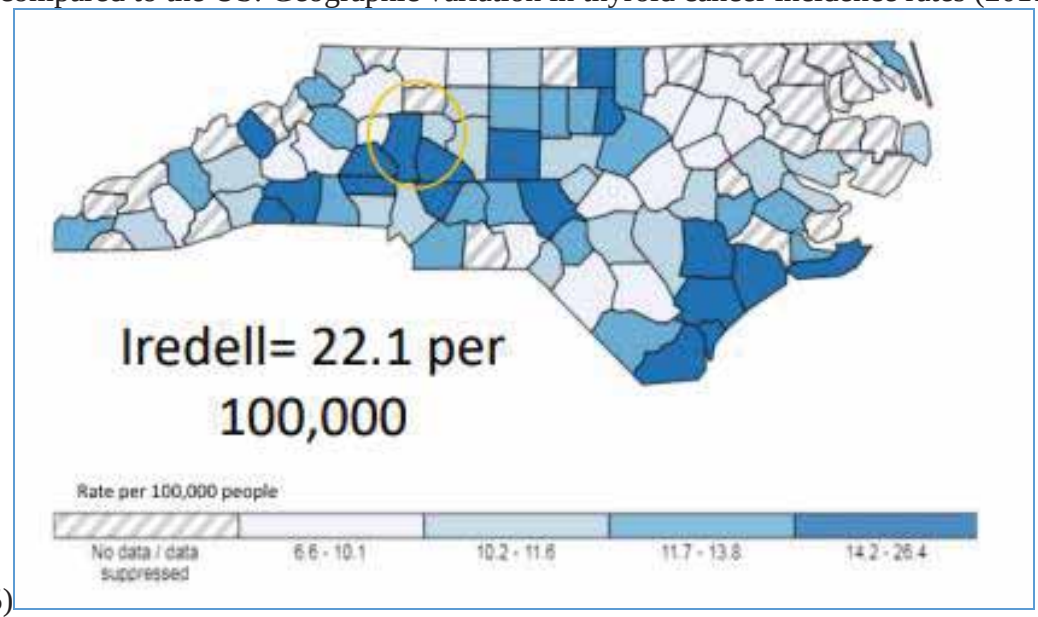
A summary of the water testing results was shared. Water sources have been tested several times. This includes wells where homeowners are concerned, water at schools, Lake Norman and water at the reservoir. These tests were sent to at least 4 different independent labs and not the same lab twice. All tests came back negative for coal ash and negative for radiation.

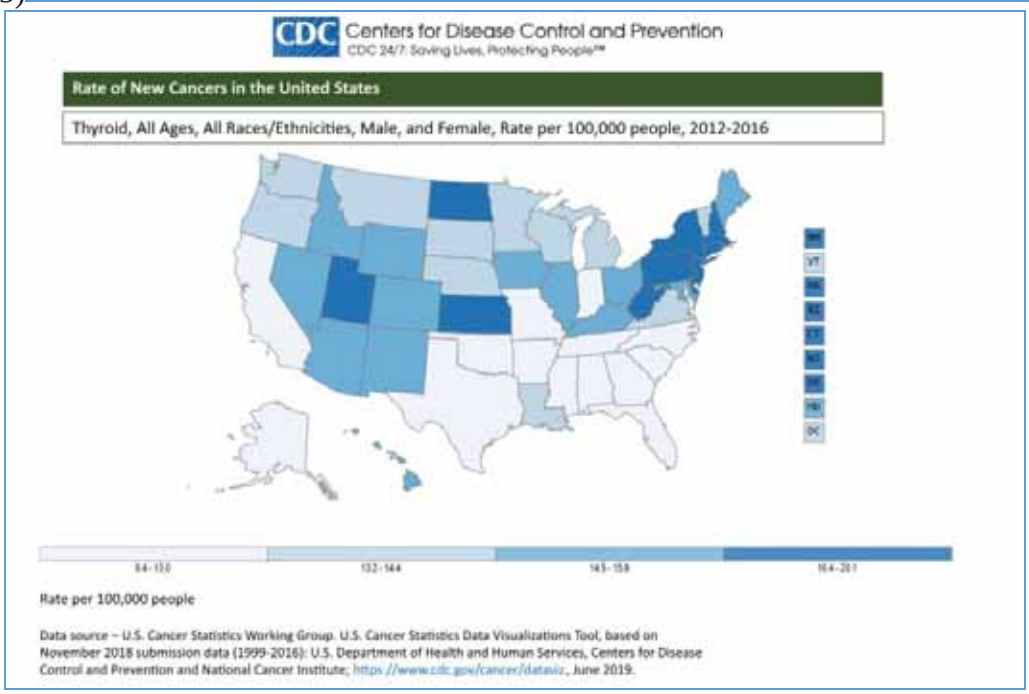
The news reporters in attendance were the most vocal about what was reported in studies. The community also voiced concerns about what is appearing on social media. Several of those concerns were addressed, including: the labs not being paid off or owned by Duke Power, the government not covering up for Duke Power, safety of water in schools, etc. She asked they get the facts before posting.

Note: There were several news crews in attendance. When this story first hit the headlines, there were several articles with attention capturing headlines. Now that more facts have been gathered and the role of the CCR in cancer cluster investigations is more understood, none of those statements have been retracted and current articles do not mention that they were made “without getting the facts FIRST” as Senator Sawyer suggested.

The next community meeting on Thyroid Cancer & Structural Coal Ash was scheduled for March 19 but was cancelled due to Covid-19. Erin Brockovich and her team were scheduled to be present at this meeting. A packed auditorium from the community was expected. A community web page is available for updated information and progress of activities. https://www.co.iredell.nc.us/1255/Thyroid-Cancer-Information

NC compared to the US: Geographic variation in thyroid cancer incidence rates (2011-15)





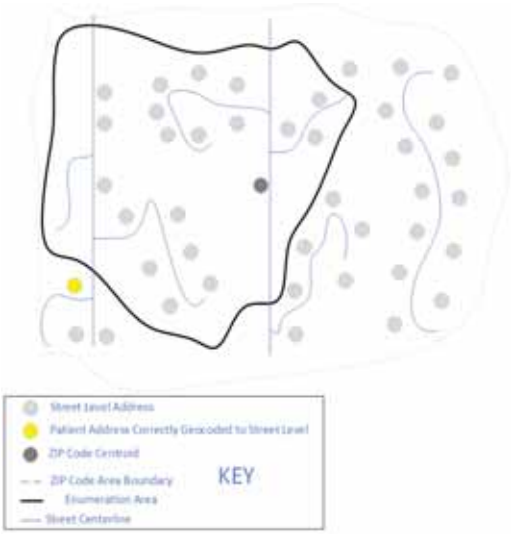
Ruth Maranda, LPN, CTR
NC CCR Education and Training Coordinator

Below is a summary on a few different topics gathered over the past few months.

Address at Diagnosis

Did you know? Every Address at Diagnosis in the NC CCR database is mapped! In the CCR, this is referred to as geocoding. It is geocoded according to Census Tract, Census Blocks, Latitude, Longitude and other geocoding wizardry!

Our Geographical Information Specialist (GIS) takes the Address at Diagnosis data and runs them through special GIS software to convert these values into coordinates that can be displayed on a map. This allows central registries to calculate incidence rates based on geographical areas.



The yellow dot on the map shows that this patient's Address at Diagnosis information provided in the abstract could be correctly mapped to their street address based on all geocoding factors.

Cancer cluster investigations and cancer case mapping depend heavily on the **STREET address AT DIAGNOSIS**. For population-based studies, mapping is very specific. PO Boxes do not provide the detail needed to map where the patient was living at the time of diagnosis.

An analysis of 2014-2018 cases reported to the NC CCR by hospitals was done. The following shows the number of hospitals and the percent of their cases reported that did NOT have a STREET address as the Address at Diagnosis. Below this are tips on collecting Address at Diagnosis information to help improve the collection of STREET address.

< 10%	66 hospitals
10-20%	31 hospitals
20-30%	7 hospitals
> 30%	3 hospitals

PATIENT ADDRESS AT DIAGNOSIS (NUMBER AND STREET) NAACCR Item #2330

Description: Identifies the patient's address **(number and street) at the time of diagnosis**. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies. There are two critical factors to this data item:

1. It should be the **street address**.
    a. Don't settle for PO Boxes. Dig a little deeper. Is it stored in a different section of the record? Do you need to ask for access to that information? Do you need to rethink how skeleton/suspense abstracts are created in your software?
    b. If the street address cannot be obtained from all resources available, then record the PO Box.

2. It should be the street address **at the time of diagnosis**.
    a. Stop and think. Was the patient living at this address at the time of diagnosis? This is most commonly a factor for non-analytic cases.
    b. <u>If it was known</u> that the patient was living in another city or state at the time of diagnosis, record as much of that address that is known.

i. For example, H&P states: Patient diagnosed 3 years ago in Florida. Florida should be entered as the State at Diagnosis in the abstract.
ii. Record "UNKNOWN" for any part of the address that is not known. If the street address and/or city in Florida is not known, record UNKNOWN.
iii. Knowing that the patient lived in Florida at the time of initial diagnosis is more important than putting the current address. The current address fields will capture this information.

c. If there is no indication that the patient was living elsewhere at the time of diagnosis, then record the street address provided in the medical record.
d. Don't forget to refer to the "Patient Address and Residency Rules" in Section One of the CCARM for further instructions on other residency situations such as military and college students.

Did you know? If a patient's address at diagnosis is NOT in NC, then we share that case with the state CCR where the patient was living at the time of diagnosis. And, we receive cases with NC addresses from other state CCR's as well. This is referred to as the Interstate Data Exchange. This exchange of data based on residency contributes to creating a complete picture of cancer incidence in NC. But it only works if the address at diagnosis is as accurate as possible!

The goal is to make every effort to identify as much as possible about where a patient was living (street address) at the time of initial diagnosis, especially if they were living in another city or state. In short, be mindful when reviewing the record. Look for street addresses and clues that the patient may have moved prior to coming to your facility. As much as we want to map every address, we don't want to map a patient to the wrong address at diagnosis!

Enhance Your NAACCR Webinar Learning Experience

Sometimes just listening to a webinar is not enough to allow it really sink in. There are many ways to reinforce the concepts discussed in the NAACCR webinars. For example, incorporate rules or talking points from the webinars into your cancer registry team meetings. Strengthen your understanding of the coding rules by completing exercises on that site on SEER*Educate. You can even do these as a team by designating a point person to be responsible for coordinating the results and presenting the findings. This allows you to identify consistent coding errors in your registry, talk about the rules as a group, and run audits on the data to correct those errors.

Bring your learning full circle: Listen to the NAACCR Webinar → Complete any related exercises on SEER*Educate → Discuss results at your next staff meeting → Run an audit on that data item(s) to improve the quality of your data.

PSA Lab Value SSDI:

The NC CCR did an evaluation of the PSA Lab Value SSDI data following the NAACCR Webinar on Prostate. Two consistent issues were identified with this new data item: Rounding and using the correct lab value.

1. Rounding: If 0-4 round down. If 5-9 round up. Record to the nearest tenth in ng/mm.

   Incorrect rounding could affect the stage group. Be sure to review the General Rules for Entering Lab Values at the beginning on the SSDI Manual (page 18).

2. Use the LAST PSA value prior to biopsy. Old rules used the highest value. NEW RULES SAY USE THE LAST!

   Be sure text includes DATE AND VALUE. Without the date, it is difficult to validate that this was the LAST PSA prior to diagnostic biopsy or treatment.

Rounding Examples:

0.2 = 0.2
7.21 = 7.2
8.56 = 8.6
11 = 11.0
99.5 = 100.0
110.35 = 110.4

When value is:

- Less than 0.1 = 0.1
- between 0.05 - 0.09 = 0.1
- ≥ 1000 = XXX.1
- "Greater than" or "less than", code next closest value.

The NC CCR also did an evaluation of a few other new 2018 data items along with some old favorites. Below are a few issues identified:

1. Grade - Issue 1: The highest grade is being coded without taking into consideration the timeframe allowed. The 2018 data items separate grade into Grade Clinical, Grade Pathological, Grade Post Therapy. Only consider the grade information that is available from the appropriate timeframe. Review the timeframes for each data item in the Grade Coding Instructions and Tables manual.

2. Grade - Issue 2: The correct codes for in situ cases and applying the priority order are not being used. For example, for breast, the grade for DCIS incorrectly used codes for numerical grades 1-3 instead of L, M and H.

   Rational from the SEER*Educate Breast case scenarios: Codes 1-3 are the preferred grading system codes for invasive cancers and **do not apply to in situ cancers**.
   https://educate.fredhutch.org/Assessments/PracticalApplicationTests.aspx
   Grade Coding Instructions and Tables manual (page 71), Note 3 states the priority order for the breast:

   - Invasive cancers: codes 1-3 take priority over A-D.
   - In situ cancers: codes L, M, H take priority over A-D

3. SS2018: For lung, SS2018 was incorrectly coded to 3 - Regional to Lymph nodes when Supraclavicular Nodes were positive. Supraclavicular node involvement **should be coded to 7 - Distant.** **IMPORTANT**: Supraclavicular LN involvement is staged differently for TNM. It is considered a regional node and coded as N3.

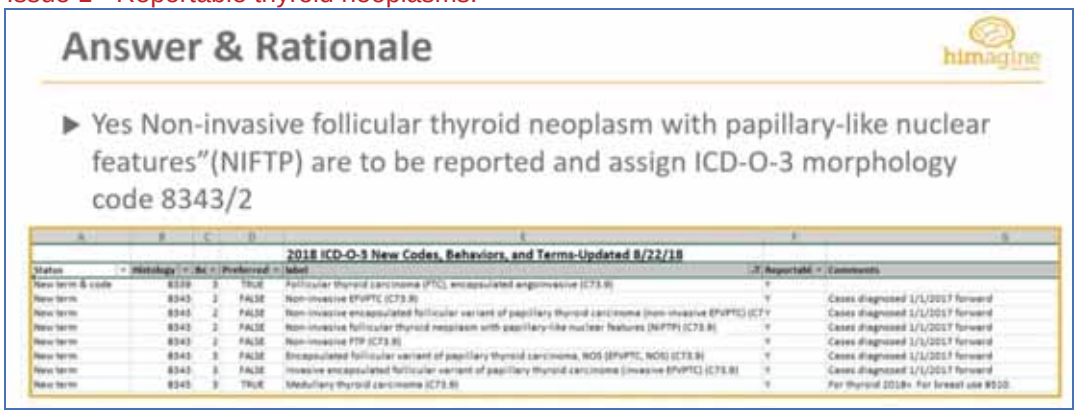
4. Regional lymph node biopsies: FNA and/or biopsy of regional nodes should be coded in the Scope of Regional LN Surgery data item as a code 1. It is not coded in the Diagnostic and/or Staging Procedure data item.

5. Behavior code for Bladder: Behavior was coded to invasive and there was no mention of involvement or invasion of tissues in the text. Review SS2018 page 273 for information on distinguishing non-invasive and invasive bladder cancer. Review the SEER Training Bladder Module:
   https://www.training.seer.cancer.gov/bladder/abstract-code-stage/keys.html

Himagine Tumor Talk Series

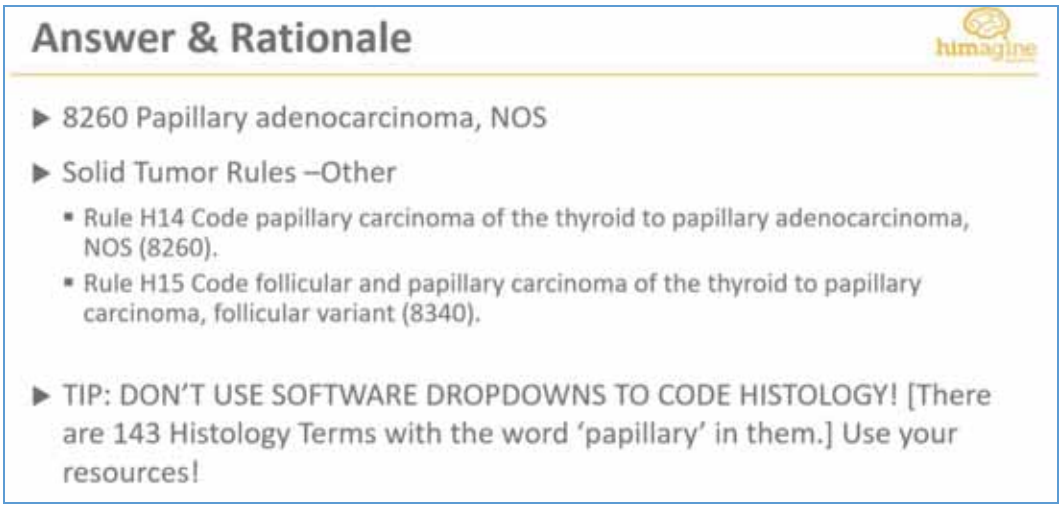
The Himagine Tumor Talk Series is a great and FREE resource that highlights certain rules and changes. The webinar is only an hour long so it focuses on selected rules. The January webinar was on Thyroid. There were many key points made in the webinar, but the two below stand out because OVER HALF of the participants MISSED the quiz question.

Coding Issue 1 - Reportable thyroid neoplasms:



This shows that registrars are NOT using the ICD-O tables updated for 2018 reporting!

Coding Issue 2 – Histology code for Papillary Carcinoma of the Thyroid:



This shows that registrars are relying on drop-down menus in the software and not using their manuals!

Here is another example identified in lung cases in NC data: Non-Small Cell Carcinoma (NSCLC) was incorrectly coded to 8010/3 (Carcinoma, NOS) instead of 8046/3 so that the case was eligible for AJCC TNM staging.

SEER inquiry System #20180112 states 'you should not change a histology to assign TNM to the case, AJCC does not determine histology coding. And while pathologists are not encouraged to use NSCLC, the code is not obsolete and should be used if there is no other specific histology'.

The 2018 Solid Tumor Rules for Lung, Rule H3 states:

Rule H3 Code the specific histology when the diagnosis is **non-small cell lung carcinoma** (NSCLC) **consistent with** (or any other ambiguous term) **a specific carcinoma** (such as adenocarcinoma, squamous cell carcinoma, etc.) when:

- The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc.)
- The patient is treated for the histology described by an ambiguous term
- The case is accessioned (added to your database) based on a single histology described by ambiguous terminology and no other histology information is available/documented

Note: If the case does not meet the criteria in the first two bullets, code non-small cell lung cancer (NSCLC) **8046**.

Resources needed to code Histology in 2018:

- NAACCR ICD-O-3 Histology Revisions and Implementation Guidelines www.naaccr.org/icdo3/
- **IARC ICD-O-3.2 Tables** www.iacr.com.fr/index.php?option=com_content&view=category&layout=blog&id=100&Itemid=577
- ICD-O-3 Manual (purple book)
- Solid Tumor Rules
- Hematopoietic Database and Manual

The resources above must be used together to code histology and determine reportability. Below is a brief outline of how to use these manuals together:

1. Know and understand the rules at the beginning of the **ICD-O-3 manual (purple book)**. When coding histology, keep in mind that regardless of the manual you are using, the general rules still apply. Use the ICD-O-3 manual to familiarize yourself with its contents and how histologies are grouped (squamous cell, adenocarcinoma, melanoma, sarcoma, lymphoma, leukemia, etc.). The ICD-O-3 is still used to assign the C code (the topography code).

2. Check the **NAACCR and IARC 2018 Updates Tables** to determine if the histology/term/code is one that has undergone some sort of change for 2018. This serves as a flag to pay particular attention when coding this term. Do not code based on what is in this table (yet). Use the Solid Tumor Rules manual first.

3. For solid tumors, follow the **2018 Solid Tumor (MP/H) rules** to determine the histology code. For hematopoietic cases, follow the **Hematopoietic and Lymphoid Manual and Database rules**.

4. If the Solid Tumor/Heme Database Rules do not provide the code that should be used, look up the term on **NAACCR and IARC 2018 Updates Tables**. If there, use the code provided.

Specific coding instructions, if applicable, are noted in the Comments column. Instructions include coding pre-2018 cases according to the 2014 histology crosswalk and most importantly, specific coding instructions for selected histologies and codes with major changes.

For example, the ICD-O-3 Matrix rule does not apply to *pleomorphic* lobular carcinoma in situ which has a new code (8519/2). Invasive pleomorphic lobular carcinoma is coded 8520/3. Assigning malignant (/3) behavior to 8519 is incorrect and will result in an edit.

5. If not in the **NAACCR and IARC 2018 Updates Tables**, then look up the term on the **IARC ICD-O-3.2 Morphology Table**. Hopefully, most site-specific issues were addressed by the Solid Tumor Manual and Heme Database.

Keeping Up With Quality Review—Even Remotely!

Frederick L. Greene, MD FACS

In these COVID-19 times, our world has become topsy-turvy. For our registry community, however, we are actually quite ready for these disruptive stretches since many cancer registrars work from home and are well versed in the technical retrieval of cancer-related data. I would go so far as to believe that much of our work has been enhanced in these sequestered times! For me, one of my joys in working with our registry is to participate in quality review of our abstracts. This is inherently a part of our Commission on Cancer accreditation process. The current pandemic, luckily, has not interfered with this process.

As many of you have heard me say, I believe that the quality review process is a vital standard for CoC Accreditation and needs to have strong clinician involvement. In my view, this involvement is not aimed at creating physician oversight of the registry, but is a process whereby clinicians can learn the importance of having a correct and up-to-date cancer archive. As a clinician, I am fortunate to work with our registry at the Levine Cancer Institute and to see the dedication to abstracting on a very personal basis.

When I site visit COC-accredited hospitals, I spend extra time talking with physicians who perform quality review and especially enquire as to their familiarity with Class of Case. As you can imagine, this engenders a “deer in the headlights” response! My message to the registrars at the individual programs is to have an in-service to teach physicians about the application of Class of Case in order to enhance clinician review.

We must always remember that the quality review process is fundamentally aimed at the educational program of our registrars. The issues raised in abstract review should serve as templates for registrar instruction on both a local and national level. I have the opportunity to

participate in these instructional sessions when our entire registry group assembles. Again, this structure gives additional meaning and importance to the abstract review concept.

It is my hope that all CoC programs have continued to perform well-done quality review during these times of remoteness. We are fortunate to have these technologies that enable us to interact for both our personal and programmatic activities. Once this pandemic has abated, I will again enjoy sitting in the same room with our wonderful registrars to perform abstracting oversight. Until then, I look forward to seeing you all on Skype! Stay well.

Stay Safe! Stay Healthy!