MODMM FALL/WINTER 2021

President's Message

by Jackie Halsey CNMT, CTR

I am proud to be a Cancer Registrar and I hope you are too. No one understands how detailed the profession is until you perform the job. We worked hard to become a CTR and to earn those credentials.

A common conversation starter when meeting new people is "What do you do for work?"

I tell them, "I am a Cancer Registrar. Cancer Registrars collect and report cancer statistics. We collect patients' history, diagnosis, treatment, follow-up, and recurrence. We report every U.S cancer patient story." Then, I will mention that I am an educator in the profession.

Some may be interested, while others will state, oh, and then move on to something else. Sometimes, my fast nature of talking while shooting out medical terms, I find I overwhelm them. A few might respond with, "Cancer, that must be a sad job. How do you handle that?"

Does this scenario seem familiar?

My answer about the job is a quick summary but deep down, Cancer Registrar's are so much more than that. Constantly, we adapt and accept change, we are always learning, plus we have an AMAZING language all our own which only other Cancer Registrars can understand. These are all reasons why I am proud to be a Cancer Registrar.

Here's another familiar scenario. One day, a friend or family member will get diagnosed with cancer and they will reach out to you thinking you are the cancer expert. You will listen to their story and offer guidance without realizing; twenty minutes fly by. Often, that person feels better after talking with you. This common scenario provides another moment when I am proud to be a Cancer Registrar.

Being a Cancer Registrar has affected me on a personal level. I turned 40 this year and my world got ROCKED. Not jamming best concert music ever ROCKED, but S.O.S, my boat is on fire, please send help, that kind of ROCKED. I was diagnosed with a Neuroendocrine Tumor (NET) Grade 2 Stomach Cancer. My CT imaging showed no adenopathy but a newer PET/CT scan using Gallium 68 as a radiotracer specialized for NET tumors found perigastric adenopathy. Clinically, I was Stage 3. Hearing it was in my lymph nodes was one of the hardest days in my life. The huge factor causing this was I knew way too much about cancer. However, after the news set in, I can still truthfully state with my whole sense of self, I am still very proud to be a Cancer Registrar.

With my knowledge I gained as a Cancer Registrar, I knew NET tumors have a great outcome. I know I can beat this life hurdle. I read my own imaging and pathology reports and was not in the dark about anything. My medical team explained items like I was a colleague of theirs. A subtotal gastrectomy with a lymph node dissection will be my first course treatment then systemic treatment will be considered.

I have floored my husband, parents, family, and friends with my cancer knowledge. Most of them did not care about specific data points like the grade, extension or the Ki-67 and only care about the stage and treatment. Am I going to be okay? As Cancer Registrars, we care about those data points. As Cancer Registrars we capture the full picture of cancer and know it is about more than just statistics. It is Cancer Registrars that help pave the way to a cure. We all should feel honored about our time, hard work, and consistent effort to succeed in this profession.

We ALL TRULY NEED to be proud to be a Cancer Registrar! I want to share my utmost gratitude and take time to thank you all for becoming a Cancer Registrar. Your work matters!

What is a NET?

NET's are a group of uncommon cancers that begin in specialized cells called neuroendocrine cells. Neuroendocrine cells have traits like those of nerve cells and hormone producing cells.

Where are they found?

Unlike other forms of cancer, neuroendocrine cells are found throughout the body. This means NET can be found almost anywhere in the body. The most common locations include the bowels, liver, appendix, pancreas, and lungs. Less commonly, they are found in the thymus gland, ovaries, and stomach.

A special NCRW packet will be mailed in February 2022 to all NCRA members. It will contain the NCRW 2022 poster, press release, and a special gift to commemorate the week.

Consider becoming a Mentor for the NCRA. FAQ about this exciting opportunity can be found here: https://www.ncra-usa.org/Portals/68/PDFs/MentorFAQ.pdf?ver=2017-05-21-223517-050

And the form to apply to become a mentor can be found here: https://www.ncra-usa.org/Education/ICA-Mentoring-Programs/Become-a-Mentor

MCRS Update/Info

By Jennifer L. Nelson, MCRS

PROSTATE:

Discussion at MCRS regarding histology codes 8500 and mixed code of 8552 and the following examples sent to Ask a SEER Registrar:

Example #1:

2019 Prostate biopsies: Right medial & lateral apex shows adenocarcinoma, ductal type, Gleason 4+4=8. Left apex, medial & lateral shows adenocarcinoma, acinar type, Gleason 3+3=6.

QUESTION 1: Is histology 8500/3 per Other Sites Rule per H13?

Rule H10 states acinar is coded to 8140 – continue onto next applicable rule.

Rule H13 – code to 8500 (adenocarcinoma and a specific type)?

This histology is not described as mixed ductal and acinar ductal carcinoma in these biopsies.

Example #2:

2019 Prostate biopsies: A, B, C, G, H, I, J & M all have adenocarcinoma, NOS, Gleason 3+4=7 & Gleason 3+3=6. L shows adenocarcinoma, ductal & focal acinar types, Gleason 4+3=7.

QUESTION 2: Is histology 8500/3 per Other Sites Rule per H13?

Since the acinar histology is preceded by the word "focal", would one continue to first applicable rule H13?

QUESTION 3: However, if example 2 had been described as adenocarcinoma, ductal and acinar types, would the code be 8500/3?

The histology is not described as mixed ductal and acinar ductal carcinoma in this tumor. Or do we infer it is "mixed" and code 8552?

QUESTION 4: Does code 8552 only apply to histologies that are specifically worded as Mixed acinar and ductal carcinoma?

Note that we reviewed SEER Educate: Other Sites 004 Scenario that discussed histologic type: Mixed acinar ductal carcinoma 8552/3. **We also reviewed the Updated 8/22/2018 ICDO table:** This contains code 8552 mixed acinar ductal carcinoma.

ASK A SEER REGISTRAR RESPONSE WAS (#23717):

It took research into the previous ICD-O update documents from 2011 to gather information on 8552/3. In 2011, April Fritz chaired the ICD-O Implementation Task Force and had direct communication with WHO/IACR ICD-O committee. Unfortunately, April did not share the ICD-O documents and kept them private. We have been unable to find them. The documents from WHO in 2011 applies to changes from the 4th Ed GI Blue Book, Hematopoietic BB, and CNS BB released at that time. This document included 8552/3 and is listed specifically with pancreatic histologies. This information was not included in the NAACCR 2014 ICD-O-3 Update and was subsequently not included in the 2018 update. ICD-O-3.1 lists 8552/3 without a site code, however, follow up with our expert pathologist indicates a mixed duct and acinar prostate tumor would be coded to duct, NOS. We will work on providing additional information in the 2021 ICD-O update as well as the revised solid tumor rules for other sites.

Q1: code to ductal per H13
Q2: Ignore the "focal" acinar and code to 8500/3
Q3: Since acinar is consider adenocarcinoma, NOS in prostate, code to 8500/3
Q4: if the DX states "mixed ductal and acinar" then you may code 8552/3.
These instructions may change once the solid tumor/MPH rules are revised for prostate and other.

MCRS SUMMARY:

- 2018 – present - Mixed acinar ductal carcinoma code to 8552/3
- 2007 – 2017 - Use the MPH manual, Other Sites, to determine histology
- 2001 – 2003 - Code to 8250/3 – acinar adenoca (8550/3) and ductal adenoca (8500/3) are both subtypes of adenoca and the histology was coded to the highest code – per SINQ 20020011.

SARCOMA & LEIOMYOSARCOMA:

Discussion at MCRS regarding the histology for Undifferentiated pleomorphic sarcoma, high grade. 8830 vs. 8802. 8830 is a new term, which includes the term high grade. Question was submitted to Ask A SEER Registrar & response from Lois Dickie was:

When the diagnosis includes "high-grade" before or after undifferentiated pleomorphic sarcoma, code 8830/3. If the diagnosis does not include high grade 8802/3 is used. Soft tissue tumors are problematic as pathologist are inconsistent in the terminology they use. WHO recently released the 5th Ed Soft Tissue/Bone tumors books and we are working with our soft tissue expert to see if we can come up with guidance on coding. Comma placement also do not matter, anytime the term high grade is used with undifferentiated pleomorphic sarcoma you are to use the code 8830.

NPCR ETC Melanoma 2021 Solid Tumor Rules Webinar 3/11/2021:

- Early & evolving melanomas are now reportable starting 1/1/2021 & forward
- Starting 1/1/2021 C44.4 requires laterality & will be separate primaries if they are right and left or a right or left & midline
- Code the most specific histology whether it is from the biopsy or the resection
    - If there is a discrepancy use the resection
        - Discrepancy meaning they are on different rows in the Solid Tumor Rules but are one tumor
- WHO broke down melanoma into two groups
    - Sun exposed skin
    - No sun exposure
- M5 -- timing is now irrelevant
- Histology priority
- There is an exception for coding histology prior to neoadjuvant therapy.

    - If the initial histology was from FNA/smear/cytology you can use the histology on resection after neoadjuvant therapy
- If tissue is sent for a consult us the histology from the consultation
- If the diagnosis is melanoma with a nodular component use 8720 as we don't know if that truly means nodular melanoma
- Can't code 8743 if the diagnosis reads superficial spreading "growth pattern."

MCRS PROSTATE QUALITY STUDY – Completed by Gail Jolitz:

As part of MCRS' ongoing quality program, 2018 prostate cases were reviewed, comparing the coded "grade clinical" to the site-specific data items "Gleason patterns clinical" and "Gleason score clinical", and verifying these codes by also reviewing text fields. (Reminder: these clinical fields are coded based on findings on biopsy or TURP and coded separately from the pathologic fields.)

Examples of inconsistencies that were identified:

- pathologic findings from a prostatectomy were coded in the clinical Gleason fields.
- "9" was coded in the Gleason fields when Gleason results were found in text.
- Gleason score of 07 is used for both "4+3" and "3+4"; these codes were sometimes turned around and that changes the clinical grade. "3+4" is a clinical grade 2; "4+3" is a clinical grade 3
- Site specific data items were coded correctly but clinical grade was coded incorrectly.

Registries may want to query your own database and look at your 2018 prostate cases. MCRS has already corrected cases sent in prior to 3/1/2021. There is no need to submit a corrected abstract.

CHRONDOSARCOMA GRADE 1

- Chondrosarcoma grade 1 is not reportable
- WHO considers this term equivalent to atypical cartilaginous tumor of bone
- Low grade considered an equivalent term
- Chondrosarcoma grade 2 and 3 are reportable
- See SEER SINQ 20210010 & 20160055 for further details
- Please note chondrosarcoma grade 1 becomes reportable (9222/3) starting with cases diagnosed 1/1/2022 & forward

ICD-O-3 IMPLEMENTATION GUIDELINES

Reminder of a good source to keep up with changes in terms and/or behavior codes is: https://www.naaccr.org/icdo3/ This is a good site to look at current guidelines vs. previous guidelines to see when a new term and/or histology code becomes reportable.

NAACCR GOLD!!

MCRS received Gold certification in June 2021 for the December 2020 data submission. This certification is a reflection of all the hard work that our reporting facilities do and belongs to all of us. A huge thank you to all

of you! If you are new to cancer registry and not exactly sure of the criteria for certification, I encourage you to check out the criteria on the NAACCR web page, https://www.naaccr.org/certification-criteria/. MCRS also received the NAACCR Fitness for use Recognition. The criteria for that are also found on the NAACCR certification web page. Again, Kudos to you all!

COMPLETENESS:

NPCR requires MCRS to monitor completeness on a monthly basis. We thought we would share the most recent completeness rates. Please note that any 2020 data are calculated using prior years. Due to the impact of Covid, numbers reflected are smaller than what will be actual.

Overall Completeness, includes path only cases:
2019 dx year – 93%
2020 dx year – ~56%, based on prior years.

Reporting registries. Overall rate of just registry submissions, not per registry:
2019 dx year – 91% complete. 98 % of registries have submitted 2019 data. 73.6% are above 90% complete.
2020 dx year – 62.4% complete. 90% of registries have data in for 2020, 75% of registries are above 50% complete.

Reminder:

Steps for Coding Histology: Cases Diagnosed 2018+

1. Refer to Solid Tumor Histology Rules or Heme Database
   If not found, then
2. Refer to the 2018 ICD O 3.2 Coding Tables
   If not found, then
3. Check your ICD O 3.0 Manual (purple book) or online version
   If not found, then
4. Check SINQ- SEER Inquiry System

MCRA/WCRA Conference Follow Up

By Jess Klaphake

MCRA/WCRA Conference Follow up:

- Conference went well with over 300 people in attendance from across the nation
- Excellent feedback from members on the speakers and topics
- Q & A, updated slides and CE certificates were sent out on October 8th, 2021
- We are hoping to continue regional conferences with Wisconsin - WI will be planner for the next regional conference in 2022
- New CTR Recognition to Kim Bechtold, Cherol Young and Sara Bernsdorf – Congratulations!

2021 MCRA/WCRA Regional Conference

By Jackie Halsey

As always, the 2021 MCRA/WCRA Regional Conference was a wonderful education conference. Thank you to the Regional Planning team for the hard work you endured planning this virtual conference. It was very informative and many CTR's appreciated it!

Even though, I enjoy the casualness of the virtual conferences, it cannot replace the personal connections that I miss. I remain hopeful that the future conferences can go back in person.

Some recap from items at the conference:

- Ambiguous Terms are important. Always check them!
- In 2022, CoC will no longer be collecting SARSCoV2 data items
- Do not use ambiguous terms for LVI
- Refer to SEER Appendix C- Helpful references for registrars
- Record the last pre diagnosis PSA prior to biopsy and/or treatment and no earlier than 3 months before diagnosis
- First, Use the STM Manual for all histologies
- Remember, the primary site for Transitional cell carcinoma is C65.9
- Per SEER, the priority order for using documentation to identify histology gives equal weight to final diagnosis and synoptic report secondary to addendum or comments
- When coding surgery, use the entire operative report as the primary source document to determine the best surgery of primary site code.
    - The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence
- Scope of Regional Lymph Node Surgery
    - If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures.
    - For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7
- Accuboost is a Non-Invasive Breast Brachytherapy (NI BB) that delivers a boost dose to lumpectomy cavity. This should be coded as Brachytherapy, NOS 07
- Join Cancer Program News Email List
- Review your Chapter 1 AJCC Manual to refresh on the exception staging rules
- AJCC Manual page 17, Both Clinical and Pathological Stage IV: A patient may be staged as both clinical and pathological Stage IV if there confirmatory microscopic evidence of a distant mets site during diagnostic workup, which is pM1.

    - Example, cT3cN1pM1 Pathological Stage IV
- AJCC Manual page 18, Imaging studies performed after surgery are included in pathological staging if they are within the time frame or staging window
- What is correct SSDI code for ipsilateral adrenal gland involvement? If surgical resection is done and tumor is confined to kidney and staging is based on size, then there is no involvement of the adrenal gland which is code 0
- Epithelioid hemangioendothelioma w/WWTR1-CAMTA1 fusion is a new histology code and one that I will use the copy and paste function
- Cases dx January 1, 2022, forward, p16 test results can be used for SQCC HPV positive or negative
- For 2021 diagnoses, the most Practical Approach to Reportability, use the ICD O 3.2
- The Cancer Surgery Standards Program (CSSP) will improve the quality of surgical care provided to people with cancer and will set evidence-based standards for oncologic surgery

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Nominating Committee Message

Erin Hammell, RHIT, CTR; Nancy Hedstrom, RHIT, CTR; Jess Klaphake, RHIT, CTR; Candace Scherping, RHIT, CTR

The nominating committee is looking for volunteers and/or nominations for executive board positions for 2022/2023. *Please strongly consider volunteering so that we may keep our organization running smoothly.*

Eligibility: Any member in good standing for one full year prior to nomination shall be eligible to hold office. To be eligible for the office of President-Elect, a member must have served one full term on the Executive Committee prior to nomination.

These are the positions open for 2022/2023:

President-Elect: Shall assume the duties of the President in his/her absence and shall succeed to the office of President at the conclusion of his/her term of office. The President-Elect shall co-chair the Professional Development committee. Ensure website information is correct.

Secretary: Shall be responsible for records of all MCRA proceedings and shall distribute minutes of all business meetings to the membership.

Treasurer: Shall be responsible for the receipt and disbursement of all funds of MCRA and shall make written reports to the Executive Committee and to the membership. The treasurer shall serve on the Membership Committee.

These are the committees needing volunteers for 2021/2022:

Professional Development Committee: Shall be Responsible for leadership in the Professional Development of MCRA membership. It shall include the President-Elect, with responsibility for educational programs. It will include persons responsible for support of members seeking CTR status, and any other members as deemed by the President or the Executive Committee.

Communications Committee: The Communications Committee will include persons responsible for the MCRA newsletter, the MODMM (The Minnesota Oncology Data Managers Monitor) and for taking photographs. Liaisons to the Minnesota Cancer Council, National Cancer Registrars association, Minnesota Health Information Management Association, Commission on Cancer, Minnesota Cancer Surveillance System, Others as felt necessary, in order to carry on the responsibilities of the communications committee.

Website Coordinator: Shall be responsible for working with the Webmaster to ensure smooth operation of the MCRA website.

Nominating Committee: There shall be at least four members on the Nominating Committee, the chairperson (appointed by the newly elected President), the immediate Past-President, and two other members elected by the MCRA at the April (Spring) Annual Meeting. They are responsible for preparing, mailing, and tallying the ballots in accord with Article V. No member of this committee shall be eligible for office.

Membership Committee: Shall be responsible for acceptance of new members and for distribution of updated rosters to the members. The MCRA Treasurer shall be a member of this committee and provide updated information on payment of dues.

If you are interested in volunteering and/or nominating anyone for any of these positions, please contact one of the above nominating committee members. Emails will be sent out closer to the Spring meeting.

Thank you for your consideration in fulfilling these positions.

Outstanding Member Award Update

By Outstanding Member Committee

There were no candidates for the Outstanding Member Award. This is traditionally awarded at the Fall Conference by the President. Nominations are open for 2022 and can be sent to Jackie at Jackie.halsey@rctc.edu, Jess at klaphakej@centracare.com, or Mona at mona.highsmith@state.mn.us See attached nomination policy and nomination form.

Treasurer Report

By Amanda Hlad

The current balance is $29,526.46. Overall total cash flow is $2,041.53, with total inflow of $5,616.44 and total outflow of $3,574.91. We have a surplus mainly because there hasn't been an in person NCRA conference to send our President to, and other expenses have been normal.

Membership News

By Chunny Daiker

The 2021 membership directory was sent out in April 2021 to all active members. Since the membership roster was distributed in April, we have added a few additional members. Welcom New members: Nicole Miller, Tasha Jacobson, Lisa Gimber, Kevin Plamann, Jene Ost, Sara Cottrell, and Terrie Walker. Membership renewal will open again in January 2022 with the due date being Feb 1, 2022. Please share our MCRA association with other coworkers in your Cancer Registry Dept, new students, and those interested in possibly joining the CTR field.

Communications

By Breana Norton, CTR

I am the new Communication Chair and I send emails from the MCRA executive board to the MCRA membership and put together the MODMM bi-yearly. If you have any suggestions about the MODMM or have any questions concerning emails from the MCRA, please feel free to reach out to me. Thanks!

Professional Development News

By Professional Development Committee

Refresh your abstracting skills today! Please take advantage of the NAACCR Webinars. These are included FREE in your MCRA yearly membership fee. The recorded NAACCR Webinars are posted on our website under the Professional Development Tab. To view them live, we had 3 volunteers to be host sites!

- Kathy Lougiu – HCMC, Minneapolis
- Jane Siekkinen – Park Nicollet, St. Louis Park
- Abby Kohler – Alomere Health, Alexandria

There will be limited spots at each of the host sites so we will be **requiring** registration to attend at one of the host sites.

And 2 winners of a drawing for the remaining two live spots were Tristen Dessellier and Janice Anastasi. Congratulations!

NAACCR Webinar dates

10/7/21 Uterus
11/4/21 Bladder
12/2/21 Treatment
1/6/22 Lung
2/3/22 Data Item Relationships
3/3/22 Abstracting and Coding Boot Camp
4/14/22 Hematopoietic and Lymphocytic Neoplasms
5/5/22 Colon
6/2/22 Central Nervous System
7/7/22 Back to the Future: What Year is it and What Did I Miss?

MCRA Website | mcra.net

By Thomas Coles, The Website Guy

The MCRA Website is continually being updated with the most currently released NAACCR Webinars, recent job postings, MCRA newsletters, among other important website-worthy tidbits. As always, feel free to reach out to me if you have any questions, comments, or concerns. Thanks!

Did you know? The Minnesota Oncology Data Managers Monitor started in 1995 Under the direction of then President, Nancy Grandner.