GCCR Register

Georgia Comprehensive Cancer Registry

Fall 2005

The Multiple Primary and Histology Coding Rules Project

Adapted from The NAACCR Narrative – Summer 2005 Edition

The Multiple Primary and Histology coding Rules Project is a SEER Program-sponsored collaborative effort to review and revise histology coding rules and multiple primary rules in a manner that promotes consistent, standardized coding by cancer registrars. The new, site-specific rules are being developed to address an assortment of problems that have been associated with inappropriate, ineffective, or inconsistent application of the general rules to specific cancer sites.

Phase I of the rule development process consists of eight cancer sites and general rules. The proposed rule changes will be available on the SEER website in late 2005. During 2006, SEER and other partners will continue the development process by conducting a field trial, producing educational materials, and facilitating a national training program. Other phases of rules development will follow shortly thereafter.

In preparation for developing the new coding rules, the SEER Quality Improvement staff identified problems with the existing rules through a number of sources including field re-abstracting audits, casefinding audits, and centralized web-based reliability studies performed over the past five years.

The existing rules were found to be no longer optimally effective. Modifications had been made in an attempt to cope with the increasing specificity of pathologic descriptive terminology and additional ICD-O-3 histology codes, in particular the combination codes. But, the current rules were set up as general rules only and did not address site-specific issues such as site groups, histology groups, and mixed and combination histology codes. Consequently, the rules were difficult to apply and confusing to navigate.

In January 2003, the Multiple Primary and Histology Coding Committee (Histology Committee) was formed to tackle problems identified in existing rules.

The Histology Committee is a diverse group with membership from all but two SEER regions, CoC, AJCC, CDC, NPCR, NCRA, NAACCR, 15 central registry representatives, and Statistics Canada. Physician guidance by specialty pathologists and clinicians has been integral to the process. Regular consultation with the editors of ICD-O-3 has helped clarify coding rules and ensures that the new rules accurately reflect the ICD-O-3 intent.

The Histology Committee determined that it was necessary to develop site-specific rules. Eight cancer sites were selected for development of site-specific rules, and general rules have been developed for all other sites. Lung, breast, and colon were first chosen because they, along with prostate, represent over 50% of all cancer cases. There were also site-specific issues for each that could be clarified. The other sites were melanoma, cancer of the head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain.

Prostate was reviewed and there were no major problems coding histology or determining multiple primaries. The eight sites selected represent Phase I of the rules development process. The process will continue with (cont. next page)

Cancer Reporting from Physician Offices - A New and Exciting Project

By A. Rana Bayakly, GCCR Director

Cancer incidence rates are affected by the completeness, timeliness, and accuracy of data reported to the central registry. The Georgia Comprehensive Cancer Registry (GCCR) collect cases from hospital and non-hospital sources with the longest delay in reporting coming from non-hospital sources. This is especially true for cancers that are usually diagnosed and treated in non-hospital settings such as physician offices (e.g., early stage prostate and breast cancers, melanomas of the skin).

NCI estimates, through routine modeling of SEER reporting patterns, that the delay-adjusted 2001 incidence rate for all sites combined is about 4% higher than the observed 2001 age-adjusted incidence rate. It is about 5% higher for prostate cancer. The continuous updates to cancer data at GCCR illustrate the dynamic nature of cancer data collection as well as the need to improve completeness and timeliness of reporting from non-hospital sources.

In July 2005, GCCR was awarded funds to test a new method of reporting cancer data to the central office from physician offices.

The CDC's National Program of Cancer Registries (NPCR) has developed web-based cancer registry software called Web Plus to improve and/or enhance cancer data collection from physician offices. Last year, the Maryland cancer registry tested the software; eight other states including Georgia were added to the test phase this year.

GCCR elected to implement the project in the southwest and central regions of Georgia. In a few months, physicians in these areas will receive a letter inviting them to participate in the testing phase. GCCR will be conducting a training session with physician office staff as well as installing Web Plus software.

It is the objective of GCCR to determine for each physician office the actual caseload and the number of missed cases. This effort will not only improve cancer completeness and timeliness, but will also allow GCCR to identify which cases should be reported by hospitals.

Special Bulletins

The NCI training website has a new module for melanoma of the skin and is the first to contain collaborative staging as a part of the exercises. Also, all of the older modules are being converted to a new format and will contain collaborative staging in the exercise portions. The web address for the site is www.seer.cancer.gov.

All MRS Users: You must export all un-exported data to GCCS before any software upgrades are performed.

Data collection of Primary Central Nervous System Tumors has arrived at GCCR. We will be distributing this NPCR training manual at the GATRA meeting in November.

Coding Rules Project (cont.)

hematopoietic diseases and lymphomas as Phase II, with review of gynecologic and all other sites to follow.

The development of the new rules involved several steps. New site-specific rules were drafted and reviewed by the committee. At the same time, cases were requested and prepared for testing the rules. Multiple rules revisions were made, based on the pre-test comments and results.

The functionality and usability of the new multiple primary and histology rules were beta-tested through a series of "mini-reliability studies" focusing on the separate cancer sites. The reliability studies included single and multiple tumors. Cases included most common histology groups and subtypes for cancer, including divisions of major and minor histology types. Reliability studies also included instructions on how to use combination codes for the histologies. The 2006 field trial will further refine implementation processes in registry operations, informatics, and statistical reporting of cancer incidence.

The new multiple primary and histology coding rules will be implemented in 2007 and have become one of the hot topics for fall registrars association workshops. The rules were presented at the SEER Abstractors and Coders Workshop at NCRA this past April 2005 and the reviews have been positive regarding the changes. The SEER Program, in cooperation with NPCR and other partners, will continue the education process in early September by inviting approximately 100 trainers/ educators to participate in dissemination and implementation of the new multiple primary and histology coding rules.

Web-based cancer registrar education will be available on the SEER training website, http://seer.cancer.gov/, in late 2005. Histology and multiple primary issues will be covered in several modules, and continuing education units will be requested of NCRA for this training module. Recorded webcasts will provide other options for mass training of registrars who cannot attend an in-person workshop. Printed materials will be provided for a stand-alone manual as well as replacement pages for insertion into the *2004 SEER Coding and Staging Manual*.

Cancer Stat Bite

By Chrissy McNamara, GCCR Epidemiologist

- During 1999-2002, an annual average of 362 new cancer cases were diagnosed among children aged 0 to 19 in Georgia: 60% of which were leukemias, lymphomas, or central nervous system (CNS) tumors.
- The overall age-adjusted childhood cancer incidence rate for this time period was 145.5 per 1,000,000.
- The highest cancer incidence rate among children aged 0 to 19 years was for leukemia (35.6 per 1,000,000), followed by CNS neoplasms with a rate of 27.9 per 1,000,000.
- Overall, males had a higher cancer incidence rate than females. This difference was most apparent in lymphomas, CNS neoplasms, and germ cell tumors. Females were more likely than males to be diagnosed with renal tumors and thyroid carcinomas.

Childhood (Ages 0-19) Cancer Incidence, GA, 1999-2002

	Both Sexes		Males		Females	
	Cases	Rate*	Cases	Rate*	Cases	Rate*
All Types	1447	145.5	805	157.3	642	133.0
I - Leukemias, Myeloproliferative & Myelodysplastic Diseases	359	35.6	194	37.6	165	33.4
II - Lymphomas & Reticuloendothelial Neoplasms	219	22.8	136	27.5	83	17.9
III - CNS & Misc. Intracranial & Intraspinal Neoplasms	276	27.9	167	32.9	109	22.6
IV - Neuroblastoma & Other Peripheral Nervous Cell Tumors	87	8.1	46	8.2	41	7.9
V - Retinoblastomas	41	3.7	25	4.4	16	~
VI - Renal Tumors	67	6.2	33	5.9	34	6.6
VII - Hepatic Tumors	11	~	***	~	<5	~
VIII - Malignant Bone Tumors	73	7.6	41	8.4	32	6.9
IX - Soft Tissue & Other Extraosseous Sarcomas	121	12.4	69	13.6	52	11.0
X - Germ Cell & Trophoblastic Tumors & Neoplasms of Gonads	64	6.6	39	7.7	25	5.4
XI - Other Malig. Epithelial Neoplasms & Malig. Melanomas	124	13.0	46	9.3	78	17.0
XII - Other & Unspecified Malignant Neoplasms	5	~	<5	~	<5	~

*All rates are per 1,000,000 and age-adjusted to the 2000 US standard population.

Welcome Wagon

I have been in the Registry field since 1997 and been certified since 1998 working in the Washington PA and Pittsburgh PA area hospitals. I have also been an LPN for the past 26 years..

My husband's name is Lenny and our 2 grown sons are Mathu and Jason. I have 4 wonderful grandchildren. I enjoy going to auctions, leisure reading, shopping for my grandchildren and roller skating as well as attending church regularly.

I continue to get acclimated to the Atlanta traffic. I've met a number of very friendly people thus far and look forward to a lengthy stay here.

Nila Thomas
Cartersville Medical Center
Cartersville

FAQ's

Q: How is melanoma size coded?
A: Very important!! Go to your Collaborative Stage book or EOD manual and carefully look at the coding for size.

- **For 2004 and later cases:** Code the size of the tumor in "CS Size"; code Breslow's depth/thickness of the tumor in "CS SSF1".
- **For 2003 and earlier cases:** Code Breslow's depth or thickness as the size of the tumor.
- **Depth:** Expressed as Breslow's and measured in hundredths of millimeters (mms).
  0.30mm = depth code 030
  1.55mm = depth code 155
- When size is stated as 0.XX mm, move the decimal point two places to the right to get depth in hundredths of mms that is 0XX. If you have a size stated as 0.Xcm, move the decimal point three places to the right to get hundredths of mms.
- Helpful hint: Compare your depth with examples in the book.
- Text should accurately reflect the size. Be careful to note the decimal point in giving the depth. Example: The size may be .9mm but incorrectly written as 9mm in the text. Make sure "mms" is written in the text, unless the path report clearly states "cms" (which would be rare and should be preceded by a decimal point). Notice the manual does not give you a choice of cms.
- In situ melanomas do not have a Breslow's depth; by definition, there is no invasion of epidermis basement membrane. Depth of true melanoma in situ should be coded "999"
- Use size 000, no mass; no tumor found, for metastatic melanoma when the primary site is unknown.

Q: A pathology report states "suspicious for primary neoplasm". The physician then ordered an additional biopsy that proved to be positive for cancer. What is the date of diagnosis?
A: The rule is "the first time a recognized medical practitioner says the patient has cancer". "Neoplasm" is an ambiguous term - not equivalent to "cancer" per se (although "malignant neoplasm" is). In this case, go with the date of the biopsy, only because the physician used the word "neoplasm".

Mark Your Calendars…

GATRA 2005 Fall Meeting
The Amazing Race: A Race Through The Registry
November 9-11, 2005
Holiday Inn Macon Conference Center
Macon, GA

Meeting highlights include: digital mammography, breast cancer treatment, brain cancer treatment, esophageal cancer treatment, palliative care, clinical trials, and more…

Cancer Registry Training

Principles and Practice of Cancer Registration, Surveillance, and Control
October 17-21, 2005

Complete details are available at http://cancer.sph.emory.edu. Financial assistance is available. Contact your regional coordinator.

Georgia Comprehensive Cancer Registry
Georgia Department of Human Resources
2 Peachtree St NW 14th Floor
Atlanta, GA 30303-3142

Thank You Note from the Georgia Comprehensive Cancer Registry

GCCR thanks the following hospitals for submitting cancer data at least two months out of three (June, July, and August 2005).

Hospitals Reported Three Months Out of Three		
Appling Health Care System	Grady Health System	Polk Medical Center
Athens Regional Medical Center	Gwinnett Health System	Rabun County Memorial Hospital
Atlanta Medical Center	Habersham County Medical Ctr	Radiation Oncology Services
Augusta Plastic Surgery Assoc, PC	Hamilton Medical Center	Redmond Regional Medical Ctr
Bacon County Health Services	Harbin Clinic	Rockdale Hospital
Barrow Community Hospital	Hart County Hospital	Satilla Regional Medical Center
Berrien County Hospital	Hillandale Hospital	SE Georgia Health Sys – B'wick
Brooks County Hospital	Houston Medical Center	SE Georgia Health Sys – Camden
Burke County Hospital	Irwin County Hospital	Smith Northview Hospital
Calhoun Memorial Hospital	Jasper Memorial Hospital	South Fulton Medical Center
Candler Health System	Jeff Davis Hospital	South Georgia Medical Center
Children's Healthcare of Atlanta	Jefferson County Hospital	Southern Regional Medical Center
Clinch Memorial Hospital	Jenkins County Hospital	Spalding Regional Hospital
Cobb Memorial Hospital	John D. Archbold Memorial Hosp	St Joseph's Hospital – Atlanta
Coliseum Health System	Kindred Hospital	St Joseph's Hospital – Augusta
Colquitt Regional Medical Center	Macon Northside Hospital	St Joseph's Candler Health Sys
Crisp Regional Hospital	McDuffie Regional Medical Center	St Mary's Health Care System
Decatur Medical Center	Meadows Regional Med Center	Stephens County Hospital
DeKalb Medical Center	Medical Center of Central Georgia	Sumter Regional Hospital
Doctor's Hospital Augusta	Medical College of Georgia	SW Georgia Regional Med Ctr
Doctor's Hospital Columbus	Memorial Health Univ Med Ctr	Sylvan Grove Hospital
Dodge County Hospital	Memorial Hospital and Manor	Tanner Health System
Donalsonville Hospital	Miller County Hospital	The Medical Center
Dorminy Medical Center	Mitchell County Hospital	Tift Regional Medical Center
Early Memorial Hospital	Monroe County Hospital	Union General Hospital
Effingham County Hospital	Morgan Memorial Hospital	University Hospital
Emanuel Medical Center	Mountainside Medical Center	Upson Regional Medical Center
Emory Adventist Hospital	NE Georgia Medical Center	VA Medical Center – Atlanta
Emory Crawford W Long Hospital	Newnan Hospital	VA Medical Center – Dublin
Emory Dunwoody Medical Center	Newton General Hospital	Walton Medical Center
Emory Eastside Medical Center	North Fulton Regional Med Ctr	Warm Springs Medical Center
Emory University Hospital	Northlake Medical Center	Washington County Reg Med Ctr
Evans Memorial Hospital	Northside Hospital	Wayne Memorial Hospital
Fairview Park Hospital	Palmyra Medical Center	Wellstar Health System
Fannin Regional Hospital	Peach Regional Medical Center	West Georgia Health System
Fayette Community Hospital	Perry Hospital	Wheeler County Hospital
Flint River Community Hospital	Phoebe Putney Memorial Hospital	Wildwood Lifestyle Center & Hosp
Floyd Medical Center	Phoebe Worth Medical Center	Wills Memorial Hospital
Grady General Hospital	Piedmont Hospital	
Hospitals Reported Two Months Out of Three		
BJC Medical Center	Elbert Memorial Hospital	Oconee Regional Medical Center
Candler County Hospital	Gordon Hospital	Putnam General Hospital
Cartersville Medical Center	Henry Medical Center	Screven County Hospital
Central State Hospital Med Surg	Hutcheson Medical Center	St Francis Hospital
Charlton Memorial Hospital	Liberty Regional Medical Center	Stewart Webster Hospital
Chatuge Regional Hospital	Louis Smith Memorial Hospital	Tattnall Memorial Hospital
Chestatee Regional Hospital	Memorial Hospital of Adel	Telfair Regional Medical Center
Coffee Regional Medical Center	Minnie G Boswell Memorial Hospital	VA Medical Center – Augusta

New CTRs

The following candidate successfully passed the CTR Exam in March 2005 and formally became a Certified Tumor Registrar:

- Crystal Cornett - Rome, GA

Congratulations!