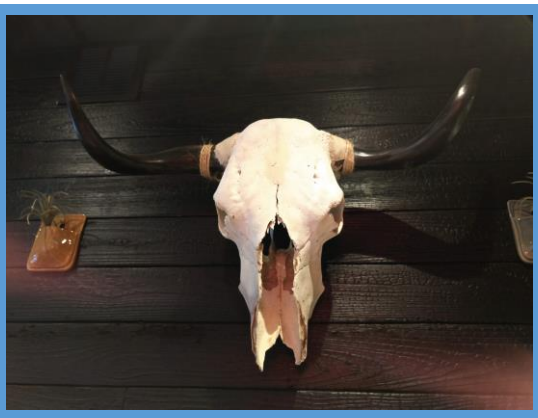
SUMMER NEWSLETTER



PR & COMMUNICATIONS

Stay Connected

If you would like to help with this newsletter, either as an editor or contributor, please email us: TRAC@trac-ct.org

Our Organization's Website www.trac-ct.org is updated regularly.

Social Media: Network with us on **Linked In** and follow us on **Facebook**!

EDUCATION

SAVE THE DATE

Annual Educational Meeting

Hosted at

Yale New Haven Smilow Cancer Hospital

November 6, 2019

We are currently in the planning process. If you have a specific topic you would like education about, please reach out to Sheri.

MEMBERSHIP

2019 Membership

It's the middle of the year. Have you moved? Have you changed to a new facility? If any of your contact information may have changed from the time you sent in your membership, please send Michele an email with updated information. Also, do you know your TRAC membership number? New members may join at any time! Simply complete the Membership Form and provide dues for the year.

From our last meeting:

The 4 general most common areas of 2018 coding errors include

a) Coding 0 vs 9 (going too fast or relying on drop downs)
b) Pathological Grade (for staging, use highest of clinical or pathologic grade)
c) (f) and (sn) suffixes (these apply to ALL sites, not just breast and melanoma)
d) Coding Scope of Regional Lymph Node surgery (when an FNA or BX is performed during clinical time frame)

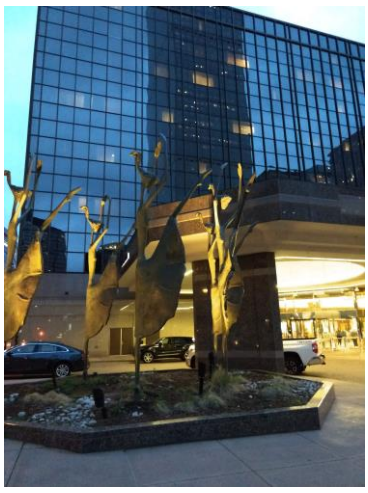
President's Message

Brooke Chang, BA, CTR

Hello again friends and colleagues! Hopefully everyone has received the new v18C Metafiles and completed most all of your "incomplete" cases by now. I hope you were successful with the Call for Data this past month. More than half of our membership attended our last educational meeting in Hartford last month! It was a great meeting and attendees earned 6.5CEs. I'd like to thank Sheri and the State of Connecticut Tumor Registry staff for the work they put into providing a good day of quality education. I added the upcoming 2019 TRAC Annual Meeting to NCRA's Education Calendar with a link to our website. http://www.ncra-usa.org/Education/State-Meetings-Calendar

Denver was a great place to visit and I was happy to see other members of TRAC attend the NCRA annual educational meeting.

The Symposia format of the conference allowed professionals to follow different tracks of education, with focus on the hospital registry, central registry, or on personal professional development. Throughout the Plenary Sessions, speakers kept discussing Natural Language Processing (NLP) and precision medicine utilizing genetics. Researchers want more accurate data faster. There is a push to explore both these fields and use the new technology when practicing medicine to drive discovery and enhance care. I attended the symposia for hospital registry. There was plenty of discussion on the changes for 2018 cases as manuals have now been finalized. Incredibly, it has taken up to April 2019 for all the resources to be finalized. Even so, your manuals continue to be updated as you'll soon read about in this publication. And yet, the ACoS COC is still pushing registrars toward concurrent abstracting by working to sunset RQRS and replace it with a pipeline of data called the Rapid Cancer Reporting System. At the very least, the workflow for the NCDB is intended to become more streamline. But it's not just "the college" who is working to streamline and enhance their processes. It's happening everywhere including places like the CDC and SEER. The goal is to acquire "Real-time Data".



It is clear no computer could replace a registrar. There are too many variables to sort through that require human logic and determine how data is collected. Rather the technology could greatly support the data collectors. Did you know the companies that perform precision medicine also employ tumor registrars? There are new opportunities for our profession all the time, even in the private sector. It will be interesting to see how this all plays out in the future.

-Brooke

NCRA Basket: Thank you Sheri for coordinating the basket and shipping the goods out to Denver. Michele and I had fun putting it all together. According to Nancy Allen, the NCRA Director of Operations and Contracts, "a little over $5K was raised from the sale of raffle tickets for the NCRA State Basket Raffle in 2019." A significant percentage of the proceeds from the State Baskets will be donated back to the State Associations who participated in the basket raffle. Krista Sterup, CTR won our State Basket. One of our members, Mary Jean also won a state basket.

Coding Quiz

Coding Sentinel Lymph Nodes Positive

A patient with Breast Cancer diagnosed Jun 2018 undergoes a Mastectomy and Sentinel LN biopsy with Axillary Dissection done at the same time. 2+/2 Sentinel LNs and 5 Regional LNs negative.

Q: How do you code Number of Sentinel Lymph Nodes Positive?

A) 02 Two Positive Lymph Nodes
B) 97 Positive sentinel nodes are documented, but the number is unspecified

TIP: you can find the answer with a rationale in the **STORE manual**. The answer can also be found at the end of this newsletter.

Vice President's Message

Sheri Amechi, CTR

We will be meeting in November at Yale New Haven Hospital. We are working on building a group of speakers and agenda. If you have a topic of interest, please let me know!

Also, please consider being a mentor for new registrars through NCRA. Contact me if you have questions.

REMEMBER

SCHOLARSHIP

If you are a member of TRAC interested in attending the Annual CRANE meeting this year, TRAC is offering to pay for your **early bird registration fee** as a Scholarship! The meeting is being held in our neighboring state Rhode Island Monday **September 16-Tuesday September 17th, 2019**.

Apply by sending an email to TRAC trac@trac-ct.org with the **Subject: TRAC Scholarship** and in the body "Please include me in the 2019 TRAC education scholarship drawing." Be sure to include your name, TRAC Membership ID# and the Facility/Company you work for. The Executive Board will select the recipient at random. Find out who we send in the next edition of our newsletter. To find out more about the CRANE Annual Meeting follow this link

From the Treasurer's Desk

Michele Wojewodzki, CTR

We have a current membership of 42 people. **Welcome** to our new members! The books were audited in early June and the audit was presented at our last business meeting, for details please review the business meeting minutes.

I have reviewed our bylaws and I'd like to know if everyone has/ knows their membership ID#. If you do not, please contact me. We will be utilizing membership ID in our upcoming elections.

BYLAWS

Committee: Cathryn Phillips CTR, Mary Jeanne Pierce CTR, Brooke Chang CTR

At the NOV 2018 TRAC meeting, attended by 33 TRAC members, two issues regarding TRAC bylaws were discussed. First, having two signatories for TRAC funds and securities. It was agreed that the TRAC President should serve as the secondary signatory. Secondly, there are discrepancies regarding when TRAC bylaws can be changed or amended**.** A consensus felt it appropriate to approve amendments at any meeting, providing adequate advance notice is provided to the membership**.**

We will be putting these topics to a vote, according to current bylaws, at the next Annual meeting in November. The bylaws were last updated in November 2016 and can be found on our organization's website.

The suggested TRAC Bylaws are as follows:

ARTICLE VI - OFFICERS

Section III - Duties

A. The President shall be the executive officer of TRAC; shall preside at the meetings of TRAC, the Board of Directors, and the Executive Committee; and shall be an ex-officio member of all committees except the Nominating Committee; **the President shall serve as the secondary signatory for all TRAC funds and securities**; The President shall officially represent TRAC at the National Cancer Registrars Association (NCRA) Annual Meeting. The President shall first seek funds from his/her hospital or other means to cover expenses, and shall submit to the TRAC Treasurer for reimbursement the paid receipts for the "Early Bird Registration" and travel expenses, using the best economical routing for travel not reimbursed by other means. In the event the President cannot attend the NCRA Annual Meeting, the Vice-President shall attend. If the Vice- President cannot attend, an alternate shall be appointed by the Executive Committee.

ARTICLE IX- MEETINGS

Section III – Voting

A. The following voting must take place at an annual meeting: **Costs for dues and meeting fees.**

ARTICLE X - FISCAL POLICIES

Section I - Fiscal Year

A. The fiscal year shall be from January 1st through December 31st.

Section II - **Fund and Securities Signatories**

A. There shall be established a primary and secondary signatory for all funds and securities of TRAC; the Treasurer shall serve as the primary signatory; the President shall serve as a secondary signatory in the event that the Treasurer is unable to sign.

Section III – Audit

A. The books and accounts of TRAC shall be audited annually and reported to the membership annually.

Nominations Committee

TRAC will be conducting an election in SEPTEMBER for a new board of directors. Now is the time to volunteer for candidacy. You can review TRAC Bylaws for a description of Board Member responsibilities. Reach out to current or past board members with questions about their time in service. Recommend an active TRAC member for candidacy (but let them know first) to our Nominations Committee! Please email trac@trac-ct.org if you would like to serve on the 2020-2021 TRAC Board OR directly contact one of our Nomination committee members: Terri, Jennifer, Tammy Corso.

ANNOUNCEMENTS

WELCOME to the **TRAC Board of Directors**: Patricia IaQuinto has volunteered to be our new Ways-N-Means person. She will be working on the Board of Directors to help find ways to grow TRAC's assets so we can continue to provide quality education our membership needs.

TRAC Board of Directors Meeting: was held on Saturday July 20, 2019 in Middletown, CT. Representatives from the Executive Committee, Bylaws Committee and Nominations Committee were present. We discussed actionable items for conducting our upcoming election, fundraising, and a comprehensive list of policies and procedures that need to be completed prior to finalization for approval.

Cancer Awareness Calendar:

July: UV Safety Month (Wear your sun glasses and sunscreen!)

AUG: Kick off for "Making Strides Against Breast Cancer" events, Summer Sun Safety Month

SEPT: Awareness month for Prostate, Ovarian and GYN, Leukemia and Lymphoma, and Childhood Cancer

https://www.cancer.org/

http://www.ashasexualhealth.org/gynecological-cancer-awareness-month/

CDC

https://youtu.be/NLX3TwVuCxk

FROM THE STATE

NANCY SANTOS, CTR

Connecticut Tumor Registry

JULY 2019 TRAC NEWSLETTER

2018 UPDATES

SEER Program and Staging Manual 2018 –partial listing of changes. The changes I've documented below are mainly related to coding.

See SEER website for a complete listing.

AIN III of the perianal skin changed to Squamous intraepithelial neoplasia III of perianal skin

Cervical in situ CA: collection stopped effective with cases diagnosed 1/1/1996 and later. As of the 2018 data submission, squamous cell carcinoma in situ is no longer required for any diagnosis year.

(RE: **Adenocarcinoma In Situ of the Cervix is reportable**). Per our Epidemiologist, Lou Gonsalves, *"based on the fact that incidence of both invasive and in situ cervical adenocarcinoma continues to increase, it would be good if we continue to collect AIS.*

Skin cancers overlapping sites in the head and neck ***ONLY*** assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; ***DO NOT USE CODE C448.***

Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site. NOTE: assign C760 for Occult Head & Neck primaries with positive cervical LNS> Schema Discriminator 1: Occult Head & Neck LNS is used to discriminate between these cases and other uses of C760.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. DO NOT CODE soft tissue as the primary site in this situation.
(ex.1) Leiomyosarcoma arises in the kidney. Code to primary site kidney C649.
(ex.2) Leiomyosarcoma arises in the prostate. Code to prostate, C619.

CODING REMINDERS

RULE CHANGE

The 2007 rules say a *Glioblastoma Multiforme* (GBM) following an Astrocytic or Glial tumor was a single primary (recurrence).
In the ***2018 Solid Tumor Rules,*** GBM subsequent to an astrocytic or glial tumor is a ***MULTIPLE PRIMARY.*** GBM is now being collected as a new primary so it's possible to analyze the frequency with which these tumors recur in a more aggressive form (GBM).

REPORTABLE MENINGIOMAS:

Intraosseous- dura layer of the meninges contacts the endosteum of the bones of the skull. The ***primary site*** for *intraosseous meningioma* is cranial meninges **C700**.

Sphenoid wing- meningioma arise in the cranial meningioma's **C700** which covers the bony structure called the sphenoid wing. The term "sphenoid wing meningioma" is used to identify the ***location*** of the meningioma because sphenoid wing meningioma's may be very invasive, spreading to the dura of the frontal, temporal and orbital regions.
Cavernous sinus- is located between the endosteal and meningeal layers of the dura.

There is no **ICD-0 code** for cavernous sinus because tumors do not arise in the sinus itself; the primary sites are: **cranial nerves** passing through the sinus (trochlear, abducent **C725**) or the cerebral ***meninges/dura*** **C700** covering the cranial nerve.

ICD-0-3 SEER Site/Histology Validation List

Errata for 6/18/2019 List – available on SEER website.

Casefinding List- Current

FY2019 ICD-10-CM / Effective dates: 10/1/2018 – 9/30/2019

https://seer.cancer.gov/tools/casefinding/

NAACCR UPDATE (received 7/12/19) from:

Lori A. Havener, CTR, Program Manager of Standards NAACCR

RE: Data Standards & Data Dictionary (Volume II), Version 18 Updates

In addition to the changes below an update has been released on, July 9th, which includes changes to several of the SEER requirements
In the Data Standards and Data Dictionary Required Status Table and recorded in the V18 CHANGE LOG.
https://www.naaccr.org/data-standards-data-dictionary/
The Data Standards and Data Dictionary (Volume II), Version 18 has been updated. The change log on the NAACCR website lists all of the changes (dated July 3 and July 8) that were made in this release.
Changes include:

- NAACCR XML IDs (n=18) that have been shortened to align the length of the NAACCR XML IDS with commercial software (e.g., SAS is under 32 characters).
- NPCR requirements (n=4)
- SEER requirement (n=1)
- Chapter III updates
- Derived SEER Cmb Stg Grp (3614) description update

EARLY/ EVOLVING MELANOMA

Reportability Change for 2018

For cases diagnosed 2018 and later, early or evolving melanoma is not reportable. None of the early/evolving melanoma types are reportable.

Some examples:

Early/evolving melanoma in situ, NOS

Early/evolving melanoma in situ, lentigo maligna type

Early/evolving melanoma in situ, (ex. superficial spreading)

Evolving/melanoma (borderline evolving melanoma) are tumors of uncertain biologic behavior. Histologic changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ.

The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium", "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or "severe melanocytic dysplasia", NOT REPORTABLE.

CODING REMINDERS

MULTIPLE cerebral meningiomas are a single primary.

MULTIPLE brain tumors of the (***same histology***) are a single primary.

Malignant CNS & Peripheral Nerves for which ***"laterality" must be coded.***

Paired Sites & Codes
Acoustic Nerve C724
Cerebral Meninges C700
Cerebrum C710
Cranial Nerves C725
Frontal Lobe C711
Occipital lobe C714
Olfactory Nerve C722
Optic Nerve C723
Parietal Lobe C713
Temporal Lobe C712

Midline tumors are common for glioblastoma multiforme and meningiomas.

*If you have an original tumor diagnosed before 1/1/2018 and a subsequent tumor diagnosed 1/1/2018 or later of the same primary site***: *USE the 2018 SOLID TUMOR RULES.***

From the desk of Cathy Phillips:

We would kindly appreciate your feedback on these two SEER initiatives:

1. What would be the best approach to capture recurrence information?

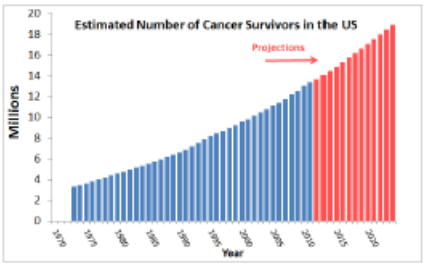
Why Is SEER important to the Research Community

- Supporting Cancer Research
  - Rapid Case Identification for Clinical Trials
    - Pediatric CC, IcanCare Study many others
  - Providing cost efficient follow up to research studies
    - VPR linkages (RadTech, CCSS, Transplant study etc)
  - Providing Real World Data for
    - Understanding disparities in outcomes
    - Understanding dissemination of new therapies or tests
    - And ultimately being able to understand how treatment works in the 95% of patients outside the clinical trial setting

Challenges for Cancer Surveillance

Capturing outcomes other than survival -recurrence

- Cancer is a chronic disease requiring
  - long term measures of outcome (recurrence)
  - Subsequent courses of therapy
  - Comorbid conditions impacting therapy and resulting from therapy
- With nearly 17 million cancer survivors in the US alone (nearly 5% of the population) lack of recurrence information is no longer acceptable

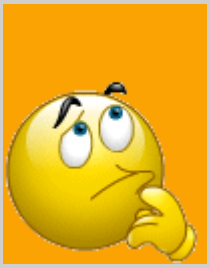


CODING REMINDERS

LCIS - BREAST

LOBULAR CA INSITU OF THE BREAST

IS THIS REPORTABLE??



AND THE ANSWER IS:

YES

We are required to collect and report these to SEER.

SINQ Question: 20140019

(Q) Is this reportable as 8520/2? Final diagnosis: Atypical Lobular Hyperplasia (ALH/LCIS). We are seeing this diagnosis quite often.

(A) AHL/LCIS is reportable. ***LCIS*** (***lobular carcinoma in situ***) is a reportable neoplasm. When LCIS is stated as the final diagnosis, ***REPORT THE CASE.***

Approach to enhancing SEER

- Main goals in enhancing SEER
  - Create a system representing population level real world data to supplement clinical trials and understand effectiveness of oncology care outside the clinical trial setting (96% of cancer patients not in clinical trials)
  - This is being done by:
    - Expanding the types of research the SEER infrastructure can support (epi, translational, clinical and potentially basic)
    - Expanding the clinically relevant data to create a longitudinal picture of each cancer patient's trajectory from diagnosis to death

Use Case Examples of Patient Trajectories – Linked data from multiple sources

	SEER Diagnostic Data	SEER Surgery/ Rad Rx Data	Treatment Claims Data	Treatment Pharmacy Data	Outcome SEER
HR+/HER 2- Breast	49 YO Stage IA ductal Oncotype Score=36	Lumpectomy (7/15) Beam Radiation	Docetaxel, Cyclo-Phosphamide (OCT NOV 2015)	Anastrozole 1 prescription 4/18	Vital Status Alive- 4/18
ER+/HER2+ Breast	70 YO Stage IA Invasive breast	Lumpectomy (1/15) Beam Radiation	Trastuzumab (3/15-3/16) Docetaxal/Carbo (3/15-3/16)	Letrizole 10/15- present 4/18	Vital Status Alive- 5/18
Lung	83 YO F Stage IIB adeno EGFR + Exxon19 ALK -	No Surg No Rad	No systemic chemo)	Gefitinib Nov 2016-Jan 2017 Erlotinib (Feb 2017)	Vital Status Dead 6/17
Stage III Melanoma	23 YO M Stage IIIC Melanoma BRAF V600E/V600K mutation **Groin Mets 10/16**	Biopsy/ Wide excision (9/15)	No systemic chemo)	Dabrafenib/ Tretinitinibt (11/16 –present)	Vital Status Alive 2/18

Time since Diagnosis

2. The SEER Quality Improvement Expert (QIE) workgroup is in the process of developing resources for registrars for abstracting rare cancer cases.

   Does anyone have any references, resources or expertise on, *"pleural mesothelioma"* or "*intra-and-extra-hepatic bile ducts"*?

*Please email Cathy: (*cathryn.phillips@ct.gov*) or call, 860-509-7163.*

CODING REMINDERS

SOLID TUMORS RULES
COLON and RECTUM
MAJOR CHANGES FOR 2018

- Neuroendocrine tumors (formerly **CARCINOID**) arising in the appendix are REPORTABLE.
- Pseudomyxoma peritonei is now classified as either high grade or low grade.

HIGH GRADE is malignant /3

***LOW GRADE is not malignant /1 (changed from /0 to /1 per July 2019 updates.**

- Dysplasia's which have an in situ (2) behavior code in the WHO ICD-0-3 Addendum ***are not reportable in the U.S.***

Code this as "CIS" only if the pathologist states it as carcinoma in situ or states intraepithelial neoplasia Grade III, or when the registry includes in their Policies and Procedures a pathologist's statement that high grade dysplasia is equivalent to carcinoma in situ.

DO NOT CODE POLYPS

- Polyps are now disregarded when coding histology. (ex.) adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma, 8140. For the purposes of determining multiple primaries, tumors coded as adenocarcinoma in a polyp for pre-2018 cases, should be treated as adenocarcinoma, 8140.

PROSTATE ANGIOSARCOMA

We wanted to share this unique case that one of our MRT's came across.

Patient with HX of Prostate Adenocarcinoma. S/P seeds 20yrs ago. Currently, presents with intractable hematuria requiring transfusions. TURP findings: noted to have a locally invasive Prostate CA, growing out of the prostatic fossa, invading the trigone and bilateral ureteral orifices.
Path: extensive fast growing angiosarcoma of the prostate with direct extension to the rectum, seminal vesicles with peritoneal carcinomatosis.
Because the second histology is not an "adenocarcinoma" this will be a new prostate primary.

"2018 SOLID TUMOR RULES" Rule M3":
"Adenocarcinoma of the Prostate is always a single primary"
NOTE 1: Report only one adenocarcinoma of the prostate per patient per lifetime.

Article on: PROSTATE ANGIOSARCOMA, "A Case Report and Literature Review"

(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4009976/)

JULY 17TH, 2019 SOLID TUMOR UPDATE

FROM: LOIS DICKIE

Based on questions and continued suggestions from registrars and educators, the decision was made to update the applicable rules at this time. Most changes are minor: *terminology, additional definitions, and new notes and examples.*

We recommend you read the July 2019 Change Log to understand what changes were made.

MAJOR CHANGES

LUNG H RULE:

We identified an issue with lung histology reporting by pathologists and after consulting with our expert lung pathologist, determined that a rule should be added to specifically address this issue.

The new lung "H RULE" addresses tumors with multiple types of adenocarcinoma and percentages of each type listed in the diagnosis. The original "H RULE" instructed registrars to code adenocarcinoma, mixed types (8255/3). Per our lung expert, ICD-0 code (8255/3) is strongly discouraged. The new "H RULE" provides instructions on coding the histology comprising the greatest percentage of tumor. LUNG TABLE 2 (Combination histology codes) has also been updated to reinforce the new "H RULE".

IMPORTANT:

We strongly suggest you review lung cases diagnosed 1/1/2018 forward with code (8255/3) to determine if a specific histology code can be assigned based on the new "H RULE". By coding a specific histology rather than the mixed histology, you will be able to assign stage.

CODING REMINDERS

DO NOT USE HISTOLOGY CODES:
8210, 8260, 8261, 8263, 8264 For C18.0 – C20.9

Colorectal Histologies

Terms that ***can*** be used to identify subtypes:

- Subtype
- Type
- Variant

Terms that ***cannot*** be used to identify subtypes:

- Architecture
- Major/majority
- Differentiation
- Features
- Foci, focus, focal
- Pattern
- Predominantly
- Any ambiguous terminology

Solid Tumor Manual Update: Colon 7/17/19

Terms & Definitions

Changes from 2007 Rules #5, bullet 3:
Behavior code for LOW-GRADE pseudomyxoma peritonei changed from /0 to /1

Table 1: Specific Histologies, NOS, and Subtypes/Variants:

"Any carcinoid mixed with neuroendocrine CA" removed as a synonym for Mixed Adenoneuroendocrine CA 8244

Multiple Primary Rules (Colon)

Rule M8: Abstract a single primary when a subsequent tumor arises at the anastomotic
site AND..

Note 1 added: "Bullet two does not apply to GIST. GIST's only start in the wall; never in the mucosa"

LUNG M RULE:

A rule was added to address separate non-contiguous tumors, one with a combination code from TABLE 2 and one with a single histology from TABLE 3.

A COMPREHENSIVE CHANGE LOG HAS ALSO BEEN POSTED FOR REFERENCE.

The updated rules published JULY 2019 apply to the following sites ***only:***

- Breast
- Colon/Rectum
- Head & Neck
- Lung
- Kidney
- Malignant CNS
- Non-malignant CNS
- Urinary

**Updates can be found on the SEER website:
https://seer.cancer.gov/tools/solidtumor/

CODING REMINDERS

Histology Rules (Colon)

Rule H2:

Code the histology and ignore the polyp when a carcinoma originates in a polyp. Term "Specific" removed from "Code the specific histology,
(causing confusion about NOS vs specific histologies).

RULE H4:

Code mixed mucinous and signet ring cell as follows:
Note added: *This rule for mucinous CA and signet ring cell CA in a single tumor. For mucinous adenocarcinoma mixed with another histology OR signet ring cell CA mixed with another histology, proceed through the rules".

RULE H5 and H6 switched places (rules reordered)

Rule H6: Code Adenocarcinoma NOS 8140 when the final diagnosis is….
Note added: "This rule is for mucinous carcinoma and signet ring
"Adenocarcinoma in a polyp" removed from the rule due to registrar feedback. The situation is addressed in a previous rule.

Please review manual the **Solid Tumor Manual for the remainder of the **July 2019 updates.**

"Sharing knowledge is not about giving people something or getting something from them. That is only valid for information sharing. Sharing knowledge occurs when people are genuinely interested in helping one another develop new capacities for action; it is about creating learning processes." -Peter Senge

CODING FAMILY HISTORY

Instructions and Rationale

Background: Family history is an historical item, and the rules/definitions are retained for consistency over time. Family history fields primarily describe the cancer histories of the patient's *first degree relatives.* **Codes 1 and 2 take precedence over all other codes.** First degree relatives are limited to the patient's:

- Parents
- Siblings
- Children

Code	Description
0	No history of cancer (in any relatives, regardless of degree)
1	At least one 1st degree relative with cancer of the same site/type
2	2 or more 1st degree relatives with cancer of the same site/type
3	First degree relative with cancer of another site/type, including unknown site
4	2nd+ degree relative with cancer
5	History in non-blood relative (e.g. brother-in-law)
7	Patient adopted, family history unknown
8	OBSOLETE 2002 forward
9	Unknown if any family history

Steps:

1. Is there no family history of cancer?
   a. If yes, code **0**
   b. If no, proceed to step 2
2. Is the patient adopted with no information on birth family?
   a. If yes, Code **7**
   b. If no, proceed to step 3
3. Are there two or more first degree relatives with cancer of the same site/type? (e.g.: father and sister)
   a. If yes, Code **2**
   b. If no, proceed to step 4
4. Is there a single first degree relative with cancer of the same type?
   a. If yes, Code **1**
   b. If no, proceed to step 5
5. Are there one or more first degree relatives with cancer(s) of different site(s)/type(s), including unknown primary site/type?
   a. If yes, Code **3**
   b. If no, proceed to step 6
6. Are there one or more 2nd + degree relatives with cancer of any site?
   a. If yes, Code **4**
   b. If no, proceed to step 7
7. Are there one or more non-blood relatives with cancer of any site?
   a. If yes, Code **5**
   b. If no, proceed to step 8
8. Is the family history of cancer unknown or not documented?
   a. If yes, Code **9**

----------End of Instructions----------

SEER SS2018

2018 SUMMARY STAGE

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemia's. SS uses all information available in the medical record (a combination of the most precise clinical and pathologic documentation of the extent of disease. Of note, the main category of Regional stage is subcategorized by the method of spread.

There are *six main categories* in Summary Stage.

Please refer to the 2018 Summary Stage manual for detailed definitions on these categories.

Code	Definition
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland

NOTE: ***Code 5*** "Regional, NOS" has been removed from the SS2018 manual, however, ***Code 5*** (Regional, NOS) is still applicable for SS2000.

GENERAL GUIDELINES

SS2000	SS2018 - REVISIONS
For each site, summary stage is based on a combined clinical operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to pathology report.	For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not, removed. a. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.
Summary Stage should include all information available through completion of surgery (ies) in the first course of treatment or within the four months of diagnosis in the absence of disease progression, whichever is longer.	Summary Stage should include all information available within ***four months of diagnosis*** in the absence of disease progression or upon completion of ***surgery (ies)*** in the first course of treatment, whichever is longer.

Summary Stage information obtained after treatment with radiography, chemotherapy, hormonal therapy, or immunotherapy has begun may be included unless it is beyond the time frame given in guideline 2 above.	Information for Summary Stage from a surgical resection ***after neoadjuvant treatment may be used,*** but ***ONLY*** if the extent of disease is greater than the pre-treatment clinical findings.
Exclude any metastasis known to have developed after the diagnosis was established.	Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when assigning Summary Stage.
Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the stage. Be sure to review clinical information carefully to assure accurate summary stage. If the operative/pathology information disapproves the clinical information, code the operative/pathology information.	Clinical information, such as a description of skin involvement for breast cancer and distant lymph nodes for any site, can change the Summary Stage. Be sure to review the clinical information carefully to accurately determine the extent of disease. a. If the operative/pathology information disproves the clinical information, use the operative/pathology information.
All schemas apply to all histologies unless otherwise noted. Exceptions to this, for example, include all Lymphomas and Kaposi Sarcoma which should be staged using the histology schemas regardless of the primary site.	Summary Stage chapters apply to ALL primary sites and histologies. Most chapters are based on primary site, while some are based on histology alone, or both primary site and histology.
Autopsy reports are used in coding summary stage just as are pathology reports, applying for the same rules for inclusion and exclusion.	Autopsy reports are used in Summary Stage just as are pathology reports, applying the same rules for inclusion and exclusion.
Death Certificate Only cases and unknown primaries are coded to “9” for Summary Stage.	Death Certificate Only (DCO) cases and unknown primaries are assigned “9” for Summary Stage; however, assign the appropriate Summary Stage when specific staging information is available on a DCO.
The Summary Stage may be described only in terms of T (tumor), N (node) and M (metastasis) characteristics. In such cases, record the Summary Stage code that corresponds to the TNM information. If there is a discrepancy between documentation in the medical record and the physician’s assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.	T,N,M information may be used to assign Summary Stage when it is the only information available. Use the medical record documentation to assign Summary Stage when there is a discrepancy between the T,N,M information and the documentation in the medical record. If you have access to the physician, please query to resolve the discrepancy. a. When there is doubt that documentation in the medical record is complete, assign Summary Stage corresponding to the physician staging.
Site-specific guidelines take precedence over general guidelines. Always consider the information pertaining to a specific site.	Chapter-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology chapter.

SSDI Manual

CERVICAL LYMPH NODES and UNKNOWN PRIMARY TUMORS of the HEAD & NECK

In AJCC 8th edition, a new chapter was introduced for situations when there are positive cervical nodes and the primary tumor is not evident (occult tumor) but the primary tumor is suspected to be from the head and neck region (***primary sites C00-C14, C30-32***) "Positive cervical nodes" is an overall term used for the head and neck regional lymph nodes, which include Levels I-VII, and other groups.

For a complete listing of these lymph nodes, see AJCC 8th Edition Chapter 5: Staging Head & Neck Cancer (pg.60; **Table 5.2** (Lymph node groups found within the seven levels and sublevels of the neck).

These guidelines pertains to cases diagnosed 2018 and forward. Prior to 2018, the guidelines were to code these cases to C14.8.

If the differential diagnosis includes non-head and neck sites, the primary site should be coded to ***C80.9.*** *Example: Pathology report states metastasis to cervical lymph node, could be from head and neck primary, lung primary or gynecological primary.*

Selecting the correct primary site is based on whether the Epstein - Barr virus (EBER test) is performed and is positive. If the EBV is done and positive, the primary site should be assigned to ***C11.9*** (Nasopharynx, NOS) instead of C760. In this case, use the AJCC Nasopharynx chapter.

	EBV Positive	EBV Negative	EBV Unknown
P16 Positive	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C10.9 Oropharynx (Schema ID 00100: Oropharynx HPV-Mediated (p16+))	C10.9 Oropharynx (Schema ID 00100: Oropharynx HPV-Mediated (p16+))
P16 Negative	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)
P16 Unknown	C11.9 Nasopharynx (Schema ID 00090: Nasopharynx)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)	C76.0 Ill-Defined Site of the Head and Neck (Schema ID 00060: Cervical Lymph Nodes and Unknown Primary)

If the p16 test for Human Papilloma Virus (HPV) is done and is positive and the (EBV is negative or unknown), the primary site should be assigned to ***C10.9***, (Oropharynx NOS) instead of C760. The AJCC HPV-Mediated (p16+) Oropharyngeal Cancer chapter will be used.

NOTE: P16 is a surrogate marker for HPV and is the only test that can be used for this discriminator.

If the neck node has not been tested or is negative for both HPV and EBV, the primary site will be coded to **C76.0** and the AJCC Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck chapter will be used.

*Refer to (pg.39) in the Site-Specific Data Item Manual for further instructions

https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1527608547

SEER Workshop-2019 NCRA Meeting Denver, CO

QUICK UPDATES

1. SEER Workshop: many issues still under review
    - NCI will be sending updates
2. EOD & Summary Stage revised 12/2019 – 1/2020
   Revised Summary Stage Manual will be posted on the SEER Website December 2019 / January 2020
   Clarifications/corrections

   NOTE: many of these have already been implemented in SEER*RSA
3. SSDIs and new coding formats
4. Reliability Study
    - Finalized answers to follow
5. Solid Tumor Rules
    - Common problems: BREAST & LUNG
    - When to use blank vs 9's
    - Changes to M and H rules
        - Ignore focus/focal
6. Tumor size: rounded codes (MD states "@ least 2.0" = 2.1
7. ICD-0-3.2 and beyond
    - New histology codes
    - Delays related to other rule revisions
    - ICD-0-5 (2025 -2026)

COC Cancer Program News – Updates and Alerts

NCDB: The Corner STORE

Stay up to date with the latest news, updates and alerts. https://www.facs.org/quality-programs/cancer/news

Here's where you can find the latest registry coding manual (STORE)

https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals

Online June 27, 2019

RQRS User Guide Updated

EPR Calculations Fields for ER and PR Data items were updated for v18.

Additional Changes have been made for Neo-Adjuvant Treatment to be added to MAC and HT.

WEBSITE SOURCE: https://www.facs.org/quality-programs/cancer/news/corner-store-062719

Online May 9, 2019

Radiation Primary Treatment Volume

Clarification for Use of Code 86 Pelvis (NOS, Non-visceral)

The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.

Scenario 1:

- The patient has a total Prostatectomy with seminal vesical removal
- Radiation treatment is stated to be directed to the prostate bed
- Code to volume 86 unless physician documentation states differently

Scenario 2:

- Patient undergoes TAH-BSO for cervical cancer
- Received post-op radiation to the pelvis.
- Code to volume 86 unless physician documentation states differently

WEBSITE SOURCE: https://www.facs.org/quality-programs/cancer/news/corner-store-050919

Online April 4, 2019

Radiation Primary Treatment Volume

Clarification for coding I-131 for Thyroid

As referenced in page 10 of the *CTR Guide to Coding Radiation Therapy Treatment in the STORE* (Version 1.0), technically, I-131 is effective wherever there are thyroid cancer cells in the body, so there is no specific anatomic treatment volume involved. Therefore, it is recommended coding radioisotope treatments as 98 (Other). While another reasonable option would be to code the volume as 93 (Whole Body), code 93 (Whole Body) has traditionally been reserved for whole body treatment with external beam radiation such as is done prior to bone marrow transplantation. For historical consistency purposes, please use 98 (Other). The next version of STORE will reflect this change.

WEBSITE SOURCE: https://www.facs.org/quality-programs/cancer/news/corner-store-040419

Coding Quiz- Answer

B. Code 97, POS sentinel nodes are documented, but the number is unspecified.

In the STORE Manual, Coding Instructions:

- **FOR BREAST ONLY**: If a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection, use code 97 in this data item, and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in *Regional Lymph Nodes Positive* [820].
- The CAP Protocol for Breast is designed to capture information from the resection (there is no diagnostic protocol for breast). As a result, when the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, only the overall total number of positive regional nodes (both sentinel and regional) is recorded; the number of positive sentinel nodes is not captured.

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