

OHIO CANCER INCIDENCE SURVEILLANCE SYSTEM



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OCISS Newsletter

OCISS Updates

OCISS Operations Supervisor

Jeremy Laws joined OCISS on Tuesday, May 28 as the new OCISS Operations Supervisor. He is backfilling the position held by Barbara Warther, who retired on March 29. Jeremy is a CTR, who holds both Bachelor and Master degrees, and comes to us with experience as a hospital registrar with The Ohio State University/James Cancer Hospital registry. Jeremy is the point of contact for cancer reporting questions. He can be reached by phone at (614) 644-9101 or by email at jeremy.laws@odh.ohio.gov.

NAACCR v 18 Update

Web Plus NAACCR v18 is now fully operational and v18C edits are in place. OCISS has appreciated the patience of all cancer reporters with this release. Several emails were sent to cancer reporters to help with processing abstracts and understanding edits.

There is one edit, in particular, that is creating confusion – CoC accredited flag. Although the error messages says it pertains to cases diagnosed 2019 or later, it runs on 2018 cases as well. Enter “0” if your facility is NOT Commission on Cancer (CoC)-accredited. Enter “1” or “2” if your facility is CoC-accredited; the value will depend on the Class of Case.

Additionally, we’ve learned that NAACCR will be issuing a corrected version of edits. They have posted a document that describes issues identified in the v18C edit metafile and how they will be corrected in the v18D release. For those of you who file upload and have your own vendor software, you can access it here: <https://www.naaccr.org/standard-data-edits/>. It is called the “Corrections Spreadsheet.” There are situations where you cannot clear the edit; per what is listed on the “Corrections Spreadsheet” you will need to keep the cases in suspense until the v18D edit metafile is made available. There are others that require follow-up with your software vendor and others that pass v18C edits that will need to be reviewed as part of a quality control process. We will keep you posted as we learn of updates on the new metafile.

At this time, OCISS is asking for reporters to submit 2018 data, though we realize some of you may already be working on 2019 data. If you file upload, please do not upload files with more than 500 cases.

OCISS had requested that any reporters with their own cancer registry software -- that had not yet converted to NAACCR v 18 -- submit any remaining data for diagnosis year 2017 by June 30. Let us know if you were unable to meet that timeline.

Death Clearance

OCISS has completed review of death certificates for calendar year 2017 with a cancer cause of death and has sent letters to physicians and hospice for additional information. Hospital follow-ups were uploaded into Web Plus in mid-June. Please contact OCISS with questions.

Audits

OCISS has been working on text to code audits on hospital cases diagnosed in 2017. We plan to send results out to hospitals in July.

Annual Data Submission

OCISS received notification that its annual data submissions to both the Centers for Disease Control and Prevention and the North American Association of Central Cancer Registries for diagnosis years 1996-2016 attained the highest levels for completeness and quality. Thank you for all that you do to submit timely, accurate, and complete cancer reports to OCISS!

Abstracting Tips from NAACCR Monthly Webinars

Once a month NAACCR hosts webinars regarding various topics for cancer registry. Each webinar provides three hours of continuing education (CE) credit, which are **available for three years after the live session** is presented. The site-specific webinars cover topics that meet the Category A requirements for CTR continuing education (via NCRA's "Category A FAQ" and email communication from NAACCR). Topics and webinars also include coding boot camp and coding pitfalls which cover the basics of cancer abstracting. The following are abstracting highlights and tips from the last few months of NAACCR webinars. Please refer to the specific webinars for more information; they are **posted on the Web Plus homepage**. If you do not have a Web Plus user profile but would like access to the webinars, please contact Jeremy Laws (jeremy.laws@odh.ohio.gov; (614) 644-9101).

Hematopoietic and Lymphoid Neoplasms (April 2019 webinar)

Please be sure to use the Hematopoietic and Lymphoid Neoplasm Coding Manual (Heme Manual) when coding all hematopoietic and lymphoid neoplasms. The manual was last updated in January 2019 (applicable to all cases diagnosed 2010+) and can be found [here](#). The SEER Heme Database is also useful for coding hematopoietic and lymphoid neoplasms and can be found [here](#).

Diagnostic Confirmation

When coding diagnostic confirmation, use code 1, positive histology, when the microscopic diagnosis is based on samples from tissue, bone marrow, or peripheral blood smear. For leukemias (9800/3 – 9948/3), use code 1, positive histology, when the diagnosis is based on a CBC WBC or peripheral blood smear.

- Code 1—positive histology
- Code 2—cytologic examination of cells (flow cytometry)
- Code 3—positive histology PLUS positive immunophenotyping AND/OR positive genetic testing results

Transformations

Hematopoietic and lymphoid neoplasm are capable of transformation. This refers to a chronic neoplasm that can transform to an acute and more severe neoplasm. For example, chronic lymphoblastic leukemia (CLL) or small lymphocytic lymphoma (SLL) (9823/3) can transform over time to diffuse large B-cell lymphoma (9680/3). Additionally, acute myeloid leukemia (9861/3) and myelodysplastic syndrome (9989/3) are both acute neoplasms that have transformed from a chronic neoplasm.

Using the Hematopoietic Database

The Heme Manual refers to these steps on page 21.

1. Identify the working histology code(s) and search in the database. When viewing the histology profile, be sure to check the sections for "Transformation to" and "Transformation from".
2. Determine the number of primaries. The multiple primary rules for hematopoietic and lymphoid neoplasms can be found on page 27 of the Heme Manual.
3. Verify or revise the working histology code(s).
4. Determine the primary site. The histology profile on the Heme Database will direct you to a module in the Heme Manual. The modules are specific to histologic type and will help you determine the primary site.

Grade

Grade is no longer applicable for cases diagnosed 2018 and later. Code the Clinical grade and Pathological grade fields to 8, not applicable. The Post-Therapy grade may be blank, or 8 if the patient had neoadjuvant therapy. The exception to this is follicular lymphomas in the lymphoma ocular adnexa schema, for which grade should be coded according to the AJCC 8th edition.

Multiple Primary Rules

Multiple Primary Rules for **chronic** vs **acute** disease are MP/H rules M8-M13.

There is an exception for rules M10, M11 and M13 when abstracting plasmacytoma (9731, 9734) and plasma cell myeloma (9732). Rule M10 *only applies* if the initial workup was completed and a *single* plasmacytoma was diagnosed. Rule M11 *does not apply* if plasmacytomas and plasma cell myeloma are diagnosed simultaneously as this is evidence of advanced disease (abstract one primary). Rule M13 *does not apply* to plasmacytomas that occur after a diagnosis of plasma cell myeloma as this is evidence of advanced disease (abstract one primary).

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AJCC Stage

Please refer to Chapter 79 of the AJCC staging manual (page 945) for hematopoietic and lymphoid neoplasms.

Lugano Classification for Hodgkin and Non-Hodgkin Lymphoma is the stage that is recorded in the AJCC Stage Group data item. The Lugano classification is used for all lymphomas eligible for staging in Chapter 79 (including CLL/SLL). Lymph nodes, Waldeyer's ring, thymus and spleen are considered nodal or lymphatic sites for the purposes of coding and staging. Therefore, it is not appropriate to use the (E) suffix, which is only used with stage 1 or stage 2 disease. The (E) suffix is used for lymphomas that arise in extranodal sites or when lymphoma arising from a node extends into an extranodal site. The exception to this is the liver. Any liver involvement is considered stage 4. Also keep in mind that involvement of bone marrow or peripheral blood is stage 4 for lymphomas.

Bulky Disease indicates a clinically enlarged mass. "Stage II bulky" is a new stage category for 8th edition. The stage description is the same as stage II but with disease bulk (be sure to look for physician statement of "bulky"). This may be considered either early or advanced stage based on lymphoma histology and prognostic factors.

- For Hodgkin Lymphoma, bulky is defined as greater than 1/3 the size of the cavity if mediastinal. If not mediastinal, bulky is defined as greater than 10 centimeters.
- For Non-Hodgkin Lymphoma, the definition for bulky disease varies based on histology.

Site-Specific Data Items (SSDIs)

- A/B Classification — no longer included as part of stage group.
- RISS Stage Group components are collected in the SSDIs.

Neuroendocrine Tumors (May 2019 webinar)

Neuroendocrine Tumors of the Pancreas

When assigning stage and histology to pancreatic cancer cases, it is imperative to differentiate adenocarcinomas that occur in the exocrine pancreas from neuroendocrine pancreatic tumors, known as pNETs, which arise in the hormone producing Islets of Langerhans cells within the pancreas.

pNETs are classified as functional and non-functional. Functional tumors are formed when cancer cells develop in hormone-producing cells. The instability of those cells can overproduce pancreatic secretions which often lead to specific sets of symptoms associated with a variety of medical syndromes. Because these symptoms are common to multiple conditions, approximately half of pNETs are misdiagnosed.

Like functional pNETs, non-functional pNETs can secrete excessive amounts of hormones; however they do not result in syndromic symptoms. Non-functional neuroendocrine tumors are oftentimes discovered incidentally and at a later stage.

Attention must be given to key terms in the clinician's text, such as neuroendocrine tumor or neoplasm, islet cell, pancreatic neuroendocrine, pNETs, PanNETs or PETs. The correct histology code is crucial for determining the behavior of the neoplasm, treatment options and prognosis.

Prognostic factors such as Ki-67 index, mitotic count, gastrin and CgA levels are not required for staging pNETs but are key in determining patient care and outcome factors.

Adrenal Neuroendocrine Tumors

Paragangliomas (PGs) are rare neuroendocrine tumors that originate in either the parasympathetic or sympathetic autonomous nervous system ganglia. Pheochromocytomas (PHs) are tumors that arise in the adrenal medulla.

From a histological standpoint, it is impossible to differentiate benign from malignant PG/PH tumors as there are no molecular or histologic markers for determining malignancy. Currently, malignancy is defined only by the presence of metastasis. Malignant PH/PGs account for 14-17 percent of PH/PG tumors. The incidence of PH/PG tumors is less than 1 per million per year, and malignant PH/PG tumors account for less than all endocrine tumors.

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OCISS

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TNM staging of PH/PG tumors is challenging. It is important to carefully review the Adrenal Neuroendocrine Tumor chapter in the AJCC 8th edition in order to stage accurately (chapter 77, page 927).

TNM staging may help in treatment and follow-up of patients with PH/PG tumors. Therefore, this staging system is based on the clinical predictors of metastases and survival of metastatic disease.

CT scans and MRIs provide useful information for determining the location/size of the mass and assessing the local extent of tumor, nodal involvement and distal spread. Biopsy of these tumors is not recommended because of risk of tumor rupture and seeding. However, evaluation of biochemical functions is critical. The final diagnosis usually is assigned once the primary tumor has been removed.

PH/PG tumors can metastasize to local/regional lymph nodes. For abdominal and pelvic PG tumors, regional lymph nodes are aortic and retroperitoneal.

ODH Releases New Cancer Publications

The Ohio Department of Health (ODH) recently released *Cancer Survival in Ohio* (May 2019). This is the first Ohio-specific report to provide a comprehensive examination of five-year relative cancer survival using OCISS data. Relative survival statistics are presented by cancer site/type, county, sex, race, age group, stage, primary payer and county type (poorest versus most affluent, rural versus urban and Appalachian versus non-Appalachian). In addition, this report includes comparisons of five-year relative cancer survival in Ohio and the United States, survival trends for all cancers combined and 23 primary cancers, survival among children and adolescents diagnosed with cancer, and information on late effects of cancer and cancer survivorship care plans.

In addition, ODH has recently released two updated site-specific cancer profiles, including: *Bladder Cancer in Ohio, 2012-2016* (April 2019) and *Stomach Cancer in Ohio, 2012-2016* (April 2019). These new profiles include Ohio-specific information on cancer incidence and mortality, trends, stage at diagnosis, histology, risk factors, signs and symptoms, early detection, and five-year relative survival statistics.

ODH's published cancer reports can be found on the Cancer Data and Statistics website at:

<https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/ohio-cancer-incidence-surveillance-system/data-statistics/data-statistics>.

Calendar of Events / Save the Date

OCRA Education and Annual Meeting

September 19 and 20, 2019

Perrysburg, Ohio

Details: <http://ohio-ocra.org/annualmtg/annualmtg.html>