

# OCISS Newsletter



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## OCISS Updates

**Web Plus:** The Centers for Disease Control and Prevention (CDC) has greatly reduced the requirements for state central cancer registry reporting of cases diagnosed in 2018. Most importantly, we will not be required to report TNM staging data for these cases. Requirements for Site Specific Data Items (SSDI) are minimal – there are only a handful that will be required.

OCISS reporting requirements for 2018 cases will mirror what we need to submit to CDC. We will not be requiring TNM staging data for 2018 cases, we will only require the SSDIs that CDC is requiring us to send to them, and we will add the newly-defined fields for Grade, radiation treatment, and SEER Summary Stage. Also, we will not be requiring reporting of Extent of Disease. Note that OCISS reporting requirements ARE NOT THE SAME as those required for facilities that are Commission on Cancer-accredited and report to the National Cancer Database.

As far as Web Plus, CDC was expecting that NAACCR v 18 software for both data entry and file upload would be available in late September; they have since moved that timeline back a month – to late October. OCISS will modify to accommodate the changes noted above as soon as the software is received. We will also go through a testing process so that, when we make the software available to Ohio reporters, the system is working properly.

Given that this will be happening at the same time as our Annual Call for Data (November 30), we do not expect that we will have new software available until the end of the year.

NAACCR has released edits for v 18 and staff have started to review; v 18A edits, however, are due out shortly. We will share our edit set as soon as it is available.

**Tobacco:** When we converted to NAACCR v 16, we added a field to collect Tobacco History data. OCISS collected this information in the past but discontinued it when we converted to Web Plus. When we added it back in, we included drop-down choices similar to what we had before. We recently realized, however, that we missed including two options — one, to capture e-cigarette use and another, to capture use of other tobacco products such as water pipes, dissolvables, etc. Those who directly enter cases into Web Plus will now see these new options. For file uploaders, we will get you the complete list of choices so you can work with your software vendor to incorporate into your NAACCR v 18 software.

**Close Out 2017:** Close Out forms for diagnosis year 2017 were emailed out in August and due back September 30. Although we realize there were delays in your being able to submit 2017 data to OCISS, we appreciate your efforts to get all 2017 cases reported. Please send in your Close Out form if you have not already done so -- even if you are not yet finished with your reporting of 2017 cases -- as this will help us understand what is still outstanding.

**Public Warehouse:** A reminder that OCISS makes aggregate cancer incidence data publicly available on the Ohio Department of Health website: <http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/StateLayoutLockdownCancers>. There are 11 canned reports that can be generated, each of which can also be customized.

**Training:** We hope you enjoyed the sessions at the Ohio Cancer Registrars Association Annual Meeting on abstraction of 2018 cases. We appreciated the opportunity to offer this training in conjunction with the Annual Meeting.

## Abstracting Tips from NAACCR Monthly and 2018 Training Webinars

NAACCR monthly Webinars are posted in [Web Plus](#). Each provides three hours of continuing education (CE) credit. CEs are available for three years after the live session is presented. NAACCR's **site-specific** webinars that cover Category A topics meet the Category A requirements for CTR continuing education ([NCRA's "Category A FAQ"](#)). The following are abstracting highlights from the last few months of NAACCR webinars. Please refer to the specific webinars and Q&A documents for more information.

**Audio Quality:** If you experience poor audio quality when *streaming* the webinar, please download the .ARF or .WMV video file to your local computer to watch.

**NOTE:** The information regarding abstraction of cases diagnosed on or after January 1, 2018 is current as of the date of the NAACCR webinar. There are periodic updates to the manuals for abstracting 2018 cases, so please refer to the most up-to-date manuals for definitive guidance in abstracting your 2018 cases.

### Thyroid and Adrenal Gland (June 2018 webinar)

- ◇ Non-invasive Follicular Thyroid Neoplasm with Papillary-like Nuclear Features (NIFTP) started to be collected as a synonym for Encapsulated Follicular Variant of Papillary Thyroid Carcinoma (EFVPTC), code 8343/2, starting with diagnosis year **2017**. When EFVPTC is specified as invasive or NOS, code as 8343/3. ([NAACCR—What you need to know for 2017](#)). This is also in the 2018 ICD-O-3 Coding Table (<https://www.naacr.org/implementation-guidelines/#ICDO3>).
- ◇ There was an additional update to the 2018 ICD-O-3 Coding Table on 8/22/2018—do NOT use 8510/3 for medullary **thyroid** carcinoma, instead code to 8345/3.
- ◇ I-131 treatment for thyroid cancer is to be coded to “26—Thyroid” in the Radiation Treatment Volume data field. This is clarified in STORE Manual 2018 with a note in the definition “Code this volume when treated with I-131 radioisotope.” Do not code I-131 scintigraphy as treatment; it is an imaging procedure.
- ◇ Synthroid is hormonal treatment for thyroid cancer, but only for the papillary or follicular histologies.
- ◇ T suffix (m) is used for multiple synchronous tumors OR for **multifocal** thyroid differentiated and anaplastic cancers. T suffix (s) is for **solitary** thyroid differentiated and anaplastic carcinoma **only** (chapter 73).
- ◇ For differentiated and anaplastic carcinoma of the thyroid (chapter 73), if the patient qualifies for pathological staging but no lymph nodes were examined microscopically, pNX may be used to calculate pathological stage group if patient has cN0 status. This is not the case for medullary thyroid cancer (chapter 74), although when there is pT4 category or microscopically proven metastasis (pM1), a pathological stage can be calculated due to “any N” in the staging table.
- ◇ Adrenal cancer is covered by 2 chapters in AJCC 8th Ed (cortical carcinoma chapter 76 and neuroendocrine chapter 77).

### Hospital Registry Operations (July 2018 webinar)

- ◇ This webinar is on hospital cancer registry operations in relation to the 2018 changes.
- ◇ First portion of the webinar covered how we learn new things, dispelled myths related to learning, identified learning barriers, and discussed effective learning strategies.
- ◇ Remainder of the webinar covered using tracking tools to manage changes. This includes cancer conference agenda templates and reports, tracking of Commission on Cancer Program Standards and cancer committee minutes. In addition, abstracting tips and guides for 2018 cases were shared along with a template on information to be collected and where to locate in electronic health records.
- ◇ Also discussed was presentation of cancer data to cancer committee and use of cancer data to make quality improvements.

## Solid Tumor (MP/H) Rules (August 2018 webinar)

- ◇ SEER's change log documents changes made since the various sections of the solid tumor rules were first posted: <https://seer.cancer.gov/tools/solidtumor/revisions.html> (please verify you have the latest version).
- ◇ AJCC staging does NOT determine number of primaries or histology; solid tumor rules determine this. **Do not** modify the histology to stage the case.
- ◇ Colon, some of the most notable changes for cases **diagnosed 1/1/2018 and later** are:
  - ⇒ Rectum and rectosigmoid are now part of the colon solid tumor rules.
  - ⇒ New multiple primary rules (rules M7 and M8) address anastomotic recurrence.
  - ⇒ Dysplasia that is assigned *in situ* behavior code of /2 per WHO and ICD-O updates is **NOT reportable** in the U.S. Pathologists frequently use the terms "severe dysplasia" or "high grade dysplasia" instead of carcinoma *in situ* (CIS). Code as CIS ONLY if the pathologists expressly states carcinoma *in situ*.
  - ⇒ Polyps are *disregarded* when coding histology, so adenocarcinoma in an adenomatous polyp is coded simply as adenocarcinoma (8140).
  - ⇒ Pseudomyxoma peritonei is now classified as either high-grade (malignant, behavior code /3) or low-grade (not malignant, behavior code /0).
- ◇ **Note:** corrections to the breast solid tumor rules have been made since the live webinar on 8/2/2018.
- ◇ Breast, some of the most notable changes for cases **diagnosed 1/1/2018 and later** are:
  - ◇ Duct or ductal carcinoma have new terms: no special type (NST), mammary carcinoma NST and carcinoma NST. Mammary carcinoma is considered a synonym for carcinoma NST and coded as 8500 instead of 8010.
  - ◇ Subtypes/variant, architecture, pattern, features are NO LONGER CODED for ductal/carcinoma *in situ* (DCIS). The majority of *in situ* breast tumors will be coded to 8500/2.
  - ◇ Instead of subtype/variant, the grade of DCIS is emphasized. Please code grade according to the new grade coding manual (<https://apps.naaccr.org/ssdi/list/>).
  - ◇ For invasive cancers, subtype/variant is only coded when it makes up >= 90% of the tumor.

## Coding Pitfalls (September 2018 webinar)

- ◇ This webinar consisted of 2 case scenarios (1 for breast and 1 for colon) and attendees followed along with the educators to work through each case using solid tumor rules, grade manual, tumor size (per STORE guidelines), AJCC TNM 8th Edition staging, extent of disease (EOD) and summary stage 2018, regional lymph node fields (per STORE guidelines), and site-specific data items (SSDIs) for each primary site.
- ◇ In AJCC TNM 8th Edition staging, there is no staging table for post-therapy, so although T, N and M may be assigned for post-therapy, the post-therapy stage group will be 88. If the patient did not receive neoadjuvant therapy prior to surgical resection, the post-therapy stage group will be blank.
- ◇ Biomarker (estrogen and progesterone receptors and HER2) results from the surgical resection (pathologic staging time-frame) may be used in the clinical AJCC staging of breast cancer if the biomarker studies were not done on the biopsy specimen (for example, due to insufficient specimen size) (reference: <http://cancerbulletin.facs.org/forums/node/77282>). This does NOT apply to grade, where clinical, pathologic and post-therapy grade must be coded based on information from their respective time-frames.
- ◇ Regional lymph nodes examined and positive (see STORE manual pages 167 and 200) is cumulative, but when there are positive regional lymph nodes from a *core needle biopsy* or *fine needle aspiration*, these are not double-counted if positive nodes are found on subsequent dissection of lymph nodes in **the same lymph node chain**.
- ◇ Each set of Solid Tumor Rules, as organized by primary site, has their own list of modifier terms that may or may not be used to code a more specific histology. Please refer to the appropriate rules depending on the primary site of the case being abstracted.



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## 2018 Diagnosis Year Educational Webinars Update

**NAACCR** (<https://education.naaccr.org/2018-implementation>) — free webinars on solid tumor rules introduction, breast, colon, lung, and CNS (benign and malignant); new radiation coding rules; and new grade coding rules.

**SEER/NCRA** (<http://www.cancerregistryeducation.org/seer>) — free webinars covering solid tumor rules: general instructions, and solid tumor rules: colon. Additional webinars will be forthcoming.

**AJCC** (<https://cancerstaging.org/CSE/Registrar/Pages/Eight-Edition-Webinars.aspx>) — head & neck staging and breast staging have been added.

## ODH Releases New Cancer Publications

The Ohio Department of Health has recently released *The Impact of Tobacco Use on Cancer in Ohio* (July 2018). Completed in collaboration with The Ohio State University, this 23-page profile includes Ohio-specific information on the 12 cancers attributed to smoking; the prevalence of tobacco use in Ohio; trends in tobacco use and tobacco-associated cancer incidence and mortality; data by county (maps); and tobacco-related events, policies, plans and initiatives. Some of the key findings include:

- ◆ Tobacco use is the leading cause of cancer—about 1 in 3 cancer deaths are caused by smoking.
- ◆ An estimated 7,700 Ohio cancer deaths each year among adults ages 35 and older can be attributed to cigarette smoking.
- ◆ Tobacco-associated cancer incidence and mortality rates are higher in southern Ohio where smoking is more common.

In addition, ODH has recently released three updated site-specific cancer profiles: *Ovarian Cancer in Ohio, 2011-2015* (August 2018), *Prostate Cancer in Ohio, 2011-2015* (July 2018) and *Uterine Cancer in Ohio, 2011-2015* (September 2018). These new profiles include Ohio-specific information on cancer incidence and mortality, trends, stage at diagnosis, survival, histology, risk factors, signs and symptoms, and screening. The reports are available at: <http://www.odh.ohio.gov/health/cancer/ocisshs/newrpts1.aspx>.

## Calendar of Events / Save the Date

**November 1, 2018** | 8:45 a.m.—2:45 p.m.

**Massachusetts Cancer Registry / Dana-Farber / Brigham and Women's Cancer Center Educational Workshop**

Boston, MA (webcast will be available)

Announcement: <http://listserv.naaccr.org/scripts/wa.exe?A2=NAACCR-LSERV;e80db995.1809b>

**November 8-9, 2018** | Indianapolis, IN

**Indiana Cancer Registrars Association (ICRA) Annual Fall Conference**

Brochure and registration: <http://www.icra-indiana.net/icra-annual-fall-conference.html>