

# Michigan Cancer Surveillance Program

## April 2007 Update

### **M**ultiple Primary and Histology Coding Rules ~

All cases diagnosed January 1, 2007 forward, **MUST** be abstracted and coded using the 2007 Multiple Primary and Histology (MP/H) Coding Rules. The rules are available in three different formats: text, matrix or flowchart. The rules however are identical across the three formats. It has been recommended that you decide which format is easiest for you to follow and to stick with that format.

The MP/H Manual will NOT be printed or distributed by SEER, CoC, NPCR or MCSP. You can download the entire manual to your desktop or print it. Registrars also have the option to download or print only one format. If you select only one format, be sure to download the Instructions and ALL of the documents associated with each set of site-specific rules. The manual can be downloaded from the SEER website at [www.seer.cancer.gov/tools/mphrules](http://www.seer.cancer.gov/tools/mphrules).

### **T**raining Web Casts ~

Web-based cancer registrar education is available on the SEER training website. SEER is providing recordings of the online MP/H Rules training sessions. The sessions and transcripts will be posted at <http://www.seer.cancer.gov>. Macromedia Flash Player is required to view the presentations, and the transcripts are available in PDF format. To complete the training for each cancer site, you must download and work through the site-specific case files before viewing the rules practicum.

### **A**mbiguous Terminology ~

The list for ambiguous terminology includes terms that have been mandated as reportable when used in a diagnosis. Effective with cases diagnosed January 1, 2007, and after, registrars are required to collect cases using the list of ambiguous terms listed below that are reportable.

- Apparent (ly)
- Appears (effective with cases diagnosed 1/1/1998 and later)
- Comparable with (effective with cases diagnosed 1/1/1998 and later)
- Compatible with (effective with cases diagnosed 1/1/1998 and later)
- Consistent with
- Favor (s)
- Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
- Most likely\*
- Presumed
- Probable
- Suspect (ed)
- Suspicious (for)
- Typical (of)

\*The presence or absence of term modifiers such as 'highly likely' or 'likely' is acceptable equivalents for 'most likely.'

There is no longer a non-reportable list of terms. If a term you are looking for does not appear on this list, the case is NOT reportable.

## **H**ow are Physicians going to be Educated about the Multiple Primary Rules? ~

Responsibility of physician education is at the Facility level. If you have not previously done so, it is recommended that the following items be covered at an educational forum for physicians and/or at Cancer Committee (CoC approved Cancer Programs).

- 1) The 2007 Multiple Primary and Histology (MP/H) Coding Rules present the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding by cancer registrars.
  - a) This project was sponsored by the National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program.
  - b) The MP/H Task Force included a diverse group with membership from the following:
    - SEER Regions (included all but two regions)
    - American College of Surgeons (ACoS) Commission on Cancer (CoC)
    - American Joint Committee on Cancer (AJCC)
    - Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR)
    - National Cancer Registrars Association of NCRA)
    - North American Association of Central Cancer Registries (NAACCR)
    - 15 Central Cancer Registry representatives
    - Canadian Cancer Registries
  
- 2) The 2007 MP/H Rules includes site-specific rules for the following sites:
  - Lung
  - Breast
  - Colon
  - Malignant Melanoma of Skin
  - Head and Neck
  - Kidney
  - Renal Pelvis, Ureter, Bladder and Other Urinary
  - Brain (Malignant Intracranial and Central Nervous System (CNS tumors))
  
- 3) The **Other Sites** rules is to be used for all solid malignant tumors that occur in primary sites NOT included in the site-specific rules.
  
- 4) Recurrence is a particularly important definition for the new rules. **Recurrence has two meanings.** They are similar, but the differences make use of the term very confusing to many registrars. The new site-specific rules have been developed to take the guess work out of trying to interpret what is meant when the term is used.
  - a) The first definition is: The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy.
  - b) The second meaning is: A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.

- 5) Registrars are to use the new rules to determine whether the patient has a recurrence of a previous cancer or a new primary for reportable solid malignant tumors only instead of a physician's statement.
  - a) The only exception is: when a pathologist compares the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.
- 6) If there is an invasive tumor following an in-situ tumor more than 60 days after diagnosis, the invasive tumor is abstracted as a subsequent primary.
  - a) The purpose behind the new rule; that it is to ensure the case is counted as an incident (invasive) case when incidence data is analyzed.
    - i) Explain that we do not want survival graphs showing people dying of in-situ disease. We also don't want survival time affected by the time between an in-situ and invasive tumor.
    - ii) CoC physicians were all supportive when the rule and rationale was presented to them.
  - b) Multiple primaries even if the medical record/physician states that it is a recurrence or progression of disease.
  - c) Rule is new for everyone except SEER registries.

NOTE: If an invasive occurs less than 60 days after an in-situ, single primary.

- 7) If the tumor has in-situ and invasive components, the in-situ term(s) are ignored and the morphology of the invasive component only is coded.
  - a) This is a change in the previous histology coding rules and is different from ICD-O-3 editors.
  - b) The consensus was that the invasive component of the tumor better explains the disease course and survival category.

*EXAMPLE:* Using the new rules, combinations of invasive duct and in-situ lobular is coded to invasive duct (8500/3) rather than the previous combination code for duct and lobular carcinoma (8523/3).

- 8) Neither laterality nor timing is used to determine multiple primaries for Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary Gland, Craniopharyngeal Duct and Pineal Gland.
- 9) Default timing rules have been established for multiple tumors (multiple tumors may be a single primary or multiple primaries. For Breast, Colon, Head and Neck, Kidney, Lung, Cutaneous Malignant Melanoma and Other Sites the default timing rules are follows:
  - a) Breast: Rule M5 – if the tumors are diagnosed **more than five (5) years** apart, multiple primaries.
    - i) The CoC breast site team helped establish this rule.
  - b) Colon: Rule M5 - if tumors are diagnosed **more than one (1) year** apart, multiple primaries.
  - c) Head and Neck: Rule M9 - if the tumors are diagnosed **more than five (5) years** apart, multiple primaries.
    - i) Data supports using a five-year rule for head and neck tumors. This rule will help prevent over counting the recurrent in-situ tumors that are prevalent in several head and neck sites.
  - d) Kidney: Rule M6 – if the tumors are diagnosed **more than three (3) years** apart, multiple primaries.

- e) Lung: Rule M8 – if the tumors are diagnosed **more than three (3) years** apart, multiple primaries.
- f) Cutaneous Malignant Melanoma of Skin: Rule M7 – if tumors are diagnosed **more than 60 days** apart, multiple primaries.
  - i) NO change from previous rule. Using 60 days instead of two (2) months for more consistent interpretation.
- g) Renal Pelvis, Ureter, Bladder and Other Urinary: Rule M7 – if tumors are diagnosed **more than three (3) years** apart, multiple primaries.
- h) Other Sites: Rule M10 – if tumors are diagnosed **more than one (1) year** apart, multiple primaries.
  - i) For ALL sites covered by this rules, the default timing rule is one year apart.

**New rules in the coding process for determining multiple primaries and histology**

**BRAIN**

- a) Rule M6 - if the original tumor was a ‘glial,’ a subsequent ‘glial’ tumor of any type is a recurrence, not a new primary.
- b) Rule M7 – tumors with histology codes on the **same** branch in Chart 1 or Chart 2, single primary.
- c) Rule M8 – tumors with histology codes on **different** branches in Chart 1 or Chart 2, multiple primaries

**BREAST**

- a) Rule M2 – is there inflammatory carcinoma in one or both breasts? If yes, single primary.
  - (1) This rule is new for registrars.
- b) Rule H13 - does the final diagnosis of the pathology report specifically state inflammatory carcinoma? If yes, code morphology to 8530 (Inflammatory carcinoma).
  - i. Inflammatory carcinoma is a clinical disease. The clinical appearance of inflammatory carcinoma is coded in Collaborative Staging extension; the CLINICAL appearance of inflammatory carcinoma is NEVER coded in histology.
  - ii. If the final diagnosis on the pathology report is ‘inflammatory carcinoma,’ code that pathologic diagnosis in ‘histologic type.’
  - iii. Do NOT code the pathologic diagnosis in ‘histologic type’ if the final diagnosis shows infiltration of dermal lymphatics but the words ‘inflammatory carcinoma’ are NOT included in the final.
    - a) By coding this way, the clinical can pull cases with a clinical diagnosis of inflammatory carcinoma by the using the CS extension and cases with a pathologic diagnosis by using the date item ‘histologic type.’
  - iv. This rule is new for registrars.

**COLON**

- a) Rule H3 – when the pathology report says ‘intestinal type adenocarcinoma’ or ‘adenocarcinoma intestinal type,’ code the morphology as 8140 (Adenocarcinoma, NOS).
  - (1) Intestinal adenocarcinoma only occurs in the stomach.
- b) Rule H4 and H21 – it is important to know whether the adenocarcinoma originated in a polyp. Any reference to a polyp trumps everything else.

- i. Code adenocarcinoma arising in a polyp (8210, 8261, or 8263) when there is any evidence that there was a polyp. Evidence of polyp may come from final diagnosis, microscopic description or gross description.
- ii. Obtaining polyp information is a specific exception to the general histology coding rule about taking information from the final diagnosis.
- c) Rule H5:
  - i. If the final diagnosis is ‘Mucinous/colloid (8480) or signet ring cell carcinoma (8490, code morphology as 8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma).
  - ii. If the final diagnosis is adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is mucinous/colloid, code morphology as 8480 (Mucinous/colloid adenocarcinoma).
  - iii. If the final diagnosis is ‘adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is signet ring cell carcinoma, code the morphology as 8490 (Signet ring cell carcinoma).
- d) Rule M6:
  - i. If the final diagnosis is adenocarcinoma and microscopic description states less than 50% of the tumor is mucinous/colloid, code morphology as 8140 (Adenocarcinoma, NOS).
  - ii. If the final diagnosis is adenocarcinoma and microscopic description states less than 50% of the tumor is signet ring cell carcinoma or percentage of mucinous colloid or signet ring cell carcinoma is unknown, code the morphology as 8140 (Adenocarcinoma, NOS).
- e) Rule H18 – if multiple in-situ or malignant polyps are present and at least one is tubulovillous, code the morphology as 8263 (Adenocarcinoma in a tubulovillous adenoma).

### KIDNEY

Kidney was previously grouped with renal pelvis and ureter. Change in the site grouping is in accordance with the change made by IARC.

### LUNG

- a) M1 Notes - use Rule 1 when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. Use default rule and abstract as a single primary.
  - a. Does NOT apply to a single tumor in the right lung and a single tumor in the left lung.

*Example:* Multiple tumors in one lung; multiple tumors in one lung and a single tumor in contralateral lung, or multiple tumors in both lungs.

### OTHER SITES

- a) Rule H10 and H20 – when the diagnosis is ‘acinar adenocarcinoma’ of the prostate, code the morphology to 8140 (Adenocarcinoma, NOS).
  - a. Reason – ‘acinar adenocarcinoma’ is NOT a histologic type; rather it confirms that the adenocarcinoma originates in the acini.

## **Hospital Registrars and Cancer Reporter Webinars ~**

Have you attended the Hospital Registrars and Cancer Reporter Webinars that are currently being presented by the North American Association of Central Cancer Registries (NAACCR)? If not, you may be interested to know that each Webinar addresses the cancer data collection for a specific site and includes a review of the anatomy for that site. The materials, which include the power point presentations and didactic exercises, are provided prior to each Webinar. The didactic exercises should be completed prior to each session as the answers and rationale are presented during the sessions, with time allotted for questions and answers. Continuing education (CE) hours are provided.

The MCSP has paid the subscription fee to host the Webinar series. Registration is therefore complimentary. As space is limited, advance registration is required. If you are interested in attending one of the sessions listed below, please contact Carmen Starkweather at 517/335-7485 or [starkweatherc@michigan.gov](mailto:starkweatherc@michigan.gov).

<u>Date</u>	<u>Title</u>
May 10, 2007	Abstracting Prostate Cancer Incidence and Treatment Data
June 14, 2007	Abstracting Lung Cancer Incidence and Treatment Data
September 13, 2007	Abstracting Breast Cancer Incidence and Treatment Data

## **NAACCR Central Registry Webinars ~**

The Michigan Cancer Surveillance Program (MCSP) has also subscribed to the NAACCR Central Registry Webinars. These Webinars either address site-specific cancer surveillance data collection or other registry operations and data usage topics. Didactic exercises are incorporated as well with each sessions and the answers and rationale are presented during the Webinar, with time allotted for questions and answers. Continuing Education (CE) hours are provided.

Registration is complimentary for these sessions. As space is limited, advance registration is required. To register for one of the sessions listed below, please contact Claudia Hardin at 517/335-9967 or [hardinc@michigan.gov](mailto:hardinc@michigan.gov).

<u>Date</u>	<u>Title</u>
May 17, 2007	Lymphoma Cancer Surveillance Data Collection
June 21, 2007	GIS Applications: Great Circle Distance Calculations; Cartography and Mapping Registry Data
July 19, 2007	Prostate Cancer Surveillance Data Collection
August 16, 2007	Breast Cancer Surveillance Data Collection
September 20, 2007	Statistical Techniques Used to Analyze Surveillance Data: Trend Analysis

## **Certified Tumor Registrars Exam ~**

A new exam content outline and weighting has been implemented for the 2007 - certification exams. For more details, go to [www.ctrexam.org/pdfs/ContentOutline07.pdf](http://www.ctrexam.org/pdfs/ContentOutline07.pdf).

The *Central Cancer Registries: Design, Management and Use* is a study resource for the 2007 CTR exams that can be downloaded at [www.ctrexam.org/resources](http://www.ctrexam.org/resources).

Application deadline: July 31, 2007

Testing Dates: September 15-29, 2007

## **New Eligibility Routes for the Certified Tumor Registrar Exam ~**

If you haven't taken the CTR exam yet, don't forget that the new eligibility routes will be phased-in starting with the 2008 certification exams. In addition to the current requirements of a minimum of two years full time (24 months or 3,900 hours) or equivalent experience in the Cancer Registry field, additional educational requirements will include two semesters/3 quarters of college-level courses in Human Anatomy and/or Physiology. For more information on Eligibility Routes, go to [www.ctrexam.org/eligibility/index.htm](http://www.ctrexam.org/eligibility/index.htm).

## **Educational Opportunities ~**

### ***NCRA Online Education Center***

If you're looking for CE opportunities to maintain your CTR credentials, the National Cancer Registrars Association Online Education Center provides Case Scenarios activities. The case scenarios are self-guided in which participants are presented with a mock medical record that includes demographical information, evaluation and treatment options. Each case scenario is followed by a set of assessment questions to test the participant's knowledge of abstracting. Topics include: Breast, Colon, Corpus Uteri, Head & Neck, Lung, Lymphoma, Melanoma, Ovary, Prostate and Thyroid. One case scenario is worth one CE credit hour and a limit of five CE hours will be awarded to a CTR during any two-year Continuing Education Cycle. The member price per case scenario is \$25.00; non-member price per case is \$35.00. For more information, visit the NCRA Online Education Center at [www.creducationcenter.org](http://www.creducationcenter.org).

### ***Principles and Practice of Cancer Registration, Surveillance, and Control***

This intensive and comprehensive 5-day training program is taught by a staff of recognized experts in cancer registration, surveillance, and control. This course is suitable for oncology program (hospital-based and central registry-based) employees with minimal knowledge of cancer, anatomy, physiology, and medical terminology. For more information, go to [www.sph.emory.edu/GCCS/training/practice/index.html](http://www.sph.emory.edu/GCCS/training/practice/index.html).

Training session dates: July 23-27, 2007 & October 15-19, 2007

### ***Advanced Cancer Registry Training***

This intensive and comprehensive 3-day training program is taught by a staff of recognized experts in cancer registration, surveillance, and control. The course is suitable for oncology program employees with existing knowledge of cancer, anatomy, physiology, and medical terminology who are specifically interested in learning about uses of the data. Topics included are advanced abstracting, descriptive epidemiology, analytic epidemiology, survival analysis, administrative/clinical uses of registry data, data presentation, advanced data editing and data analysis. For more information, go to [www.sph.emory.edu/GCCS/training/practice/index\\_adv.html](http://www.sph.emory.edu/GCCS/training/practice/index_adv.html).

New dates are currently being scheduled.

### ***Principles of Oncology for Cancer Registry Professionals***

*Principles of Oncology* is an intense 5-day training program in cancer registry operations and procedures emphasizing accurate data collection methods. The program includes extensive site-specific, hands-on case coding, abstracting and staging sessions. This course is suitable for cancer program employees with less than one year of experience but with minimal knowledge of cancer anatomy, and medical terminology, as well as, registrars preparing for the certification examination. For complete information about the curriculum, registration and travel information, please visit [www.afritz.org/courses.htm](http://www.afritz.org/courses.htm).

May 7-11, 2007, Reno, NV

July 2007, Baltimore, MD

December 10-14, 2007, Reno, NV

### **Submission of Data via File Transfer Protocol ~**

The MCSP is currently working on establishing a FTP site (File Transfer Protocol). Reporting facilities can submit their data via the Internet using a secured website. Upon receipt of the data, the facility will receive confirmation of their data submission, and in the near future, error listings as well. If any facility wants to be a pilot site by sending their data through FTP, please contact Terry McTaggart at (517) 335-9624 or [McTaggart@michigan.gov](mailto:McTaggart@michigan.gov).

### **Question and Answer ~**

*Question:* If a patient was diagnosed with ‘duct carcinoma’ of the right breast in 1998 and is seen in February of 2007, with a new tumor in right breast, which is positive for a diagnosis of “duct carcinoma,” when does the timing rule for breast in the Multiple Primary and Histology Coding Rules take effect?

*Answers:* Apply the new 2007 Multiple Primary and Histology Coding Rules to the new tumor in the right breast in February 2007. Rule M5 – are the tumors diagnosed **more than five (5) years** apart? If yes, abstract the new tumor as a subsequent primary.

### **MCSP Staff ~**

If you have any questions regarding cancer reporting or would like more information about in-services, please feel free to give one of us a call.

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