

# OSCaR Update

Oregon State Cancer Registry

Volume 9, Quarter 3

## Manager's Update

Donald Shipley, MS

If you read the staff list next to this article, you might notice some changes. No, we have not lost any staff, nor have we gained new people. Still there are a few changes that call for congratulations.

Jeff Soule has been promoted to Research Coordinator. Jeff works closely with outside researchers as we collaborate on various studies and projects. He is currently orchestrating our first attempt at rapid case ascertainment and the project is going very well.

Deborah Towell has been promoted to Program Coordinator for the central registry. Her new responsibilities include overseeing day-to-day registry operations. It is no surprise to me and I imagine no surprise to you that Deborah handles all her duties well and usually with a smile.

Last but not least, congratulations to Alyssa Elting who has recently married and become Alyssa Elting McGuire. I hope you will all join me in wishing Alyssa and her new husband Isaac all the best.

The Fall Workshop is just around the corner. The OSCaR staff has pulled together a great line-up for our day. I know you will enjoy seeing the many and diverse ways in which registry data are being used to address cancer control efforts at all levels. Claudia and LeeLa will be providing useful information related to abstracting. Just maybe, if all goes well, we will also be able to give a demonstration of the long awaited web-based cancer reporting system! So, please plan to join us in Portland for the workshop.

### \*\*\*\*\*OSCaR Update\*\*\*\*\*

Newsletter is now electronic only!

Many organizations have started going electronic-only with their publications to cut costs and to hopefully do their part to help the environment. OSCaR is joining this trend, and beginning with this edition of the newsletter, we will no longer be sending printed copies of the newsletter.

The OSCaR Update will still be available in a convenient electronic format on our website at:

[www.oregon.gov/DHS/ph/oscar/update.shtml](http://www.oregon.gov/DHS/ph/oscar/update.shtml)

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1. Cancer Reporting Completeness
2. Fall Workshop information
3. Coding Tips: Renal Pelvis, Ureter, Bladder and Urethra

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# Claudia's QA/Training Corner

Claudia Feight, RHIT, CTR

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Greetings Registrars-

I recently attended another "Train the Trainer" seminar in Atlanta last month. The workshop provided a valuable opportunity to network with my counterparts in other state registries such as Alaska, Nevada, Arizona, California, Washington, and Puerto Rico. It was a great chance to exchange ideas and information with other education and training coordinators and CDC staff.

At the seminar, we all had the opportunity to make presentations on specific sections of the MP/H rules on CNS tumors. Even though I'm sure we were all a bit nervous, we all learned a lot about preparation and delivery of presentations in our respective fields. We also discussed web conferencing quite extensively at the seminar. We are excited that CDC/NPCR is able to sponsor OSCaR in web conferencing using Microsoft Live meeting. We can now realize our goal to reach out to all registrars regardless of where they are working. At the meeting we also obtained NPCR Education and Training Series modules and OSCaR will be offering these trainings in the future. The modules cover a variety of topics from "Abstracting for the Beginner" to advanced registrar skills in Multiple Primary and Histology Rules on a multitude of primary sites. We have some work to do before we can make it available, but we are making progress and will let everybody know when the modules are available.

At the upcoming Fall Workshop, I will be focusing on CNS tumors and will be presenting information and providing registrars with some hands-on exercises. As you probably remember, the rules for the non-malignant CNS tumors were approved prior to the required reporting in 2004. This was before the new MP/H Rules were developed, and therefore, the non-malignant rules were not presented in the same format as the new rules. Subsequently, the Multiple Primary and Histology Task Force reformatted the non-malignant CNS tumors to be consistent with the new format. So my presentation will include the new malignant CNS MP/H Rules and the reformatted non-malignant CNS rules. I realize this all might seem a bit confusing, but in a nutshell, both non-malignant and malignant CNS tumors will have the same format!

On a final note, I recently asked April Fritz about the status of an updated version of the "Brain Book." She replied that she is, "under contract with SEER to update the Brain Book. It's a work in progress, and I don't have a definite date of completion, but it will likely be after the first of the year" (2009). I wanted to mention this issue since I have recently had a few questions from registrars regarding the Brain Book. I am looking forward to the update.

Thank you for your support of the central registry. We hope to see you at the workshop, and we hope these upcoming opportunities will be valuable to you all.

Claudia Feight, QA and Training Coordinator

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**From I&R #23120 (7/26/07)**

QUESTION

If "most likely" is an ambiguous diagnostic term, is "likely?"

ANSWER

"Likely" is not list as an ambiguous term in FORDS, thus it would not constitute a diagnosis unless it specifically says "most likely."

**Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Text**  
**C659, C669, C670-C679, C680-C689**  
**(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)**

**UNKNOWN IF SINGLE OR MULTIPLE TUMORS**

*Note:* Tumor(s) not described as metastasis

**Rule M1** When it is not possible to determine if there is a **single tumor or multiple tumors**, opt for a single tumor and abstract as a single primary. \*  
*Note:* Use this rule only after all information sources have been exhausted.

\* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.  
This is the end of instructions for Unknown if Single or Multiple Tumors.

**SINGLE TUMOR**

*Note 1:* Tumor not described as metastasis  
*Note 2:* Includes combinations of in situ and invasive

**Rule M2** A **single tumor** is always a single primary. \*  
*Note:* The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.  
\* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.

Multiple tumors may be a single primary or multiple primaries.  
*Note 1:* Tumors not described as metastases  
*Note 2:* Includes combinations of in situ and invasive

**MULTIPLE TUMORS**

**Rule M3** When no other urinary sites are involved, tumor(s) in the **right renal pelvis AND** tumor(s) in the **left renal pelvis** are multiple primaries. \*\*  
*Note:* Use this rule and abstract as a multiple primary unless documented to be metastatic

**Rule M4** When no other urinary sites are involved, tumor(s) in both the **right ureter AND** tumor(s) in the **left ureter** are multiple primaries. \*\*  
*Note:* Use this rule and abstract as a multiple primary unless documented to be metastatic

**Rule M5** An **invasive tumor following a non-invasive or in situ** tumor more than 60 days after diagnosis is a multiple primary. \*\*  
*Note 1:* The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.  
*Note 2:* Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease

**Rule M6** Bladder tumors with any **combination** of the following histologies: **papillary carcinoma (8050), transitional cell carcinoma (8120-8124), or papillary transitional cell carcinoma (8130-8131)**, are a single primary. \*

**Rule M7** Tumors diagnosed **more than three (3) years** apart are multiple primaries. \*\*

- Rule M8** Urothelial tumors in two or more of the following sites are a single primary\* (See Table 1)
- Renal pelvis (C659)
  - Ureter(C669)
  - Bladder (C670-C679)
  - Urethra /prostatic urethra (C680)
- Rule M9** Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. \*\*
- Rule M10** Tumors in sites with ICD-O-3 **topography** codes with **different** second (Cxxx) and/or third characters (Cxxx) are multiple primaries\*
- Rule M11** Tumors that **do not meet any** of the above **criteria** are a single primary.\*  
**Note:** When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

**This is the end of instructions for Multiple Tumors.**

\* Prepare one abstract. Use the **histology coding rules to assign the appropriate histology code.**

\*\* Prepare two or more abstracts. Use the **histology coding rules to assign the appropriate histology code to each case abstracted.**

**SINGLE TUMOR**

- Rule H1** Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology report is not available.**  
**Note 1:** Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
  - Physician's reference to type of cancer (histology) in the medical record
  - CT or MRI scans
- Note 2:** Code the specific histology when documented.  
**Note 3:** Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

- Rule H2** Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site.**  
**Note:** Code the behavior /3.

- Rule H3** Code **8120** (transitional cell/urothelial carcinoma) (Table 1 - Code 8120) when there is:
- Pure transitional cell carcinoma or
  - Flat (non-papillary) transitional cell carcinoma or
  - Transitional cell carcinoma with squamous differentiation or
  - Transitional cell carcinoma with glandular differentiation or
  - Transitional cell carcinoma with trophoblastic differentiation or
  - Nested transitional cell carcinoma or
  - Microcystic transitional cell carcinoma

- Rule H4** Code **8130** (papillary transitional cell carcinoma) (Table 1 - Code 8130) when there is:
- Papillary carcinoma or
  - Papillary transitional cell carcinoma or
  - Papillary carcinoma and transitional cell carcinoma

**Rule H5** Code the histology when only **one histologic type** is identified **Note** : Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma). **Rule H6** Code the invasive histologic type when a single tumor has **invasive and in situ** components.

**Rule H7** Code the most **specific histologic term**:

**Examples**

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

**Note 1:** The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with \_\_\_\_\_differentiation

**Note 2:** The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with \_\_\_\_\_differentiation.

**Rule H8** Code the histology with the **numerically higher** ICD-O-3 code.

**This is the end of instructions for Single Tumor.**

**Code the histology according to the rule that fits the case.**

**MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY**

**Rule H9**

Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

**Note 1:** Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

**Note 2:** Code the specific histology when documented.

**Note 3:** Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

**Rule H10**

Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

**Note:** Code the behavior /3, 316

**Rule H11**

Code **8120** (transitional cell/urothelial carcinoma) (Table 1 – Code 8120) when there is:

- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

**Note:** Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.

**Rule H12**

Code **8130** (papillary transitional cell carcinoma) (Table 1 – Code 8130) when there is:

- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

**Rule H13** Code the histology when only **one histologic type** is identified **Note:** Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

**Rule H14** Code the histology of the **most invasive** tumor.

- Note:** See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.
- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
  - If both/all histologies are invasive, code the histology of the most invasive tumor.

**Rule H15** Code the histology with the **numerically higher** ICD-O-3 code.

**This is the end of instructions for Multiple Tumors Abstracted as a Single Primary. Code the histology according to the rule that fits the case.**

**Table 1 – Urothelial Tumors**

**Note:** Excludes pure squamous carcinoma, glandular (adeno) carcinoma, or other bladder tumor histologies.

Urothelial/Transitional Cell Tumors Code	Code
With squamous differentiation	8120
With glandular differentiation	
With trophoblastic differentiation	
Nested	
Microcystic	
Transitional cell, NOS	
Papillary carcinoma	8130
Papillary transitional cell	
Micropapillary	8131
Lymphoepithelioma-like	8082
Plasmacytoid	
Sarcomatoid	8122
Giant cell 8031	8031
Undifferentiated	8020

# CTR News

Deborah Towell, CTR; Nancy Henderson, CTR; LeeLa Coleman, CTR;  
Becky Gould, CTR; Joan Pliska, CTR

## CODING TIPS

- In MPH the renal pelvis, ureter, bladder and urethra are defined as contiguous sites because they share urothelial lining. These sites are lined by transitional epithelium, also known as urothelium.
- Multiple bladder tumors:
  - Remember to use the rules in hierarchical order
  - Papillary/bladder tumors occurring more than 3 years apart do not have to be accessioned as separate primaries.
  - Rule M5 If a bladder tumor is non-invasive or in situ and recurs as an invasive, it is a new primary
  - Rule M6 All other papillary/transitional cell bladder tumors that recur are a single primary (recurrence)
  - All subsequent occurrences of papillary/transitional cell bladder tumors are the same primary (recurrences). You never reach rule M7 (the three year rule) for papillary/transitional cell tumors of the bladder.
- Use C68.9 (Urinary System, NOS) for multiple tumors that are abstracted as a single primary (as determined by MPH rules).

## DISTINGUISHING BETWEEN RENAL PELVIS VS. KIDNEY

### Renal pelvis

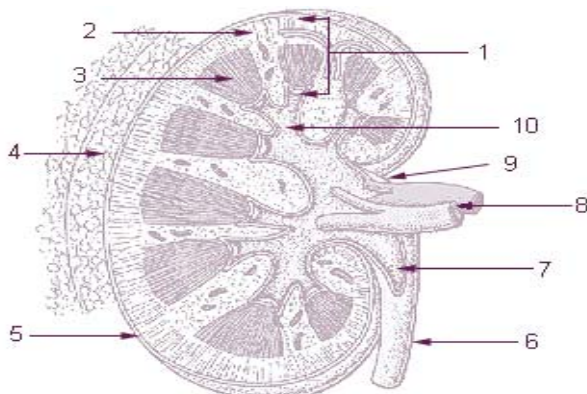
- Inner part of the kidney and continuous with Ureter
  - Consists of cup-like divisions called "calyces"
  - Major calyces receive urine from smaller minor calyces and drain collecting ducts
- Transitional cell carcinoma usually begins in renal pelvis (very rarely in kidney)
- Terms in pathology report that refer to renal pelvis
  - Nephron
  - Collecting system
  - Collecting duct
  - Calyx, clayces

### Kidney parenchyma

Surrounds the outside of the kidney

Renal cell carcinoma originates in kidney parenchyma

## UPPER URINARY TRACT ANATOMY



- 1 Parenchyma
- 2 Cortex
- 3 Medulla
- 4 Perirenal fat
- 5 Capsule
- 6 Ureter
- 7 Pelvis of kidney
- 8 Renal vessels
- 9 Hilum
- 10 Calyx

### References:

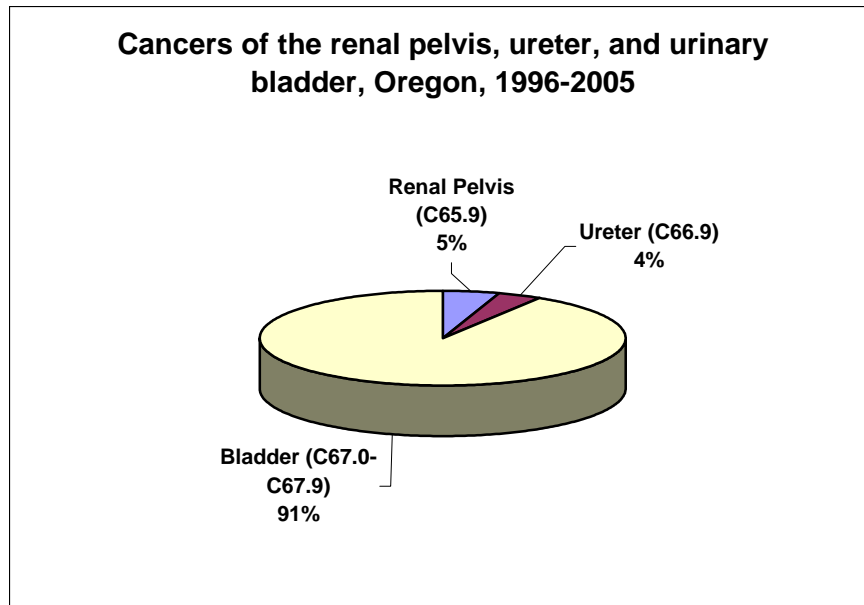
Multiple Primary and Histology Coding Rules  
SEER Training Website  
SEER Training Web Cast "Beyond the Basics"

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# Analyst's Angle

Cathy Riddell; Joan Pliska, CTR; Alyssa Elting McGuire

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## Oregon Cancer Reporting Completeness

Diagnosis Year	Hospital cases	MD office cases	Path only cases	Death Cert only cases	Total Cases	% Complete
2006	19,480	1,662	94	pending	21,236	95.6%
2007	12,987	769	108	pending	13,864	62.4%
2008	69	0	0	pending	69	0.3%

**Note:** These numbers reflect cases that have already gone through the QA review process and have been merged into our main database.

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*"The purpose of the registry shall be to provide information to design, target, monitor, facilitate, and evaluate efforts to determine the causes or sources of cancer among the residents of Oregon and to reduce the burden of cancer and benign brain tumors in Oregon."*