

"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."



OSCAR UPDATE

Oregon State Cancer Registry

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Manager's Update

Donald Shipley, MS

Registrars around the country are anxiously awaiting information on the many and varied changes that have been fueling rumors for several months. In an attempt to let all of you know what we know, I'm sending along this information, recently released from NAACCR regarding the changes for cases diagnosed on or after January 1, 2010.

- A table of the new and revised data items is in the updated version of NAACCR's Volume II, Version 12.
- The record layout in Data Standards and Data Dictionary, Volume II, Version 12 has expanded from a character length of 6,694 to 22,824, mostly because of expanded text fields, requested by member organizations.
- Many new data items and changes to existing data items came from the work and coordinated efforts between the taskforces that developed the AJCC Cancer Staging Manual 7th Edition and the Collaborative Staging System Version 2.00.00. There are about 55 new data items related to these changes.
- All date formats have changed to CCYYMMDD, and the non-date values, i.e., 00000000, 88888888, and 99999999, used in date fields are incorporated in either the new status fields or the new date flag fields (approximately 28).
- Pathology data items (approximately 30) were added to describe the origin of the pathology report(s) contributing to the cancer abstract as requested by the NAACCR Pathology Data Work Group as part of the interoperability initiative.
- Race (1-5) added new codes for Indian and Pakistani.

The staff of the central registry will provide as much training and information as possible between now and 2010 so we will all be ready for the changes ahead. For additional information about the coming changes, visit the NAACCR website: www.naacr.org/standards/volumeii

Oregon Cancer Reporting Completeness

Diagnosis Year	Hospital cases	MD office cases	Path only cases	Death Cert only cases	Total Cases	% Complete
2006	19,430	2,545	87	507	22,569	101.1%
2007	18,232	1,692	138	Pending	20,062	89.9%
2008	2,960	27	1	Pending	2,988	13.4%



Claudia's QA/Training Corner

Claudia Feight, RHIT, CTR

Greetings Registrars: We have been working diligently on revising the Cancer Reporting Standards, Vol. 1 manual that will soon be available to reporting facilities. This has been a tedious task that has required participation from all of us at OSCaR. The Casefinding ICD-9-CM reportable list is also being revised. You will be receiving updated information in the not-too-distant future.

In January, we submitted the National Program of Cancer Registries (NPCR), Cancer Surveillance System (CSS) 2009 Annual Call for Data. We also submitted our data file to NAACCR in late 2008. We recently received a detailed report on these submitted data. The report provides Information on the number of cases by year, major site, and reporting source, in addition to other data. This report helps OSCaR track trends and changes in data received by the registry over time. All years of our Registry's data are summarized. The NAACCR Call for Data is used for certification of OSCaR, and they also form the basis of "Cancer Incidence in North America," and the "Annual Report to the Nation." We were recently notified that, due to the delay in the release of federal mortality data, NAACCR may not be able to release registry certification results in April. Of course, here at OSCaR, our inquiring minds want to know the status ASAP, but it looks like we will have to be patient this year.

In the last newsletter, I discussed the requirement that NPCR requires us to participate in an audit of compliance with NPCR standards on data quality and completeness every 5 years. As I noted, even though the auditors will be on site at the reporting facilities, this is an audit of OSCaR's performance and not the individual hospitals. This audit will take place June 22nd through July 3rd of this year. Within the next 8 weeks, we should be notified which nine hospitals have been randomly selected and the audit team will be visiting. We will keep you updated.

As you know, education and training is central to quality assurance at OSCaR, and preliminary planning has already started for the Fall Workshop. So, if you have any suggestions for us on training topics to discuss or presentations you would like to see, please let me know. We always appreciate getting feedback from you.

Thank you for all your hard work. Feel free to call with questions or suggestions!

Regards,
Claudia

CTR News

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

Benign and Borderline Intracranial and CNS Tumors Coding Tips

This newsletter focuses on non-malignant CNS, i.e., "benign brain," tumors. Reportable benign and borderline tumors have a behavior code of /0 or /1 and originate within the cranial vault or spinal canal. Below are a few tips on topics that seem to cause confusion.

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Reportability: is it a CNS site?

Make sure the tumor originates within the cranial vault or spinal canal.

- For example, nonmalignant bone tumors that arise in the skull or paranasal sinuses, such as a chondroma, would not be reportable. Report only if primary site is intracranial.
- Non-malignant *peripheral* nerve tumors are not reportable.

Reportability: is there an ICD-O-3 code for the term in the medical record?

The terms “tumor” and “neoplasm” are reportable because there are ICD-O-3 codes for these terms. “Mass” and “lesion”, *unless* there are additional reportable terms, are not reportable. For example:

- A mass in right temporal lobe would not be reportable because there is no ICD-O-3 code for “mass”.
- A left frontal lobe neoplasm would be reportable because there is an ICD-O-3 code for neoplasm.
- A “cystic neoplasm” or “hypodense mass” would not be reportable because there is no ICD-O-3 code for “cystic” or “hypodense.”

Grade

The ICD-O-3 grade (sixth digit of the morphology code) describes the histologic grade or differentiation of tumor. WHO grade, for CNS tumors, describes the aggressiveness of the tumor. They are not the same.

- The ICD-O-3 grade or differentiation code for nonmalignant CNS tumors is always “9”.
- The WHO grade is always coded in collaborative stage site specific factor 1 field, not in the ICD-O-3 grade field.

Laterality

If multiple non-malignant tumors of the same site and same histologic type are diagnosed in both sides of a site listed as lateral, the tumors would be considered separate tumors and two abstracts prepared. Be sure to read your SEER Multiple Primary and Histology Coding Rules manual.

Transformation

In the rare instance that a previously diagnosed nonmalignant tumor (behavior code /0 or /1) transforms into a malignant tumor (behavior code /2 or /3) the tumors are considered two primaries and two abstracts should be prepared.

One more thing

While “mass” and “lesion” should not be used to determine *reportability*, these terms can be used to determine number of primary tumors. Be sure to carefully read SEER Multiple Primary and Histology Coding Rules.

References

Available online (free):

SEER Multiple Primary and Histology Coding Rules:

<http://seer.cancer.gov/tools/mphrules/download.html>

FORDS Facility Oncology Registry Data Standards. Revised for 2009

<http://www.facs.org/cancer/coc/fordsmanual.html>

NPCR Data Collection of Primary Central Nervous System Tumors

<http://cdc.gov/cancer/npcr/training/btr/>

Collaborative Staging Manual and Coding Instructions. NIH Pub. No. 04-5496, 2006.

<http://www.cancerstaging.org/cstage/manuals.html>

Not available online:

International Classification of Diseases for Oncology. Third Edition.

Geneva: World Health Organization, 2000. Fritz A, Percy C, Jack A, Shanmugaratnam K, Sobin L, Parkin D, Whelan S, eds.

FROM SEER MULTIPLE PRIMARY AND HISTOLOGY CODING RULES

Benign and Borderline Intracranial and CNS Tumors

Histology Coding Rules – Text

C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753

Note: Malignant intracranial and CNS tumors have a separate set of rules.

Do not change the behavior code when during the lifetime of the patient when a tumor(s) progresses from a benign /0 to an uncertain whether benign or malignant /1 behavior.

These rules apply to tumors that occur within the cranial vault or within the spinal canal (reportable)

Note: Non-malignant peripheral nerve tumors are not reportable

Equivalent or Equal Terms (Terms that can be used interchangeably)

- Tumor, mass, lesion, neoplasm
- Type, subtype, variant

Definitions

Benign: ICD-O-3 behavior code of /0.

Borderline: ICD-O-3 behavior code of /1.

Cerebellum: The part of the brain below the back of the cerebrum. It regulates balance, posture, movement, and muscle coordination.

Corpus Callosum: A large bundle of nerve fibers that connect the left and right cerebral hemispheres. In the lateral section, it looks a bit like a "C" on its side.

Different lateralities: The right side of a site and the left side of a site are different lateralities.

Frontal Lobe of the Cerebrum: The top, front region of each of the cerebral hemispheres. Used for reasoning, emotions, judgment, and voluntary movement.

Infratentorial: Tumors located in the posterior fossa, cerebellum, or fourth ventricle.

Invasive: ICD-O-3 behavior code of /3.

Medulla Oblongata: The lowest section of the brainstem (at the top end of the spinal cord). It controls automatic functions including heartbeat, breathing, etc.

Meninges: The three membranes that cover the brain and spinal cord. The outside layer is the dura mater and is the most resilient. The center layer is the arachnoid membrane. The thin innermost layer is the pia mater.

Mesencephalon: The region of the brainstem located above the pons.

Nerve sheath: A protective covering around nerves.

Occipital Lobe of the Cerebrum: The region at the back of each cerebral hemisphere that contains the centers of vision and reading ability (located at the back of the head).

Parietal Lobe of the Cerebrum: The middle lobe of each cerebral hemisphere between the frontal and occipital lobes. It contains important sensory centers (located at the upper rear of the head).

Pituitary Gland: A gland attached to the base of the brain that secretes hormones. It is located between the Pons and the Corpus Callosum, above the Medulla Oblongata. Synonym: Hypophysis.

Pons: The region of the brainstem located below the mesencephalon and above the medulla oblongata.

Progression of disease: For the purposes of these rules, progression is defined as a change to a more aggressive behavior (Example: a change from /0 to /1).

Spinal Cord: A thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).

Timing: The amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

Transformation: The histology of a disease process may change over time.

Table 1 –Paired Sites

Table Instructions: Use this table to Identify paired sites (Rule M5).

Column 1: Paired Sites	Column 2: Code
Cerebral meninges, NOS	C700
Cerebrum	C710
Frontal lobe	C711
Temporal lobe	C712
Parietal lobe	C713
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Acoustic nerve	C724
Cranial nerve	C725

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumors not described as metastases

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: Tumors not described as metastases

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

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

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.

Note: Tumors not described as metastases

- Rule M3** An **invasive** brain tumor (/3) and either a **benign** brain tumor (/0) or an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **
- Rule M4** Tumors with ICD-O-3 **topography** codes that are **different** at the second (Cxxx) and/or third characters (Cxxx), or fourth (Cxxx) are multiple primaries. **
- Rule M5** Tumors on **both sides** (left and right) of a **paired site** (Table 1) are multiple primaries. **
- Rule M6** An atypical choroid plexus papilloma (9390/1) following a choroid plexus papilloma, NOS (9390/0) is a single primary.*
Note: Do not code progression of disease as multiple primaries.
- Rule M7** A neurofibromatosis, NOS (9540/1) following a neurofibroma, NOS (9540/0) is a single primary.*
Note: Do not code progression of disease as multiple primaries.
- Rule M8** Tumors with two or more histologic types on the **same branch** in Chart 1 are a single primary.*
- Rule M9** Tumors with multiple histologic types on **different branches** in Chart 1 are multiple primaries. **
- Rule M10** Tumors with **two or more histologic types** and at least **one** of the histologies is **not listed** in Chart 1 are multiple primaries. **
- Rule M11** Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **
Note: Use this rule when none of the histology codes are listed in Chart 1.
- Rule M12** Tumors that **do not meet any** of the above criteria are a single primary.*
Note: Timing is not used to determine multiple primaries for benign and borderline intracranial and CNS tumors.

- * Prepare one abstract
- ** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted. This is the end of instructions for Multiple Tumors.

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 tumor (histology) in the medical record
 - PET, CT or MRI scans
- Note 2:* Code the specific histology when documented.
Note 3: Code the histology to 8000 (neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
- Rule H2** Code the histology when only **one histologic type** is identified.
- Rule H3** When there are **multiple histologies** and all histologies are in the **same branch** on Chart 1, code the more specific histology
- Rule H4** 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 H5** 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 tumor (histology) in the medical record
 - PET, CT or MRI scans
- Note 2:* Code the specific histology when documented.
Note 3: Code the histology to 8000 (neoplasm, NOS) or as stated by the physician when nothing more specific is documented.
- Rule H6** Code multiple meningiomas of uncertain behavior to 9530/1
Note 1: This is a rare condition that is usually associated with neurofibromatosis type 2 and other genetic disorders
Note 2: Use this code only for meningiomas with uncertain behavior; do not use this code for multiple benign or malignant meningiomas
- Rule H7** Code the histology when only **one histologic type** is identified.
- Rule H8** Code the histology from the original diagnosis.
Note: Do not change the behavior code when a later tumor(s) shows progression of disease.
- Rule H9** When there are **multiple histologies** and all histologies are in the **same branch** on Chart 1, code the more specific histology **Rule H10** 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.

Analyst's Angle

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Benign and borderline brain/CNS tumors reported to the Oregon State Cancer Registry, 2004-2006

Histology and Behavior	Total Cases	2004 Cases	2005 Cases	2006 Cases
9530/0: Meningioma, NOS	469	156	142	171
9560/0: Neurilemoma, NOS	279	96	98	85
9531/0: Meningothelial meningioma	35	10	15	10
9537/0: Transitional meningioma	23	12	4	7
9532/0: Fibrous meningioma	22	7	4	11
9539/1: Atypical meningioma, NOS	19	4	5	10
9533/0: Psammomatous meningioma	17	4	6	7
9161/1: Hemangioblastoma	16	7	2	7
8000/0: Neoplasm, benign	12	3	7	2
9505/1: Ganglioglioma, NOS	10	3	4	3
8000/1: Neoplasm, uncertain whether benign or malignant	9	5	0	4
9383/1: Subependymoma	9	3	3	3
9394/1: Myxopapillary ependymoma	9	6	2	1
9534/0: Angiomatous meningioma	9	5	1	3
9413/0: Dysembryoplastic neuroepithelial tumor	7	2	0	5
9530/1: Meningiomatosis, NOS	6	2	1	3
9570/0: Neuroma, NOS	6	2	1	3
9120/0: Hemangioma, NOS	4	3	1	0
9121/0: Cavernous hemangioma	4	1	2	1
9350/1: Craniopharyngioma	4	1	2	1
9538/1: Clear cell meningioma	4	0	2	2
9084/0: Dermoid cyst, NOS	3	0	0	3
9390/0: Choroid plexus papilloma, NOS	3	1	1	1
9540/0: Neurofibroma, NOS	3	0	2	1
9540/1: Neurofibromatosis, NOS	3	0	2	1
Miscellaneous (histology = 8680/1, 8815/0, 8831/0, 8850/0, 9080/0, 9122/0, 9150/0, 9150/1, 9161/0, 9351/1, 9384/1, 9390/1, 9490/0, 9492/0, 9505/0, 9506/1, 9539/0, 9550/0)	24	8	9	7



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