THE ORANJ OBSERVER

A MESSAGE FROM OUR PRESIDENT

Donna McNally, ORANJ President 2017

Happy Spring everyone!

I am getting myself acclimated to the Office of President once again, and it has been both a pleasure and a challenge in my new role. This leads to me to asking for volunteers for ORANJ. We have many committees and we truly welcome your support!

ORANJ was delighted once again this year for having Governor Christie sign the Proclamation of "April 10th through April 14, 2017 as Cancer Registrars Week". We are very proud of ORANJ and NCRA for working hard to recognize our profession.

I am very excited that ORANJ and PACR offered our **very FIRST Regional conference** on May 11, 2017. Kudos to the planning committee from both organizations! We made history!! Planning a multi-state Regional conference is not as easy as it would appear. We had a great turn-out and received rave reviews. The conference offered 6 CEUs and 2 of those CEUs were dedicated to staging, which will help the attendees with meeting their new educational requirement from NCRA. We were also delighted to offer the conference registration at a minimal rate, bearing in mind the hardship of high registration costs. We know all CoC accredited facilities strive to obtain a "Commendation Status" in as many Standards as they possibly can. We are grateful that we afforded registrars the opportunity for "Commendation" in **Standard 1.11**: All Certified Tumor Registrar staff attends a national or **regional** cancer-related educational meeting at least once during the three-year cycle.

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PRESIDENT'S MESSAGE

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We have been asked by many members to offer this "Regional Conference" again and potentially annually. This is certainly something that the Executive Committee supports and we will try our best to accommodate.

Our next two upcoming ORANJ educational meeting dates are as follows:

- July 26, 2017 NJ Hospital Association, Princeton
- November 16 – 17, 2017 Annual Meeting Golden Nugget, Atlantic City

It was great seeing a lot of your faces at the 2017 NCRA Annual Conference! I am glad we had an opportunity to share a nice dinner together with some of our members.

I'd like to say a very special "Thank You" to all my Committee Chairs and to the Executive Board. We've experienced some challenges thus far as new members are getting acclimated to learning new Policies and Procedures and getting comfortable in their new roles. They are a great group of professionals that I've had the privilege to collaborate with. It's all about "Team Work". We are in the process of updating our Policies and Procedures and hope to have them all approved and sent out to the Membership before our Annual Meeting.

Please feel free to reach out to me or anyone of our Chair's on issues/ideas you'd like to share, and please visit us at: www.oranjonline.com

All my best,

Donna

ORANJ/PACR REGIONAL MEETING

BY: ROXANN SEEPERSAD

The Oncology Registrars Association of New Jersey (ORANJ) and the Pennsylvania Association of Cancer Registrars (PACR) co-sponsored an ORANJ/PACR Regional Meeting at Thomas Jefferson University, in Philadelphia, Pennsylvania on Thursday May 11,2017. During this time, members of both organizations were provided an educational experience to enhance their knowledge as oncology(cancer) registrars.

The day began with a motivational speech given by Leah Keisow from Fox Chase. Leah Keisow presented ways in which cancer registrars can become motivated, stay motivated, and help motivate others while performing their daily tasks. Cindy Stern, of Penn Cancer Network, followed by providing useful information on the Cancer Registry role regarding clinical trials, and ways to keep up with and achieve cancer committee goals. Cindy displayed how the data cancer registrars abstract aids in the development and advancement of clinical trials. She then presented Unraveling of Commission on Cancer (CoC) standards, which helped the attendees capture how important developing, initiating, and evaluating program goals are when looking at cancer treatment and prevention in the population. Without data and data entry, developing these goals would be difficult, and that is what Jocelyn Hoopes presented. Jocelyn Hoopes also reiterated that as cancer registrars our positions are quite vital in population health, as data is the key to many fundamental cancer treatment and prevention programs.

The day progressed with presentations by Dr. Jen Johnson and Dr. James A. Posey III. Dr. Jen Johnson presented on targeted therapies of Non-Small Cell Lung Cancer. Her presentation showed attendees exactly how vital the role of cancer registrars is in developing and choosing appropriate target therapies for Non-Small Cell Lung Cancer. Dr. James A. Posey III, provided useful information on colorectal cancer and how data has allowed for earlier screenings, diagnoses and improved overall survival rates over the years.

Overall, the presentations concluded that cancer registrars are a vital piece in the innovation of modern medicine and improvement of population health as it relates to cancer.

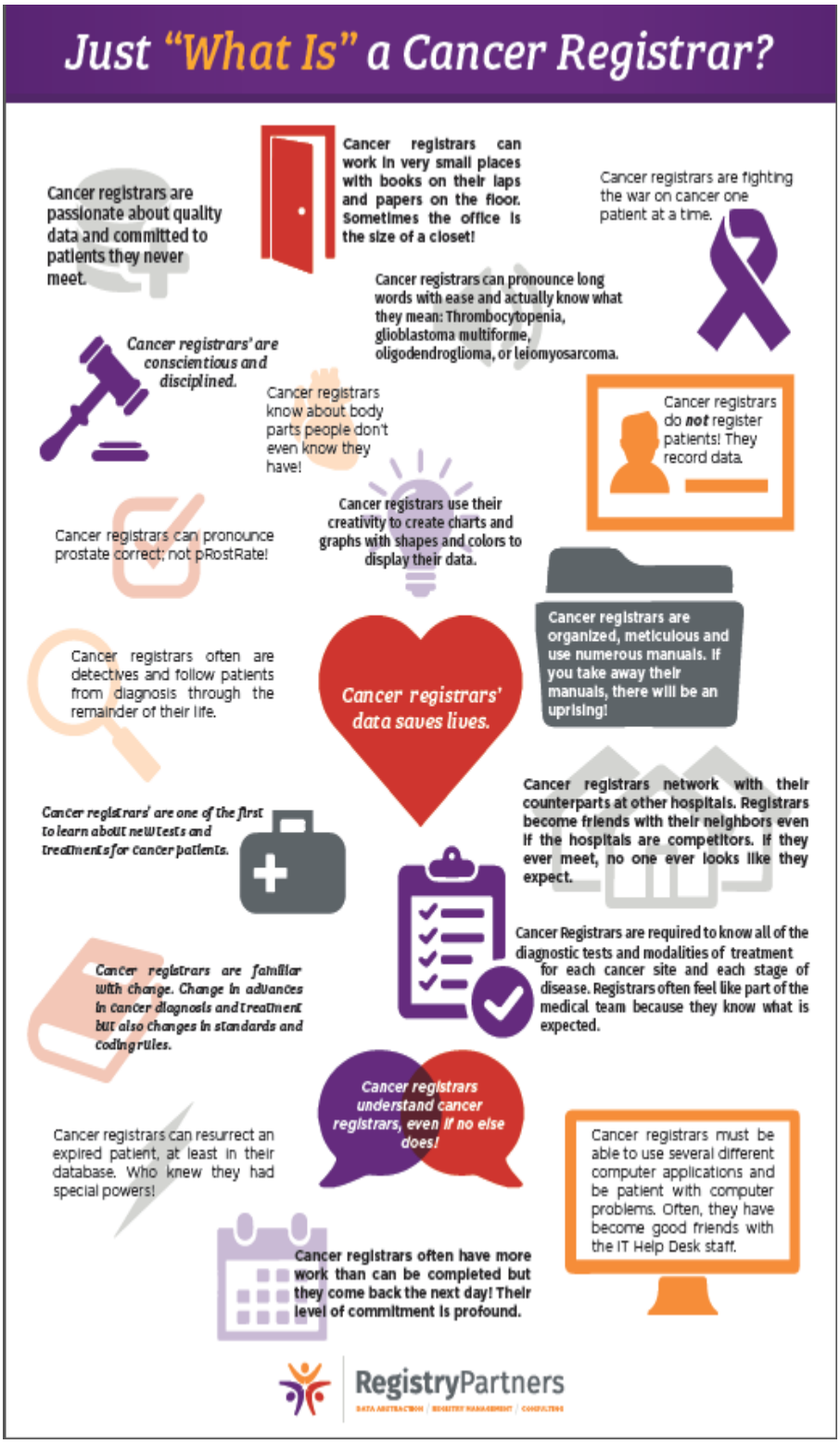
New Jersey State Cancer Registry

celebrated the staff's dedication to the field of cancer registry during NCRW week with a bagel brunch that included yogurt, fresh fruits, and other treats such as donuts and personalized M&Ms. Staff played party games including "How Well Do You Know Your (Work) Neighbor?" where the staff tried to match previously submitted little known facts about their coworkers. They also played a cancer ribbon awareness game in which staff identified ribbons representing various cancers. NCRW themed favors were distributed to all and a delicious cake was brought in to close out the out the celebration. - S. Schwartz, H. Stabinksy

The Registry Staff at Centrastate celebrated by going out to lunch. "We relaxed together, laughed and had a great time. We included our student, also who is a part-time registrar-in training as well."

Jeannie Mazza, CTR

"**Cancer registrars** capture a complete summary of history, diagnosis, treatment, and disease status for every cancer patient."- NCRA



"**Cancer registrars** are an integral part of the oncology health care team. They ensure reliability of data through completeness, timeliness, and validity for use in research, education, treatment planning, and scientific papers."- ORANJ

AJCC 8th Edition Dedication

The AJCC Cancer staging Manual, 8th Edition is dedicated to all **CANCER REGISTRARS** in recognition of their:

- Education and unique commitment to the recording and maintenance of data that are so vital for the care of the cancer patient:
- Professionalism in the collection of factors that are fundamental to sustaining local, state, and national cancer registries;
- Dedication to the cataloging of information crucial to cancer research;
- Leadership, support, and promulgation of the principles of cancer staging;
- AND THEIR POSITIVE IMPACT ON CANCER PATIENT OUTCOMES.

"**Cancer Registrars** are vital data specialists, collecting cancer data and working closely with physicians, hospital administrators, and other health care professionals to maintain a record of each patient's history, diagnosis, treatment and health status."- NJSCR

2017 NCRA ANNUAL CONFERENCE RECAP

By Heather Stabinsky and Fran Krol

Highlights of Staging Rules

Presented by: Donna Gress

- Assigning stage is the role of the **managing physician**
  - Pathologist/Radiologist can provide T/ N/ M information but can't assign stage group
- **STAGE**= Aggregate information, T/ N/ M= CATEGORIES
- **Clinical Stage** is from the point the cancer is first suspected and ends at treatment
- Surgical Diagnostic Staging Procedure **DOES NOT=** treatment
- "Any T" is **all** T categories **EXCEPT** Tis
- **pM1** can come from cytology from FNA, core biopsy, incisional/excisional bx, resection of metastatic site
  - direct **extension into an organ may not** be M category (ex colon extension into liver= pT4)
- A short course of endocrine therapy **DOES NOT =** neoadjuvant treatment for AJCC staging (do not use yp)
  - Refer to NCCN guidelines for information on treatment that satisfies neoadjuvant definition
- Pathological stage= a managing physician may combine c/p T and N. That does not = pathologic stage for the registry- do not record

Abstracting Tool: Endometrial Cases

Presented by: Melissa Riddle, CTR

- **DO NOT USE FIGO TO CODE GRADE**
  - FIGO Stage= the extent of disease ***(Code the FIGO Stage from a statement by the physician. Do not convert T, N, and M or TNM Stage Group into FIGO stage to code this field. If FIGO Stage is not stated, use code 999).***
  - FIGO Grade= the **percent of non-squamous** part of the tumor
- **FIGO Grade & Definition:**
  - **I** Equal or less than 5% of a non-squamous solid growth pattern; **Grade 1**
  - **II** 6-50% of a non-squamous or non-morular solid growth pattern**; Grade 2**
  - **III** Greater than 50% if a non-squamous or non-morular solid growth pattern**; Grade 3**

- **Endometrial Carcinoma** = Carcinoma/Adenocarcinoma NOS.
- **Endometrial carcinoma DOES NOT** = Endometrioid adenocarcinoma
- **Treatment- Radiation-** if Brachytherapy is given, it is most likely **HDR intracavitary** (Tandem and Ovoid) (Dose= 88888)

Coding Surgical Treatments: Melanoma:

Presented By: Melissa Riddle CTR

- Review all of the codes for surgical treatment of melanoma.
- *Conventional Mohs* surgery margins are processed in frozen sections unlike *slow Mohs surgery* where margins are processed as rush permanent sections.
  - Both coded the same.
- Code what is stated on the OP report (*planned* or *intended*).
- The pathology report is complementary information.
- Look for SLN biopsy and code it. **If a sentinel lymph node fails to map you still code sentinel lymph node code because you code the intent.**
- **Watch the margins** when coding surgery. Wide local excision requires a known microscopic negative margins. If margins aren't known use codes 20-36.

Guidelines for Coding Radiation Therapy Treatments for Breast Cancer

Present by: Wilson Apollos, MS, RTT, CTR

- **Standard EBRT generally includes** a regional dose in range of 4680-54Gy with a boost (typically electron)_ in range of 700 cGy to 14 Gy with standard fraction size of 180-200cGy
- **Code 21=Orthovoltage**.
    - **Zeiss intrabeam** system is an intraoperative (IORT) brachytherapy also known as **electronic** brachytherapy. This should be coded to **21 – Orthovoltage**.
    - **XOFT Axxent** eBX system delivers tx via minature linac with energy in KV range also known as **electronic brachytherapy Code as 21, orthovoltage.**
- **Code 52=Brachytherapy**, intracavitary HDR.
    - **Mammosite Rt**
        - Utilizes a balloon that is inserted into the lumpectomy cavity and inflated.
        - Mammosite ML (multi lumen) has 4 lumens for the iridium seed to travel. Important to code correctly.
            - **Example**: pt undergoes mammosite brachy 2x a day for 5 days, you would code 10 separate fractions.
            - This therapy uses Ir 192 seeds which is considered HDR and should be coded to **52, brachytherapy, intracavitary HDR.**
- **Code 31=IMRT** for VMAT, tomotherapy, rapid Arc, SIB-IMRT and DART
- Current RT volume codes often don't capture tx fields (chest wall, supraclavicular region), but **registrars should carefully document any treatment field not covered by a code in their text**

Gynecologic Brachytherapy Procedures Guidelines for Coding

Presented by: Wilson Apollo, MS, RTT, CTR

Endometrial cases at higher risk for locoregional recurrence:

- Advanced age at the time of diagnosis
- Higher tumor grade
- Extensive myometrial invasion
- LVI+.

- **EBRT (external beam radiation therapy)** reduces local recurrence rates but increased patient toxicity.

- **Vaginal Brachytherapy (VBT)** reduces vaginal recurrence to 0-3% (in patients with high risk factors). Pelvic (non-vaginal) recurrence down to 0-4.1%.

- **RTOG (Rad Therapy Oncology Group)** recommends:
    - Combo of **EBRT** & **VBT**
    - Patients with high risk histology benefit from **VBT and chemotherapy.**

- **HDR**: (high dose rate) dose rate great than 12 Gy/hr. Used with temporary implants.
- **LDR**: (low dose rate) dose rate in range of 0.4 to 2.0 Gy/hr. Mostly permanent isotopes implanted on patients. (Can also be implanted temporarily.)

- If EBRT is administered with brachytherapy, **code the brachytherapy as the boost**.
    - Remember to enter **88888 for RT Boost Dose** for the brachytherapy.
    - Code brachytherapy procedures based on whether it is **intracavitary vs interstitial** and **LDR vs HDR** (codes 50-54).
    - If brachytherapy is given alone, code as the regional dose.

Conceptual Review on The Evolution and Management of Cancer: When Will We Find "The Cure"?

Presented by: Hank C. Hill, MD

- Out of US, Canada, France, Germany, Italy, Japan, United Kingdom, the United States has the highest death rates from cancer (deaths from all causes per 100,000 pop [standardized rates])
- Lung cancer rates are falling in males, but increasing in females
- In the United States, the black male population has the highest death rate from cancer (all cancers combined, 1999-2013)
- Colon/Rectal cancers is up among younger adults
    - Among Americans ages 55 and younger has risen since 1989; greatest among adults in their 20s and 30s
- United States per capita healthcare spending is more than twice the average of other developed countries
- Health Disparity Solution: Political will comes from public demand
- **National Cancer Institute**
    - Precision Medicine Initiative = $215 million
    - Precision Medicine Initiative: Oncology = $70 million
    - https://www.cancer.gov/about-cancer/treatment/types/precision-medicine
    - **Cannabinoid-induced tumor growth inhibition**: lung, glioma, thyroid, lymphoma/leukemia, skin, uterine, prostate, neuroblastoma, colorectal

2017 SEER ADVANCED TOPICS FOR CANCER REGISTRARS

By Maureen Romero

New 2018 Grade Differentiation Items

Presented by Peggy Adamo

There will be two **New GRADE** items for 2018 as follows:

1.) AJCC Grade Clinical

2.) AJCC Grade Pathologic

Instructions:

*Record the AJCC grade value used when directly assigning the AJCC [clinical] [pathologic] stage.

Solid Tumor Rules 2018 Updates

Presented by Lois Dickey

- The new **Solid Tumor Database** – 2018 will include the following:
  - Electronic free-standing reference tool
  - Independent of Solid Tumor Rules Manual
  - Capability to Search by site
  - Features include:
    - **Genetics Data & Biomarkers**
    - **Treatment(s)**
    - **Abstractor Notes**
    - **Signs & Symptoms**
    - **Diagnostic Exams**
    - **Recurrence & Metastasis**

- The new **Solid Tumor Manual** – 2018 will include the following:
  - No longer called MPH Manual
  - Text format only
  - No change in how to use the rules
  - Expanded histology tables
  - Non-reportable neoplasms included
  - Independent of Solid Tumor Database
  - **Site Specific Updates:**
    - **Head & Neck** will include new tables for histology, primary & contiguous sites, & a guide to assigning primary site.
    - **Breast**, **Female Reproductive Organs**, **Male Genitals**, **Soft Tissue**, & **Bone** will feature new codes, behaviors, and terms/alternative names.
    - **Lung** will contain new codes, behaviors, and terms/alternative names, as well as, additional tables will be added.
    - **Kidney** & **Urinary** will feature new codes and terms/alternate names.

For Us By Us

Examining topics of interest to cancer registrars.

Ask the Experts

Submit questions regarding coding difficulties.

Dear Expert,

Please help me code grade for the following case:

Diagnosis: Fragmented appendix with: goblet cell carcinoid tumor (typical goblet cell carcinoid): well differentiated neuroendocrine tumor; intermediate grade (grade 2 net). Size 3.5 cm; tumor infiltrates through appendiceal wall to subserosa. Maximum mitotic rate 2/10hpf.

I am not sure which of the following to choose.

1. **Code 1** for well differentiated.
2. **Code 2** as documented (grade 2 NET).
3. **Code 3** for intermediate grade (SEER Coding Manual pg.98 – intermediate grade & intermediate differentiation are coded differently).

Please help.

Sincerely,

Cancer Registrar

SEE PAGE 15 FOR ANSWER!!!!

Have You Heard

Share new topics pertaining to cancer.

1. **Vaccine may prevent progression of DCIS to breast cancer.**
   http://www.healio.com/hematology-oncology/breast-cancer/news/online/%7Bc0bfc58d-4875-4b31-8f5e-3390cba9117f%7D/vaccine-may-prevent-progression-of-dcis-to-breast-cancer

2. **The Mesentery, the Organ You Didn't Know You Had.**
   A topic that was briefly discussed during the April 2017 Colon NAACCR Webinar was the possibility of the mesentery being a new digestive organ. Discussion amongst scientists has been ongoing.

   Click the links to learn more.

   http://www.cnn.com/2017/01/04/health/new-organ-mesentery/

   http://time.com/4621074/mesentery-organ-human-body/

   http://www.livescience.com/57370-mesentery-new-organ-identified.html

What Works for You

Offer an idea, tip, or suggestion that is working well for your registry.

RQRS – Tracking Treatment

By Stephanie Guertler

Penn Medicine/Virtua

1. It is important to know the expected course of treatment for the stage of the primary tumor you are abstracting. For example, a higher stage breast case will have chemo during the first four months, then radiation for 30-40 days, and then hormone after that. You should have a sense of when these treatments will be completed to abstract your case. Of course, not every case will follow the expected timeline due to roadblocks such as insurance issues, comorbidities, patient relocation, and changes in physicians. **Document** these roadblocks as they happen with the current date. This **documentation becomes very important** in preventing the need to reread the medical record every time you visit a case. You will enter RQRS cases more often than non-RQRS cases and using the **confidential notepad field in Metriq** is the optimal place to document info.

2. One idea is to enter the patient treatment schedules of RQRS cases **utilizing a calendar such as Outlook**. Develop an occurrence check that meets your schedule. I devote every Friday to my RQRS cases & treatment letters without fail. On a typical Friday, I review 20-30 cases for new information making it extremely important to remain consistent with this plan to prevent the workload from building up. If no information is found on a patient, I investigate why, **document,** and re-schedule that patient's case for another Friday to re-check.

3. If I have exhausted my resources utilizing Outlook scheduling and still cannot get the patient's treatment information, I forward the case to my supervisor making her aware of the missing treatment. This helps to make sense of discrepancies when RQRS compliance reports are run and makes my supervisor aware that she may need to communicate with the physician's office staff.

For Us By Us

OOPS!!! Don't Forget the Ops. Observations Are KEY!

By Stephanie Guertler, Penn Medicine/Virtua

It can be a difficult task plowing through the surgical jargon of an Operative Report (OP). Questions like what stitchery is being used, what anatomical structures are being re-located, and what instruments are being utilized routinely come up. **What registrars want to know** is did the surgeon see more, or less, disease than anticipated. Did he or she observe any mets or abnormal nodes? Was the surgeon able to resect all the tumor as planned and if not, what was left behind? Why you ask? Well, a surgeon's observations assist us in staging the case. The report may include the exact location of the primary tumor, the tumor size, and extent of the spread beyond the primary site, especially when only an exploratory procedure is done. Pay attention to the Pre-Op & Post-Op headers at the top of the report, they may be different depending on findings.

Examples:

1. A **breast OP report** may include information if a sentinel lymph node (SLN) procedure was performed & if it yielded identifiable SLN's. Remember, to code the SLN procedure even if the SLN was not found. A breast surgeon will very often mention if a patient is having reconstruction done or not in a mastectomy case. This helps with the surgical coding for us.
2. In the case of a **TURBT (bladder),** a surgeon will describe exact location of tumor(s) and how extensive they appear. Surgeon may even indicate if the resection was grossly complete or not.
3. A **colon case** will have the surgeon mention the appearance of the liver (clean or mets), appearance of regional LN's, extension of disease into adjacent organs or structures.
4. A **GYN case** will have the surgeon observe how the diaphragm appears (seeding or not), how successful debulking was, liver appearance and observation of LN's.
5. A **thoracic/lung** case will help with the observance of LN stations that will assist in staging. (Whether actual LNs were sampled or not).

Pathology is very important, but
DON'T FORGET THE OPS!

For Us By Us

COMMITTEE COMMUNICATIONS

Web & Publications Committee

Chair: Maureen Romero
Committee Members: Suzanne Schwartz, Roxann Seepersad, Stephanie Guertler, Maithili Patnaik

The Committee is currently working on website updates, integrating the website with Facebook & Twitter, and collaborating with other committees to enhance **ORANJ's Website and Newsletter**. Our tasks are still a work in progress, so stay tuned for updates.

Please submit any ideas or articles for future newsletters or website improvements to maureen.romero@doh.nj.gov or suzanne.schwartz@doh.nj.gov.

We hope to see you at the ORANJ Meeting in July!

Ways and Means Committee

Co-chair: Linnette Frey
Co-chair: Stephanie Hill

NCRA Annual ORANJ Basket Donation 2017

The winner of this year's **ORANJ Basket at the NCRA** Annual Meeting basket raffle was Sandra Williams from MedStar, Georgetown University Hospital in Washington, DC! The theme for this year's basket was **"A Taste of New Jersey",** and contained a selection of wines from local wineries, salt water taffy from the Jersey shore, two cookbooks featuring classic NJ dishes, and two stemless wine glasses. **Congratulations Sandra!**

Thank you Ways and Means Committee-Great job!

Cancer Registry Management (CRM) at Rowan College of Burlington County

Rowan College at Burlington County's Health Information Technology department would like to thank all the facilities who allowed RCBC Cancer Registry Management students the opportunity to complete their professional practice experience (PPE) at their sites. If you are interested in hosting a student for their professional practice experience, please reach out to Susan Scully, Director of Health Information Technology at sscully@rcbc.edu.

A special thanks to the New Jersey State Cancer Registry for organizing an onsite seminar which provided students the specific requirements to fulfill their clinical hours.

Congratulations to the graduates of the program. To date, two students earned an Associate's in Cancer Registry Management and four students earned the Certificate in Cancer Registry Management. All students who have taken the CTR Exam have passed.

Currently 20 students are enrolled in either the degree or certificate programs.

For details about the Cancer Registry Management Associate of Applied Science Degree (AAS.MCR) or Certificate in Cancer Registry Management (CRT.MCR), visit the HIT website at rcbc.edu/hit or call 609-894-9311, extension 1711.

Ask the Experts Answer

Question on page 10

Coding grade for NETs is slightly different from coding grade for other solid tumors.

Since this diagnosis includes "Well differentiated" and "Grade 2" assign grade code 2, the higher grade. According to our expert pathologist consultant, "intermediate" fits best with grade 2.

See SINQ 20160023 for NET grade coding instruction

05/04/2017

Contribute to The ORANJ Observer by submitting an article, question, comment, or photo for inclusion in next newsletter:

- **"Ask the Expert" –** Submit questions about coding difficulties.
- **"What Do You Think?" –** Share an idea, tip, or suggestion on how a registrar can do something better or overcome an obstacle.
- **"Have You Heard?" –** Share new treatments/drugs/procedures that pertain to cancer.

Send the submissions to Maureen Romero.