

OSCaR Update

Manager's Update Donald Shipley, MS

Spring seems to be the time of year when travel begins to increase. Recently, I attended a meeting of the NAACCR Board of Directors and Committee Chairs in San Antonio, Texas. Most of the agenda focused on future directions for NAACCR including hiring a new executive director for the organization.

I also recently returned from the NPCR Program Directors Meeting in Atlanta, Georgia. This was one of the best program directors meetings I have attended. I came away from the meeting with some ideas and information that will help OSCaR improve operations and keep up with advances in the cancer surveillance field. I will be sharing information from other state registries with OSCaR staff so we can all learn from each other.

My most recent trip was to the annual NAACCR conference in Denver, June 7-14. The theme of this meeting was "Ascending New Heights in Cancer Surveillance." The conference highlighted the future directions of cancer surveillance in light of emerging technologies in cancer detection and treatment, innovations in registry operations and data analysis methodologies, and survivorship issues. The focus of presentations was on the innovations, methodologies, tools, and research that elevate the purpose and relevance of a cancer surveillance program within the larger context of a comprehensive cancer control system.

Claudia Feight was the OSCaR representative attending the NCRA Educational Conference in Minneapolis, Minnesota. Claudia reports that the meeting was very informative. She was happy to see some familiar Oregon faces at the meeting. Claudia discusses the NCRA Conference in further detail in her article on the next page.

OSCaR staff members are currently working with the OCRA education committee to plan and organize the 2008 OCRA/OSCaR Fall Workshop. The agenda is filling up with a variety of excellent speakers. I hope we will see you all in Portland for this valuable educational event.

Special points of

Interest:

- Update on meetings and conferences
- Colon definitions
- Colorectal histologies chart

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Claudia's QA Corner

Claudia Feight, RHIT, CTR

Greetings Registrars:

I hope spring is treating you all well. I recently returned from the 34th Annual NCRA Educational Conference in Minneapolis, and I thought it was cold in Minnesota until I got into Denver, where it had just snowed. I think we can safely assume the worry of snow here has now passed.

I wanted to briefly talk about the new Educational and Training Series from the National Program of Cancer Registries (NPCR). Since OSCaR is an NPCR registry, we will be intimately involved with this educational series. The Journal of Registry Management, 2008 (Volume 25, Number 1) had an article written by Linda Mulvihill explaining the new program and NPCR's goal to build education capacity and local expertise within each state/central registry. In addition to the public law authorization to provide training for registry personnel, the 2007 NPCR Program standards require each NPCR funded program to designate an education coordinator/trainer. This individual must be a certified cancer registrar. So with that in mind, I am representing Oregon in that capacity. The OSCaR CTR staff will also be very instrumental in these statewide continuing education efforts.

There are 12 proposed modules and most are already finished. Some are designed for central registry use, but the majority are meant for hospital based cancer registry professionals. These modules will be presented in a variety of formats, of which, we will have details about later in the summer.

Thank you for all your hard work and dedication to the cancer registry field. We will be sending out detailed information on these modules in the near future and look forward to working with you all!

Claudia Feight, RHIT, CTR
Quality Assurance/Training Coordinator

Oregon Cancer Reporting Completeness

Diagnosis Year	Hospital cases	MD office cases	Path only cases	Death Cert only cases	Total Cases	% Complete
2005	19,874	1,725	509	480	22,108	109%
2006	18,662	1,378	3	Pending	20,043	99%
2007	5,751	710	Pending	Pending	6,461	32%

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

Colon Multiple Primary Rules – Text
C180 - C189
(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.

* 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 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Adenocarcinoma in adenomatous polyposis coli (**familial polyposis**) with one or more malignant polyps is a single primary.*

Note: Tumors may be present in multiple segments of the colon or in a single segment of the colon.

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are different at the second (Cxxx), third, (Cxxx) or fourth (C18x) character are multiple primaries. **

Rule M5 Tumors diagnosed **more than one (1)** year apart are multiple primaries. **

Rule M6 An **invasive** tumor following an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **

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 M7 A **frank** malignant or in situ **adenocarcinoma** and an in situ or **malignant** tumor in a **polyp** are a single primary.*

Rule M8 Abstract as a single primary* when one tumor is:

- **Cancer/malignant neoplasm, NOS (8000) and** another is a **specific histology** or
- **Carcinoma, NOS (8010) and** another is a **specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and** another is a **specific adenocarcinoma** or
- **Sarcoma, NOS (8800) and** another is a **specific sarcoma**

Rule M9 **Multiple** in situ and/or malignant **polyps** are a single primary.*

Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*

Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

Note 2: All cases covered by Rule M11 are in the same segment of the colon.

* 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. 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 cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

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

RuleH2

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

Note: Code the behavior /3.

Rule H3

Code **8140** (adenocarcinoma, NOS) when pathology describes only **intestinal type adenocarcinoma** or adenocarcinoma, intestinal type.

Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.

Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.

Rule H4

Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma in a polyp
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note 1: It is important to know that the adenocarcinoma originated in a polyp.

Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.

RuleH5

Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:

- **Mucinous/colloid** (8480) or **signet ring cell carcinoma** (8490) or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid** or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell carcinoma**

Rule H6

Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:

- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
- The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell carcinoma** or
- The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**

Rule H7

Code **8255** (adenocarcinoma with mixed subtypes) when there is a combination of mucinous/colloid and signet ring cell carcinoma.

Rule H8

Code 8240 (carcinoid tumor, NOS) when the diagnosis is **neuroendocrine carcinoma** (8246) and carcinoid tumor (8240).

Rule H9

Code 8244 (composite carcinoid) when the diagnosis is **adenocarcinoma and carcinoid tumor**.

Rule H10 Code **8245** (adenocarcinoid) when the diagnosis is **exactly "adenocarcinoid."**

Rule H11 Code the histology when only **one histologic type** is identified.

Rule H12 Code the invasive histology when both **invasive and in situ** histologies are present.

Rule H13 Code the most **specific histologic term** when the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma 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 H14 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

Note: These rules only apply to multiple tumors that are reported as a single primary.

Rule H15 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
- From CT, PET or MRI scans

Note 2: Code the specific histology when documented.

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

Rule H16 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H17 Code **8220** (adenocarcinoma in adenomatous polyposis coli) when:

- Clinical history says **familial polyposis** and final diagnosis on the **pathology report** from resection is adenocarcinoma in **adenomatous polyps** or
- There are **> 100 polyps** identified in the resected specimen or
- The number of polyps is not given but the diagnosis is **familial polyposis**

Rule H18 Code **8263** (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous

Note: Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.

Rule H19 Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:

- There are **> 1 and <= 100 polyps** identified in the resected specimen or

- There are multiple polyps (adenomas) and the number is not given and **familial polyposis is not mentioned**

• **Note:** Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).

Rule H20

Code the histology of the **most invasive** tumor when:

- There is a frank adenocarcinoma and a carcinoma in a polyp or
- There are in situ and invasive tumors or
- There are multiple invasive tumors

Note 1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H21

Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma **and** the microscopic description or surgical gross describes polyps or
- The final diagnosis is adenocarcinoma **and** there is reference to residual or pre-existing polyps or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H22

Code the histology when only **one histologic type** is identified.

Rule H23

Code the more specific histologic term when the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
- Carcinoma, NOS (8010) and a specific carcinoma or
- Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
- Sarcoma, NOS (8800) and a 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.

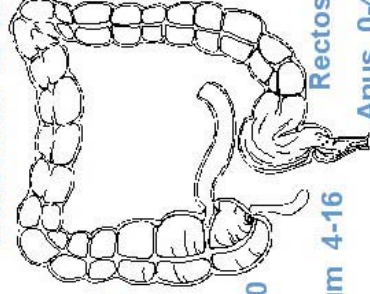
Rule H24

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.

Colonoscopy Measurements from Anal Verge

Transverse 82-132



Ascending 132-147

Descending 57-82

Sigmoid 17-57

Cecum at 150

Rectum 4-16

Rectosigmoid 15-17

Anus 0-4

Equivalent or Equal Terms

Note: For the purpose of these rules, the words "exophytic" and "polypoid" are not synonymous with a polyp

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ___ differentiation.

CTR News

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

COLON DEFINITIONS

From SEER Multiple Primary and Histology Coding Rules Manual

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Adenoma: A **benign** lesion composed of tubular or villous structures showing **intraepithelial neoplasia** (See definition of **intraepithelial neoplasia**).

Composite carcinoid (8244): One tumor which contains both carcinoid and adenocarcinoma.

Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in: a condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

Frank adenocarcinoma: Adenocarcinoma arising from the colon wall (no evidence of a polyp)

In Situ: Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

Intraepithelial neoplasia, high grade may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

Intraepithelial neoplasia, low grade is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

Intramucosal tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria.

Invasive tumor: A tumor that penetrates the basement membrane and invades the lamina propria.

Most invasive: The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:

- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolonic fat, subserosal fat)
- Retroperitoneal fat (pericolonic fat)
- Mesenteric fat (pericolonic fat)
- Serosa (visceral peritoneum)

Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing **extra**-cellular mucin comprising more than 50% of the tumor. Note that "mucin-producing" and "mucin-secreting" are not synonymous with mucinous.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor (8240), atypical carcinoid tumor (8249).

Pericolonic fat: A general term for the fat surrounding the colon. Subserosal fat, retroperitoneal fat and mesenteric fat are pericolonic fat.

Signet ring cell carcinoma (8490): An adenocarcinoma containing **intra**-cellular mucin comprising more than 50% of the tumor.

Transmural: Through the wall of the colon (the tumor has extended through the colon wall and may invade a regional organ or regional tissue).

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is not a histologic type; it is a non-specific term.



Analyst's Angle

Catherine Riddell; Joan Pliska, CTR; Alyssa Elting McGuire

Most common histologies for invasive colorectal tumors diagnosed in 2005 from Oregon State Cancer Registry data

Histology	Count
8140/3: Adenocarcinoma, NOS	1,220
8480/3: Mucinous adenocarcinoma	132
8263/3: Adenocarcinoma in tubulovillous adenoma	102
8210/3: Adenocarcinoma in adenomatous polyposis coli	72
8000/3: Neoplasm, malignant	67
8261/3: Adenocarcinoma in villous adenoma	45
8240/3: Carcinoid tumor, malignant	27
8481/3: Mucin-producing adenocarcinoma	24
8490/3: Signet ring cell carcinoma	24
8010/3: Carcinoma, NOS	23

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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."

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