December 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Rutgers, The State University of New Jersey
Edward J. Bloustein School of Planning and Public Policy
Undergraduate Public Health Program

The Edward J. Bloustein School is seeking a part time lecturer (PTL) to teach two new courses in cancer surveillance that are core requirements for a recently created Certificate in Cancer Surveillance that the program in Undergraduate Public Health is launching in Fall, 2023. *The certificate program will prepare undergraduate students and applicants to a standalone program for entry-level jobs as Certified Tumor Registrars (CTR), and to be competitive for related jobs in the cancer surveillance field.* While it seeks to prepare the student to take the national CTR exam, it also offers a broader understanding of cancer surveillance which involves the *ongoing, timely, and systematic collection and analysis of information on new cancer cases, extent of disease,* screening tests, treatment, survival, and cancer deaths.[1]

Interested applicants for the PTL can reach out to Heather Stabinsky, at NJSCR for more information (stabinhl@cinj.rutgers.edu).

Solid Tumor Rules: 2023 Other Sites Available

The 2023 Other Sites Rules have undergone comprehensive revisions and have been posted on the SEER Website. The 2023 consolidated pdf is now available for download for use beginning with cases diagnosed 1/1/2023 forward.

The Solid Tumor Rules Editors strongly recommend reading through the entire Solid Tumor Other Sites module prior to using. The other sites rules now align with the other solid tumor site modules, however, there are some differences:

- New site-based M and H rules have been added to address changes in clinical practice
- Histology tables for the majority of site groups covered by Other Sites Solid Tumor Rules have been added as histology coding reference tools. It is important to read the information provided in each table to use the tables correctly as some additional histology coding instructions are included in select tables.

The updated Solid Tumor Rules may be accessed at:
https://seer.cancer.gov/tools/solidtumor/

NEW Coding Shorts on FLccSC
NEW GRADE Webinar on FLccSC

http://njs.fcdslms.med.miami.edu/

Only have a few minutes and or want to know an answer without combing through a full webinar?
Check out NJSCRs coding shorts!
New shorts added regularly!

NJSCR Monthly Submission Reminder!

Once your cases have been a submitted, check your submission confirmation email. **This will show if the cases have been accepted or rejected**. Please email a confirmation back to njscrdat@doh.nj.gov that the file name and number of records sent/received is correct. Always check your confirmation email and monthly completeness email from your facility representative. **Submission goal is 50% by January and 75% by April as a target to help facilities stay on track.**

SSDI General Manual Recording Values

Record the lab value as one less than stated when a value is reported as "less than X," and as one more than stated when a value is reported as "more than X."

SSDIs with decimals in their code structures:
Example 1: PSA stated as < (less than) 5. Record 4.9
Example 2: hCG lab value resulting findings of < (less than) 1. Record 0.9
Example 3: Ki-67 reported as > (greater than) 20%. Record 20.1

SSDIs without decimals in their code structure:
Example 1: ER Percent Positive stated as < (less than) 60%. Record 059 (59%)
Example 2: PR Percent Positive stated as > (greater than) 75%. Record 076 (76%)
Example 3: ER Percent Positive < (less than) 50%. Record 049 (49%)
**https://apps.naaccr.org/ssdi/list/

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

November 2022 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

Reportability Reminders

Reportable Beginning 01/01/2021

- All GIST tumors are reportable and classified as 8923/3
- Nearly all thymomas are reportable; the exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8597/0)

NEWLY PUBLISHED: REPORTABLE FOR 2021+

- **Squamous Intraepithelial neoplasia, grade II, or AIN II 8077/2**

See SEER SINQ SEER Inquiry System - Question 20220025 Details (cancer.gov)

Reportable Beginning 01/01/2022

- Intestinal-type adenoma, high grade. Term is reportable for stomach and small intestine.
- Adenomatous polyp, high grade dysplasia. Term is reportable for stomach and small intestine.
- Serrated dysplasia, high grade. This is reportable for stomach and small intestine.
- Low grade appendiceal mucinous neoplasm (LAMN)

Check out NAACCR IC-0-3 Implementation Guidelines https://www.naaccr.org/icdo3/

See SEER Summary of Changes for more newly reportable terms!

https://seer.cancer.gov/tools/codingmanuals/index.html

Date of Regional Lymph Node Dissection

Example: TAH BSO with bilateral Pelvic Sentinel Lymph Node Dissection performed.

How would you code Date of Regional Lymph Node Dissection?

Leave blank

Leave Date of Regional Lymph Node Dissection Date blank when only a sentinel lymph node biopsy is performed.

Check out the SEER Manual and CA forum for more information!

https://seer.cancer.gov/tools/codingmanuals/index.html

https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/sentinel-and-regional-nodes/107547-sln-bx-for-endometrial-primaries

NEW Coding Shorts on FLccSC

http://njs.fcdslms.med.miami.edu/

Only have a few minutes and or want to know an answer without combing through a full webinar?
Check out NJSCRs coding shorts!
New shorts added regularly!

Solid Tumor Rules *updated*

The Solid Tumor Rules have been updated and now available on the SEER Registrar website.

- Important changes to reportable neoplasms in malignant CNS and non-malignant CNS sites have been included in this update.
- Rules in some sites have been re-written for clarification purposes.

It is important to review the 2023 change log to see what revisions have been made. ***The 2023 Update includes changes that apply to cases diagnosed January 1, 2023, and after.*** The editors recommend that until these changes are implemented, registrars continue using the current Solid Tumor Rules, updated September 2021, for cases diagnosed from January 1, 2018, through 12/31/2022

https://seer.cancer.gov/tools/solidtumor/

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October 2021 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Tobacco Use Smoking Status #344
When to assign:

Code 1- The patient currently smokes OR it is known that the patient stopped smoking within 30 days prior to diagnosis.
Code 2- Medical records state "Former Smoker" OR the Patient has smoked tobacco in the past but does not smoke now.
Code 3- The patient is noted to have smoked but current smoking status is unknown OR it is known that the patient "recently" stopped smoking, but it is not known how long ago.
Code 9- The medical record only indicates "No" OR the record has no information about smoking status or history OR it is documented that the patient used or uses smokeless or chewing tobacco or E-cigarettes or vapes, but tobacco use is not mentioned.

** SEER Coding and Staging Manual 2023

HPV Histology Coding Tips
Beginning with diagnosis 01/01/2022

- P16 test results **can be used** to code squamous cell carcinoma, HPV positive (8085) and squamous cell carcinoma, HPV negative (8086).
- **Non-keratinizing squamous cell carcinoma, HPV *positive* is coded 8085** for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.
- **Keratinizing squamous cell carcinoma, HPV *negative* is coded 8086** for sites listed in Head and Neck Solid Tumor Rules Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071.

** https://seer.cancer.gov/tools/codingmanuals/index.html
See SEER Coding and Staging Manual 2023
Summary of Changes (September 2022)

New Reportable Diagnosis for 2023
Cases diagnosed 01/01/2023+

High-grade astrocytoma with piloid features (HGAP) (9421/3).
Lymphangioleiomyomatosis (9174/3)
Mesothelioma in situ (9050/2)
Diffuse leptomeningeal glioneuronal tumor (9509/3)
Report multinodular and vacuolating neuronal tumor (9509/0)
Report juvenile xanthogranuloma (9749/1) C715 is the most common site.
Report pilocytic astrocytoma/juvenile pilocytic astrocytoma as 9421/1 for all CNS sites.
Report diffuse astrocytoma, MYB- or MYBL1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1)

**https://seer.cancer.gov/tools/codingmanuals/index.html
See SEER Coding and Staging Manual 2023
Summary of Changes (September 2022)

Question:
When the only source of information states the diagnosis as two terms, one reportable and one non-reportable, separated by a "slash" (/), should we report the case using the reportable term?

Examples:
- ultrasound of the right eye: consistent with a nevoma/melanoma; we could not find any indication that nevoma is a reportable term
- bladder biopsy pathology report: severe urothelial dysplasia/carcinoma in situ (CIS)

Answer:
If possible, try to obtain further information.
If no further information can be obtained, **accession the case using the reportable term,** melanoma, and CIS in the respective examples, when there is a single report in which both reportable and non-reportable diagnostic terms are listed with a slash and there is no other information. **Most often, the slash indicates the terms are being used synonymously.**

** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20220011/

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.
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September 2022 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

Coding Histology- site-specific rules are important!

The Solid Tumor Editors recommend coding histology using ***in priority order***:

1. The Solid Tumor Rules
2. The 2021 Cutaneous Melanoma Solid Tumor Rules
3. Updated ICD-O histology codes and terms which can be found at: https://seer.cancer.gov/icd-o-3/
4. The ICD-O-3.2

Using Solid Tumor Rules to code Histology

Code the histology diagnosis prior to **neoadjuvant therapy**. Neoadjuvant therapy can change the histological profile of the tumor. ***See site-specific Histology modules for exceptions to this rule.***

Priority order for using documentation to code Histology

For each site, priorities include tissue/histology, cytology, radiography/scans, and physician diagnoses, and biomarkers.

You must use the priority order that precedes the histology rules for each site.

Tissue pathology (and/or biomarkers, if applicable) always takes precedence.

Tissue pathology- for all sites *except breast and CNS*, 2018 Rules instruct **"Code the most specific histology from biopsy or resection.** When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor)."
****Solid Tumor Rules** https://seer.cancer.gov/tools/solidtumor/

Grade for Non-Malignant CNS and Malignant CNS Tumors

Check out the grade manual and Solid Tumor Rules for grade codes associated with CNS histology.

CNS WHO classifications use a grading scheme that is a "malignancy scale" ranging across a wide variety of neoplasms rather than a strict histologic grading system that can be applied equally to all tumor types.

Code the WHO grading system for selected tumors of the CNS as noted in the AJCC 8th edition Table 72.2 where WHO grade is not documented in the record.

Examples:

Meningioma diagnosed clinically
Clinical grade code 1

Medulloblastoma (including all subtypes) resected
Pathologic grade code 4

Schwannoma diagnosed clinically
Clinical grade code 1.

** https://seer.cancer.gov/manuals/2023/appendixc.html
https://apps.naaccr.org/ssdi/list/

Ovary and Fallopian Tube
Residual Tumor Volume Post Cytoreduction

Information for this SSDI can be found in the operative report, procedure report or managing physician notes.

The surgery to remove as much cancer in the pelvis and/or abdomen as possible, reducing the "bulk" of the cancer, is called "debulking" or "cytoreductive" surgery.

Physicians should record the presence or absence of residual disease, if residual disease is observed, the size of the largest visible lesion should be documented.

Code 97 should be used if no cytoreductive surgery was performed.

**https://staging.seer.cancer.gov/eod_public/home/2.2/

Hospital Registrars!

2023 SEER Program and Staging Manual is available on the SEER website.
seer.cancer.gov/tools/codingmanuals/index.html

You still have access to the 2022 SEER Manual here: seer.cancer.gov/tools/codingmanuals/historical.html

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. **Always check your manuals!**

August 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces p: (609) 633-0500

Determining reportability using Radiology Reporting and Data Systems (RADS)

The following cancer cases *are reportable* unless there is information to the contrary

- Liver cases with an LI-RADS category LR-4 or LR-5 (LR-3, see below)
- Prostate cases with a PI-RADS category 4 or 5

The following *are NOT reportable* without additional information

- Breast cases designated BI-RADS 4, 4A, 4B, 4C or BI-RADS 5
- Lung cases designated Lung-RADS 4A, 4B, or 4X
- Liver cases based only on an LI-RADS category of LR-3
- Colon cases with only C-RADS information (C-RADS category C4 is not reportable by itself)
- Head and Neck cases with only NI-RADS information (NI-RADS category 3 is not reportable by itself)
- Ovarian or fallopian tube cases with only O-RADS information (none of the O-RADS categories are reportable without additional information)
- Thyroid cases with only TI-RADS information (none of the TI-RADS categories are reportable without additional information)

https://seer.cancer.gov/seer-inquiry/inquiry-detail/20210075/
https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_E.pdf

Borderline Ovarian Tumor Reportability

Ovarian mucinous borderline tumor
with microinvasion is ***NOT Reportable***

For an ovarian mucinous borderline tumor, the term "microinvasion" is not an indication of malignancy. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor and are not affected by microinvasion or invasion in implants. **Though a case may be staged, this does not mean it is reportable.**

Ovarian mucinous borderline tumor
with foci of intraepithelial carcinoma is ***Reportable***

This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

See Appendix E1 of the 2022 SEER Program Coding and Staging Manual for more examples of reportability!
https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_E.pdf

Congratulations!

The New Jersey State Cancer Registry (NJSCR) recognizes the efforts of these facilities and congratulates them for successfully submitting greater than 95% of their expected 2021 caseload by July 1, 2022.

Cooperman Barnabas Medical Center
Bayshore Medical Center
Cape Regional Medical Center
Carewell Health
CentraState Medical Center
Chilton Medical Center
Christ Hospital
Clara Maass Medical Center
Community Medical Center
Cooper University Hospital
Englewood Health
Hackettstown Medical Center
Hoboken University Medical Center
Hudson Regional Hospital
Hackensack University Medical Center
Hunterdon Medical Center
Inspira Medical Center Mullica Hill
Inspira Medical Center Vineland
Jersey Shore University Medical Center
JFK University Medical Center
Monmouth Medical Center
Monmouth Medical Center, Southern Campus
Morristown Medical Center
Newton Medical Center
Ocean University Medical Center
Overlook Medical Center
Palisades Medical Center
Penn Medicine Princeton Medical Center
Riverview Medical Center
Robert Wood Johnson University Hospital Hamilton
Robert Wood Johnson University Hospital
Robert Wood Johnson University Hospital Somerset
Southern Ocean Medical Center
St. Mary's General Hospital
St. Luke's Hospital - Warren Campus
University Hospital
The Valley Hospital

NET Pancreas

EOD Primary Tumor: The terms "**abutment**," "**abut(s)**," "**encases**," or "**encasement**" of the major blood vessels can be interpreted as involvement of these structures.

Check out the Operative Report for information!
https://staging.seer.cancer.gov/eod_public/home/2.2/

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July 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Clinical and Pathologic Tumor Size (TS)

TS Clinical, TS Pathologic, and TS Summary are all required data items (SEER).

Code 998: Alternate descriptions of tumor size for specific sites:

- Familial/multiple polyposis
  - Rectosigmoid and rectum (C19.9, C20.9)
  - Colon (C18.0, C18.2-C18.9)
- ***If no size is documented in the following situations:***
  - Circumferential
    - Esophagus (C15.0-C15.5, C15.8-C15.9)
  - Diffuse; widespread: three-fourths or more; linitis plastica
    - Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9)
  - Diffuse, entire lung or NOS
    - Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9)
  - Diffuse
    - Breast (C50.0-C50.6, C50.8-C50.9)

** https://seer.cancer.gov/tools/codingmanuals/index.html

Review the SEER Program Coding and Staging Manual for full list of coding instructions.

Solid Tumor Rules 2018 General Instructions:

Recurrence and Timing Rules

Use the Multiple Primary Rules as written to determine whether a subsequent tumor is a new primary or a recurrence. **The ONLY exception** is when a **pathologist compares slides from the subsequent tumor to the "original" tumor** and documents the subsequent tumor is a recurrence of the previous primary. Never code multiple primaries based only on a physician's statement of "recurrence" or "recurrent".

** https://seer.cancer.gov/tools/solidtumor/

NJSCR Data Updates for 2022

https://www.cancer-rates.info/nj/, New Jersey's official source for cancer statistics has been updated with cancer incidence data through 2019. Statewide and county-level cancer incidence data are available by cancer site, gender, race, and ethnicity. NEW to this site are incidence data for childhood cancers in New Jersey, also through 2019. https://www.nj.gov/health/ces/cancer-researchers/cancer-data/index.shtml

CONGRATULATIONS REGISTRARS!

The New Jersey State Cancer Registry has been awarded the Registry of Distinction award by the Center for Disease Control and Prevention (CDC) and National Program for Cancer Registries (NPCR). This achievement indicates that the New Jersey State Cancer Registry met the CDC NPCR National Data Completeness and Quality Standard.

NJSCR recognizes this achievement would not have been possible without the hard work and dedication of all the registrars of New Jersey. Thank you for your continued commitment to providing high quality cancer data.

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June 2022 E-Tips	New Jersey State Cancer Registry Cancer Epidemiology Services http://www.nj.gov/health/ces (609) 633-0500

Hematopoietic Coding Tips

New Note for Diagnostic Confirmation for cases diagnosed 2022+

Use **Code 3** "Positive histology PLUS positive immunophenotyping or genetic testing" for histologies:

Myelodysplastic Syndromes
Acute Leukemias of ambiguous lineage
Precursor Lymphoid Neoplasms
Acute Myeloid Leukemia and related Precursor Neoplasms

Summary Stage 2018 and EOD Primary Tumor for Myeloma and Plasma Cell Disorders

EOD Primary Tumor

Plasma cell myeloma/multiple myeloma (9732) is a widely disseminated plasma cell neoplasm, characterized by a single clone of plasma cells derived from B cells that grows in the bone marrow.

It is always coded to 700 for systemic involvement.

SEER Summary Stage 2018

Note 4: Lymphoplasmacytic lymphoma (9671) and Waldenstrom Macroglobulinemia (9761) are now collected with the plasma cell disorders. **These are systemic diseases and should always be coded 7.**

** Summary Stage 2018: Myeloma and Plasma Cell Disorders | EOD Data SEER*RSA (cancer.gov)

** NAACCR Hematopoietic and Lymphocytic Neoplasms Webinar

NCRA's Central Registry Badge Program

A new program designed to help hospital registrars understand the general operations and responsibilities of central registries. Earn six (6) CE hours upon successful completion of this program. The enrollment period for this activity is 180 days.

http://www.cancerregistryeducation.org/products/1739/ncras-central-registry-badge-program

NEWLY UPDATED!

2022 NJSCR Program Manual and 2022 Reportable List are posted!

Look at the NJSCR website for more information!

https://www.state.nj.us/health/ces/reporting-entities/njscr/

SEER SINQ Updated as of 05/27/2022

Question:

Should neoadjuvant chemotherapy be coded for an incidental second primary discovered at the time of surgery? If so, how is the diagnosis date coded?

The patient had neoadjuvant chemotherapy for rectal carcinoma. An AP resection revealed an incidental second primary intramucosal carcinoma in adenomatous polyp in the descending colon. Is the chemotherapy coded as therapy for the intramucosal carcinoma of the descending colon?

Answer:

Record the neoadjuvant therapy only for the first primary and do not record the neoadjuvant therapy for the incidental new primary found on surgery.

History:

*Answer for cases diagnosed **prior** to 2022*

The neoadjuvant chemotherapy is recorded for both primaries.
For the second primary, code the actual diagnosis date and use the date of diagnosis as the date of systemic therapy.

** https://seer.cancer.gov/seer-inquiry/inquiry-detail/20110088/

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May 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Lymph Node Coding Tips

Date of First Surgical Procedure for 2021+ for FNA/Biopsy of Regional Lymph Node

Record the date of the first/earliest surgery if Surgery of Primary Site, Sentinel Lymph Node Biopsy, Scope of Regional Lymph Node Surgery (**excluding cases coded to 1**), or Surgical Procedure of Other Site was recorded as part of the first course of therapy.

Scope of Reg LN Surg Code 1 (Biopsy or aspiration of regional lymph node, NOS) **is not considered treatment.**

If surgery was not performed, then RX Date surgery Flag must =11. Surgery is considered "not performed".

Do not code surgery to distant lymph nodes in scope of regional lymph node surgery.

Coding Sentinel Lymph Nodes Positive for Breast ONLY

Use **code 97** in this data item and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in Regional Nodes Positive (NAACCR Item #820) **when a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection**

** https://seer.cancer.gov/tools/codingmanuals/ SEER Program Coding and Staging Manual 2022

Race abbreviations in Text!

Abbreviations can generate confusion, as they may vary among different institutions and different specialties. Because abbreviations should be understood by any reader, only those that are clear and precise should be used.

Follow NAACCR approved abbreviation list when including text.
http://datadictionary.naaccr.org/default.aspx?c=17&Version=22

Do not make up abbreviations to describe race.
If no abbreviation can be found on list, **provide fully texted word**.
Text is used to confirm the codes provided within your abstract.

Description:
35-year-old white female
Proper Text:
35 YO WF or W/F

Description:
96-year-old Black Male
Proper Text:
96 YO BM or B/M

Description:
77-year-old Asian Indian Female
Proper Text:
77 Y/O Asian Indian Female

Reasoning:
No approved abbreviations available for Asian Indian

Description:
26-year-old American Indian Male
Proper Text:
26 YO American Indian Male

Reasoning:
No approved abbreviations available for American Indian

Radiation Updates for 2021+

If primary site in pelvic region is surgically removed, **code to primary site**.

When intracavitary HDR brachytherapy is administered to the vaginal cuff for endometrial cancer or cervical cancer, post therapy, primary treatment volume is Vagina.

**NAACCR Webinar: Treatment 2021

Timing Guidelines for PSA

- Record the *last pre-diagnosis PSA lab value prior to diagnostic biopsy* of prostate and initiation of treatment
- All lab values must be done no earlier than approximately three months before diagnosis
- *Example-*
  12/5/19 PSA: 44.8
  3/2/20 PSA: 42.2
  5/5/20 biopsy: +adenocarcinoma
  SSDI PSA= **42.2**

ps://www.naaccr.org/wp-content/uploads/2021/09/SSDI-Manual_v-2.1-2022.pdf?v=1652909128

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April 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
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(609) 633-0500

Solid Tumor Rules Changes for 2022 highlights

Colon Solid Tumor Rules

Timing changes to rules M7 and M8:

The timing for subsequent tumors at the anastomosis has changed from 24 months to 36 months.
The change is effective for cases diagnosed beginning 1/1/2022 forward.
For cases diagnosed 1/1/2018 through 12/31/2021, the timing rule remains at 24 months.

Low grade appendiceal neoplasm (LAMN) will become reportable effective for cases diagnosed 1/1/2022 forward.
LAMN may be either in situ 8480/2 or malignant 8480/3 based on physician statement of behavior.
LAMN diagnosed prior to 1/1/2022 are not reportable

Head and Neck Solid Tumor Rules

Cases diagnosed 1/1/2022 forward:
Beginning with cases diagnosed 1/1/2022 forward, **p16 test results can be used to code**:
Squamous cell carcinoma, HPV positive (8085) and Squamous cell carcinoma, HPV negative (8086)

For more information on STR changes, see the SEER Site Specific Modules page
**https://seer.cancer.gov/tools/solidtumor/revisions.html

Common coding issues found on EOD Primary Tumor for Testis Primary

Pay close attention to the extension found on the orchiectomy.

Code 100
Pathologic assessment Only. For Pure Seminomas Only: Tumor **less than 3cm**, limited to the testis **Without** LVI or **unknown** LVI

Code 150
Pathologic assessment only. For pure seminomas only. Tumor **greater than or equal to 3 cm**, limited to the testis **WITHOUT** LVI or **unknown** if LVI

Code 300
Pathological assessment only. Tumor limited to testis (including rete testis invasion) ***WITH*** **lymphovascular invasion**

Code 400
Pathological assessment only
Epididymis, **Hilar soft tissue**, Mediastinum (of testis), Visceral mesothelial layer

Check out the EOD RSA site
to see the other available EOD Primary Tumor codes for Testis
**https://staging.seer.cancer.gov/eod_public/input/2.1/testis/eod_primary_tumor/?breadcrumbs=(~schema_list~),(~view_schema~,~testis~)

Common coding issues found on Surgery codes for Testis Primary

When coding the surgery, make sure you use the most specific information from the Operative Report.

Code 40 Excision of testicle with cord or cord not mentioned (Radical Orchiectomy)

Code 80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

**https://seer.cancer.gov/manuals/2022/appendixc.html
Select Testis, Surgery codes

Exciting News!
NJSCR is updating the Program Manual and Reportable List for 2022!
Anticipated completion is June 2022.
Hospital Registrars feel free to reach out to your representative with questions.

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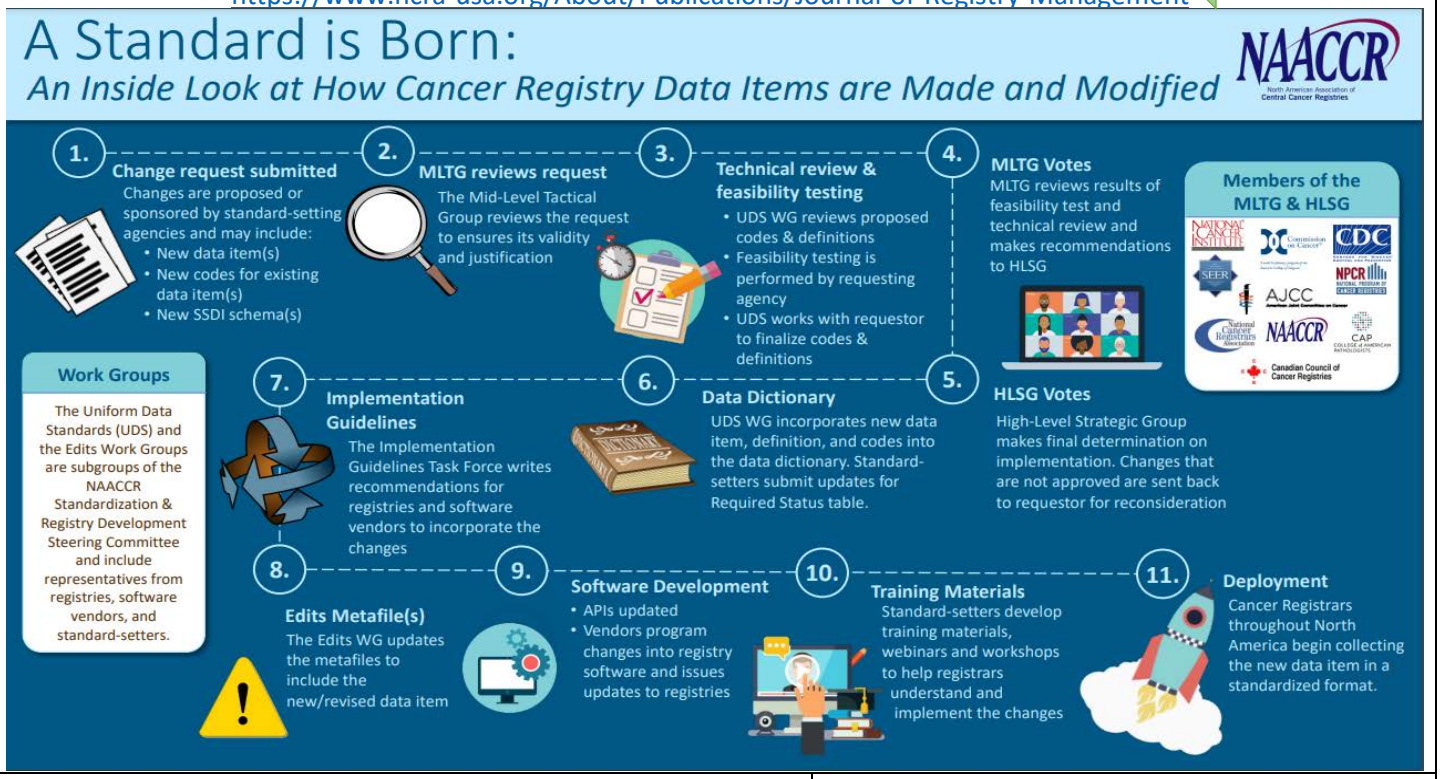
March 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Curious how cancer registry data items are created?

Check out the NAACCR's poster found in the Journal of Registry Management
https://www.ncra-usa.org/About/Publications/Journal-of-Registry-Management



Coding Pathologic Grade

The grade from **clinical work up** from the primary tumor can be used for **grade pathologic** in different scenarios based on behavior or surgical resection:

Behavior	**Surgical Resection**	**No Surgical Resection**
Tumor behavior for the clinical and the pathological diagnoses are the same AND the clinical grade is the highest grade. Tumor behavior for clinical diagnosis is invasive, and the tumor behavior for the pathological diagnosis is in situ.	Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection. Surgical resection is done of the primary tumor and there is no residual cancer.	Surgical resection of the primary tumor has not been done, but there is positive confirmation of distant metastases during the clinical time frame.

**https://www.naaccr.org/wp-content/uploads/2021/08/Grade-Manual_v-2.1-2022.pdf?v=1641497051

Question:

Summary Stage 2018/Extension--Prostate: Can imaging be used to code SEER Summary Stage 2018? MRI shows tumor involved the seminal vesicles and the patient did not have surgery. AJCC does not use imaging to clinically TNM stage a prostate case.

Answer:

Per Note 5 of the 2018 SEER Summary Stage Prostate chapter: Imaging is not used to determine the clinical extension unless the physician clearly incorporates imaging findings into their evaluation. This note was added to be in line with how AJCC stages; therefore, AJCC and Summary Stage agree. **Do not use the MRI findings when that is all you have, and the physician does not document agreement with the MRI.**

**https://seer.cancer.gov/seer-inquiry/inquiry-detail/20190030/?cancer_site_category.raw=Prostate

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email. The information provided here is correct as the distribution date of the newsletter. Always check your manuals!

February 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Effective for Cases Diagnosed 01/01/2022

Do not accession a case based ONLY on suspicious cytology. Accession the case when a reportable diagnosis is confirmed later.

The date of diagnosis is the date of the suspicious cytology.

This is a change to previous instructions.
The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology.
See Date of Diagnosis for more information.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.
Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

**https://seer.cancer.gov/manuals/2022/SPCSM_2022_MainDoc.pdf

Updated SSDI PSA (Prostatic Specific Antigen) Lab Value

2 new codes have been added for the PSA Lab Value SSDI.

- **XXX.2** Lab value not available, physician states PSA is negative/normal
- **XXX.3** Lab value not available, physician states PSA is positive/elevated/high

A known lab value takes priority over codes XXX.2 and XXX.3

The **lab value takes priority** even if the physician documents the interpretation.

Example: Patient noted to have a PSA of 7.6. Physician notes that the value is elevated
Code 7.6 instead of XXX.3 (elevated)

**https://staging.seer.cancer.gov/eod_public/schema/2.1/prostate/?breadcrumbs=(~schema_list~)

Clarification for Coding Liver Fibrosis Score

Note 6: Use code 7 if there is a clinical diagnosis (no microscopic confirmation) of severe fibrosis or cirrhosis.

Physician statement of cirrhosis can be used.

**https://staging.seer.cancer.gov/eod_public/input/2.1/liver/fibrosis_score/?breadcrumbs=(~schema_list~),(~view_schema~,~liver~)
**https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101713-cirrhosis-nos-for-liver-primary

Tips for Coding Primary Site: Bladder

C67.8 Bladder, overlapping lesion
Single tumor (any histology) that overlaps subsites in bladder **OR**
Single or discontinuous tumors which are urothelial CA in situ (8120/2) AND ONLY bladder and 1 or both ureters are involved

C67.9 Bladder, NOS
Multiple non-contiguous tumors within bladder and subsite not documented

C68.8 Overlapping lesions of urinary organs
Single tumor overlaps 2 urinary sites and site of origin unknown (Renal pelvis C68.8 and ureter; bladder and urethra; bladder & ureter*)

C68.9 Urinary system, NOS
Multiple discontinuous tumors in multiple organs within urinary system C68.9 (Renal pelvis and ureter; bladder and urethra; bladder & ureter*)

* See C67.8 for 8120/2 when only bladder and ureter(s) are involved

**NAACCR Cancer Surveillance 2021-2022 Webinar Series: Bladder 2021
**https://seer.cancer.gov/tools/solidtumor/STM_2018.pdf

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January 2022 E-Tips

New Jersey State Cancer Registry
Cancer Epidemiology Services
http://www.nj.gov/health/ces
(609) 633-0500

Radiation Coding Information and Tips

- "Whole Pelvis" implies RT to primary site or tumor bed and regional lymph nodes.
- "Vagina cuff" implies intracavitary brachytherapy.
- If dose/fraction and total dose is provided in Gy or cGy units for any brachytherapy procedure, capture this information in your abstract. **Do not use codes 99998 or 999998 if this information is found in treatment summary!**
- If brachytherapy is only mode of treatment and dose is not provided in cGy, code to 999999 for total dose.
- You cannot, add dose from EBRT phase to that of brachytherapy phase to get total dose!

** GYN Guidelines for Coding EBRT & Brachytherapy Treatments by Wilson Apollo, MS, CTR, RTT WHA Consulting NAACCR 2021-2022 Webinar Series Uterus 2021

Question:
Cirrhosis, NOS for Liver Primary
Fibrosis Score - SSDI manual states: Use Code 7 for Clinical statement of advanced/severe fibrosis or cirrhosis, AND not histologically confirmed or unknown if histologically confirmed.

Does the cirrhosis also have to be "advanced/severe"?
Is it:
Advanced/severe fibrosis OR
Cirrhosis, NOS
Or is it
Advanced/severe: fibrosis or cirrhosis

Answer:
Cirrhosis, NOS can only be used when it is microscopically confirmed (see code 1).

For a clinical diagnosis only (no microscopic confirmation), it must state advanced/severe fibrosis or cirrhosis.

If the only information you have is Cirrhosis, NOS based on clinical evaluation, then you can't use code 7 and would have to code 9.

Per code 7, it must state "advanced/severe fibrosis or (advanced/severe) cirrhosis" on an imaging report to code 7. A statement of Cirrhosis only (or Cirrhosis, NOS) is not enough to code 7.
** https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/101713-cirrhosis-nos-for-liver-primary

Check out the NJSCR Website

Updated Reportable list, current and previous Etips can be found on the NJSCR website.
https://www.state.nj.us/health/ces/reporting-entities/registrars/

Registry Resources

- 2021 NJSCR Program Manual
- Cancer Registry Statute (New Updated 2018)
- Reportable List, Word Format (NEW updated 2021)
- Reportable List, PDF Format (NEW updated 2021)
- SEER ICD-10-CM Case Finding List

E-Tips

- Current 2021 E-Tips: Helpful tips from the NJSCR
- 2020 E-Tips
- 2019 E-Tips

Hospital Registrars!

The reporting deadline for 2021 cases remains July 1.

Facilities should look to have at least 50% of their cases reported by the end of January 2022.

Make sure to let your NJSCR Representative know if you have had any personnel changes.

Questions can be sent to your facility's NJSCR Representative or by calling 609-633-0500. DO NOT REPLY to this email.