January is National Cervical Cancer Screening Month. Cervical cancer begins in the lining of the cervix (organ connecting the uterus and the vagina), and is one of the most common cancers of a woman’s reproductive organs. In the United States in 2017, there will be an estimated 12,820 new cases and 4,210 deaths due to cervical cancer. The two main types of cancer of the cervix are squamous cell carcinoma (80% - 90%) and adenocarcinoma (10% - 20%).

Most cases of cervical cancer are found in women over the age of 30. This type of cancer forms slowly and may not show any symptoms. The primary risk factor that increases a women’s chance of developing cervical cancer is Human Papilloma Virus (HPV) infection; other risk factors include smoking, diet, weakened immune system and family history of this cancer.

The best way to prevent cervical cancer is to find it early by the Pap test. This screening procedure can find abnormalities in cervical cells before cancer develops. Most cervical cancers are found in women who have not had the Pap test when they should. There are now vaccines that can protect women against HPV.
Among cancers that affect both men and women, colorectal cancer (cancer of the colon or rectum) is the second leading cause of cancer deaths in the United States. Every year, more than 140,000 Americans are diagnosed with colorectal cancer, and more than 50,000 people die from it.

Colorectal cancer screening saves lives. If everyone who is 50 years old or older were screened regularly, as many as 60% of deaths from this cancer could be avoided.

Reference: http://www.cdc.gov/features/colorectalanawareness/

Kansas Cancer Registry Spring Meeting 2017

TBA

NCRA 2017 Annual Education Conference

April 5-8, 2017
Washington, D.C.

(Check out the National Cancer Registrars Association website at http://www.ncra-usa.org)
Abstracting Questions and Answers

Questions adapted from: www.cancerbulletin.facs.org/

Question
A path report is presented to you with fragments from the descending colon, ascending colon, and sigmoid colon, but only the ascending colon (C18.2) and sigmoid colon (C18.7) tested positive for adenocarcinoma, while the other was diagnosed as benign. All of the fragments were taken at the same time. What would you code the primary site as?

Answer
Since the ascending colon and sigmoid colon both tested positive for adenocarcinoma, the code should be overlapping lesions of the colon (C18.8). This would have been the case if all three sites had proven to be indicative of an adenocarcinoma diagnosis.

Question
For the cervix, the SEER Program Code Manual denotes CIN III and carcinoma in situ of the cervix as not being reportable for cases diagnosed in 1996 or later, but does not list "adenocarcinoma" or "squamous cell carcinoma." Are these histologies still reportable?

Answer
For the primary site cervix to be reportable, the histology behavior code must be 3 (indicating invasiveness) for all cases diagnosed 1996 or later. So, adenocarcinoma and squamous cell carcinoma are reportable, if they are invasive and not in situ.

Question
Reportability--Colon: Is a biopsy that is possible for invasive adenocarcinoma considered reportable?

Answer
This case is not reportable. If a biopsy was not performed, and instead a clinical diagnosis listed as “possible” for invasive adenocarcinoma was given, then it is not be reportable.

Question
MP/H Rules/Histology--Colon: How is histology coded if a patient has two invasive adenocarcinomas in one segment of the colon (e.g. descending colon [C18.6]) with one diagnosed in December of 2011, and the other diagnosed in January of 2013?

Answer
For cases diagnosed 2007-2016, the steps used to arrive at the correct decision are:

Step 1: Open the Multiple Primary and Histology Coding Rules Manual. Choose one of the three formats (i.e., flowchart, matrix or text) and go to the Colon Histology rules to determine the histology code for this case. The Module you use depends on the behavior and number of tumors identified in the primary site.

Step 2: Start at M1 in the section of COLON MULTIPLE PRIMARY RULES. Try using the flowchart in this example. The rules are intended to be reviewed in consecutive order from Rule M1 to Rule M11. Stop at the first rule that applies to the case you are processing. Stop at Rule M11.

Step 3: After looking over M1 to M3 with no conclusion—we arrive at M4—which would lead us to deduce this example as a multiple primary, but the ICD-O-3 topography codes are the same (C18.6); Therefore, we must move on to rule M5. Rule M5 indicates that if the tumors are diagnosed more than one (1) year apart, they must be multiple primaries. In this example, the diagnosis dates were given in an interval of more than one year. So, we have reached the rule that conclusively mandates a multiple primary for this diagnosis. We may now stop at Rule M5 and proceed to abstract this diagnosis as—at a minimum—the second primary (02).

Do you have any questions that you would like answered in an upcoming newsletter?
Email your question(s) to: vhundley@kumc.edu
### Reporting Schedule

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<th>Month of Diagnosis</th>
<th>Due to KCR by:</th>
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<td>January 2016</td>
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### Are You Current?

- KCR is now ready to accept NAACCR Record Layout Version 16. Use NAACCR Record Layout Version 16 and NAACCR Version 16 Edits to abstract all cases diagnosed January 1, 2016 and prior.
- Use Collaborative Staging & Coding Manual, Version 02.05 for cases diagnosed January 1, 2004 – December 31, 2015 (https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx) to code collaborative stage fields.
- Use the web-based Hematopoietic & Lymphoid Neoplasm Database (http://www.seer.cancer.gov/seertools/hemelymph/) for coding all diagnosis years. You must now select a diagnosis year to be shown the correct information and the correct version of the manual.
- Please check our website to download the Kansas Cancer Registry Coding and Information Manual, (http://www.kumc.edu/kcr/downloads.aspx)
- Effective October 1, 2015, use ICD-10-CM diagnosis codes for casefinding. You can find the KCR ICD-10-CM casefinding list on the Downloads page of our website.
- Collaborative Stage Transition Updates. You can find all newsletters at: http://seer.cancer.gov/registrars/cstnms/
- AJCC has free training materials now available at: https://cancerstaging.org/CSE/Registrar/Pages/Presentations.aspx
We would like to wish you and your families a very Happy New Year!

From the Kansas Cancer Registry Staff

Updating Contact Information!

Please visit our website (www.kumc.edu/kcr/downloads)

Submit the updated form to Victoria Hundley (Email: vhundley@kumc.edu; Fax: 913-588-7384)

The Kansas Cancer Registry (KCR) collects and maintains a population based longitudinal database of all Kansans diagnosed with cancer. KCR is the only population-based source of information on cancer incidence in the State of Kansas. It provides information on the occurrence of cancer, stage at diagnosis, survival and sub-populations affected by different types of cancer. Registry information can be used by researchers to evaluate the effectiveness of new treatments and by public health professionals to implement and monitor prevention efforts. Thanks to facilities across the state of Kansas who report cancer cases, KCR has quality data to help in the fight against cancer.

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Thanks to all KCR staff members who contributed to the publication of this newsletter.

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