

## Collecting Cancer Data: Pancreas

NAACCR 2011-2012 Webinar Series  
1/5/2012



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## Q&A

- Please submit all questions concerning webinar content through the Q&A panel.

Reminder:

- If you have participants watching this webinar at your site, please collect their names and emails.
  - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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## Fabulous Prizes



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### Agenda

- Updates
- Coding Moment
- Pancreas
  - Overview
  - Quiz 1
  - Collaborative Stage Data Collection System
  - Quiz 2
  - Review of Exercises

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### Updates

- Schedule changes
  - The February and May topics have been switched
    - 2/2/12  
Collecting Cancer Data: Lung
    - 5/3/12  
Collecting Cancer Data: Hematopoietic
  - The June and July webinars are the second week of the month
    - 6/14/12 (changed)  
Using and Interpreting Data Quality Indicators
    - 7/12/12 (not a change)  
ICD-10-CM and Cancer Surveillance

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### Updates

- Multiple Primary and Histology (MP/H) Coding Rules
  - Revised September 27, 2011
  - <http://www.seer.cancer.gov/tools/mphrules/download.html>
- Added codes to Multiplicity Counter data item
  - 00: No primary tumor identified
  - 89: Multicentric, multifocal, number unknown
  - Effective for 1/1/2011 diagnoses and forward




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Coding Moment

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**2012 REVISIONS AND CHANGES**

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**2012 Revisions and Changes**

- Collaborative Stage Data Collection System
  - Version 02.04 (v02.04)
    - Effective for cases diagnosed 1/1/2012 and forward
    - Use for all cases regardless of diagnosis year once v02.04 is implemented in registry
    - <http://cancerstaging.org/cstage/manuals/coding0204.html>



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**2012 Revisions and Changes**

- Collaborative Stage Data Release Notes v02.04
  - <http://cancerstaging.org/cstage/news/release-notes.pdf>
  - Summary of Changes for v02.04
    - Description of changes in fields and whether or not change requires manual review



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### 2012 Revisions and Changes

- Implementation Guide for Registries and Vendors v02.04
  - <http://cancerstaging.org/cstage/news/implementation-guide.pdf>
    - Registry personnel
      - Provides a background for the changes in v02.04 and information about case preparation and review
    - Software developers and/or in-house or outside vendors
      - Designed to point out particular steps and considerations in upgrading software to v02.04 and assisting registries with the review and upgrade process



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### 2012 Revisions and Changes

- Hyperlinked CS Coding Instructions
  - Download from <http://cancerstaging.org/cstage/manuals/coding0204.html>
- Download CS Coding Instructions to your desktop (not hyperlinked)
  - General Rules Part I Section1: <http://cancerstaging.org/cstage/manuals/pt1sec1v0204.pdf>
  - Part I Section 2: Lab Tests, Tumor Markers, and Site-Specific Factor Notes: <http://cancerstaging.org/cstage/manuals/pt1sec2v0204.pdf>
  - Part II: Not yet available



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### 2012 Revisions and Changes

- Online Help Version of CS Instructions
  - v02.03
    - <http://cancerstaging.org/cstage/manuals/coding0203.html>
  - V02.04
    - Online help installation instructions
      - <http://www.cancerstaging.org/cstage/manuals/cs-manual-install-instructions.pdf>
    - Download Online Help
      - [CS\\_Coding\\_Online\\_Help\\_V0204.exe](#)



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### 2012 Revisions and Changes

- Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Database
  - Revisions effective 1/1/2012
    - Scheduled for March 2012 release



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### 2012 Revisions and Changes

- Standards for Cancer Registries Volume II: Data Standards and Data Dictionary
  - Record Layout Version 12.2 (v12.2)
    - Effective 1/1/2012
  - <http://www.naaccr.org/StandardsandRegistryOperations/Volumell.aspx>



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### 2012 Revisions and Changes

- Standards for Tumor Inclusion and Reportability
  - Reportable diagnoses
    - Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008)*
    - Canadian Council of Cancer Registries (CCCR)
      - Includes borderline malignancies for all topographies in ICD-O-3
        - » Behavior code 1



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### 2012 Revisions and Changes

- Standards for Tumor Inclusion and Reportability
  - Use of ambiguous terms
    - Do not substitute synonyms such as “supposed” for “presumed” or “equal” for “comparable”
    - Do not substitute “likely” for “most likely”
    - Use only the exact words on the list



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### 2012 Revisions and Changes

- Revised data items
  - RX Summ—Surg/Rad Seq
    - Radiation/Surgery Sequence
    - NAACCR data item #1380
  - Revisions
    - 6: Intraoperative radiation with other radiation given before **and**/or after surgery
    - 7: Surgery both before and after radiation
      - » New code



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### 2012 Revisions and Changes

- Revised data items
  - RX Summ—Systemic/Sur Seq
    - Systemic/Surgery Sequence
    - NAACCR data item #1639
  - Revisions
    - 6: Intraoperative systemic therapy with other therapy administered before **and**/or after surgery
    - 7: Surgery both before and after systemic therapy
      - » New code



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### 2012 Revisions and Changes

- Comorbid/Complication 1-10
  - Comorbidities & complications
    - Secondary diagnoses
  - May use either ICD-9-CM or ICD-10-CM
    - Enter first 5 characters of ICD-10-CM code



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### 2012 Revisions and Changes

- *Cancer Program Standards 2012: Ensuring Patient-Centered Care*
  - Patient-centered needs
  - Quality of care and outcomes
  - <http://www.facs.org/cancer/coc/cocprogramstandards2012.pdf>



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Pancreas

### OVERVIEW



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### Pancreatic Cancer

- Estimated new cases and deaths from pancreatic cancer in 2011
  - United States
    - New cases: 44,030
    - Deaths: 37,660
  - Canada
    - New cases: 4,100
    - Deaths: 3,800

American Cancer Society: Cancer Facts and Figures 2011  
Canadian Cancer Society Website: [http://info.cancer.ca/cce-  
ecc/default.aspx?Lang=E&toc=36](http://info.cancer.ca/cce-<br/>ecc/default.aspx?Lang=E&toc=36)



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### Pancreatic Cancer

- The incidence rates have risen over the last several decades
  - The second most common malignant tumor of the gastrointestinal tract
  - The fourth leading cause of cancer related death in adults



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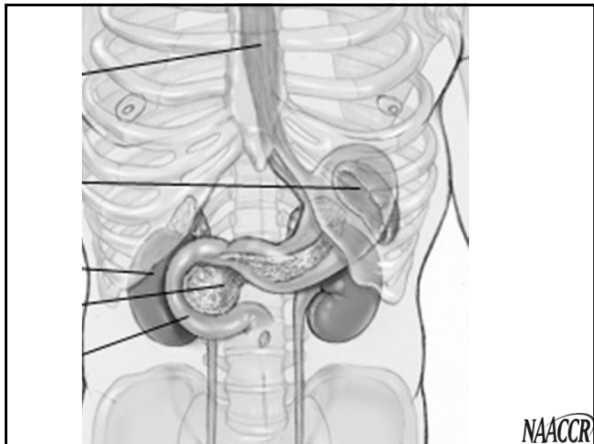
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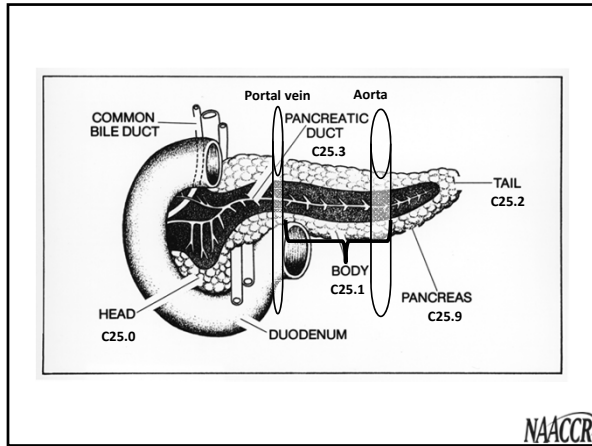
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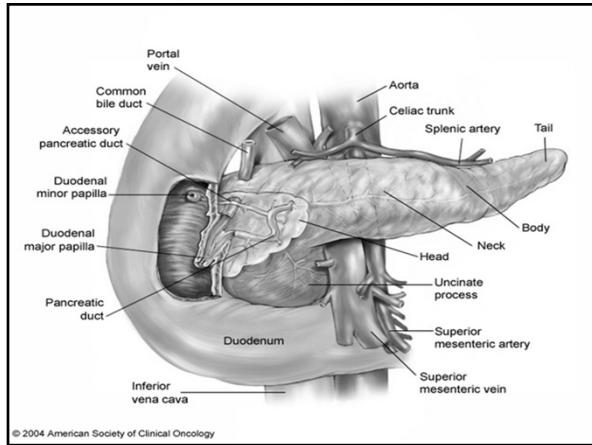
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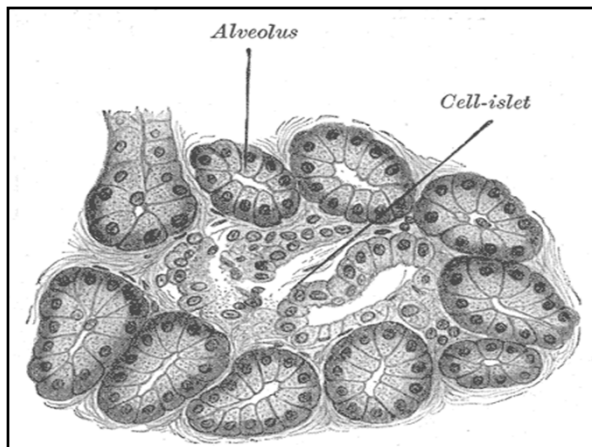
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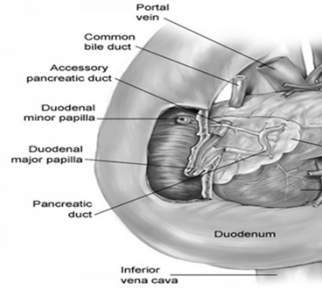
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### Exocrine Function of the Pancreas

- The pancreas is primarily composed of acinar cells
  - Acinar cells secrete a digestive enzymes into the duodenum via the pancreatic duct to help digest food.



© 2004 American Society of Clinical Oncology

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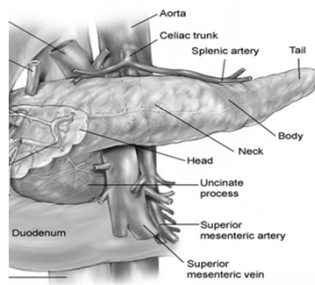
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### Endocrine Function of the Pancreas

- Islets of Langerhans are composed of two major cell types
  - Alpha cells secrete the hormone glucagon
  - Beta cells secrete insulin




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### Topography Coding

Description	Code
Pancreas, NOS	C25.9
Head of the Pancreas	C25.0
Body of the Pancreas	C25.1
Tail of the Pancreas	C25.2
Pancreatic Duct (Wirsung, Sanottrini, or major duct)	C25.3
Islets of Langerhans	C25.4
Neck of the Pancreas	C25.7




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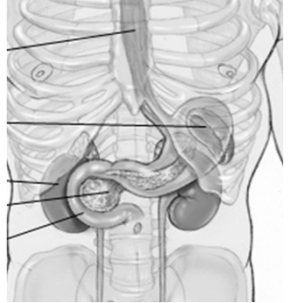
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### Regional Lymph Nodes

- Regional lymph nodes:
  - Hepatic
  - Lateral aortic (lumbar)
  - Peripancreatic, NOS
  - Pyloric
  - Retroperitoneal
  - Superior mesenteric



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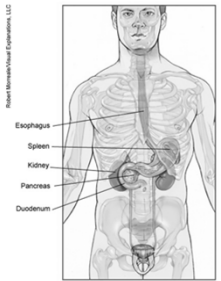
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### Distant Metastasis

- Liver
- Peritoneal Cavity
- Lungs



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### Question

- We have a pathology report from a pancreatic biopsy done in 2010. The final diagnosis is neuroendocrine tumor of the pancreas and our pathologist says 3 times in the path report that it is benign. However the pathologist stages it as T1 (quoting AJCC 7th ed).
  - Is this a reportable case?

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**Answer**

- The AJCC Staging Manual should not be used to determine reportability.
  - CoC, SEER, NPCR, and NAACCR do not require benign or borderline tumors of the pancreas.
  - CCCR does not require benign tumors of the pancreas.
  - Hospitals or state/provincial registries may collect them as reportable by agreement.



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**Exocrine Histologies**

- Ductal adenocarcinoma
  - Mucinous noncystic carcinoma
  - Signet-ring cell carcinoma
  - Adenosquamous carcinoma
  - Undifferentiated (anaplastic) carcinoma
  - Undifferentiated carcinoma with osteoclast-like giant cells
  - Mixed ductal-endocrine carcinoma



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**Question**

- Should I code a ductal cell carcinoma of the pancreas to the pancreatic duct (C25.3) or to the part of the pancreas from which it arises.



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**Answer**

- Code ductal carcinoma of the pancreas to the part of the pancreas where it arises
  - Carol Johnson, SEER



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**Exocrine Histologies**

- Serous cystadenocarcinoma
- Mucinous cystadenocarcinoma
- Papillary-mucinous carcinoma
- Acinar cell carcinoma
- Acinar cell cystadenocarcinoma
- Pancreatoblastoma
- Solid pseudopapillary carcinoma



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**Excocrine Histologies**

- Pancreatic intraepithelial neoplasia (PanIn III or PAIN III)
  - PanIn III is the equivalent of carcinoma in situ and should be reported as Tis
  - Per rule H2 in the MP/H rules, code PanIn III as glandular intraepithelial neoplasia grade III (8148/2)



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### Endocrine Histologies

- Pancreatic endocrine tumor, functional\*
  - Insulin-secreting (insulinoma)\*
  - Glucagon-secreting (glucagonoma)\*
  - Somatostatin-secreting (somatostatinoma)\*
- Pancreatic endocrine tumor, nonsecretory\*
- Mixed ductal-endocrine carcinoma
- Mixed acinar-endocrine carcinoma

\*Must be referred to as malignant to be reportable



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### Question

- What is the correct code for "non-secretory pancreatic endocrine tumor" with positive lymph nodes on excision indicating a malignant tumor?



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### Answer

- Code as islet cell carcinoma (8150/3)
  - SEER SINQ 20081049



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### Neuroendocrine vs. Carcinoid

- Neuroendocrine is an “umbrella” or “NOS” term that includes carcinoids.
  - For all sites, remember that all carcinoids are neuroendocrine.
  - Not all neuroendocrine are carcinoids.



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### Mixed Endocrine/Exocrine Carcinoma

- If a single tumor includes both an endocrine carcinoma (islet cell carcinoma (8150/3)) and an exocrine carcinoma (acinar carcinoma(8550/3)), code to mixed islet cell and exocrine adenocarcinoma (8154/3)
- See Table 2 in the Other chapter of the MP/H manual



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### Carbohydrate Antigen 19-9 (CA 19-9)

- Can be used to differentiate malignancy and inflammatory processes of the pancreas
- CA 19-9 levels may identify tumor progression or recurrence following definitive therapy
  - Presence of a normal CA 19-9 does not preclude recurrence



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### Mitotic Count

- High mitotic activity, a high degree of pleomorphism, and tumor necrosis have all been shown to correlate strongly with malignant potential.
- A low mitotic index is of little prognostic value, and many malignant tumors show little to no mitotic activity.



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### Serum Chromogranin A (CgA)

- Serum Chromogranin A (CgA) has been shown to be a useful marker for neuroendocrine tumors.



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### Treatment

- Poor survival rate with any stage of pancreatic exocrine cancer
- Clinical trials
  - Appropriate treatment alternatives for patients with any stage of disease



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**Treatment**

- Surgical resection is only potentially curative technique
  - More than 80% of patients present with disease that cannot be cured with resection
  - Median survival of resected patients ranges from 15-19 months
  - 5 year actuarial survival rate is about 20%



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**Criteria for Resection**

- No peritoneal or hepatic metastasis
- No abutment, distortion, thrombus, or venous encasement of the portal or superior mesenteric vein
- Must have a clear fat plane around the celiac axis, hepatic artery, and superior mesenteric vein



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**Work-up**

- Pancreatic protocol CT
- Pancreas protocol MRI
- Endoscopic ultrasound (EUS)
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Biopsy
  - CT guided
  - EUS guided (preferred)



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**Surgery**

- Pancreatoduodenectomy (Whipple procedure)
  - Removal of:
    - Distal half of the stomach (antrectomy)
    - Gall bladder and its cystic duct (cholecystectomy)
    - Common bile duct (choledochectomy)
    - Head of the pancreas
    - Duodenum
    - Proximal jejunum
    - Regional lymph nodes



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**Surgery**

- Distal pancreatectomy
  - Removal of the body and tail of the pancreas and spleen
- Total pancreatectomy
  - Similar to a Whipple, but the entire pancreas is removed
  - Patient will be required to take supplemental enzymes and insulin



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**Surgery Codes**

- 35: Local or partial pancreatectomy and duodenectomy
  - 36: WITHOUT distal/partial gastrectomy
  - 37: WITH partial gastrectomy (Whipple)
- 40: Total pancreatectomy
- 60: Total pancreatectomy and subtotal gastrectomy or duodenectomy



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**Chemotherapy/Radiation**

- Adjuvant Therapy
  - Chemotherapy
  - Chemoradiation
  - IMRT
- Neoadjuvant Therapy
  - Performed on patients that are borderline surgical candidates
  - Chemoradiation



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**Chemotherapy/Radiation**

- Primary Treatment
  - Intent is palliative and improved survival
- Chemotherapy
  - 5fu and Gemcitabine
  - Clinical trials
- Chemoradiation
- Radiation
  - IMRT



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Questions?

**QUIZ 1**



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Pancreas

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**COLLABORATIVE STAGE DATA COLLECTION SYSTEM**




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**CSV2 Pancreas Schemas**

Pancreas Schemas	ICD-O-3 Codes
Body and tail of pancreas	C25.1, C25.2
Head of pancreas	C25.0
Other and unspecified pancreas	C25.3-C25.4, C25.7-C25.9

- Assign primary site for islet tumors to pancreas subsite in which tumor arises




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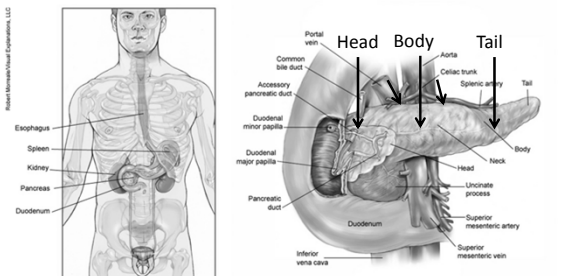

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**Pancreatic Tumor Location**


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### CS Tumor Size: Pancreas

- Assignment of T1 and T2 categories is based on tumor size
- Physician’s assignment of T category may be used to code CS Tumor Size if no other information is available
  - Code 992
    - Stated as T1 with no other information on tumor size
  - Code 993
    - Stated as T2 with no other information on tumor size



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### CS Extension: Pancreas

- Code 000 – in situ
  - Includes pancreatic intraepithelial neoplasia III (PanIn III)
- Codes 100, 150, 200, & 300
  - Tumor limited to pancreas
  - Assignment of T1 and T2 categories is based on tumor size
  - Use codes 150 & 200 to code CS Extension based on a statement of T with no other extension information available
- Codes 400 – 810
  - Tumor directly extends beyond the pancreas
    - Discontinuous involvement is coded in CS Mets at DX



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### CS Extension: Pop Quiz

- CT scan abdomen: 2.3 cm tumor of pancreas head, confined to organ.
- Exploratory laparotomy: Tumor in head of pancreas (cT2); multiple metastatic lesions of liver discovered upon liver palpation
- Biopsy of pancreas: Invasive ductal carcinoma



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### CS Extension: Pop Quiz

- What is the code for CS Tumor Size?
  - 023: 23 mm
  - 993: Stated as T2 with no other information on size
- What is the code for CS Extension?
  - 100: Confined to pancreas
  - 200: Stated as T2 with no other information on size
  - 630: Liver



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### CS Lymph Nodes: Pancreas

- Involvement of pericholedochal, superior mesenteric, and/or pyloric nodes
  - Code involvement in CS Lymph Nodes
    - Pancreas head
      - Code 110
    - Other pancreas
      - Code 100
  - Code involvement in CS Mets at DX
    - Pancreas body or tail
      - Code 07



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### CS Lymph Nodes: Pancreas

- Involvement of celiac axis and/or splenic nodes
  - Code involvement in CS Lymph Nodes
    - Pancreas body or tail
      - Code 110 for splenic node involvement
      - Code 210 for celiac node involvement
    - Other pancreas
      - Code 100
  - Code involvement in CS Mets at DX
    - Pancreas head
      - Code 05 for celiac node involvement
      - Code 07 for splenic node involvement



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**CS Mets at DX: Pancreas**

- Code 05
  - Head of pancreas schema
    - Distant lymph nodes: Celiac axis
- Code 07
  - Head of pancreas schema
    - Distant lymph nodes: Pancreaticosplenic and splenic
  - Body and tail of pancreas schema
    - Distant lymph nodes: Pericholedochal, superior mesenteric, and pyloric



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**CS Mets at DX: Pancreas**

- Code 10
  - Body and tail of pancreas
    - Distant lymph nodes other than in code 07
  - Head of pancreas
    - Distant lymph nodes other than in code 05, 07
  - Other and unspecified pancreas
    - Distant lymph nodes



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**CS Mets at DX: Pancreas**

- Code 40
  - Distant metastasis except distant lymph nodes
  - Seeding of peritoneum
  - Positive peritoneal cytology
  - Carcinomatosis



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**CS Lymph Nodes & CS Mets at DX:  
Pop Quiz**

- Distal pancreatectomy:
  - Op report: Large pancreatic tail tumor extending into fat. Liver palpated and no lesions identified. No lesions in peritoneal cavity.
  - Final pathologic diagnosis: Adenocarcinoma of tail of pancreas with extension into mesenteric fat. 1 of 3 mesenteric lymph nodes with metastasis.



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**CS Lymph Nodes & CS Mets at DX:  
Pop Quiz**

- What is the code for CS Lymph Nodes?
  - 000: No regional node involvement
  - 110: Anterior proximal mesenteric nodes; posterior proximal mesentery nodes; regional lymph nodes, NOS
  - 800: Lymph nodes, NOS
- What is the code for CS Mets at DX?
  - 00: No distant metastasis
  - 07: Superior mesenteric nodes
  - 99: Unknown



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**SSF1: Carbohydrate Antigen 19-9  
(CA 19-9) Lab Value**

- Record the highest pre-treatment CA 19-9 lab value
  - Exact value to nearest tenth in U/ml
- Record code 000 only if lab value is 0.0 U/ml
- Code any value less than or equal to 0.1 as 001
- Record the stated closest value for uncertain values



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**SSF1: Pop Quiz**

- Discharge summary: Patient had Whipple procedure for adenocarcinoma of body of pancreas. Pre-operative CA 19-9 was 0.04 U/ml.
- What is the code for SSF1?
  - 000: 0.0 U/ml
  - 001: 0.1 or less U/ml
  - 004



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**SSF2: Serum Chromogranin A (CgA) Lab Value**

- Record the highest pre-treatment CgA lab value
  - Exact value to nearest ng/ml
- Record code 000 only if lab value is 0 ng/ml
- Code any value less than or equal to 1 as 001
- Assign code 997 if there is no pre-treatment CgA lab value, but there is a stated interpretation of test result



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**SSF2: Pop Quiz**

- Discharge summary: Patient admitted with jaundice. Abdominal CT scan showed 2 cm tumor confined to head of pancreas. Pre-treatment CgA elevated. Resection of head of pancreas; well-differentiated neuroendocrine carcinoma.
- What is the code for SSF2?
  - 997: Test ordered, results not in chart
  - 999: Unknown



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**SSF3: Mitotic Count**

- Record mitotic count to nearest tenth of a mitosis
- Code mitotic count per 10 high power fields (HPF)
- Use codes 001-008 when mitoses reported as decimal number per 10 HPF
- Use code 009 when mitotic rate is 0.9 mitosis per 10 HPF OR stated as less than 1 mitosis per 10 HPF
- Use codes 010-100 when mitotic rate is between 1 and 10 mitoses per 10 HPF
- Assign code 996 if there is a denominator other than 10 HPF




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**SSF3: Pop Quiz**

- Final pathologic diagnosis from distal pancreatectomy: Neuroendocrine carcinoma of tail of pancreas
  - Record contains no information about mitotic count
- What is the code for SSF3?
  - 000: 0 mitoses per 10 HPF
  - 998: No histologic specimen from primary site
  - 999: Unknown




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**Standard Setters SSF Requirements  
CS v02.03: Pancreas**

- SSF1: CA 19-9 Lab Value
  - Not required: CoC, SEER, NPCR
  - Collect if readily available in clinical chart: Canadian Council of Cancer Registries
- SSF2: CgA Lab Value
  - Not required: CoC, SEER, NPCR
  - Collect if readily available in clinical chart: Canadian Council of Cancer Registries
- SSF3: Mitotic Count
  - Not required: CoC, SEER, NPCR
  - Collect if in pathology report: Canadian Council of Cancer Registries




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Questions?

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**QUIZ 2**



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**Coming up!**

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- **2/2/12**  
– Collecting Cancer Data: Lung
- **3/1/12**  
– Abstracting and Coding Boot Camp: Cancer Case Scenarios

**And the winners of the fabulous prizes are....**

80



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**Thank You!**

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