

December 2004 Monthly Memo

WHAT'S NEW:

THE FOLLOWING INFORMATION IS CURRENTLY AVAILABLE ON THE FCDS WEBSITE.

- 2003 FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY FOR 2000
- EDUCATION AND TRAINING WEB MODULES (Under Edu and Training)
- FCDS REGISTER VOL. 25

ON THE WEB:

- **UROLOGY HEALTH.ORG**
http://www.urologyhealth.org/adult/index.cfm?cat=04&topic=139-88k
- **MEDLINEPLUS MEDICAL ENDCYCLOPEDIA**
http://www.nlm.nih.gov/medlineplus/ency/article/000525.htm
- **INCIDENCE: KIDNEY AND RENAL PELVIS CANCER**
http://seer.cancer.gov/faststats/html/inc_kidrp.html



Abstracting, Coding, and Staging Kidney and Ureter Cancer

SEER Training Website: http://training.seer.cancer.gov/ss_module12_kidney/00_kidney_home.html

ICD-O-3 SITE CODES

RELATED ADJECTIVES

- Kidney = nephro-, renal
- Renal pelvis = Calyx, calyceal
- Ureter = ureteral

ICD-O-3 CODES

ICD-O-3	Term
	Kidney
C64.9	Kidney, NOS
	Renal pelvis
C65.9	Renal pelvis
	Ureter
C66.9	Ureter
	Other and unspecified urinary organs
C68.0	Urethra
C68.1	Paraurethral gland
C68.8	Overlapping lesion of urinary organs
C68.9	Urinary system, NOS

MORPHOLOGY AND GRADE

ICD-O-3 MORPHOLOGY CODES

If the diagnostic term in the pathology report is not in the list below, be sure to consult your ICD-O manual.

Adenocarcinomas (81403) of the kidney parenchyma are the most common (85% of all tumors).

Hypernephroma, renal cell carcinoma or Grawitz tumor (83123)

Clear cell (83103)

Papillary (82603)

Granular cell (83203)

Spindle cell (80323)

Transitional cell carcinoma—(81203) most common morphology in renal pelvis; may be a function of a urothelial field defect.

Papillary carcinoma—(81303)

Squamous cell carcinoma—(80703) < 15% of renal pelvis tumors

Other histologies

Wilms tumor (nephroblastoma; 89603)—large bulky tumor of childhood; rare in adults

Lymphoma (many cell types)

Sarcoma (many cell types)

Hemangiopericytoma (91503)

(Continued on page 5)

FCDS Q & A



QUESTION

Multiple Primaries--Kidney: How many primaries are reportable in a patient treated with a bilateral nephrectomy that revealed multiple tumors within each kidney and the histology in both the left and the right kidney was "renal cell carcinoma, indeterminate type: multiple histologically identical tumors" and the clinical discharge diagnosis was "bilateral renal cell carcinoma, probably surgically cured"?

ANSWER

See 'Rules for Determining Multiple Primaries' in Section II, Page 70, rule 6a of the FCDS Data Acquisition Manual. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has one

or two independent primaries. The following scenarios apply:

1. If it is determined that there are two independent primaries, two abstracts are to be prepared, each with the appropriate laterality and extent of disease information.

2. If it is determined that there is only one primary, laterality should be coded according to the side in which the single primary originated and a single abstract prepared.

3. If it is impossible to tell in which of the pair the single primary originated, laterality should be coded a '4' and a single record submitted.

In the example above, the physician will need to supply some additional information in order for the abstractor to determine which of these three scenarios apply.

QUESTION:

What is the correct primary site for cerebellopontine angle mass compatible with an acoustic neuroma?

ANSWER:

The correct primary site code would be C72.4, acoustic nerve. An acoustic neuroma is a benign slow-growing tumor of the nerve which connects the ear to the brain. The tumor is located at the base of the brain, where the auditory nerve leaves the skull cavity and enters the bony structure of the inner ear. Synonyms for acoustic neuroma include angle tumor, cerebellopontine angle tumor and vestibular schwannoma.





Deadlines & Reminders

2004 Jean Byers Award for Excellence in Cancer Registration

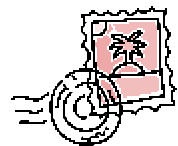
In accordance with national standards for evaluating completeness, FCDS will be awarding the 2004 Jean Byers Award for Excellence in Cancer Registration in November 2004. All facilities eligible for the award will be notified and an announcement will be made in the *FCDS Monthly Memo* and *The Register*. In order for reporting facilities (excluding Free-standing Ambulatory Patient Care Centers and Pathology Labs) to receive the Jean Byers Award for Excellence in Cancer Registration for the 2002 cancer case admissions, they must meet the following criteria:

1. Timeliness- All deadlines met with respect to the 2002 cancer case admissions
 - 2002 Annual Caseload Submission Deadline June 30, 2003
 - 2002 Death Certificate Notification Deadline- December 19, 2003
2. Completeness- All cases reported to FCDS
 - 2002 AHCA Audit Deadline – August 30, 2004
 - No more than 5% (or 35 cases, whichever number is greater) of the 2002 cancer case admissions reported to FCDS within 2 months (60 days) following the June 30, 2003 deadline (late reporting of 2002 cancer case admissions)
 - No more than 10% of the 2002 cancer case admissions reported to FCDS within 12 months following the June 30, 2003 reporting deadline. (Due to delinquent 2002 case reporting, missed cases found on Death Certificate Notification or missed cases found on AHCA Completeness Audit)

Pathology Laboratories

Every anatomic pathology laboratory that reads biopsy and surgical resection specimens collected from patient encounters within the state of Florida **MUST** electronically submit the specified data for every malignant cancer case. **Specimens read between January 1, 2004 and June 30, 2004 must be submitted to FCDS on or before December 31, 2004.**

(July 1, 2004 through December 31, 2004 are due June 30, 2005)



FCDS MAILING INFORMATION

For those facilities and physician offices that need to mail patient(s) medical records, please use our general mailing information listed below.

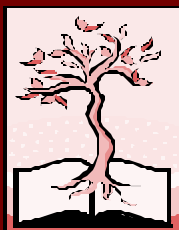
In order to protect and properly handle all packages, particularly those containing confidential patient information, we ask that US Postal Service mail including Express mail, Priority mail, and Certified mail be sent to the PO Box address below:

FCDS/University of Miami School of Medicine
P. O. Box 016960 (D4-11)
Miami, FL 33101

FCDS STREET ADDRESS SHOULD ONLY BE USED FOR COURIER PACKAGES

(Federal Express, UPS, Airborne Express)

FCDS/University of Miami School of Medicine
1550 NW 10th Ave, Fox Bldg
Room 410
Miami, FL 33136



FCDS

WEB-MODULES

Education and Training

- **Reporting Requirements for Intracranial and CNS Tumors**, Presented by Stuart Herna
- **Data Access for Dept. of Health Personnel and Approved Researchers**, Presented by Jill MacKinnon
- **Collaborative Staging Part 1 & 2**, Presented by Stuart Herna
- **Correct/Delete Single Entry Records**, Presented by Mark Rudolph

The Florida Cancer Data System (FCDS) is pleased to announce the FCDS Web Training Modules, now available on the FCDS website at <http://fcds.med.miami.edu>, under Education and Training. The modules are designed to assist registrars and their staff with clarification on rules, reporting requirements, data definitions, policies, and procedures.

NCI/THE
ROLLINS

The National Cancer Institute in collaboration with the Rollins School of Public Health at Emory University is pleased to announce the availability of a new web-based training module on **Pancreatic and Biliary Cancer**.

This new training module is now available at:
<http://www.training.seer.cancer.gov>

EDIT #0032

Edit #0032, Patient has multiple primaries and dx confirmation is not equal to 1, 2, 4, or 5 on all sequences, has been changed from a warning to an edit. An edit override (Force) is required by NAACCR, therefore, documentation of the diagnostic method must be submitted for all cases that receive this edit.

THE 2004 FCDS DATA ACQUISITION

The 2004 FCDS Data Acquisition has been updated. Replacement pages are available on our website. Please visit www.fcds.med.miami.edu to download the updated pages.



Abstracting, Coding, and Staging Kidney and Ureter Cancer (Cont'd)

(Continued from page 1)

Grade of tumor correlates with stage; superficial tumors are usually grade I-II; infiltrating tumors are commonly grade III-IV.

Synonyms for in situ carcinoma: CIS, Stage 0, CIN grade III, confined to epithelium, intraepithelial, involvement up to but not including the basement membrane, noninfiltrating, noninvasive, no stromal involvement, papillary noninfiltrating, noninvasive papillary, stage "Ta".

EXTENT OF DISEASE EVALUATION

COMMON METASTATIC SITES

If the diagnostic term in the pathology report is not in the list below, be sure to consult your ICD-O manual.

Spread	Primary Site/Mets
LYMPHATIC SPREAD	Common iliac lymph nodes are second station (metastatic) nodes.
HEMATOGENOUS SPREAD	Lung, bone, liver; brain (from kidney parenchyma). kidney and ureter cancer can grow through the renal vein and vena cava directly into the heart.

EXTENT OF DISEASE EVALUATION

DEFINITIONS

Key words/possible involvement:

Terms which indicate possible involvement by tumor. Common terms are provided, but the list is not all-inclusive.

Other words/no involvement: other terms seen in reports which indicate an abnormality but do not indicate a neoplastic process. Common terms are provided, but the list is not all-inclusive.

Key information: information to look for in the report of the study. Key information helps define the extent of disease.

DIAGNOSTIC STUDIES

Physical Exam

Key information: abdominal mass, flank mass, abdominal distention, accessible lymph nodes, secondary masses; abdominal tenderness, organomegaly (hepatosplenomegaly, hepatomegaly, splenomegaly), fluid wave.

Laboratory Studies

Alkaline Phosphatase

Urinalysis

BUN (Blood Urea Nitrogen)

Renal Function Tests urine chemistry (protein or albumin) tests to measure the output of the kidneys

Liver Function Tests (LFT)

Imaging

Key information: size and location of primary tumor, extension into pubic bone; spread to adjacent tissues or organs; regional lymph nodes; sites of distant organs or lymph nodes involved.

KUB (Kidneys-Ureters-Bladder) x-rays to evaluate the status of the urinary system. No dye is injected during the procedure. Also called: abdominal flat plate, plain films of abdomen.

Key words/involvement: stricture, mass, mass effect, metastases, lytic lesion, osteolytic lesion, blastic lesion, osteoblastic lesion, surface irregularities of bladder, filling defect in the bladder, non-functioning kidney, nonvisualized kidney, ureteral obstruction.

Other words/no involvement: if there is no specific reference to visible abnormality in the urinary tract.

IVP (Intravenous Pyelogram) series of x-rays which evaluate the structure and function of the kidney, ureters and bladder after radiopaque dye has been injected intravenously. Also called: pyelography, excretory urogram, excretion urography. Excludes: KUB (Kidneys-Ureters-Bladder) radiography during which no dye is used.

Key words/involvement: stricture, mass effect, metastases, lytic lesion, osteolytic lesion, blastic lesion, osteoblastic lesion, surface irregularities of bladder, filling defect in the bladder, non-functioning kidney, nonvisualized kidney, ureteral obstruction.

Other words/no involvement: if there is no specific reference to visible abnormality in the urinary tract.

Retrograde Pyelogram series of x-rays to evaluate the upper urinary tract by using a cystoscope to insert catheters through ureters to level of renal pelvis and inject radiopaque contrast dye. The pelvis, calyces and ureter of a kidney are visualized during this procedure. Retrograde pyelogram is useful if intravenous pyelography is inadequate due to nonvisualized kidney. Also called retrograde pyelography.

Key words/involvement: mass, stricture, lesion, filling defect, extrinsic mass, narrowing, metastases, non-functioning kidney.

Other words/no involvement: if there is no specific reference to visible abnormality in the urinary tract.

(Continued on page 6)

Abstracting, Coding, and Staging Kidney and Ureter Cancer (Cont'd)



(Continued from page 5)

Nephrotomography radiographic evaluation of kidneys by taking films of serial, thin sections of renal tissue. Also called: renal tomography, renal tomos. Excludes: computerized tomography of the lungs and plain x-rays of the kidneys.

Key words/involvement: lesion, irregular density, space occupying lesion, cavitary lesion, homogenous parenchymal lesion with sharply defined margins, multiple opacities, metastases.

Other words/no involvement: if there is no specific reference to visible abnormality in the lungs; references to calcifications, hamartomas, angiomyolipoma, granulomas, cysts, vascular abnormalities, and other benign conditions.

Renal Angiography invasive radiographic procedure that injects dye into renal vessels to determine the location of and blood flow to a kidney tumor. The contrast material visualizes both the renal blood vessels and the collecting systems. Also called: digital intravenous angiography, digital fluorography, renal arteriography, renal venography, renal angiogram

Key words/involvement: stricture, mass, mass effect, extrinsic mass, metastases, filling defect, obstruction, space occupying lesion, neovascularization, vascular parasitization.

Other words/no involvement: if there is no specific reference to abnormality of the renal vasculature; references to cysts, hamartomas, angiomyolipomas

Renocystogram x-rays to visualize the bladder, ureters and kidneys after the introduction of intravenous radiopaque contrast material.

Key words/involvement: stricture, mass, mass effect, metastases, filling defect in the kidney or bladder, nonfunctioning kidney, ureteral obstruction

Other words/no involvement: if there is no reference to abnormality in the urinary tract

Renal Ultrasound a non-invasive technique to locate abnormalities in the kidney and renal pelvis by recording the patterns of sound waves reflected by tissues. Also called: ultrasonography, echography, sonography, kidney ultrasound, sonogram. The report is sometimes called a scan.

Key words/involvement: density, mass effect, area of increased attenuation, abnormal density, abnormal echo, cystic mass

Other words/ no involvement: if there is no specific reference to mass, density, metastases, or lesion

Imaging, Abdomen/pelvis

Imaging, Bone

Imaging, Brain

Imaging, Liver/spleen

Tumor Markers

Key information: prognostic (what treatment to use if the tumor should recur).

CEA (Carcinoembryonic Antigen)—a blood test measuring the presence of an antigen in malignancies arising in enterodermal (embryonic) or gastrointestinal tissue. Persistent elevated levels indicate residual or recurrent metastatic carcinoma. CEA assay is non-specific for identifying a kidney and ureter cancer, but it does indicate the presence of malignancy. Smokers may have an elevated CEA without malignant disease.

Normal range: <2.5 ng /ml. Normal range may vary somewhat depending on the brand of assay used. Levels > 10 ng/ml suggest extensive disease and levels > 20 ng/ml suggest metastatic disease.

Endoscopies

Key information: largest size of tumor, gross description of tumor, presence of multiple tumors, degree of induration of ureteric wall, extension outside of organ (kidney or ureter).

Cystoscopy

Cystourethroscopy

Ureteroscopy

Operative Report

Key information: surgeon's description of involved tissues and nodes; fixation of bladder; invasion of adjacent organs; exact location of lesion(s); description of epithelial surface of bladder.

Examination under Anesthesia (EUA)

Pathology

Key information: cell type; depth of invasion (mucosa, submucosa, muscular layer, perivesical fat, serosa and connective tissue); size of lesion; adjacent tissue involved (prostate, urethra, parametrium); involvement of regional lymph nodes; multifocal tumors

Cytology Reports

KIDNEY AND URETER CANCER STAGING

Criteria for TNM Clinical Staging: Physical examination and history, histologic confirmation of tumor, urinary endoscopy, urinary cytology, pyelography, imaging (radiographic and computer assisted), and other evaluations to de-

(Continued on page 7)



Abstracting, Coding, and Staging Kidney and Ureter Cancer (Cont'd)

(Continued from page 6)

termine metastatic involvement; laparotomy may be included in clinical staging.

Criteria for TNM Pathologic Staging: Radical nephrectomy, including removal of the primary tumor, entire kidney, adrenal gland, perinephric fat, Gerota's fascia, renal vein and lymph node resection are required for pathologic staging. For renal pelvis and ureteral cancers, the ureter and a portion of the bladder (bladder cuff) should also be resected.

AJCC 6th Edition--KIDNEY		AJCC 6th Edition—RENAL	
Stage I	Primary < 7cm	Stage 0a	Noninvasive papillary carcinoma
Stage II	Primary > 7cm	Stage 0is	Carcinoma in situ
Stage III	Perinephric tissue* within Gerota's fascia	Stage I	Subepithelial connective tissue invaded
	One positive regional node	Stage II	Muscularis invaded
	Vena cava	Stage III	Beyond muscularis into peripelvic/ periureteric fat or renal parenchyma
Stage IV	Beyond Gerota's fascia > 1 positive regional node Distant metastases	Stage IV	Adjacent organs, through kidney into perinephric fat, any positive node(s), distant metastasis

*adrenal gland, fat, renal veins

Abstracting Keys

The terms lamina propria and submucosa can be used interchangeably because these structures tend to merge when there is no muscularis mucosae.

Invasion of the mucosa may be interpreted by the pathologist as either in situ or invasive; determine whether the pathologist is describing in situ or localized tumor.

If the depth of invasion is not specified by the pathology report, code as T1, invasion of subepithelial connective tissue.

CT scanning is as good as MRI for determining the size and extent of renal masses.

Superficial muscle invasion is defined as less than half-way through the muscle coat (three layers).

Deep muscle invasion is considered half-way or more through the muscle coat.

If the depth of muscle invasion is not stated by the surgeon or pathologist, stage as T2, invasion of superficial muscle.

There is a high degree of correlation between the grading (differentiation or aggressiveness) of the tumor and the stage (invasiveness).

It is important to have a good surgical or biopsy specimen so that muscle layers can be seen and assessed. The prognostic dividing line is between T2 and T3, so read carefully the description of the depth of muscle invasion.

In the AJCC staging system for Tumor, the suffix "m" may be added to indicate a multifocal tumor; such as T2m.

Cystectomy is usually not considered a treatment option unless the stage is at least Stage II, unless the tumor is superficially extensive.

Papillary and in-situ tumors can have a long protracted course with multiple recurrences and then suddenly become invasive.

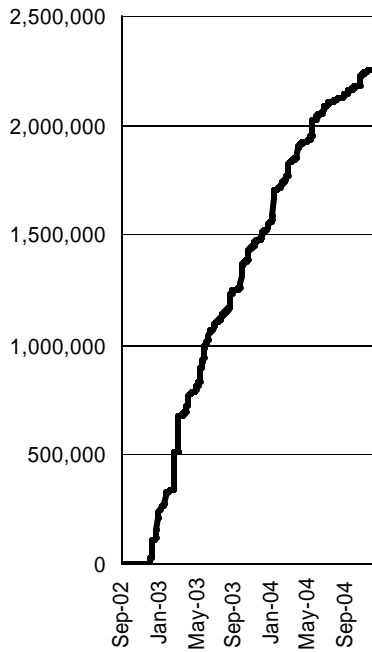
Primary kidney and ureter cancer (hypernephroma) is more unpredictable than most solid tumors. Metastases have been identified in sites as finger tips, eyelids and nose. The primary tumor and/or distant metastases may spontaneously regress.



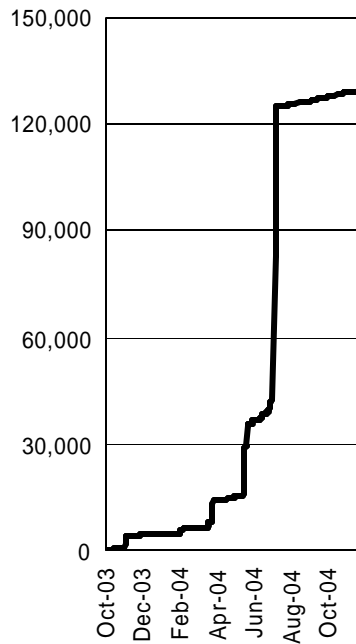
Florida Cancer Data System

Pathology & Radiation Reporting

Path



Radiation



PROJECT DIRECTOR:
Lora Fleming, MD, PhD

ADMINISTRATIVE DIRECTOR:
Jill Mackinnon, CTR

EDITORIAL STAFF:
Mark Rudolph, M.S.
Mayra Alvarez, RHIT, CTR
Melissa K. Williams

CONTRIBUTORS:
Kelly Large, CTR
Megsys Herna, CTR



66046E

P.O. BOX 016960 (D4-11)

MIAMI, FL 33101

